

VII. Institutional Services

A. Introduction

This chapter focuses on three types of institutions in Virginia that serve individuals with intellectual or other developmental disabilities (ID and DD, respectively): Training centers operated by the state and certified as Intermediate Care Facilities for Persons with Mental Retardation (ICFs-MR) plus community-based ICFs-MR and nursing facilities (nursing homes) licensed by the state but operated by local public agencies and private nonprofit or for-profit organizations. All of the state's training centers as well as most community ICFs-MR and nursing facilities are certified for Medicaid or Medicare reimbursement for services and monitored by state agencies on a regular basis. While each category of institution has unique characteristics based on its function, all provide daily room and board as well as varying levels of health care and other services. Throughout this chapter, in keeping with national reports, references to "large" institutions apply to those having a building or unit with a capacity for 16 or more residents.

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

- Has the primary purpose of providing "health or rehabilitative services to persons with mental retardation or persons with related conditions,"
- Meets certain standards specified by federal regulations (42 CFR 483.400, subpart I *et seq.*),
- Has been certified to meet additional requirements (42 CFR 442.100, subpart C) as evidenced by a valid agreement between the state Medicaid agency and the facility,
- Fully meets the requirements for a state license to provide services that are above the level of room and board, and
- Provides "active treatment" to all individuals served and for whom payment is requested (42 CFR 483.440).

Active treatment is federally defined as "aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services...". Its goals must be to help the individual (1) acquire the essential skills or behaviors that enable him or her to function as independently as possible and (2) prevent or slow the loss of current "optimal functional status." Regulations require active treatment to include:

- A comprehensive functional assessment by an interdisciplinary team that includes an individual's developmental strengths and preferences, specific functional and adaptive social skills which need to be acquired, presenting disabilities and their causes when possible, and service needs without regard to availability;

- An Individual Program Plan (IPP) that describes opportunities for individual choice and self-management, measurable outcomes to be achieved, and specific specialized and generic strategies, supports, and techniques to be implemented;
- Individualized services or interventions provided in a continuous active treatment 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 of the functional assessment and IPP by the interdisciplinary team at least annually or as indicated by the individual’s circumstances.

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

Virginia’s Medicaid State Plan has included ICF-MR services for over 30 years, and the state directly owns and operates five ICFs-MR, known as **training centers**, through its **Department of Behavioral Health and Developmental Services (DBHDS)**. Central Virginia Training Center (CVTC) in Amherst County and Southside Virginia Training Center (SVTC) began operation in 1911 and 1939, respectively, although with different functions, services, and names. Southeastern Virginia Training Center (SEVTC), Southwestern Virginia Training Center (SWVTC), and Northern Virginia Training Center (NVTC) began operations as ICFs-MR in the mid-1970s.

Historically, many current residents of the state’s training centers were admitted in childhood, adolescence, or early adulthood during the 1960s and 1970s when placement in a state institution was considered to be either the only option or most appropriate option, and their placements were viewed as lifelong or “permanent.” Since 2005, however, DBHDS reports that all five training centers have experienced increased requests for admissions and consultation services for individuals diagnosed with mild or moderate intellectual disability and co-occurring behavioral challenges. To address this, regional efforts have been underway for several years to provide services for these individuals through collaborations by the training centers, state psychiatric hospitals, and Community Services Boards. As a part of these efforts, DBHDS has identified the need for expansion of specialized residential units and consultation services for communities similar to the Pathways program discussed later in this chapter.

The majority of ICFs-MR statewide are owned and operated by public agencies such as Community Services Boards or by private nonprofit or for-profit organizations. These facilities,

referenced in this assessment as “**community ICFs-MR**,” are licensed by DBHDS and defined by state regulations (12 VAC 35-105-20) as a service that:

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

Community ICFs-MR are subject to the same minimum federal requirements as the state’s larger training centers. Either directly or by contract, they are required to provide their residents with the same array of medical, health, and rehabilitative therapies as required by those residents’ individual comprehensive functional assessments.

The *Code of Virginia* (32.1-123) defines a **nursing home** as “...any facility or any identifiable component of any facility licensed pursuant to this article in which the primary function is the provision, on a continuing basis, of nursing services and health-related services for the treatment and inpatient care of two or more nonrelated individuals, including facilities known by varying nomenclature or designation such as convalescent homes, skilled nursing facilities or skilled care facilities, intermediate care facilities, extended care facilities and nursing or nursing care facilities.” It further defines a “*certified nursing facility*” as “...any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing home, whether freestanding or a portion of a freestanding medical care facility, that is certified as a Medicare or Medicaid provider, or both...” under Title XVIII of the national *Social Security Act* (42 USC 1395). Entities exempted from this definition and subsequent provisions of the Code of Virginia (32.1-124 through 136) include institutions licensed by DBHDS, institutions or portions thereof licensed by the State Board of Social Services, nursing homes owned or operated by the federal government, and nursing homes owned or operated by the state unless it is certified as a nursing facility.

Consumer guides published by CMS and by the **Department of Medical Assistance Services (DMAS)**, the state’s Medicaid agency, (www.feddesk.com/freehandbooks/1216-4.pdf and http://dmasva.dmas.virginia.gov/Content_atchs/ltc/ltc-guide_srvcs.pdf, respectively) describe nursing homes as long-term care facilities designed to serve people who are determined to have functional impairments due to aging, an injury, or a prolonged illness or chronic condition and who require nursing, medical care, or other supports and environmental adaptations but do not have adequate community supports. These facilities offer room and board, nursing care 24 hours a day, personal care, supervision, and various therapies and

rehabilitation. As with community ICFs-MR, they may be operated by local public agencies or by private nonprofit and for-profit organizations.

Several major initiatives affecting institutional services and promoting **person-centered practices** have begun recently in Virginia. Person-centered practices promote more effective communication with, not to, individuals to determine what is important to and for them, identify the supports that they need and their desired outcomes, and facilitate their individual control over those supports and outcomes. More detailed descriptions of these practices for individuals with disabilities, their families, caregivers, and service providers can be found at www.dbhds.virginia.gov/ODS-PersonCenteredPractices.htm.

Findings by the **Office of the Inspector General (OIG) for Behavioral Health and Developmental Services** in its 2007 systemic review of Virginia's training centers, discussed in more detail in the monitoring and evaluation section of this chapter, were very critical of direct services at those facilities with respect to both the general lack of opportunities for their clients' self-determination and community inclusion as well as a lack of person-centered practices. Since 2008, DBHDS has implemented a system-wide, ongoing training program, **Person-Centered Virginia**, which addresses these issues and, since July 2009, the training centers have implemented Person-Centered Plans as part of the treatment planning process. Nonetheless, the OIG still identifies many of its 2007 findings as active and continues to monitor training center progress in these areas.

Advancing Excellence in America's Nursing Homes (www.nhqualitycampaign.org) is a "culture change" initiative started in 2006 by various national organizations including CMS and the American Health Care Association. It promotes improvements in both the quality of care and the quality of life for individuals served in nursing homes, encouraging those facilities to design environments and adopt person-centered and individualized practices.

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

Effective October 1, 2010, to ensure that individuals reside in the "least restrictive environment," CMS requires new elements in the comprehensive assessment of each potential or current nursing home resident that occurs at admission, annually, and whenever there is a significant change in a resident's status. This **Return to Community Referral Assessment** requirement is designed to ensure that individuals receive information about community living

options when requested and that appropriate planning for transition occurs if the individual wishes to return to the community. Additional information on this requirement is detailed in later sections of this chapter and is available at www.olmsteadva.com/mfp/MDS3SectionQ.htm or www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage.

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

As experienced in other states and noted in the Kaiser Commission's *MFP: 2010 Snapshot*, Virginia's project start-up and its number of transitions has been much slower than expected. Causes for this slow progress have included delays in the development and approval of operational protocols, outreach to institutions, and the recruitment and training of Transition Coordinators as well as the lack of affordable, accessible housing, stressed state resources for necessary activities, and the amount of time needed to arrange appropriate community services.

The following table shows Virginia's progress at the time of this assessment toward meeting its initial goal of transitioning 1,041 individuals from institutions to community settings by the end of federal fiscal year (FFY) 2011, as reported by the MFP Coordinator at the Department of Medical Assistance Services (DMAS).

PROGRESS TO-DATE IN VIRGINIA'S MFP DEMONSTRATION PROJECT

<u>Date of Count</u>	Total	Transitioned		Plans in Development	
	Enrollees	Number	Percent	Number	Percent
September 3, 2009	95	57	60%	38	40%
June 30, 2010	182	136	75%	46	25%
February 28, 2011	289	204	71%	85	29%

Source: Department of Medical Assistance Services (DMAS).

Originally a four-year initiative, the CMS extended MFP for four more years. To strengthen the program and address the issues being faced by Virginia and other states, CMS made program changes and approved additional funding effective in June 2011. All MFP participants must still meet eligibility criteria for Medicaid HCBS Waivers at time of discharge; however, the original MFP eligibility requirement that an individual be resident in an institution for six consecutive months was reduced to three months. Additional administrative funding received by Virginia is to be used add several new positions at DMAS and the Department of

Behavioral Health and Developmental Services (DBHDS) focusing on discharge planning, housing, and transition.

Despite these efforts, the Commonwealth clearly has a very long way to go in rebalancing and reforming its service system for individuals with disabilities. A major annual report, *The State of the States in Developmental Disabilities*, has consistently ranked Virginia near the bottom among the states and the District of Columbia for its spending on behalf of individuals with intellectual and other developmental disabilities. In 2006 and 2009, Virginia ranked 45th in the nation for its overall fiscal effort, defined as total spending for community services and publicly or privately operated institutions other than nursing facilities per \$1,000 of total state personal income. When the report looked only at state spending for community-based services, however, Virginia's ranking improved slightly from 46th in 2006 to 43rd in 2009.

As noted above, DBHDS has been working to improve person-centered practices that promote self-determination at the state's training centers. It has also been working with stakeholders through various initiatives to change the state's current service system and reduce its reliance on institutional services to one that supports community integration for all individuals with intellectual and developmental disabilities, including those with the most significant disabilities. In addition, since entering office in 2010, the administration of Governor Bob McDonnell has expressed a strong commitment to reduce Virginia's reliance on institutional services, specifically its state-operated training centers.

Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia, a new strategy implemented by DBHDS in 2010, sets forth an agenda and related initiatives for the next three years to enhance the service system so that it will "...promote self-determination, empowerment... health, and the highest possible level of participation by individuals receiving services in all aspects of community life." Implementation teams are working to develop specific action steps, outcomes, and timelines for each strategic initiative. For developmental disability services, they include building community service capacity, addressing housing needs, creating employment opportunities, and strengthening case management and support coordination capability.

DBHDS plans further downsizing of the state's training centers, and in his presentation to legislative committees in January 2011, its Commissioner observed a significant shift, "Families are no longer selecting training centers." DBHDS' 2010 annual report to the General Assembly calls for a reduction of 57 beds, resulting in estimated annual savings of \$10 million. Closing one unit at Central Virginia Training Center (CVTC) would save another \$1.2 million.

