DBHDS

Hiram Davis Medical Center

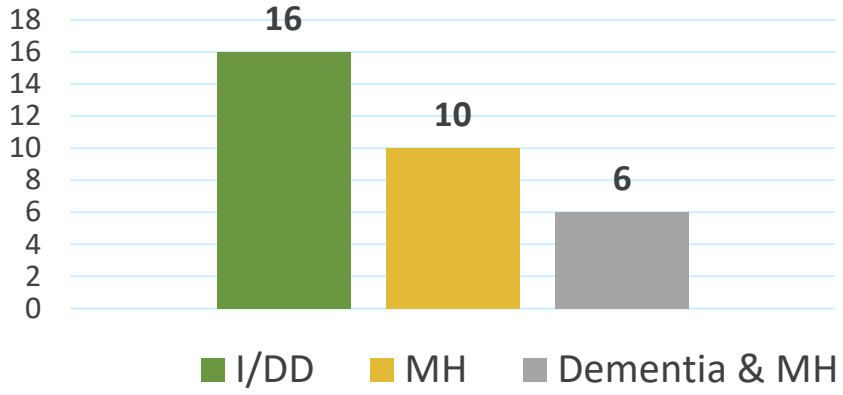
Closure Plan to Ensure Safe Patient Discharges and Successful Staff Transitions

Nelson Smith, Commissioner
Department of Behavioral Health & Developmental Services

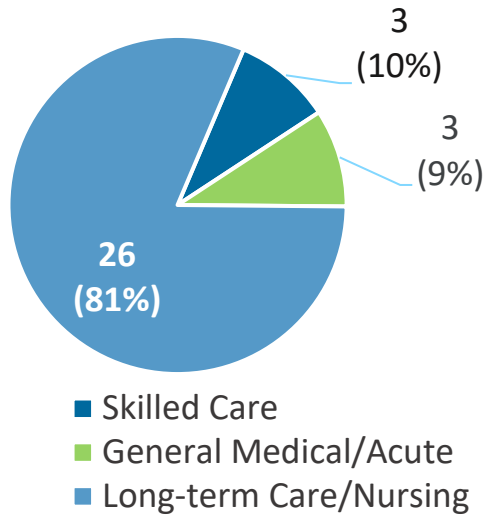
Current HDMC Patient Snapshot

This planning process has included all patients regardless of diagnosis

Current Census	32
Current Occupancy	**34%**
Percent census reduction since 8/2024 closure announcement	**26%**
Discharges currently planned	**6**
Patients who still need placements	**26**



Diagnosis



Beds by Care Level

§ 37.2-316 Planning Team

Included **families, staff, advocates, CSBs, providers, and officials**

28 public meetings held; all recorded and posted online

Dedicated webpage with agendas, presentations, reports, and recordings

Email box for feedback anytime from anyone

Public comment offered at every meeting

All subgroup reports and the full plan **posted online**

2-week public comment period on draft closure plan

1. **Supporting Patients** – Transition individuals to services in the locality of their residence prior to admission or the locality and setting of their choice.

2. **Supporting Staff** – Resolution of issues on the restructuring implementation process, such as employee transition planning and appropriate transitional benefits.

3. **Building and Enhancing Community Services**
   - New and expanded community services needed
   - Plan for community services infrastructure for current and future capacity needs
   - Creation of new and enhanced community services

Options Considered

Planned closure & transition	Add on to new CSH	Renovate existing HDMC	Renovate a CSH building	Rebuild a smaller HDMC
• Uses existing community and SEVTC capacity • Enables reinvestment to community services • Minimizes disruption • Prioritizes person-centered placements and staff stability	• Lack of space at the new site • Federal CMS rules prohibit reimbursement for skilled nursing within an Institution for Mental Disease (IMD) such as CSH	• Would require a full 24-month evacuation of all patients and staff with no guarantee of return • Triggers complete CMS recertification and major Code upgrades	• Building 93 was considered, but it is not designed for hospital use • Would require total rebuild - full gut renovation and CMS recertification as a hospital • Incompatible with life-safety, accessibility, and medical-gas standards for skilled-nursing care • Would remove evacuation capacity • With systems at risk of failure before construction is complete, DBHDS cannot ensure safe operations through a years-long renovation, increasing the likelihood of unplanned evacuations, patient care disruption, and staff displacement	• Extremely costly compared to community alternatives • No viable site • HDMC census continues to decline with limited demand • Most states rely on community care rather than stand-alone centers • Like renovation, extremely high safety and cost risks during procurement and construction of a rebuild

