

## VII. Institutional Supports

### A. Introduction to Institutional Services

This chapter focuses on two types of institutions in Virginia that serve individuals with intellectual (ID) or other developmental disabilities (DD): (1) state- and non-state-operated facilities certified as **Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)**, and (2) **nursing facilities** licensed by the State but operated by local public agencies and private nonprofit or for-profit organizations. Note that in this *Assessment*, all references to the term “mental retardation” (MR) have been changed to “intellectual disability.” Not all statutory or regulatory language has caught up to this change, and an ICF/IID is the equivalent of what was termed an “ICF/MR.”

The State’s **Training Centers**, non-state-operated ICFs/IID, and nursing facilities are certified for Medicaid or Medicare reimbursement for services and monitored by state agencies on a regular basis. While each category of institution has unique characteristics based on its function, all provide daily room and board as well as varying levels of health care and other services that are defined by state and federal regulation. Throughout this chapter, in keeping with national reports, references to “**large institutions**” apply to those having a building or unit with a capacity for 16 or more residents.

With its first Training Center closing by June of 2014, Virginia will join 39 states that have closed one or more of its state-operated institutions. Three other state-operated Training Centers are scheduled to close by 2020, leaving the Southeastern Virginia Training Center open with a bed capacity of 75. Nationally, a substantial shift to small, community-based, non-state-operated residential services has occurred. During the past decade, several states have significantly decreased their number of community, intermediate care facilities for individuals with intellectual disabilities (ICFs/IID). They have done so by converting them to small residences of 6 or fewer residents who receive services and supports through increased funding of **Medicaid Home and Community Based Services (HCBS) Waivers**. Alaska no longer has any ICFs/IID, and 20 states have fewer than 10 each.

In 2008, under the authority of the national Civil Rights of Institutionalized Persons Act (CRIPA, 42 USC 1997 et seq.) the **US Department of Justice (DOJ)** began an investigation of services at Central Virginia Training Center (CVTC). Among other findings, the DOJ found that CVTC failed to provide for “reasonable care and safety” as evidenced by

*repeated accidents and injuries, inadequate behavioral and psychiatric interventions, and inadequate physical and nutritional management supports ... CVTC’s failure to identify root causes of bad outcomes and respond to prevent their recurrence.*

The investigation was later expanded to include examination of whether individuals at that facility as well as those already discharged from it were being served in **the most integrated settings appropriate to their needs** and examined state policies, procedures, and practices regarding admissions and discharges by all Training Centers. The DOJ concluded that Virginia had failed systematically to

*provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs in violation of the ADA [Americans with Disabilities Act, 42 USC. 12101 et seq.]*

and that these deficiencies

*have resulted in needless and prolonged institutionalization of, and other harms to, individuals in CVTC and other segregated Training Centers*

in violation of their civil rights.

Specifically, the DOJ found that the Commonwealth:

- failed to develop a sufficient quantity of community-based alternatives for individuals now served at all Training Centers, especially those with complex needs;
- failed to use resources already available, such as the Money Follows the Person (MFP) project and Medicaid Home and Community Based Services (HCBS) Waivers to expand community-based services; and
- placed individuals with intellectual and developmental disabilities now in the community at risk of unnecessary institutionalization at state Training Centers by (1) failing to develop a sufficient quantity of community services, including respite and crisis services to prevent admission when they experience crises; and (2) failing to develop a sufficient quantity of community services, especially Medicaid HCBS Waiver slots, to maintain community life and prevent admission to state Training Centers.

The Commonwealth negotiated a **Settlement Agreement** rather than litigate against the findings as some states have done. In August of 2012, a federal judge entered the Settlement Agreement and appointed an Independent Reviewer. The target population for the Agreement is individuals who (1) currently reside at any Training Center, (2) meet the criteria for the Medicaid ID or DD Waiver Waiting Lists, or (3) currently reside in a nursing facility (NF) or intermediate care facility (ICF). With respect to individuals residing in the Training Centers, the Department of Behavioral Health and Developmental Services (the lead agency for implementation of the Agreement) has and continues to put forth extensive efforts to ensure quality discharges to the community.

The General Assembly approved \$30 million for state fiscal year (SFY) 2012 and an additional \$30 million for SFY 2013 to meet the requirements of the DOJ Settlement Agreement. These were called “Trust Fund dollars,” and they were intended to

*enhance and ensure for the coming years the quality of care and treatment provided to individuals receiving public mental health, developmental, and substance abuse services.*

The \$30 million appropriated in SFYs 2012 and 2013 was directly deposited to (1) provide or improve community-based services, including new Medicaid Home and Community Based Services (HCBS) Waivers to transition individuals from state Training Centers to community settings, and (2) expand the capacity of community-based providers to serve the DOJ target population. That Trust Fund has subsequently been expended. All new General Fund dollars are being appropriated as General Funds and included in the DBHDS budget.

The Budget Act and Code of Virginia § 37.2-318 established the **Behavioral Health and Developmental Services Trust Fund (BHDS Trust Fund)** as a special, nonreverting fund for the deposit of all proceeds from the sale of surplus DBHDS land (mental health or Training Center property) as well as other moneys appropriated by the General Assembly and any private donations. Net proceeds from the sale of surplus property at the Southeastern Virginia Training Center (SEVTC) in Chesapeake was approximately \$300,000 as of June 30, 2014. The final deposit of \$4 million plus was scheduled to occur in January of 2015. However, when the General Assembly passed the budget in June of 2014, it eliminated \$5.4 million from the BHDS Trust Fund with the rationale that at least that much in General Funds had been provided for in community services. This depleted all the money currently in the Trust Fund and all of the remaining proceeds that would have been received from the sale of the SEVTC.

On February 13, 2012, the Secretary of Health and Human Resources submitted a plan to transition individuals from state Training Centers to community-based settings to the Governor and the Chairs of the House Appropriations and Senate Finance Committees. This plan was submitted pursuant to the amended 37.2-310 of the Code of Virginia, which relates to the administration of the BHDS Trust Fund and is available at [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD862012/\\$file/RD86.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD862012/$file/RD86.pdf). The plan was based on a number of factors, including the following:

- the declining Training Center census (down 42 percent since SFY 2000) and, therefore, less need for Training Center beds;
- the advanced age of the centers (more than 35 years old) and their significant infrastructure needs;
- the 10-year, court-enforced Settlement Agreement with the Department of Justice; and
- Virginia being 4<sup>th</sup> among the states in the number of individuals with ID living in large settings like Training Centers (37 percent) and ranking 48<sup>th</sup> in the number of people served in community-based settings of less than 15 people (63.4 percent).

Among other provisions, the plan requires that long-term admissions to Training Centers end. According to DBHDS projections presented to the DOJ Stakeholder Advisory Committee in April of 2013, the total cost of Settlement Agreement implementation over 10 years is

estimated to be \$2.4 billion. Virginia's General Fund share of the cost is estimated at \$1.2 billion. With projected savings and offsets of \$867.1 million from facility closures and appropriations in place before the \$60 million allotted to the Trust Fund, projected additional General Fund dollars required are estimated at \$340.4 million. The presentation is available at <http://www.dbhds.virginia.gov/settlement/IX%20Budget%20Update%2004-17-13.pdf>.

In January of 2014, the DBHD submitted a required update to its Training Center Closure Plan to the Governor and the Chairs of the Senate Finance and House Appropriations Committee. The update continues to recommend the closure of four training centers on the same timetable as originally proposed. It provides an update on census reduction goals and discharge targets. The report also addresses community capacity development, critical incidents and deaths, regional information, and budget updates. More information is included in the **Access to and Delivery of ICF/IID Services** section of this chapter, in relevant sections of other chapters, and the update is available online at <http://www.dbhds.virginia.gov/settlement/Item%20314.O.%20Quarterly%20Report%201-10-14.pdf>.

The Settlement Agreement is complex and contains provisions related to the Training Centers, community services and supports, housing, employment, case management, and quality assurance. DBHDS has dedicated a web page to the Settlement Agreement that houses all documents, including the DOJ Findings Letter, the Settlement Agreement, reports of the Independent Reviewer, and implementation updates by the DBHDS. Other documents and resources are also available on the page, which can be found at <http://www.dbhds.virginia.gov/settlement.htm>.

The situation at Virginia's Training Centers is extremely fluid. The population continues to decline, and initiatives related to the DOJ Settlement Agreement are ongoing. Because this *Assessment* is based primarily on state and federal fiscal year data, by the time this *Assessment* is released, some data, particularly data related to Training Center census, will be out of date. DBHDS has available a multitude of reports and data on its website at <http://www.dbhds.virginia.gov> for those seeking more detailed and comprehensive information that is beyond the scope of this *Assessment*.

## **B. Intermediate Care Facilities for Individuals with Intellectual Disabilities**

Federal regulations (CFR 440.150), based on the Social Security Act (42 USC 1396 et seq.), define an **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICFs/IID)** as an institution or a distinct part of a facility other than an ICF/IID, that:

1. has the primary purpose of providing "health or rehabilitative services to persons with intellectual disability or persons with related conditions,"

2. meets certain standards specified by federal regulations (42 CFR 483.400, subpart I et seq.),
3. has been certified to meet additional requirements (42 CFR 442.100, subpart C) as evidenced by a valid agreement between the state Medicaid agency and the facility,
4. fully meets the requirements for a state license to provide services that are above the level of room and board, and
5. provides “active treatment” to all individuals served and for whom payment is requested (42 CFR 483.440).

**Active treatment** is federally defined as

*aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services*

Its goals must be to help the individual (1) acquire the essential skills or behaviors that enable him or her to function as independently as possible and (2) prevent or slow the loss of current “optimal functional status.” For complete information, refer to

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Intermediate-Care-Facilities-for-Individuals-with-Mental-Retardation-ICFMR.html>.

The majority of ICFs/IID statewide are owned and operated by public agencies such as Community Services Boards or by private, nonprofit or for-profit organizations. These facilities, referenced in this *Assessment* as **non-state-operated ICFs/IID**, are defined by state regulations (12 VAC 35-105-20) as a service that:

1. is licensed by DBHDS to provide care to individuals diagnosed with intellectual disability or a developmental disability due to brain injury who do not need “...nursing care, but require more intensive training and supervision than may be available in an assisted living facility or group home,”
2. complies with standards established in Title XIX of the Social Security Act and related federal regulations,
3. provides health or rehabilitation services, and
4. provides active treatment to individuals to achieve more independence in functioning and improved quality of life.

**Non-state-operated ICFs/IID** are subject to the same minimum federal requirements as the State’s large Training Center ICFs/IID. Either directly or by contract, they are required to provide their residents with an array of medical, health, and rehabilitative therapies as required by those residents’ individual, comprehensive functional assessments.

The **Centers for Medicare and Medicaid Services (CMS)**, an agency of the US Department of Health and Human Services, is authorized to certify ICFs/IID, to establish the detailed minimal requirements under which they operate, to monitor their compliance with those requirements, and to set penalties for noncompliance. Federal regulations require that, once a state has chosen to fund ICF/IID services or any other allowable service as an optional service under Medicaid, the state must continue to cover that service until it has been removed from the state's annual **Medicaid State Plan**.

An annual **directory** of ICFs/IID, nursing facilities, hospital long-term units, and mental health facilities statewide is produced by the Office of Licensure and Certification at the Virginia Department of Health (VDH). It is available online at <http://www.vdh.virginia.gov/OLC/Facilities/> or on the DBHDS website at <http://www.dbhds.virginia.gov/OL-default.htm>.

## 1. Eligibility for ICF/IID Services

As federally required, an **applicant for entry into an ICF/IID**, whether state- or non-state-operated, must have a primary diagnosis of intellectual disability (ID), as determined by a formal assessment by a licensed, qualified professional, and must meet the level-of-functioning requirements for an ICF/IID. The Virginia Administrative Code (12 VAC-34-190-10) defines the diagnosis criteria as:

1. onset prior to age 18 of significantly sub-average intellectual function, as demonstrated by performance on a standardized measure of intellectual functioning administered in conformity with accepted practice, and
2. concurrent, significant limitations in adaptive behavior, as expressed in conceptual, social, and practical adaptive skills.

Individuals served in non-state-operated ICFs/IID must have Medicaid or Medicare public insurance, private insurance, or the ability to pay for care directly.

As required by the Code of Virginia § 37.2-505, referral for potential admission to one of the State's five Training Centers (ICFs/IID) is the responsibility of local **Community Services Boards or Behavioral Health Authorities** (jointly referred to as **CSBs**). Most of the individuals still remaining in Virginia's Training Centers are either individuals diagnosed with severe or profound intellectual disability and co-occurring complex medical or physical conditions, such as cerebral palsy, or "dually diagnosed" individuals with an intellectual disability and co-occurring mental illness who have challenging behaviors.

## 2. Access to and Delivery of ICF/IID Services

All ICFs/IID, whether they be state- or non-state-operated, are covered by the same state and federal regulations. Individuals must receive "all necessary services" appropriate to their individual needs based on an individual assessment. An **Individualized Support Plan (ISP)** must be developed, and active treatment must be provided according to that plan. Assessments

must be conducted regularly to determine and update the individual's service and support needs, and reassess whether the individual continues to need the ICF/IID level of care. Involvement by the individual (or his or her parents, guardian, or authorized representative, as appropriate) in treatment planning is required, and involvement by a CSB support coordinator is requested. Individuals served in ICFs/IID must be certified annually to ensure that they are receiving the appropriate level of care. Any transition to another residential or service setting must be planned to ensure continuity of needed services and supports.

**a. State-operated Training Centers (ICFs/IID)**

Virginia's Medicaid State Plan has included ICF/IID services for over 30 years, and the State directly owns and operates five, large ICFs/IID, known as **Training Centers**, through its **Department of Behavioral Health and Developmental Services (DBHDS)**. These are

- Central Virginia Training Center (CVTC) in Amherst County,
- Southside Virginia Training Center (SVTC) in Petersburg,
- Southeastern Virginia Training Center (SEVTC) in Chesapeake,
- Southwestern Virginia Training Center (SWVTC) in Hillsville, and
- Northern Virginia Training Center (NVTC) in Fairfax.

In July of 2012, DBHDS presented a plan that was approved by the General Assembly to cease residential operations at 4 of the 5 Training Centers. The plan was presented as part of implementation of the Settlement Agreement with the Department of Justice. Although facility closure is not required under the Agreement, the Commonwealth determined that it could not continue to operate a dual-system of services (institution and community) and meet the tenets of the Agreement. The plan notes that it conservatively estimates that there will be fewer than 600 individuals residing in Training Centers in SFY 2015 and fewer than 300 by SFY 2019. As of March 14, 2014, there were 661 individuals residing in the State's Training Centers ([http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD862012/\\$file/RD86.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD862012/$file/RD86.pdf)). The Settlement Agreement calls for a minimum of 805 Medicaid Home and Community Based Services (HCBS) Waiver slots from SFY 2012 to SFY 2020 to transition individuals from Training Centers into the community. A total of 380 waiver slots were available to Training Center residents in SFYs 2012 through 2014.

The first Training Center to close will be Southside Virginia Training Center (SVTC) no later than June of 2014 (prior to publication of this *Assessment*). The final closure in 2020 will be Central Virginia Training Center (CVTC), which also houses a skilled nursing unit. The Southeast Virginia Training Center (SEVTC) is the only Training Center that will remain open after 2020. It has an operational capacity of 75 beds.

In SFY 2012, 15 new, 5-bed homes were developed on the SEVTC campus to serve the individuals remaining at that downsized facility. Construction of 11 residences in Region 5 (Tidewater) was also completed to serve individuals leaving SEVTC. Of the 11 buildings, 6 were

waiver homes and 5 were small ICFs/IID. Renovations of 2 buildings at CVTC were completed, as was construction of two ICFs. Commitments were made to fund an additional 11 residences near the CVTC.

Three types of **admission to state-operated Training Centers** are authorized by state Code and regulation.

1. Respite admission: residential supports provided to an individual with mental retardation [intellectual disability] on a short-term basis because of the emergency absence of or need to provide routine or periodic relief of the primary caregiver for the individual (12 VAC 35-200-10). Both emergency and respite care temporary admissions are intended to be of short duration, and neither involves a judicial certification of eligibility unless the individual's stay extends past the limits set by state law of 21 consecutive days or a total of 75 days in any calendar year.
2. Emergency admission: the temporary acceptance of an individual with mental retardation [intellectual disability] into a Training Center when immediate supports are necessary and no other community alternatives are available (12 VAC 35-200-10).
3. Regular admission: the acceptance of an individual with intellectual disability to a Training Center for a period typically longer than 21 consecutive days. A regular admission is based on consideration of the preliminary evaluation and requires a judicial certification in accordance with § 37.2-806 of the Code of Virginia. Judicial certification is not an involuntary admission, and the individual has the right to appeal the admission order to the Circuit Court.

In the past, **admission and discharge protocols** were combined in the DBHDS *Admission and Discharge Protocols for Individuals with Intellectual Disabilities*. The most recent protocols took effect March 1, 2011. They are online at <http://www.dbhds.virginia.gov/documents/ODS/ods-Admission-Discharge-Protocol.pdf>. However, in light of the Settlement Agreement with the Department of Justice, these protocols are now being separated. New discharge protocols have been developed and admission protocols were updated in January of 2014. Admissions to **Southside Virginia Training Center** are closed. All admission requests will be funneled by the appropriate community services board (CSB) to either **Central Virginia Training Center** or **Southwestern Virginia Training Center**, depending on which CSB is requesting admission on behalf of the individual. Southeastern Virginia Training Center is still over its established capacity of 75 and is not taking admissions at this time.

