



Hiram Davis Medical Center

Plans for Safe, Successful Transitions

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The closure process was initiated to avoid a crisis-driven emergency evacuation




Key infrastructure risks:

- HVAC deterioration
- Aging building systems: plumbing, electric, etc.
- Legionella still exists but remediated to “safe” levels
- Inability to renovate while occupied
- Risk of emergency evacuation

Key operational realities:

- Facility built in 1974
- No major renovations in 50 years
- Major repairs require full vacating for ~24 months
- Estimated renovation cost: \$94M+
- Rebuild estimate: \$145M+



Current Census		28
 Current Building Occupancy		30%
 Discharges Currently Planned		5
 Patients Still Needing Placements		23

Admissions to HDMC During the Past Two Fiscal Years	
Source (FY25 – FY26)	Admissions
State Facilities	30
Community	11



Over the past two years, 73% of referrals came from state facilities. Community admissions averaged less than 6 per year. All admissions were short-term stays.

All placements are based on clinical need, informed choice, and support requirements.



SEVTC Skilled Nursing

Who: I/DD Diagnosis/Formal Training Center

- Two homes being renovated
- Skilled nursing certification
- Approximately 4 HDMC individuals
- Capacity can be adjusted based on resident choice



Existing Community Placement

Who: Complex Medical with I/DD, MH, and/or dementia

- Waiver Homes
- Intermediate Care Facilities (ICFs)
- Nursing Facilities
- Specialized Settings



Community Development







Who: Complex Medical with I/DD, MH, and/or dementia

- Identify Supports
- Equipment
- Specialized Training
- Provider Capacity-Building for Complex Medical or Behavioral Support Needs



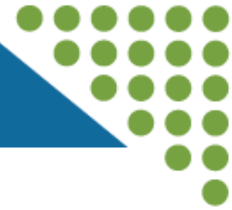
Placement decisions must balance individual choice, clinical need, and least restrictive environment principles.

DBHDS is using an established, individualized discharge process.

	Individualized choice-based planning
	Family/authorized representative involvement
	Pre-move meetings
	Staff/provider training
	Trial visits
	Post-transition monitoring

This is the same comprehensive process used when Virginia closed four training centers and moved over 800 individuals to new community settings from 2014-2020. It requires planning, coordination, and time. 





Community Service Delivery & Oversight

Community provider contracts and service partnerships

Workforce, training, and technical assistance supports

Sustainability through telehealth, funding, and capacity monitoring



Quality, Safety & Risk Management

Provider qualification standards

Pre-admission readiness reviews

Incident reporting & human rights protections



Governance, Reporting & Accountability

Integrated transition workplan

Monthly performance reporting

Progress updates



Stakeholder Engagement & Communication

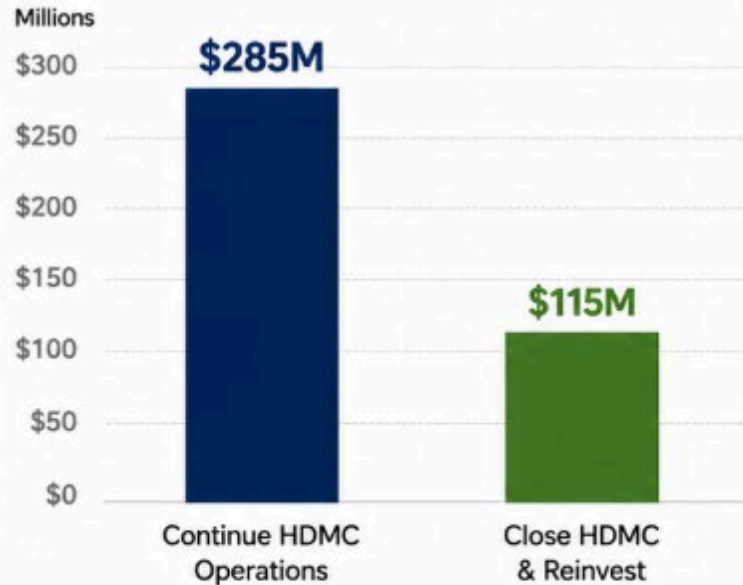
Family engagement & transition liaisons

Staff transition support

Provider readiness & outreach



FINANCIAL IMPACT OVER 6 YEARS



 Projected savings of **\$170M**

REINVESTMENT PRIORITIES



Community Capacity

- SEVTC skilled nursing homes
- Community residential development
- Provider start-up grants
- Behavioral health supports



Clinical Services

- Specialized medical equipment
- Shared clinical services at Central State



Workforce

- Workforce training
- SEVTC skilled nursing homes



Reinvesting in community services strengthens behavioral health capacity, supports individuals and families, and builds a more sustainable system for the future.