*CSH = Central State Hospital

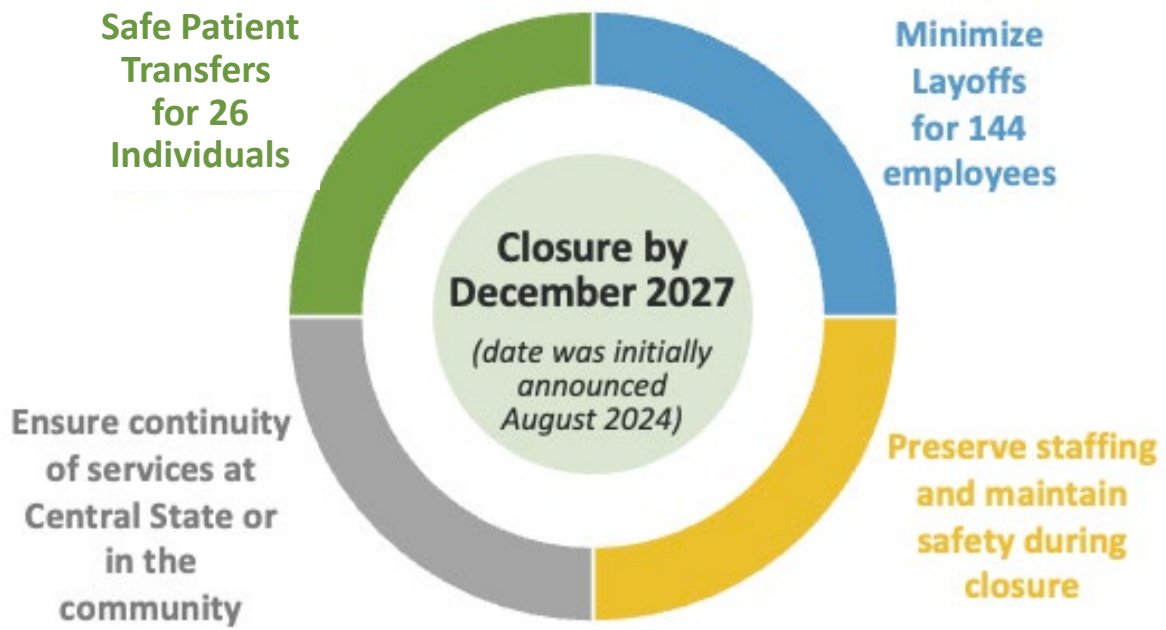
Operations During Transition

Admissions Policy Aligned to Closure – Cease new permanent admissions. Limit temporary admissions from DBHDS facilities to time-limited, clinically-necessary cases approved by a centralized review; discharge plan must be in place with a preference to stabilize and discharge to community settings.

Life Safety and Infection Control – Maintain rigorous life-safety practices and infection control; continue all monitoring, mitigation, and contingency planning while census declines.

Placement Data and Progress Management – Track and report monthly: census, transition status, barriers, and anticipated discharge dates. Use a dashboard or similar method to drive case conferences and unblock barriers.

