V. Institutional Care and Supports

Since the mid-1970s, there has been a national trend toward reducing the number of individuals with disabilities receiving care in large institutions and toward the closing of state-operated institutions. As noted in the annual national report, *Residential Services for Persons with Developmental Disabilities: Status and Trends*, the population of persons with intellectual disabilities (ID) or developmental disabilities (DD) living in large public institutions peaked at 194,650 in 1967 and had declined to 38,305 persons by 2006. Twelve states, moreover, had fewer than 200 persons in state-operated ID/DD facilities during 2006. In 1991, New Hampshire became the first state to close all of its public institutions serving persons with ID/DD. Since then, thirty-seven states and the District of Columbia have closed at least one such institution. Virginia is now one of thirteen states that have not closed any state-operated ID/DD institutions. By 2006, eight states and the District of Columbia had closed all such institutions. During calendar year 2006, three states closed one large ID/DD facility each: Georgia, Ohio, and Pennsylvania. In addition, California projected that it would close one facility during 2007.

The number of persons with ID/DD living in similar private institutions for 16 or more and in nursing facilities has also declined. According to a policy brief by the University of Minnesota Institute on Community Integration, from 1990 to 2002, nationally the number of persons with ID/DD living in large private Intermediate Care Facilities for Mental Retardation (ICFs-MR) dropped from 32,926 to 24,708, a 23.5 percent decline. During the same period, the population in nursing facilities dropped from 44,803 to 30,308, a 32.4 percent decline.

Another national trend over time has been a substantial shift to community-based, *non-state* residential services. The annual residential services report noted that only 12.0 percent of all persons with ID/DD receiving residential services lived in state-operated settings. Although each of the fifty states had at least one ICF-MR in operation during 2006, not all states operate these facilities themselves. Since 1977, the number of community non-state ICFs-MR has increased overall, but by the end of Fiscal Year 2006, a majority (63.1 percent) had six or fewer residents. In addition, Alaska had no ICFs-MR; and nineteen states had fewer than ten ICFs-MR each. Moreover, during the past decade, several states significantly decreased the number of community ICFs-MR by converting them to small (six or fewer) residences supported by Medicaid Waivers.

Nationally, according to the University of Minnesota Institute on Community Integration, on June 30, 2006, 59.9 percent of the population of residents in large state facilities for intellectual and/or developmental disabilities (ID/DD) were in the 40–62 age range; and 10.8 percent were ages 63 or older. Children and youth younger than age 15 comprised only 0.4 percent of state ID/DD populations. At least 21 states reported having no residents younger than age 15 in state ID/DD facilities; and in another 11 states, youths younger than age 15 made up less than 1 percent of all residents.

Throughout this chapter, the term *mental retardation* and the term *intellectual disability* are synonymous. The term *mental retardation* is used as needed when it refers to a specific law, regulation, or program, or when material is being quoted.

A. What Are Institutional Supports?

Some individuals with intellectual disabilities (ID) or related severe, chronic disabilities receive services in highly structured, congregate settings or “institutions.” Federal regulation (42 CFR 435.1009) broadly defines an institution as being: “an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.” Institutions under these regulations must provide services that are appropriate to the needs of each individual served. When serving persons with intellectual disabilities or related conditions, these highly structured residential settings must have the primary purpose of providing diagnosis, treatment, or rehabilitation for this population; and must specifically provide “ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services.” Institutional care and supports in Virginia are provided by a variety of public and private agencies and organizations.

In Virginia, individuals with ID/DD receive publicly funded services in all three categories of institutions, state-operated and non-state-operated ICFs-MR and nursing facilities. Each type of institution has unique characteristics, and subsequent discussions in this chapter will generally deal with each separately. Both the state and a variety of private organizations operate these publicly supported facilities. The public insurance programs, Medicaid and Medicare, typically provide much of the funding for this care.

Intermediate Care Facilities for Mental Retardation (ICFs-MR): The U.S. Social Security Act (Title XIX, Section 1905) describes an ICF-MR as an institution, or a distinct part of a larger institution, which:

- ✔ Has the primary purpose of providing “health or rehabilitative services for mentally retarded individuals or persons with related conditions”;
- ✔ Meets standards prescribed by the Secretary of Health and Human Services; and
- ✔ Provides “active treatment” to all individuals served.

Active treatment is federally defined [42 CFR 483.440(a)] as “the aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services.” Provision of active treatment [42 CFR 483.440(c)] must include:

- ✔ A comprehensive functional assessment of the individual, by an interdisciplinary team, to include developmental strengths, specific functional and adaptive social skills needed to be acquired, presenting disabilities and (when possible) their causes, and service needs;
- ✔ An Individual Program Plan (IPP) that describes individual choice and self-management, measurable outcomes to be achieved, and specific specialized and generic strategies, supports, and techniques to be employed;

- ✔ Acquisition of "the behaviors necessary for the individual to function with as much self-determination and independence as possible and the prevention or deceleration of regression or loss of current optimal functional status";
- ✔ Individualized services or interventions provided in a continuous program in sufficient intensity and frequency to support achievement of IPP objectives;
- ✔ Documentation of accurate, systematic, behaviorally stated data about individual performance toward meeting IPP goals as the basis for program changes; and
- ✔ Review and update, as indicated, of the functional assessment and IPP at least annually.

The **Centers for Medicare and Medicaid Services (CMS)** under the Secretary of the U.S. Department of Health and Human Services is authorized to certify Intermediate Care Facilities for Mental Retardation (ICFs-MR), to establish the detailed rules under which they operate, to monitor compliance with those rules, and to set penalties for noncompliance. As discussed in more detail in this report's Health chapter, federal regulations require states to cover certain specific services under Medicaid, but allow them the option to cover others. Once a state has chosen to cover an optional service under Medicaid, however, it must cover that service until such a time as it has been removed from the state's annual State Plan.

Congress authorized federal matching funds for ICF-MR services as a State Plan option in 1971. Since then, Virginia has chosen to include ICF-MR services in its Medicaid State Plan. Virginia's ICF-MR services cover institutions of four or more beds for people with intellectual disabilities that provide active treatment as defined by CMS. The Virginia State Medical Facilities Plan further defines an ICF-MR as a facility licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) that:

- ✔ Provides care to individuals with mental retardation (intellectual disabilities) who do not need skilled nursing care, but require more intensive training and supervision than would be available in a rooming home, boarding home, or group home;
- ✔ Complies with standards established in Title XIX of the Social Security Act;
- ✔ Provides health or rehabilitation services; and
- ✔ Provides active treatment to individuals with disabilities to achieve a more independent level of functioning.

Virginia operates five ICFs-MR for persons with intellectual disabilities: Central Virginia Training Center (CVTC) in Amherst County, Northern Virginia Training Center (NVTC) in Fairfax County, Southeastern Virginia Training Center (SEVTC) in the City of Chesapeake, Southside Virginia Training Center (SVTC) in Dinwiddie County, and Southwestern Virginia Training Center (SWVTC) in Carroll County. Residence data for each of these facilities, including recent population trends, appears later in this chapter as appropriate.

Non-State-Operated Intermediate Care Facilities for Mental Retardation (ICF-MR): In addition to Virginia's five large state Training Centers, other small non-state-operated ICFs-MR

serve persons with intellectual disabilities through Medicaid funding. Non-state-operators of ICFs-MR include local Community Services Boards (CSBs) as well as nonprofit and other private organizations. In FY 2007 there were 31 of these facilities statewide ranging in size from 4 to 88 beds, a range unchanged since state Fiscal Year 2005. These ICFs-MR are required to provide the same array of medical, health, and rehabilitative therapies to all residents and are subject to the same strict federal regulations as the larger state Training Centers.

Nursing Facilities: The *Code of Virginia*, §32.1-123, defines a nursing home as being any institution, or any identifiable component of any institution, that includes inpatient beds for the primary function of providing ongoing nursing and health-related services for the treatment of two or more unrelated individuals who may require various types of long-term care. Nursing homes are known by varying titles, including convalescent homes, nursing facilities, skilled nursing or skilled care facilities, intermediate care facilities, or extended care facilities.

In its *Senior Citizens Handbook*, the Virginia State Bar defines a nursing home in more common terms as "a long-term care facility designed for people who need less care than a hospital provides, but for whom adequate services are not reasonably available in the home or community. They are designed for those needing long-term nursing or convalescent care due to aging, injury, or prolonged illness." As examples of that level of care, the State Bar handbook lists administering medicines, preparing special diets, rendering treatments prescribed by a doctor, and total nursing care. The handbook further describes nursing facilities as being certified by federal and state agencies to provide levels of care that range from custodial care to skilled nursing care and that can only be delivered by trained professionals.

Virginia began covering nursing facility services through its Medicaid program in 1969. In 1990, nursing facility care became a federally mandated Medicaid service for persons meeting eligibility requirements based on medical need. The *Code of Virginia* assigns responsibility for the licensing of nursing facilities to the Virginia Department of Health.

B. Who Is Eligible for Institutional Supports?

State-Operated Training Centers (ICFs-MR): As Virginia's designated agency with responsibility for publicly funded services for persons with intellectual disabilities, the **Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)** has programmatic, financial, and administrative responsibility for the state's five regional Training Centers, which are certified as ICFs-MR. As required by *Code of Virginia*, §37.2-50, the Community Service Board (CSB) that operates in the jurisdiction where the person lives must provide face-to-face prescreening services for all referrals for potential admission to a state Training Center. Detailed information on the prescreening process is provided in the next section of this chapter.