Adverse findings by the **U.S. Department of Justice (DOJ)** are likely to result in additional changes at the training centers. The national *Civil Rights of Institutionalized Persons Act (CRIPA, 42 USC 1997 et seq.)* authorizes DOJ to seek remedies for a pattern or practice that violates the constitutional or federal statutory rights of institutionalized individuals, and in 2008, DOJ began an investigation of services at CVTC. It later expanded that investigation to include examination of whether individuals at that facility as well as those already discharged from it

were being served in the most integrated settings appropriate to their needs and examination of state policies, procedures, and practices regarding admissions and discharges by all training centers. The investigation included extensive, system-wide interviews with DBHDS leadership, CVTC staff and residents, community providers, directors of Community Services Boards (CSBs), and individuals discharged from CVTC to localities throughout the state. On February 10, 2011, the Commonwealth received a letter from DOJ reporting on its completed investigation (www.governor.virginia.gov/news/viewRelease.cfm?id=606) containing a summary of facts supporting its findings and identifying "...minimum steps necessary to remedy the deficiencies."

Federal regulations restrict the use of restraints to emergency situations and only for the length of time required for the emergency to be resolved; however, DOJ sharply criticized CVTC for using restraints as part of individual treatment plans and as an intervention of first, rather than last, resort. It further found that CVTC failed to provide for "reasonable care and safety," as evidenced by:

"...repeated accidents and injuries, inadequate behavioral and psychiatric interventions, and inadequate physical and nutritional management supports. An overarching cause of these harms is CVTC's failure to identify individuals' needs, identify root causes of bad outcomes, and respond to prevent their recurrence. ...Particularly concerning during our initial tours in 2008-09 was CVTC's use of restraints."

DOJ concluded that Virginia had failed systematically to "...provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs in violation of the ADA" (*Americans with Disabilities Act*, 42 U.S.C. 12101 *et seq.*) and that these deficiencies "...have resulted in needless and prolonged institutionalization of, and other harms to, individuals in CVTC and other segregated training centers" in violation of their civil rights. Specifically, DOJ found that the state:

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

In its findings, DOJ complimented the Commonwealth's acknowledgement of the problems and willingness to work toward an amicable solution. It was pleased by the state's

recent “down-payment” of \$30 million to improve services for individuals with intellectual and other disabilities. These funds proposed by the Governor and approved by the 2011 General Assembly comprise a **Behavioral Health and Developmental Services Trust Fund** to be used to provide or improve community-based services, including new Medicaid HCBS Waivers to transition individuals from state training centers to community settings. Other, related budget proposals for state fiscal year (SFY) 2012 approved by the legislature (and covered further in the Medicaid and Community Supports chapters of this assessment) included:

- \$400,000 for five new DBHDS positions to assist individuals served at the training centers and their families in planning for transition to community settings,
- Restoration of \$7.1 million in previous cuts to improve staffing ratios, and
- \$200,000 for DBHDS to contract with consultants for staff training.

Since March 2011, the Governor and Attorney General of Virginia, with collaboration by DBHDS, DMAS, and other relevant parties, have been in negotiation with DOJ to determine how the state will resolve the deficiencies identified by its investigation, and a settlement agreement is expected to be signed by the summer of 2011. If, however, DOJ determines that a resolution of its concerns is not possible, then the U.S. Attorney General may initiate a lawsuit pursuant to CRIPA and ADA under the latter statute’s “Olmstead” integration mandate.

B. Eligibility for Institutional Services

State-Operated Training Centers (ICFs-MR): As required by the *Code of Virginia* (37.2-505), referral for potential admission to one of the state’s five training centers, operated by the Department of Behavioral Health and Developmental Services (DBHDS) as intermediate care facilities for persons with mental retardation (ICFs-MR), is the responsibility of local **Community Services Boards or Behavioral Health Authorities** (jointly referred to as **CSBs**). Details of this face-to-face screening process, conducted by the CSB for the jurisdiction where an individual lives, are detailed later in this chapter.

Eligibility for training center admission is the same as for the Medicaid Home and Community Based Services (HCBS) Intellectual Disability (ID) Waiver. An applicant must have a primary diagnosis of mental retardation (while the preferred term “intellectual disability” is used throughout this assessment, “mental retardation” remains the statutory designation), as determined by a formal assessment by a licensed, qualified professional, and must meet the level-of-functioning requirements for an ICF-MR. The *Virginia Administrative Code* (12 VAC-34-190-10) defines the diagnosis criteria as onset prior to age 18 of significantly sub-average intellectual function, as demonstrated by performance on a standardized measure of intellectual functioning administered in conformity with accepted practice, and concurrent significant limitations in adaptive behavior, as expressed in conceptual, social, and practical adaptive skills.

For regular admission (12 VAC 35-190-30), an individual must also be judicially certified as needing training center services, the center must be the least restrictive environment

that meets the individual's needs, and the training center serving the jurisdiction where the individual lives must have available space and service capacity to meet those needs.

Most individuals admitted to and residing in a state training center have one or more significant disabilities in addition to an intellectual disability. Many have a concurrent visual or hearing impairment, ambulation difficulties, a neurological disorder, neuro-behavioral issues, or a mental illness. Both the 2008-2014 and 2010-2016 DBHDS *Comprehensive State Plans* (www.dbhds.virginia.gov) identify two distinct populations served at the training centers: individuals diagnosed with severe or profound intellectual disability and co-occurring complex medical or physical conditions, such as cerebral palsy, and “dually” diagnosed individuals with an intellectual disability and co-occurring mental illness who have challenging behaviors.

Community ICFs-MR: As described above for the state's training centers, eligibility for admission to a publicly or privately operated community intermediate care facility for persons with mental retardation (ICF-MR) is based on state regulations. An applicant must have a primary diagnosis of intellectual disability, meet ICF-MR level-of-functioning requirements, and be screened by a professional regarding the appropriateness for the residence. Individuals must also have Medicaid or Medicare public insurance, private insurance, or the ability to pay for care directly.

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

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

To be admitted, individuals must be determined to have both functional needs and nursing or other medical needs based on the results of a formal, standardized assessment by a health care professional. As noted in this chapter's introduction, the federal Centers for Medicare and Medicaid (CMS) made important changes to this process that took effect on October 1, 2010. CMS now requires new elements in the comprehensive assessments of potential or current nursing facility residents that occur at admission, annually, or whenever there is a significant change in a resident's status. This **Return to Community Referral Assessment** features additional resident interview items, including a specific question about whether the individual is interested in speaking with someone about the possibility of moving out of the

nursing facility and back into the community. If the individual requests such information, CMS guidelines require the nursing facility to initiate care planning to provide it. This does not commit the individual to a move, but guarantees that he or she will receive information about doing so.

If the individual does want to move to the community and has transition needs that the facility cannot plan for or provide, the facility must make a referral to an appropriate community resource. The community agency then serves as the initial point of contact to provide residents with introductory information about community resources, and collaborates with the nursing facility to make arrangements for transition to community living. In either instance, the nursing home is still responsible for development and documentation of the discharge according to CMS regulations. Based on CMS guidance, Virginia has designated Area Agencies on Aging (AAAs) to serve as the local contact agency (LCA) with the primary, but not exclusive, role for information and technical assistance for nursing facility transition. Other public or private entities, including Centers for Independent Living (CILs), can and do also provide this information and assistance.

Additional information on nursing facility assessment processes and planning for transition to community residence appears in later sections of this chapter.

C. Access to and Delivery of Institutional Services

State-Operated Training Centers (ICFs-MR): Two distinct categories of training center admissions are authorized under the *Code of Virginia* (37.2-805 through 807): **temporary admissions** due to emergencies or for respite care and **judicial certification of eligibility**, commonly referred to as “regular admission.” Regulations (12 VAC 200-20 and 200-30) vary for the two types of admissions, such as time limitations for temporary admissions. To protect an individual’s rights, stays longer than the limits set for temporary admissions require judicial certification.

As noted above, state law requires **Community Services Boards (CSBs)** to provide prescreening services for all individuals referred for potential admission to a training center. Responsibility for prescreening is assigned to the CSB that serves the city or county where an individual resides or, if the individual is a minor, where his or her parent or guardian resides or to the CSB that provides an individual with case management. An individual, or his or her parents, guardian, or authorized representative if appropriate, must contact the CSB to start the admissions process. If an individual is not able to make necessary decisions regarding his or her admission or treatment and there are no family members available to do so, the CSB will conduct a capacity evaluation and assist in finding an authorized representative.

For all admission requests, a **CSB Support Coordinator**, also referred to as a **case manager**, must conduct a face-to-face interview with the individual and complete a preadmission screening report. This report includes a standardized application form; information

on the individual's medical history, current medical conditions, and medications; housing or living arrangements, natural supports, and social history; an Individualized Education Plan (IEP) for school-aged children and youth up to age 22 or a vocational assessment for adults, as appropriate; and a discharge plan that states the services to be provided upon discharge and its anticipated date. A formal evaluation by a qualified, licensed psychologist must be available or obtained to verify the individual's diagnosis of intellectual disability (mental retardation) and current level of cognitive functioning. In addition, the case manager must conduct a **Level of Functioning (LOF) Survey** that assesses the individual's strengths and weaknesses in adaptive functioning and in activities of daily living to determine whether he or she meets the level of functioning requirement for an intermediate care facility for persons with mental retardation (ICF-MR) placement or Medicaid Home and Community Based Services (HCBS) Waiver.

Based on this information, the case manager must determine if community services and supports are available to meet the individual's needs and, if so, inform the individual and his parents, guardian, or authorized representative, if appropriate, that community services are a potential option. Once individuals and their parents, guardians, or authorized representatives, if appropriate, have been fully informed of their options, the individuals or their parents, guardians, or authorized representatives, if appropriate, must sign a written declaration of their "choice" of services, including, but not limited to, placement in a training center. It is current CSB practice that admission to a training center is initiated only after community options have been exhausted.

If admission to a training center is chosen as an option, the CSB case manager forwards the completed written prescreening report to the executive director, or designee, of the training center serving the geographic area in which the individual resides for review and determination of whether admission is appropriate for that individual. A response must be returned to the CSB within ten days, and upon receipt, the CSB notifies the individual and his parents, guardian, or authorized representative, if applicable, of the determination.

Once the training center and CSB staff have determined that the individual is eligible for **regular admission** to a training center, state regulations (12 VAC 35-190-51 *et seq.*) authorize the CSB or a parent, guardian, or authorized representative of that individual to initiate judicial proceedings to certify that legal eligibility requirements (37.2-806) for admission have been met. The individual must be present at any hearing, have an opportunity to prepare his or her defense, if any, and have an attorney present on his or her behalf. A judge or special justice may request that a physician, licensed psychologist, or the CSB case manager who assessed the individual attend the proceeding and certify that an assessment was conducted within 30 days of the proceeding and certify its findings relevant to admissions criteria. Based on the information obtained and observation of the individual, the judge or special justice may authorize the parent, guardian, or authorized representative of the individual to admit the individual to a training center and authorize the appropriate facility to accept the individual. It must be emphasized that this judicial certification is not an involuntary admission, and the individual has the right to appeal the admission order to the Circuit Court.

Both emergency and respite care **temporary admissions** are intended to be of short duration, and neither involves a judicial certification of eligibility unless the individual's stay

extends past the limits set by state law of 21 consecutive days or a total of 75 days in any calendar year. An emergency admission means a “temporary acceptance” into a training center “when immediate care is necessary and no other community alternatives are available.” A respite care admission is specifically intended to “provide temporary, substitute care for that which normally provided by the primary caregiver.” Respite admissions may be sought because the individual’s primary caregiver has been hospitalized or needs periodic relief from caregiving.

DBHDS reports that, at the time of this assessment, almost all of the individuals admitted to and residing in the state’s training centers are adults. Southeastern and Southwestern Virginia Training Centers (SEVTC and SWVTC) have a children’s residential services license from DBHDS to serve small numbers of youth, ages eight through 17 at SEVTC and ages 12 through 21 at SWVTC. Youth admitted to these two facilities typically have a dual diagnosis of intellectual disability and mental illness, and these facilities are considered to be “providers of last resort” for these age groups. In addition to its certified ICF-MR units for adults with intellectual disabilities, Central Virginia Training Center (CVTC) has certified nursing units which can accommodate up a total of 104 residents.

The 2010-2016 DBHDS *Comprehensive State Plan* provides a more detailed snapshot of the average ages for training center residents and the average lengths of their stays for episodes of care. In state fiscal year (SFY) 2009, only two percent of all training center residents were below age 22, while eight percent were over age 65, and the average age of residents has risen slowly over recent years from 47 in SFY 2005 to 47.7 in SFY 2007 to 48 in SFY 2009. DBHDS attributes this increase to the long lengths of stay for many residents, a lack of community providers to support the aging population of persons with intellectual disabilities, the need for community residential programs that support individuals who require tube feeding, and the complex medical needs of many training center residents.

The following table compares the age distribution of training center residents at the end of selected recent state fiscal years (SFY), including both residents of the certified nursing units at CVTC and residents of ICF-MR certified units at all of the training centers. Counts reflect all individuals “on-books” at the end of each state fiscal year, June 30, and the amount and percent of change is for the entire period shown. On-books refers to all persons admitted to a facility, but not yet discharged, and includes any who were off-campus on a pass or on leave.

STATE TRAINING CENTER RESIDENTS BY AGE

Age Category	SFY 2005	SFY 2007	SFY 2010	Change	Percent
0-5 years	0	0	0	0	----
6-15 years	4	5	1	-3	-75%
16-21 years	4	11	6	+2	+50%
22-54 years	1,039	965	722	-317	-31%
55-64 years	299	267	295	-4	-1%
65 years or older	170	139	136	-34	-20%
Total	1,516	1,387	1,160	-356	-23%

Source: Department of Behavioral Health and Developmental Services (DBHDS).

Overall, the number of residents declined by more than 23 percent from SFY 2005 to SFY 2010, with most of that decline coming in residents ages 22 through 54 (317 fewer, minus 31 percent) and ages 65 and older (34 fewer, minus 20 percent). For all three years, individuals ages 22 through 54 comprised the greatest proportion of residents, 62 percent at the end of SFY 2010. Individuals ages 55 through 64 made up the second largest sub-population, 25 percent for that same year. Those ages 65 and over comprised 12 percent, and those ages 21 and younger, less than one percent at that time.

The next table shows the total number of admissions to all state training centers by admissions category for those same years as well as the amount of change for the entire period.

STATE TRAINING CENTER ADMISSIONS BY TYPE

Admissions Type	SFY 2005	SFY 2007	SFY 2010	Change	Percent
Judicial Certification	107	23	12	-95	-89%
Emergency	38	53	37	-1	-3%
Respite Care	41	60	59	+18	+44%
Total	186	136	108	-78	-42%

Source: Department of Behavioral Health and Developmental Services (DBHDS).

The significant decline in admissions indicated above, 42 percent from SFY 2005 to SFY 2010, is primarily due to an even more substantial decrease in judicial certification, or regular, admissions of 89 percent, with most of that decline occurring between SFY 2005 and SFY 2007. The overall decline in total admissions was moderated by an increase in emergency admissions between SFY 2005 and SFY 2007 before returning to the earlier level by SFY 2010 and by respite care admissions, which declined considerably between SFY 2005 and SFY 2007 then were essentially stable between SFY 2007 and SFY 2010. DBHDS reports that the overall drop in admissions, driven by the decline in regular admissions, has resulted from the department and its CSB partners making a concerted effort, as required by state regulations, to ensure that all community alternatives have been exhausted prior to making a request for a regular admission.

Additional procedural guidelines for both the CSBs and training centers, entitled *Admissions and Discharge Protocols for Individuals with Intellectual Disabilities*, provide detailed information on the specific roles and responsibilities for each entity during the admission and discharge processes based on statutory requirements as well as the Community Services Performance Contract between DBHDS and the CSBs. These protocols help to ensure consistency and improve continuity of services statewide for individuals referred to or served at the training centers. In 2010, DBHDS staff and representatives from the CSBs and the Virginia Office for Protection and Advocacy (VOPA) met to review and revise the protocols. The revised protocols were adopted and implemented on March 1, 2011, and are posted on the DBHDS website (www.dbhds.virginia.gov/documents/ODS/ods-Admission-Discharge-Protocol.pdf).

An **admission appeal** is possible when any admission request is denied. A Training center's director must provide a written statement of the reason or reasons for the denial and may

also provide recommendations for alternative services. If the parent, guardian, or authorized representative, as applicable, for the individual denied admission disagrees with this decision, either that person or the CSB representative may submit a written request for reconsideration of the decision by the DBHDS Commissioner within ten days of receiving the decision notice.

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

Since May 2009, as a part of the ISP process, all training centers have been phasing in implementation of the **Supports Intensity Scale (SIS)**. Developed by the American Association for Intellectual and Developmental Disabilities (AAIDD), this standardized assessment measures the pattern and intensity of supports needed by persons with intellectual and developmental disabilities to be successful. It will be administered every three years for each resident and is currently the only available assessment instrument for this population that measures the frequency and level of support needs rather than an individual’s “deficits.”

Using information from the SIS and other assessments, an individual’s interdisciplinary team must review his or her progress at 30, 60, 90, and 180 days following regular admission to a training center. Thereafter, team reviews are conducted annually or whenever circumstances warrant. A Qualified Mental Retardation Professional (QMRP), or Service Coordinator, who works with the individual must also conduct quarterly reviews. Whenever an annual or special review identifies a change in an individual’s status, such as medical issues, that would significantly affect that individual’s discharge potential, statutes require that training center staff collaborate with the CSB to ensure that the individual’s CSB Support Coordinator (case manager) is informed of any changes in the services or supports needed for the individual’s discharge plan.

The *Code of Virginia* (37.2-505) requires that this discharge plan developed at the initial meeting of an individual’s interdisciplinary team, in consultation with training center staff and the individual’s CSB Support Coordinator, include the following information:

- The anticipated date of discharge from the training center;
- A description of all the services and supports needed for the individual’s successful return to and life in the community, such as psychiatric, social, educational, medical, housing, employment, legal, advocacy, transportation, and others as indicated; and
- The specific public and private providers who agree to supply these needed services, consistent with the right of the individual or his or her parents, guardian, or authorized representative, if applicable, to choose his or her own providers.

The table below shows the **operational capacity** for Virginia's training centers near the end of selected state fiscal years (SFY) and the overall change from 2005 to 2010. Annual dates are not consistent due to data system limitations. Operational beds are those for which a facility is funded for staff and services. Counts for CVTC include both the beds in its certified ICF-MR, nursing facility, and acute care units. The CVTC acute care beds were closed as of July 1, 2010.

OPERATIONAL CAPACITY (BEDS) AT VIRGINIA TRAINING CENTERS

Virginia Training Center	June 30, 2005	July 5, 2007	July 9, 2009	July 1, 2010	Change	Percent
Central (CVTC)	611	577	558	510	-101	-16.5%
Northern (NVTC)	200	200	200	200	0	0.0%
Southeastern (SEVTC)	200	200	200	200	0	0.0%
Southside (SVTC)	395	359	361	307	-88	-22.3%
Southwestern (SWVTC)	223	215	210	210	-13	-5.8%
Total	1,629	1,551	1,529	1,427	-202	-12.4%

Sources: Department of Behavioral Health and Developmental Services (DBHDS). *Comprehensive State Plans* for 2006-2012, 2008-2014, and 2010-2016, and DBHDS Office of Developmental Services.

As the table shows, the total number of operational beds at all training centers decreased 12.4 percent, from 1,629 at the end of SFY 2005 to 1,427 at the end of SFY 2010. While three training centers, CVTC, SVTC, and SWVTC, experienced declines, most of the reduction occurred at CVTC, which dropped by 16.5 percent, and SVTC, which dropped by 22.3 percent. SWVTC, which experienced a drop of 5.8 percent between SFY 2005 and SFY 2009, saw no decline for SFY 2010.

Average Daily Census (ADC) reflects the *average* number of residents on-books, including those on pass or leave, at a facility over a period of time, usually the state fiscal year. ADC and residents' length of stay are important factors affecting the availability of admissions at state training centers. The next table shows the ADC for selected years between SFY 2005 and SFY 2010 as well as the change for that entire period.

AVERAGE DAILY CENSUS (ADC) AT VIRGINIA TRAINING CENTERS

Training Center	SFY 2005	SFY 2007	SFY 2010	Change	Percent
Central (CVTC)	556	509	400	-156	-28.1%
Northern (NVTC)	194	172	166	-28	-14.4%
Southeastern (SEVTC)	181	187	145	-36	-19.9%
Southside (SVTC)	346	311	265	-81	-23.4%
Southwestern (SWVTC)	216	209	194	-22	-10.2%
Total	1,493	1,388	1,170	-323	-21.6%

Source: Department of Behavioral Health and Developmental Services (DBHDS).

During this period, ADC declined for all state training centers by 21.6 percent at a rate of approximately 66 individuals per year, a total of 323 individuals from SFY 2005 to 2010. All of

the training centers experienced a decline, with the largest decreases in numbers and percent occurring at CVTC (156, or 28.1 percent) and SVTC (81, or 23.4 percent). The population at SEVTC declined by nearly 20 percent, mostly after SFY 2007, reflecting the downsizing effort as a replacement facility with only 75 beds is being constructed. Declines at CVTC also accelerated from 47 (8.5 percent) between SFY 2005 and 2007 to 109 (21.4 percent) between SFY 2007 and 2010. In contrast, the ADC at NVTC fell by 22 individuals (11.3 percent) from 2005 to 2007, then by only 6 (3.5 percent) from 2007 to 2010. SWVTC experienced the lowest decrease for the entire period (10.2 percent).

Since the end of SFY 2010, DBHDS reports, the number of residents at Virginia's training centers has continued to decline, totaling only 1,113 as of December 16, 2010.

DBHDS attributes these census declines to several factors. CSBs, in cooperation with training center staff, have worked to minimize the number of long-term admissions and ensure that all emergency and respite admissions are for less than the regulatory limit of 75 days. They have also increased efforts to find community placements, resulting in more discharges. These reductions in new long-term admissions have contributed to the increase in average age of training center residents noted above, and some of the decline in the ADC can be attributed to deaths of elderly residents due to aging and other natural causes.

According to the DBHDS 2010-2016 *Comprehensive State Plan*, the **average length of stay (ALOS)** for all training residents in SFY 2009 was 28.6 years. For that year, 2.6 percent of episodes of care (38) lasted less than seven days, while 10.1 percent (145) were for more than 50 years. The following table shows ALOS at the end of state fiscal years (SFY) 2005, 2007, and 2010. As before, the averages are based on all residents who were on-books, and the data for 2007 has been updated from what appeared in the 2008 edition of this assessment.

AVERAGE LENGTH OF STAY (ALOS) AT VIRGINIA TRAINING CENTERS

Training Center	Years of Stay		
	SFY 2005	SFY 2007	SFY 2010
Central (CVTC)	38.1	39.6	41.8
Northern (NVTC)	21.9	23.5	25.8
Southeastern (SEVTC)	17.3	18.4	21.3
Southside (SVTC)	28.0	30.0	32.4
Southwestern (SWVTC)	17.8	19.1	21.9

Source: Department of Behavioral Health and Developmental Services (DBHDS), AVATAR database.

As this table shows, the average length of stay for all training centers has been slowly increasing. By the end of SFY 2010, they ranged from 21.3 years at SEVTC to 41.8 years at CVTC. The variation in ALOS among the training centers can be attributed, in part, to differences in their duration of operation. As described earlier, NVTC, SEVTC, and SWVTC

began operations in the mid-1970s, while CVTC and SVTC have operated since 1911 and 1939, respectively; although not as ICFs-MR for that entire time.

Institutional trends across the United States provide useful benchmarks for monitoring progress in Virginia. According to *Residential Services for Persons with Developmental Disabilities: Status and Trends*, an annual national report, nine states had closed all of their large state-operated institutions for individuals with intellectual or developmental disabilities (ID/DD) by June 30, 2009. Virginia is now one of only ten states that have not close any state-operated institutions for this population. The report further noted that only 0.6 percent of all persons with ID/DD receiving services nationally lived in residences with 16 or more beds.

Another national trend has been the substantial shift to small community-based, non-state-operated residential services. By the end of federal fiscal year (FFY) 2009, only 1.3 percent of all residential settings for individuals with ID/DD were state-operated. In addition, during the past decade, several states have significantly decreased their number of community intermediate care facilities for persons with mental retardation (ICFs-MR) by converting them to small residences of six or fewer residents receiving services and supports through Medicaid Home and Community Based Services (HCBS) Waivers. Alaska no longer has any ICFs-MR, and 20 states have fewer than ten each, 1.1 percent of the total nationally.

In 2005, the Virginia Department of Behavioral Health and Developmental Services, under its former agency name, produced a legislative report, *House Document #76: The Cost and Feasibility of Alternatives to the State's Five Mental Retardation Training Centers* (www.dbhds.virginia.gov/documents/reports/OMR-HouseDocument76.pdf) that concluded:

“The most feasible, cost-effective option for Virginia is the combination of developing community alternatives, reducing the size of the state training centers by re-focusing their purpose and function, and making needed renovations to these centers necessary for the maintenance of safety standards and increased efficiency.”

This report recommended an overall reduction of 100 individuals per year across all of the state's training centers, from an average census of 1,524 in state fiscal year (SFY) 2005 to 724 by the end of SFY 2012. It emphasized that expansion of the types and capacity of community services and supports was essential to achieving this goal. As noted above, however, the *total* number of residents for all Virginia's training centers on December 16, 2010, was still 1,113.

At the time of this assessment, Virginia has no specific plans to close any of its five training centers, but this could change as a result of the U.S. Department of Justice's investigation findings discussed in the introduction to this chapter. In December 2005, then Governor John Warner proposed an infusion of funding for behavioral health and developmental services that included tens of millions of capital outlay dollars for redesign and rebuilding of Central Virginia Training Center (CVTC) and Southeastern Virginia Training Center (SEVTC).

As a result of extensive public advocacy opposing the rebuilding of these two large institutions, in 2009, his successor, Governor Tim Kaine, proposed the closure of SEVTC. The General Assembly did not agree to this proposed closure and reaffirmed, albeit at a lower dollar amount, the plans to rebuild CVTC and SEVTC.

Subsequently, the 2009 General Assembly allocated \$23 million in General Fund capital outlay funds to construct a replacement facility for SEVTC with 75 beds, as noted earlier, and \$24 million to renovate CVTC at a capacity of 300 beds. In addition, for the first time in Virginia's history, the legislature designated capital outlay funds, in the amount of \$18.4 million, to build community residences, community ICFs-MR and Medicaid HCBS Waiver group homes, as a part of the downsizing of each facility.

In a presentation to the 2011 General Assembly, the DBHDS Commissioner reported that construction on the new 75-bed SEVTC and for the community residences in the surrounding Tidewater area began in late September 2010, with completion of the new SEVTC scheduled for September 2011. Renovations at CVTC have begun on two buildings and, along with planned work on additional buildings at that site, are expected to continue through 2015. As of January 2011, planning for the community residences near CVTC in the greater Lynchburg area was still underway.

Community ICFs-MR: Individuals seeking admission to a non-state-operated community intermediate care facility for persons with mental retardation (ICF-MR) apply directly to the provider organization responsible for the institution's operation. Currently, a number of these ICFs-MR are operated by local Community Services Boards (CSBs) and others are operated by private nonprofit and for-profit entities. Their geographic service areas vary, and each determines its own application and admissions processes. Most ICFs-MR operated by CSBs serve individuals within their own local jurisdictions first, but they can serve individuals from outside of their localities if they choose to do so. Private providers may accept referrals from anywhere in the state. A directory of ICFs-MR, nursing facilities, hospital long-term units, and mental health facilities statewide produced by the Office of Licensure and Certification at the Virginia Department of Health (VDH) is available online at www.vdh.virginia.gov/OLC/Facilities/.

All community ICFs-MR are covered by the same state and federal regulations as the state's training centers. Individuals must receive "all necessary services" appropriate to their individual needs based on an individual assessment, an Individualized Support Plan (ISP) must be developed, and active treatment must be provided according to that plan. Assessments must be conducted regularly to determine and update the individual's service and support needs, as well as to reassess whether the individual continues to need the ICF-MR level of care. Involvement by the individual or his or her parents, guardian, or authorized representative, as appropriate, in treatment planning is required, and involvement by a CSB Support Coordinator is requested. Individuals served in community ICFs-MR must be certified annually to ensure that they are receiving the appropriate level of care. Any transition to another residential and service setting must be planned to ensure continuity of needed services and supports.

The table below contains data provided by the Department of Medical Assistance Services (DMAS) showing the number of individuals served in community ICFs-MR for state fiscal years (SFY) 2007 and 2010 by age groups.

PERSONS SERVED IN COMMUNITY ICFs-MR BY AGE

Age Groups	SFY 2007	SFY 2010
Under 1 year	0	0
1-5 years	8	9
6-14 years	44	44
15-20 years	68	52
Subtotal for Ages 1-20	120	105
21-44 years	111	132
45-64 years	102	137
Subtotal for Ages 21-64	213	269
65-74 years	5	17
75-84 years	2	0
85 & older	0	0
Subtotal for Ages 65 & older	7	17
Total for All Ages	340	391

Source: Department of Medical Assistance Services (DMAS).

In SFY 2010, children and youth ages one through 20 comprised 26.9 percent of all individuals served by community ICFs-MR, and their total number declined by 12.5 percent from SFY 2007. Even though the number of elderly community ICF-MR residents ages 65 and over more than doubled during this time, the proportion of elderly residents remained small at 4.3 percent in SFY 2010. In contrast, adults ages 21 through 64 made up 68.8 percent of community ICF-MR residents in SFY 2010, and their total number increased by 26.3 percent from SFY 2007. Of these adults, those ages 44 through 64 increased at an even higher rate, by 35.0 percent, more than twice the rate of growth for all ages, 15.0 percent.

The state has also experienced growth in the number of community ICFs-MR. The Virginia Department of Health (VDH) reports an increase of 44 percent in recent years, from 25 in SFY 2005 to 21 in SFY 2007 to 36 in SFY 2010. At the end of SFY 2010, community ICFs-MR had a total capacity of 391 beds, an average of 10.9 each. The majority of community ICFs-MR across the state had eight or more beds, with the smallest having four beds and the largest, St. Mary's Home for Disabled Children, a specialized ICF-MR for children and adolescents in Norfolk, having 88. This large number at one facility contributed to the Tidewater region of the state having the largest number of community ICF-MR beds.

Since a single provider may be licensed for and operate more than one community ICF-MR at different locations, the number of providers has grown slightly less than the number of facilities. DMAS maintains data on "enrolled" ICF-MR providers, meaning those approved for Medicaid reimbursement, and such approval first requires licensing by the Department of

Behavioral Health and Developmental Services (DBHDS), which is further contingent on a determination by VDH that the facility meets federal regulations. There were a total of 19 enrolled providers at the end of SFY 2004, 28 at the end of both SFY 2005 and 2006, 30 at the end of SFY 2007, and 33 at the end of SFY 2010. Three of those enrolled in 2007 and 2010 were based out-of-state.

Nursing Facilities (Nursing Homes): State law requires that admission to a nursing facility be based on a formal, face-to-face assessment by a trained, qualified professional. Individuals may be screened while at home or in another community setting or during a treatment stay at an inpatient hospital. Community-based assessments are conducted by a social worker from the local social services department and a nurse from the local health department. Results of their assessments are forwarded to the director of the local health department for a decision on whether nursing care is necessary. In compliance with federal regulations, the state Department of Medical Assistance Services (DMAS) requires pre-screeners to discuss available community service options as well as nursing facility options with the individual being screened.

Screeners conduct their assessment using the **Uniform Assessment Instrument (UAI)**, a standardized, multi-dimensional questionnaire that addresses an individual's social functioning, physical and mental health, medical and nursing needs, and functional abilities. Medical or nursing needs include such things as wound care and assistance in medication administration. Functional ability refers to the degree of assistance that an individual requires to complete daily living activities such as bathing, toileting, or dressing. Based on the information gathered using the UAI, the screener determines the person's care needs, whether he or she meets the criteria for nursing home care, and whether or not he or she will be at risk of nursing home placement if additional assistance is not received.

When UAI screening indicates that an individual may have or does have a diagnosis of an intellectual or other developmental disability (ID/DD) or a serious mental illness, federal regulations require an additional "Level II" evaluation, the **Pre-Admission Screening and Resident Review (PASRR)**, to ensure that a nursing facility is the most appropriate setting to meet both the individual's medical and physical needs and his or her behavioral or psychiatric needs. In Virginia, when ID/DD or a serious mental illness is suspected or known based on the UAI, the local pre-screener sends a report to DMAS and the Department for Behavioral Health and Developmental Services (DBHDS). Staff from these two agencies consult on the findings as indicated, and if a PASRR has not been completed recently, DMAS, as the purchasing agency, will typically request a PASRR evaluation through its contract with Dual Diagnosis Management Ascend (DDM Ascend), a private provider. This evaluation must be completed within five to seven working days of receipt of the UAI assessment. Based on the PASRR findings, DBHDS conducts a Quality Assurance review and advises DMAS on appropriate placement and specialized services needed by the individual. DMAS then determines whether or not a nursing facility is appropriate.

If an individual needs to be assessed during a hospital stay, a hospital social worker or discharge planner typically conducts the UAI evaluation and explains its results. When support

needs are identified, the staff person must describe the long-term care options available, both institutional and community-based. State and federal regulations also require that hospital staff ask the individual about their preference for receiving services. If after receiving this information, an individual chooses to stay in the community, the hospital must make a referral to appropriate community resources

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

The *Guide to Choosing a Nursing Home*, a booklet available online from CMS (www.medicare.gov/Publications/Pubs/pdf/02174.pdf), encourages individuals interested in nursing facility care to contact or meet with local AAAs, CILs, or other appropriate community resources to identify all available long-term care options. Quality of care information for making a more informed choice can also be obtained using the Medicare Nursing Home Compare online tool (www.medicare.gov/NHCompare/Home.asp) or by contacting VDH, DMAS, the Virginia Department for the Aging (VDA) Long-Term Care Ombudsman program, or local consumer affairs offices. Comparative site visits to various facilities being considered are also recommended.

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

During state fiscal year (SFY) 2010, there were 279 nursing facilities in operation statewide, each unique in its day-to-day operation. Because of staff availability, especially psychiatrists or psychologists, they vary in their capacity to serve individuals with complex needs such as serious mental illness, intellectual disability, or behavioral problems, and as a result, variation exists in the populations that they accept for services. According to DMAS data, most primarily serve individuals ages 65 and over.

The information in the table below, drawn from the comprehensive assessments and a billing records database maintained by DMAS, shows the number of individuals served in

nursing facilities for selected state fiscal years (SFY) between 2004 and 2010 by age category. The overall change for that period is also indicated.

PERSONS SERVED IN NURSING FACILITIES

Age Groups	SFY 2004	SFY 2005	SFY 2006	SFY 2007	SFY 2010	Change
Under 1 year	11	10	1	0	1	-10
1-5 years	17	20	20	16	21	+4
6-14 years	33	33	24	19	38	+5
15-20 years	35	25	21	22	29	-6
Subtotal for Ages 1-20	96	88	66	57	89	-7
21-44 years	779	782	702	676	622	-157
45-64 years	3,297	3,512	3,793	3,884	4,251	+954
Agers 65 & older	23,536	23,347	24,221	24,252	22,588	-948
Total for All Ages	27,708	27,729	28,782	28,869	27,550	-158

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

From SFY 2004 to SFY 2007, the number served in nursing facilities grew annually, increasing by 1,161 individuals (4.2 percent) for that period, then declined by 1,319 individuals (4.6 percent) between SFY 2007 and SFY 2010. During this period, the primary residents of Virginia's nursing facilities were those over age 65, comprising 85 percent of residents in SFY in 2004, 84 percent in SFY 2007, and 82 percent in SFY 2010. The slightly declining proportion of elderly residents reflects the overall reduction of their numbers by 948 individuals (4 percent) from SFY 2004 to SFY 2010 as well as annual increases in the number of adults ages 45 through 64 that have resulted in a gain of 954 individuals (29 percent) between those years. Moreover, after declining from 96 to 57 (41 percent) between SFY 2004 and SFY 2007, the number of children and youth under age 21 increased (56 percent) to 89 in SFY 2010, nearly equaling the number served six years earlier. Children ages six to 14 made up most of this increase.

National data also reflect increasing numbers of non-elderly adults residing in nursing facilities. Recent research at the University of Maryland's Department of Public Policy analyzed data from the annual CMS Nursing Home Data Compendia, and found that, although rates of nursing home residence by adults ages 65 and older decreased in 36 states between 2000 and 2007, rates for adults ages 31 to 64 increased in 48 states, declining only in Alaska and Arizona. The study also found significant variability among the states in their rates of nursing home use by age groups.

Individuals with intellectual or developmental disabilities (ID/DD) are a sub-population served at nursing facilities, and preliminary data from the 2011 edition of the *State of the States in Developmental Disabilities* ranks Virginia as 17th highest among the states in utilization of nursing facilities to serve individuals with ID/DD. While the average utilization rate among all the states was 10.7 individuals per 100,000 of general population, Virginia's rate was 15.1 per 100,000.

Data obtained from DMAS identifies the number of individuals with ID/DD receiving services in nursing facilities as 906 in state fiscal year (SFY) 2010; however, this DMAS database included information from the Uniform Assessment Instruments (UAI) of only 64.4 percent of the individuals receiving services that year and may be an undercount. Of these individuals, 87.2 percent were ages 45 and older and only 3.1 percent were age 20 or younger. Specifically, this count included one individual between ages one and five, 17 between ages six and 14, ten between ages 15 and 20, 88 between ages 21 and 44, 368 between ages 45 and 64, and 422 aged 65 or older.

Methodologies and disability definitions or categories vary among reports on placement of persons with ID/DD in nursing facilities, making determination of trends difficult. The *State of the States in Developmental Disabilities* national report mentioned above analyzes data collected from both state ID/DD agencies and from the CMS Online Survey, Certification, and Reporting (OSCAR) system. Its most recent analysis indicates that 1,130 Virginians with ID/DD were served in nursing facilities across Virginia in SFY 2004; 1,163 in SFY 2006; and 1,184 in SFY 2009. This reflects a total increase for the period of only 54 individuals (4.8 percent). At the time of this assessment, the 2011 edition of this report is not available online, but the 2008 report can be found at www.cu.edu/ColemanInstitute/stateofthestates. State profiles also available at that website have been updated with 2009 data.

A second source, the annual *Residential Services for Persons with Developmental Disabilities* report by the Institute on Community Integration at the University of Minnesota (<http://rtc.umn.edu/docs/risp2009.pdf>) uses data only from state ID/DD agencies. Data obtained for its 2010 edition from the Virginia Department of Behavioral Health and Developmental Services (DBHDS) covers only individuals with intellectual disabilities (ID) served in nursing facilities for SFY 2004 (460) and SFY 2006 (899), but includes individuals with intellectual or other developmental disabilities (ID/DD) for SFY 2008 (2,823) and SFY 2009 (2,877). This change in the data provided by DBHDS reflected its recently expanded mission to include coordination and planning for other developmental disabilities in addition to its existing responsibilities for intellectual disabilities.

In tracking nursing home utilization, the national Centers for Medicare and Medicaid Services (CMS) uses the broader federal population category of “blind or disabled” that includes individuals with acquired disabilities in addition to those with ID/DD. The number of individuals in this category grew by 18 percent (772) from SFY 2004 (4,276) to SFY 2007 (5,048) and by another 14 percent (711) by SFY 2010 (5,759). The proportion of the population served in nursing homes who are blind or disabled has also increased over this time, from 15 percent in SFY 2004 to 17.5 percent in SFY 2007 then 20.9 percent in SFY 2010.

D. Available Institutional Services

The facilities covered below are required by federal and state regulations to provide or to obtain a full range of appropriate medical, health, and rehabilitative services to meet the needs

identified by formal assessment of the individuals whom they serve. Core services, which may be provided either directly or by contract, include physical, occupational, and recreational therapy; speech pathology; and nutritional, medical, dental, pharmaceutical, psychological, and social services. Intermediate care facilities for persons with mental retardation (ICFs-MR), either state-operated training centers or community ICFs-MR, may also provide vocational training, as appropriate.

State-Operated Training Centers (ICFs-MR): The stated goal for the state's training centers, as for all intermediate care facilities for persons with mental retardation (ICFs-MR), is to provide highly individualized services in the least intrusive and restrictive manner possible, subject to the realities of life in such large facilities. Although long-term admissions have historically been their main function, training centers also provide short-term respite and emergency stays, and their operator, the Department of Behavioral Health and Developmental Services (DBHDS) has promoted short-term stays, such as for behavioral management and intervention, as a new model of service. In addition to providing ICF-MR services, one of these five facilities, Central Virginia Training Center (CVTC) near Lynchburg, also operates certified skilled nursing units.

Over the past decade, in addition to the core services mentioned above, each of the state's training centers has been charged with directly providing or contracting with private clinicians to provide services and specialized supports on an outpatient basis through **Regional Community Support Centers (RCSC)**. These centers are intended to serve individuals with intellectual disabilities living in nearby communities who are referred for services by their local Community Services Boards (CSBs). Services provided through the RCSCs vary somewhat depending on regional needs and priorities. During state fiscal year (SFY) 2010, they included psychological or behavioral consultations and testing; multiple dental procedures; laboratory, medical, and preventative services; pediatric neurology; nursing and nutritional consultation; physical therapy; rehabilitative engineering; speech and language therapies; therapeutic recreation; and autism support groups. RCSC's also provided training for staff of community provider agencies.

In August 2003, Southwestern Virginia Training Center (SWVTC) opened its **Pathways Program** to serve individuals with intellectual disabilities and a concurrent diagnosis of mental illness or complex behaviors who live in the community. The program's goal is to provide those individuals with community supports or intensive intervention in a structured environment, when indicated, to resolve the emotional or behavioral issues threatening their community placement. A designated unit of eight ICF-MR certified beds provides diagnostic consultation; medical, behavioral, and psychiatric treatment; and as appropriate, short-term stabilization specifically for this population. When an inpatient admission is indicated, the maximum length of stay at the training center is targeted at 90 days, but it may be extended based on individual needs. Referrals must be made by a local Community Services Board (CSB), and oversight is provided by a regional council comprised of representatives from the CSBs, SWVTC, and Southwestern Virginia Mental Health Institute. Other training centers provide similar services, but not necessarily through a designated program or unit.

DBHDS *Comprehensive State Plans* since 2005 have noted an evolving role for the training centers in the continuum of care. The 2008-2014 plan was the first to report that all training centers are engaged in "...a cultural transition to person-centered processes and are expanding their mission to make short-term and transitional facility-based services more readily available." As noted earlier, DBHDS has implemented staff training on person-centered principles and practices at all of the training centers and CSBs, and further indicating progress, the 2010-2016 plan states that the training centers "...have expanded their missions to make short-term and transitional facility-based services more available." The future role for the training centers articulated by DBHDS is to be a support and temporary safety net to help individuals with intellectual disabilities remain in the community through provision of short-term respite care, crisis stabilization, assessment, and treatment for behavioral challenges and provision of services and supports for individuals with complex medical needs that cannot be met in the community until appropriate community services are made available.

Community ICFs-MR: Centers for Medicare and Medicaid Services (CMS) regulations require that public or private nonprofit or for-profit community ICFs-MR, like the state training centers, provide the core services listed above either directly or by contract and that their services be tailored to meet each individual's unique needs.

Nursing Facilities (Nursing Homes): Based on their residents' needs, nursing facility services may include assistance with and supervision of daily living, recreation, and social activities. Room and board, some medical equipment and supplies, and laundry services are included in the daily rate. Skilled nursing care as well as physical, occupational, and speech therapies and medical, dental, and pharmaceutical services are usually provided on premises. Additional equipment and other services, including adult day care or respite care, may also be provided.

E. Cost and Payment for Institutional Services

Services at all three types of institutions covered in this chapter are funded from both private and public sources. The national public health insurance programs, Medicare and Medicaid, are a significant source of funding. Other sources of payment include personal, out-of-pocket expenditures as well as various types of purchased private insurance such as long-term care insurance, Medicare Supplemental Insurance ("Medigap"), or managed care health insurance.

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

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

- Nursing Facility (NF): Any long-term bed specifically certified for Medicaid reimbursement.
- Intermediate Care Facility for Persons with 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.

Intermediate Care Facility for Persons with Mental Retardation (ICF-MR): The table below compares the number of individuals served, total operational expenditures, and annual per capita cost for the state's training centers and community ICFs-MR for state fiscal years (SFY) 2005, 2007, and 2010. Detailed budget and expenditure information for the state's training centers were provided by the **Department of Behavioral Health and Developmental Services (DBHDS)**. Details of Medicaid expenditures related to Community ICFs-MR were provided by the **Department of Medical Assistance Services**. Information on persons and services covered by private payments is not available.

ICF-MR EXPENDITURES

Service Provider	Number Served	State Funds	Federal Funds	Other Funds	Total Funds	Per Capita Cost
SFY 2005						
State Training Centers*	1,524	\$27,641,581	\$169,331,755	\$164,161	\$197,137,497	\$129,355
Community ICFs-MR**	318	\$14,656,346	\$14,656,346	\$0	\$29,312,692	\$92,178
SFY 2007						
State Training Centers*	1,512	\$35,465,187	\$188,905,085	\$547,650	\$224,917,922	\$148,755
Community ICFs-MR**	340	\$19,833,047	\$19,833,047	\$0	\$39,666,094	\$116,664
SFY 2010						
State Training Centers*	1,197	\$107,779,606	\$125,956,724	\$366,091	\$234,102,421	\$195,574
Community ICFs-MR**	391	\$20,657,952	\$33,124,793	\$0	\$53,782,745	\$137,552

Sources: *Department of Behavioral Health and Developmental Services, Office of Developmental Services.

**Department of Medical Assistance Services (DMAS). Note that DMAS information for SFY 2005 has been updated since the 2008 edition of this assessment.

From SFY 2005 to SFY 2010, the number served by the state's training centers declined by 21.5 percent (327 individuals) while the number served at community ICFs-MR increased by 23 percent (73 individuals). Costs for both types of ICF-MR, however, grew considerably. Between SFY 2005 and SFY 2010, the annual per capita cost for the training centers increased by 51.2 percent (\$66,219), with the sharpest growth over the past three years during increased downsizing efforts by DBHDS. Per capita cost for community ICFs-MR grew at a similar rate over this period of 49.2 percent (\$45,374); nevertheless, their cost remains appreciably lower than for the training centers.

In addition to the operating expenditures detailed above, ICFs-MR have ongoing costs for maintenance and renovation, including modifications to meet federal life and safety and other plant standards. Funding for building maintenance and repair at the training centers comes from state general funds and state capital outlay funds that are appropriated by the General Assembly or obtained, with its approval, through the sale of bonds. As noted earlier, all of the training centers have buildings in use that are at least 35 years old, and two have even older buildings. According to the DBHDS 2008-2014 *Comprehensive State Plan*, inadequate funding over time for maintenance and renovation resulted in poor building conditions and aging structures that are often no longer appropriate for the needs of the individuals served and their programs.

The next table lists capital improvement expenditures for renovation and upgrading of residential areas and the physical plant at each of the state's training centers in state fiscal years (SFY) 2005 through 2010.

CAPITAL IMPROVEMENT EXPENDITURES AT VIRGINIA TRAINING CENTERS

Training Center	2006	2007	2008	2010
Central (CVTC)	\$1,417,683	\$4,341,256	\$2,500,000	\$1,985,554
Northern (NVTC)	\$379,936	\$1,153,474	\$1,000,000	\$0
Southeastern (SEVTC)	\$203,321	\$848,549	\$2,500,000	\$170,726
Southside (SVTC)	\$244,461	\$1,388,463	\$36,474	\$0
Southwestern (SWVTC)	\$978,188	\$2,555,031	\$0	\$1,727,456
Total	\$3,223,589	\$10,286,773	\$6,036,474	\$3,883,736

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

The amounts shown above for Central Virginia Training Center (CVTC) and Southeastern Virginia Training Center (SEVTC) in SFY 2010 are the expenditures for that year from the General Assembly's 2009 appropriation of \$24.5 million for extensive renovations to CVTC and \$23 million for building of a replacement 75-bed facility for SEVTC. The remainder of those funds will be spent on these projects through SFY 2015. Including funds from that appropriation, the projected capital outlay budget for all state training centers in SFY 2011 is \$8,781,782.

In addition to funding for their residential services and capital outlays, the training centers receive funds to operate their outpatient **Regional Community Support Centers (RSCS)**. Funding for the RSCS at Northern Virginia Training Center to provide specialized medical services and clinical consultation, dental services, and respite care, as well as provider education and training, was first established in January 1996 as \$350,000 per year. Each of the four remaining training centers listed above has been appropriated \$200,000 per year from SFY 2009 through SFY 2012.

Nursing Facilities (Nursing Homes): Almost all nursing facilities in the state are certified for either Medicaid or Medicare according to the Virginia Department of Health (VDH), Division of

Long Term Care's website (www.vdh.virginia.gov/OLC/LongTermCare); however, public insurance coverages for these facilities vary. **Medicaid** will pay most costs incurred in a CMS-certified nursing facility for persons with income and assets meeting eligibility limits. Others, including about half of all nursing facility residents, pay costs out of their own savings, as noted in the CMS nursing home guide referenced earlier. Many individuals who move into nursing facilities initially do not qualify financially for Medicaid but eventually exhaust their savings and other resources, enabling them to become eligible for Medicaid. More detailed information on these eligibility requirements can be found in the Medicaid chapter of this assessment.

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

Medicare Supplemental Insurance, often called "**Medigap**," helps pay for items not covered by Medicare such as deductibles and copayments. Most Medigap plans will help pay for skilled nursing care, but only when that care is covered by Medicare. Some employer group health insurance plans and long-term care insurance plans can help cover nursing facility costs, but a managed care insurance plan will help pay for care only if it has a contract with a particular nursing facility. Cost and benefits for all of these types of plans vary widely, but many nursing facility residents who pay for care out of their own private funds receive some assistance from these plans. Video and written consumer information about them is available online through the National Association of Insurance Commissioners (NAIC), which represents state health insurance regulators (www.naic.org/cipr_topics_page.htm).

While much less expensive than intermediate care facilities for persons with mental retardation (ICFs-MR), annual nursing home costs are substantial. The *Genworth 2010 Cost of Care Survey* reports that the median annual cost of nursing home care in Virginia was \$65,700 for a semi-private room and \$73,000 for a private room. According to the Virginia Department of Medical Assistance Services (DMAS), a total of \$725.8 million in Medicaid funds were expended on nursing home care in state fiscal year (SFY) 2008, which represented 14 percent of all Medicaid expenditures for that year. In SFY 2010, the amount grew to \$793.4 million, 12 percent of all Medicaid expenditures.

In 2010, the Virginia General Assembly reduced Medicaid reimbursement rates for nursing homes by three percent effective in SFY 2012; however, the 2011 General Assembly voted to reverse that decision, eliminating the planned SFY 2010 rate reduction. The 2011 budget amendment also restored full funding to continue an incentive payment for long-stay rehabilitation hospitals in SFY 2012 that had been eliminated by the legislature in 2010. The amendment provided a total of \$50.6 million in general funds to cover both of these reauthorized expenditures.

F. Monitoring and Evaluation of Institutional Services

The Virginia Department of Health (VDH) and the Virginia Department of Behavioral Health and Developmental Services (DBHDS) have responsibilities for oversight and monitoring of all nursing facilities and public or private intermediate care facilities for persons with mental retardation (ICFs-MR). The jurisdictions and activities of each agency are different as further explained below.

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

- Regulatory oversight of medical care service providers licensed by VDH through routine onsite investigations and by enforcing state licensure regulations;
- Receiving and investigating complaints by individuals regarding the quality of care for services provided by hospitals, nursing facilities, home care providers, hospice organizations, and the quality of care provided through managed care health insurance plans;
- Inspecting health care facilities, programs, and services for compliance with federal regulations, including Medicare, Medicaid, and clinical laboratory improvement programs; and
- Certifying the quality of care standards governing managed care health insurance plan providers and maintaining a registry of private review agencies.

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

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

If no deficiencies are found, surveyors deem the ICF-MR or nursing facility to be in compliance with standards. A finding of noncompliance results when deficiencies exist that have the potential to either result in more than a minimal impact on the individual served or compromise the individual's ability to "...maintain and/or reach his/her highest physical, mental and/or psychological well-being as defined by an accurate and comprehensive resident assessment, plan of care and provision of services." Noncompliant findings initiate a six-month enforcement period for correction. For both types of facilities, the most serious finding on noncompliance is immediate jeopardy, which means that noncompliance with standards either has caused or is likely to cause "serious injury, harm, impairment or death," and immediate corrective action is necessary. When this finding is made, the facility must immediately take all actions necessary to come into compliance with standards and to ensure processes that will prevent future reoccurrence, and these actions must be approved by the surveyors as being sufficient to resolve the citation.

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

After completing an inspection, VDH-OLC surveyors discuss their findings with the facility's administrator or designee. When a deficiency in meeting one or more standards is found, the facility administrator must submit a plan of correction that addresses each identified deficiency citation within a specified timeframe. VDH-OLC reviews the plan of correction and either accepts it or notifies the facility of any plan of correction item that it does not accept as adequately resolving a deficiency. When the latter occurs, the facility must revise the plan until accepted. The facility administrator is then responsible for ensuring that the plan of correction is

implemented and monitored so that compliance is maintained. A provider is expected to take the actions necessary to achieve compliance within 45 days of the findings notification.

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

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

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

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

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

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

Complaints pertaining to the provision of health care that may seriously jeopardize patient health or safety or that relate directly to other state and federal regulatory requirements

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

As Virginia's designated intellectual disabilities agency, the **Department of Behavioral Health and Developmental Services (DBHDS)** licenses community intermediate care facilities for persons with mental retardation (ICFs-MR) and has oversight responsibilities for the programmatic, financial, and administrative activities of the state's five training centers. It also licenses non-institutional providers of mental health, intellectual disability, and substance abuse services. The state's training centers are certified by VDH for Medicare and Medicaid but are not licensed by either agency. Like all ICFs-MR, however, they are subject to monitoring by the state **Office of the Inspector General (OIG) for Behavioral Health and Developmental Services** and the state and federally authorized **Virginia Office for Protection and Advocacy (VOPA)**. Additional information on oversight and monitoring responsibilities and activities of DBHDS and these other agencies related to non-institutional service providers can be found in the Community Supports chapter of this assessment.