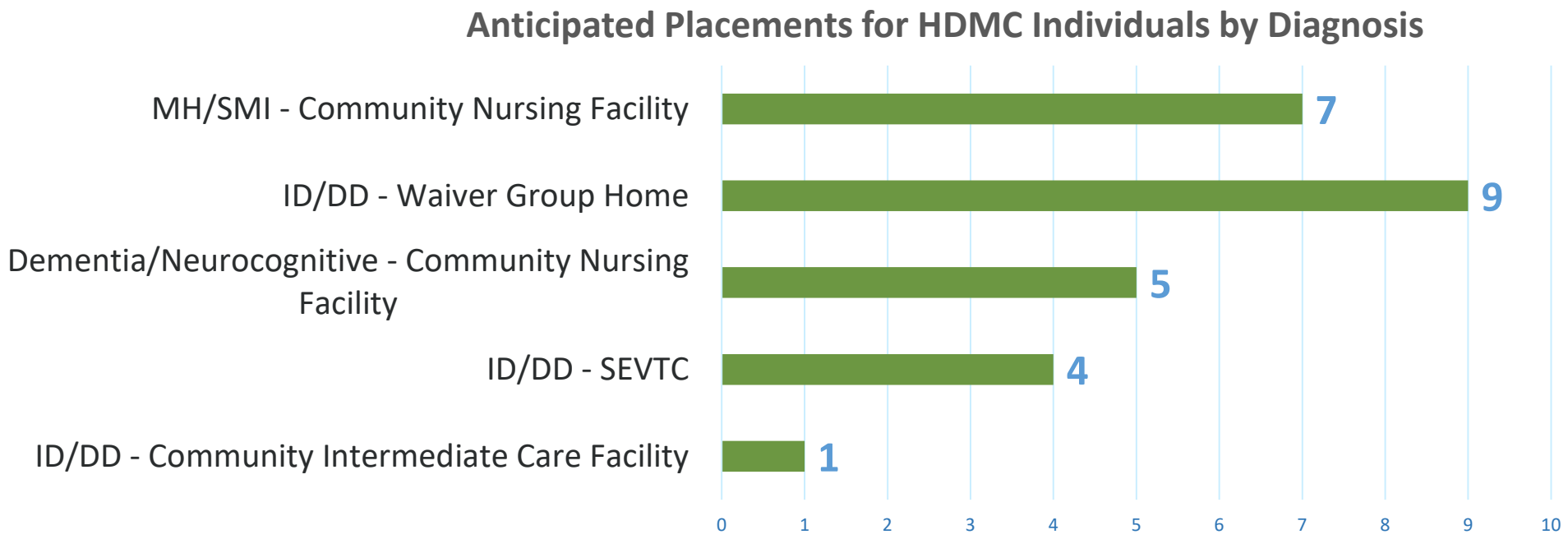
Communications – Issue regular updates to families/guardians and staff; maintain a public webpage with information; provide a single point of contact for transition questions.



Anticipated Locations
(as of Oct 29, 2025)

Of the 32 patients currently at HDMC:

- 6 discharges are currently planned
- Based on conversations with individuals and families, DBHDS *anticipates* the placement options for the **remaining 26 people** may be chosen as shown to the right:



Diagnosis	Anticipated Location	Count
Mental Health/Serious Mental Illness (MH/SMI)	Community Nursing Facility	7
Intellectual Disability/Developmental Disability (ID/DD)	Waiver Group Home	9
Dementia/Neurocognitive	Community Nursing Facility	5
Intellectual Disability/Developmental Disability (ID/DD)	Southeastern Virginia Training Center	4
Intellectual Disability/Developmental Disability (ID/DD)	Community Intermediate Care Facility	1
	Total	**26**

Based on conversations with families, DBHDS anticipates the current **14 patients with ID/DD** who have not selected a new home will choose:

- Medicaid Waiver group homes (9)
- SEVTC (4), or
- Community intermediate care facilities (1)

Once families choose a new location, DBHDS will work with them to identify providers and carefully plan safe transitions

Individuals with ID/DD

Medicaid Waiver group homes, sponsored residential homes, community Intermediate Care Facilities (ICF/IID), and community nursing facilities when medically necessary.

- Execute one-time development supports for community providers (start-up, equipment, specialized training) to develop capacity for complex medical/behavioral support.
- Utilize DBHDS' established discharge process (choice-based, team- driven) to plan and execute moves.
- Prepare SEVTC to meet skilled nursing/long-term care standards (environmental modifications, equipment, policies/procedures) and upskill/hire staff to required certifications.