To be eligible for admission, an applicant must have a primary diagnosis of intellectual disability and must meet the level-of-care requirements for an Intermediate Care Facility for Mental Retardation (ICF-MR), including the need for active treatment as defined earlier. The

definition of intellectual disability used in determining eligibility is the standard enacted by the American Association on Intellectual and Developmental Disabilities (AAIDD, formerly the American Association on Mental Retardation) in 2002. Under that definition, intellectual disability is one originating before age 18, which is characterized by significant limitation both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical skills. The AAIDD identified five assumptions essential to the application of this definition:

1. Limitations in present functioning must be considered within the context of community environments typical of the individual's age, peers, and culture;
2. Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor, and behavioral factors;
3. Within an individual, limitations often coexist with strengths;
4. An important purpose of describing limitations is to develop a profile of needed supports; and
5. With appropriate personalized supports over a sustained period, the life functioning of the person with an intellectual disability generally will improve.

Most people admitted to and residing in the state's Training Centers have one or more significant disabilities in addition to an intellectual disability (ID), which may include ambulatory difficulties, seizure disorders, behavior challenges, mental illness, and visual or hearing impairments. Many residents have multiple disabilities. As noted in the DMHMRSAS *Comprehensive State Plan, 2008–2014*, two distinct populations are served at the Training Centers. The majority of residents have been diagnosed with severe or profound ID and co-occurring complex medical or physical conditions. The second population is individuals who have mild or moderate levels of ID and have co-occurring challenging behaviors or mental illness. In recent years, requests for admission have been increasing for this latter group.

Almost all of the individuals admitted to and residing in the state's Training Centers are adults. In recent years, a small number of youths have been admitted to the Training Centers. Southeastern and Southwestern Virginia Training Centers are licensed under the "core standards" for residential services to serve adolescents (i.e., ages 13–17), and adolescents admitted typically have co-occurring mental illness or challenging behaviors. Central Virginia Training Center alone has skilled nursing units, in which three youths younger than age 15 currently reside, and an acute care unit.

The average age of the residents systemwide in the state's Training Centers was 47 years old in FY 2005, and 47.7 years old in FY 2007. The following chart compares the age distribution of Training Center residents at the end of state Fiscal Years (FY) 2005 and 2007. As these point-in-time data indicate, the total number of residents' systemwide declined by 129, or 8.5 percent, between June 30 of 2005 and of 2007.

NUMBER OF STATE TRAINING CENTER RESIDENTS BY AGE

Age Category	June 30, 2005	June 30, 2007	Change
0–5 years	0	0	0
6–15 years	4	5	1
16–21 years	4	11	7
22–54 years	1,039	965	-74
55–64 years	299	267	-32
65 years or older	170	139	-31
TOTAL	**1,516**	**1,387**	**-129**

Source: DMHMRSAS.
*Number is based on those residents "on-books" at the facility. "On-books" includes all persons admitted to a facility, but not yet discharged, and also includes those who are on pass or leave.

While the number of youth age 15 and younger has declined, the number of residents ages 16–21 almost tripled from 4 to 11 during this time period. Although the largest numerical decrease (74) from 2005 to 2007 was among persons ages 22–54, this represents only a 7.1 percent decline since they comprise the greatest proportion of residents systemwide. The number of residents ages 55–64 decreased by 32, or 10.7 percent; and elderly residents (ages 65 and older), by 31, or 18.2 percent.

Non-State-Operated Public and Private ICFs-MR: As with admission to a state-operated Training Center, admission eligibility to a non-state-operated public or private Intermediate Care Facility for Mental Retardation (ICF-MR) is based on the federal regulations. The person must have a primary diagnosis of intellectual disability and must meet the requirements for the ICF-MR level of care, including the need for active treatment, based on a Level of Functioning (LOF) Survey. Residents of non-state-operated ICFs-MR are likely to have similar needs to those residing in Training Centers, including medical and/or behavioral needs. Although complexity of medical needs is often stated as the reason for maintaining or expanding ICFs-MR, research has shown that individuals with significant medical needs can be effectively served in the community through flexible Home and Community Based Waivers or other noninstitutional community-based services.

Nursing Facilities: Generally, nursing facility admissions occur when an individual meets one or more of the following criteria:

- ✔ Cannot care for him or herself and requires more care than the family can provide,
- ✔ Has extensive medical needs,
- ✔ Has been recommended for nursing facility placement by his or her physician,
- ✔ Has had a preadmission screening that indicated the need for nursing facility care, or
- ✔ Has recently been discharged from a hospital and requires temporary skilled nursing care before returning home.

For persons with developmental and other disabilities, the first of these three conditions typically applies.

Eligibility for admission to a nursing facility is determined by formal assessment by a healthcare professional. The **Uniform Assessment Instrument (UAI)** is used to assess the needs of individuals seeking any public, long-term care services in Virginia and must be completed as a part of all nursing facility screenings. This multidimensional, standardized questionnaire assesses an individual's social, physical, and mental health as well as his or her "functional abilities." Information gathered from the UAI determines the person's care needs and service eligibility. Functional ability refers to the degree of assistance that an individual requires to complete daily living activities such as bathing, toileting, or dressing. Determination of medical or nursing needs includes such items as wound care and administration of medications.

Individuals in a hospital or other acute care facility, considered to be in need of a nursing facility, are assessed by staff members there. When an individual living at home may need more-intensive nursing services and may not be able to afford nursing facility care, a home visit is made by a team consisting of a nurse from the local public health department and a social worker from the local department of social services. During its visit, this team assesses the individual's needs and capabilities to determine whether he or she meets the criteria for nursing home care and whether or not he or she will be at risk of nursing home placement if additional assistance is not received. This information is given to the local health department director, and a decision is made whether nursing care is necessary and most cost efficient.

The placement of persons with disabilities in nursing facilities varies by disability definition or category. According to data from the University of Colorado's Coleman Institute, in state Fiscal Year 2004, a total of 1,130 Virginians diagnosed with intellectual or developmental disabilities resided in nursing facilities statewide; and in FY 2006, the number of persons increased by 2.9 percent to 1,163.

Using the broader federal category of "blind or disabled," the state Department of Medical Assistance Services (DMAS) reported much higher numbers of persons receiving nursing facility services. The number of individuals who are blind or disabled served in nursing facilities increased by 764, 17.9 percent, from 4,276 to 5,040 between FYs 2004 and 2007. By FY 2007, this population represented 17 percent of all persons in nursing facilities, an increase of 2 percent since FY 2004.

DMAS data on the number of Virginians residing in nursing homes by age group is presented in the following table. [Note: The 2004 data have been revised by DMAS since the *2006 Biennial Assessment.* Between FY 2004 and FY 2007, the total number of persons served in nursing homes increased from 27,708 in FY 2004 to 28,869 in FY 2007, an increase of 1,161, or 4.2 percent. The primary residents of Virginia's nursing homes are, and have been, the elderly (those ages 65 years or older), who comprised 84.9 percent of all nursing home residents in FY 2004 and 84.0 percent in FY 2007.

RECIPIENTS OF NURSING FACILITY SERVICES BY AGE CATEGORY

Age Category	FY 2004	FY 2005	FY 2006	FY 2007	Change
Younger than age 1	11	10	1	0	-11
Ages 1–5	17	20	20	17	0
Ages 6–14	33	33	24	19	-14
Ages 15–20	35	25	21	22	-13
Total Under Age 21	**96**	**88**	**66**	**58**	**-38 / 40%**
Ages 21–44	779	782	702	676	-103 / 13%
Ages 45–64	3,297	3,512	3,793	3,884	587 / 18%
Older than age 64	23,536	23,347	24,221	24,251	715 / 3%
Overall TOTAL	**27,708**	**27,729**	**28,782**	**28, 869**	**1,161 / 4%**

Source: Department of Medical Assistance Services (DMAS), 11/9/07.

As the data indicate, there has been a decrease in use of nursing facility services for children and youths (ages 0–20): the total number of youths in nursing facilities decreased from 96 in FY 2004 to 58 in FY 2007, a decline of 39 percent.

Lists of nursing facilities in Virginia are available from multiple sources, including the SeniorNavigator Web site (www.seniornavigator.com). A search of this database using the keywords *nursing home*, *skilled nursing facility*, *nursing facility*, or *ICF-MR* will generate a list for a specific area. Information is also provided regarding the number and types of certified beds, based on the latest available information from the Virginia Department of Health (VDH). Information on assisted-living facilities can be found on the Department of Social Services (DSS) Web site. A directory of long-term care facilities statewide can be found at the Web site for the VDH Office of Licensure and Certification.

The federal Centers for Medicare and Medicaid Services (CMS) Web site provides a list of certified nursing facilities for all states. Its online resource, Nursing Home Compare (www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteria.asp), uses ten measures to rate the quality of care offered by each nursing facility. Information on each measure and its importance to resident care is also discussed on the Web site.

C. How Are Institutional Supports Accessed and Delivered?

State-Operated Training Centers (ICFs-MR): As already mentioned above, statewide availability of ICF-MR services is provided through a network of large institutions, referred to as Training Centers, and operated by the **Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)**.