The **DBHDS Office of Licensing** ensures that new community ICFs-MR comply with licensing regulations, policies, and procedures; that existing ICFs-MR maintain compliance; and that Child Protective Services reference checks, as well as criminal and central registry background checks, are conducted for all staff of all providers licensed by DBHDS. Office of Licensing staff process license renewals and written Service Modification Applications that must be submitted 30 to 60 days before a provider adds or changes either a service within a program or a program location. A New Applicant Training DVD covering these requirements is available from the office for a fee.

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

Issues addressed by these human rights regulations include, but are not limited to: protection from neglect, abuse, and exploitation; a nutritionally adequate diet; safe and sanitary

housing; participation in nontherapeutic labor; attendance or nonattendance at religious services; use of telephones; the availability of suitable clothing; and possession of money and valuables. Most importantly, they also address an individual's right to participate in decisions about his or her treatment and the due process procedures to be followed when an individual with a disability may not be able to make an informed decision.

Complaints about human rights violations are reviewed by **Local Human Rights Committees (LHRCs)** that serve specific regions of the state, and appeals are reviewed by the State Human Rights Committee. LHRCs also review and approve plans for human rights protections by license applicants and by institutions or programs renewing their licenses.

The State Board for Behavioral Health and Developmental Services also adopts and implements regulations requiring the public and private facilities and programs licensed or funded by DBHDS to supply the DBHDS Central Office with non-privileged 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 DBHDS Office of Human Rights or by State or Local Human Rights Committees of any human rights violations or abuse or neglect of individuals with disabilities.

As noted above, the **Office of the Inspector General (OIG) for Behavioral Health and Developmental Services** provides additional oversight and monitoring for facilities or programs licensed or operated by DBHDS, primarily involving quality and standards of care issues. The *Code of Virginia* (37.2-424) authorizes the OIG 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...." Reports on each OIG onsite visit, study, or investigation are published on its website (www.oig.virginia.gov) and include its findings and recommendations for service or system improvements along with responses from the facilities or programs identifying the actions that they have taken or will be taking to address each OIG finding.

With respect to quality assurance for community ICFs-MR and the state's training centers, the OIG's duties include:

- Conducting announced and unannounced inspections on an ongoing basis and 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 to prevent problems, abuses, and deficiencies in programs and services and to improve the effectiveness of those programs and services.

The OIG conducted a systemic review of all five of the state's training centers in 2007 and, in May 2008, published a report (#139-07) that examined "...the extent to which the experiences of individuals in the Virginia training centers reflect the principles of self-determination, person-centered planning and choice." Inspection teams conducted unannounced visits lasting three to five days each at all training centers and included direct observations of a random sample of individuals at each facility both in the residential units and in on-campus day activities, interviews with staff, and record reviews. While the OIG's observations at all of the training centers found that staff interacted with clients in a respectful manner, some of its key findings were that:

- Training centers did not routinely offer opportunities for individuals to experience community integration through visits to local parks, shops, and other venues, and when offered, the majority of community outings occurred in groups of three or more individuals which limited personal integration and fostered segregation;
- The majority of training center clients did not have opportunities to participate in community-based events such as churches, service organizations, and recreational clubs;
- Individuals residing in the training centers were provided little opportunity for choice, and opportunities for new experiences to enable personal growth and enhanced choice were significantly limited; and
- Most individuals were not actively supported in achieving a valued role either in the facility or the community.

In 2008, the OIG also published a *Review of Active Findings for the State Operated Training Centers* (#150-08) to assess follow-up on findings of its 2005 systemic review of these facilities. During the intervening years, the DBHDS Office of Developmental Services led an initiative to promote person-centered principles in both community and facility services. The OIG review commended DBHDS and its Office of Developmental Services on their efforts to-date to clarify the current and future role of training centers within the service system and noted improvements in several areas that resolved previous OIG findings, such as:

- A completed review of strategic direction as well as organizational mission and values,
- Elimination of the use of isolated time-out at Southeastern Virginia Training Center (SEVTC),
- Developing plans to implement person-centered practices, and
- Regularly implemented evaluation processes with input from individuals served, families, and community providers on the quality of services and the effectiveness of the facilities' relationship with the broader service system.

Other past findings that remained active and subject to ongoing OIG and review included implementation of person-centered practices at each facility, increased programming space for vocational and life skills development at SEVTC and Southwestern Virginia Training Center (SWVTC), and increased efforts to provide opportunities for individuals served at the training centers to experience community integration.

The OIG conducted an inspection of the Pathways Program at SWVTC in 2009 that included client observations on the unit and record reviews. In its report (#176-09), the OIG complimented SWVTC on its documentation and person-centered practices, noting that:

- “Each of the 90-day records that were reviewed could serve as an exemplar for person-centered planning and comprehensive, integrated team effort” (page 6), and
- Behavioral plans were “... individualized, detailed, strength and preference-based, and consistently applied and documented” (page 7).

The OIG noted that several Pathways staff had worked in mental health, that all staff had training in co-occurring mental illness and behavioral management, and that resolution or improvement of behavioral issues was achieved in almost all cases. In addition the OIG found that Pathways provided extensive case consultations, including periodic psychiatric consultations, for individuals in the home community that diverted their admission to training centers. Pathways’ capacity to respond to emergencies, however, was found to be limited and the process to be “more complex and slower than desired.”

In its September 2010 *Semi-Annual Report*, the OIG noted that DBHDS was in the process of revising its training center admissions and discharge processes and, with respect to several related important and long-standing system issues, recommended that DBHDS complete work to:

- Establish a statewide policy on the role of training centers in providing emergency services for individuals who have co-occurring intellectual disability and mental illness or severe behavioral management challenges and formalize admission protocols accordingly;
- Develop and implement a formal plan to enable more consistent reporting of critical incidents across the training centers;
- Develop a standard method or process for determining “readiness for discharge” and implementing discharge to more integrated settings; and
- Increase efforts to “actively educate” family members or authorized representatives regarding community options.

This OIG report also provided the first summary of findings related to the **U.S. Department of Justice (DOJ)** investigation into potential violations of the *Civil Rights of Institutionalized Persons Act (CRIPA)* and Title II of the *Americans with Disabilities Act (ADA)* at Central Virginia Training Center (CVTC) near Lynchburg. DOJ notified the Commonwealth

of its intent to investigate in August 2008 and, as noted in the introduction to this chapter, issued its letter of findings in February 2011.

DHBDS hired consultants experienced in DOJ cases to provide technical assistance to the training center staff, and at the end of each site visit, DOJ consultants shared their initial findings and concerns about both CVTC and the state's service system for individuals with intellectual and other developmental disabilities with state counsel, CVTC administrators and staff, and other state officials. The OIG has been actively involved in monitoring these investigations as well as DBHDS activities to address DOJ findings. A very brief summary of the DOJ findings along with an online link to a more complete listing and the Governor's response was included in the introduction to this chapter.

The **Virginia Office for Protection and Advocacy (VOPA)**, as previously noted, serves as an additional oversight entity for the state's facilities and programs for individuals with disabilities. Authorization for its activities is provided by the various federal statutes and by the *Code of Virginia* (51.5-39.2) as:

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

Prior to 2010, VOPA received approximately \$220,000 per year of state general funds to supplement the federal funding that primarily supported its activities. That year, however, the General Assembly eliminated its state funding, and at the time of this assessment, VOPA continues to operate without state support.

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

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

With regards to the latter, VOPA is specifically authorized to access records of an individual with a disability: “(1) who by reason of his mental or physical condition is unable to authorize the Office to have such access; (2) who does not have a legal guardian or for whom the Commonwealth, or designee of the Commonwealth, is the legal guardian; and (3) with respect to whom a complaint has been received by the Office or with respect to whom there is probable cause to believe that such person has been subjected to abuse or neglect.”

In conducting its investigations, VOPA may review records, interview clients, and observe care. When violations are found, it first attempts to resolve complaints through administrative remedies, but if violations are not resolved in a reasonable time, it has the authority to pursue legal or other alternative remedies to protect individuals' rights.

Directors of all state facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) are required by the Code of Virginia (37.2-709) to send information about critical incidents or deaths of clients to VOPA in writing within 48 hours of their occurrence. A critical incident is defined as being "...serious bodily injury or loss of consciousness requiring medical treatment." VOPA professionals review these reports to identify data trends as well as possible instances of abuse and neglect and conducts follow-up investigations as the office deems appropriate.

VOPA regularly monitors facility conditions and follows up on injuries to individuals served at the state's training centers and other institutions. Reports on most recently published investigation of an April 2009 incident at Southeastern Virginia Training Center (SEVTC) and its other investigations can be found online at www.vopa.state.va.us/Investigations/Investigations.htm. Its annual performance reports and other additional information on its activities and initiatives can be reached using links from that webpage.

G. Institutional Services Sources Referenced in This Chapter

Links to websites and online documents reflect their Internet addresses in March 2011. Some documents retrieved and utilized do not have a date of publication.

Websites:

Code of Federal Regulations (CFR):

www.gpoaccess.gov/cfr/index.html

Kaiser Family Foundation:

www.kff.org

Health Policy Explained:

www.kaiseredu.org

State Health Facts:

www.statehealthfacts.org

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

www.oig.virginia.gov

Office of the Secretary of Health and Human Services (HHR) of Virginia:

www.hhr.virginia.gov

Health Reform Initiative:

www.hhr.virginia.gov/Initiatives/HealthReform

National Association of Insurance Commissioners (NAIC):

www.naic.org

Consumer Guides:

www.naic.org/index_ltc_section.htm

National Long-Term Care Ombudsman Resource Center:

www.ltcombudsman.org

SeniorNavigator:

www.seniornavigator.org

U.S. Department of Health and Human Services (HHS):

www.hhs.gov

Centers for Medicare and Medicaid (CMS):

www.cms.gov

CMS Community Living Initiative:

www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp

Medicaid topics:

www.cms.gov/home/medicaid.asp

Medicare topics:

www.cms.gov/home/medicare.asp

My Medicare:

www.medicare.gov/default.aspx

Medicaid Nursing Home Compare:

www.medicare.gov/NHCompare/Home.asp

Nursing Homes, Paying for Care:

www.medicare.gov/nursing/Payment.asp

Office of Certification and Compliance:

www.cms.gov/CertificationandCompliance

Preadmission Screening and Resident Review (PASRR):

www.cms.gov/pasrr

National Clearinghouse for Long-Term Care Information:

www.longtermcare.gov/LTC/Main_Site/Planning_LTC/Information/index.aspx

U.S. *Social Security Act* (42 USC 1496):

www.ssa.gov/OP_Home/ssact/title19/1905.htm

Virginia Department for the Aging:

www.vda.virginia.gov

Office of the State Long-Term Care Ombudsman Program:

www.elderrightsva.org/default.aspx

Virginia Department of Behavioral Health and Developmental Services:

www.dbhds.virginia.gov

Virginia Department of Health:

www.vdh.virginia.gov

Division of Long-Term Care:

www.vdh.virginia.gov/OLC/LongTermCare

Laws, Regulations & Guidelines:
www.vdh.virginia.gov/OLC/Laws/index.htm

Office of Licensure & Certification:
www.vdh.virginia.gov/olc

Virginia Department of Medical Assistance:
www.dmas.virginia.gov

Money Follows the Person demonstration project:
www.olmsteadva.com/mfp

MDS 3.0 Section Q Implementation:
www.olmsteadva.com/mfp/MDS3SectionQ.htm

Virginia General Assembly:
<http://legis.state.va.us>

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

House Appropriations Committee:
<http://hac.state.va.us/welcome.htm>

Senate Finance Committee:
<http://sfc.virginia.gov>

2011 State Budget:
<http://leg2.state.va.us/MoneyWeb.NSF/sb2011>

Documents:

- Braddock, David; Hemp, Richard; and Rizzolo, Mary C.; et al. (2008). *The State of the States in Developmental Disabilities, Seventh Edition*. Washington, D.C.: American Association on Intellectual and Developmental Disabilities. Retrieved from: www.cu.edu/ColemanInstitute/stateofthestates.
- Braddock, David; Hemp, Richard; Rizzolo, Mary C.; Haffer, Laura; & Taqnis, Shea. (February 6, 2011). *The State of the States in Developmental Disabilities: 2011-Preliminary Report*. Aurora, Colorado: University of Colorado Department of Psychiatry, Anschutz School of Medicine. Not available online.
- Commonwealth of Virginia, Community Integration Implementation Team. (2009). *Virginia's Comprehensive Cross-Governmental Strategic Plan to Assure Continued Community Integration of Virginians with Disabilities: 2009 Progress Report*. Retrieved from: www.olmsteadva.com/downloads/ED62009ProgressReport081009.doc.
- Genworth Financial, Inc. (April 2010). *Genworth 2010 Cost of Care Survey*. Richmond, Virginia. Retrieved from: www.genworth.com/content/products/long_term_care/long_term_care/cost_of_care.html
- Kaiser Family Foundation. (February 2011). *Money Follows the Person: A 2010 Snapshot* (Issue Paper). Washington, D.C. Retrieved from: www.kff.org/medicaid/8142.cfm.
- Kaiser Family Foundation. (2007). *Nursing Home Care Quality: Twenty Years After the Omnibus Budget Reconciliation Act of 1987*. Washington, D.C. Retrieved from: www.kff.org/medicare/7717.cfm.

- Lakin, K. Charlie; Larson, Sheryl; Salmi, Patricia; & Webster, Amanda. (2010). *Residential Services for Persons with Developmental Disabilities: Status and Trends through 2009*. Minneapolis, Minnesota: Research and Training Center on Community Living, Institute on Community Integration, College of Education and Human Development, University of Minnesota. Retrieved from: <http://rtc.umn.edu/docs/risp2009.pdf>.
- Miller, Nancy A. (2010). *Relations among HCBS Investment and Nursing Home Rates of Use for Working-Age and Older Adults: A State Level Analysis*. Manuscript submitted for publication. Baltimore, Maryland: Department of Public Policy, University of Maryland.
- Office of the Inspector General for Behavioral Health and Developmental Services for Virginia. (July 1, 2009). *Inspection of Southwestern Virginia Training Center, OIG Report #176-09*. Retrieved from: www.oig.virginia.gov/documents/FR-SWVTCPrimary176-09.pdf.
- Office of the Inspector General for Behavioral Health and Developmental Services for Virginia. (October 21, 2010). *OIG Semi-Annual Report: April 1, 2010 to September 30, 2010*. Richmond, Virginia. Retrieved from: www.oig.virginia.gov/rpt-AnnualSemiAnnual.htm.
- Office of the Inspector General for Behavioral Health and Developmental Services for Virginia. (2006). *Systemic Review of the Training Centers Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services: OIG Special Report, 127-05*. Retrieved from: www.oig.virginia.gov/documents/SS-SysRevofTrainingCenters127-05.pdf.
- Office of the Inspector General for Behavioral Health and Developmental Services for Virginia. (September 30, 2008). *Review of Active Findings for the State-Operated Training Centers, OIG Report # 150-08*. Retrieved from: www.oig.virginia.gov/documents/SS-SysRevofTrainingCenters150-08.pdf.
- Office of the Inspector General for Behavioral Health and Developmental Services for Virginia. (2007). *Review of Community Services Boards MR Case Management Services for Adults: OIG Special Report 142-07*. Retrieved from: www.oig.virginia.gov/LicensedCommunityPrograms.htm.
- Office of the Inspector General for Behavioral Health and Developmental Services for Virginia. (May 28, 2008). *Review of the Self-Determination and Person-Centered Experience of Individuals Served in Training Centers Operated by DMHMRSAS: Report #139-07*. Retrieved from: www.oig.virginia.gov/documents/ss-SysRevofTrainingCenters139-07.pdf.
- Perez, Thomas E., Assistant Attorney General, Civil Rights Division, U.S. Department of Justice. (February 10, 2011) *Letter to the Honorable Robert F. McDonnell, Office of the Governor*. Washington, D.C. Retrieved from: www.governor.virginia.gov/news/viewRelease.cfm?id=606.
- Stewart, James W. III., Commissioner, Virginia Department of Behavioral Health and Developmental Services. (January 25, 2011). *BHDS Biennium Budget Update*. Presentation to the Health and Human Resources Subcommittee of the Senate Finance Committee for the Virginia General Assembly.
- Stewart, James W. III., Commissioner, Virginia Department of Behavioral Health and Developmental Services. (January 13, 2011). *Major Issues facing the Commonwealth's*

- Behavioral Health and Developmental Services System*. Presentation to the joint meeting of the Senate Education and Health Committee and the House Health, Welfare, and Institutions Committee of the Virginia General Assembly. Retrieved from: www.dbhds.virginia.gov/PressReleases/content/110113VABHDDSystemIssues.pdf.
- U.S. Department of Health and Human Services, Centers for Medicare and Medicaid. (November 2008). *Guide to Choosing a Nursing Home* (Revised), CMS Publication # 02174. Baltimore, Maryland. Retrieved from: www.medicare.gov/Publications/Pubs/pdf/02174.pdf.
- U.S. Department of Health and Human Services, Centers for Medicare and Medicaid. (2010). *MDS 3.0 Section Q Implementation Questions and Answers*. Baltimore, Maryland. Retrieved from: www.cms.gov/CommunityServices/downloads/MDS3_0_Section_Q_Implementation_problems_solutions.pdf.
- U.S. Department of Health and Human Services, National Institute on Aging. (August 2009). *Nursing Homes: Making the Right Choice*. Washington, D.C.. Retrieved from: www.nia.nih.gov/HealthInformation/Publications/nursinghomes.htm.
- Virginia Administrative Code, 12 VAC 5-371-10 *et seq.* (2010) *Rules and Regulations for the Licensure of Nursing Facilities*. Retrieved from: <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC5-371>.
- Virginia Administrative Code, 12VAC 35-115 *et seq.* (2010). *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services*. Retrieved from: <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC35-115>.
- Virginia Administrative Code, 12 VAC 35-190 -10 *et seq.* (2010). *Regulations Establishing Procedures for Voluntary Admissions to State Training Centers* (Effective August 19, 2009). Retrieved from: <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC35-190>.
- Virginia Administrative Code, 12 VAC 35-200-10 *et seq.* (2010). *Regulations for Emergency and Respite Care Admission to State Training Centers* (Effective September 16, 2009). Retrieved from: <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC35-200>.
- Virginia Department of Behavioral Health and Developmental Services. (June 25, 2010). *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia*. Retrieved from: www.dbhds.virginia.gov/documents/100625CreatingOpportunities.pdf.
- Virginia Department of Behavioral Health and Developmental Services. (December 1, 2010). *Item 304-N: Fiscal Year 2010 Annual Report: Submitted to the Governor and the Chairs of the House Appropriations and Senate Finance Committees*. Retrieved from: www.dbhds.virginia.gov/documents/olpr-Item304N-Annual-DBHDS-Rep-2010-10.pdf.
- Virginia Department of Behavioral Health and Developmental Services, Office of Planning and Development. (December 8, 2009). *Comprehensive State Plan, 2010-2016*. Retrieved from: www.dbhds.virginia.gov/documents/reports/opd-StatePlan2010thru2016.pdf.
- Virginia Department of Behavioral Health and Developmental Services, Office of Developmental Services. (2011). *Quarterly Report of Office Activities, October – December 2010*. Retrieved from: www.dbhds.virginia.gov/ODS-UsefulInformation.htm#report.

- Virginia Department of Health, Office of Licensure and Certification. (2010). *Directory of Long Term Care Facilities*. Richmond, Virginia Retrieved from: www.vdh.virginia.gov/OLC/Facilities/documents/2011/pdf/2011%20LTC%20directory%20final.pdf.
- Virginia Department of Medical Assistance Services. (June 26, July 2, July 10 and July 16, 2008). *Transition Coordination: The Real Nuts and Bolts*. Training presentation. Richmond, Virginia. Retrieved from: www.olmsteadva.com/mfp/downloads/MFPTransitionCoordinationTraining.ppt.
- Virginia Department of Medical Assistance Services, Division of Long Term Care. (August 2009). *A Guide for Long-Term Care Services in Virginia*. Retrieved from: http://dmasva.dmas.virginia.gov/Content_atchs/ltc/ltc-guide_srvcs.pdf.
- Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. (March 26, 2003). *Admission and Discharge Protocols for Persons with Mental Retardation Served in State Training Centers*. Retrieved from: www.dbhds.virginia.gov/documents/ODS/OMR-AdmissionDischargeProtocols.pdf.
- Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. (2005). *The Cost and Feasibility of Alternatives to the State's Five Mental Retardation Training Centers*. House Document No. 76: Report to the Governor and the General Assembly of Virginia. Retrieved from: www.dbhds.virginia.gov/documents/reports/OMR-HouseDocument76.pdf.
- Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. (September 25, 2007). *A Study of the Mental Retardation Service System in Virginia: Report to the General Assembly*. Retrieved from: <http://leg2.state.va.us/DLS/h&sdocs.nsf/682def7a6a969fbf85256ec100529ebd/2d4f53ea40dcf4d185257386005de2bb?OpenDocument>.
- Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, Office of Planning and Development. (December 2005). *Comprehensive State Plan, 2006–2012*. Retrieved from: www.dbhds.virginia.gov/documents/reports/opd-stateplan.htm.
- Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, Office of Planning and Development. (November 2007). *Comprehensive State Plan, 2008–2014*. Retrieved from: www.dbhds.virginia.gov/documents/reports/opd-stateplan.htm.