Plans for Individuals with ID/DD at Southeastern Virginia Training Center (SEVTC)

For those who select state facility care, SEVTC will be readied to accept those with ID/DD and enhanced medical needs:

- **Availability** – DBHDS anticipates 2 homes (5 beds each) will meet immediate need.
- **Construction** – Skilled nursing beds to be licensed and CMS-certified. The General Assembly provided $3M for renovations for bathrooms, lifts, oxygen delivery, nurse call, ventilation, ADA requirements.
- **Staffing** – Upskill and hire additional staff to meet certification requirements for skilled nursing beds.

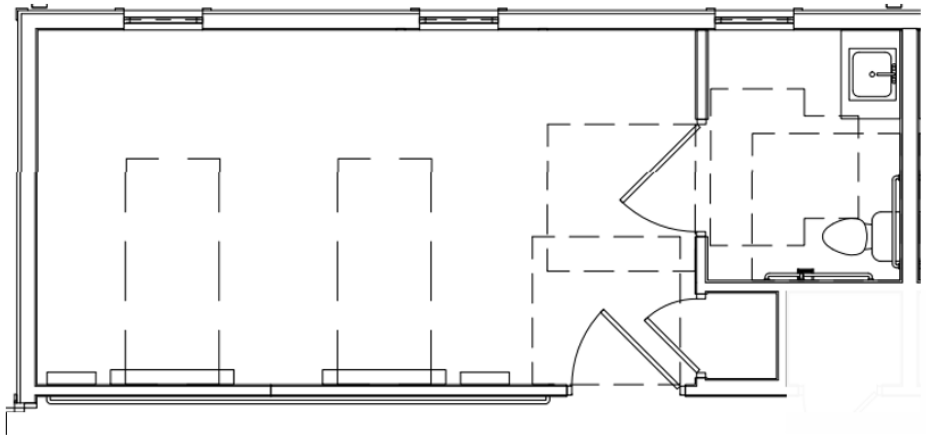
Southeastern Virginia Training Center (SEVTC)

SEVTC Plans for CMS-Certified Skilled Nursing Beds

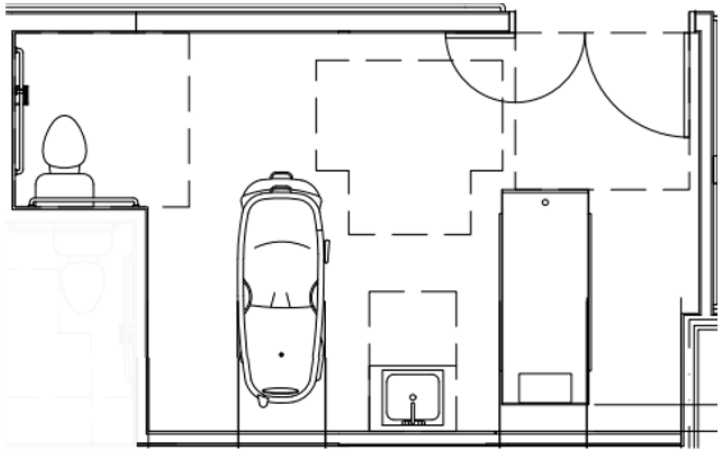
Construction Timeline

NOV 2025	DEC 2025	JAN 2026	FEB 2026	MARCH 2026	APRIL 2026	MAY 2026
Construction Begins →						Open Certified Beds

Preliminary Floor Plans



Bedroom #1 – 2 beds



Hall Bathroom with trolley gurney and a shower

https://youtube.com/shorts/HTUJjRVUCrM?feature=share

Plans for Patients with Serious Mental Illness (SMI) and Dementia/Neurocognitive Disorders

- Specialized mental health group homes with medical supports, memory care units, and community nursing facilities with behavioral capacity.
- Maintain/expand provider contracts for mental health and memory care individuals.
- Behavioral consultation in nursing facilities to reduce disruptions/hospitalizations.
- Crisis linkages (mobile crisis, step-up/step-down) for stabilization during and after transition.

DBHDS anticipates the current **12 patients with SMI and dementia/neurocognitive disorders** will choose community nursing facilities. DBHDS has contracts with providers who can support HDMC patients with SMI, dementia, or neurocognitive disorders.