Prescreening and Admission: Admission to a state Training Center is governed by *Code of Virginia*, §§37.2-805 and -806, **judicial certification of eligibility for admission**, which is commonly referred to as "regular admission," and §37.2-807, **emergency or respite care admission**. It is important to note that both emergency and respite care are considered to be a distinct type of admission from that defined under §37.2-806. They do not require judicial

certification of eligibility for admission, and the *Code* specifically limits the duration of such admissions to no more than 21 consecutive days or a total of 75 days in any calendar year.

As noted earlier, the *Code of Virginia*, §37.2-505, requires **Community Service Boards (CSBs)** to provide prescreening services for all referrals for potential admission to a state Training Center. *Code*, §§37.2-805–806, further require a CSB prescreening report as part of the judicial certification of eligibility for admission. In all cases, a face-to-face contact between the individual and CSB screeners is required to confirm the appropriateness of an individual's admission to a Training Center. If an individual is not able to make the necessary decisions regarding his or her admission or treatment, and if there are no family members available to do so, CSBs must arrange for an authorized representative, if one is available, to admit the individual. If such a representative is not available, judicial certification is sufficient.

As a part of the prescreening process, the CSB reviews all pertinent information and options with the individual, family member, or his or her authorized representative, as appropriate, and then confirms and documents the choice of Training Center placement. The CSB then completes an application for admission and forwards it to the Training Center serving the area in which the individual resides. After review of the application, the Training Center notifies the CSB of its decision regarding admission; and the CSB, in turn, informs the individual, family member, or representative. For judicial certification of eligibility, if the individual is determined to be eligible for admission, the CSB initiates a judicial proceeding to certify that eligibility as required by the state *Code*. In all cases, if admission is denied, the CSB can request reconsideration through the DMHMRSAS Central Office. In current practice, admission to a Training Center is initiated only after community options for services and supports have been exhausted.

In Fiscal Year 2007, regulations pertaining to Training Center admissions were submitted for public comment, and revised regulations are anticipated during 2008. After the revised admission regulations are adopted and published, an update of the current protocols is expected.

The following table identifies the number of admissions to all state Training Centers for Fiscal Years 2005 and 2007 by admission category. As the data indicate, during that period, the total number of admissions declined by 50, or almost 27 percent. The most significant decrease was in the number of judicial certification admissions (84, 78.5 percent). Although the number of emergency or respite care admissions increased, these admissions are limited in duration by state *Code*.

ADMISSIONS TO STATE TRAINING CENTERS BY CATEGORY

Type of Admission	2005	2007	Change
Judicial Certification	107	23	-84/ -78.5%
Emergency	38	53	15/ 39.5%
Respite Care	41	60	19/ 46.3%
TOTAL	**186**	**136**	**-50/ -26.9%**

Source: Office of Mental Retardation, DMHMRSAS, 10/29/07.

Discharge Planning: An individual admitted under judicial certification (*Code of Virginia*, §37.2-807) must receive individualized treatment planning during his or her stay at a Training Center. Within 30 days of admission, an interdisciplinary team (IDT), in consultation with CSB staff, must develop the Individualized Habilitation Plan, which identifies services to be provided to meet the resident's needs. The individualized habilitation plan and the discharge plan must include input from the resident, or family member, or authorized representative (AR) if applicable, and the CSB on the services and supports to be provided under both plans. To facilitate participation, the meetings may be conducted through teleconferencing or videoconferencing, if necessary.

The Training Center IDT must regularly review the progress of the resident and make any necessary changes to the individualized habilitation plan and a "Needs upon Discharge" form. These reviews are conducted at 60, 90, and 180 days following admission to a Training Center, and annually thereafter. Following any IDT meeting, the Training Center social worker is required to document any changes in the resident's status that affect his or her discharge plan and to ensure that the CSB case manager is informed of any changes.

After the initial IDT meeting and in consultation with the Training Center social worker, CSB staff members begin development of the individual's discharge plan. That plan includes the anticipated date of discharge from the Training Center, and a description of the services and supports needed for the resident's successful return to the community. The plan must also specify the public and private providers who have agreed to supply those services. The selection of services must be consistent with the right of the individual, or family member, or AR if applicable, to choose his or her own providers.

The admission and discharge processes are guided by statutory regulations and by the DMHMRSAS policies and procedures, entitled "Admission and Discharge Protocols for Persons with Mental Retardation Served in State Mental Retardation Facilities, 3/26/03" (hereafter referred to as Protocols). This document is available on the DMHMRSAS Web site. The Protocols detail the specific roles and responsibilities required of both the Training Centers and the Community Services Boards (CSBs) throughout the admission and discharge processes based on requirements of the *Code of Virginia* as well as the Community Services Performance Contract between DMHMRSAS and the CSBs. The Protocols thereby help to ensure consistency and improve continuity of services statewide for individuals referred to or served at a state facility.

In September 2007, the DMHMRSAS Office of Human Rights released the final revised *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the DMHMRSAS* (12 VAC 35-115). Section 35-115-40 of this regulation, which applies to judicially certified admissions, was changed to read: "If an individual certified for admission to a state Training Center or his authorized representative requests discharge, the director or his designee shall contact the individual's community services board to finalize and implement the discharge plan." This change significantly promotes facility

response to individuals desiring community placement. Corresponding revisions to the 2003 Admissions and Discharge Protocols had not been made at the time of this publication.

Two important factors that have an impact on access to and availability of the state Training Centers are facility census and residents' length of stay. The following table shows the average daily number (or "census") of residents in Virginia's five Training Centers for Fiscal Years (FY) 2005 and 2007. The total Average Daily Census (ADC) decreased by 105 residents, or 7.0 percent, during that time. Among these facilities, the most change in ADC occurred at Southside Virginia Training Center (SVTC), which experienced a decrease of 35 (10.1 percent), and at Northern Virginia Training Center (NVTC), which decreased by 22 (11.3 percent). In contrast to the other state facilities, the ADC at Southeastern Virginia Training Center (SEVTC) increased by 6 (3.3 percent).

AVERAGE DAILY CENSUS (ADC) OF VIRGINIA TRAINING CENTERS

Virginia Training Center	FY 2005	FY 2007	Change
Central (CVTC)	556	509	-47 / -8.5%
Northern (NVTC)	194	172	-22 / -11.3%
Southeastern (SEVTC)	181	187	6 / 3.3%
Southside (SVTC)	346	311	-35 / -10.1%
Southwestern (SWVTC)	216	209	-7 / -3.2%
TOTAL	**1,493**	**1,388**	**-105 / -7.0%**

*SOURCE: AVATAR database, DMHMRSAS, 11/30/05 and 1/24/08, respectively.
Counts reflect residents "on books" at the two points-in-time. "On books" refers to all residents admitted but not discharged from the facility, including those on pass or leave.

Historically, placement at a state Training Center was viewed as being lifelong, or "permanent." Many current residents were admitted in childhood, adolescence, or early adulthood during the era in which placement in a state institution was viewed as the only or most appropriate placement option. The following chart depicts the average length of stay in years for residents at each Training Center at the end of state Fiscal Years 2005 and 2007. According to DMHMRSAS data, the average length of stay for residents across all Training Centers increased slightly during that time. The average stay for residents at the end of FY 2007 ranged from 19.1 years at SWVTC to 39.5 years at CVTC. The variation can be partially attributed to the differences in facilities in length of operation: NVTC, SEVTC, and SWVTC began operations in the mid-1970s, while CVTC and SVTC began decades earlier (although not as ICFs-MR).

Average Length of Stay for Training Center Residents

Virginia Training Center	June 30, 2005	June 30, 2007
Central (CVTC)	38.1 years	39.5 years
Northern (NVTC)	21.9	23.4
Southeastern (SEVTC)	17.3	18.4
Southside (SVTC)	28.0	29.9
Southwestern (SWVTC)	17.8	19.1

Source: Office of Mental Retardation, DMHMRSAS, 1029/07.
Length of stay was based on residents "on books" at the two points-in-time. "On books" are all residents admitted but not discharged from the facility, including those on pass or leave.

Non-State-Operated Public and Private ICFs-MR: Individuals seeking admission to a non-state-operated community ICF-MR apply directly to the institution. Each of these ICFs-MR determines its own application and admissions processes. Most serve individuals within their own locality first, but can serve individuals from outside of their locality if they choose to do so. A number of current small ICFs-MR are operated by local Community Services Boards (CSBs); others are operated by private entities.

Non-state-operated public or private ICFs-MR, are covered by the same federal regulations as the state Training Centers. Residents must receive "all necessary services" appropriate to individual needs, an Individualized Habilitation Plan must be developed, and active treatment must be provided according to that plan. Regular assessments must be conducted to determine if residence in the facility at the ICF-MR level of care continues to be appropriate. Discharge planning is required to be an ongoing component of service planning to ensure that the level of care continues to match individual needs and preferences, that any transition to another residential and service setting is properly planned, and that there is movement of individuals into and out of the ICF-MR facility when their needs so indicate.

Virginia regulations (12 VAC 5-300-30) state that the establishment of a new ICF-MR should not be authorized unless the following conditions are met:

- ✔ Alternatives to the services proposed for the new ICF-MR are not available in the area to be served by the new facility.
- ✔ There is a documented source of resident referrals for the facility.
- ✔ The applicant can identify the manner in which the proposed new facility fits into the continuum of care for persons with mental retardation (intellectual disabilities).
- ✔ There are specific local conditions requiring the development of a new ICF-MR.
- ✔ Alternatives to the development of a new ICF-MR consistent with the Home and Community Based Waiver program have been considered and can be reasonably discounted in evaluating the need for a new facility.

- ✔ The proposed new facility is consistent with the current DMHMRSAS Comprehensive Plan and the mental retardation (intellectual disability) service areas for the catchment area identified in the plan.
- ✔ Ancillary and supportive services needed for the new facility are available.
- ✔ Service alternatives for residents of the proposed new facility who are ready for discharge are available.

The state requirement that ICFs-MR with fewer than 12 beds obtain a Certificate of Public Need was eliminated in 2005. This change in certification requirements may be contributing to the growth of new smaller ICFs-MR, and to the conversion of existing group homes, whose residents receive services under Home and Community Based Waivers, into ICFs-MR. The Department of Health recommended ICF-MR certification for four group homes in 2005; two in 2006; and two in 2007.

Nursing Facilities: Once an individual has entered a nursing facility, a comprehensive plan of care is required that assesses his or her needs for supervision, assistance with daily living activities, therapy, nursing care, and other services. This plan includes assessments of the resident's clinical and psychosocial needs, appropriate interventions to meet them, treatment goals, and the measures to identify progress in achieving the goals. A discharge plan is also required, in the form of a written summary that includes the services to be delivered, goals to be achieved, and the postdischarge plan or final disposition at the time of discharge from the nursing facility. This discharge summary becomes a part of the resident's clinical record.

The operation of each nursing facility is unique. The vast majority provide services primarily for elderly residents, and they may or may not recognize and meet the needs of younger individuals for peer interaction, social activity, and maximum integration into the community.

D. What Institutional Supports Are Available?

All Intermediate Care Facilities for Mental Retardation (ICFs-MR), whether they are state Training Centers or non-state-operated facilities, are supported with a high level of funding and resources through a 1:1 match of state and federal Medicaid funding. As noted earlier, in compliance with federal regulations, ICFs/MR must assess the resident's needs, and subsequently provide a full range of appropriate medical, health, and rehabilitative services to meet those needs. Examples include physical, occupational, and recreational therapy, vocational training, speech pathology, and nutritional, medical, dental, pharmaceutical, psychological, and social services.

State-operated Training Centers (ICFs-MR): The goal of the Training Centers, as with any other ICF-MR, is to provide highly individualized services in the least intrusive and restrictive manner possible, subject to the realities of life in an institutional facility. Although long-term care has been their main function, Training Centers also provide short-term respite and

emergency care. One of the five, Central Virginia Training Center near Lynchburg, also operates skilled nursing units and an acute care unit.

Since 2003, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) has engaged in restructuring efforts to create an integrated service system with increased emphasis on community infrastructure and service expansion to serve more individuals in their home communities, closer to family and friends; and renovation or modernization of facilities' physical plants as well as more effective, efficient use of the Training Centers. Change in the role of the Training Centers has been evident in two initiatives that have created specialized services for persons with intellectual disabilities living in localities to address current gaps in the community system: consultation services for persons with co-occurring intellectual disability and mental illness (ID/MI) or challenging behaviors and outpatient clinics known as Regional Community Support Centers (RCSC). The RCSCs offer clinical services that are otherwise unavailable or not accessible from community health care and other resources. The RCSC services being provided vary somewhat by facility, since needs are regionally determined. The RCSCs are discussed in more detail in the Health Services chapter of this report.

Development of the first specialized unit to serve individuals living in communities who have co-occurring MR/MI occurred at the Southwestern Virginia Training Center (SWVTC), which opened the **Pathways MR/MI Program** in August 2003. The Pathways Program, a designated unit of eight ICF-MR certified beds, is designed primarily to provide diagnostic consultation, treatment (medical, behavioral, and psychiatric), and short-term stabilization for persons with a dual diagnosis of intellectual disability and mental illness in this population. The maximum length of stay in Pathways is 90 days. This program was created to address community needs for intensive intervention in a structured environment that focuses on emotional or behavioral issues threatening individuals' community placement. All referrals must be made by a local Community Services Board (CSB). Pathways oversight is provided by a regional MR/MI Council comprised of representatives from the CSBs and the SWVTC.

According to DMHMRSAS, increased demands for services to persons with mild or moderate intellectual disabilities and co-occurring behavioral challenges have been, and continue to be, experienced by all the Training Centers. As of January 2008, SWVTC is the only Training Center to implement a formal inpatient program for that need. For several years, however, different efforts have been underway in each region to address issues of co-occurring disabilities based on regional needs and issues. These regional efforts include collaborative arrangements among] the Training Centers, the state mental hospitals, and the CSBs. Much of this work is evolving as adjustments are made to accommodate "lessons learned" from previous experience. DMHMRSAS has identified the need for specialized residential units and expanded consultation to communities for these populations at all Training Centers in its *Comprehensive State Plan 2008–2014*. As described in the report, these residential units will have the goal of returning individuals to their communities within a year, and will have consultation services as a means to prevent institutionalization. Creation of such programs statewide will require an infusion of new fiscal resources.

In its *Comprehensive State Plan 2006–2012*, DMHMRSAS proposed implementation of a Level of Care Model to expand the range of services and supports for individuals who meet the level of care criteria for an ICF-MR. This model includes five levels of services and supports that range from basic community-based nonresidential services and supports to intensive 24-hour facility-based services, which would be referred to as "Intensive Support Centers" (ISC). The ISC would provide residential care to those individuals who could be served in a small ICF-MR or an MR Waiver group home. According to the *Comprehensive State Plan 2008–2014*, all Training Centers are engaged in "a cultural transition to persons-centered processes and are expanding their mission to make short-term and transitional facility-based services more readily available."

Virginia does not have current plans to close any of the state's five Training Centers. Under consideration for the last two years have been proposals for extensive renovations at CVTC and SEVTC to address health and safety violations (for additional detail see the Cost and Payment section of this chapter). DMHMRSAS also proposed, in 2005, an overall target census reduction of 100 individuals per year over the next 8 years. As DMHMRSAS data indicate, the number of operational (staff-funded) beds at the Training Centers has decreased, almost exclusively at the two largest and oldest facilities—CVTC and SVTC. The chart below depicts data from two consecutive DMHMRSAS *Comprehensive State Plans* regarding the number of operational beds at approximate points-in-time for 2005 and 2007.

Number of Operational Beds for State Training Centers

Facility	June 30, 2005*	July 5, 2007**	Amount of Change
CVTC	611	577	-34
NVTC	200	200	0
SEVTC	200	200	0
SVTC	395	359	-36
SWVTC	223	215	-8
TOTAL	**1,629**	**1,551**	**-78**

*Source: DMHMRSAS *Comprehensive State Plan, 2006–2012*.

**Source: DMHMRSAS *Comprehensive State Plan, 2008–2014*.

Non-State-Operated, Public and Private ICFs-MR: As noted previously, all ICFs-MR, public and private, must offer a full range of medical, health, psychiatric, and rehabilitative services to all residents, as indicated, and must provide ongoing active treatment. ICFs-MR have stringent statutory health and fire/life safety requirements; their services and supports are medically oriented and delivered in highly structured environments with 24-hour supervision and medical staff available at all times.

Virginia has been experiencing growth in the number of smaller non-state ICFs-MR. Data from the Department of Medical Assistance Services (DMAS) indicates that there were 25 non-state-operated ICFs-MR statewide in FY 2005, and 31in FY 2007, an increase of 24 percent. Requests to convert group homes, whose residents received Home and Community Based (HCB)

Medicaid Waivers, into ICFs-MR have been made to the Virginia Department of Health in recent years. According to 2007 data from the Virginia Department of Health, while a few non-state ICFs-MR are limited in size to four residents, most have a bed capacity of 8 or more; and one ICF-MR in Norfolk has 88 beds. Across regions, the Tidewater area has the highest number of non-state ICF-MR beds.

According to state DMAS statistics, the number of "enrolled" ICF-MR providers similarly increased over time. To be enrolled means that the provider is approved by DMAS for Medicaid reimbursement. Approval for enrollment requires that the ICF-MR be licensed by the DMHMRSAS and determined to be compliant with federal regulations by the state Department of Health. A single provider may operate more than one ICF-MR at different locations. The total number of enrolled ICF-MR providers at the end of four consecutive state Fiscal Years (FY) were: FY 2004, 19 enrolled providers; FY 2005, 28; FY 2006, 28; and FY 2007, 30 (of which 3 were out-of-state providers). As the data indicate, the number of enrolled non-state ICF-MR providers increased by 11, or 57.9 percent, between FY 2004 and 2007. The largest increase occurred between FYs 2004 and 2005, however, and since then, the number has been fairly stable.

Nursing Facilities: Nursing facilities provide total care of the individual, which includes health, personal care, and household functions. Based on the person's 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 the premises. Additional equipment and other services, including adult day care or respite care, may also be provided.

Overall, the level of care provided by nursing facilities has increased significantly over the past decade. Many nursing facilities now supply much of the recuperative nursing care that was previously provided in a hospital setting and focus on rehabilitation so that individuals can return to their own homes.

E. Cost and Payment for Institutional Supports

Intermediate Care Facilities for Mental Retardation (ICFs-MR): For persons in ICFs-MR, whether the state Training Centers or non-state-operated public or private facilities, Medicaid is the primary payer for services. In Virginia, Medicaid payments (reimbursements) for ICFs-MR services are made up of 50 percent federal funds and 50 percent matching state general funds. To qualify for Medicaid reimbursement, ICFs-MR must be certified and comply with federal standards referred to as Conditions of Participation (42 CFR Part 483, Subpart I, Sections 483.400–483.480). The eight operational areas covered by these standards are: management, protections for persons with disabilities, facility staffing, active treatment services, behavior and facility practices, health-care services, physical environment, and dietetic services.

Detailed budget and expenditure information for the state Training Centers may be obtained from the Department of Mental Health, Mental Retardation and Substance Abuse

Services (DMHMRSAS). Details of Medicaid expenditures related to institutional supports can be obtained from the Department of Medical Assistance Services (DMAS). The following tables contain a summary of the number of individuals served and expenditures for the Training Centers as well as non-state-operated public and private ICFs-MR for state Fiscal Years 2005 and 2007. Information on persons and services covered by private payments is not available.

As the data below indicate, the annual average operational costs for a state Training Center grew from $129,355 in Fiscal Year (FY) 2005 to $148,755 in 2007, an increase of 15 percent. For those same FYs, the annual average cost of a non-state-operated ICF-MR grew from $89,096 to $116,665, an increase of 30.9 percent. Between FY 2005 and 2007, state Training Centers served 12 fewer individuals, a decrease of only 0.7 percent; and non-state-operated ICFs-MR, 19 more individuals, or 5.9 percent. The data clearly indicate that community-based, non-state ICFs-MR services are generally less expensive than state services. If an individual is eligible for Medicaid services based on need, however, but a Home and Community Based Waiver slot is not available for a person with an intellectual disability, then he or she may choose to request services in an ICF-MR, including a state Training Center.

FY 2005 ICF-MR Expenditures						
Service	**Number Served**	**State Funds**	**Federal Funds**	**Other Funds**	**Total Funds**	**Average Annual Operational Cost**
State Training Centers*	1,524	$27,641,581	$169,331,755	$164,161	$197,137,497	**$129,355**
Non-State-operated ICFs-MR*	321	14,300,000	14,300,000	0	$28,600,000	**$89,097**
FY 2007 ICF-MR Expenditures						
Service	**Number Served**	**State Funds**	**Federal Funds**	**Other Funds**	**Total Funds**	**Average Annual Operational Cost**
State Training Centers *	1,512	$35,465,187	$188,905,085	$547,650	$224,917,922	**$148,755**
Non-State-operated ICFs-MR**	340	$19,833,046	$19,833,046	0	$39,666,093	**$116,665**

*Source: Office of Mental Retardation, DMHMRSAS.
**Source: Department of Medical Assistance Services, DMAS.

According to the DMHMRSAS *Comprehensive State Plan, 2008–2014*, inadequate funding over time for maintenance and renovation has resulted in poor building conditions and aging structures. Current buildings often are no longer appropriate for the needs of residents and programs. Significant investment is now needed to maintain compliance with federal standards regarding the living areas as well as Fire/Life Safety. The table below describes Training Center

capital improvement expenditures made in Fiscal Years 2005 through 2007 for renovations and upgrading of residential areas and physical plant, and the corresponding budgeted amounts for Fiscal Year 2008. Budgeted expenditures for FY 2008 address planning costs for facility replacement at CVTC and SEVTC, roof replacement at NVTC, and outsourcing a boiler at SVTC. No capital improvement expenditures are planned in FY 2008 at SWVTC.

ACTUAL AND PLANNED EXPENDITURES FOR CAPITAL IMPROVEMENTS TO TRAINING CENTERS

Virginia Training Center	FY 2005	FY 2006	FY 2007	FY 2008
Central (CVTC)	$306,954	$1,417,683	$4,341,256	$2,500,000
Northern (NVTC)	86,233	379,936	1,153,474	1,000,000
Southeastern (SEVTC)	28,072	203,321	848,549	2,500,000
Southside (SVTC)	160,414	244,461	1,388,463	36,474
Southwestern (SWVTC)	65,397	978,188	2,555,031	N/A
TOTAL	**$647,070**	**$3,223,589**	**$10,286,773**	**$6,036,474**

Source: Office of Mental Retardation, DMHMRSAS.

Nursing Facilities: Operators of nursing facilities may be private nonprofit or for-profit organizations or public governmental entities. Almost two-thirds of nursing facilities in America are Medicaid- or Medicare-certified. According to a Kaiser Family Foundation report, in 2005, Medicaid accounted for 44 percent of all expenditures for nursing home care nationally; Medicare, 16 percent. Individuals paid out of pocket for 26 percent of all nursing home expenditures.

Under certain limited conditions, Medicare will pay some nursing facility costs for qualified beneficiaries who require skilled nursing or rehabilitation services following a hospital stay. For costs to be covered, the nursing facility must be certified by the Centers for Medicare and Medicaid Services (CMS), and the hospital stay must have lasted at least three days immediately prior to the nursing facility admission.

Medicaid will pay most costs incurred in a CMS-certified nursing facility for persons with limited income and assets meeting eligibility requirements. According to the Virginia State Bar's *Senior Citizens Handbook*, about half of all nursing facility residents pay nursing facility costs out of their own savings. Many people who stay in nursing facilities for long periods of time and do not initially qualify financially for Medicaid eventually exhaust their savings and other resources, which enables them to become eligible for Medicaid.

Medicare Supplemental Insurance, often called Medigap, helps pay for items not covered by Medicare such as deductibles and co-payments. 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 will also help to cover nursing facility costs, but managed-care plans will not help pay for care unless the nursing facility has a contract

with the particular insurance plan. The benefits and costs of private Long-Term Care Insurance plans vary widely. Many nursing facility residents who pay for care out of their own private funds receive some assistance from these plans. Additional information on these plans is available from *A Shopper's Guide to Long-Term Care Insurance*, a free publication of the National Association of Insurance Commissioners (NAIC), which represents state health insurance regulators, cited in the references at the end of this chapter.

F. Monitoring and Evaluation of Institutional Supports

State-Operated Training Centers (ICFs-MR): As Virginia's designated intellectual disabilities (mental retardation) agency, the **Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)** has oversight responsibilities for the programmatic, financial, and administrative activities of the five state Training Centers. The *Code of Virginia*, §37.2-400, further charges DMHMRSAS with ensuring the protection of both human and civil rights and provision of care consistent with basic human dignity for every person served in a hospital, training center, other facility, or program that is operated, funded, or licensed by DMHMRSAS, excluding those operated by the Department of Corrections. A description of the mission of the **DMHMRSAS Office of Human Rights** may be found in the previous chapter of this report on Community Living Supports.

The **State Board for Mental Health, Mental Retardation and Substance Abuse Services** is required by state statute to adopt and implement the Human Rights Regulations, which must be followed by all the facilities and programs listed under the statute. These regulations delineate the rights of individuals with disabilities with respect to various issues, such as a nutritionally adequate diet, safe and sanitary housing, participation in nontherapeutic labor, attendance or nonattendance at religious services, the use of telephones, the availability of suitable clothing, and possession of money and valuables, among others. Of most importance, the Human Rights Regulations address an individual's participation in treatment decision-making and the due process procedures to be followed when an individual with a disability may be unable to make an informed decision. Complaints about human rights' violations are reviewed by **Local Human Rights Committees** that serve specific regions of the state, and appeals are reviewed by the **State Human Rights Committee**.

The State Board for Mental Health, Mental Retardation and Substance Abuse Services must also adopt and implement regulations requiring the public and private facilities and programs licensed or funded by DMHMRSAS to provide the Department with nonprivileged information and statistical data related 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 DMHMRSAS 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.

Another avenue of oversight and monitoring for facilities or programs licensed or operated by DMHMRSAS, primarily for quality and standards of care issues, is the **Office of the Inspector General (OIG) for Mental Health, Mental Retardation and Substance Abuse Services**, which is also described in detail in the Community Living Supports chapter. The *Code of Virginia*, §37.2-424, gives the OIG responsibility to "inspect, monitor and review the quality of services provided in state hospitals, Training Centers, licensed mental health treatment units in state correctional facilities, and in community programs as defined in Code Section *§37.2-403*." With respect to quality assurance for these designated services, the OIG's duties include:

- Conducting announced and unannounced inspections on an ongoing basis in response to specific complaints of abuse, neglect, or inadequate care or other information received and as a result of monitoring serious incident reports;
- Conducting unannounced inspections at each state facility at least once annually; and
- Making policy and operational recommendations in order to prevent problems, abuses, and deficiencies in and to improve the effectiveness of programs and services.

The OIG publishes reports on each on-site visit, study, or investigation on his Web site. Each report includes investigative findings and recommendations for service or system improvements. Reports on state Training Centers and psychiatric hospitals include DMHMRSAS responses, which often identify the steps it has taken or will be taking to address each OIG finding or recommendation. In 2005, the OIG published a *Systemic Review of Training Centers Operated by DMHMRSAS* (OIG Report 127-05). A similar report had been published in 2004.

The focus of this review, based on inspections during November and December 2005, was an evaluation of service quality. Overall, the OIG found that the Training Centers provided comprehensive health care for the residents, and, generally, these facilities were clean. Several qualities-of-care issues were identified. Few resident individualized habilitation plans were person-centered and consumer-driven; and residents had very limited opportunities for choice, for community integration experiences, or for participation with people outside their living units. Specific to discharges, the process for determining discharge readiness was found to vary between facilities. In addition, the level of involvement by Community Service Board (CSB) case managers was very low for residents who were not determined "ready for discharge," and involvement was variable for those deemed ready for discharge.

As a result of this report, DMHMRSAS joined with the Partnership for People with Disabilities at Virginia Commonwealth University to develop a Person-Centered Planning (PCP) training curriculum, and training has been offered to staff members at Training Centers, to CSBs, and to private providers. Throughout Fiscal Years 2006 and 2007, DMHMRSAS continued to promote Web-based training for those staff members through the College of Direct Support,

including modules on PCP and positive behavioral supports. An initiative to address consistent discharge readiness determination was begun, and expectations that CSBs would assign case managers to Training Center residents and that case managers be more involved in habilitation planning were expressed. The OIG is, and will be, monitoring facility progress of these initiatives.

In 2007, the OIG report, *Review of Community Services Board Mental Retardation Case Management Services for Adults (*142-07), noted that Training Center residents still received low priority for CSB case management services. Based on a CSB survey, while 36 CSBs assigned a case manager (usually a supervisor) for Training Center residents, most designated these cases as inactive or on a monitoring status, which typically meant only an annual facility visit and responses to facility correspondence. It was noted that case management activities may increase if the resident was deemed “ready for discharge.” Although not reimbursed by Medicaid for this service, five CSBs (Central Virginia, Hampton–Newport News, Loudoun, Rappahannock Area, and Region Ten) assigned active case management status to facility residents.

Like other Intermediate Care Facilities for Mental Retardation (ICFs-MR), the Training Centers are also monitored for compliance with federal standards of care and Conditions of Participation by the **Virginia Department of Health (VDH)**, the state agency tasked with this responsibility on behalf of the U.S. Centers for Medicare and Medicaid (CMS). This monitoring process is described in more detail below under Non-State-Operated ICFs-MR and Nursing Homes.

Medicaid certification or recertification and related inspection surveys in 2006 and 2007 indicated varying degrees of problems for both resident safety and clinical care at the Training Centers. Central Virginia Training Center (CVTC) was cited in May 2007 for ongoing use of resident rooms that have “pony walls” (i.e., walls that do not reach the ceiling) in four residential buildings, which violates current Fire/Life Safety standards (2000) set by CMS, posing significant danger to residents in the event of fire, and which also violate individual rights to dignity and privacy. SVTC was also cited for having pony walls in two buildings. SVTC responded that another building had been renovated, and all residents in pony wall units would move there in July 2007. After the move, the pony wall units would be decertified. In its response, CVTC stated that some renovation was underway, and requests for funding for planned renovations had been made. Other physical plant issues identified in the survey reports included, but were not limited to: poor plant maintenance such as detached ceiling tiles and leaking commodes (NVTC), and failure to evaluate effectiveness of fire drills and to address negative results (SVTC).

Clinical citations at the Training Centers included, but were not limited to: failure to obtain informed consents for locked units (CVTC and NVTC), failure to ensure adequate staffing (SWVTC and, to a more significant degree, SEVTC), and failure to provide adequate treatment plans or interventions (SEVTC, SWVTC and NVTC). Of grave concern were the citations of Immediate Jeopardy received by CVTC in May 2007 for failure to: protect client rights, protect residents from injury, and provide sufficient, trained direct care staff. These serious citations were resolved after receipt by VDH of an acceptable Plan of Correction from the facility.

In several major documents (e.g., its *Comprehensive State Plans for 2006–2012* and *2008–2014*; and the 2007 legislative *Study of the Mental Retardation Services System*), DMHMRSAS points out that continued, significant investment in the capacity of community services and supports is a necessary prerequisite for system change. DMHMRSAS has recommended significant community investments such as: expansion of Mental Retardation (MR) Waiver slots to reduce demand for institutional services; increases in MR Waiver reimbursement rates to assure community capacity; and expansion of community services and supports, including other Waiver services and family supports.

Non-State-Operated ICFs-MR and Nursing Facilities: The **Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)** licenses non-state-operated Intermediate Care Facilities for Mental Retardation (ICFs-MR) based on standards that it develops consistent with federal statutory requirements. Those standards include monitoring of compliance with Human Rights regulations by the **DMHMRSAS Office of Human Rights**. Under the *Code of Virginia*, §37.2-409, the State Board for Mental Health, Mental Retardation and Substance Abuse Services is authorized to set the maximum number of residents served in an ICF-MR. In addition to DMHMRSAS licensing, the **Virginia Department of Health (VDH)** is responsible for certifying that facilities maintain compliance with federal Centers for Medicare and Medicaid Services (CMS) standards and eligibility for ICF-MR funding. CMS certification is required for an ICF-MR to receive Medicaid reimbursements for services provided.

State laws govern the licensure of **nursing facilities** and specify conditions that they must meet in order to operate. In keeping with federal requirements, all states require Nursing Facility Administrators to be licensed, which means that they must have the appropriate training to manage a nursing facility, pass a state licensure exam, and remain knowledgeable in the current rules and regulations governing nursing facilities.

In order to receive federal reimbursement, ICFs-MR and other nursing facilities must also conform to specific standards. The designation “CMS certified” identifies a nursing facility that has been found to meet those standards and thus to be eligible for reimbursement from Medicare and Medicaid by the federal Centers for Medicare and Medicaid Services (CMS). In many cases, some beds are certified for both Medicare and Medicaid. Nursing facilities may be certified by CMS as one of the following:

- A Skilled Nursing Facility (SNF): Any long-term care bed specifically certified for Medicare reimbursement.
- A Nursing Facility (NF): Any long-term bed specifically certified for Medicaid reimbursement.
- An Intermediate Care Facility for Mental Retardation (ICF-MR): 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 mental retardation (intellectual disability) or a developmental disability.

Federal regulations (Titles XVIII and XIX of the Social Security Act) require that states designate an official Survey Agency for Medicare and Medicaid. Through *Code of Virginia*, §32.1-137, that responsibility has been given to the **Department of Health (VDH),** which carries out this requirement through its **Office of Licensure and Certification (OLC)**. The OLC's medical facility inspectors, who conduct both state and federal regulatory inspections, are health-care professionals such as physicians, registered nurses, dietitians, social workers, and laboratory medical technologists. *Code of Virginia*, Chapter 5 of Title 32.1 (§32.1-123 et seq.), tasks VDH OLC with these specific oversight duties:

- Regulatory oversight of medical care service providers by conducting routine on-site 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 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
- Promoting quality-of-care standards governing Managed Care Health Insurance Plan providers and Private Review Agencies.

In addition, OLC is responsible for determining and certifying the public need for new construction and renovations of acute and long-term care medical facilities, new health-care services provided in those facilities (Chapter 4 of Title 32.1, §§ 32.1-102.1 et seq.), development and promulgation of twenty-one sets of regulations, and coordination of OLC legislative activities.

OLC is required to conduct scheduled inspections of all nursing and health-care facilities licensed by the VDH, including home care organizations, hospice programs, hospitals, outpatient surgical hospitals, and nursing facilities. OLC also makes unannounced on-site inspections of each facility to determine compliance with licensure standards. As part of each inspection, the OLC representative may review records as well as interview employees, residents, or family members. After the inspection, the OLC representative discusses his or her findings with the facility administrator or designee. The facility administrator must then submit an acceptable plan for correcting any deficiencies found. After review of the plan, OLC notifies the facility of any item in the plan of correction that is not acceptable. The facility administrator is then responsible for assuring that the plan of correction is implemented and monitored so that compliance is maintained.

State law charges the OLC with responsibility for investigating complaints regarding alleged violations of the standards or statutes as well as complaints of abuse, neglect, or exploitation of the persons in nursing or health-care facilities that it licenses. Section 32.135 of the *Code of Virginia* describes the authority and scope of administrative sanctions for violations. Complaints may be received in writing or orally and may be made anonymously. Immediate

imposition of administrative sanctions can be imposed by the VDH Commissioner when the health and safety of residents are deemed in jeopardy. The licensee must be notified of the VDH's intent to impose these sanctions and has the right to appeal. Possible sanctions are:

- Restricting or prohibiting new admissions to any nursing facility;
- Petitioning the court to impose a civil penalty, to appoint a receiver, or both; or
- Revoking or suspending the license of a nursing facility.

A special category of institutional care is **Children's Residential Facilities.** Created to address legislative concerns about duplicative regulatory efforts, the **Office of Interdepartmental Regulation (OIR)** is responsible for coordinating all regulatory activities for community residential facilities serving children and adolescents, with the exception of psychiatric hospitals providing acute care to youths or providers offering residential care in their own homes (e.g., foster homes). This includes children served in residential programs under the Comprehensive Services Act (CSA) (see Community Living Supports chapter for more information on CSA). The OIR also conducts training for regulatory personnel and facility providers, and processes personnel background checks, among other activities. The OIR is comprised of representatives of the state Departments of Mental Health, Mental Retardation and Substance Abuse Services; Social Services; Education; and Juvenile Justice.

"CORE" standards must be met by all residential providers for youths. These standards "establish the minimum level of regulation that is necessary to provide protection and treatment/programming to vulnerable children in out-of-home care." New residential applicants must submit a detailed program description to the OIR, which reviews the population to be served, the primary focus of the residential program, the services to be provided, and staff qualifications. The OIR then assigns each facility applicant to a "lead agency," which will conduct all licensing visits and activities. After the assignment, the OIR requires the provider to complete an application; and the lead agency requests submission of program policies, procedures, and forms required by regulations. If formal review of material finds that the applicant is in compliance with regulations, then a recommendation is made to the lead agency head for issuance of a license.

The 2007 report, *Evaluation of Children's Residential Services Delivered through the Comprehensive Services Act*, raised serious concern that current licensing and regulatory enforcement processes appear inadequate to ensure the health and safety of youths. In comparing standards used in neighboring states and those recommended by national experts, the Joint Legislative Audit and Review Commission (JLARC) found that Virginia's licensing standards are less stringent. Although many providers exceed standards on their own accord, current standards inadequately address minimum staff initial or annual training and qualifications specific to the population being served; do not require full-time, on-site supervisory staff; and inadequately address responsibilities and qualifications of key program staff, including administration. Moreover, due to inadequate resources for state agency licensure staff, the frequency and thoroughness of licensing inspections may not be sufficient to protect the youth.

JLARC made a number of recommendations pertaining to licensure oversight to increase overall service quality statewide and to achieve consistency in interpretation and enforcement. These included, but were not limited to, the following: develop clearer, stronger licensure standards governing the operation of residential facilities; using national guidelines, assess state agency workloads to determine the additional resources needed to improve oversight and enforcement; and develop clear guidelines for issuing systemic deficiencies and taking enforcement actions based on the scope and severity of violations. The full report is available on the JLARC Web site.

G. Areas of Concern for Institutional Supports

The chapter detail provides information on the breadth and depth of services available to persons with disabilities in institutional settings. Cited throughout the chapter are important statistical data regarding program activities, persons served, and other relevant data. Section G focuses on the specific areas in which further improvements may be needed to move the system forward and ensure that the needs of students with disabilities throughout the Commonwealth are met. The Virginia Board for People with Disabilities (VBPD) identified the issues and concerns below through a variety of mechanisms, including: (1) review and analysis of the numerous source documents referenced within and listed at the end of this chapter, (2) public comment received via VBPD's six public forums held throughout the state in the spring of 2007, and (3) written comment and information provided and verified by state agencies in their reviews.

The concerns below are not all-inclusive, but represent those that VBPD has identified as important to systems improvement. The concerns are not listed in any order of priority.

1. **Effect of Institutional Entitlement on Systems Transformation:** A continuing challenge for persons with significant disabilities in Virginia is that nursing home and ICF-MR facility services remain an entitlement, while community-based services are not an entitlement. Although nursing facilities are established as an entitlement by federal regulation, ICFs-MR services are an entitlement because Virginia has chosen ICF-MR as an "optional" service in its Medicaid State Plan. While progress is being made toward rebalancing the current system, the institutional entitlement continues to be a factor in maintaining a disproportional funding commitment to institutions while community services remain under- or inconsistently developed. Since state moneys are finite, the costs of running institutions (and in the case of Training Centers, also renovations to maintain current federal standards) ultimately take significant resources away from community services.
2. **Concern over the Growth of Smaller Institutions:** The Board continues to be concerned about the number and utilization of smaller institutions, such as Intermediate Care Facilities for persons with mental retardation (ICFs-MR) and nursing facilities. As noted in the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) *Study of the Mental Retardation Service System*, comparatively low reimbursement rates and lack of funding for "general supervision" exert a negative impact on staffing and expansion of more individualized residences. The higher funding levels for ICFs-MR and nursing homes can be an unintended incentive to convert group homes or other

types of congregate living residences into ICFs-MR. In addition, the elimination of the requirement for a Certificate of Public Need (COPN) for ICFs-MR having up to 12 beds facilitates development of new institutions, and may be responsible in part for the growth of larger ICFs-MR such as the recent 24-bed (2–twelve beds) ICF-MR in Virginia Beach. As noted in the chapter detail, since 2005, the Department of Health has recommended ICF-MR certification for conversion of eight group homes. This is a trend that raises concern.

Several participants in the 2007 public comments events stated that the Board has a bias against ICFs-MR and urged the Board to alter its position. The Board understands that ICFs-MR may be the only option available to individuals who need services in a state with limited resources. The Board believes, however, that the development of community infrastructure and services should focus on noninstitutional options, and is pleased that the DHMRSAS 2007 *Study of the Mental Retardation Service System* supports this focus. With an appropriate design and funding of Home and Community Based (HCB) Waivers, any service provided by a licensed institution can be provided in the community with equal effectiveness to the consumer and at less long-term cost to the Commonwealth.

3. **Lack of a Comprehensive, Integrated Inter-Agency "Blueprint" for Services to Persons with Intellectual Disabilities (ID):** Similar to other individuals with disabilities, persons with ID are served by a number of state agencies and funding streams, among which DMHMRSAS has been central. Issues surrounding the maintenance of state Training Centers, for example, are complex and are highly interrelated with numerous other state policy decisions, especially covered Medicaid services and reimbursement rates, infrastructure development, community capacity-building, and workforce development. Initiatives such as those conducted by the Office for Community Integration and those led by the Department of Medical Assistance Services—including Money Follows the Person and System Transformation—are strengthening interagency partnerships in planning system change; policy disconnects, however, still exist. A long-range plan is needed for the future intellectual disabilities system that operationalizes the steps to be taken—specific Medicaid as well as infrastructure and service components to be developed, as well as regulatory changes—and measurable objectives with timeframes for completion. The DMHMRSAS 2007 *Study of the MR Services System* is a positive step towards creation of a blueprint.

4. **Inadequate Discharge Planning/Case Management for Persons Residing in State-Operated Training Centers:** Unlike admissions to state mental health facilities, state Training Center admissions have been considered to be long-term, even lifetime, in nature. This is evident from data relating to the average length of stay in Training Centers. The Training Centers are beginning to be used for short-term crisis stabilization, however, especially for those with intellectual disabilities and co-occurring mental illness or severely challenging behaviors. As stipulated in the *Code of Virginia*, in planning discharge for a person receiving services in a state facility, a clinical decision determines whether the individual is "ready for discharge." For Training Center residents, most of whom were admitted decades ago, the determination of clinical readiness is not relevant. Instead, discharge as an option is directly related to whether adequate supports and services are

available in the community, and whether the individuals or families (or authorized representatives, as appropriate) wish community placement and waiver services, and whether a waiver "slot" is available to them. The revised *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services* (12 VAC 35-115-70) issued in the fall of 2007 now state that Training Center staff members must notify the appropriate Community Service Board (CSB) immediately of a resident's request for discharge**.**

The CSBs are responsible for providing case management and discharge planning services to persons residing in Training Centers. As noted in the DMHMRSAS Inspector General's 2007 study, *Mental Retardation Case Management Services for Adults,* only five CSBs assigned active case management status to the residents. The 2007 DMHMRSAS MR Waiver Study reported that many family members of Training Center residents prefer that placement because of perceived permanence, safety, and oversight. As noted by the University of Minnesota Institute for Community Living, however, fear often is a key barrier to overcome in developing community-focused and person-centered services. Since admissions have historically been considered long-term, the reality of whether meaningful discharge activities occur that would truly facilitate future planning on a person-centered level (for example, exploring potential community-living opportunities) is unclear. Most important, in order for individuals, or their families or authorized representatives, to make the choice of community-based services, real choices in services need to be readily available and funded.

5. **Inadequate Information Provided to Individuals with Disabilities and Their Families**: Many families continue to be unaware of the difference between a small intermediate care facility for persons with mental retardation (ICF-MR) and a group home funded through individuals receiving Home and Community Based (HCB) Waiver services. The Virginia Board for People with Disabilities (VBPD) and the Medicaid Waiver Technical Assistance Center located at the Endependence Center in Tidewater continue to receive reports of families who are already utilizing HCB Waivers agreeing to institutional placements or agreeing to allow their family member to remain in a group home that is converting to an ICF-MR without adequate information or understanding that, in doing so, their waiver slot will be forfeited. Often the institutional residents are referred to as group or "community" homes, creating further confusion for families. Subsequent options to change their desired living situation within Virginia are greatly reduced for these individuals when they give up their waiver slot.

6. **Health, Welfare, and Safety Conditions at the Training Centers**: Both institutional and community service providers must ensure the health, welfare, and safety of its service recipients and residents in the case of residential providers. The aging and condition of state Training Centers continue to cause major concerns for the dignity, safety of, and active treatment services to residents. As noted in the 2007 DMHMRSAS *Study of the Mental Retardation Service System*, the building design and residential space at state Training Centers often is no longer adequate to meet the needs of residents, which have changed over

the decades; and "significant physical plant improvements to ensure the continued health and safety of their residents" are needed. As noted in the chapter, Medicaid certification/recertification and related inspection surveys during 2006 and 2007 identified problems regarding safety and maintenance of buildings as well as quality of clinical care.

Also related to these inadequate buildings' issues, as part of its public comment on revision to the Human Rights regulations, the Board noted that the abuse and neglect oversight system can be problematic. In contrast to the Human Rights Advocates who are hired by and report directly to the Director of the Office on Human Rights, abuse and neglect investigators are facility employees who report to the facility Director, and the Manager for Abuse and Neglect is hired by and reports to the Associate Commissioner for Facility Management.

7. **Children Being Served in Nursing Facilities and Intermediate Care Facilities for Persons with Mental Retardation (ICFs-MR):** Though the numbers have declined since 2004, youths ages 20 and younger with disabilities are still being served in institutions. Families often do not receive the information they need to make real choices and are unaware of the potential option of a Home and Community Based (HCB) Waiver. Sufficient services and supports, especially medical and nursing care, must be made available to families so that they can care for their children at home if they choose to do so.

   The Virginia Board for People with Disabilities (VBPD) remains concerned about the number of children with disabilities in ICFs-MR and nursing facilities, and the efforts of some advocates to loosen criteria for admission of children into Training Centers. Both public comment provided to VBPD as well as the experience of several of its own Board members indicate that families who choose institutional placements are often not aware of community-living options and supports such as HCB Waivers. As noted above in Issue 5, sometimes families already utilizing HCB Waivers agree to institutional placements without adequate information or understanding of the consequences. In Northern Virginia, three ICFs-MR actually use "group home" in their names, creating further confusion for families as to whether the residence is an HCB Waiver home or an ICF-MR. In 2007, VBPD awarded a grant to the Virginia Association of Centers for Independent Living (VACIL) to conduct outreach to families of children at risk of placement in an institution or children currently in institutions. The goal is to help interested families learn about and obtain community supports to preserve the family or to rejoin the family by helping to transition the child back into the community.

8. **Erroneous Perceptions Regarding Care and Support of Individuals Who have Complex Medical Needs:** There continues to be misconceptions regarding how to serve people who have significant needs, including those perceived as "medically fragile." Too often an assumption is made by health care and other professionals that these individuals can only be served in an institution. Research has shown that with the appropriate services and supports, persons with complex medical needs can, in fact, be served in their homes or in other community settings. As additional evidence of this, a 2006 Virginia Board for People with

Disabilities grant to the Virginia Association of Centers for Independent Living (VACIL) resulted in 45 individuals transitioning out of nursing homes and into independent or family living, non-congregate settings.

9. **Isolation of Residents at Training Centers:** According to the 2005 Office of the Inspector General (OIG) for the Department of Mental Health, Mental Retardation and Substance Abuse Services *Systemic Review of State Training Centers*, the degree to which Training Centers offer activities that promote community integration (i.e., leaving the campus for activities), is variable and limited, being most limited at the larger facilities. Over time, facilities built (often with family support) features that keep services self-contained on campus, such as swimming pools, rather than partner with community resources (such as YMCA/YWCA) to promote more-normalized experiences with community members. As long as residents remain isolated within Training Centers, their segregation is counter to community integration and, most important, promotes misconceptions that these individuals cannot be served in the community, which thwarts systems transformation.

10. **Lack of Person-Centered Practices for Persons Residing in Institutions:** The Commonwealth has been engaged in instituting person-centered practices (PCP) into the service system for close to twenty years and has invested significant resources in trying to do so; yet, person-centered practices still elude many who receive services, especially those in institutional settings. The values and service delivery approaches fundamentally embedded in a system that promotes person-centered thinking and principles need to be universally understood and integrated into the planning processes for all individuals receiving services regardless of the environment in which services are being provided and regardless of the agency either funding or operating the service. A core understanding of these values and implementation of the associated principles and practices is especially important at nursing facilities, ICFs-MR, and other institutions to ensure maximum consumer choice in an environment that can otherwise inherently limit such choice.

H. Board Recommendations for Institutional Supports

The Virginia Board for People with Disabilities puts forth the following recommendations relating to policy and practice that would encourage and promote true choice for residents of institutions.

1. **Equalize the Entitlement Status of Institutions and Community Living:** The Virginia Board for People with Disabilities (VBPD continues to recommend that the Medicaid State Plan be amended so that Home and Community Based Medicaid Waiver services be given the same entitlement status as currently exists in Virginia for ICF-MR (institutional) services.

2. **Implement Person-Centered Practices (PCP) Systemwide:** VBPD recommends that training and education on person-centered practices, including values, planning, and support, be expanded throughout the service delivery system and included in university programs and continuing education for human services. To effect a systemic paradigm shift, aggressive

state leadership is needed to set expectations, develop policies and protocols, revise regulations, and expand training. Person-centered principles and practices (PCP) need to be universally understood and integrated into the fabric of planning and service delivery for individuals with disabilities at every level regardless of the environment in which the services are being provided. There are three current initiatives that each have a specific goal to bring person-centered services and practices to the service system: the Money Follows the Person Demonstration Project, the Systems Transformation Grant, and the Person-Centered Planning Workgroup assembled by the Department of Mental Health, Mental Retardation and Substance Abuse Services in response to the Office of Inspector General's (OIG) recommendations from OIG Reports 126-05 and 127-05. In order to ensure that these current initiatives actually bring PCP to the forefront of service delivery—with systemic versus splintered success—it is important to gain an understanding of why past attempts have failed. The strategies used and barriers confronted need to be identified, discussed, assessed, and fully understood with questions such as "Why didn't this work before?" and "What do we need to do differently?" asked at each juncture of planning, implementation, and evaluation.

3. **Provide Active Case Management Services to Persons Residing in Institutions:** VBPD recommends that the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) work with community services boards (CSBs) to ensure that discharge planning for individuals with intellectual disabilities/developmental disabilities who reside in training centers is an ongoing process that begins at admission. Quarterly reviews should be comprehensive and meaningful. VBPD recognizes that additional funding may be needed in order to provide active case management to all training center residents. The work of the five CSBs that already do this should be examined to ascertain how they are able to conduct these activities and the results thereof. Residents, family members, and authorized representatives should be provided with information on potential community living options on an ongoing, face-to-face basis by the appropriate entity. Long-term residents of institutions, including those who have authorized representatives, should be afforded the opportunity for community experiences that will enable them to explore their wishes and support options. Within confidentiality guidelines, families should be provided information about individuals who have successfully transitioned into the community following long-term institutionalization.

4. **Implement a Moratorium on Conversion of Home and Community Based (HCB) Waiver Funded Group Homes to Intermediate Care Facilities for Persons with Mental Retardation (ICF-MR) Status:** The Commonwealth should provide funding support and incentives to encourage the immediate development of new community-living opportunities, including noncongregate living options, as an alternative to institutionalization. While VBPD is strongly opposed to ICFs-MR and supports individualized living options, it recognizes that the creation of new ICFs-MR has continued because of the underfunding of community alternatives. VBPD therefore also recommends that the state limits the size of any new ICF-MR to no more than four beds and provides sufficient funding to create alternatives so that ICFs-MR of any size need not be built.

5. **Eliminate the Institutionalization of Children in Virginia (Younger than Age 21):** VBPD believes that families should never have to make the difficult decision to place their children in an institutional setting because they cannot obtain the services and supports they need within their homes and local communities. The Commonwealth should make a clear commitment to providing sufficient long-term funding to develop and maintain services that will allow children to grow up with a family. VBPD recommends that the appropriate executive branch or legislative agency conduct a study to examine the reasons for admissions of children and youths to training centers, nursing facilities, ICFs-MR (state and non-state), and long-stay hospitals to include contributing community service gaps, length of stay, impact of long-term institutionalization on family relationships, cost comparison to community services, and identification of successful strategies in other states to support youths and families in the home.

VBPD recommends that Virginia follow the lead of the State of Georgia, which in 2005 developed a goal of "a Georgia where children are prevented from going into institutions/facilities or are brought safely home from institutions/facilities into homes and families." As a result of this goal, the Georgia legislature passed a resolution that required nursing homes, state hospitals, private ICFs, and public and private hospitals serving children in long-term care submit an annual progress report to the Speaker of the House and develop a budget proposal for the 2008 fiscal year. It also established an oversight committee comprised of members of the three federal partners and other interested stakeholders, including legislators, to monitor the progress of the agencies. A summit was held to discuss ways for successfully moving the children to permanent homes and families. In 2006, the Georgia legislature approved funds so that all of the children in its state-administered institutions could go home. The state continues to work on this same goal for children in private facilities and nursing homes.

Institutional Supports Sources Referenced in This Chapter

Web Sites:

Centers for Medicare and Medicaid Services (CMS):
www.cms.hhs.gov/Certificationandcomplianc

Code of Virginia: http://leg1.state.va.us

Kaiser Family Foundation: http:www.kff.org

SeniorNavigator: www.seniornavigator.org/

U.S. Social Security Administration: www.ssa.gov/OP_Home/ssact/title19/1905.htm

Virginia Association of Non-Profit Homes for the Aging: www.vanha.org

Virginia Department for the Aging: www.vda.virginia.gov

Virginia Department of Health: www.vdh.virginia.gov. See also:
www.vdh.virginia.gov/quality/COPN/COPN.asp

www.vdh.virginia.gov/OLC/Laws/documents/COPN/SMFP%20composite%202003.pdf
www.vdh.virginia.gov/quality/Forms/ICF-MR-Narrative.pdf

Virginia Department of Medical Assistance: www.dmas.virginia.gov. See also:
Statistical Reports: www.dmas.virginia.gov/downloads/Stats_06/RECVCAG-06.pdf

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS): www.dmhmrsas.virginia.gov. See also:

www.dmhmrsas.virginia.gov/CFS (Children and Family Services)
www.dmhmrsas.virginia.gov/OMR (Office of Mental Retardation)
www.dmhmrsas.virginia.gov/OCC (Office of Community Contracting)
www.cvtc.dmhmrsas.virginia.gov/feedback.htm
www.swvtc.dmhmrsas.virginia.gov/rcsc.htm
www.swvtc.dmhmrsas.virginia.gov/pathways.htm

Virginia Healthcare Association: www.vhca.org

Virginia Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services: www.oig.virginia.gov

Virginia State Bar: www.vsb.org

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