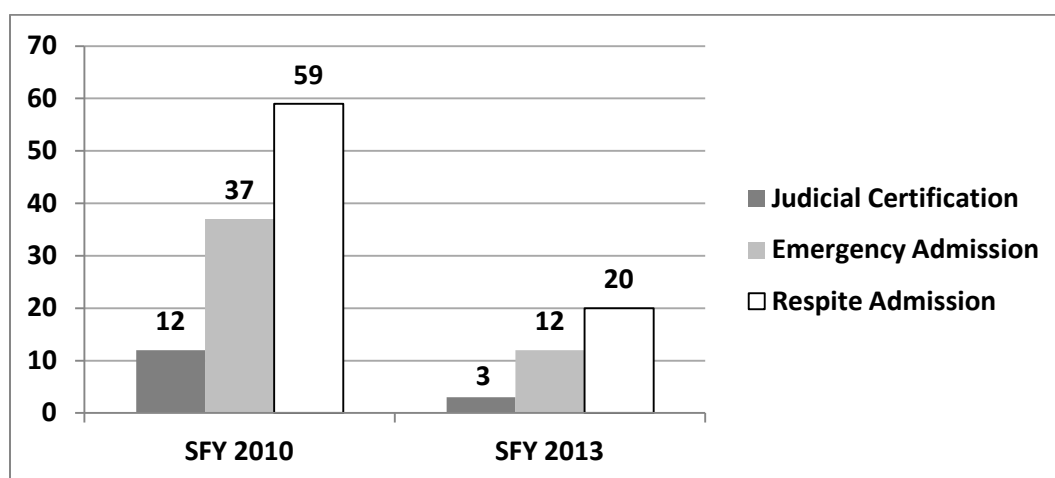
Admission to a Training Center can be initiated only after a community services board (CSB) representative has explored and exhausted all community options. Individuals and their families or authorized representatives must be fully informed about community services and supports that are available to meet the individual's needs. Once fully informed of options, the individuals (or their parents, guardians, or authorized representatives, if appropriate) must sign a written declaration of their "choice of services," including, but not limited to, placement in a Training Center. They must also be informed that if the individual has a Medicaid Home and



Community Based Waiver, they will lose their waiver slot. (See the **Medicaid** chapter for more information on waivers and available slots.)

**Figure 24** shows the decline in Training Center admissions from SFY 2010 to SFY 2013. The Trust Fund Plan noted that since 2007, there were an average of 12.6 long-term, regular admissions per year for all 5 Training Centers, 42 emergency admissions, and 66 respite admissions. Admissions have decreased significantly from those numbers not only as a result of the DOJ Settlement Agreement but due to concerted efforts by the DBHDS and local community services boards to ensure, consistent with state regulations, that all community alternatives have been exhausted prior to making a request for a regular admission. Judicial certifications in SFY 2013 were down 75 percent from 2010; respite admissions were down 66 percent; and emergency admissions were down 68 percent over the same 7 years.

**Figure 24. Training Center Admissions by Type**



Source: Department of Behavioral Health and Developmental Services: *Update on Implementation of DOJ Settlement Agreement to Joint Committee on Training Center Closures*, July 18, 2013.

An **admission appeal** is possible when any admission request is denied. A Training Center’s director must provide a written statement of the reason for the denial and may also provide recommendations for alternative services. If the parent, guardian, or authorized representative for the individual denied admission disagrees with this decision, that person or the CSB representative may submit a written request for reconsideration. The request must be submitted within 10 days of receiving the decision notice.

The Code of Virginia (37.2-505) requires that a discharge plan be developed at the initial meeting of an individual’s interdisciplinary team in consultation with Training Center staff and the individual’s CSB support coordinator. The plan must include the following information:

1. the anticipated date of discharge from the Training Center;

2. a description of all the services and supports needed for the individual's successful return to life in the community (such as psychiatric, social, educational, medical, housing, employment, legal, advocacy, transportation, and others); and
3. the specific public and private providers who agree to supply these needed services, consistent with the right of the individual (or his or her parents, guardian, or authorized representative, if applicable) to choose his or her own providers.

As a result of the DOJ Settlement Agreement, DBHDS implemented new guidelines and processes at Training Centers to improve the discharge process for transitioning Training Center residents to the community. In its July 1, 2012 **Training Center Community Integration Project Update**, DBHDS reported establishing five community integration managers (CIM) positions, one at each Training Center. The role of the CIMs is to coordinate the internal Training Center discharge process and ensure that discharges occur in a timely manner and in compliance with the Settlement Agreement. Detailed information on the transition decision-making process, the moving process, team member roles and responsibilities, and post-move monitoring are described in the update, which is available at <http://www.dbhds.virginia.gov/settlement/121022CommIntegrationProject.pdf>.

New discharge protocols are in effect. The DBHDS **Training Center to Community Discharge Workflow Process and Activities** can be found at <http://www.dbhds.virginia.gov/documents/ODS/TC%20to%20Community%20Move%20Workflow%20process%20and%20Activities.pdf>. In these protocols, DBHDS establishes procedures to ensure that the training centers

*use person-centered principles and practices to help individuals living in training centers and those who support them to identify and make informed choices regarding specific protections, supports, and services necessary to live successfully in a more integrated setting and to define requirements for discharge planning, transition, pre-move activities, and post-move monitoring.*

According to the protocols, the discharge process typically takes about 12 weeks to complete and includes the following activities:

1. an initial pre-move meeting,
2. individual/authorized representative and CSB reviews of providers,
3. provider tours,
4. provider information requests,
5. day visits,
6. evening visits,
7. provider training and overnight visits,
8. final pre-move meeting,

9. preparation for moving,
10. moving, and
11. post-move monitoring.

More information on the requirements for post-move monitoring are covered in the **Monitoring and Evaluation of ICF/IID Services** section of this chapter below.

In its April 17, 2013 update of the Training Center **Community Integration Project** (<http://www.dbhds.virginia.gov/settlement/121022CommIntegrationProject.pdf>), DBHDS discusses the role of **Regional Support Teams (RSTs)**. The RSTs established under the Settlement Agreement

*provide recommendations and assistance in resolving barriers to the most integrated community setting consistent with an individual's needs and informed choice.*

Informally referred to as “barrier-busting teams,” there is an RST in each region coordinated by Community Integration Managers (CIM) and Community Resource Consultants. The teams include individuals with a diversity of experience in ID/DD services and complex medical and behavioral supports. The RSTs receive their referrals from the CIMs under the following circumstances:

- A **Personal Support Team (PST)** working with the individual to develop his or her discharge plan recommends that the individual move to a nursing facility or congregate setting (ICF/IID or group home) with more than 5 beds. (PSTs were established to resolve barriers and gaps in services and ensure that individuals are informed of choices.)
- There is difficulty in identifying or locating supports at various, specified timeframes.
- The PST cannot agree on a discharge plan outcome within 15 days of the annual meeting or within 30 days of admission to the Training Center.
- The individual or their **authorized representative (AR)** opposes moving or does not wish to participate in the discharge planning process.
- The individual has not moved within 3 months of locating a provider.
- It is recommended that the individual remain at the Training Center (requires reassessment every 90 days).

Almost all of the individuals residing in the State’s Training Centers are adults. Southeastern and Southwestern Virginia Training Centers (SEVTC and SWVTC) have a children’s residential services license from DBHDS to serve small numbers of youth, ages 8 through 17 at SEVTC and ages 12 through 21 at SWVTC. Youth admitted to these two facilities typically have a dual diagnosis of intellectual disability and behavioral challenges, and these facilities are considered to be “providers of last resort” for these age groups.

In addition to its certified ICF/IID units for adults with intellectual disability, Central Virginia Training Center (CVTC) has a certified, skilled nursing unit that can accommodate up to a total of 104 residents. In its Fiscal Year 2013 *Annual Report, Item 314.K*, DBHDS reported that in SFY 2013, 83 individuals received skilled nursing services. This was down 12 percent from the previous year when 94 individuals received skilled nursing services, according to the 2012 *Annual Report, Item 314.K*.

**Table 74** compares the **age distribution** of Training Center residents at the end of selected state fiscal years (SFYs), including both residents of the certified nursing units at CVTC and residents of the ICF/IID-certified units at all of the Training Centers. Counts reflect all individuals “on books” at the end of each state fiscal year, June 30, and the amount and percent of change is for the entire period shown. On-books refers to all persons admitted to a facility, but not yet discharged, and includes any who were off-campus on a pass or on leave. There are few individuals in the Training Centers below the age of 21. It is likely that the two, additional individuals on-books in SFY 2012 in this age category were respite or emergency admissions. The largest decrease in census has been in the 22-to-54 age group. This is not unexpected as individuals over 55 are likely to have more significant health needs, which may require a longer planning period prior to discharge.

<b>Table 74. Ages of State Training Center Residents by SFY</b>					
<b>Age Category</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>% Change 2010–2013</b>
<b>Birth to 5 years</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0.00</b>
<b>6 to 15 years</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>0.00</b>
<b>16 to 21 years</b>	<b>6</b>	<b>6</b>	<b>8</b>	<b>5</b>	<b>- 17.0%</b>
<b>22 to 54 years</b>	<b>722</b>	<b>565</b>	<b>480</b>	<b>387</b>	<b>- 46.0%</b>
<b>55 to 64 years</b>	<b>295</b>	<b>279</b>	<b>315</b>	<b>300</b>	<b>+ 1.70%</b>
<b>65 years or older</b>	<b>136</b>	<b>235</b>	<b>174</b>	<b>123</b>	<b>+ 9.60%</b>
<b>Total</b>	<b>1,160</b>	<b>1,086</b>	<b>978</b>	<b>816</b>	<b>- 29.70%</b>

Source: Department of Behavioral Health and Developmental Services.

**Average Daily Census (ADC)** reflects the *average* number of residents on-books (including those on pass or leave) at a facility over a period of time, usually the state fiscal year. **Table 75** shows the ADC at selected points in time from March 2010 through July 2013. The total Training Center census has declined by a third just in the last 4 years. As a further comparison, the July 2013 census was down 56 percent from the census in 2000, which was 1,746 ([http://hac.virginia.gov/subcommittee/Training\\_Centers\\_Closure\\_Joint\\_Sub/07-18-13/DBHDS%20-%20DOJSpecialSubcommittee%2007-18-13.pdf](http://hac.virginia.gov/subcommittee/Training_Centers_Closure_Joint_Sub/07-18-13/DBHDS%20-%20DOJSpecialSubcommittee%2007-18-13.pdf)).

Table 75. Average Daily Census at State Training Centers					
Training Centers	March 2010	June 2011	June 2012	July 2013	% Change
Central (CVTC)	426	381	342	300	- 29.6%
Northern (NVTC)	170	157	153	135	- 20.6%
Southeastern (SEVTC)	143	124	104	84	- 41.2%
Southside (SVTC)	267	243	197	113	- 57.7%
Southwestern (SWVTC)	192	181	173	156	- 18.8%
<b>Total</b>	<b>1,198</b>	<b>1,086</b>	<b>969</b>	<b>788</b>	<b>- 34.2%</b>

Source: Department of Behavioral Health and Developmental Services. *Update on Implementation of the DOJ Settlement Agreement to Joint Committee on Training Center Closures*, July 18, 2013.

As **Table 75** shows, all of the Training Centers experienced a decline, with the largest percentage decreases at SVTC (as the first facility scheduled to close), at SEVTC (due to the downsizing of that facility to 75 beds), and at CVTC, the largest training center in the State and the last scheduled to close. Southside Virginia Training Center closed on June 30, 2014.

In its quarterly *Update to the Training Center Closure Plan* to the Governor and Chairs of the Senate Finance and House Appropriations Committee, DBHDS reported on revised census reduction targets as shown in **Table 76**.

Table 76. Revised Census Reduction Targets for State Training Centers for SFYs 2013–2020								
Admissions	2013	2014	2015	2016	2017	2018	2019	2020
SVTC *	80	118	N/A	N/A	N/A	N/A	N/A	N/A
NVTC *	14	60	74	N/A	N/A	N/A	N/A	N/A
SWVTC	15	20	20	40	40	36	N/A	N/A
CVTC	26	35	50	56	50	50	35	23
<b>TOTALS</b>	<b>135</b>	<b>248</b>	<b>144</b>	<b>96</b>	<b>90</b>	<b>86</b>	<b>35</b>	<b>23</b>

\* SVTC is scheduled to close in SFY 2014, NVTC in SFY 2015.

Source: DBHDS Update to Training Center Closure Plan, January 10, 2014.

These updated targets have some significant differences from those presented in the DBHDS *Update on the Implementation of the Settlement Agreement* provided to the Joint Committee on Training Center Closures. At that time, it was anticipated that 51 individuals would transition out of NVTC in SFYs 2013 and 2014, but that target was revised downward to

14 in SFY 2013 and upward from 51 to 74 in SFY 2015, which is the projected date of closure for that facility. Both family resistance to the closure and lack of community capacity in Northern Virginia are the likely reasons for these revisions. Southwestern Virginia Training Center’s original discharge targets were set to begin in SFY 2016, but as of the January 2014 revisions, it now has discharge targets for each year through SFY 2018. The targets at CVTC remain fairly close to the original, although more individuals (48) are targeted for discharge in the final year, compared to 23 in the original targets.

**b. Non-state-operated ICFs/IID**

Individuals seeking admission to a non-state-operated, community, intermediate care facility for individuals with intellectual disability (ICF/IID) apply directly to the provider organization responsible for the institution’s operation. Currently, a number of the ICFs/IID are operated by local Community Services Boards (CSBs), and others are operated by private nonprofit and for-profit entities. Their geographic service areas vary, and each determines its own application and admissions processes. Most ICFs/IID operated by CSBs serve individuals within their own local jurisdictions first, but they can serve individuals from outside of their localities if they choose to do so. Private providers may accept referrals from anywhere. **Table 77** below contains data provided by the Department of Medical Assistance Services (DMAS) showing the number of individuals served in non-state-operated ICFs/IID for state fiscal years (SFYs) 2010 and 2013 by age groups.

<b>Table 77. Persons Served in Non-state-operated ICFs/ IID by Age for SFYs 2010 and 2013</b>		
<b>Age Groups</b>	<b>SFY 2010</b>	<b>SFY 2013</b>
<b>Under 1 year</b>	<b>0</b>	<b>2</b>
<b>1 to 5 years</b>	<b>9</b>	<b>8</b>
<b>6 to 14 years</b>	<b>44</b>	<b>44</b>
<b>15 to 20 years</b>	<b>52</b>	<b>55</b>
<b>Subtotal for Ages 1 to 20</b>	<b>105</b>	<b>109</b>
<b>21 to 44 years</b>	<b>132</b>	<b>157</b>
<b>45 to 64 years</b>	<b>137</b>	<b>176</b>
<b>Subtotal for Ages 21 to 64</b>	<b>269</b>	<b>333</b>
<b>65 to 74 years</b>	<b>17</b>	<b>29</b>
<b>75 to 84 years</b>	<b>0</b>	<b>3</b>
<b>85 and older</b>	<b>0</b>	<b>0</b>

<b>Table 77. Persons Served in Non-state-operated ICFs/ IID by Age for SFYs 2010 and 2013</b>		
<b>Age Groups</b>	<b>SFY 2010</b>	<b>SFY 2013</b>
<b>Subtotal for Ages 65 and Older</b>	<b>17</b>	<b>32</b>
<b>Total for All Ages</b>	<b>391</b>	<b>474</b>

In SFY 2010, children and youth ages one through 20 comprised 26.9 percent of all individuals served by non-state-operated ICFs/IID. In SFY 2013, the number of children and youth increased to 109, but children and youth comprised a smaller percentage (22.9 percent) of an otherwise growing number of individuals served in non-state-operated ICFs/IID. The SFY 2013 total population in non-state-operated ICFs/IID rose 21.2 percent from SFY 2010. The most significant growth was in the population of individuals ages 45 to 64. It is possible that the overall increase is due at least in part to the transition of some Training Center residents to non-state-operated ICFs/IID, including homes that have been developed by the State near Southeastern and Central Virginia Training Centers.

The state has experienced growth in the number of non-state-operated ICFs/IID. A single provider may be licensed for and operate more than one community ICF/IID at different locations. Therefore, the number of providers does not increase at the same rate as the number of beds. DMAS maintains data on “enrolled ICF/IID providers,” meaning those approved for Medicaid reimbursement. Such approval first requires licensing by the Department of Behavioral Health and Developmental Services (DBHDS), which is further contingent on a determination by the Virginia Department of Health that the facility meets federal regulations.

**Table 78** shows a 15.6-percent increase in total bed capacity and a 19-percent increase in the number of facilities since 2010. The number of ICFs/IID has more than doubled since SFY 2007 when there were only 21 non-state-operated ICFs/IID. Of the current 48 ICFs/IID, 25 percent (12) have a bed capacity of 10 or more. Only 10 (20.8 percent) have 4 beds or less. St. Mary’s Home for Disabled Children, with 92 beds, has 20.3 percent of all non-state-operated ICF/IID beds.

<b>Table 78. Non-state-operated ICFs/IID Bed Capacity by SFY</b>				
<b>Capacity</b>	<b>SFY 2007</b>	<b>SFY 2010</b>	<b>SFY 2013*</b>	<b>% Change</b>
<b>Total Beds</b>	<b>340</b>	<b>391</b>	<b>452</b>	<b>+ 32.9%</b>
<b># of ICFs/IID</b>	<b>21</b>	<b>36</b>	<b>48</b>	<b>+ 129.0%</b>

\* Report dated April 2013.  
Source: DBHDS Office of Licensing website.

### 3. Available ICF/IID Services

ICFs/IID, whether state- or non-state-operated, are required by federal and state regulations to provide or to obtain a full range of appropriate medical, health, and rehabilitative services to meet the needs identified by formal assessment of the individuals whom they serve. Core services, which may be provided either directly or by contract, include physical, occupational, and recreational therapy; speech pathology; and nutritional, medical, dental, pharmaceutical, psychological, and social services. Intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) may also provide vocational training, as appropriate. The Central Virginia Training Center (CVTC) operates certified skilled nursing units. And, as noted in the **Access to and Delivery of ICF/IID Services** section of this chapter, the Training Centers also provide short-term respite and emergency stays for behavioral management and intervention.