Gateway


Waverly Rehabilitation and Health Care Center

Plans for VCBR and Special Hospitalization Patients

Special Hospitalization Alternatives (for other DBHDS Facilities) – Replace HDMC ‘special stays’ with contracted community stabilization/rehabilitation. Standardize referral protocols, acceptance criteria, and hospitals/nursing facility agreements to ensure timely admissions.

Individuals with VCBR Histories – Identify providers with appropriate safeguards and competencies and provide technical assistance for risk management, care planning, and coordination with legal and public safety partners.

Virginia Center for Behavioral Rehabilitation

Cross-Cutting Standards for all Patient Transitions

Individualized transition plan (ITP)	Ensure all ITPs cover medical, behavioral, social, communication, and mobility needs, developed with the individual and their AR.
Pre-move planning	Records transfer, medication reconciliation, durable medical equipment and supplies, transportation, staffing handoffs, and benefits/billing readiness.
Choice and trialing	Offer a range of qualified providers and, when feasible, trial visits, gradual transitions, or virtual tours to support informed choice and reduce anxiety and improve outcomes.
Care continuity	Align prescribers, pharmacies, therapies, and specialty clinics before moving dates; schedule post-move follow-ups.
Post-transition monitoring	Expand monitoring to include health and safety outcomes, patient and family/guardian satisfaction, and quality-of-life measures, with follow-up case conferencing. Intensive check-ins at 72 hours, 14/30/60/90 days, quarterly for one year; rapid response supports.
Therapies & specialty medical services	Ensure continuity of physical, occupational, speech, dental, behavioral health therapies during transition, alongside medication and pharmacy continuity.

Plans for Community Services Build & Continuity

Replace Former HDMC Services – Cover through CSH and community partners: pharmacy; laboratory; radiology; dental (incl sedation); PT/OT/speech/recreational therapy; podiatry; internal medicine; general surgical consults; gynecology; and palliative/end-of-life.

Capacity Development & Funding Approach – One-time start-up grants for providers that commit to serving complex needs. Leverage Medicaid reimbursement and targeted contracts for sustainability.

Access and Coordination

- Coordinate referrals via CSBs/facility services; set clear service standards, monitor utilization and track outcomes.
- Provide transportation supports where needed.
- Formal evaluation of community service capacity with outcome measures.
- Regional mapping to ensure as many services as possible near home communities.

Community Services Delivery Channels

Community Contracts	Contract with community providers to deliver specialty services close to where people live
Mobile/ Telehealth	Use mobile and telehealth in rural/underserved areas and to support post-placement stability
Outpatient Services	Expand outpatient clinic capacity (dental, rehabilitation, specialty medical, and therapies) through community providers, supplemented by mobile and telehealth services to reach underserved areas
Training Program	Implement a nursing facility training and consultation program in partnership with VDH, consistent with Executive Order 52 (Aug 2025), to strengthen oversight and quality in nursing homes
Long-term Stability	Incorporate long-term sustainability measures (*e.g.*, Medicaid rate adjustments and carry-forward funds where permissible) to ensure expanded community services are viable beyond start-up grants
Workforce	Establish workforce development strategy for community providers – specialized training, recruitment/retention supports
Education	Incorporate community education and technical assistance for families, CSBs, and providers to ensure clarity about new service pathways and how to access supports

Plans for Staff - Ensuring Workforce Stability

Goals – Maintain safe staffing; minimize layoffs by placing HDMC staff into comparable DBHDS roles; retain critical skills across the system.

Retention and Stability

- Progressive bonuses for staff who remain longer, enhanced amounts for hard-to-fill clinical roles.
- Scheduling flexibility, training access, and recognition incentives to stabilize teams.
- Regular updates on closure progress, job openings, transition resources, other employee assistance.

Retirement-Eligible Staff – Benefits counseling and clear retirement timelines to support informed decisions while ensuring coverage.