#### a. State-operated Training Centers (ICFs/IID)

Training centers provide highly structured, intensive services in a large facility setting. The Department of Behavioral Health and Developmental Services (DBHDS) website addresses the changing role of state facilities, stating:

*In the evolutionary movement towards a single, integrated system of care, increased emphasis has been placed on the establishment of community services and on the more effective and efficient use of state facilities. This emphasis has defined the role of state facilities as one of several resources in an overall continuum of care.*

Procedural variations exist in **treatment and discharge planning** by type of admission. For regular admissions, the Code of Virginia § 37.2-806 specifies that an individual must receive active treatment throughout his or her stay at a Training Center and that the treatment be based on an “individualized habilitation plan” describing the services that will be provided to meet the individual’s needs as identified by assessment. Within 30 days of admission, an interdisciplinary team must collaborate with CSB staff to develop this plan, referred to by DBHDS as an **Individualized Support Plan (ISP)**. The ISP must include supports toward a discharge plan as well as input from the individual, and/or his or her family members, guardian, or authorized representative, if applicable, and the CSB. To facilitate the participation of external participants, meetings may be conducted using teleconferencing or video-conferencing if necessary.

All Training Centers conduct the **Supports Intensity Scale (SIS)** as part of the ISP process. Developed by the American Association on Intellectual and Developmental Disabilities (AAIDD), this standardized assessment purports to measure the level and types of supports needed by persons with intellectual and developmental disabilities to be successful (as opposed to measuring the individual’s deficits.) It is administered every three years for each resident of Training Centers. However, there have been continuing concerns in other states and more recently in Virginia with respect to the validity and reliability of the SIS and how SIS results are used to make decisions regarding the services and supports needed by the individual. DBHDS is



now reviewing the usage of the SIS and processes for its usage are anticipated to undergo significant modification.

As of the time of this report, using information from the SIS and other assessments, an individual's interdisciplinary team reviews his or her progress at 30, 60, 90, and 180 days following regular admission to a Training Center. Thereafter, team reviews are conducted annually or whenever circumstances warrant, such as when the interdisciplinary team (IDT) identifies a major change in the individual's needs. A Qualified Intellectual Disability Professional (QIDP), or service coordinator, who works with the individual, must also conduct quarterly reviews. Whenever an annual or special review identifies a change in an individual's status that would significantly affect that individual's discharge potential (such as medical issues), statutes require that Training Center staff collaborates with the Community Services Board (CSB) to ensure that the individual's CSB support coordinator (case manager) is informed of any changes in the services or supports needed for the individual's discharge plan.

Over the past decade, in addition to the core services mentioned above, each of the State's Training Centers has been tasked to directly provide or contract with private clinicians to provide some services and specialized supports on an outpatient basis through **Regional Community Support Centers (RCSC)**. For more information on the RCSCs, see the **Health Care** chapter of this *Assessment*.

#### ***b. Non-state-operated ICFs/IID***

As with the state-operated Training Centers, the Centers for Medicare and Medicaid Services (CMS) regulations require that non-state-operated ICFs/IID provide the core services listed above either directly or by contract and that the services be tailored to meet each individual's unique needs. This requirement applies to all ICFs/IID be they public or private, nonprofit or for-profit.

### **4. Cost and Payment for ICF/IID Services**

Services at state- and non-state-operated ICFs/IID are funded by private and public sources. The national public health insurance programs, Medicare and Medicaid, are a significant source of funding. Other sources of payment include personal, out-of-pocket expenditures as well as various types of purchased, private insurance such as long-term care insurance, Medicare Supplemental Insurance ("Medigap"), or managed care health insurance.

To receive reimbursement through Medicare or Medicaid, facilities must conform to specific federal **Centers for Medicare and Medicaid Services (CMS)** standards in eight operational areas: management, client rights, facility staffing, active treatment services, behavior and facility practices, health care services, physical environment, and dietetic services. To be "CMS certified" and thus eligible for reimbursement, a facility must be found to meet those standards based on an inspection by the designated state agency. Note that Central Virginia Training Center operates a skilled nursing unit. Beds at a facility may be CMS certified for Medicare, Medicaid, or both under the following categories.

- **Skilled Nursing Facility (SNF):** Any long-term care bed specifically certified for *Medicare* reimbursement.
- **Nursing Facility (NF):** Any long-term care bed specifically certified for *Medicaid* reimbursement.
- **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID):** Any long-term care bed specifically certified for a *Medicaid* reimbursement program designated to provide care or supervision for residents who have a primary diagnosis of intellectual disability (ID) or a developmental disability (DD).

**Table 79** and **Table 80** compare the number of individuals served, total operational expenditures, and the annual, per capita cost for the State’s Training Centers and non-state-operated ICFs/IID for SFYs 2010, 2011, and 2012. Detailed budget and expenditure information for the State’s Training Centers were provided by the **Department of Behavioral Health and Developmental Services (DBHDS)**. The **Department of Medical Assistance Services** provided details on Medicaid expenditures related to non-state-operated ICFs/IID. Information on persons and services covered by private payments is not available.

Table 79. Expenditures for State-operated ICFs/IID (Training Centers) by SFY						
State Fiscal Year	Number Served	State Funds	Federal Funds	Other Funds	Total Funds	Per Capita Cost
2010	1,197	\$97,978,045	\$122,380,664	\$463,164	\$220,821,883	\$184,479
2011	1,105	\$97,750,264	\$127,182,881	\$3,483,248	\$225,416,393	\$203,997
2012	1,013	\$117,841,792	\$109,041,285	\$497,974	\$227,381,051	\$224,463
2013	868	\$114,403,187	\$112,598,189	\$627,782	\$227,629,158	\$262,246

Source: Department of Behavioral Health and Developmental Services.

Table 80. Expenditures for Non-state-operated ICFs/IDD by SFY						
State Fiscal Year	Number Served	State Funds	Federal Funds	Other Funds	Total Funds	Per Capita Cost
2010	391	\$20,657,952	\$33,124,793	\$0	\$53,782,745	\$137,552
2011	422	\$23,902,815	\$35,424,102	\$0	\$59,326,917	\$140,585
2012	427	\$33,003,452	\$33,003,452	\$0	\$66,006,904	\$154,583
2013	475	\$38,719,065	\$38,719,065	\$0	\$77,438,130	\$163,028

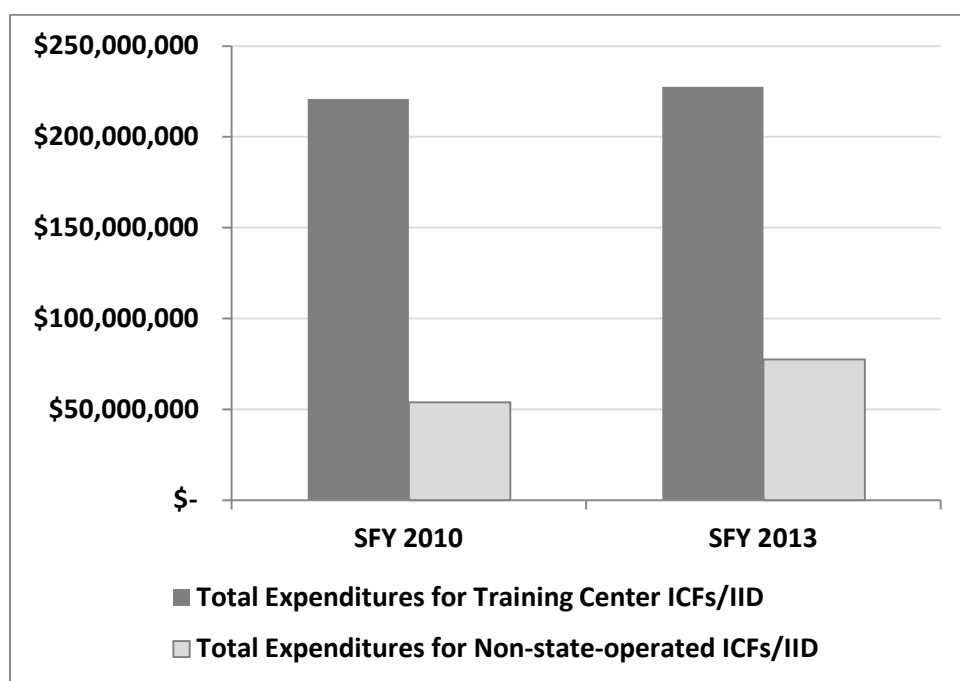
Source: Department of Medical Assistance Services.

**Table 79** and **Table 80** show the rising **costs of providing ICF/IID services** in both training centers and ICFs/IID. But the two types of placements paint a different picture more easily

visualized in **Figure 25** and **Figure 26** below. Despite the significant census reductions, the overall cost of providing Training Center services has remained about the same, up 3.08 percent since SFY 2010. However, the per capita cost of providing these services has increased 42.1 percent between SFYs 2010 and 2013. This is because buildings still need to be maintained and services provided at certain levels to meet standards of care, regardless of the number of individuals residing in the Training Centers.

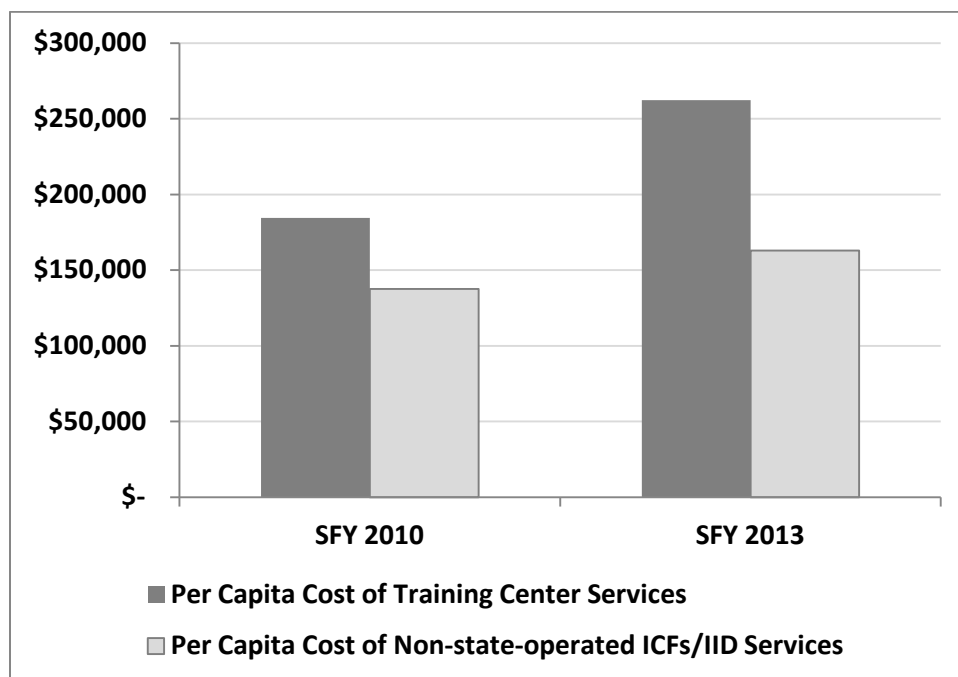
As the census continues to decrease, the per capita cost will continue to increase although it will be mitigated somewhat when buildings and Centers close. As a result of the census reduction and closed units/buildings, actual savings in SFY 2013 was \$5.6 million; **projected savings** for SFY 2014 is \$19.4 million, down from an earlier projection of 23.4 million. Projected savings for SFY 2015 is \$42.1 million and for SFY 2016, \$58.4 million.

**Figure 25. Total Expenditures for Training Centers vs. Non-state-operated ICFs/IID by SFY**



On the other hand, the total expenditures for non-state-operated ICFs/IID services have risen about 44 percent since SFY 2010. This rise is likely due funds provided for the development of new ICFs by the General Assembly prior to the Settlement Agreement as well funds for ICF/IID beds that are being developed as a result of the Agreement. The per capita cost for non-state-operated ICFs/IID has also increased but at a far lower level than the increase in per capita Training Center cost at 18.5 percent.

**Figure 26. Per Capita Cost of Training Center Services vs. Non-state-operated ICFs/IID Services by SFY**



In addition to the operating expenditures detailed above, there have been ongoing, significant costs for Training Center maintenance and renovation, including modifications to meet federal life and safety, and other physical plant standards. As noted earlier, all of the Training Centers have buildings in use that are at least 35 years old, and 2 have even older buildings. SEVTC's 15 residential cottages are new but will, of course, require ongoing maintenance dollars. There will be a continuing need to invest dollars at the remaining 3 Training Centers (following the closure of SVTC) to ensure that the buildings in use meet life and safety codes.

The DBHDS' *2014–2020 Comprehensive State Plan* notes that the Department will implement closure plans that maintain existing property while expending minimum funds. As units and Centers close, significant savings should be realized. In addition, the *2014–2020 Comprehensive State Plan* notes that as Centers close, every effort will be made to sell those properties at market value with those dollars then reinvested into community services and supports. Funding for building maintenance and repair at the Training Centers comes from state General Funds and state Capital Outlay Funds that are appropriated by the General Assembly or obtained, with its approval, through the sale of bonds. **Table 81** lists capital improvement expenditures for renovation and upgrading of residential areas and the physical plant at each of the State's Training Centers in SFYs 2010 through 2013.

<b>Table 81. Capital Improvement Expenditures at Training Centers by SFY</b>				
<b>Training Center</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Central (CVTC)	\$1,985,554	\$4,231,489	\$6,808,699	\$3,609,115
Northern (NVTC)	\$0	\$2,539,312	\$1,862,544	\$629,671
Southeastern (SEVTC)	\$170,726	\$7,576,015	\$14,216,493	\$139,653
Southside (SVTC)	\$0	\$2,463,532	\$574,091	\$1,020,229
Southwestern (SWVTC)	\$1,727,456	\$1,111,826	\$332,661	\$1,075,429
<b>Total</b>	<b>\$3,883,736</b>	<b>\$17,922,174</b>	<b>\$23,794,488</b>	<b>\$6,474,097</b>

Source: Department of Behavioral Health and Developmental Services, Office of Fiscal Services.

The amounts shown above for Central Virginia Training Center (CVTC) and Southeastern Virginia Training Center (SEVTC) in SFY 2010 are the expenditures from the General Assembly's 2009 appropriation of \$24.5 million for extensive renovations to CVTC and \$23 million for building a replacement, 75-bed facility for SEVTC. A total of \$7,492,518 in SFY 2011 and \$14,064,128 in SFY 2012 were related to the construction of the new SEVTC. All of the remaining expenditures were for capital maintenance.

In addition to funding for their residential services and capital outlays, the Training Centers receive designated funds to operate their outpatient **Regional Community Support Centers (RSCS)**. Funding for the RSCS at Northern Virginia Training was first established in January of 1996 as \$350,000 per year. Each of the 4 remaining Training Centers listed above was appropriated \$200,000 per year from SFYs 2009 through 2012. As noted earlier, the model of locating the community medical services at the Training Centers is being phased out. For more information on the RCSCs, see the **Health Care** chapter of this *Assessment*.

## 5. Monitoring and Evaluation of ICF/IID Services

Regulations and processes involving monitoring and certification of ICFs/IID and nursing facilities follow the same processes. To avoid duplication, information regarding these processes, including Virginia Department of Health certification and monitoring is included only once, in the **Monitoring and Evaluation of ICFs/IID and Nursing Facilities** section of this chapter. This section focuses on the specific responsibilities related to ICFs/IID by the **Department of Behavioral Health and Developmental Services (DBHDS)**, the **Office of the Inspector General for BHDS (OIG-BHDS)**, and the **Independent Reviewer** for the Department of Justice Settlement Agreement. The role of the protection and advocacy system, the **disAbility Law Center of Virginia**, formerly the Virginia Office for Protection and Advocacy (VOPA), is also briefly discussed.

### Department of Behavioral Health and Developmental Services (DBHDS)

Pursuant to Code of Virginia § 37.2-405, DBHDS is responsible for licensing community intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) and has oversight responsibilities for the programmatic, financial, and administrative activities of the State's five Training Centers. It also licenses private providers of community behavioral health, intellectual disability, and substance abuse services. The State's **Training Centers** are certified by the Virginia Department of Health (VDH) for Medicare and Medicaid but are not licensed by VDH or DBHDS. (See the **Monitoring and Evaluation of ICFs/IID and Nursing Facilities** section of this chapter below.)

The **DBHDS Office of Licensing** ensures that new, non-state-operated ICFs/IID comply with licensing regulations, policies, and procedures; that existing ICFs/IID maintain compliance; and that child protective services reference checks, as well as criminal and central registry background checks, are conducted for all staff of all providers licensed by DBHDS. Office of Licensing staff processes license renewals as well as written Service Modification Applications that must be submitted 30 to 60 days before a provider adds or changes either a service within a program or a program location. As of January 2013, information provided on the DBHDS licensure page of its website did not indicate that any non-state-operated ICF/IID had a provisional license. Information on revoked licenses and/or licensing violations was not available.

The Code of Virginia (§ 37.2-400) also charges DBHDS with ensuring the protection of human and civil rights and the provision of care consistent with human dignity for every person served by the Training Centers, non-state-operated ICFs/IID, and community programs that it operates, funds, or licenses, excluding those operated by the Department of Corrections. The **DBHDS Office of Human Rights** develops and monitors compliance with the human rights regulations (12 VAC 34-115-10) adopted and implemented by the State Board for Behavioral Health and Developmental Services.

Provisions addressed by the human rights regulations include, but are not limited to: protection from neglect, abuse, and exploitation; a nutritionally adequate diet; safe and sanitary housing; participation in non-therapeutic labor; attendance or nonattendance at religious services; use of telephones; the availability of suitable clothing; and possession of money and valuables. Most importantly, the regulations address an individual's right to participate in decisions about his or her treatment and the due process procedures to be followed when an individual with a disability may not be able to make an informed decision without support.

Complaints about human rights violations are reviewed by **Local Human Rights Committees (LHRCs)** that serve specific regions of the state, and appeals are reviewed by the **State Human Rights Committee**. LHRCs also review and approve plans for human rights protections by license applicants and by institutions or programs renewing their licenses. For more information on human rights processes, including how to file a complaint, see <http://www.dbhds.virginia.gov/OHR-default.htm>.

As one of its responsibilities, the State **Board for Behavioral Health and Developmental Services** (BHDS) adopts and implements regulations that require the public and private facilities and programs licensed or funded by DBHDS to supply non-privileged information and statistical data to designated offices in the Department. This data is specific to:

- the results of investigations of abuse or neglect,
- deaths and serious injuries,
- instances of seclusion and restraint, including the duration, type, and rationale for use per person, and
- findings by the DBHDS Office of Human Rights or by State or Local Human Rights Committees of any human rights violations or abuse or neglect of individuals with disabilities.

For more information on the responsibilities of the State Board, see <http://www.dbhds.virginia.gov/adm-StateBoardDefault.htm>.

The State Human Rights Committee’s *2012 Annual Report on the Status of the Human Rights System* (<http://www.dbhds.virginia.gov/documents/reports/OHR-SHRC2012AnnualReport.pdf>) was presented in July of 2013. **Table 82** shows the number of abuse and neglect allegations and those that were substantiated from calendar years 2008 through 2012.

<b>Table 82. Abuse and Neglect Allegations at Training Centers and Number Substantiated by SFY</b>					
<b>Training Centers</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
CVTC	98/36	87/21	46/15	56/18	51/21
NVTC	12/3	19/11	19/11	24/16	11/5
SEVTC	19/10	14/7	13/5	25/13	6/5
SVTC	75/34	60/36	92/57	123/110	58/25
SWVTC	72/19	57/11	38/17	56/22	36/10
<b>Total</b>	<b>276/102</b>	<b>237/86</b>	<b>208/105</b>	<b>284/179</b>	<b>162/66</b>
<b>Percent Substantiated</b>	<b>37%</b>	<b>36.3%</b>	<b>50.5%</b>	<b>63%</b>	<b>40.7%</b>

Source: The State Human Rights Committee *2012 Annual Report on the Status of the Human Rights System*.

As the figures show, the number of abuse and neglect allegations reached a high in 2011—the year that also had the highest level of substantiated allegations at about two-thirds. It is important not to draw too many conclusions with respect to the decrease in allegations in 2012 as this coincides with significant census reduction efforts due to the DOJ Settlement

Agreement. The report also notes that in 2011, SVTC had multiple findings of neglect due to staff sleeping, lack of care, and exploitations. It further noted that these problems had been resolved. In general, the rate of founded allegations in the Training Centers is much higher than the founded rate for complaints in all state-operated facilities (Training Centers, state mental health facilities, and the Virginia Center for Behavioral Rehabilitation, which houses individuals who have been civilly convicted for sexual offenses). Substantiated allegations for all facilities reached a high of 34 percent in 2011.

The *2013 Annual Report of the Status of the Human Rights System* had not yet been published at the time of this report. The *DBHDS Fiscal Year 2013 Annual Report (Item 314.K)* noted that there were 473 allegations of abuse, neglect, or exploitation filed in state facilities and that 139 were determined to be founded. However, the report did not separate out the Training Centers from mental health facilities.

**Table 83** shows the number of human rights complaints processed formally and informally from calendar years 2008 through 2012. The *2012 Annual Report on the Human Rights System* notes that the vast majority of the complaints are resolved at the facility director's level or below. There were 7 human rights complaints heard on appeal at the local level and 5 on the state level, but it is not known whether these were complaints filed about Training Centers.

Table 83. Human Rights Complaints at Training Centers by SFY					
Training Centers	2008	2009	2010	2011	2012
CVTC	3	4	60	12	7
NVTC	4	0	1	9	1
SEVTC	2	7	2	3	4
SVTC	12	16	2	3	1
SWVTC	22	7	11	3	20
<b>Total</b>	<b>43</b>	<b>34</b>	<b>76</b>	<b>30</b>	<b>33</b>

Source: The State Human Rights Committee, *2012 Annual Report on the Status of the Human Rights System*.

As part of work being undertaken as a result of the **DOJ Settlement Agreement**, significant improvements to oversight and accountability are underway, but much work remains. According to the DBHDS March 2012 *Creating Opportunities Implementation Report*, all Training Centers (as well as community services boards and other community providers) are required to implement risk management and quality improvement processes, including establishing uniform risk triggers and thresholds. **Regional Quality Councils (RQC)** meet quarterly and assess relevant data, identify trends, and recommend responsive action. Advocacy organizations are not included on the RQCs, although there are reportedly parent representatives.



Discharge process standardization began prior to Court approval of the Settlement Agreement. As noted earlier, five community integration managers were hired to assist with the discharge process at each Training Center. In its *Fiscal Year 2012 Annual Report to the Governor and Chairs of the Senate Finance and House Appropriations Committees, Item 314K* (<http://www.dbhds.virginia.gov/documents/RD360.pdf>) and the July 31, 2013 *DOJ Implementation Update to the Governor and Chairs of Senate Finance and House Appropriations Committee*, DBHDS reported that all Training Center residents had discharge plans and that pre-move and post-discharge monitoring processes had been established. These processes include the following:

- **Training Center:** Visits at 3, 10, and 17 days after discharge; contact with the individual's authorized representative (AR) to determine satisfaction; 2 visits in the home and 1 at day services.
- **Licensing:** Enhanced licensing visit guidelines (within 2 months of move). The enhanced licensing protocol can be found at <http://www.dbhds.virginia.gov/documents/Enhanced%20Licensing%20Visit%20Protocol%20-%20website%20verison.pdf>.
- **Human rights:** Visit within 1 month of move.
- **CSB case manager:** Visits on day 7 and monthly visits for 12 months following enhanced case management guidelines.
- **Community resource consultant:** Visits within 7-90 days of move to meet with individual in their home setting, review the Individual Support Plan (ISP) and provide technical assistance if needed.

An education and training plan was developed and implemented on **Person-Centered Thinking**, terms of the Settlement Agreement, the discharge process, and community options. Training is provided to all new Training Center employees and is required for all employees each January. The July 31, 2013 *DOJ Implementation Update* notes that all discharge plans are updated within 30 days of discharge, and the DBHDS Central Office receives monthly reports regarding individuals who have moved and the types of placements.

The January 2014 *DOJ Implementation Plan Update, Item 314.V.I.* to the Governor and Chairs of the Senate Finance and House Appropriations Committee, (<http://www.dbhds.virginia.gov/settlement/Item%20314.O.%20Quarterly%20Report%201-10-14.pdf>) further described the discharge process and the work done with individuals, families, and providers to ensure that "each essential support need" is met prior to the individual's transition from a Training Center into the community. DBHDS regularly contacts families and authorized representatives (ARs) to assess receptivity to long-term placement in the community. A community integration preference score is assigned and, as of November 18, 2013, it was reported that:

- 19 percent of individuals were in the process of moving, actively considering community options, or will be seeking options in the future;
- 27 percent were willing to participate in the discharge process but wanted more information;
- 30 percent were not reachable or non-responsive; and
- 25 percent were not willing to participate in the discharge process at the current time.

DBHDS noted that some of those saying “no” were not saying no to the discharge process but were indicating “not yet.” These numbers are fluid and updated quarterly.

DBHDS has examined **provider capacity** across all regions. According to the January 2014 *DOJ Implementation Update* and the *2014 Update to the Training Center Closure Plan*, the areas that have the most limited capacity are the southwestern region, which lacks capacity in the area of licensed congregate care and other key services, such as behavioral supports, that will slow downsizing progress at SWVTC. Northern Virginia is the principal area in which there is limited capacity for residential, day support, and employment services due to limitations of the Medicaid Home and Community Based Waivers, inadequate waiver rates, the high cost of delivering services, and high developmental costs. The factors, according to DBHDS, are keeping providers from expanding services to individuals at NVTC who want to move into the community and will hamper progress in meeting discharge targets without intervention.

To help with this situation, the Department of Medical Assistance Services’ (DMAS’) SFY 2014 budget includes \$7.8 million for **exceptional** Medicaid ID Waiver rates. This will fund a 25-percent increase for ID Waiver congregate residential services to meet the needs of individuals with significant medical or behavioral challenges. The rates, approved by the 2013 General Assembly, will enable Training Center residents with complex needs to move to quality community settings. It also will enable individuals with complex needs who are already living in the community to receive services from providers with more expertise. The rates are required to be approved by the Centers for Medicare and Medicaid Services (CMS) and by DBHDS. Approval was initially expected in December of 2013 but has been delayed. Once approved, emergency regulations will need to be issued to implement the rates.

**Bridge funding** is now available to pay the providers that serve individuals with complex needs who are transitioning from SVTC and NVTC (the first two Training Centers slated to close). This is a repurposing of state General Funds to provide the necessary additional support dollars. In October of 2013, Virginia approved limited funding to support discharge planning and the moving process to relocate these individuals to their own homes or to a provider home licensed by the DBHDS. While approved in October of 2013, the funds were not available until 2014 but are retroactive.

According to the DBHDS *Bridge Fund Guidelines*, bridge funding cannot be used to purchase goods or services that can be funded through Medicaid or any other means at the time that funding is provided. It also cannot be used to supplement transitional services that are

currently available through the Money Follows the Person (MFP) Program or the Intellectual Disability Waiver. Bridge funding cannot be used for ICFs/IID. Providers who receive bridge funding must agree to support the individual for whom the funding is sought for a minimum of 12 months unless the individual chooses another provider or the provider is unable to meet the individual's needs. The guidelines are at <http://www.dbhds.virginia.gov/documents/ODS/Bridge%20Funding%20Final%20Guidelines%202-6-14.pdf>.

Examples of possible use of **bridge funding pre-discharge** include the following:

- home and vehicle modifications, assistive technology, and durable medical equipment; and
- specialized staff training to address the unique needs of the transitioning individual.

Acceptable **post-discharge bridge funding** examples include the following:

- Room and board subsidies for verified room and board costs that exceed the amount available through other sources [such as Supplemental Security Income (SSI), other social security programs, etc.] for individuals living in DBHDS-licensed provider homes or the individual's own home. Room and board cannot be covered by Medicaid according to federal rules; the use of state bridge funding for room and board subsidy will continue only until the rate study being conducted by the Human Services Research Institute (HSRI) for DBHDS is complete and new rates are approved.

According to DBHDS, the process is as follows: A provider who is serving individuals transitioning from NVTC and/or SVTC will provide DBHDS with verification of their monthly mortgage and/or rent. They will subtract from that monthly cost, the amount of money that is paid by the residents (i.e., the portion of each resident's SSI payments or other available funds that can be charged to them.) The rate subsidy the providers receive is the verified difference. The intent of using bridge funding for room and board subsidies is to increase residential service capacity, particularly for individuals with ID in northern Virginia.

- General/overnight supervision for individuals receiving congregate residential supports (currently not allowable under state Medicaid regulations).
- Off-site supervision to support individuals who receive congregate residential supports and may require out-of-home care such as hospitalizations.
- Necessary nutritional supplements and special foods that do not meet the criteria for sole source of nutrition as required under state Medicaid rules.
- Infrastructure grants to help DBHDS-licensed residential providers strengthen their internal processes and programs to avoid or mitigate the risk of harm to individuals.

- Extended medical supports that can be used for private-duty nursing for continuous nursing needs (not currently an ID Waiver service) and for Applied Behavioral Analysis (ABA) for individuals whose behavioral needs require direct therapy or intervention. ABA is not currently an ID Waiver service nor a component of the crisis stabilization services covered by ID Waivers.
- Infrastructure grants for employment, prevocational and day support programs. These funds would be used to (1) deliver or enhance training provided to direct support professionals (DSP); (2) create continuous quality improvement plans; and (3) develop community integration initiatives to implement new federal Home and Community Based Waiver requirements; and (4) establish mentoring teams to support DSPs in identifying and addressing risk of harm; and (5) upgrade assistive technologies used and needed by multiple individuals.

It will be critical to closely monitor the use of bridge funding, particularly with respect to room and board subsidies, and to evaluate its impacts, both on provider service capacity and on the individuals served using bridge funds pre- and/or post-discharge. Appropriate usage and the ability to prevent and identify fraud will be essential.

In SFY 2012, the DBHDS began developing a new **quality improvement process** that focused on the state facilities and community programs. At that time, it deferred implementation of quality measures for developmental services in light of the DOJ Settlement Agreement as the Agreement itself contains extensive data reporting and quality improvement requirements. Data are required to be collected in the areas of:

- safety/freedom from harm;
- physical, behavioral health and well being;
- avoiding crises, stability;
- choice and self-determination;
- community inclusion;
- access to services; and
- provider capacity.

Activities undertaken to address quality improvements include work done by project teams that address the following areas: case management, provider risk management, incident reporting, mortality review, licensing, and quality service reviews. For more detail, refer to the *DOJ Stakeholders Group—Quality Management Project Team Updates*, from April 17, 2013 at <http://www.dbhds.virginia.gov/settlement/VII%20Quality-RM%204-17-13.pdf>.

The initial focus for developmental services has been case management services and information collected by case managers as well as provider risk management. This has included the development of “risk triggers” for facility, CSB, and community private providers and the

process for reviewing the trigger and threshold data. The review process will be executed by the Regional Quality Councils established under the Settlement Agreement.

### **Independent Reviewer on Compliance with the DOJ Settlement Agreement**

Since the 2011 edition of this *Assessment*, the **Independent Reviewer** (referred to hereafter as the Reviewer) has begun working to verify and report on Virginia's implementation of the Department of Justice (DOJ) Settlement Agreement. The Reviewer is responsible for factual investigation and verification of data and documentation provided by DBHDS. The Reviewer submits reports to the DOJ every six months. At the time of this assessment, all of the Reviewer's reports indicate that the Commonwealth has made a good faith effort to implement the Agreement and to be "substantially in compliance" with a number of provisions and "not in compliance" with a lesser number of requirements. There are also requirements for which the Reviewer has not yet made a determination on compliance. These reports can be found at <http://www.dbhds.virginia.gov/settlement.htm>.

Each of the Reviewer's reports is an update on progress made in various areas. The third report, *Report of the Independent Reviewer on Compliance with the Settlement Agreement in United States v. Commonwealth of Virginia* was issued in December of 2013 and included a number of items related to ICFs/IID and nursing facilities. (See the **Nursing Facilities** section of this chapter below for the latter.) Other chapters of this *Assessment* include Reviewer comments on those respective areas (e.g., **Community Living Supports, Community Housing, Employment**, etc.). The report is lengthy, so only specific highlights are included below. The complete report can be found at <http://www.dbhds.virginia.gov/settlement/131206%20Report%20of%20the%20Independent%20Reviewer%203.12CV059.pdf>.

The Reviewer and his expert consultants used a monitoring questionnaire to obtain information on **48 individuals** who had moved from Southside Virginia Training Center and Northern Virginia Training Center in the last two quarters of state fiscal year (SFY) 2013. Two-person teams then reviewed a random sample (noted to be statistically significant) of 28 individuals, 22 from Southside Virginia Training Center (SVTC) and 6 from Northern Virginia Training Center (NVTC). These facilities were chosen because they are the first 2 scheduled to close with SVTC transitions well underway. In addition to noting that the Commonwealth has created and implemented a detailed **discharge planning and transition process** for Training Center residents, the Reviewer found a number of **positive outcomes** related to the individuals who had transitioned. These included but were not limited to:

- Individuals who had transitioned had improved behavior and health.
- They had adjusted to their new homes and lived in homes that were attractive, in appealing neighborhoods, and close to resources.
- Individuals were clean, well kempt, and had properly fitted clothing.

- Authorized representatives (ARs) who had been reluctant to move their loved one had visited frequently, were satisfied with the placements, and noted positive changes.
- The Commonwealth has made available some increased resources to assist individuals with complex needs who are moving from SVTC and NVTC. As noted above, approval on the exceptional rate is pending with the federal Centers for Medicare and Medicaid. At the time of the Reviewer's report, bridge funding was noted as an additional resource but was not available yet. Those funds did become available in early 2014 as noted previously.

A representative of the Virginia Network of Private Providers (VNPP), in testifying before a subcommittee of the 2014 General Assembly, provided her organization's perspective that the exceptional rates and bridge funding were inadequate to resolve capacity issues critical to Settlement Agreement implementation. Other advocacy organization representatives also testified with respect to the need for rate increases and significant, additional resources in the community.

The Independent Reviewer also had less positive findings, noted to be "**areas of concern**" with respect to the sample of individuals who had left the Training Centers. He found that the range of **integrated housing options** available to individuals had not changed, although it was noted that the Commonwealth was taking important steps to build capacity in the future. He noted that in his judgment,

*the greatest barrier to the Commonwealth achieving the goals of the Agreement is providing a sufficient number and variety of integrated programs that promote skill development and community participation with the following specific areas of concern:*

- **Program options** (including employment options) that offered "most integrated settings" were not available to many individuals. The Reviewer found that the Personal Support Teams (PSTs) described some community options to individuals and their authorized representatives (ARs) but did not describe supports and services that met needs and offered the most integrated setting. The Reviewer notes that this was reportedly because such services and supports were not available. He further noted that documentation did not indicate that steps were undertaken to resolve barriers.
- The individual's support plans and daily routines did not support **skill development** to increase independence or participation in the community. The Reviewer noted that Individual Services Plans (ISPs) did not usually include a description of the individual's skills or what skills or community involvement were being taught or supported, reflecting a "lack of adequate attention to habilitation." The Reviewer reported that there did not appear to be a "core program expectation" to help individuals learn skills and increase their ability to participate in community life. It was also noted that community trips did not appear to be skill development oriented. In addition, ISPs did

not reflect the supports needed for individuals to work, even when the individual had previously worked at the Training Center or expressed a desire to work.

- The Reviewer found that the community residential and day services offered to individuals in the sample he studied were **limited to congregate options** (group homes and day support centers). He found that Personal Support Teams (PSTs) had not consistently described available and appropriate program options in the most integrated setting that would meet the needs of the individuals. An example provided by the reviewer was that residential options with four or fewer beds, subsidized independent housing options, supported employment, and integrated day opportunities were not described or offered and were almost always unavailable. The reviewer further found that **barriers were often not identified**, and when they were, steps were not taken to address the barriers.
- Community activities were primarily group based, and none of the individuals sampled had **daily, integrated activities**.
- The Independent Reviewer also addressed the requirement in the DOJ Settlement Agreement for the **transition of youths** (under age 22) who are in nursing facilities and large ICFs/IID. As noted in an earlier, 25 children were expected to transition in SFY 2013, but only 11 did so. All of the children who transitioned had intellectual disability (ID), and it was noted that they did not leave as a result of the Commonwealth's initiative. The Reviewer deferred a determination on whether the Commonwealth was in compliance with the requirements of the Agreement.

Other positive findings and areas of concern as set forth by the Reviewer can be found in these reports. The fourth report of the Independent Reviewer was released on June 6, 2014. That report focuses how the Commonwealth is addressing services to individuals who have transitioned or are in the process of transitioning from institutional settings into the community, including but not limited to: crisis services, licensing community living options, integrated employment and day activities, and services for individuals with behavioral challenges. It can be found at <http://www.dbhds.virginia.gov/settlement/ODS-140606IRReport.pdf>.

### **Office of the State Inspector General (OSIG)**

On April 12, 2011, then Governor Bob McDonnell signed **government reform legislation** that included the establishment of a State Inspector General to investigate waste and inefficiencies in state government. The code change (2.2-307 et seq.) was a result of recommendations from the Governor's Commission on Government Reform (<http://www.reform.virginia.gov/>). The law established the **OSIG** to be headed by a State Inspector General to:

- investigate complaints alleging fraud, waste, abuse, or corruption by a state agency or non-state agency or the officers and employees thereof, and

- examine the management and operation of state agencies.

In addition to other provisions, the code change consolidated the Offices of Inspector General of the Departments of Behavioral Health and Developmental Services, Corrections, Juvenile Justice, and Transportation, and the Department of the State Internal Auditor into this new office.

Prior to and since the consolidation, the purpose of the **OIG for Behavioral Health and Developmental Services** (OIG-BHDS) is to provide additional oversight and monitoring for facilities or programs licensed or operated by DBHDS, primarily involving quality and standards of care issues. The OIG-BHDS resigned from his position in March of 2014. Originally authorized under Code of Virginia § 37.2-424, the mandates for the OIG-BHDS were moved to the new code section at § 2.2-309.1. As noted by the former state OIG in his *SFY 2013 Annual Report to the Governor and General Assembly of Virginia* ([http://osig.virginia.gov/media/2408/annualreport2013\\_20130829.pdf](http://osig.virginia.gov/media/2408/annualreport2013_20130829.pdf)), the BHDS division is exclusively responsible for:

- conducting annual, unannounced inspections of the 16 state facilities operated by DBHDS;
- inspecting, monitoring and reviewing the quality of services at the state-operated facilities and the 814 providers of behavioral health and developmental services;
- assuring that the General Assembly and Joint Commission on Health Care are fully and currently informed of significant problems; and
- investigating specific complaints of abuse, neglect, or inadequate care.

Reports on each OIG onsite visit, study, or investigation are published on the OSIG website. Reports from the OIG-BHDS published prior to 2013 can be found at <http://www.oig.virginia.gov>. Those published in and after 2013 are located at <http://www.osig.virginia.gov>. Reports include findings and recommendations for service or system improvements along with responses from the facilities or programs identifying the actions that they have taken or will be taking to address each OIG finding.

In its September 2010 semi-annual report, the OIG-BHDS recommended that DBHDS complete work in the areas of emergency services, critical incident reporting, determining readiness for discharge, and educating family members and authorized representatives of individuals residing in state Training Centers about community options. See <http://www.oig.virginia.gov/documents/SAR-4-1-10-9-30-10.pdf>). This report also provided the first summary of **findings related to the US Department of Justice (DOJ) investigation** that resulted in the Settlement Agreement. The OIG-BHDS has been monitoring DBHDS activities to implement the Settlement Agreement. (More information is included in the **Community Living Supports** chapter of this *Assessment*.)



The *SFY 2013 Annual Report to the Governor and General Assembly of Virginia* by the state OIG ([http://osig.virginia.gov/reports/docs/AnnualReport2013\\_20130829.pdf](http://osig.virginia.gov/reports/docs/AnnualReport2013_20130829.pdf)) reported on the former OIG-BHDS activities during SFY 2013. During that year, the OIG reviewed 680 critical incidents, 11 abuse/neglect cases, and 74 deaths. The report included information on deficiencies of the behavioral health and developmental disabilities system that remain outstanding from previous reports published by the OIG-BHDS. Recommendations were made with respect to a number of areas. Those related, at least in part, to individuals with ID/DD are noted below.

Recommendations include the need for:

- improved performance measures and accountability, including integration into the DBHDS strategic planning process;
- development of quarterly updates (that are compliant with the Health Insurance Portability and Accountability Act) summarizing the number of individuals and issues related to the Extraordinary Barriers List (EBL) at each state facility to document the number and type of issues related to the ability of residents to successfully transition from facility to community; and
- evaluation of supported housing requirements needed for each region to reduce the Extraordinary Barriers List with a report of findings to the commissioner and OIG by January of 2013.

#### **disAbility Law Center of Virginia (dLCV)**

As the Commonwealth's protection and advocacy system, **dLCV**, formerly the Virginia Office for Protection and Advocacy (VOPA) serves as an additional oversight entity for the State's facilities and programs for individuals with disabilities. Authorization for its activities is provided by various federal statutes and by the Code of Virginia (51.5-39.2) as

*[T]he agency to protect and advocate for the rights of persons with mental, cognitive, sensory, physical, or other disabilities and to receive federal funds on behalf of the Commonwealth of Virginia to implement the federal Protection and Advocacy for Individuals with Mental Illness Act, the federal Developmental Disabilities Assistance and Bill of Rights Act, the federal Rehabilitation Act, the Virginians with Disabilities Act and such other related programs as may be established by state and federal law.*

In carrying out its responsibilities to support and defend the rights of individuals with disabilities, the Code of Virginia § 51.5-39.4 gives it the authority to:

- Resolve complaints concerning violations of individuals' rights when related to their disabilities, and
- Access facilities, institutions, providers, and records of these facilities, institutions, and providers consistent with various sections of the Code of Virginia.

With regards to the latter, dLCV is specifically authorized to access records of an individual with a disability

*who by reason of his mental or physical condition is unable to authorize the Office to have such access; (2) who does not have a legal guardian or for whom the Commonwealth, or designee of the Commonwealth, is the legal guardian; and (3) with respect to whom a complaint has been received by the Office or with respect to whom there is probable cause to believe that such person has been subjected to abuse or neglect.*

Directors of all state facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) are required by the Code of Virginia § 37.2-709 to send information about critical incidents or deaths of clients to dLCV in writing within 48 hours of their occurrence. A critical incident is defined as being “serious bodily injury or loss of consciousness requiring medical treatment.” dLCV staff reviews these reports to identify data trends as well as possible instances of abuse and neglect and conducts follow-up investigations as the office deems appropriate. dLCV also regularly monitors facility conditions and follows up on injuries to individuals served at the state’s Training Centers and other institutions. When violations are found, dLCV first attempts to resolve complaints through administrative remedies but has the authority to pursue legal or other alternative remedies to protect individuals’ rights.

dLCV posts its investigation reports on its website. The most recent report posted related to care and conditions in Training Centers was under the auspices of VOPA, dLCV’s predecessor, and addressed **dental care** in the Training Centers. VOPA had the following findings described in detail in their report, which also referenced an investigation by the Virginia Department of Health Professions:

- The Training Centers failed to comply with the accepted standard of care for the provision of daily dental care.
- The Training Centers failed to comply with the accepted standard of care applying to the practice of dentistry.

A number of specific recommendations were included in the report. For more information on the findings and recommendations, see <http://disabilitylawva.org/wp-content/uploads/2013/06/dental-care-investigation-report-March-2012.pdf>.

## C. Nursing Facilities

Referred to as a “nursing facility” in this *Assessment*, the Code of Virginia (§ 32.1-123) defines a **nursing home** as

*any facility or any identifiable component of any facility licensed pursuant to this article in which the primary function is the provision, on a continuing basis, of nursing services and health-related services for the treatment and inpatient care*

*of two or more nonrelated individuals, including facilities known by varying nomenclature or designation such as convalescent homes, skilled nursing facilities or skilled care facilities, intermediate care facilities, extended care facilities and nursing or nursing care facilities.*

It further defines a **certified nursing facility** as

*any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing home, whether freestanding or a portion of a freestanding medical care facility, that is certified as a Medicare or Medicaid provider, or both*

under Title XVIII of the national Social Security Act (42 USC 1395). Entities exempted from this definition and subsequent provisions of the Code of Virginia (§ 32.1-124 through 136) include institutions licensed by DBHDS, institutions or portions thereof licensed by the State Board of Social Services, nursing facilities owned or operated by the federal government, and nursing facilities owned or operated by the State unless it is certified as a nursing facility.

As of October 1, 2010, to ensure that individuals reside in the “least restrictive environment,” CMS required new elements in the comprehensive assessment of each potential or current nursing facility resident that occurs at admission, annually, and whenever there is a significant change in a resident’s status. This **Return to Community Referral Assessment** requirement is described in more detail in the **Eligibility for Nursing Facilities** section of this chapter below.

In a federally initiated effort to have states shift the balance of their systems from institutional to community-based services, the Commonwealth received \$28 million in federal funding beginning in July of 2008 for a **Money Follows the Person (MFP)** demonstration project. With these funds, Virginia planned to facilitate the transition of 1,041 individuals back to community settings of their choice during state fiscal years 2009 through 2011. These individuals are elderly (325) or have intellectual or other developmental disabilities (358 each) and are currently receiving services in institutions, such as nursing facilities, ICFs/IID, and long-stay hospitals. To do so, the State’s MFP project enriched services provided under several of the Medicaid Home and Community Based Services (HCBS) Waivers. Through trained staff at Transition Coordination agencies, MFP developed and implemented transition plans that supported individuals’ housing and transportation needs.

The Kaiser Family Foundation’s Kaiser Commission on Medicaid and the Uninsured issued its most recent MFP Snapshot in February of 2013. According to its report, *Money Follows the Person: A 2012 Survey of Transitions and Costs*, 25,000 individuals nationwide have transitioned back to the community as of August of 2012, and 6,400 transitions were in progress at that time. Three states, Ohio, Texas, and Washington, made up nearly half (43 percent) of all transitions. As noted in the Kaiser Commission’s MFP: Snapshots for 2010, 2011, and 2012, start-ups under the program were slow, but states have increased transitions significantly since

2010. The report is available at

<http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8142-03.pdf>.

Originally a 4-year initiative, MFP was extended until 2016 under the Affordable Care Act (ACA). To strengthen the program and address the issues being faced by Virginia and other states, CMS made program changes and approved additional funding effective June of 2011 through 2016. All MFP participants must still meet eligibility criteria for Medicaid HCBS Waivers at the time of discharge; however, the original MFP eligibility requirement that an individual be a resident in an institution for 6 consecutive months was reduced to 3 months. Additional administrative funding received by Virginia was used to add several new positions at DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) to focus on discharge planning, housing, and transitions.

Virginia was much like other states in its slow start up and its number of overall transitions. According to the Department of Medical Assistance Services (DMAS), there have been 696 MFP transition program enrollments and 539 actual transitions between 2008 and 2013. 469 individuals made the transition between 2008 and 2012, and an additional 70 people transitioned between January and May of 2013. These individuals moved using the Medicaid Home and Community Based Waiver supports shown in **Table 84**.

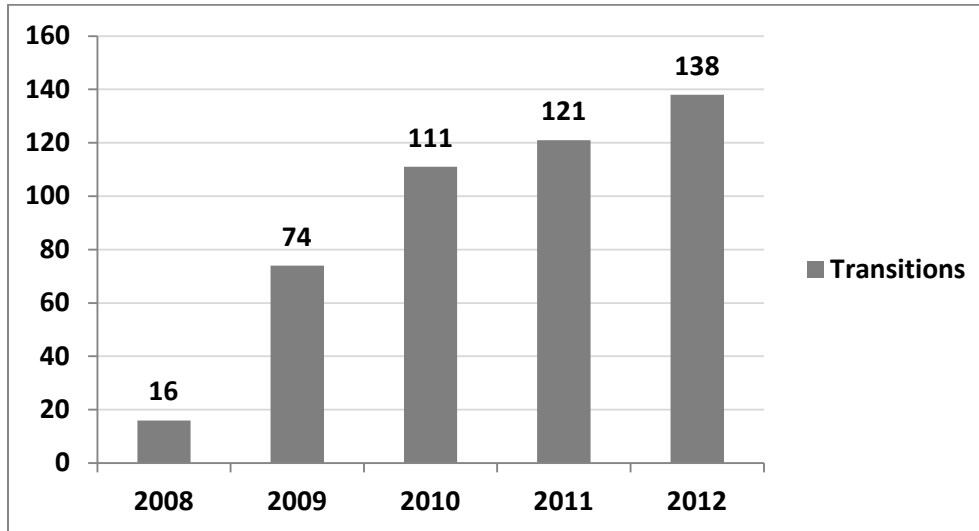
Table 84. Money Follows the Person Transitions for CYs 2008–2013						
Medicaid Waiver	EDCD Waiver	ID Waiver	DD Waiver	Tech Waiver	AIDS Waiver	PACE Program
Number Transitioning	197	329	7	2	3	1

Causes of slow progress included delays in the development and approval of operational protocols, outreach to institutions, and the recruitment and training of transition coordinators. Continuing problems cited by DMAS include the resistance of nursing facilities and other institutions to MFP outreach, a lack of affordable, accessible housing, stressed State resources for necessary activities, and the amount of time needed to arrange appropriate community services. Since the beginning of the program, there also has been a **barrier to securing environmental modifications or assistive technology** that individuals need in order to transition. This has yet to be resolved: *The waiver cannot pay for services until the individual has left the institution; yet, the individual cannot leave the institution until they have the needed modifications.* Funding from the Department of Housing and Community Development for this purpose has been exhausted. A number of interagency meetings have been held to discuss possible solutions, but as of the time of this assessment, no resolution has been achieved. It is unclear how many individuals this affects.

As **Figure 27** shows, transitions have increased slowly but steadily since 2010. Standing at 70 transitions between January and May of 2013, the total for the year should reach or exceed the number of transitions completed in 2012. MFP transitions must be made to a setting of 4 beds or less. The vast majority of MFP transitions (over 75 percent) under the ID Waiver have

been to group homes with a smaller number moving to apartments. For those exiting through the EDCD waiver, the majority have gone to an apartment with slightly fewer moving back to their own homes. The DD Waiver does not allow for transition to a congregate facility.

**Figure 27. Annual MFP Transitions for CYs 2008–2012**



Source: Department of Medical Assistance Services, *Data Updates: Money Follows the Person Program*. Note that this chart represents 460 transitions, not the 469 figure discussed above, which represents an updated figure in a more recent report. A further breakdown to determine in what years the additional 9 transitions took place is not available.

Between 2008 and 2012, the highest number of transitions (111) was in the Central Virginia region, and the majority of these individuals were between 45 and 65 years old. This is consistent with the national average age of 56 years as noted in the Kaiser Commission report referenced above. Most of the Virginians who transitioned during that time period (over 80) had been in an institution for less than 1 year. About 50 individuals were in an institution for 1 to 2 years, and about 25 were in an institution for 6 to 10 years. The range of time spent in an institution prior to discharge was less than 1 year to over 50 years. The 2013 figures (not final at the time of this assessment) provide a different age range. As of May 2013, 55 of 70 individuals who transitioned were between the ages of 22 and 64. Five were under the age of 22, and 10 were over 65. It is positive that there is more participation and transitions are now increasing. However the numbers remain quite low, and the Money Follows the Person program has not met expectations.

The target population of the **Department of Justice Settlement Agreement** sets forth particular requirements for children in NFs and ICFs. The Agreement requires DBHDS and the Department of Medical Assistance Services (DMAS) to target waiver slots for children younger than 22 who reside in NFs and ICFs and want to transition to the community. The Settlement Agreement required 25 children to transition using the Intellectual Disability (ID) waiver, and 15 children using the Developmental Disability (DD) Waiver in SFY 2013. That did not happen. As of

the July 31, 2013 DBHDS, *DOJ Implementation Update to the Governor and Chairs of the Senate Finance and House Appropriations Committee* (Item 315.V.I. of the 2012 Appropriations Act) only 11 children had transitioned. DBHDS and DMAS have been meeting with NFs and ICFs to discuss how to work directly with families. A workgroup that includes The Arc of Virginia, the Virginia Board for People with Disabilities, and Centers for Independent Living was established to assist, but there has not been significant progress. The DOJ Independent Reviewer, in his December 6, 2013 *Report on Compliance with the Settlement Agreement*, found the Commonwealth to be out of compliance with respect to this requirement. For more information, see [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD1612013/\\$file/RD161.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD1612013/$file/RD161.pdf) and the **Monitoring and Evaluation of ICF/IID Services** section of this *Assessment*.

Around the time that the report was issued, DBHDS staff requested technical assistance from PASRR Technical Assistance Consultants (PTAC) to formulate a new plan to increase the number of children transitioning from NFs and ICFs/IID. A draft implementation plan was submitted in March of 2013. Comment on the plan was solicited and more work has been done on the plan. In his fourth report, the Independent Reviewer notes that the revised plan will

*reportedly include initiatives to prevent the further unnecessary institutionalization of children.*

The Reviewer states that the

*success of the plan will be increased if the range of supports available to individuals transferring from Training Centers is available for children transitioning from nursing facilities. These include Bridge Funds, enhanced rates, 24-hour nursing, customized community programs ... and housing supports.*

See <http://www.dbhds.virginia.gov/settlement/ODS-140606IRReport.pdf>.

## **1. Eligibility for Nursing Facilities**

As detailed in *A Guide for Long-Term Care Services in Virginia* by the Department of Medical Assistance Services (DMAS), admissions to one of these facilities may occur when an individual:

- cannot care for personal needs and requires more care than his or her family or loved ones can or is willing to provide;
- has extensive or complex medical conditions that may be unstable or has the potential for instability;
- has been recommended for nursing facility placement by his or her physician;
- has a medical condition that requires observation and assessment to assure evaluation of needs due to an inability for self-observation or self-evaluation; or
- lacks adequate supports and resources, including environmental adaptation for functional needs, to ensure his or her health and safety.

The guide is available at [http://dmasva.dmas.virginia.gov/Content\\_attachments/ltc/ltc-guide\\_srvcs.pdf](http://dmasva.dmas.virginia.gov/Content_attachments/ltc/ltc-guide_srvcs.pdf).

The federal Centers for Medicare and Medicaid Services (CMS) requires a **Return to Community Referral Assessment** (also referred to as MDS Section Q) that includes a specific question about whether the individual is interested in speaking with someone about the possibility of moving out of the nursing facility and back into the community. If the individual requests such information, CMS guidelines require the nursing facility to initiate care planning to provide it. This does not commit the individual to a move but guarantees that he or she will receive information about the options and process for making a transition. More information about these guidelines is at <http://www.vdh.virginia.gov/OLC/LongTermCare/returntocommunity.htm>. If the individual does want to move to the community and has transition needs that the facility cannot plan for or provide, the facility must make a referral to an appropriate community resource. The community agency then serves as the initial point of contact to provide the resident with introductory information about community resources and collaborate with the nursing facility to make arrangements for the individual's transition to community living. In either instance, the nursing facility remains responsible for discharge planning and development of a post-discharge plan with the resident and his or her family, as appropriate.

Based on CMS guidance, Virginia has designated Area Agencies on Aging (AAAs) to serve as the local contact agency (LCA) with the primary, but not exclusive, role of providing information and technical assistance for nursing facility transition. The LCA's role is to contact individuals referred to them by nursing facilities through the MDS Section Q processes in a timely manner, provide information about choices of community services and supports appropriate to the person's needs, and collaborate with the nursing facility to effect the transition. The LCA referrals go to the State's Centers for Independent Living (CILs) if the interested individual is not eligible for the Money Follows the Person (MFP) initiative described above. If the individual has an intellectual disability, the LCA referral goes to the local CSB. If the individual is MFP eligible, the LCA refers the individual to the MFP transition coordinator that the individual chooses for transitioning to the EDCD or Tech Waiver. They may also refer to the local screening clinic or the DD case management organization of the individual's choice. Each state determines the extent of the LCA's contact and roles. Other public or private entities, including Centers for Independent Living (CILs), also can and do provide this information and assistance.

## **2. Access to and Use of Nursing Facilities**

Admission to a nursing facility is required to be based on a formal, face-to-face assessment by a trained, qualified professional. Individuals may be screened while at home or in another community setting or during a treatment stay at an inpatient hospital. Individuals may also be screened in the nursing facility if the screening is not done prior to admission or when the individual needs Medicaid long-term care support (e.g., Medicaid Waiver or PACE) at the time of transition from the facility to the community. Community-based assessments are conducted by a social worker from the local social services department and a nurse from the local health

department. Results of their assessments are forwarded to the director of the local health department for a decision on whether nursing care is necessary.

A screener conducts the assessment using the **Uniform Assessment Instrument (UAI)**, a standardized, multi-dimensional questionnaire that addresses an individual's social functioning, physical and mental health, medical and nursing needs, and functional abilities. Federal regulations (§ 483.20 Resident Assessment) require that the individual be reassessed every three months. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed, direct care staff members on all shifts.

Although the requirements are clear, throughout the implementation of the **Money Follows the Person (MFP) Program**, reports have been made by transition coordinators and peer mentors that there have been numerous instances in which it has been found that a person in a nursing facility did not have a UAI in their file. In some instances, individuals could not transition from nursing facilities with Medicaid-funded community supports such as the EDCD Waiver or PACE because they did not have a UAI that indicated that they required nursing facility care (although they were in the nursing facility). Data on the number of individuals to whom this applies is not kept; however, the reports over several years at MFP and other meetings have been so widespread that even if anecdotal, they bear examination.

Further, there is an acknowledged significant backlog in local departments of social services, health departments, and hospitals for completing UAI screenings. This led to the passage of HB 702 by the Virginia General Assembly. HB 702 amends § 32.1-330 of the Code of Virginia, adding § 32.1-330.4. The new code section requires that the Department of Medical Assistance Services (DMAS) contract with other public or private entities to conduct the required community-based and institutional screenings in addition to or in lieu of the screening teams described in the Code in jurisdictions in which that team has been unable to complete a screening within 30 days of the individual's application. This should eliminate the backlog and lead to identification of all individuals who are required to have—but do not have—a UAI. However, it does not resolve concerns expressed by advocates over a number of years that the UAI represents a medical model of assessment and is not person centered.

Medical or nursing needs include such things as wound care and assistance in medication administration. Functional ability refers to the degree of assistance that an individual requires to complete daily living activities such as bathing, toileting, or dressing. Based on the information gathered using the UAI, the screener determines the person's care needs, whether he or she meets the criteria for nursing facility care, and whether or not he or she will be at risk of nursing facility placement if additional assistance is not received. When UAI screening indicates that an individual may have or does have a diagnosis of an intellectual or other developmental disability (ID/DD) or a serious mental illness, federal regulations require an additional "Level II" evaluation, the **Pre-Admission Screening and Resident Review (PASRR)**.



The PASRR determines whether a nursing facility is the most appropriate setting to meet both the individual's medical and physical needs and his or her behavioral or psychiatric needs. In Virginia, when ID/DD or a serious mental illness is suspected or known based on the Uniform Assessment Instrument (UAI), the local pre-screener sends a report to DMAS and the Department of Behavioral Health and Developmental Services (DBHDS). Staff members from the two agencies consult on the findings as indicated and, if a PASRR has not been completed recently, DMAS (as the purchasing agency) will typically request a PASRR evaluation through its contract with Dual Diagnosis Management Ascend (DDM Ascend), a private provider. This evaluation must be completed within 5 to 7 working days of receipt of the UAI assessment. Based on the PASRR findings, DBHDS conducts a Quality Assurance review and advises DMAS on appropriate placement and specialized services needed by the individual. DMAS then determines whether or not a nursing facility is appropriate.

Nursing facility residents with ID/DD, as well as those eligible for the Money Follows the Person demonstration project described above, are part of the target population in the Commonwealth's Settlement Agreement with the Department of Justice. Therefore, helping individuals who want to move out of nursing facilities make the transition and diverting individuals who could be supported in the community from moving into nursing facilities is an increasing priority.

If an individual needs to be assessed during a hospital stay, a hospital social worker or discharge planner typically conducts the UAI evaluation and explains its results. When support needs are identified, the staff person must describe the long-term care options available, both institutional and community-based. State and federal regulations also require that hospital staff ask the individual about their preference for receiving services. If after receiving this information, an individual chooses to stay in the community, the hospital must make a referral to appropriate community resources.

If an individual chooses institutional care, hospital staff provides him or her with a list of nursing facilities in the area that have available beds, and in all cases, a nursing facility selected by an individual must provide that individual with a written description of services, charges, and fees *before* the individual moves to that facility. Lists of nursing facilities are also available from SeniorNavigator (<http://www.seniornavigator.com>) using a search for key words such as nursing facility, skilled nursing facility, or nursing facility in a specific geographic area. The information provided will include the number and type of certified beds based on the latest available information from the Virginia Department of Health (VDH).

The *Guide to Choosing a Nursing Home*, a booklet available online from CMS (<http://www.medicare.gov/Publications/Pubs/pdf/02174.pdf>), encourages individuals interested in nursing facility care to contact or meet with local AAAs, CILs, or other appropriate community resources to identify all available long-term care options. Quality-of-care information for making a more informed choice also can be obtained using the Medicare Nursing Home Compare online tool (<http://www.medicare.gov/NHCompare/Home.asp>) or by contacting VDH, DMAS, the Virginia Department for Aging and Rehabilitative Services (DARS)

Division of Aging Long-Term Care Ombudsman program, or local consumer affairs offices. Comparative site visits to various facilities being considered are also recommended.

Once an individual has entered a nursing facility, a comprehensive plan of care must be developed based on a formal assessment of his or her needs for supervision, assistance with daily living activities, therapy, nursing care, and other related services. This plan includes assessments of the resident's clinical and psychosocial needs, appropriate interventions to meet them, treatment goals, and measures to identify progress in achieving the goals. If the individual received a PASRR evaluation as a part of his/her assessment, the plan must also incorporate its recommendations. A written discharge plan is also required as part of the individual's clinical record and must include the services to be delivered, goals to be achieved, and the post-discharge services needed or final disposition at the time of discharge.

In 2010, DMAS developed and implemented **Virginia Gold** in collaboration with other state agencies, long-term care providers, and stakeholders to improve the quality of care in nursing facilities by increasing retention of Certified Nursing Assistants (CNAs) through better employee benefits, workforce models, and organizational practices. The Virginia Gold pilot projects involved five nursing facility grantees and ended on August 2011. It focused on enhanced staff orientations, peer mentoring, coaching supervision, staff rewards and recognition, and training. Each grantee had a work plan with objectives; tracked the monthly number of CNAs employed, the number terminated, and the reasons for termination, such as retirement, resignation, or dismissal for cause; and submitted mandatory reports on project activities, their results, and progress toward meeting program objectives.

In July 2012, DMAS published a *Review of the Virginia Gold Quality Improvement Program* ([http://www.dmas.virginia.gov/Content\\_atchs/ltc/vagold-rpt3.pdf](http://www.dmas.virginia.gov/Content_atchs/ltc/vagold-rpt3.pdf)). The agency found that the program achieved its intended goal of improving quality of care by developing a supportive work environment for CNAs and that the program may represent a good investment for states and other interested organizations.

In interviews with participants, peer mentoring was noted to be an effective strategy for improving retention. Other strengths reported from the CNA focus groups included greater recognition, professional and relational skills training, and supportive relationships among staff. Weaknesses reported by the focus groups included inconsistent or insufficient peer mentoring, inadequate reward incentives for CNAs, limited combined relationship skills training for CNAs, nursing and supervisory staff, and strained relationships among some CNAs, nursing and supervisory staff. Overall it was reported by the small group of individuals involved in the pilots (a study limitation) that retention was improved and residents received a better quality of care.

According to the Virginia Department of Health, in 2013, there were more than 279 nursing facilities containing 31,927 beds located throughout Virginia. All but 15 nursing facilities are certified for federal reimbursement under Medicare and Medicaid (<https://www.vdh.virginia.gov/OLC/LongTermCare/>). During state fiscal year (SFY) 2010, the number of nursing facilities was the same. The facilities are each unique in their day-to-day

operation. Because of staff availability, especially psychiatrists or psychologists, they vary in their capacity to serve individuals with complex needs such as serious mental illness, intellectual disability, or behavioral problems and, as a result, variation exists in the populations that they accept for services. According to DMAS data, most nursing facilities primarily serve individuals ages 65 and over. The information in **Table 85** shows the number of individuals served in nursing facilities in SFYs 2010 and 2013.

<b>Table 85. Ages of Nursing Facility Residents by SFY</b>			
<b>Age Groups</b>	<b>2010</b>	<b>2013</b>	<b>% Change</b>
Under 1 year	1	1	0%
1–5 years	21	21	0%
6–14 years	38	31	- 18.4%
15–20 years	29	29	0%
<b>Subtotal for Ages 1–20</b>	<b>89</b>	<b>82</b>	<b>- 7.9%</b>
21–44 years	622	584	- 6.1%
45–64 years	4,251	4,607	8.4%
<b>Subtotal for Ages 21–64</b>	<b>4,873</b>	<b>5,191</b>	<b>6.5%</b>
Ages 65 and older	22,588	22,668	0.35%
<b>Total for All Ages</b>	<b>27,550</b>	<b>27,941</b>	<b>1.4%</b>

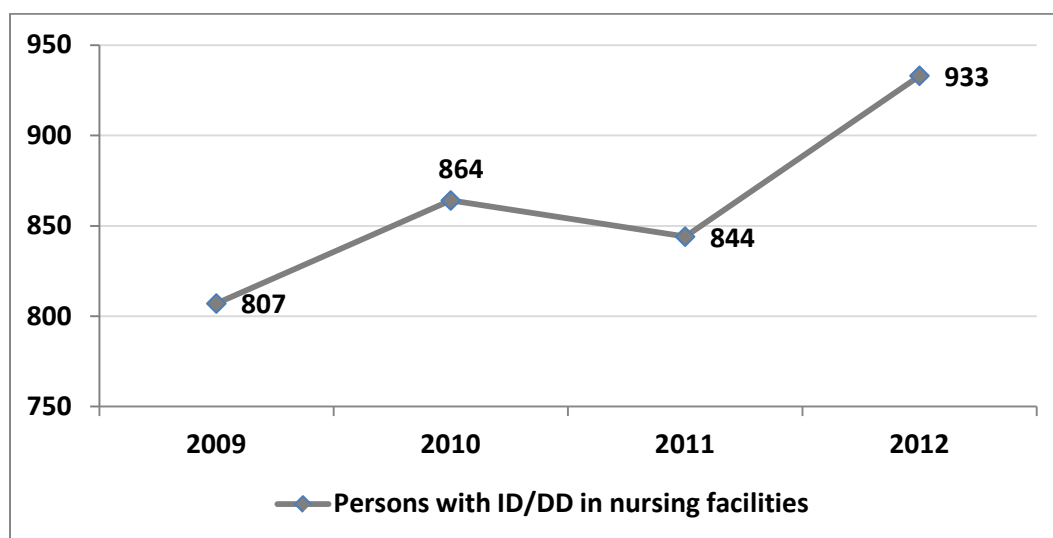
Source: Department of Medical Assistance Services, Long-Term Care Division.

Overall the number of individuals in nursing facilities remains stable. The population of those between 6 and 14 years old has gone down over 18 percent, which is positive. However, there are still 82 children under age 21 living in nursing facilities. These children are part of the target population for the Commonwealth’s Settlement Agreement with the Department of Justice. A potentially concerning trend is the increase in the number of people between the ages of 45 and 64 entering nursing facilities, particularly with the Commonwealth’s focus on aging in place. In SFY 2014, there were 27,708 individuals in nursing facilities. The number of children under a year old has decreased from 11 in SFY 2004 to 1 in SFY 2013, while those between the ages of 1 and 14 has remained about the same.

Individuals with intellectual or developmental disabilities (ID/DD) are a sub-population served at nursing facilities, and preliminary data from the 2013 edition of the *State of the States in Developmental Disabilities* (<http://www.stateofthestates.org/>) reports Virginia as being one of 26 states with nursing facility census reductions between FFYs 2009 and 2011. However, Virginia’s nursing facility census remains higher than the national average utilization rate. That

rate was 10.1 out of 100,000 of general population; Virginia's rate was 13.4 per 100,000. **Figure 28** shows a steady increase in the number of individuals with ID/DD residing in nursing facilities with the exception of SFY 2011 when there was a decrease. SFY 2012 shows a sharp uptick in the reported number of residents with ID/DD residing in nursing facilities. Upon inquiry, the Department of Behavioral Health and Developmental Services (DBHDS) did not have an explanation for the increase.

**Figure 28. Reported Number of Nursing Facility Residents with ID/DD in Virginia**



Sources: Department of Behavioral Health and Developmental Services and University of Minnesota, *Residential Services and Trends for Persons with Intellectual and Developmental Disabilities: Status and Trends through Fiscal Year 2011*, National Residential Information Systems Project (2013).

In addition to the issues above among the reports that provide data on the placement of people with ID/DD in nursing facilities, methodologies and disability definitions or categories vary, making it difficult to identify trends. The *State of the States in Developmental Disabilities* (the national report mentioned above) analyzes data collected from both state ID/DD agencies and from the CMS Online Survey, Certification, and Reporting (OSCAR) system. The University of Minnesota Institute on Community Living publishes another report, *Residential Services for Persons with Intellectual and Developmental Disabilities: Status and Trends through Fiscal Year 2011—National Residential Information Systems Project (RISP)* (<http://rtc.umn.edu/risp/docs/risp2011.pdf>). This report provides information from state survey data regarding residential settings for people with ID/DD, including average daily census, facility depopulation, expenditures, utilization rates, facility closures for state- and non-state-operated residential settings, as well as information on status and changes in Medicaid-funded residential and related services.

While this comparative information can be useful, the information is only as good as the data provided by the states. In **Figure 28** above, the Virginia Board for People with Disabilities chose to leave 2008 data out because, according to the Department of Behavioral Health and

Developmental Services (DBHDS), during that year (and all previous years), the number reported by to the national RISP report included nursing facilities at ICFs/IIDs as well as generic nursing facilities, thus inflating the total. DBHDS provided corrections to the University of Minnesota's RISP report SFYs 2009 and 2010 after the 2011 edition of this *Assessment* was published. For SFY 2013, DBHDS reported that certain diagnosis categories were added based on Department of Medical Assistance Services (DMAS) diagnostic codes for payment to facilities. These include multiple sclerosis, muscular dystrophy, spina bifida, and some categories of brain injury. This is problematic since some, but not everyone, in these categories would meet the definition of developmental disability, and it also indicates that individuals who did meet the definition in years past were not included in the figures that denoted the number of individuals with ID/DD. At this point it is clear that the Commonwealth is not meeting its obligation under the Settlement Agreement to identify individuals in nursing facilities with ID/DD, and that the data provided over the course of many years are unreliable.

### **3. Available Nursing Facility Services**

The nursing facilities (NFs) covered below are required by federal and state regulations to provide or to obtain a full range of appropriate medical, health, and rehabilitative services to meet the needs identified by formal assessment of the individuals they serve with:

- room and board,
- 24-hour-a-day nursing care,
- personal care,
- supervision, and
- various therapies and rehabilitation.

They may be operated by local public agencies or by private nonprofit and for-profit organizations.

**Core services**, which may be provided either directly or by contract, include physical, occupational, and recreational therapy; speech pathology; and nutritional, medical, dental, pharmaceutical, psychological, and social services. Based on their residents' needs, nursing facility services may include assistance with and supervision of daily living, recreation, and social activities. Room and board, some medical equipment and supplies, and laundry services are included in the daily rate. Skilled nursing care, as well as physical, occupational, and speech therapies and medical, dental, and pharmaceutical services, are usually provided on premises. Additional equipment and other services, including adult day care or respite care, may also be provided.

### **4. Cost and Payment for Nursing Facility Services**

Nursing facilities are funded from both private and public sources. Medicare and Medicaid are significant sources of funding. However, to be covered by Medicare, medical conditions

apply, and an individual must receive the services from a Medicare-certified, skilled nursing facility immediately following a qualifying hospital stay of at least 3 days. Other sources of payment include personal, out-of-pocket expenditures as well as various types of purchased private insurance such as long-term care insurance, Medicare Supplemental Insurance (“Medigap”), or managed care health insurance. Managed care will only pay for nursing facility services if the facility has a contract with the plan. Medigap insurance is sold by private companies and can help pay some of the health care costs not covered by Medicare such as copayments, coinsurance, and deductibles. For more information, go to <http://www.medicare.gov/nursing/Payment.asp>.

Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to comply with the requirements in 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs (<http://www.law.cornell.edu/cfr/text/42/part-483/subpart-B>). To receive reimbursement through Medicare or Medicaid, facilities must conform to specific federal **Centers for Medicare and Medicaid Services (CMS)** standards. Nursing facilities may be CMS certified for Medicare, Medicaid, or both under the following categories.

- **Skilled Nursing Facility (SNF):** Any long-term care bed specifically certified for **Medicare** reimbursement.
- **Nursing Facility (NF):** Any long-term bed specifically certified for **Medicaid** reimbursement.

Almost all nursing facilities in the State are certified for either Medicaid or Medicare according to the Virginia Department of Health (VDH), Division of Long Term Care’s website (<http://www.vdh.virginia.gov/OLC/LongTermCare>). However, **public insurance** coverage for these facilities varies. **Medicaid** will pay most costs incurred in a CMS-certified nursing facility for persons with income and assets meeting eligibility limits. Others, including about half of all nursing facility residents, pay costs out of their own savings, as noted in the CMS nursing home guide referenced earlier. Many individuals who move into nursing facilities initially do not qualify financially for Medicaid but eventually exhaust their savings and other resources, enabling them to become eligible for Medicaid. More detailed information on these eligibility requirements can be found in the **Medicaid** chapter of this assessment.

Most nursing facility care is not covered by the basic **Medicare** plan, but under limited conditions, it will pay for up to 90 days of certified skilled nursing facility care when an individual has had at least a 3-day inpatient hospital stay immediately prior to the nursing facility admission and the care has been determined to be medically necessary to recover from an illness or injury.

**Medicare Supplemental Insurance**, often called “**Medigap**,” helps pay for items not covered by Medicare such as deductibles and copayments. Most Medigap plans will help pay for skilled nursing care, but only when that care is covered by Medicare. Some employer group health insurance plans and long-term care insurance plans can help cover nursing facility costs, but a managed care insurance plan will help pay for care only if it has a contract with a

particular nursing facility. Costs and benefits for all of these types of plans vary widely, but many nursing facility residents who pay for care out of their own private funds receive some assistance from these plans.

Annual nursing facility costs are substantial. The *Genworth 2013 Cost of Care Survey* (<https://www.genworth.com/corporate/about-genworth/industry-expertise/cost-of-care.html>) reports that the median annual cost of nursing facility care in Virginia was \$74,460 for a semi-private room, an increase of over 13 percent from the 2010 survey figure of \$65,700. For a private room, the cost went from \$73,000 in 2010 to \$83,950 in 2013, a 15-percent increase.

According to the Virginia Department of Medical Assistance Services (DMAS), a total of \$836.9 million in Medicaid funds were spent on **nursing facility care** in state fiscal year (SFY) 2013. It accounted for 11 percent of total Medicaid expenditures for the year. In SFY 2010, \$793.4 million in Medicaid funds were expended on **nursing facility care**, 12 percent of all Medicaid expenditures. In 2010, the Virginia General Assembly reduced Medicaid reimbursement rates for nursing facilities by 3 percent effective in SFY 2012; however, the 2011 General Assembly voted to reverse that decision, eliminating the planned SFY 2010 rate reduction. The 2011 budget amendment also restored full funding to continue an incentive payment for long-stay rehabilitation hospitals in SFY 2012 that had been eliminated by the legislature in 2010. The amendment provided a total of \$50.6 million in General Funds to cover both of these reauthorized expenditures.

## 5. Monitoring and Evaluation of ICFs/IID and Nursing Facilities

The Virginia Department of Health (VDH) and the Virginia Department of Behavioral Health and Developmental Services (DBHDS) have responsibilities for oversight and monitoring of all nursing facilities and public or private intermediate care facilities for individuals with intellectual disability (ICFs/IID). The jurisdictions and activities of each agency are different. The responsibilities of DBHDS with respect to ICFs/IID were covered in the **Monitoring and Evaluation of ICF/IID Services** section of this chapter. This section addresses VDH responsibilities.

Titles XVIII and XIX of the national Social Security Act (42 USC 1395 and 1396, respectively) require that each state designate an official “**survey and certification agency**” for Medicare and Medicaid to monitor and certify facilities’ compliance with national standards of care on behalf of the federal **Centers for Medicare and Medicaid Services (CMS)**. The Code of Virginia (32.1-137) assigns this responsibility to **Virginia Department of Health (VDH)**, where it is carried out by the **Office of Licensure and Certification (OLC)**. VDH-OLC certifies the State’s Training Centers and public or private non-state-operated ICFs/IID, and it licenses or certifies all nursing facilities statewide. State statutes specify these oversight duties for VDH-OLC:

- providing regulatory oversight of medical care service providers licensed by VDH through routine onsite investigations and by enforcing state licensure regulations;

- receiving and investigating complaints by individuals regarding the quality of care for services provided by hospitals, nursing facilities, home care providers, hospice organizations, and the quality of care provided through managed care health insurance plans;
- inspecting health care facilities, programs, and services for compliance with federal regulations, including Medicare, Medicaid, and clinical laboratory improvement programs; and
- certifying the quality of care standards governing managed care health insurance plan providers and maintaining a registry of private review agencies.

VDH-OLC is required to conduct initial Medicare and Medicaid **certification surveys** for all new facilities and recertification surveys for each facility no later than 15 months after the last day of its previous survey. Unannounced onsite inspections to determine ongoing compliance with federal standards for health, safety, and quality of care are also required as part of the recertification process. Surveys are also required to investigate complaints, and “revisit” surveys” determine if facilities have corrected previously cited deficiencies. Its surveyors are health care professionals such as physicians, registered nurses, dietitians, social workers, and laboratory medical technologists. To ensure uniform, consistent interpretation and application of federal standards, they receive extensive training in federal standards, survey techniques, and procedures and methods for assessing direct services and treatment plans. Assessments of facility compliance with federal life and safety code requirements are provided by the Office of the Fire Marshall within the Virginia Department of Fire Programs under contract with VDH.

During each facility survey, VDH-OLC surveyors formally review clinical records as well as interview employees and individuals receiving services or their family members or guardians. Federal regulations require surveyors to directly observe the actual provision of services and care to individuals and, based on those systematic observations, assess the outcomes of care for individuals served as well as whether the services meet those individuals’ current needs. Quality of care is further examined by reviewing facility data on outcome indicators for medical, nursing, and rehabilitative care; dietary and nutritional services; activities and social participation; sanitation and infection control; and physical plant conditions. The survey also includes a review of the facility’s compliance with federal requirements for clients’ rights.

If no deficiencies are found, surveyors deem the ICF/IID or nursing facility to be in compliance with standards. A finding of **noncompliance** results when deficiencies exist that have the potential to either result in more than a minimal impact on the individual served or compromise the individual’s ability to

*maintain and/or reach his/her highest physical, mental and/or psychological well-being as defined by an accurate and comprehensive resident assessment, plan of care and provision of services.*



Noncompliant findings initiate a 6-month enforcement period for correction. For both types of facilities, the most serious finding on noncompliance is **immediate jeopardy**, which means that noncompliance with standards either has caused or is likely to cause “serious injury, harm, impairment or death,” and immediate corrective action is necessary. When this finding is made, the facility must immediately take all actions necessary to come into compliance with standards and to ensure processes that will prevent future reoccurrence, and these actions must be approved by the surveyors as being sufficient to resolve the citation.

Federal regulations establish several categories for citations of noncompliance with standards that apply to nursing and skilled nursing facilities, but not to ICFs/IID. Surveyors of these facilities must cite the seriousness of deficiencies based on their “severity,” the degree of actual harm or potential for harm to individuals, and their “scope,” whether they are isolated occurrences, constitute a pattern of care, or are widespread. **“Substandard quality of care” (SQC)** is a very serious citation of deficiency for nursing facilities that refers to either any deficiency in facility practices, resident quality of life, or quality of care that constitutes immediate jeopardy or a “pattern of widespread potential for or actual harm” that does not reach the level of immediate jeopardy (42 CFR 483.13 et seq.). As with immediate jeopardy, a nursing facility must immediately take corrective action.

After completing an inspection, VDH-OLC surveyors discuss their findings with the facility’s administrator or designee. When a deficiency in meeting one or more standards is found, the facility administrator must submit a plan of correction that addresses each identified deficiency citation within a specified timeframe. VDH-OLC reviews the plan of correction and either accepts it or notifies the facility of any plan of correction item that it does not accept as adequately resolving a deficiency. When the latter occurs, the facility must revise the plan until accepted. The facility administrator is then responsible for ensuring that the plan of correction is implemented and monitored so that compliance is maintained. A provider is expected to take the actions necessary to achieve compliance within 45 days of the findings notification.

VDH forwards each survey’s findings to the US Centers for Medicare and Medicaid Services (CMS) and the **Virginia Department of Medical Assistance Services (DMAS)**, the State’s designated Medicare and Medicaid administrative agency. Based on these findings, either CMS or DMAS may impose enforcement remedies for noncompliance with standards of care and, in the case of ICFs/IID, for noncompliance with their required “Conditions of Participation.” Remedies may range from mandatory staff in-service training, to civil monetary penalties and denial of payment for new admissions. Termination of Medicaid or Medicare certification may be imposed on an ICF/IID that no longer meets the Conditions of Participation or when the facility’s deficiencies pose immediate jeopardy to their residents’ health and safety.

State and federal regulations authorize **termination of the provider agreement** for a nursing facility licensed by VDH if it still fails to comply with federal standards 6 months after a finding of noncompliance. Immediate imposition of administrative sanctions or civil penalties can also be imposed by the VDH commissioner for noncompliant facilities when:

- the health and safety of residents are deemed at risk;
- quality of care has been severely compromised;
- illegal acts in the facility were permitted, aided or abetted; or
- the facility's program or services deviated significantly from those for which the license was issued without prior written approval from VDH-OLC or the facility failed to correct such deviation within a specified time.

Upon receipt of VDH's notice of intent to impose sanctions and its rationale for doing so, a facility licensed by VDH has the right to appeal under the State's Administrative Process Act (Code of Virginia 2.24000 et seq.). Possible sanctions that VDH may impose include the following:

- restricting or prohibiting new admissions to the facility;
- petitioning the court to impose a civil penalty (such as a fine), to appoint a receiver, or both; or
- revoking or suspending the facility's license.

The **VDH-OLC Complaint Unit** has the responsibility for receiving and processing allegations of violations of the standards of care and of abuse, neglect, or exploitation of individuals served by nursing facilities and other providers that VDH licenses. Complaints may be made anonymously by phone (toll-free, 800-955-1819) or in writing using a Consumer Complaint Report form that is posted online along with a copy of the confidentiality policy at <http://www.vdh.virginia.gov/OLC/Complaint/index.htm>.

Complaints pertaining to the provision of health care that may seriously jeopardize patient health or safety or that relate directly to other state and federal regulatory requirements are referred to a VDH-OLC surveyor for investigation. When the investigation is complete, the licensee and the complainant, if known, are notified of its findings. When violations are found, the same procedures for resolution and monitoring described above for certification surveys applies. Whenever VDH-OLC finds that there has been abuse or neglect, it notifies the **Adult Protective Services Division** of the **Virginia Department of Social Services (DSS)**. If the facility is not found to be in violation of applicable state or federal regulations, the complainant, if known, is notified and informed other available options for addressing the complaint, including referral to the State Office of the Long Term Care Ombudsman or another appropriate state regulatory agency. All investigative survey reports for nursing and skilled nursing facilities are also forwarded to the **State Office of the Long Term Care Ombudsman**, and that office is alerted of any findings of substandard quality of care (SQC).

The **State Office of the Long Term Care Ombudsman** was established nationally under the federal Older Americans Act in 1972 (42 USC. § 3001 et seq.). The program is mandated to receive, investigate, and resolve complaints made by or on behalf of persons in nursing facilities and assisted living facilities. In Virginia, the General Assembly expanded the program's scope in

1983 to include community-based, long-term care services provided by state and private agencies. The **Virginia Association of Area Agencies on Aging (V4A)**, which is a private nonprofit organization, manages and operates the program under contract with the Virginia Department for Aging and Rehabilitative Services (DARS). It receives federal, state, local and charitable contributions.

The Long-Term Care Ombudsman Program consists of the Office of the State Long-Term Care Ombudsman at V4A and 20 local offices located in area agencies on aging throughout the State to provide direct service in their communities. Pursuant to the provisions of the Older Americans Act and Virginia Code (§ 51.5-140), the Office of the State Long-Term Care Ombudsman has **statutory access** (with consent and within specific code provisions) to resident, facility, and patient records in assisted living facilities, adult care programs, certified nursing facilities and nursing facilities, and state hospitals operated by the Department of Behavioral Health and Developmental Services. The 2014 General Assembly passed HB 240, which modifies § 51-5-40 to expand access to records for the purpose of investigating complaints to

*providers of services by an area agency on aging or any private nonprofit or proprietary agency whenever the entity has the consent of the client, patient, or individual receiving services or his legal representative.*

It also stipulates that

*a client, patient, or individual receiving services is unable to consent to the review of his medical and social records and has no legal representative and access to the records is necessary to investigate a complaint, access shall be granted to the extent necessary to conduct the investigation. Access is also granted to the entity if a legal representative of the client, patient, or individual receiving services refuses to give consent and the entity has reasonable cause to believe that the legal representative is not acting in the best interests of the client, patient, or individual receiving services.*

In addition to the training and oversight of the local Ombudsman offices, duties of the Office of the State Long-Term Care Ombudsman include the following:

- addressing **systemic care problems** through participation in committees, task forces, and advisory boards working on issues such as staffing, workforce development, survey and enforcements processes, long-term care financing, and quality standards; and
- analyzing and monitoring the development and implementation of laws, regulations, and policies that relate to the **health, safety, welfare, and rights** of long-term care recipients; and **program data, trends and issues** in long-term care.

For more information on the Ombudsman program including how to access Ombudsman services or policies and procedures relating to the program, go to

<http://www.elderrightsva.org/aboutlongtermcare.aspx> or  
<http://www.vda.virginia.gov/ombudsman.asp>). For information on the top 10 long-term care deficiencies nationally and in Virginia for 2010–2012, see the Department of Health website at <https://www.vdh.virginia.gov/OLC/LongTermCare/documents/deficiency/Top%2010%20Health%20Deficiencies%202012.pdf>.

## D. Chapter References

Links to websites and online documents reflect their Internet addresses in June of 2014. Some documents retrieved and utilized do not have a date of publication.

### 1. Websites Referenced

**Code of Federal Regulations (CFR): 42 CFR Part 43**

<http://www.law.cornell.edu/cfr/text/42/part-483/subpart-B>

<http://www.gpoaccess.gov/cfr/index.html>

**Code of Virginia**

<http://lis.virginia.gov/cgi-bin/legp604.exe?000+cod+37.2-505>

<http://lis.virginia.gov/cgi-bin/legp604.exe?111+ful+CHAP0871>

**Kaiser Family Foundation**

<http://www.kff.org>

**Office of the Inspector General for Behavioral Health and Developmental Services**

<http://www.oig.virginia.gov>

**Office of the State Inspector General**

<http://www.osig.virginia.gov>

**SeniorNavigator**

<http://www.seniornavigator.org>

**State of the States in Developmental Disabilities (2013)**

<http://www.stateofthestates.org>

**US Department of Health and Human Services (HHS)**

<http://www.hhs.gov>

**Centers for Medicare and Medicaid Services (CMS)**

<http://www.cms.gov>

**Intermediate Care Facilities for Individuals with Mental Retardation**

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-topics/Delivery-Systems/Institutional-Care/Intermediate-Care-Facilities-for-Individuals-with-Mental-Retardation-ICFMR.html>

**Nursing facilities**

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Nursing-Facilities-NF.html>

**CMS Community Living Initiative**

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Community-Living/Community-Living-Initiative.html>

**My Medicare**

<http://www.medicare.gov/default.aspx>

**Medicaid Nursing Home Compare**

<http://www.medicare.gov/NHCompare/Home.asp>

**Medigap**

<http://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html>

**Paying for Nursing Home Care**

<http://www.medicare.gov/nursing/Payment.asp>

**Office of Certification and Compliance**

<http://www.cms.gov/CertificationandCompliance>

**Preadmission Screening and Resident Review (PASRR)**

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html>

**National Clearinghouse for Long-Term Care Information**

<http://www.longtermcare.gov/>

**US Social Security Act (42 USC 1496)**

[http://www.ssa.gov/OP\\_Home/ssact/title19/1905.htm](http://www.ssa.gov/OP_Home/ssact/title19/1905.htm)

**Virginia Department for Aging and Rehabilitative Services**

**Office of the State Long-Term Care Ombudsman Program**

<http://www.vda.virginia.gov/ombudsman.asp>

**Virginia Department of Behavioral Health and Developmental Services**

<http://www.dbhds.virginia.gov>

**Enhanced Licensing Protocol**

<http://www.dbhds.virginia.gov/documents/Enhanced%20Licensing%20Visit%20Protocol%20-%20website%20version.pdf>

**Executive Progress Report**

[https://solutions.virginia.gov/pbreports/rdPage.aspx?rdReport=vp\\_AgencyExecutiveProgressReport&Agency=720&selAgency=720&selBiennium=2&selSPVersion=2&Run=Run](https://solutions.virginia.gov/pbreports/rdPage.aspx?rdReport=vp_AgencyExecutiveProgressReport&Agency=720&selAgency=720&selBiennium=2&selSPVersion=2&Run=Run)

**Regional Support Teams**

<http://www.dbhds.virginia.gov/settlement/Regional%20Support%20Team%20Description.pdf>

**Settlement Agreement**

<http://www.dbhds.virginia.gov/settlement.htm>

**Stakeholder Group Meetings: Minutes and Supporting Materials. (January 2014, November 2013, July 2013, April 2013)**

<http://www.dbhds.virginia.gov/Settlement.htm#Meetings>

**DBHDS Training Center to Community Discharge Work Flow Process and Activities**

<https://www.dbhds.virginia.gov/documents/ODS/TC%20to%20Community%20Move%20Workflow%20process%20and%20Activities.pdf>

**Virginia Department of Health**

<http://www.vdh.virginia.gov>

**Division of Long-Term Care**

<http://www.vdh.virginia.gov/OLC/LongTermCare>

**Laws, Regulations and Guidelines**

<http://www.vdh.virginia.gov/OLC/Laws/index.htm>

**Office of Licensure and Certification**

<http://www.vdh.virginia.gov/olc>

**Return to Community Assessment**

<https://www.vdh.virginia.gov/OLC/LongTermCare/returntocommunity.htm>

**Virginia Department of Medical Assistance**

<http://www.dmas.virginia.gov/>

**Money Follows the Person demonstration project**

[http://www.dmas.virginia.gov/Content\\_pgs/ltc-mfp.aspx](http://www.dmas.virginia.gov/Content_pgs/ltc-mfp.aspx)

**MDS 3.0 Section Q Implementation**

<http://www.olmsteadva.com/mfp/MDS3SectionQ.htm>

**Virginia Office of the Long Term Care Ombudsman**

<http://www.elderrightsva.org>

**2014 State Budget proposals**

<http://leg2.state.va.us/MoneyWeb.NSF/sb2014>

**2013 State Budget**

<http://leg2.state.va.us/MoneyWeb.NSF/sb2013>

**2011 State Budget**

<http://leg2.state.va.us/MoneyWeb.NSF/sb2011>

## **2. Documents Referenced**

Dix, Heidi, Assistant Commissioner, Department of Behavioral Health and Developmental Services. (2014). *Summary of Independent Reviewers Report*. Retrieved from [http://www.dbhds.virginia.gov/settlement/IR%20Report%20Overview-Pres\\_1\\_3\\_12.pdf](http://www.dbhds.virginia.gov/settlement/IR%20Report%20Overview-Pres_1_3_12.pdf)

Fletcher, Donald J. (December 6, 2012). *Report of the Independent Reviewer on Compliance with the Settlement Agreement, United States v. Commonwealth of Virginia: March 6, 2012–October 6, 2012*. Retrieved from <http://www.dbhds.virginia.gov/settlement/121206IRReport.pdf>

Fletcher, Donald J. (June 6, 2013). *Report of the Independent Reviewer on Compliance with the Settlement Agreement, United States v. Commonwealth of Virginia: October 7, 2012–April 6, 2013*. Retrieved from <http://www.dbhds.virginia.gov/settlement/130606%20Report%20of%20the%20Independence>

[nt%20Reviewer%203.12CV059%20copy.pdf](#)

Fletcher, Donald J. (December 6, 2013). *Report of the Independent Reviewer on Compliance with the Settlement Agreement, United States v. Commonwealth of Virginia: April 7, 2013–October 6, 2013*. Retrieved from <http://www.dbhds.virginia.gov/settlement/131206%20Report%20of%20the%20Independent%20Reviewer%203.12CV059.pdf>

Fletcher, Donald J. (June 6, 2014). *Report of the Independent Reviewer on Compliance with the Settlement Agreement, United States v. Commonwealth of Virginia: October 7, 2014–April 6, 2014*. Retrieved from <http://www.dbhds.virginia.gov/settlement/ODS-140606IRReport.pdf>

Genworth Financial, Inc. (103). Genworth. *2013 Cost of Care Survey*. Richmond, Virginia. Retrieved from [https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568\\_032213\\_Cost%20of%20Care\\_Final\\_nonsecure.pdf](https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032213_Cost%20of%20Care_Final_nonsecure.pdf)

Hazel, William A., M.D. (February 13, 2012). *Secretary of Health and Human Resources' Plan to transform the system of care for individuals with intellectual disability in the Commonwealth of Virginia, in accordance with amended § 37.2-319 of the Code of Virginia relating to the administration of the Behavioral Health and Developmental Services Trust Fund*. Retrieved from [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD862012/\\$file/RD86.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD862012/$file/RD86.pdf)

Kaiser Family Foundation. (February 2011). *Money Follows the Person: A 2010 Snapshot* (Issue Paper). Washington, D.C. Retrieved from <http://www.kff.org/medicaid/8142.cfm>

Kaiser Family Foundation. (February 2013). *Money Follows the Person: A 2012 Survey of Transitions and Costs*. Retrieved from <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8142-03.pdf>

Lakin, K. Charlie; Larson, Sheryl; Salmi, Patricia; & Webster, Amanda. (2010). *Residential Services for Persons with Developmental Disabilities: Status and Trends through 2009*. Minneapolis, Minnesota: Research and Training Center on Community Living, Institute on Community Integration, College of Education and Human Development, University of Minnesota. Retrieved from <http://rtc.umn.edu/risp/docs/risp2009.pdf>

Lakin, K. Charlie; Larson, Sheryl; Salmi, Patricia; & Webster, Amanda. (2013). *Residential Services for Persons with Developmental Disabilities: Status and Trends through 2011*. Minneapolis, Minnesota: Research and Training Center on Community Living, Institute on Community Integration, College of Education and Human Development, University of Minnesota. Retrieved from <http://rtc.umn.edu/risp/docs/risp2011.pdf>

Office of the Inspector General for Behavioral Health and Developmental Services, G. Douglas Bevelacqua. *OIG Semiannual Report: October 1, 2011 to March 31, 2012*. Retrieved from <http://www.oig.virginia.gov>



- Office of State Inspector General Michael F.A. Morehart. (August 12, 2013). Letter to DBHDS Commissioner James W. Stewart III re: OSIG Inspections of the State Facilities Operated by the Department of Behavioral Health and Developmental Services (DBHDS) pursuant to Code of Virginia § 2.2-309.1. Retrieved from <http://www.osig.virginia.gov/reports>
- Office of State Inspector General Michael F.A. Morehart. (August 2013). *Annual Report to the Governor and the General Assembly of Virginia*. Retrieved from [http://osig.virginia.gov/media/2408/annualreport2013\\_20130829.pdf](http://osig.virginia.gov/media/2408/annualreport2013_20130829.pdf)
- Old Dominion University, Social Science Research Center. (June 2013). *Human Rights Complaint Process Stakeholder Survey and Focus Group Results Summary*. Not available online.
- Perez, Thomas E., Assistant Attorney General, Civil Rights Division, US Department of Justice. (February 10, 2011). Letter to the Honorable Robert F. McDonnell, Office of the Governor. Washington, D.C. Retrieved from [http://www.dbhds.virginia.gov/settlement/IR%20Report%20Overview-Pres\\_1\\_3\\_12.pdf](http://www.dbhds.virginia.gov/settlement/IR%20Report%20Overview-Pres_1_3_12.pdf)
- Stewart, James W. III. Commissioner, Virginia Department of Behavioral Health and Developmental Services. (2013). *DBHDS Update: Training Center Closures & Implementation of DOJ Settlement Agreement*. PowerPoint presentation. Retrieved from <http://www.dbhds.virginia.gov/settlement/130911ClosureUpdate.pdf>
- Stewart, James W. III. Commissioner, Virginia Department of Behavioral Health and Developmental Services. (January 11, 2013). *Virginia's Implementation of the Settlement Agreement with the US Department of Justice*. Presentation to the Joint Subcommittee on Training Center Closure. Retrieved from <https://www.dbhds.virginia.gov/Documents/130111JointSubcommDOJ.pdf>
- Stewart, James W. III. Commissioner, Virginia Department of Behavioral Health and Developmental Services. (July 18, 2013). Presentation to the Joint Subcommittee on Training Center Closure. Retrieved from [http://hac.virginia.gov/subcommittee/Training\\_Centers\\_Closure\\_Joint\\_Sub/07-18-13/DBHDS%20-%20DOJSpecialSubcommittee%2007-18-13.pdf](http://hac.virginia.gov/subcommittee/Training_Centers_Closure_Joint_Sub/07-18-13/DBHDS%20-%20DOJSpecialSubcommittee%2007-18-13.pdf)
- Stewart, James W. III. Commissioner, Virginia Department of Behavioral Health and Developmental Services. (October 17, 2013). *Update on the Implementation of the DOJ Settlement Agreement and Training Center Closure to the Senate Finance Committee*. Retrieved from <https://www.dbhds.virginia.gov/Documents/131017SF-DOJ.pdf>
- US Department of Health and Human Services, Centers for Medicare and Medicaid. (No date). *Guide to Choosing a Nursing Home* (Revised), CMS Publication # 02174. Baltimore, Maryland. Retrieved from <http://www.medicare.gov/Publications/Pubs/pdf/02174.pdf>
- US District Court, Eastern District of Virginia (August 23, 2012). *United States of America v. Commonwealth of Virginia*. Settlement Agreement. Retrieved from

<http://www.dbhds.virginia.gov/documents/reports/opd-StatePlan2012thru2018.pdf>

Virginia Administrative Code, 12 VAC 5-371 et seq. (2010) Rules and Regulations for the Licensure of Nursing Facilities. Retrieved from <http://www.vdh.virginia.gov/OLC/Laws/documents/nursingHomes/nursing%20facility%20regs.pdf>

Virginia Administrative Code, 12 VAC 35-25.19 et seq. Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services. Retrieved from <http://www.dbhds.virginia.gov/documents/Chapter%20105%202013.pdf>

Virginia Administrative Code, 12 VAC 35-115 et seq. (2012). Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services. Retrieved from <http://www.dbhds.virginia.gov/documents/HumanRights/OHR-RevisedRegulations.pdf>

Virginia Administrative Code, 12 VAC 35-190 -10 et seq. (Effective August 19, 2009). Regulations Establishing Procedures for Voluntary Admissions to State Training Centers. Retrieved from <http://register.dls.virginia.gov/details.aspx?id=1842>

Virginia Department of Behavioral Health and Developmental Services. (June 25, 2010 and subsequent updates). *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia*. Retrieved from <http://www.dbhds.virginia.gov/CreatingOpportunities.htm>

Virginia Department of Behavioral Health and Developmental Services. (December 1, 2010). *Item 304-N: Fiscal Year 2010 Annual Report: Submitted to the Governor and the Chairs of the House Appropriations and Senate Finance Committees*. Retrieved from <http://www.dbhds.virginia.gov/documents/olpr-Item304N-Annual-DBHDS-Rep-2010-10.pdf>

Virginia Department of Behavioral Health and Developmental Services. (2012). *SVTC and CVTC Special Project 2012: Guidance Document for CSBs/Private Providers/Training Center Discharge Coordinators*. Retrieved from <http://www.dbhds.virginia.gov/documents/ODS/ods-svtc-GuidanceDoc-TC-2012-initiative-funding.pdf>

Virginia Department of Behavioral Health and Developmental Services. (October 22, 2012). *DOJ Settlement Report*. Retrieved from <http://www.dbhds.virginia.gov/settlement/121022FY13Report.pdf>

Virginia Department of Behavioral Health and Developmental Services (December 1, 2012). *Fiscal Year 2012 Annual Report (Item 314K) to the Governor and the Chairmen of the House Appropriations and Senate Finance Committee*. Retrieved from <https://www.dbhds.virginia.gov/documents/RD360.pdf>

- Virginia Department of Behavioral Health and Developmental Services, State Human Rights Committee. (July 19, 2013). *State Human Rights Committee 2012 Annual Report on the Status of the Human Rights System* presented to the State Board of Behavioral Health and Developmental Services on July 23, 2013. Retrieved from <http://www.dbhds.virginia.gov/documents/reports/OHR-SHRC2012AnnualReport.pdf>
- Virginia Department of Behavioral Health and Developmental Services (July 31, 2013). *DOJ Implementation Update Pursuant to Code of Virginia § 37.2-319 (HB 2533/SBI 486) and Item 315V.I. of the 2012 Appropriations Act to the Governor and the Chairs of the Senate Finance and House Appropriations Committee*. Retrieved from <http://www.dbhds.virginia.gov/Settlement.htm>
- Virginia Department of Behavioral Health and Developmental Services (January 10, 2014). *Update to the Training Center Closure Plan Pursuant to per Item 314.L. of the 2013 Appropriations Act to the Governor and the Chairs of the Senate Finance and House Appropriations Committee*. Retrieved from [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD782014/\\$file/RD78.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD782014/$file/RD78.pdf)
- Virginia Department of Behavioral Health and Developmental Services (August 12, 2013). *DBHDS Citation Dispute Resolution*. Retrieved from <http://www.dbhds.virginia.gov/documents/DBHDS%20Citation%20Dispute%20Resolution%20Process.pdf>
- Virginia Department of Behavioral Health and Developmental Services (August 26, 2013). *Response to OSIG Inspections of the State Facilities Operated by the Department of Behavioral Health and Developmental Services (DBHDS) pursuant to the Code of VA § 2.2-309.1*. Retrieved from [https://governor.virginia.gov/media/2407/dbhds\\_unannouncedinspection\\_response\\_2013\\_0826.pdf](https://governor.virginia.gov/media/2407/dbhds_unannouncedinspection_response_2013_0826.pdf)
- Virginia Department of Behavioral Health and Developmental Services. Office of Developmental Services (March 1, 2013). *Regional Support Teams: Supporting Individuals in the Most Integrated Setting, Purpose, Membership, Referral-- Information for Training Centers*. PowerPoint presentation. Not available online.
- Virginia Department of Behavioral Health and Developmental Services (2013). *Training Center Community Integration Project*. PowerPoint Presentation. Retrieved from <http://www.dbhds.virginia.gov/settlement/121022CommIntegrationProject.pdf>
- Virginia Department of Behavioral Health and Developmental Services (April 17, 2013). *Training Center Community Integration Project Status Update*. PowerPoint Presentation. Retrieved from <https://www.dbhds.virginia.gov/settlement/II%20TC%20Discharges-Cmtv%20Integration%204-17-13.pdf>

Virginia Department of Behavioral Health and Developmental Services (January 10, 2014). *Fiscal Year 2013 Annual Report (Item 314K)* to the Governor and the Chairmen of the House Appropriations and Senate Finance Committee. Retrieved from <http://www.dbhds.virginia.gov/documents/Item%20314%20K%20DBHDS%20Annual%20Report.pdf>

Virginia Department of Health, Office of Licensure and Certification. (No date). *Directory of Long Term Care Facilities*. Richmond, Virginia. Retrieved from <http://www.vdh.virginia.gov/OLC/Facilities/documents/pdf/LTC%20PUBLIC%20DIRECTORY%202013.pdf>

Virginia Department of Medical Assistance Services. (December 2013). *Report on the Effectiveness of the Exceptional Rate Increase in Addressing the Transition of Institutionalized Individuals to the Community*. Retrieved from [http://leg2.state.va.us/dls/h&sdocs.nsf/fc86c2b17a1cf388852570f9006f1299/9422082059ac0ff185257b5800715847/\\$FILE/RD64.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/fc86c2b17a1cf388852570f9006f1299/9422082059ac0ff185257b5800715847/$FILE/RD64.pdf)

Virginia Department of Medical Assistance Services, Division of Long Term Care. (July 1, 2013). *A Guide for Long-Term Care Services in Virginia*. Retrieved from [http://www.dmas.virginia.gov/Content\\_atchs/ltc/ltc-guide\\_srvcs.pdf](http://www.dmas.virginia.gov/Content_atchs/ltc/ltc-guide_srvcs.pdf)

Virginia Department of Medical Assistance Services (No date). *Distribution of MFP Participant Transitions 2008–December 31, 2012*. Not available online.