As of October 31, 2025

Location Preferences of HDMC Staff	# of staff	%
Central State Hospital	89	64%
Burkeville Campus (Piedmont Geriatric & VA Center for Behavioral Rehabilitation)	13	9%
Central Office	3	2%
Eastern State Hospital	3	2%
Southeastern Virginia Training Center	1	1%
Retiring	20	14%
Leaving State Service	6	4%
Unknown	5	4%
Total	**140**	100%

Plans to Keep Staff in the DBHDS System

Placement Pipeline

- **Move 36 staff** (25% of current staff) to CSH
- **Preferential hiring** at DBHDS facilities, (*e.g.*, CSH, SEVTC, VCBR, Piedmont Geriatric, and Central Office) plus moving assistance over 50 miles
- **Training and career development** - Provide cross-training and credentialing pathways
- Career counseling, resume and interview support

HDMC Departments Moving to New CSH	Full-time	Wage
Dental	5	
Pharmacy	14	
Laboratory	5	2
Radiology	3	
Physical Therapy	3	
Other Therapies	4	
Total	**34**	**2**

Note: Many more staff may move from HDMC to CSH through preferential hiring.

Renderings of the new Central State Hospital

Quality and Communication

Quality, Safety, & Risk Management	• Provider qualification standards • Readiness reviews pre-admission • Incident reporting & corrective action plans • Contingency placements for denials • Maintain civil/human rights protections
Governance, Reporting, & Accountability	• DBHDS project management structure • Integrated workplan: patients, staff, community • Monthly reports: placements, readmissions, incidents, staffing, service continuity • Regular public updates
Stakeholder Engagement & Communication	• Family meetings and transition liaisons • Staff HR clinics and vacancy bulletin • Provider readiness sessions/TA • Legislative/local government updates

6-Year Fiscal Analysis

6-year cost to continue HDMC: $285M (including renovations, downtime)

HDMC Continual Operations							
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	6 Year Total
HDMC Operating Costs	$18,625,415	$15,347,342	$28,654,485	$29,514,120	$30,399,543	$31,311,529	$153,852,435
Loss of Revenue	$14,400,822	$14,400,822					$28,801,644
DD Community Services General Fund	$590,000	$607,700					$1,197,700
DD Community Services Medicaid Waivers or ICF	$3,637,000	$3,746,110					$7,383,110
HDMC Capital Renovation Cost	$94,110,000						
TOTAL 6 YEAR IMPACT	**$285,344,888**						

- There is only one estimate to renovate HDMC at $94M. This estimate was used for the above, but this is for more beds than a rebuild of HDMC would need
- A new professional estimate would be needed to provide a smaller bed count, or a new build
- The new Central State Building is not conducive to an addition

6-Year Fiscal Analysis

HDMC Closure

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	6 Year Total
HDMC Operating Costs	$21,926,364						
Shared Service CSH	$6,728,121	$6,929,965	$7,137,864	$7,352,000	$7,572,560	$7,799,737	$43,520,246
Medical Staff and Supplies for MH Facilities	$1,216,478	$596,478	$596,478	$596,478	$596,478	$596,478	$596,478
Retention Bonus Costs	$3,000,000						
SEVTC Operating Costs	$2,019,322	$2,079,902	$2,142,299	$2,206,568	$2,272,765	$2,340,948	$13,061,802
DD Community Services General Fund	$590,000	$607,700	$625,931	$644,709	$664,050	$683,972	$3,816,362
DD Community Services Medicaid Waivers or ICF	$3,637,000	$3,746,110	$3,858,493	$3,974,248	$4,093,476	$4,216,280	$23,525,607
WTA Costs	$2,000,000	$500,000					
Total	**$41,117,285**	**$13,960,155**	**$14,361,065**	**$14,774,002**	**$15,199,328**	**$15,637,414**	**$115,049,249**
SEVTC Capital Costs	$4,500,000						
Potential Sale of HDMC	$13,042,367	FICAS Study 2017					
TOTAL 6 YEAR IMPACT	**$119,549,249**						

- **Estimated savings -** $170M – reinvested in community and SEVTC
- **Key investments -** SEVTC renovations, workforce support, CSH shared services, community provider fund

Timeline and Next Steps

- **November 2025:** Final closure plan submitted to the Governor and JCHC for review and General Assembly approval
- Final approval rests with the Governor and the General Assembly
- DBHDS will incorporate any Governor or GA feedback or revisions
- Following final approval, DBHDS would follow the phased plan below: