COMMONWEALTH of VIRGINIA

JACK BARBER, M.D.
INTERIM COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

November 21, 2017

The Honorable Thomas K. Norment, Jr., Co-chair
The Honorable Emmett W. Hanger, Jr., Co-chair
Senate Finance Committee
14th Floor, Pocahontas Building,
900 East Main Street,
Richmond, VA 23219

Dear Senator Norment and Senator Hanger:

Item 319. D.3. of the 2016 Appropriations Act required the Department of Behavioral Health and Developmental Services (DBHDS) to "*procure an independent contractor, with extensive experience in certification of health care facilities in accordance with federal requirements, to determine the necessary requirements and to assist staff at Eastern State Hospital in implementing such requirements to seek the appropriate Medicaid certification of all or a portion of the Hancock Geriatric Treatment Center."* Budget language also required that the Commissioner *"shall report on the contract and the progress to obtain Medicaid certification of the Center to the Chairmen of the House Appropriation and Senate Finance Committee by December 1, 2016."* In consultation with the General Assembly, DBHDS was granted an extension on this report to repost and re-solicit requests for proposals with more appropriate deadlines, allow time for the selected vendor to contract with their own certification experts and develop quality data, plans and recommendations.

Please find enclosed the report in accordance with Item 319 D.3. as prepared by Health Management Associates and the Behavioral Health Policy Collaborative. Please do not hesitate to contact me if you have any questions about this report.

Sincerely,

Jack Barber, M.D.

Enc.

Cc: William A. Hazel, Jr., M.D.
Joe Flores
Susan E. Massart
Mike Tweedy

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November 21, 2017

The Honorable S. Chris Jones, Chair
House Appropriations Committee
900 East Main Street
Pocahontas Building, 13th Floor
Richmond, Virginia 23219

Dear Delegate Jones:

Item 319. D.3. of the 2016 Appropriations Act required the Department of Behavioral Health and Developmental Services (DBHDS) to "*procure an independent contractor, with extensive experience in certification of health care facilities in accordance with federal requirements, to determine the necessary requirements and to assist staff at Eastern State Hospital in implementing such requirements to seek the appropriate Medicaid certification of all or a portion of the Hancock Geriatric Treatment Center."* Budget language also required that the Commissioner *"shall report on the contract and the progress to obtain Medicaid certification of the Center to the Chairmen of the House Appropriation and Senate Finance Committee by December 1, 2016."* In consultation with the General Assembly, DBHDS was granted an extension on this report for it to be due October 1, 2017 to ensure a contractor was found and the data was provided in an appropriate format.

Please find enclosed the report in accordance with Item 319 D.3. as prepared by Health Management Associates and the Behavioral Health Policy Collaborative. Please do not hesitate to contact me if you have any questions about this report.

Sincerely,

Jack Barber, M.D.

Enc.

Cc: William A. Hazel, Jr., M.D.
Joe Flores
Susan E. Massart
Mike Tweedy

November 16, 2017

Report to the Chairmen of the
House Appropriation and Senate Finance Committees
Commonwealth of Virginia General Assembly

Certification and Funding Options: Hancock Geriatric Treatment Center

Behavioral Health Policy Collaborative, LLC

Health Management Associates

The work for this report was funded under Contract No. 720-4562, effective March 10, 2017, issued by the Virginia Department of Behavioral Health and Developmental Disabilities to the Behavioral Health Policy Collaborative, LLC.

Suggested Citation:

Hutchings, G., Barnum, S., Casanova, P., Eckart, G., Edwards, B., Lasky, G., Smith, A. (November 14, 2017). Report to the Chairmen of the House Appropriation and Senate Finance Committees, Commonwealth of Virginia General Assembly. Certification and Funding Options: Hancock Geriatric Treatment Center. Behavioral Health Policy Collaborative, LLC: Alexandria, VA., Health Management Associates, Olshesky Design Group, LLC.

About Behavioral Health Policy Collaborative

The Behavioral Health Policy Collaborative (BHPC) was founded in 2001 in Alexandria, Virginia as a private consulting firm specializing in behavioral healthcare policy and practice. BHPC's clients are public and private sector organizations dedicated to improving mental health and substance abuse systems, services and outcomes. BHPC offers nationally recognized experts on national- and state-level behavioral health policy, clinical, and practice matters as well as effective technical assistance for a wide range of mental health and substance abuse-related topics and issues.

BHPC staff for this project included Gail P. Hutchings, MPA, BHPC President and CEO, who contributed her substantive expertise garnered during previous and current Federal and state positions and consulting roles. These include Chief of Staff of the Substance Abuse and Mental Health Services Administration, Deputy Executive Director of the National Association of State Mental Health Program Directors, and project director and senior consultant on several training and technical assistance activities with a variety of state mental health/behavioral health authorities as well as federally-funded technical assistance centers. BHPC offers more than 30 years of successful project planning and management expertise and experience.

About Health Management Associates

Health Management Associates, Inc. (HMA) is widely regarded as a leader in providing strategic, technical, and analytical and implementation services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. HMA's behavioral health team is composed of individuals with extensive experience in both clinical practice and policy, making it uniquely positioned for behavioral health consultation in the areas of system review, needs assessment, and strategic planning. For this project, the HMA team included staff members with extensive experience in public behavioral health policy, hospital finance, Medicaid, and other publicly-funded programs, including former state behavioral health and Medicaid staff.

About Olshesky Design Group, LLC

ODG, an architecture, interior design, master planning and construction firm, was founded in 2000 and recently added environmental consulting to its practice. ODG is dedicated to a mission of providing design excellence while achieving optimal functional, economic and environmental performance. ODG has been designing sustainable projects since it was founded in 2000. ODG's architects and engineers have more than 30 years of experience preparing capacity studies and facility condition assessments.

BEHAVIORAL HEALTH POLICY COLLABORATIVE, LLC
4923 Waple Lane ♦ Alexandria, VA 22304 ♦ (703) 566-1177
GHutchings@BehavioralHealthPolicy.com

Jack Barber, M.D., Acting Commissioner
Department of Behavioral Health and Developmental Services
1220 Bank St.
Richmond, VA 23219

Dear Dr. Barber:

In March 2017, DBHDS contracted with the Behavioral Health Policy Collaborative (BHPC) to develop a report determining the feasibility of successful application to the Centers for Medicare and Medicaid Services for Medicaid certification as a Nursing Facility for all or a portion of the Hancock Geriatric Treatment Center (HGTC) based within Eastern State Hospital.

BHPC and its partners, Health Management Associates and Olshesky Design Group, have completed a review of HGTC's certification history, conducted an assessment of the needs of the populations being served and the clinical services provided at HGTC, performed a physical plant review, and have reviewed existing and forthcoming regulatory requirements relevant to certification. This report provides and overview of our findings, identifies a set of associated certification options, and includes our recommendations.

Given that HGTC is part of a larger system of care for older Virginians with behavioral health conditions in in the Commonwealth, decisions about HGTC affect not only HGTC and the current patient population, but also that larger system. The findings and recommendations in this report are based on our review of HGTC with an eye toward identifying certification options, though some of the findings may apply more globally. In assessing this report and making any subsequent decisions about HGTC, we recommend consideration of the impact of those decisions in the context of the broader system as a means to ensure that state resources, both facilities and funds, are aligned with the Commonwealth's goals and priorities for serving the geropsychiatric population in Virginia.

I am pleased to submit this report and thank you and the Department for the opportunity to engage in this important work to ensure appropriate and quality services for Virginians with disabilities. I also express my appreciation for the cooperation and assistance of the staff of the Department of Behavioral Health and Developmental Services, including staff at HGTC.

Sincerely,

Gail P. Hutchings, M.P.A.
President and CEO

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Abbreviations

ADL	Activities of Daily Living
ALF	Assisted Living Facility
BHPC	Behavioral Health Policy Collaborative, LLC
CNA	Certified Nurse Assistant
CfCs	Conditions for Coverage
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CoP	Conditions of Participation
CSB	Community Service Board
DAP	Discharge Assistance Program
DBHDS	Department of Behavioral Health and Developmental Services
DMAS	Department of Medical Assistance Services
DON	Director of Nursing
EBL	Extraordinary Barriers List
ECO	Emergency Custody Order
EHS	Eastern State Hospital
FCI	Facility Condition Index
HCBS	Home and Community Based Services
HGTC	Hancock Geriatric Treatment Center
HMA	Health Management Associates
hprd	hours per resident per day
ICPT	Incompetent to Proceed
IMD	Institution for Mental Disease
LPN	Licensed Practical Nurse
LTSS	Long Term Services and Supports
LVN	Licensed Vocational Nurse
MDS	Minimum Data Set
NA	Nurse Aide
NGRI	Not Guilty by Reason of Insanity
ODG	Olshesky Design Group
RAFT	Regional Older Ault Facilities Mental Health Support Team
RN	Registered Nurse
SMI	Serious Mental Illness
TDO	Temporary Detention Order
VAC	Virginia Administrative Code

Executive Summary

Hancock Geriatric Treatment Center (HGTC) is part of the campus of Eastern State Hospital (ESH), located in Williamsburg, Virginia. ESH is a state operated facility, exempt from state hospital licensure by Virginia statute. In addition to the geriatric units within HGTC, ESH also provides acute psychiatric inpatient services for adults, including both civil and forensic commitments.

HGTC sought and was awarded Medicaid certification as a nursing facility, effective January 1, 1973. From 1973 to 2008, HGTC was surveyed annually, and retained certification through those years. HGTC received occasional citations during these years, as is common for most nursing facilities, with issues about documentation and staffing, but was able to mitigate the citations through corrective action plans, and remained certified.

In 2010, HGTC was surveyed by the Centers for Medicare and Medicaid Services (CMS) state contractor, and found in non-compliance for serious deficits in quality of care. HGTC was notified by CMS on August 25, 2010 that the facility was terminated from the nursing facility program and no longer eligible for Medicaid reimbursement, and Medicaid certification was withdrawn effective September 12, 2010. HGTC subsequently attempted to achieve recertification, completing a corrective action plan addressing the deficiencies cited in the 2010 surveys, and requested another survey in 2011. On March 28, 2011, CMS notified HGTC that the facility was reinstated as eligible for Medicaid reimbursement effective March 14, 2011. From 2011 to 2014, HGTC was surveyed multiple times and successfully maintain certification, with no indication of serious issues regarding the continuation of Medicaid certification.

In February 2015, HGTC was again surveyed. As a result of the 2015 survey, HGTC received written notification from CMS that HGTC did not meet the definition of a nursing facility. This included the finding that HGTC was an institution for mental disease (IMD) and, as such, is prohibited from being certified as a nursing facility. The Department of Behavioral Health and Developmental Services (DBHDS), in part based on advice from attorneys, determined not to pursue remediation via a plan of correction, or informal dispute resolution. A determination was made that the nursing facility Conditions of Participation (CoP) are not compatible with the HGTC's model of care, and HGTC would not be able to reach and maintain compliance with the federal certification requirements. CMS decertified HGTC on August 26, 2015.

In March of 2017, DBHDS engaged Behavioral Health Policy Collaborative, LLC (BHPC) to develop a report that included certification options and a recommendation for whether to seek Medicaid nursing facility certification of all or a portion of the HGTC at ESH. BHPC engaged Health Management Associates (HMA), and Olshesky Design Group, LLC (ODG) as partners in the endeavor.

In developing the report, the team reviewed relevant state and federal regulations, obtained documentation from HGTC's certification surveys and completed interviews with key informants regarding the 2015 survey and subsequent decision making. The team also completed an on-site clinical services review, and an on-site facility condition assessment. The team's findings and observations from completing these activities are summarized below and addressed more fully throughout the report.

At the time of the 2015 decertification of HGTC as a nursing facility, the citations appear to have been valid. Interviews with staff confirmed that the restrictions observed and documented in the survey findings were in place at the time of the survey and had been for prior surveys. This includes that HGTC was operating as an IMD during prior survey periods, even though that had never been cited as a barrier to certification by the state survey agency.

The on-site assessment of the current operation of HGTC was conducted to assess both the needs of current residents and to identify what changes would be needed to achieve recertification as a nursing facility. The BHPC Team's review was of 2017 clinical services and a sample of current patients. The HGTC patient population in 2017 includes individuals whose clinical and other service needs are not appropriate to be served by a nursing facility. Such patients include those who require some type of psychiatric stabilization or active treatment for serious mental illness (SMI). For the health and safety of patients and staff, it would be difficult if not impossible to provide these patients with the range of choices and freedoms expected by the nursing facility certification requirements.

Since the 2015 HGTC certification, CMS issued new federal requirements for nursing facility certification. The emphasis of the revisions is primarily around issues of resident independence, self-determination, privacy, and choice, all issues that HGTC was cited for when certification was terminated. And, issues that likely remain as barriers today if nursing home recertification is sought.

During this time period and to date, Commonwealth of Virginia statutory changes significantly increased demand for state psychiatric hospital beds. Virginia law now provides that state-operated hospitals cannot refuse the admission of a person held under an Emergency Custody Order (ECO) following a Temporary Detention Order (TDO) evaluation when an alternative facility cannot be found and the ECO eight-hour period is expiring. There are no exceptions to this requirement.

Because of the nursing facility decertification, the residents in HGTC lost access to Medicaid reimbursement for their care, which shifted the full cost of providing services to the Commonwealth. At the same time, the new statutory and regulatory pressures on the state operated hospitals in Virginia resulted in a rapid increase in admissions at HGTC and elsewhere. The increased demand for beds, coupled with the fact that HGTC was no longer a certified nursing facility, resulted in HGTC beds being used for general psychiatric admissions for older adults. HGTC's role of accepting statewide referrals for geriatric patients needing nursing facility level of care shifted to a largely regional role.

The shift in population demanded an increased focus on acute stabilization to meet the treatment needs of individuals admitted to those beds. This focus has implications for the model of care and staffing needs at HGTC. This shift combined with a high demand for beds has led to admission practices wherein a TDO often determines priority for admissions and placement rather than the clinical need or current medical, cognitive and psychiatric functioning, and a strain on staffing trying to meet the needs of varying levels and types of needs of patients on a single unit that can result in some patients not receiving individualized and appropriate care.

While the HGTC facility condition assessment conducted by our team did identify some deficiencies (areas requiring remediation), the building itself is relatively new, built in 2008, and is in generally good or excellent condition. BHPC's Team also assessed the Kitchen and Dining Facility, Building

13 of ESH, which was built in 1954. The latter building was included in the assessment because it is mission critical to providing services to HGTC patients regardless of certification status and funding source. The Superstructure and Substructure of Building 13 were built to last well beyond 100 years and are in good condition, however, the systems in the building are designed for a shorter life span. Some systems in the facility (i.e., the sanitary waste piping, drainage for boilers, air handling units) need immediate attention and are critical to maintaining the mission of HGTC.

Relative to nursing facility certification, the issue of whether HGTC is an IMD seems the most challenging to overcome. The HGTC characteristics that identify it as an IMD are not ones easily subject to change including: being under the jurisdiction of the state's mental health authority, being maintained primarily for the care and treatment of individuals with mental diseases, and having more than 50% of all patients admitted based on a need for institutionalization as a result of mental disease. Admission requirements to HGTC require an individual to have a psychiatric diagnosis, which on its face argues that the facility meets the federal definition of an IMD.

Based on these findings, the BHPC Team's recommendation is that HGTC not seek to recertify as a nursing facility and rather, increase its focus on: providing acute stabilization for older adults with psychiatric symptoms; assessment and evaluation of complex cases that require an interdisciplinary team made up of psychiatric, medical and neurological specialists to discern individual conditions and provide differential diagnosis and recommendations for placement (e.g., inpatient psychiatric care verses community based long-term care); treatment of individuals with serious mental illness (SMI) who are aging and have intractable or poorly controlled psychiatric symptoms and subsequent behavioral challenges, including older adults with forensic commitments.

There are numerous reasons that the BHPC Team does not recommend HGTC recertification as a nursing facility. In addition to the IMD issue, there are important competing demands for the 80 beds located at HGTC. Following the changes to admission requirements for State facilities, many of these 80 beds are now needed for individuals with acute psychiatric needs whose admission was not based on the need for long-term nursing facility services. Second, even if HGTC could seek to establish a dedicated unit to certify as a nursing facility to support older adults in the Commonwealth who need long-term care, it would take a significant effort to bring HGTC up to the standards for certification—particularly the new Federal requirements. This would take financial and other investment and require significant changes to the model of nursing care at the facility when it was operating as a nursing facility. These efforts include relocating patients currently at HGTC who do not have a nursing facility level of care, and the challenge of meeting the updated certification requirements for nursing facilities that are even more focused on individual freedoms and choice than the requirements that were in place at the time of decertification.

In addition, BHPC's Team recommends that DBHDS, ESH, and HGTC explore options for developing the capacity for long term services and supports (LTSS) outside of the state hospital system for HGTC patients who need nursing facility level of care, whether they have a stabilized primary psychiatric conditions or neurocognitive disorders with behavioral issues. DBHDS can focus efforts on developing community based LTSS options that would allow individuals to receive community based care and reside outside of a nursing facility and could develop strategies to support private nursing facilities to successfully admit and care for individuals who no longer need the psychiatric acute care offered at ESH. This might include working with a private operator(s) to

develop nursing facility capacity with a model of care and operating protocols that satisfy nursing facility requirements while also being properly staffed to handle difficult to place populations (including geriatric patients with a psychiatric history or current behavioral challenges).

Under a separate effort from this report, DBHDS engaged HMA to create a Virginia Geropsychiatric System of Care Report that will present a comprehensive plan for the publicly funded geropsychiatric system of care in Virginia. The report will identify the appropriate array of community services including the costs and revenues for each option. The options and recommendations in the forthcoming report will further detail options for the development of community based LTSS.

Chapter 1: Hancock Geriatric Treatment Center Certification History

Summary Having initially gained nursing facility certification in 1973, HGTC maintained this certification, with one brief lapse from August 2010 to March 2011, until 2015. In 2015, CMS determined that HGTC did not meet the definition of a nursing facility and provided specific citations of the failure to meet the definition, as well as citations regarding other compliance failures. HGTC initially began the process of developing a corrective action plan to remediate the citations. However, a decision was made between leadership at the Department of Behavioral Health and Developmental Services (DBHDS) and ESH that the nursing facility CoP were not compatible with HGTC model of care, and that HGTC would not be able to reach and maintain compliance with the federal requirements. CMS decertified HGTC effective August 26, 2015.

Approach/Methodology

In preparation for writing this chapter, the BHPC Team reviewed state and federal regulations and guidance documents, and documents specific to the HGTC's certification history. In addition, the team conducted in-depth interviews with key informants from the DBHDS Central Office, ESH and HGTC, and the Department of Medical Assistance Services (DMAS).

Overview of Hancock Geriatric Treatment Facility

HGTC is located on the campus of ESH in Williamsburg, Virginia. ESH is part of DBHDS' state psychiatric hospital system and is accredited as a hospital by The Joint Commission. ESH is a state operated facility, exempt from state licensure by Virginia statute.

Historically, HGTC, though located on the ESH campus, has maintained a separate certification from ESH. ESH historically has maintained a psychiatric hospital certification or accreditation. Whereas HGTC, though located on the ESH campus, has historically been certified as a Medicaid nursing facility. HGTC became certified as a nursing facility in 1973. Over its history, there were two instances of loss of federal certification, the most recent decertification occurred in 2015.

Brief Overview of Federal Regulations Related to Nursing Facilities

In order for a healthcare institution to participate in and receive federal payment from Medicare and/or Medicaid, the entity must meet the federal government requirements mandated by the Social Security Act (the Act) for program participation. These requirements include a certification of compliance with the health and safety requirements called Conditions of Participation (CoP) or Conditions for Coverage (CfCs), which are set forth in Section 42 of the Code of Federal Regulations (CFR). Both nursing facilities and psychiatric hospitals are among the types of providers that are subject to federal healthcare quality standards under Medicare and Medicaid.

There are significant differences in the federal CoP and requirements by healthcare institutional type. For example, the CoP for psychiatric hospitals were developed to ensure that the care delivered, and the documentation of that care, demonstrates a person-centered treatment plan focused on the individual patient's assessed needs. The plan must be utilized to provide comprehensive active treatment to stabilize the acute care needs of the patient, with a focus on a return to the community. In contrast, the nursing home CoP prioritize resident rights, privacy, autonomy, and quality of life and care, as befitting the nursing home serving as the individual's residence over a longer period of time.

Conditions of Participation (CoP) for psychiatric hospitals differ from those for nursing facilities.
CoP for psychiatric hospitals focus on active treatment of patients and return to the community.
CoP for nursing facilities focus on resident rights, privacy, autonomy, and quality of life with assumption that the nursing facility is the individual's home over a longer period of time.

State survey agencies under contract with the CMS provide on-site inspection of institutions and recommend whether the institution meets the applicable CoP or CfCs. If the institution meets certification standards, the HHS Secretary may approve the state agency's recommendation.[1] In Virginia, state-operated hospitals are exempt from state hospital licensure requirements. The Commonwealth relies on federal certifications and accreditation agencies to assess and monitor the quality and safety of its state operated hospitals. In Virginia, the state survey agency under contract to CMS is the Virginia Department of Health.

In the case of a state operated nursing facility, the state survey agency conducts the certification survey and the CMS regional office certifies compliance or noncompliance, and determines whether the facility is eligible to participate in the Medicare or Medicaid programs. These decisions may be appealed if the institution is found not to meet the requisite requirements.[2]

Section 1919 of the Social Security Act defines a nursing facility as an institution that is primarily engaged in providing skilled nursing care, rehabilitation services for the rehabilitation of injured, disabled, or sick persons, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental disease. Nursing facilities, termed skilled nursing facilities in Medicare regulations and intermediate care facilities in Medicaid language, must be compliant with the requirements for long term care facilities established at 42 CFR Part 483 Subpart B in order to receive federal reimbursement.

Subsections (b) Provision of Services, (c) Resident Rights, and (d) Administration and Other Matters of Section 1919 establish nursing facility requirements that generally require a nursing facility to (emphasis added):

- care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident,

[1] 42 C.F.R. §§ 488.10 through 488.12
[2] 42 C.F.R. § 488.24

- provide *services and activities* to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident,
- protect and promote the rights of each resident, and
- be administered in a manner that enables it to *use its resources effectively and efficiently* to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

These requirements are heavily focused on the concepts of privacy, home like atmosphere, choice, dignity, self-determination and autonomy, and apply for an "institution within an institution" as well as free standing facilities. HGTC, if recertified as a nursing facility, would be considered an "institution within an institution." Regulations issued by CMS in October of 2016 give further insight into the designation of an "institution within an institution":

> Distinct part—(1) Definition. A distinct part SNF or NF is physically distinguishable from the larger institution or institutional complex that houses it, meets the requirements of this paragraph and of paragraph (2) of this definition, and meets the applicable statutory requirements for SNFs or NFs in sections 1819 or 1919 of the Act, respectively. A distinct part SNF or NF may comprise one or more buildings or designated parts of buildings (that is, wings, wards, or floors) that are: In the same physical area immediately adjacent to the institution's main buildings; other areas and structures that are not strictly contiguous with the main buildings but are located within close proximity to the main buildings; and any other areas that CMS determines on an individual basis, to be part of the institution's campus. A distinct part must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant.

Of particular note are the federal laws and regulations defining institutions for mental diseases (IMD). An IMD is defined at Section 1905(i) as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services". Regulations at 42 CFR 435.1010 further define an IMD by stating that whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. Evidence includes:

- whether the facility is licensed or accredited as a psychiatric facility,
- is under the jurisdiction of the state's mental health authority,
- specializes in provider psychiatric/psychological care and treatment (judged on patient records, staff qualifications, or if the facility was established and maintained primarily for the care and treatment of individuals with mental diseases), or
- has more than 50 percent of all its patients admitted based on a current need for institutionalization as a result of mental diseases (regardless of what services are provided).

There may be an inconsistency in the federal policy in statute regarding IMDs. While 1905(a)(14) allows that nursing facility services can be covered for older adults in an IMD, 1919(a) says no nursing facility can be certified if it is an IMD. The CoP for nursing facilities to be able to participate in the Medicare or Medicaid programs prohibit IMDs from participating as nursing facilities. This prohibition is at Section 1919(a)(1), and in Appendix PP of the State Operations Manual[3], which provides guidance to surveyors, and concludes the definition of facility (skilled nursing facility and nursing facility) with the following:

> For Medicare, an SNF (*see* section 1819(a)(1) of the Act), and for Medicaid, and (*sic*) NF (*see* section 1919(a)(1) of the Act) may not be an institution for mental diseases as defined in §435.1010 of this chapter.

An Institution for Mental Disease (IMD) is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services.

The CoP for nursing facilities to be able to participate in the Medicare or Medicaid programs prohibit IMDs from participating as nursing facilities.

Hancock Geriatric Treatment Center Nursing Facility Certification History

HGTC is a facility on the campus of ESH. In March of 1973, HGTC sought and was awarded Medicaid certification as a nursing facility, effective January 1, 1973. From 1973 to 2010, HGTC was surveyed annually, and retained certification through those years. HGTC received occasional citations during these years, as is common for most nursing facilities, with issues in documentation and staffing, but was able to mitigate the citations through corrective action plans, and remained certified.

In 2010, HGTC was surveyed by the state survey agency and found in non-compliance for serious deficits in quality of care. HGTC was found to have multiple deficits in patient safety, treatment and preventing harm to patients. Surveyors completed additional surveys on two occasions over several months. It is unclear from available records whether HGTC completed a corrective action plan to attempt to remediate the findings and maintain certification. HGTC was notified by CMS on August 25, 2010 that the facility was terminated from the nursing facility program and no longer eligible for Medicaid reimbursement. After that letter was received, HGTC attempted to rectify the deficiencies cited by surveyors, but was not able to achieve substantial compliance within the federally defined timelines. Medicaid certification was subsequently withdrawn effective September 12, 2010.

The deficiencies cited included "H" level citations, the second most serious category of deficiency and one instance of "J" category of Immediate Jeopardy, defined as danger to health and safety. The deficiencies listed in the decertification letter included multiple occasions of non-compliance with restraint and seclusion safety requirements, lack of a full time Director of Nurses, multiple occurrences of failure to assure resident well-being, and multiple occasions that the Quality Assurance Committee did not meet as required.

[3] Appendix PP of the State Operations Manual, found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-03-08-2017.pdf

To achieve recertification, HGTC completed a corrective action plan addressing the deficiencies cited in the 2010 surveys, and requested another survey in 2011. Subsequent to the requested survey, on March 28, 2011, CMS notified HGTC that the facility was reinstated as eligible for Medicaid reimbursement effective March 4, 2011.

From 2011 to 2014, HGTC was surveyed multiple times and successfully maintained certification with no indication of serious issues regarding the continuation of Medicaid certification. In February 2015, HGTC was again surveyed in an unannounced survey by the state survey agency, and on this occasion an individual from CMS accompanied the state team. It is common for a CMS staff person to accompany state surveyors as part of CMS monitoring and oversight of the performance of the state survey agency.

At the point of the 2015 survey, HGTC's nursing facility certification included approximately 80 beds, with a shared dining area. The number of beds included in HGTC's nursing facility footprint decreased over time. Prior to 2008, HGTC nursing facility beds were in two buildings, each with three wards, with a total of 291 beds. Leading up to 2008 and a planned move to the new (current) building, HGTC engaged in a concentrated effort to reduce the HGTC census. The new planned building had 150 beds. The reduction from 291 to 150 beds was accomplished by transferring people to other facilities and at times stopping admissions. By the time the move to the new building happened in 2008, the HGTC census was at or below 150. The new building was, in 2008, a dedicated certified nursing facility within ESH.

Between 2012 and 2015, ESH electively decertified a significant number of beds within HGTC to repurpose those beds for forensic populations, leaving 80 beds as HGTC's certified nursing facility at the time of the 2015 survey.

Following the 2015 survey, HGTC received written notification from CMS' Philadelphia Regional Office that the survey found that HGTC did not meet the definition of a nursing facility, specifically citing 1919(a) of the Act as precluding a nursing facility from being an IMD. This finding was startling, since at no time in the past thirty plus years had there been any question of HGTC not meeting the definition of a nursing facility.

Following the 2015 survey, HGTC received written notification from CMS' Philadelphia Regional Office that the survey found that HGTC did not meet the definition of a nursing facility, specifically citing the prohibition of IMDs from participating as nursing facilities.

The survey also cited multiple compliance deficiencies in which services delivered did not meet quality or other requirements. There were eighteen citations identified by the survey itemized as "f tags":[4]

Tag 150: Does Not Meet the Definition of a Nursing Facility because an it is an IMD

Tag 151: Ability of Resident to Exercise Rights without Reprisal (incidents of withholding privileges such as TV or phone as reprisal for not attending group, or other infractions)

[4] Department of Health and Human Services Survey Report February 26, 2015

Tag 157: Notification of Family or Authorized Representative of Condition Change, Injury, Decline, Room Change (multiple incidents of injury and other changes in condition not reported)

Tag 163: Right to Choose a Personal Physician (residents all have physician of facility's choice)

Tag 167: Right to Easily Accessible Survey Results (survey results not available to residents and families as required)

Tag 170: Right to Privacy, Send and Receive Unopened Mail (all mail opened in view of staff)

Tag 174: Access to Privacy for Telephone Calls (no attempt at providing privacy for phone calls)

Tag 225: Investigate and Report Allegations/Individuals (no documentation of follow up or investigation of reports of confrontations and altercations)

Tag 240: Care and Environment Promote Quality of Life (barren community areas, no individualization of rooms, no activities other than assigned groups)

Tag 241: Dignity and Respect of Individuality (involuntary personal searches)

Tag 242: Self Determination and Right to Make Choices (residents restricted to unit, all personal items confiscated)

Tag 244: Listen/Act on Group Grievance/Recommendation (failure to follow up on matters brought to team)

Tag 252: Safe Clean Homelike Environment (lack of personal items, all rooms the same)

Tag 274: Comprehensive Assessment after Significant Change (multiple instances of no documentation of assessment following significant change in condition)

Tag 278: Assessment Accuracy, Coordination (lack of follow up for significant medical conditions requiring outside specialty appointment for potential serious medical issues)

Tag 279: Comprehensive Individualized Care Plans (care plans reviewed were all the same [(list of groups, no therapy notes])

Tag 309: Provide Care and Services for Highest Well Being (all items in prior f Tags, inappropriate use of restraint and seclusion)

Tag 329: Drug Regimen is Free from Unnecessary Drugs (no evidence of using non pharmacologic approaches before administering PRN psychotropics)

As is standard, the 2015 termination letter CMS issued subsequent to the survey and documentation of findings included an opportunity for redress, with the opportunity for HGTC to develop and implement a corrective action plan. Record research revealed that HGTC started to develop a corrective action plan to remediate the findings.[5] The standard process also includes options for informal dispute resolution. In part due to advice from attorneys engaged on the question, and based on discussion between DBHDS, HGTC and ESH senior leadership, DBHDS decided not to

[5] Department of Health and Human Services Survey Report, February 26, 2015

pursue remediation or dispute resolution, concluding that the nursing facility CoP are not compatible with the HGTC's model of care, and therefore HGTC would not be able to reach and maintain compliance with the federal requirements[6]. Development of the corrective action plan was halted, and CMS decertified HGTC effective August 26, 2015. Without the nursing facility certification, HGTC was no longer able to bill Medicaid for services for Medicaid eligible residents at HGTC.

[6] Interview with Chris Bowman 4/7/2017

Chapter 2: Status, Needs, and Trends of Populations Served

Summary HGTC has served distinct populations of older adults with psychiatric disorders, with shifts in the target population occurring as the Commonwealth's publicly funded resources and model of care for older adults has adjusted to changing policy, economic, and environmental factors. The BHPC Team's review of the current population being served concluded that HGTC is serving three populations: individuals 65 and older with neurocognitive disorders who may also have psychiatric needs and behavioral challenges; individuals 65 and over with a stabilized psychiatric disorder; and individuals both over and under 65 who require some type of psychiatric stabilization or treatment for serious mental illness. The former two populations are appropriate for care in a nursing facility, though the model of care and programming for each may differ. However, the latter population is not appropriately served in a nursing facility and is appropriately treated in an inpatient psychiatric hospital. All three of these populations have a mix of often complex needs including: chronic health and medical deterioration, behavioral health/psychiatric conditions, and changes in neuro-cognitive functioning. Statutory and regulatory pressures on state operated hospitals have created a high demand for beds, and EDO/TDO status of an individual often determines priority of admission and placement rather than patients' clinical need or current medical, cognitive and psychiatric functioning.

Approach/Methodology

The BHPC Team engaged in a multi-pronged approach to review and assess the trends in populations served by HGTC and their subsequent service needs. The BHPC Team collaborated with DBHDS staff to define a data request that included available information on populations served in HGTC. Data collected and reviewed was limited to a small sample of individuals over 64 years of age and included demographic, diagnosis, utilization of services and length of stay. At the time of the chart review, there were patients under the age of 64 at HGTC, but they were not included in the review sample.

In addition to data review, the BHPC team conducted telephone interviews with key leaders within the HGTC facility including the Hospital Director, Medical Director, Director of Operations, Chief Nursing Executive, and an Attending Physician.

Both the data review and initial interviews informed a targeted full day site visit to HGTC. The site visit included additional meetings with hospital administrative staff including the Hospital Director, Chief Nursing Executive, Medical Director, Directors of Social Work and Psychology, and quality/regulatory staff, and members of the geriatric teams (e.g., nurses, social workers, psychologist, medical providers, and nurse managers). The BHPC Team also toured HGTC giving

them an opportunity to observe interactions between staff and patients, and allowing them to learn about the physical needs of patients and how HGTC was addressing those needs (e.g., medical beds, privacy in rooms, assistance with eating, etc.). The last component of the onsite visit was a brief chart review of 10-12 HGTC patient records representative of older adult patients with both civil and forensic legal status, including individuals on the Extraordinary Barriers List (EBL). The EBL is a list of hospital patients who have been deemed clinically ready for discharge for at least two weeks, but have not yet been discharged due to a variety of factors centered upon inadequate community based housing and services.

Population Status, Needs, and Trends

Brief History of the Role of Hancock Geriatric Treatment Center

HGTC has served distinct populations of older adults with psychiatric disabilities, with shifts in the target population occurring as the Commonwealth's publicly funded resources and model of care for older adults with psychiatric disabilities has adjusted to changing policy, economic, and environmental factors. The state psychiatric hospital system in Virginia has always served as the primary provider for publicly funded older adults needing long-term psychiatric placement for serious mental illness (SMI) and for individuals with neurocognitive or behavioral issues. Historically, geriatric care at ESH primarily entailed long-term psychiatric placement for individuals with serious mental illness (SMI) who had aged while in psychiatric institutions, and where ESH served as the long-term placement for individuals with neurocognitive (including dementia) and behavioral issues. Administrators noted some acute psychiatric admissions in HGTC for older adults that required traditional state psychiatric hospital evaluation and stabilization, however, this group did not represent the majority of the population served.

As early as 1973, HGTC was certified by the Bureau of Medical and Nursing Facilities Services at the Virginia Department of Health to participate in Medicaid's Intermediate Care Program (nursing homes). The certification provided access to federal Medicaid funding to the Commonwealth for serving this population. From 1973 to 2010, HGTC continued to be utilized primarily for nursing facility placement, while facing periodic challenges in maintaining compliance with those applicable certification standards. Despite these challenges HGTC became a primary resource for the community and other State psychiatric hospitals seeking placement for older adults with behavioral health needs that required nursing facility care.

Beginning in 2010, HGTC began experiencing a period of nursing facility certification challenges that included plans of correction and ultimately decertification occurring in 2015.

Population Status

The BHPC Team reviewed the current status, needs and trends of the patients being served in the footprint of what had been the HGTC certified nursing facility, prior to decertification. The BHPC Team concluded that the current population being served includes three different basic populations:

- individuals age 65 and older with neurocognitive disorders such as Alzheimer's disease who appear to need nursing facility level of care, and who often had a secondary psychiatric condition or more often a behavioral challenge (secondary to neurocognitive) which resulted in their referral to HGTC;

- individuals age 65 and over with a stabilized psychiatric disorder who appear to need a nursing facility level of care based on functional status and/or need for nursing or rehabilitation services; and
- individuals both over and under age 65 who require some type of psychiatric stabilization or treatment for serious mental illness (SMI) and who do not appear to need a nursing facility level of care.

The former two populations may be appropriate for care in a nursing facility, though the model of care and programming for each may differ. However, when a person has a neurocognitive disorder (especially with behavioral challenges), the person often presents similarly to an individual with a psychiatric illness, and often the treatment is the same—psychiatric medications and other techniques used in psychiatric facilities— hence they end up in State facilities and have been historically served there. These individuals are not "average' nursing facility residents, but more complex, difficult, and sometimes aggressive. The latter population is not appropriately served in a nursing facility and is appropriately treated in an inpatient psychiatric hospital, at least for a period of time where acute psychiatric symptoms can be treated and stabilization achieved.

Often conditions are overlapping and interacting, creating additional complexity in treatment. Based on the BHPC Team's assessment, HGTC (similarly to the other VA State psychiatric hospitals) is seeing civilly committed and forensic populations with new and increasingly significant and challenging trends in service needs.

HGTC (similarly to the other VA State psychiatric hospitals) is seeing civilly committed and forensic populations with new and increasingly significant and challenging trends in service needs.

HGTC leadership described the following recent changes in the population admitted for care:

- Increased medical fragility such as individuals on oxygen and individuals with multiple medical conditions.
- Increased admissions of individuals who are not ambulatory and need significant support for daily living with particular concern about the number of individuals who have choking hazards at meal times.
- Increased acute psychiatric admissions with more difficult to treat mental health conditions and who are difficult to discharge even when psychiatrically stable.
- Increased neurocognitive admissions with significant behavioral challenges who are denied care by community nursing facilities due to insurance type or as a result of behavior secondary to neurocognitive conditions (separate from any objective determination of appropriate level of care).
- Individuals with a combination of these conditions.

HGTC is also seeing some increase in admissions of adults with co-occurring substance use disorders; particularly addiction to pain medication. The challenge for the psychiatric hospital is management of addiction complicated by real need for chronic pain management in addition to potential withdrawal concerns for alcohol and other substances which they are not medically prepared to manage. This population need also requires changes to the model of care, which is not

currently grounded in evidence based substance use disorder treatment. Additionally, the workforce, including physicians may need education on alternatives to pain management and how to address palliative care for individuals with significant medical conditions who are at risk for addiction.

Observations based on chart reviews, discussion with HGTC staff, and observations during the on-site clinical review include:

- The individuals placed on the EBL are largely the same as individuals generally served by HGTC, including non-EBL civil commitments. Placement on the EBL occurs when individuals have been determined clinically ready for discharge and have remained in the state hospitals for more than 14 days beyond that determination. The BHPC Team found that contributing factors for geriatric individuals being on the EBL are rarely if ever due to a complexity unique to the individual's case but rather a system challenge related to universal barriers to community placement. Universal barriers include but are not limited to: nursing facility placement availability (even for individuals who have been accepted by a community setting but are awaiting the right kind of opening); lack of private insurance; individuals waiting on other funding sources, due to their Medicaid pending, requesting Discharge Assistance Program (DAP) funds, or going through the Money-Follows the Person process; medical complexity, particularly for individuals who require oxygen or who have complex chronic health conditions; individuals with neuro-cognitive disorders who have behavioral challenges (even if the behavior is low risk and well controlled); individuals with guardianship concerns; individuals with some monetary resources that are not easily used or transferred, preventing eligibility for public funding/coverage such as Medicaid (e.g., they are part owners of a family property, spouse is living in their home, etc.); and the appropriate array of housing units and other residential settings with accessible services and supports.
- HGTC has seen a small increase in admission of older adults with criminal charges or forensic admissions and is currently serving a small population of individuals who have aged at ESH during their forensic sentence. HGTC staff are unsure why they are seeing an increase of admissions with older adults with new criminal charges. However, they are clear that once individuals are in a jail, jails are under tight restrictions on moving individuals with serious mental illness out of the jail setting, both from the existing Department of Justice lawsuit and the new state statutes requiring timely placement for treatment. State laws have, in effect, made state psychiatric hospitals into the admission resource of last resort, which has led to an increase in Incompetent to Proceed (ICPT) cases and a focus on restoration of competency cases, and thus additional pressure to use HGTC beds for non-nursing facility level of care populations.
- The increase in forensic admissions has been a challenge for HGTC because many of these older adults do not have the level of cognitive functioning needed to be restored as is expected for ICPT cases. Individuals cannot proceed in their criminal proceedings to determine sentencing or elimination of forensic status without competency, and treatment is not likely to result in competency, thus these individuals are stuck in legal limbo. The hospital also remains in limbo as it is unable to change the individual's legal status through treatment and it cannot discharge these individuals to the community (even when clinically appropriate). Some of these individuals could be served in the community in nursing facility settings, but cannot be moved with a forensic status.

- Some of the aging forensic population at HGTC are individuals found Not Guilty by Reason of Insanity (NGRI) by Virginia criminal courts. These individuals served their resulting commitment at ESH and were transitioned to HGTC as a result of the need for more hands on assistance due to physical or cognitive decline from aging or diseases. Some of these individuals continue to work through the treatment requirements and the forensic process to gain conditional release. However, many of these individuals' cognitive functioning has declined significantly either as a result of life-long serious mental illness or normal neuro-cognitive aging. In these cases, much like with ICPT, the individual and the hospital remain stuck in a legal process that is no longer meaningful for the cognitive capacity of the individuals engaged. Individuals with an NGRI status with dementia cannot complete a conditional release plan and yet cannot be considered for community placement without one. This means that either the legal process is changed (conditional release is granted without the normal completion of the program) or the individual is destined to live out their life at HGTC.

Individuals with an NGRI status with dementia cannot complete a conditional release plan and yet cannot be considered for community placement without one.

The BHPC Team's review and assessment of HGTC focused on today's patients rather than residents of the HGTC nursing facility prior to the 2015 decertification. If the patient population today is representative of what it was at the time of the 2015 certification review, then the protocols that were cited as evidence of non-compliance with the nursing facility CoP may have been necessary for the health and safety of the residents and staff, because of the presence of an acute care population within the unit. However, they are inconsistent with the definition of care and services intended to be provided by a nursing facility. The certification failure may have been caused, in part, by an attempt to compress two separate models of care. Beyond this challenge, the current population served at HGTC appears to represent some of the recent trends in increased demand for inpatient services. DBHDS' own review in 2015 of the HGTC resident population supports the theory that HGTC was serving a mixed patient population with different needs. In May of 2015, DBHDS conducted a preliminary review of HGTC residents as a result of certification issues raised by CMS and determined that of the 75 HGTC nursing facility residents at the time, nine would be appropriately placed in a nursing facility, while 50 would be appropriately placed in an inpatient psychiatric hospital setting, and 16 residents could be considered for discharge and placement in a less restrictive community based setting.

The three populations described above, being served today by HGTC, often have a mix of complex needs, including:

1. **Chronic Health and Medical Deterioration**- Aging can affect older adults in vastly different ways. While vigorous activity and well-being extend into late age for some, others are afflicted by multiple chronic illnesses and increasing disability. These medical conditions, taken together with co-occurring psychiatric disorders, can complicate treatment.
2. **Behavioral Health/Psychiatric Conditions**—As individuals age, they can experience mental health and/or substance use issues. For some older adults, the mental health or substance use condition has been a long-term psychiatric chronic health condition that is

changing as they age and may include experiencing an acute episode within older adulthood. Other individuals have a first episode or first experience with psychiatric illness in older adulthood. For example, depression in older adults is common as a result of increased social isolation, loss of significant others, other losses such as shifting to retirement or loss of physical functioning, or other major life changes. Some individuals have episodes of serious mental illness with mania or psychosis as a first episode and thus require acute care stabilization and treatment as part of their aging process. These same or other individuals may experience addiction to prescription drugs or other substances.

3. **Neuro-Cognitive Functioning**—As adults age, they are at risk for neurocognitive changes ranging from moderate memory loss and changes in executive functioning to more significant disease such as various forms of dementia and Alzheimer's which significantly impact functioning. Current estimates are that 1 in 10 of those older than age 65 has dementia. The prevalence increases with age; 32% of those over age 85 have dementia. These numbers have greatly increased with the aging of the "baby boomer" population. In 2017, 190,000 Virginians are estimated to have dementia, a 36% increase from 2015.[7]
4. **Behavioral and Social Functioning**—As individuals age they can become more complex in behavior and social functioning as a result of any single or a mix of the factors listed above (medical, psychiatric, or neurocognitive changes). Disruptive behaviors can present as significant confusion and loss of capacity for daily living skills (e.g., personal hygiene, self-care, independent living skills, etc.) or in other cases as verbal or physical aggression that is often impulsive and can cause physical risk to both the individual and caretakers. Individuals with neuro-cognitive challenges often wander, pace, and are intrusive with others impacting social relationships and one's ability to live in the community.

Because people rarely present distinctly within the aforementioned groups, even these categories are difficult to separate out for the older adult population. Often conditions are overlapping and interacting creating additional complexity in treatment.

Population Needs

Individuals with a nursing facility level of care generally require custodial care, support that assists individuals with activities of daily living, including assistance with or supervision of health-related activities that they would otherwise be able to handle themselves (e.g., using eye drops, oxygen, and taking care of colostomy or bladder catheters). Older adults in nursing facilities also have increasingly complex chronic, post-acute or occasionally acute medical needs that nursing facilities need to be able to manage or be prepared to address. These older adults can include older adults with stabilized psychiatric conditions who may not have neurocognitive conditions.

There are differences in programming for people with neurocognitive conditions versus those with a stabilized psychiatric condition. For long-term care of neurocognitive conditions, the treatment focus is on memory care (e.g., crafts, reminiscing groups, and social activities for distraction/quality of life) as well as hygiene, daily living activities, and ambulatory maintenance (e.g., walking) which are appropriate to all nursing facility residents.

[7] 2017 Alzheimer's Disease Facts and Figures. Alzheimer's Association. Pp 17-21.

For all geriatric populations at HGTC, there is a need for expertise in palliative and end of life care, particularly as discharge and community placement becomes an increasing barrier. Even some new admissions quickly experience a need for end of life planning and care as the medical complexity of the population also intensifies. Because of this trend, physicians and other staff at HGTC are serving patients who are facing increasingly difficult end of life care decisions and support needs. HGTC does not have palliative care or hospice type services, though current leadership acknowledged this as an emerging and growing need for serving the geriatric population.

In addition to the general nursing facility service needs for a geriatric population, individuals who have behavioral, cognitive or psychiatric conditions also require specialized services. The table below outlines the needs of the different populations and associated levels of care and staffing being provided by HGTC.

TABLE 2-1
Treatment, Level of Care, and Staffing Needs by Population

Population/Primary Condition	Level of Care Needed	Treatment Needs	Workforce/Resources Needed for Population
Older adults with neuro-cognitive disorders	Long-term Nursing Facility Care	Adequate space for wandering; adequate staffing for daily activities of living including bathing, toileting, and other functions; treatment focus on memory and pleasant activities to pass time and enhance quality of life; adequate medical support such as neurology as part of care planning. For some individuals secure or highly supervised settings. Medical services and support is also required.	Certified Nursing Assistants; RNs; Neurologist; Geriatrician and additional medical support such as palliative care; neuropsychology; music therapists. Facility Needs: Specialized medical beds, medical equipment, few patients per room
Older adults with neuro-cognitive disorders and behavioral challenges	Long-term Nursing Facility Care	Adequate staff for supervision of intrusive behavior; management of verbal and physical aggression during activities of daily living; workforce with specific training in addressing behavior for adults with impaired cognitive functioning as well as medical treatment and supervision.	Certified Nursing Assistants; RNs; Neurologist; Geriatrician; Neuropsychology; Behavioral specialists to assist and train staff in managing difficult behaviors. Facility Needs: Specialized medical beds, medical equipment, few patients per room
Older adults with acute psychiatric disorders	Inpatient Psychiatric Care	Adequate space for pacing, verbal response to hallucinations; adequate staffing such as psych-techs trained in treatment delivery of psychiatric milieu with focus on psychiatric rehabilitation and symptom reduction/self-	Psychiatric Technicians; Psych RNs; Psychiatry; Social Work; Psychology; Psych-Rehab Specialists. Facility Needs: off unit therapy spaces; on-unit access to outdoors; line of sight units for

Population/Primary Condition	Level of Care Needed	Treatment Needs	Workforce/Resources Needed for Population
		management; targeted groups with content appropriate for psychiatric needs such as social skills, structured hygiene support, and medication adherence.	safety and supervision; fewer patients per room
Older adults with serious mental illness with long-term hospitalization (as a result of illness that fails to stabilize or forensic status)	Inpatient Psychiatric Care	Adequate diversity of group treatment options to address discharge readiness, community living skills, community passes, self-management of symptoms, and medication education with recovery based models of care; individualized treatment approaches with milieu staff reinforcement of targeted treatment goals; capacity for community outings and other activities to support recovery; medical services.	Psychiatric Technicians; Psych RNs; Psychiatry; Social Work; Psychology (forensic and neuropsychology); Psych-Rehab Specialists. Facility Needs: off unit therapy spaces; on-unit access to outdoors; line of sight units for safety and supervision; fewer patients per room.

Trends

Increased Forensic Admissions

Forensic admissions include people who are admitted to ESH following a Not Guilty by Reason of Insanity (NGRI) determination by the criminal court, and those determined by the courts as Incompetent to Proceed (ICPT). When an individual is determined NGRI, the individual must be evaluated and a determination made whether the individual be released with conditions, released without conditions, or committed to a state psychiatric hospital. When an individual is determined ICPT, the individual is to receive treatment to restore competency, either outpatient or inpatient. If the court finds that inpatient hospital treatment is necessary, the individual must be transferred to and accepted by the hospital designated by the DBHDS Commissioner no later than 10 days from the receipt of the court order requiring treatment to restore the defendant's competency.

Across all ages, there is a growing wait list for NGRI and ICPT, and currently a long wait for admission to state hospitals from jails. Despite working to enhance restoration to competency rates for ICPT, (reportedly 40 days at ESH which is the fastest in the state), the NGRI list has doubled in the past couple of years with more entering the state hospital as older adults. ESH's region has three and a half times as many NGRI cases than any other region in the Commonwealth and twice as many as the next highest region.

Adult patients admitted to ESH on forensic status may also age in the hospital and begin to develop medical and neuro-cognitive challenges. As their cognitive functioning declines, it is harder for them to complete the steps required to meet conditions of release for NGRI, or to restore competency for ICPT. This places the individual in limbo as they are unable to discharge to the community due to

failed completion of their forensic stay and yet they can no longer benefit from forensic programming and often do not need the level of care provided at ESH.

Increased Temporary Detention Order Admissions

Recent statutory changes have increased demand for state psychiatric hospital beds. Virginia law now provides that state-operated hospitals cannot refuse the admission of a person held under a TDO following an evaluation completed under an ECO when an alternative facility cannot be found and the ECO period is expiring. Because of the short assessment time (eight hours), Community Service Boards (CSBs) are often unable to stabilize or identify a community or private hospital bed alternative for an older adult in crisis (whether it is a crisis related to psychiatric or neuro-cognitive disorders). This often means that to meet the statutory timeframe requirements CSBs are forced to refer individuals to the state psychiatric hospital that are required to admit them.

There are clearly times that individuals are appropriately referred to the state psychiatric hospitals. However, officials interviewed also believe that the increase in numbers of admissions includes individuals who do not need that level of care. These individuals are being referred simply as a byproduct of meeting new policy and statutory requirements complicated by inadequate crisis and diversion services. There is consistent reporting among the state psychiatric hospitals and the CSB that other provider groups have taken advantage of these policy changes, including private hospitals that prefer to refuse a behavioral health admission, and private nursing facilities seeking to discharge more "difficult" residents, both knowing that the state psychiatric hospital is required to accept a referral and the costs of state inpatient care will be borne by the Commonwealth. This relieves the private providers of any risk or concern about placement. Both community behavioral health providers and state hospital staff report an increase in TDO admissions under this statutory change. ESH reports that it cannot deflect admissions, even when its units are full or ESH believes an individual might be more appropriately served in another setting.

Demographic Changes Including an Aging Population

Three in four Americans over the age of 65 have multiple chronic illnesses that last more than a year and limit basic daily functional activity[8]. Functional status is the best predictor of longevity and well-being and is defined as how well a person can provide for his or her own needs. Geriatric physical illnesses, such as progressive cardiovascular, arthritic and neurocognitive diseases, strike at the heart of an older person's functional ability and independence and lead many elderly people to be reliant on others for basic needs that require close supervision and/or institutionalization. The ESH region, like remainder of the country, is facing the impact of the "baby boomer" demographic. According to the Virginia Division

Between 2020 and 2040, there will be a 53% increase in the number of Virginians over age 85. While the population numbers remain relatively small as a share of the total population, the need for long term services and supports in the over 85 age group is significant, so this rate of growth has serious implications for public spending.

[8] Gerteis J, Izrael D, Deitz D, LeRoy L, Ricciardi R, Miller T, Basu J. *Multiple Chronic Conditions Chartbook.*[PDF - 10.62 MB] AHRQ Publications No, Q14-0038. Rockville, MD: Agency for Healthcare Research and Quality; 2014.

for the Aging, the percent of Virginia's population over age 60 will increase from 14.7% to 25% by 2025 at which point there will be 2 million people in this group.

Recent population projections[9] published by the University of Virginia's Weldon Cooper Center for Public Services demonstrate the acceleration of the aging population. The figures below illustrate the increasing number of Virginian's projected to be age 65 and older in each or 2020, 2030, and 2040 relative to 2010 Census data[10]; and the number of Virginians expected to be age 85 and older in each of those years. Between 2020 and 2040, there will be a 53% increase in the number of Virginians over age 85. While the population numbers remain relatively small as a share of the total population, the need for long term services and supports in the over 85 age group is significant, so this rate of growth has serious implications for public spending.

FIGURE 2-1
Virginia's Projected Population Age 65 and Older

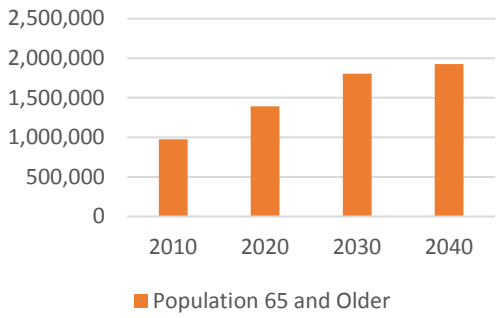
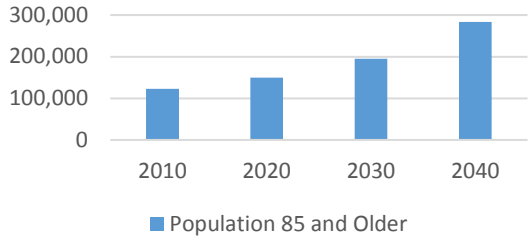


FIGURE 2-2

Virginia's Projected Population Age 85 and Older



Barriers to Discharge Pressures Continue

When ESH determines that an individual is clinically ready for transition to a less restrictive or acute setting, and when ESH and the CSB cannot complete a discharge within 14 days of the date the person was determined clinically ready for discharge, patients are added to the EBL. There are a variety of barriers that have historically prevented timely discharge including:

[9] Population Projections by Age and Sex for Virginia and its Localities, 2020-2040, Demographics Research Group of the Weldon Cooper Center for Public Service, June 2017

[10] U.S. Census Bureau, *Census 2000 Summary File 1* and *2010 Census Summary File 1*.

- No willing provider due to the nature of the patient's legal status or charge, being a sex offender, having complex medical conditions, and/or having a history of violence.
- Patients being accepted at residential programs, assisted living facilities, or a nursing home, but not discharged because the accepting facilities do not have available and/or appropriate beds.
- Lack guardianship or in the process of obtaining a guardian.
- Waiting on funding sources due to pending Medicaid, requesting Discharge Assistance Program (DAP) funds, or going through Money-Follows the Person process.
- Lack of community housing and services appropriate to the patient's needs.
- Needed continued annual funding after discharge to help support them in the community.

Assessment of Identified Needs and Trends

ESH is experiencing what we have termed a "funnel effect." The funnel is very wide at the top with a variety of factors driving demand for admissions to ESH and HGTC, and very narrow and restricted at the bottom due to barriers to successful discharge and return to the community. This funnel results in individuals entering ESH and HGTC and staying, while the pressure at the top of the funnel continues. ESH is running at maximum operational capacity and has occasionally had to exceed operational capacity. Average length of stay for HGTC is three-six months, but there are no short-term admissions due to the complexity of finding a placement even for the more "simple cases." Some individuals remain in the hospital for decades. Most concerning is that not all of those individuals need an inpatient level of care, having neither a hospital or a nursing facility level of care need. This situation not only wastes valuable resources with people being served in the costliest setting (inpatient care), but threatens violations of the Supreme Court's *Olmstead* decision, the Americans with Disabilities Act, and the Rehabilitation Act, all requiring that people with disabilities have civil rights to be served in the least restrictive setting that is most appropriate to their care needs.

In order to respond to the sheer numbers of admissions, HGTC has had to move back to a regional approach focused on providing immediate access to beds for all populations served and thus can no longer specialize with regard to population model and unit design which had allowed it to act as a statewide resource for nursing facility care. Attempting to serve multiple sub-populations of older adults within a unit (those who are aging with SMI, who are no longer acute but have retractable psychiatric illness and are not ready for community living, and those with acute psychiatric episodes), is resulting in a model of care that does not best meet the needs of any population. These competing priorities for use of existing bed capacity may further complicate any future pursuit of HGTC recertification for nursing facility beds.

In summary, decertification as a nursing facility combined with new statutory and regulatory pressures on state operated hospitals has been two-fold for HGTC: 1) ESH is experiencing a rapid increase in admissions (as are all state psychiatric hospitals in Virginia); and 2) because HGTC is no longer a certified nursing facility and because there is pressure on the whole system to accept admissions, the geriatric beds are now used for general psychiatric admissions for older adults.

As a result, rather than accepting referrals from other state psychiatric hospitals throughout the state for individuals needing nursing facility level care, HGTC has adopted a more regional approach for

prioritizing admissions. These shifts in frequency and type of admissions dramatically impact the use of beds across all state operated hospitals. The shift in population and focus on acute stabilization also means a change in the model of care and staffing needs at HGTC. With a high demand for beds, priority of admission and placement is not always based on clinical need or current medical, cognitive and psychiatric functioning. Varying levels and types of needs of patients on a single unit create a strain on staffing and can result in some patients not receiving individualized and appropriate care.

These competing priorities for use of existing capacity may further complicate any future pursuit of recertification for nursing facility beds. Current pressures will be compounded by the growth in the sheer numbers of older adults in the state and the resulting growth in conditions such as dementia. The prevalence of Alzheimer's alone, the most common cause of dementia, is 11% for people age 65 and older, and 32% for people age 85 and older.[11]

[11] Alzheimer's Association. 2016 Alzheimer's Disease Facts and Figures. *Alzheimer's & Dementia* 2016;12(4).

Chapter 3: Clinical Services Assessment

Summary With diversification of patient population fueled by regulatory changes, HGTC is attempting to simultaneously provide nursing facility and psychiatric facility care models. The result is that neither model is sufficient or appropriate. Chart reviews indicated a lack of active psychiatric treatment, a need for training on standards of practice for psychiatric inpatient care, and sub-standard documentation (e.g., documenting once a year or every six months rather than every shift, and not documenting the short-term changes in psychiatric presentation).

Approach/Methodology

The BHPC Team engaged in a multi-pronged approach to review and assess the clinical services provided by HGTC. The Team collaborated with DBHDS staff to define a data request that included available information on populations served at HGTC. Data collected and reviewed was limited to individuals over 64 years of age and included demographic, diagnosis, utilization of services and length of stay. In addition to data review, the Team conducted telephone interviews with key leaders within HGTC including the Hospital Director, Medical Director, Director of Operations, Chief Nursing Executive, and an Attending Physician.

Both the data review and initial interviews informed a targeted full day site visit to HGTC. The site visit included additional meetings with hospital administrative staff including the Hospital Director, Chief Nursing Executive, Medical Director, Directors of Social Work and Psychology, quality/regulatory staff, and members of the geriatric treatment teams (e.g., nurses, social workers, psychologist, medical providers, and nurse managers). The BHPC Team also toured HGTC to observe interactions between staff and patients and to learn about the physical needs of patients and how HGTC was addressing those needs (e.g., medical beds, privacy in rooms, assistance with eating, etc.). The last component of the onsite visit was a brief chart review of 10-12 patient records representative of geriatric civil and forensic patients with a particular focus on individuals on the EBL.

Clinical Services Provided at HGTC

The types of services currently delivered at HGTC include:

- Assistance with activities of daily living (e.g., bathing, dressing, feeding, toileting, walking)
- Nursing services
- Medication administration
- In-house medical teams comprised of general internists, family physicians and/or advanced practice nurses. These teams perform several functions:
    - Evaluating new admissions for medical care needs and screening for appropriateness of services that can be provided in the hospital.
    - Managing chronic physical illnesses, such as hypertension and diabetes.

  - Ordering and evaluating basic medical tests and arranging for outside diagnostic and therapeutic tests, if necessary.
  - Evaluating the need and making referrals for subspecialty care.
  - Evaluating acute medical conditions 24/7 and assessing the need for follow-up level of care, including arranging transfers.
- Referral relationships with local specialist providers and medical centers for subspecialty, procedural and emergency care.
- Extensive psychiatric evaluation and ongoing medication monitoring delivered by unit psychiatrists who lead the clinical team and approach to care.
- Psychological assessment with individualized treatment plan development, meaning the process of collection of information, clinical evaluation of that information, functional behavior assessment and forensic evaluation.
- Group therapy with a range of options which largely focused on memory care and quality of life activities including within the treatment mall.
- Individual therapy offered on some units with social work or psychology staff for individuals with psychiatric conditions.
- Music therapy and other recreational therapies.
- Social work discharge planning and resource and benefit determination and acquisition.

Clinical Services Assessment

During previous periods of nursing facility certification, HGTC's model of care was concentrated towards individuals with neuro-cognitive conditions and medical concerns related to normal aging. This model of care is more custodial and residential than traditional psychiatric hospital active treatment approaches, and these differences are reflected in the Federal certification standards for nursing facilities. For example, nursing facility programming requires hiring certified nursing assistants (CNAs) to support daily activities of living such as bathing and toileting; adapting space to provide for more open areas for residents with dementia who wander; adding additional hospital beds, wheelchairs and Hoyer lifts to support care for individuals with physical or medical needs; offering programming to enhance quality of life (e.g. pleasant activities and memory/reminiscing groups; and documentation requirements that reflect a nursing facility standard of care.

Effective inpatient psychiatric units, on the other hand, have a different milieu with a faster pace of care, more robust scheduling and programming throughout the day with a focus on active treatment. The milieu of a well-run psychiatric unit is highly therapeutic and purposeful with active engagement of patients in the moment, stabilization of symptoms and education and training for patients in self-management of psychiatric conditions. Specific to staffing, psychiatric technicians are needed rather than CNA's to provide therapeutic intervention throughout the day (e.g., distracting individuals from psychosis, discussing awareness of social skills and personal space, teaching individuals to work through conflict). Although geriatric inpatient units also include a focus on support of daily living activities, the degree of support for long-term care needs is different. Furthermore, the social work and psychology staff on a psychiatric unit should provide daily group psychotherapy on topics ranging from symptom management, recovery planning, crisis awareness and wrap around planning,

social skills, and evidence based treatment approaches such as Dialectical Behavioral Therapy and Cognitive Behavioral Therapy. Effective psychiatric units also engage psychiatric rehabilitation services geared towards returning to work and developing skills for community functioning.

Currently HGTC is attempting to provide both nursing facility and psychiatric facility care models to a mixed population of residents and patients within the same units. The result is that neither model is sufficient or appropriate. In some instances, meeting the CoP for one group conflicts with meeting the CoP for the other. The pressure at ESH to handle the increased volume of admissions has not provided an environment that supports thoughtful execution of program design, staffing, or training for the workforce at HGTC. Instead, HGTC has adapted as quickly and organically as possible but in a reactive rather than proactive manner. This transition has left many staff members at HGTC describing the geriatric units as having "lost their identities." The staff are no longer matched to the population and the program model is mixed and confusing with reliance on some elements of long-term custodial care and some elements of acute psychiatric treatment.

HGTC is attempting to provide both nursing facility and psychiatric facility care models to a mixed population of residents and patients within the same units. The result is that neither model is sufficient or appropriate.

Ideally the model of care and the services provided are specifically designed to meet the needs of the population. As professionals evaluate and determine the etiology of a person's symptoms (e.g., behavior is secondary to psychosis versus dementia) an individual is assigned to a unit that is specific to that condition and an individualized treatment plan is created. The care delivery team's expertise and capacity, along with the unit design, supports the underlying treatment need. Of course, some individuals have a mixture of etiology such as medical and neurocognitive, or psychiatric and behavioral, with conditions interacting and intensifying each other in an additive manner. However, even in those cases the individual's needs are prioritized and the most pressing symptoms drive the approach to care and the type of unit that would be best for stabilization and treatment.

For HGTC, providing a defined treatment model appropriately matched to patient need has been a challenging task. HGTC has begun an effort to create sub-populations and differing service models by creating geriatric units separated by physical space. Some units are geared more towards acute psychiatric admissions, some are focused on the more complex medical needs, and some on caring for individuals with neuro-cognitive and behavioral challenges. Although separation of sub-populations is a movement in the right direction to meeting population need, it is happening without full implementation of distinct models of care. For example, the units are not fully staffed with the appropriate mix of staff (psychiatric technicians or CNAs) and many staff may need additional training or updates in training to meet the specific needs of the populations being served.

Overall, the BHPC Team's assessment is that despite efforts to specialize the units, the HGTC units remain more geared towards custodial care than inpatient psychiatric care. The chart reviews in particular indicated a lack of active psychiatric treatment, a need for training on standards of practice for psychiatric inpatient care, and sub-standard documentation (e.g., documenting once a year or every six months rather than every shift, and not documenting the short-term changes in psychiatric presentation).

Furthermore, the chart review indicated some concerns about HGTC's work with patients whose cases include guardians. There were a few cases in which the guardian was clearly not supporting the best care for the individual—delaying active treatment or refusing medications for psychosis. In psychiatric settings, the provider's role is to either educate the guardian of the need for treatment or work with the legal system to assign a guardian who will support recommendations for treatment that are in the best interest of the individual. The HGTC teams seemed to have a custodial philosophy of care with perhaps too much acceptance of guardian wishes.

Lastly, the Team identified the following services as minimal or missing for older adult populations:

- Minimal psychological testing except in forensic settings, meaning administration of a tool designed and validated to yield a finding.
- Minimal neuropsychological screening with no onsite full neuropsychological assessment which makes exploration of etiology between neurocognitive and psychiatry and subsequent treatment planning more difficult.
- Minimal treatment specifically addressing substance use disorders.
- No end of life care such as palliative or hospice care.
- No memory care, age appropriate social activities, or ambulation maintenance activities.

Clinical Services Assessment Certification Implications

The BHPC Team's assessment of the current HGTC operations concludes that the deficiencies that were documented in the 2015 survey that resulted in decertification remain a concern should the Commonwealth choose to seek recertification. These include:

- Failure to meet to meet the definition of a nursing facility as identified in Federal Regulations—The federal CoP states that nursing facilities may not be primarily for the care and treatment of mental disease. There is a strong likelihood that surveyors would view HGTC as primarily for the care and treatment of mental illness. As noted in Chapter One, the federal regulations consider the following in assessing whether the character of an institution is an IMD:
    - whether the facility is licensed or accredited as a psychiatric facility,
    - is under the jurisdiction of the state's mental health authority,
    - specializes in provider psychiatric/psychological care and treatment (judged on patient records, staff qualifications, or if the facility was established and maintained primarily for the care and treatment of individuals with mental diseases), or
    - has more than 50 percent of all its patients admitted based on a current need for institutionalization as a result of mental diseases (regardless of what services are provided).

  The individuals admitted to HGTC appear to continue to include a majority of individuals with psychiatric diagnoses and, especially with the influx of more acute psychiatric patients at the facility, it would be a challenge to maintain a distinct nursing facility unit that was not serving a majority of individuals who need psychiatric care. For example, the demand for psychiatric beds for ESH is expected to continue due to the TDO and last resort law, and it

might be difficult for the larger facility to leave beds empty at HGTC for nursing facility level of care when acute admissions need to be accommodated.

- Failure to promote and protect the rights of all residents to be free from interference, coercion or reprisal from the facility in exercising their rights-- These restrictions remain and would be a barrier to certification as a nursing facility.
- Failure to ensure each resident had the right to retain and use their personal possessions and to treat their belongings with respect unless to do so would infringe upon the rights, health and safety of others residents-- As long as HGTC requires the flexibility to serve individuals with primary psychiatric needs within the same units as individuals who have neurocognitive needs and need assistance with activities of daily living, there will be conflicting policies and continued inability to meet nursing facility CoP.

- Failure to promote and enhance the resident's right to make choices by subjecting residents to restrictions and limitations necessary for the care of some of the facility's residents-- The survey findings are reflective of the challenges and tension that facility administrators identified when trying to protect the safety and wellbeing of residents with psychiatric and behavioral issues while promoting resident rights and quality of life. These challenges remain and are further aggravated by the influx of psychiatric admissions to the ESH and the use of HGTC to serve patient overflow.

Chapter 4: Physical Plant Assessment

Summary While the HGTC physical plant assessment did identify some deficiencies (areas requiring remediation), the building itself is relatively new, built in 2008, and is in generally good or excellent condition. BHPC's Team also assessed the Kitchen and Dining Facility, Building 13 of ESH, which was built in 1954. The building was included in the assessment because it is mission critical to providing services to HGTC patients regardless of certification status and funding source. The Superstructure and Substructure of Building 13 were built to last well beyond 100 years and are in good condition, however, the systems in the building are designed for a shorter life span. Some systems in the facility need immediate attention and are critical to maintaining the mission of HGTC.

Approach/Methodology

As part of the BHPC Team, the Olshesky Design Group, LLC conducted a facility condition assessment of HGTC and the dining room/kitchen building 13 in Williamsburg from April 12, 2017 through April 21, 2017. The facility condition assessment centered on the superstructure and systems for each facility to address the aging physical plant. The on-site assessment included a visual assessment of the hospital, which typically does not include assessing work to be done behind walls, or in confined spaces, equipment not attached to the building, site work or other buildings. If a building element or system is or may be deficient and it is behind walls, or in a confined space, then testing or a Comprehensive Study is recommended. The cost estimates for addressing issue areas are based on the site investigators field work by trained professionals, review of drawings and reports, interviews with key site personnel, and are referenced to national cost estimating guidance, RS Means. ODG's study did not include a "modernization" initiative, an assessment of building code compliance, nor future expected costs. However, some suggestions for modernization are addressed later in the report, particularly related to modernization to meet population needs.

In advance of the on-site assessment visit, the Olshesky Design Group requested that representatives from HGTC complete a Pre-Site Visit Checklist. The Pre-Site Visit Checklist covered topics including but not limited to:

- Logistics for the site visit including security and facility access for the Team, and meeting space for the site visit Team during the assessment
- Identification of the building(s) to be included in the assessment
- Specification of building details such as whether the building(s) have interstitial space or have roof access
- Identification of any limitations to access facility equipment
- Specification of building information required to complete the assessment including but not limited to: drawings, site plans, equipment lists, renovation dates, service calls, and inspection reports

Conditions rated in this study use the Facility Condition Index (FCI). The FCI is an indicator of condition derived by dividing the costs of current deficiencies, or repairs, required for the facility by the current replacement value of the facility.[12] The suggested condition ratings are assigned facility condition index ranges as follows:

FCI Range:	Condition Rating:
Under 5%	Good
5% to 10%	Fair
Over 10%	Poor

Physical Plant Assessment

The physical plant assessment included assessment of two buildings: The HGTC and the Kitchen and Dining Room Facility which is Building 13. Appendix A provides the full report of the Physical Plant Assessment including a description of deficiencies, pictures of the physical plant associated with the deficiencies, a priority level and year, and a breakdown of labor and material cost. The remainder of this section provides an overview of the findings.

HGTC Physical Plant Assessment Results

The current HGTC was built in 2008 for providing services to the geriatric population. More recently it has become a hospital of last resort for psychiatric patients. Modifications have been made and are being made for this population as they are of varying ages, and some changes have been made to accommodate space for TDOs. The Value of Deficiencies for the HGTC is $277,242. In addition, it is recommended that a Comprehensive Study be done to provide greater ventilation to the four small Nutrition Rooms, one in each Pod. A Comprehensive Study needs to be done to determine the size and cost of a Jib Crane to enable large equipment to reach the roof of HGTC. If $100,000 is added for these costs, then the total cost of deficiencies is $377,242. The Replacement Value of HGTC is $45,433,301 and if site work is included the value is $49,976,631. The Facility Condition Indexes 0.005 or less than 1%**,** and the HGTC is considered to be in Good Condition**.** The table below summarizes the HGTC physical plant assessment findings.

TABLE 4-1
HGTC Facility Condition Assessment Summary Findings

HGTC Facility Condition Assessment Findings	
Physical Plant Element	**Estimated Cost of Remediation**
A. Substructure: Foundations and Basement Construction	$0
Foundation: appears in excellent condition. It was built in 2008. The foundation is concrete block with a life expectancy of 50 years, and on a concreate footing with a life expectancy of 75 years.	
Basement Slab: Slab on grade appears in excellent condition. It was built in 2008 and has a life expectancy of 50 years.	

[12] "Managing the Facilities Portfolio", by National Association of Colleges and University Business Officers, NACUBO and Applied Management Engineering, Robert Brooks, partner. Published 1991. The Facility Condition Index, FCI, is the ratio of the cost of the Deficiencies to the Current Replacement Value, a measure of the Condition of the Facility.

HGTC Facility Condition Assessment Findings	
Physical Plant Element	**Estimated Cost of Remediation**
B. Exterior Enclosure	$0
Superstructure: Roof Construction: Excellent condition. It was built in 2008. The roof construction, metal joists supporting a metal deck with rigid insulation on top has a lifespan of 30 years.	
Superstructure: Structure: Structure appears in excellent condition. It is metal joists supported by steel I beams. The structural system has a lifespan of 75 years.	
Exterior Wall: The mortar joints and brick are in excellent condition. The brick life expectancy if 75 years. The fiber cement siding is in excellent condition.	
Exterior Windows: Exterior windows are in very good condition.	
Exterior Doors: Generally in very good condition.	
Roof Coverings and Openings: The roof membrane, rubberized EPDM, membrane flashings and sloped insulation are in excellent condition. It was installed in 2008 and has a 20-year lifecycle.	
C. Interiors	$7,679
Interior Construction and Stairs: Stair to Roof: Current roof access stair is a Ship's Ladder without a Safety Cage. The Ship's Ladder should have a Safety Cage. There should be standard run and riser stairs to the roof, like the stairs to the roof in most other buildings on the ESH campus, including Building 13. These types of stairs are necessary to provide mechanic access to the roof. There is mechanical equipment that needs periodic servicing on the roof. Tools, hoses, and equipment need to be carried to the roof which is difficult if not impossible with a Ship's Ladder. The round rungs on the Ship's Ladder are slippery when wet. There is room to install an inclined ladder with the base at least 5'-0" in front of the current location of the Ship's Ladder. The inclined ladder would need to include treads and a handrail for safety.	
D. Services	$119,563
Plumbing Fixtures: Patient Tubs: The Patient Tubs leak at the door seal. The Tub Seal for the Liberti tubs has failed. The company is no longer in business. Alternative seals have been tried, but have not worked. ODG's recommendation is to replace all eight tubs with tubs manufactured by Rane and which are being used in the Adult Mental Health Hospital and are working fine.	
Plumbing Fixtures: Hose Bib: Hose bins need to be installed on the roof in order to periodically clean the Air Handling Unit coils. The humidifiers are no longer being used and a study determined they are no longer needed. The humidifiers could be removed and the water that is piped to the humidifiers could be used for a hose bib.	
HVAC Distribution Systems, CVPC Piping: The CVPC piping is sagging and it has warped in some cases which is visible from the Mechanical Room. ODG recommends adding more hangers in the Mechanical Room. Hangers should be no greater that 4'-0" apart.	
HVAC System: ODG Heard complaints of rooms being either too hot or too cold, and the users of the space have no way of moving the thermostat temperature. This is controlled by Building and Grounds. Building and Grounds makes adjustments to the temperatures in various offices.	
Nutrition Room Ventilation: There is insufficient ventilation in the Nutrition Room, RM 223 in Pod 2, and the similar room in the other three Pods. The Nutrition Room is small and has a Kitchenette in it and heat is generated by the refrigerator. ODG recommends completion of a Comprehensive Study to determine if another duct, or a larger duct, needs to be added to these rooms.	
E. Equipment	$150,000

HGTC Facility Condition Assessment Findings	
Physical Plant Element	**Estimated Cost of Remediation**
Jib Crane: A jib crane needs to be installed to move heavy equipment from the Loading Dock on and off of the roof. Currently the Ship's Ladder provides limited access for equipment to the roof. The roof hatch limits the size of equipment that can be conveyed to the roof. There is a base on the roof near the Loading Dock that would accommodate a jib crane. ODG recommends completion of a Comprehensive Study to determine the size of jib crane needed.	
Nurses Call System: The Nurse Call System has not been working. It was explained that there have been shorts in it. There is also a risk that the Nurse Call System could be used as a ligature device. ODG recommends removing the current Nurse Call System and either: 1) install a hard wire system that would cost, based on FICAS report, between $300,000 and $400,000; or 2) purchase a wireless system which would cost approximately $110,000. The second option is included in the Value of Deficiencies with an added $40,000 contingency, and ESH staff have already talked with four vendors to explore this option.	
Total Value of all HGTC Deficiencies	**$277,242**
Estimated Budget to Complete Comprehensive Studies	$100,000
Estimated Value of HGTC Deficiencies Plus Completion of Recommended Comprehensive Studies	**$377,242**

Kitchen and Dining Room Facility, Building 13, Physical Plant Assessment Results

The Kitchen and Dining Facility, Building 13, was built in 1954. This building was included in the assessment because it is essential to delivery of services to residents of HGTC. While the Superstructure and Exterior Wall were built to last well beyond 100 years and are in good condition, the systems in the building are designed for a shorter lifespan. Some systems in the facility need immediate attention. The Deficiency Report prepared for Building 13 is focused on critical needs relative to HGTC and it is not a complete assessment of this facility. ODG recommends that the critical needs be addressed immediately. The total Value of Deficiencies for the kitchen and dining facility of Building 13 is $1,627,401. In addition to correction of identified deficiencies, ODG recommends completion of a Comprehensive Study to determine the size and cost of the four Air Handling Units needed in the basement. The table below summarizes the Kitchen and Dining Facility assessment findings.

TABLE 4-2
Kitchen and Dining: Building 13 Facility Condition Assessment Summary Findings

Kitchen and Dining Facility Condition Assessment Findings	
Physical Plant Element	**Estimated Cost of Remediation**
A. Substructure: Foundations and Basement Construction	$0
Foundation and Basement Construction: Is generally in very good condition. It was built in 1954. The substructure was built to last well beyond 100 years.	
Basement Slab: In very good condition.	
B. Exterior Enclosure	$461,740.27

Kitchen and Dining Facility Condition Assessment Findings	
Physical Plant Element	**Estimated Cost of Remediation**
Superstructure: Floor and Roof Construction: Is generally in very good condition. It was built in 1954. The superstructure was built to last well beyond 100 years. The structure is sound and in very good condition. The roof structural slab is in very good condition.	
Exterior Wall: The mortar joints and brick are in very good condition. The brick vents need to have the plastic covers removed. The brick vents are there to ventilate the structure and are essential to serve that purpose. If they are not removed, significant decay could occur.	
Exterior Windows: Generally exterior windows are in good shape, with the exception of the monitor windows which need immediate replacement. The monitor windows were installed in 1954 and have a lifespan of 45 years. They have exceeded their useful life by 18 years. The window frames are bent in some cases and not all the windows close completely. The monitor motor does not operate. The shaft and extension arms need to be replaced.	
Roof Coverings and Openings: The roof membrane, rubberized EPDM, membrane flashings and sloped insulation are in critical condition and need immediate replacement. The roof membrane was installed in 1991 and has a 20-year lifecycle. It has exceeded its useful life by 6 years. The current condition has slightly sloped insulation in some places, no slope in some places, and a reverse slope or sloping to a pond in other cases. In some cases, bubble have formed on the roof.	
C. Interiors	$568,960.65
Interior Finishes: Floor Finishes: Floor finishes are generally in good condition with the exception of the replacement tile in the Kitchen. It was not grouted properly and is hollow below the tile. This is a high priority item. If it fails, kitchen service would be difficult if not impossible to provide with carts. ODG recommends completion of a Comprehensive Study to determine which tile is hollow and how much of it needs to be replaced.	
Ceiling Finishes: Several ceiling tiles have been replaced with plastic in several rooms, primarily: Room 103, Diet Manager's Room; Room 103A, Conference Room; Room 102, Patient Dining Hall/Cafeteria; and Room 101A, Office. The tiles have been replaced with plastic due to roof leakage associated with the failure of the roof membrane. Once the roof membrane is replaced, the ceiling tiles should be replaced.	
D. Services	$596,700.26
Plumbing: Sanitary/Storm water Waste Piping: The sanitary waste piping needs to be replaced. It was installed in 1954 and its useful life is 30 years. It has exceeded the manufacturer's useful life by 33 years. It is in need of critical replacement and is a high priority item for immediate replacement. The basement has been flooding when there is large rainfall.	
Plumbing: Sanitary Waste: Drain for Three New Boilers: When three new boilers were installed in 2016, their drains were tied into an existing floor drain. The existing floor drain and its pipe size were not modified. The existing floor drain was designed to handle only its load, not the increased boiler flushing load. Due to the increased load on the existing floor drain, flooding now occurs in the basement North-South corridor, and in the far East-West corridor and in nearby rooms. The three boilers flush water two times a day. If the water is flushed at a typical speed, the water overwhelms the drains and water will come up out of the floor drain closest to the three boilers. If there is heavy rain, water will come up from the floor drains, as explained by Building and Grounds Staff. Water at the closest drain has come up about 1.5 feet. Water will come up at the two intermediate drains along the hall, and come up a maximum of 6" at the end of the hall drain to the South.	

Kitchen and Dining Facility Condition Assessment Findings	
Physical Plant Element	**Estimated Cost of Remediation**
There is a sump pump but it is insufficient for even average rainstorms. ODG removed the sump pump cover and found that the pipe connecting the pipe water on the interior of the building was not connected to the exterior pipe. It has since been connected. The water will be pumped out more quickly from the basement hallway, however, the flooding will still occur and needs immediate attention. ODG recommends installing a new drain pipe to daylight.	
Domestic Plumbing: The domestic plumbing, copper piping in the Basement crawl space to the first-floor fixture, needs to be replaced. It was installed in 1954 and its useful life is 20 to 25 years, so it has exceeded its useful life by approximately 40 years. This is a high priority item and should be replaced within the next 12 months. The insulation for the piping also needs to be replaced.	
HVAC System: The four Air Handling Units, or Heating and Ventilation Units, in the basement that serve the building (H-1, H-2, H-3 and H-4) need to be replaced immediately. This is a critical item and needs immediate attention. Water sits in many of these units and the air being blown from them may not be healthy. The steam and condensation lines in the crawl space and on the first floor need to be replaced immediately. They are in critical condition and are badly corroded. While ODG was on site, one line broke. The pipes have a useful life of 75 years, but have corroded so badly that they need immediate replacement. The window AC units on the east side of the building need to be replaced with a rooftop Air Handling Unit. The rooftop unit will cool the offices more efficiently and provide more comfort throughout the suite. Two of the air conditioners are located on an interior wall and are putting additional heat into the kitchen storage which is open to the kitchen. This is exacerbating the hot air in the kitchen. Heating and Ventilating Units in the Kitchen, and their associated piping, need to be removed. The four units no longer operate and water drips from the piping. A new rooftop unit, a Heat Pump, needs to replace these inoperable units. The rooftop unit would provide the needed cool air for the kitchen. The kitchen currently gets very hot in the summer time, including temperatures above 90 degrees. This is an immediate need.	
Total Value of Kitchen/Dining, Building 13 Deficiencies	**$1,627,401**

Physical Plan Assessment Certification Implications

None of the findings of the Physical Plant Assessment are related to the 2015 CoP survey findings that led to the decertification of HGTC as a nursing facility. However, new federal rules governing Medicare and Medicaid participation for Long Term Care facilities went into effect on November 28, 2016 that contain provisions that would affect any HGTC recertification effort. Physical plant requirements under the new final rule at 483.90 include that a certified nursing facility must:

- Provide sufficient space and equipment in dining, health services, recreation, living, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's assessment and plan of care.
- Maintain all mechanical, electrical, and patient care equipment in safe operating condition.

- Conduct regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.
- For facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after November 28, 2016, bedrooms must accommodate no more than two residents.
- A separate bed of proper size and height for the safety and convenience of the resident.
- Each resident room must be equipped with or located near toilet and bathing facilities. For facilities that receive approval of construction from State and local authorities or are newly certified after November 28, 2016, each resident room must have its own bathroom equipped with at least a commode and sink.
- The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside.
- Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents.

The new rules at 483.90 do not change the existing requirements in 483.70 regarding existing § 483.70(a) "Life safety from fire" and § 483.70(b) "Emergency power." The Facility Condition Assessment did not include a compliance review of HGTC relative to the Life Safety Code. The Life Safety Code is a set of fire protection requirements designed to provide a reasonable degree of safety from fire. It covers construction, protection, and operational features designed to provide safety from fire, smoke, and panic. Facilities participating in the Medicare and Medicaid programs must comply with the Life Safety Code as part of CoP.

Chapter 5: Staffing Pattern and Administrative Support Assessment

Summary This chapter provides an overview of state and federal staffing requirements for certified nursing facilities, and identifies the current staffing available at HGTC. The facility would need to make significant changes to the current staffing at HGTC to meet new federal nursing facility CoP. This includes rebuilding a staff of Certified Nurse Assistants, maintaining required Director of Nurses and other nursing staff to meet federal requirements, as well hiring staff to manage key CoP requirements including an MDS Coordinator and administrative support staff to manage resident records, plan activities and provide other supports. ESH administrators report that HGTC is experiencing significant challenges in filling current staff vacancies and in attracting the quality of staff desired and needed to ensure quality care.

Approach/Methodology

In preparation for writing this chapter, the BHPC Team reviewed existing state and federal regulations regarding nursing facility staffing requirements, as well as literature available on recommended staffing patterns based on category of staff and staffing ratios. Requirements and recommendations were then compared to existing HGTC staffing to identify gaps.

Staffing Pattern and Administrative Support Assessment

State and Federal Staffing Requirements

The Virginia Administrative Code 12 VAC 5-371-200 sets out the staffing requirements for Nursing Homes in Virginia. The Code of Federal Regulations also sets requirements for staffing in order to receive federal reimbursement for eligible individuals. Federal approval of compliance is the determination of the contracted survey team, reached by observation, review of daily staffing reports, and interviews with staff, residents, and families. It is important to note that compliance with state staffing requirements does not ensure federal approval.

The table below compares the Virginia Administrative Code and the Code of Federal Regulations language on staffing requirements for nursing facilities.

TABLE 5-1
Virginia Administrative Code and the Code of Federal Regulations: Staffing Requirements for Nursing Facilities

Virginia Administrative Code and the Code of Federal Regulations: Staffing Requirements for Nursing Facilities		
Staffing Requirement	**12-VAC 5-371-200(A)**	**42 CFR Section 483**
Director of Nurses (DoN)must be an RN licensed by the state	X	X
Nursing Supervisor Designated by the DON	X	
RN at least 8 hours per day 7 days a week		X
Nursing staff of RNs, LPNs, and Certified Nursing Assistants (CNAs) sufficient to provide care to the residents of the facility	X	X
CNAs must be certified within 120 days of hire	X	
CNAs must be certified within 90 days of hire		X
The DoN will not act as the Supervisor or Charge Nurse in facilities with 60 or more residents	X	X

These regulations lay the foundation for the development of a facility staffing plan that effectively and efficiently provides the means for comprehensive and individualized care required for certification. While not explicitly stating acceptable staffing ratios, the intent is clear that staffing be adequate to maintain residents' health and welfare in a manner that comports with the clinical and quality of life requirements for nursing facilities. Though the federal and state regulations do not specify numbers, there are examples found in literature.

While not explicitly stating acceptable staffing ratios, the intent is clear that staffing be adequate to maintain residents' health and welfare in a manner that comports with the clinical and quality of life requirements for nursing facilities.

The National Citizens' Coalition for Nursing Home Reform, a non-governmental organization that provides information and leadership on federal and state regulatory and legislative policy development and models and strategies to improve nursing home care and life for residents (in 1995 and an updated version in 1998) recommends for every nursing facility:

- A full-time RN Director of Nursing
- A full-time RN Assistant Director of Nursing (in facilities of 100 beds or more)
- a full-time RN Director of In-service Education
- An RN nursing supervisor on duty at all times (24 hours, 7 days per week)
- Direct caregivers (RN, LPN, LVN, or CNA)
    - Day 1:5 residents
    - Evening 1:10 residents
    - Night 1:15 residents
- Licensed nurses (RN, LPN, or LVN) not assigned to direct care
    - Day 1:15 residents
    - Evening 1:20 resident

In 2000, CMS reported that the preferred minimum staffing level was when nursing home residents received three hours of total staff time per day -- two hours of nursing assistant time and one hour of licensed nurse time. The optimum staffing level, according to CMS, is one hour of licensed nurse time and three hours of nursing assistant time.

In 2001, CMS increased its recommendation to "4.1 mean total (nursing aides [NAs] plus licensed nurses) direct care hours per resident per day (hprd) and 1.3 licensed nurse hprd (.75 for registered nurses [RNs] and .55 for licensed vocational nurses [LVNs] [as] the minimum staffing levels associated with a lower probability of poor resident outcomes, such as weight loss and pressure ulcers (Kramer and Fish 1001)." These studies also "showed that 2.8 to 3.2 NA hprd, depending on the acuity level of the NH population, were necessary to consistently provide all of these daily care processes" ["care related to incontinence care, feeding assistance, exercise, and activities of daily living (ADL) independence enhancement (e.g., dressing)"].[13]

CMS directs surveyors to assess whether the facility being surveyed has the appropriate classifications of staff to meet the unique needs of the residents and to ensure the highest level of quality and well-being. Surveyors assess not only the numbers of staff but their level of preparedness to provide care in an individualized manner, and understanding of the concepts of dignity, respect, self-determination and choice inherent in the federal nursing facility survey elements.

In the table below are sample compliance questions that state contracted surveyors must answer as part of the CMS Medicaid certification process for nursing facilities.

TABLE 5-2
Sample Surveyor Questions for Nursing Facility Certification

Sample Surveyor Compliance Questions for Nursing Facility Certification
Does the facility have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and individual plans of care?
Does the facility provide services by sufficient numbers of licensed nurses and other nursing personnel, on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans?
Did the facility designate a licensed nurse to serve as a charge nurse on each tour of duty?
Does the facility use a registered nurse for at least 8 consecutive hours a day, 7 days a week?
Did the facility designate a registered nurse to serve as the director of nursing on a full-time basis?
Did the facility ensure that the director of nursing served as a charge nurse only when the facility had an average daily occupancy of 60 or fewer residents?

[13] Staffing Ratios in Nursing Homes, Carol Howe, MD, MLS, Arizona College of Medicine, Tucson, AZ

In addition, the surveyor is directed to answer the following questions via interview of licensed staff interviews and supervisory interviews:

Determine whether the licensed nursing staff are available to:

- Supervise and monitor delivery of care by nursing assistants according to resident's care plans.
- Assess resident condition changes.
- Monitor dining activities to identify concerns or changes in resident needs.
- Respond to nursing assistant request for assistance.
- Correct inappropriate or unsafe nursing assistant techniques.
- Identify training needs for nursing assistants.
- Assure there are adequate staff to meet needs of residents.
- Assure that staff are knowledgeable about the needs of the residents and are capable of delivering care as planned.
- Assures staff are appropriately deployed to meet needs of residents.
- Provides orientation for new or temporary staff regarding resident needs and interventions.
- Assures that staff are advised of all changes to care plans.

Nursing assistant staff are interviewed to determine knowledge of individual resident's needs:

- Provision of fluids and foods.
- Provision of turning, positioning, skin care for residents at risk for pressure ulcers.
- Provision of incontinence care.

Residents, family, other resident representatives are interviewed regarding:

- Staff response to request for assistance.
- Timeliness of staff responding to call lights.

Surveyors are asked to determine if issues are facility wide, cover all shifts, or are limited to certain units, shifts, or days of the week.

CMS survey requirements were revised in November 2016, and become effective November 28, 2017. These revised survey directives will have impact on nursing facilities throughout the country. The emphasis of the revisions is primarily around issues of resident independence, self-determination, privacy, and choice, all issues that HGTC was cited for when certification was terminated. [14] [15]

[14] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-03-08-2017.pdf
[15]https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/List-of-Revised-FTags.pdf

Staffing Patterns Assessment Certification Implications

Attracting and maintaining adequate staffing in nursing facilities is a critical issue throughout the country, and Virginia is no exception. HGTC faces unique challenges because since 2015 when HGTC was decertified, the composition of the staff has changed significantly, and would no longer meet certification requirements. The total number of individuals now available to staff HGTC would not pass a survey for number or category at this time.

There are many skilled and caring staff at HGTC, but the numbers are dwindling through attrition and inability to replace gaps in staff with appropriately skilled staff. The HGTC administrators report significant difficulty in recruiting qualified staff. Key informants attributed this to multiple factors including: HGTC is not generally seen as a desirable place to work, a reputation as a place one would not want their family to be placed, and even an internal culturally-held belief that once a patient is admitted, he or she will be at HGTC "forever.". Further, current staff are required to work overtime, further straining existing staff. The Director of Nurses notes that while it is very difficult to attract nurses with critical thinking skills and long-term care experience, she is working with a new Human Resources Director to develop a recruitment team, and she is leveraging the rotation of student nurses through the facility as a potential source of recruitment.

When the decision was made to relinquish Medicaid certification, CNAs at HGTC were replaced over time with non-certified direct care associates. The staff today do not meet the minimum requirements of certified nursing facilities, and would have to become certified or be replaced by CNAs. Nursing facility regulations require that CNAs successfully complete at least 75 hours of training and competency testing.

To meet nursing facility certification requirements, HGTC would need to develop a staffing plan based on a staff-resident ratio or use an hours per patient day methodology. HGTC would need to hire certain registered nurse administrative position(s) (such as an Assistant Director of Nurses and/or an In-service Director), clinical RNs and licensed practical nurses (LPNs), and CNAs. Although the nursing facility certification requirements do not address the need for psychiatric technicians specifically, nursing facilities are required to have staff that can address the special needs of residents, so HGTC would need to ensure a sufficient type and number of psychiatric personnel to meet the psychiatric needs of the residents. Both CNAs and psychiatric technicians would benefit from cross training to understand the needs of residents in both physical and behavioral health, including appropriate care for individuals who have dementia. Interviews with key informants revealed that many residents of HGTC require assistance with eating, so it may be necessary to include feeding assistants as another category of hire, or ensure sufficient CNA staff available to provide assistance at meal times.

Most nursing facilities employ a registered nurse coordinator to complete the required federal Minimum Data Set (MDS) assessments for all existing and new residents (conducted at regular intervals as well as whenever there is a change in patient condition), and submit the data to the CMS portal. While certified, HGTC employed a MDS Coordinator, but that person is no longer employed at HGTC. The MDS position would have to be replaced to ensure proper compliance with the MDS CoP. This MDS Coordinator position, like other administrative nursing staff, would not count as direct care staff. In addition, the nursing team requires the assistance of administrative support staff

to manage resident records, transcribe orders, schedule appointments, plan activities, and provide other support activities.

Further, regardless of certification, based on the needs of the patient population at HGTC, HGTC may want to consider hiring a consulting pharmacist to conduct drug regimen reviews, provide in-services, and participate in policy meetings.

Chapter 6: Certification and Funding Options

The following options fall into one of two categories. The first category includes certification options for HGTC that would facilitate either Medicaid or Medicare funding for services provided by HGTC. The second category includes options that have the potential to facilitate Medicaid funding for people currently served in HGTC that may be able to be served elsewhere in settings that allow Medicaid reimbursement. These options are not mutually exclusive and the Commonwealth may determine to pursue multiple options. In Chapter 7 we make recommendations based on our assessment of the options discussed in this chapter and in the context of findings from throughout this report.

Option A: Attempt HGTC Certification as a Medicaid Certified Nursing Facility

Having lost and then regained Medicaid nursing facility certification in 2011, DBHDS, ESH and HGTC have completed the process of implementing a corrective action plan to address survey findings. However, in the prior recertification experience, the duration from loss of certification to regaining Certification was approximately six months, and during the period of no certification, HGTC continued to operate as a nursing facility and to work on development and implementation of the corrective action plan intended to support the recertification effort. Since the 2015 survey and loss of Medicaid nursing facility certification, HGTC has not continued to operate as a nursing facility and has not been working toward a corrective action plan. The effort at this point would be an effort to gain certification, rather than an effort to merely address the 2015 survey findings.

Such an effort would require development and implementation of a comprehensive plan to ensure compliance with all of the CoP, including new CoP some of which become effective in November 2017 and others which become effective in November 2019. Key elements of such a plan are summarized in the table below.

TABLE 6-1
Key Elements of a Medicaid Nursing Facility CoP Compliance Plan

Key Elements of a Medicaid Nursing Facility CoP Compliance Plan	
CoP Gap Analysis	Complete a review and gap assessment of all nursing facility Conditions of Participation, not just those that were identified as deficient in the 2015 survey, and implement and monitor action plans to address identified gaps.
Staffing	Develop and execute a staffing plan that establishes target staffing levels and staff/resident ratios or an hours per patient day methodology, re-establishes certified nursing assistants with appropriate training, re-establishes a position for a registered nurse to perform as the Minimum Data Set Coordinator; establishes the needed training requirements for different staff, and outlines a recruitment strategy that addresses the recruitment challenges faced by Eastern State Hospital and Hancock Geriatric Treatment Center. Staff would need to be in place in order for CMS to survey.

Key Elements of a Medicaid Nursing Facility CoP Compliance Plan	
Facility	Identify the physically distinguishable unit or units within the HGTC facility and number of beds targeted to become a designated nursing facility, for appropriate nursing facility level of care admissions only.
Relocate Patients	Identify and relocate patients from the target nursing facility footprint within HGTC that cannot be served in a nursing facility compliant with the Conditions of Participation, or who do not need a nursing facility level of care. Conversely, identify any patients with a nursing facility level of care that can be served in a CoP compliant nursing facility and relocate them, if necessary, to the designated unit or units.
Physical Plant	Address certain physical plant deficiencies, described in detail in Chapter 4. Of particular concern are the systems in Building 13 which need immediate attention. Also consider options for modernizing the designated nursing facility to meet the programmatic and therapeutic needs of the resident population.
Model of Care/ Programming	Develop a model of care and associated programming consistent with the nursing facility resident population needs. Some of this will be driven by the CoP but HGTC would have specific programming needs based on its population.

If such a certification effort were successful, one of the benefits would be the ability to capture Medicaid reimbursement for Medicaid eligible residents of the nursing facility. One of the potential downsides is that the certified nursing facility unit(s) and beds would not be available to satisfy other competing demands for beds at ESH and HGTC that exist due to both demographics and the statutory and regulatory environment.

The BHPC Team's assessment is that the key challenges to success of this option include:

- Recruiting and retaining adequate staff to meet staffing plan requirements.
- Ensuring that the culture of the facility is appropriate to a nursing home, rather than to an acute care treatment setting.
- Finding capacity in the system to relocate patients not appropriately served in a nursing facility.
- Restricting admission to only nursing facility-appropriate individuals.
- Demonstrating that HGTC, while housed on the campus of, sharing facilities with, and taking admissions from a psychiatric hospital (ESH), is not an IMD.

This last challenge may be the hardest to overcome, and may be insurmountable. The HGTC characteristics that identify it as an IMD are not ones easily subject to change including: being under the jurisdiction of the state's mental health authority, being maintained primarily for the care and treatment of individuals with mental diseases, and having more than 50% of all patients admitted based on a need for institutionalization as a result of mental disease. It is difficult to imagine a successful argument to CMS that will overcome its concern that HGTC is an IMD. However, there may be an apparent contradiction in federal statute that the Commonwealth may choose to explore

with CMS. While 1905(a)(14) allows that nursing facility services can be covered for older adults in an IMD, 1919(a) says no nursing facility can be certified if it is an IMD. The 1919(a) provision was cited by the survey team in 2015 as the basis for the finding that HGTC did not meet the definition of a nursing facility. A decision to decertify is reviewed and approved by CMS Central Office, so this finding and its statutory and regulatory basis was reviewed and approved by the Central Office based on a recommendation from the CMS Regional Office and the state survey agency resulting from the 2015 survey.

Option B: Attempt Certification as a Medicare Certified Psychiatric Hospital

Historically, HGTC maintained a separate certification as a Medicaid nursing facility from ESH's certification as a psychiatric hospital, which ESH lost effective April 2016 as a result of deficiencies identified during a survey to assess compliance with the Medicare CoP for psychiatric hospitals. If ESH attempts recertification as a psychiatric hospital, there is an option to include HGTC within that certification.

The survey resulting in loss of ESH certification found a continued systematic failure to provide medical records that document the treatment given to patients and the facility staff who provided the services. The report referenced the following as evidence of noncompliance:

- Treatment interventions were stated in vague terms, consisted of a long list of groups that did not relate to the short-term goal or were non-individualized generic discipline functions rather than directed at specific interventions.
- The facility failed to develop Master Treatment Plans that identified patient-centered, short-term goals in observable, measurable, behavioral terms.
- The facility failed to provide active treatment or alternative treatments for two of the nine active patients who were not motivated or cognitively able to remain engaged in active treatment.
- Failure to provide patients with needed nursing care and failure to guide nursing staff in addressing individual patient care needs.

ESH and DBHDS have experience with the psychiatric hospital certification process and CoP based on ESH's prior and recent certification, and the psychiatric hospital certification maintained by other DBHDS facilities. The CoP for hospitals is at 42 CFR 482, including special CoP for psychiatric hospitals at 42 CFR 482.60-62.

ESH would be required to seek initial certification, meaning a full enrollment and survey process must be completed, rather than the process for periodic survey or partial survey. ESH's request for readmission must include justification indicating that the reasons for termination no longer exist. At the time of the survey, ESH inclusive of HGTC, would need to be in full operation and providing services to patients including furnishing all services necessary to meet the applicable definition, demonstrate the operational capability of all facets of its operations, and provide reasonable assurance that the deficiencies that caused termination will not recur.

ESH, inclusive of HGTC, would need to determine the physically distinguishable part of the institution for which to pursue certification, and complete a gap analysis between its operations and the hospital CoPs and the special CoPs for psychiatric hospitals including special medical record

requirements and special staffing requirements. A key element for specifying the "distinguishable part" is that it should include only beds specifically for patients who need active treatment and for whom treatment may be reasonably expected to improve their condition. The survey will include assessment of CoPs for the non-distinguished part only as it affects the health and safety of patients in the distinct part.

If the effort to obtain ESH certification as a psychiatric hospital were successful, one of the benefits would be the ability to capture Medicare reimbursement for Medicare covered patients in the hospital. Another benefit would be that the effort to meet and maintain the CoP would facilitate improvements in quality of care.

Similar to the nursing facility certification option, recruiting and retaining adequate staff to meet staffing requirements could present a challenge to a psychiatric hospital certification effort, as could be relocating patients who are not appropriate for active treatment. The BHPC Team did not review or assess the ESH psychiatric hospital certification history for this report, so we cannot determine what challenges prevented remediation of the survey findings via a plan of correction, nor their severity and the feasibility of overcoming them.

A consideration for whether to pursue certification of HGTC as part of an ESH psychiatric hospital certification should ultimately be determined by how the Commonwealth wants to use its state facilities and funding. Nationally, there have been historic changes in how state psychiatric hospitals are utilized, the types of patients they serve, and the services they provide. From the 1950s through the 1980s, state psychiatric hospitals provided services to many elderly individuals, many with dementia and other brain disorders that are no longer the focus of treatment in state psychiatric hospitals across the country. For example, in 1970, patients age 65 and older represented 29.3 percent of residents in state and county psychiatric hospitals, and there were 81,621 patients (24 percent) with a diagnosis of organic brain syndrome (of which 45,811 were age 65 and older). Today, due to coverage for older adults under the Medicaid and Medicare programs implemented in the late 1960s, many elderly individuals with mental illness receive care in their own homes or in nursing homes or other residential providers that specialize in Alzheimer's and other dementia services. In 2014, only 8.8 percent of state and county psychiatric hospital patients were age 65 and older.[16]

From the 1950s through the 1980s, state psychiatric hospitals provided services to many elderly individuals, many with dementia and other brain disorders that are no longer the focus of treatment in state psychiatric hospitals across the country. In 1970, patients age 65 and older represented 29.3% of residents in state and county psychiatric hospitals. In 2014, only 8.8% of state and county psychiatric hospital patients were age 65 and older.

[16] Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014, National Association of State Mental Health Program Directors, August 2017, Ted Lutterman, Robert Shaw, William Fisher, Ph.D., Ronald Manderscheid, Ph.D. Available at http://www.nri-inc.org/media/1319/tac-paper-10-psychiatric-inpatient-capacity-final-09-05-2017.pdf

Option C: Develop Nursing Facility Capacity for Geropsychiatric Clients Outside of HGTC and ESH

In other states and even within Virginia, there are Medicaid certified private nursing facilities that serve older individuals with psychiatric diagnoses and with neurocognitive conditions with behavior issues. DBHDS, ESH, and HGTC can explore options for further developing the capacity for long term services and supports (LTSS) for this population outside of the state hospital system. This would involve developing and implementing strategies to support private nursing facilities to successfully admit and care for individuals who no longer need the acute care offered at ESH and HGTC.

There are a host of reasons that private nursing facilities might avoid admitting residents with SMI or neurocognitive with behavior issues, and under this option, the task is to identify those reasons, and develop mechanisms to support private nursing facilities in successfully dealing with these reasons while mitigating risks to the nursing facilities. What follows is a list, not exhaustive, of some of the reasons and risks for resisting admission paired with potential strategies to mitigate the risks and increase placement of older individuals with a need for nursing facility level of care and who have SMI or neurocognitive conditions and behavioral issues into private nursing facilities.

TABLE 6-2
Mitigation Strategies to Increase Placement of Geropsychiatric Individuals in Private Nursing Facilities

Issue	Potential Mitigation Strategy
Psychotropic Medications	Provide training to private nursing facility operators on regulations and acceptable use of medications as part of a treatment plan, ordered by a physician, and with resident consent. Training would address: restrictions on using psychotropics as a chemical restraint, for patient discipline, or for staff convenience; and appropriate treatment planning and monitoring of that plan; and a full understanding of the regulatory environment in which use of medications must be used to help residents attain or maintain the highest practical level of wellbeing, or to ensure physical safety of the resident or other residents. Provide support to private nursing facility operators in appealing CMS survey findings that the facility has used medications inappropriately, when the appeal has merit.
Staffing	Partner with other agencies to develop workforce initiatives that create a pipeline of qualified staff needed to operate a nursing facility, and in particular one that is attempting to serve difficult-to-place populations.
Staff Training	Provide support teams in communities that offer training for staff in privately operated nursing facilities for managing and de-escalating difficult resident behaviors.

Issue	Potential Mitigation Strategy
Cost	Create new reimbursement options to support the need for increased staffing ratios for private facilities that admit patients with challenging behaviors or the need for more active supervision, including those that might be associated with dementia.
Transportation	Provide transportation options to support private nursing facility operators in transporting residents who become agitated with the process and the unfamiliarity that frequently accompanies transportation from the nursing facility to other locations. Develop protocols that minimize unnecessary patient transport, for example, conduct assessments in nursing facilities.
Resident Refusal of Treatment	Develop and provide training and provide technical assistance for private nursing facility operators in managing situations where residents or their guardians refuse treatment.
Treatment Plan	Provide training and technical assistance to privately-owned nursing facilities on developing, implementing and monitoring person-centered treatment plans. This would include development of transition plans documenting the specific services and supports needed to successfully transition an individual from an inpatient acute setting to a nursing facility setting.
Escalation Management	Provide "on-call" back-up to privately operated nursing facilities to assist them in managing and de-escalating difficult resident behaviors.

While all of the strategies identified above require an investment, they support serving individuals in a nursing facility eligible for Medicaid reimbursement as long as the nursing facility was developed and managed in such a way as to ensure that it did not become an IMD.

If there is no capacity in the Commonwealth to leverage existing nursing facilities, an option is to work with a private operator(s)to develop nursing facility capacity with a model of care and operating protocols for difficult-to-place residents. This model of care would have to satisfy the nursing facility CoP while also being properly staffed to handle difficult-to-place populations (including geriatric patients with a psychiatric history and/or current behavioral challenges).

An example of a state that has pursued this option is Connecticut, where the State's Medicaid program worked with a private contractor to develop a nursing facility that specializes in serving individuals who are recent parolees from correctional facilities, and individuals who have had a history of psychiatric conditions. The Connecticut facility received federal certification as a nursing facility for Medicare and Medicaid in 2017. Several points from the State's experience with this nursing facility are instructive for Virginia.

Connecticut first pursued the development of this specialized nursing facility to address a system capacity challenge. A Connecticut newspaper story when the facility opened reported, "Inmates eligible for release often languished in prison, as nursing homes refused referrals from the

Department of Corrections and the Department of Mental Health and Addiction Services (DMHAS). In 2011, the Malloy administration sought a facility operator for 60 West, and SecureCare Options LLC submitted the winning bid."

The facility was developed and opened and residents were admitted. However, in 2015, CMS upheld a 2014 state survey and certification decision denying Medicare/Medicaid certification to the nursing facility. At that time, CMS found that the Department of Correction patients in the facility did not meet Medicare program guidelines. CMS considered the residents to be "inmates" living in a secure unit with no medical justification to support the (secure) placement. Maintaining security over the residents, which included a significant number of sex offenders, was a condition that had been established by the mental health, social service and correction departments in developing the facility.

In support of viewing residents as inmates (and therefore excluded under Medicaid statute from federal reimbursement for all Medicaid services), CMS found that individuals who no longer met the criteria for release to the nursing facility would return to the custody of the Corrections system. Further, CMS found that these and other practices did not comport with a long-term care facility's duty to "protect and promote resident rights to a dignified existence, assure resident transfer and discharge rights and assure rights to be free from restraints imposed for purposes of discipline or convenience and not required to treat medical symptoms." The State appealed the CMS decision, and Connecticut provided a state-only reimbursement for residents during the appeal.

The State was ultimately successful in its appeal gaining certification in June of 2017, in part through modifications in the facility's operation. As operated today, Corrections-involved individuals who are served in 60 West are clearly parolees, not inmates. For example, residents are not required to live at 60 West as a condition of parole. Staffing is based on resident need, not concern for security. All residents' rights are assured as required under the federal Conditions of Participation for nursing facilities. This includes the right of individuals who improve as a result of the rehabilitation or other services provided at 60 West to be discharged into the community. Residents can move to other facilities as well. The State has worked to assist individuals to relocate into the community under Money Follows the Person.

60 West is open and available to serve anyone from the public, as well as individuals referred from the Corrections system or from the state's mental health system; however, the large majority of residents come from individuals who are paroled or are referred from within the mental health system. The State is careful to ensure that the balance of the total resident population does not cause the nursing facility to be an IMD.

Regarding the geropsychiatric population at 60 West, the State indicated this was mostly a population needing assistance due to dementia. 60 West includes a dementia unit that, again, operates pursuant to federal nursing facility CoP.

It appears that Connecticut achieved certification for 60 West by modifying its program design to ensure that the facility can operate in full compliance with the Medicare/Medicaid CoP. The State is pleased with how well 60 West is operating, including that it appears to be a high-quality nursing facility that provides supportive care to residents. It is helping to fill a system capacity need for hard to place individuals who need nursing facility services. The State's system goals, however, do not include building additional specialized facilities around the State. The preference is to continue to

place as many individuals as possible within the larger long-term services and supports (LTSS) system in the State, and both State systems (corrections and mental health) are encouraged to seek other placement before turning to 60 West. The State hopes that the success of 60 West will help other nursing facility operators to understand that parolees and geropsychiatric residents can be admitted and properly served within the regular nursing facility environment.

An important note, there was and continues to be community concern over having 60 West operate in the community. While the public protests and concerns have eased with the successful operation over the past five plus years, there is still on-going litigation that relates in part to whether property values were impacted in the area.

Replicating this option in Virginia would not be a quick fix. Finding the right nursing facility provider to work with, securing bricks and mortar or constructing a new facility, developing a common vision, and securing state licensure would take considerable time and funding. However, it is one option to consider for accessing Medicaid funding for this population in need of care.

Regardless of whether leveraging existing private nursing facility capacity or developing new, another potential benefit of this option is the inclusion of these individuals in Virginia's Managed Long-Term Services and Supports system. Medicaid eligible individuals living in nursing facilities, with some exceptions, are included in Virginia's Managed LTSS program wherein they are required to enroll in a Medicaid Managed Care Plan which is responsible for an integrated delivery model inclusive of medical services, behavioral health services, and LTSS. Current excluded populations include certain specialized settings including the state facilities of Piedmont, Catawba, and HGTC. Under this scenario, there is both Medicaid reimbursement and the ability to include the Medicaid Managed Care Plans in identifying ways to incentivize privately owned nursing facilities to accept and serve individuals coming out of HGTC (and other DBHDS facilities).

Another potential benefit of this option is the inclusion of these individuals in Virginia's Managed Long-Term Services and Supports system. Medicaid eligible individuals living in nursing facilities, with some exceptions, are included in Virginia's Managed LTSS program wherein they are required to enroll in a Medicaid Managed Care Plan which is responsible for an integrated delivery model inclusive of medical services, behavioral health services, and LTSS. This would provide Medicaid reimbursement and the ability to include the Medicaid Managed Care Plans in solutioning for ways to incentivize privately owned nursing facilities to accept and serve individuals coming out of HGTC.

Virginia's Managed LTSS program, Commonwealth Coordinated Care Plus, is a new program and part of significant changes in how DMAS is organizing and paying for the care of Medicaid eligibles age 65 and older, and adults and children with disabilities. Further exploration of the option of leveraging existing nursing facility capacity or developing new capacity should be undertaken in partnership with DMAS- both as a means to support success of the Commonwealth Coordinated Care Plus program and to ensure that in developing the option there is no inadvertent creation of an IMD or other barrier to Medicaid reimbursement.

Option D: Develop Community Based Long Term Services and Supports Capacity

With the increasing focus over time on independence, self-determination, privacy, choice, and comfortable home-like atmosphere, there has also been an increased focus across the country in the development of community-based options for individuals needing a nursing facility level of care to receive services outside of the nursing facility setting. Across the country, State Medicaid agencies have engaged in rebalancing initiatives to help move people, and money, from institutions into community settings, and to prevent people from entering nursing facilities in the first place.

One of the drivers for rebalancing was the 1999 *Olmstead* Supreme Court Decision which found that people with disabilities have a right to receive state funded supports and services in the least restrictive setting appropriate to their needs, most often meaning in the community rather than an institution. The *Olmstead* decision only involved one type of institution, which was a psychiatric hospital. However, courts quickly made clear that *Olmstead* applied to all state and Medicaid funded institutions, including nursing facilities. The *Olmstead* Decision created community integration requirements that have subsequently been reinforced through law and regulation, the calculation that home and community based services (HCBS) are typically less expensive than comparable institutional care, and beneficiary preference for HCBS.[17]

The Medicaid program has historically had a bias for nursing facility placement as nursing facility coverage is a mandatory Medicaid State Plan service, while providing long-term services and supports to Medicaid eligibles in the community has required states to pursue waivers. CMS now strongly encourages states to shift from reliance on institutional care to home and community based services. And states are now using federal funding and flexibility to expand HCBS including: participating in the State Balancing Incentive Program, implementing Money Follows the Person programs, using new Medicaid State Plan options to provide HCBS, and building incentives into their managed LTSS programs to increase beneficiary access to HCBS. Virginia's Commonwealth Coordinated Care Plus program may be a vehicle not only for Medicaid reimbursement for HGTC residents who can be moved into privately owned nursing facilities, but also for Medicaid reimbursement for HGTC residents who can be transitioned to HCBS services to meet their nursing facility level of care need.

Rebalancing initiatives have required investments in community based long term services and supports that allow people to live in the least restrictive setting possible while getting home and community based services. As part of a separate project, the Department of Behavioral Health and Developmental Services has engaged HMA to develop a comprehensive plan for the publicly funded geropsychiatric system of care in Virginia. This report is expected to describe the current community capacity for geropsychiatric services, and to the extent possible provide options and recommendations to the Commonwealth about the appropriate array, costs and revenues of community-based and state-operated inpatient hospital services for Virginia's future geropsychiatric system of care, including implications for HGTC.

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[17] Measuring Long-Term Services and Supports Rebalancing, February 2015, MaryBeth Musumeci, The Henry J. Kaiser Family Foundation. Available at https://www.kff.org/medicaid/fact-sheet/measuring-long-term-services-and-supports-rebalancing/

Chapter 7: Recommendations

Summary The BHPC Team recommends pursuing a combination of approaches to increase community based long term services and supports in lieu of attempting to recertify HGTC as a Medicaid certified nursing facility. This recommendation is premised on a goal of providing geropsychiatric individuals and those with neuro-cognitive conditions with behavior issues the appropriate level of service, and with Medicaid as a participant payer. The assessment suggests that HGTC may face an insurmountable challenge to achieving nursing facility certification based on the CoP which specify that a nursing facility may not be an IMD. The Team also recommends consideration, in the context of decision making across the Commonwealth's entire geropsychiatric system of care, of pursuing Medicare certification as a psychiatric hospital for HGTC as part of ESH is a decision is made to seek such certification for ESH. This certification effort would act as a forcing factor for quality improvement and allow Medicare billing.

In identifying and assessing the Commonwealth's options for how to proceed with certification and funding for HGTC, the BHPC Team's foundational principle has been that goal is to provide geropsychiatric individuals and those with neuro-cognitive conditions with behavioral issues the appropriate level of service, and with Medicaid as a participant payer. Under any option, to provide the right level of service will mean developing capacities specific to distinct populations and their needs that can be effectively served by a defined model of care. Also under any option, to ensure that Medicaid is a participant payer, the Commonwealth will need to be cognizant that it does not develop capacity that is not Medicaid reimbursable due to the IMD exclusion.

HGTC is one part of the Commonwealth's system of care for meeting the needs of older Virginian's with psychiatric and neuro-cognitive conditions. Ultimate decisions about how to proceed with HGTC should be made in the context of that larger system and a determination is needed by the Commonwealth about how it wants to leverage its state operated psychiatric hospital system, and what investments it is willing to make in developing community based options for the geropsychiatric population and the population with dementia.

The current environment, inclusive of the culture of the system of care and state regulatory and statutory drivers, has resulted in a situation where state operated facilities are the only option for low income older Virginians with significant psychiatric and neurocognitive conditions. With the competition for beds at HGTC, and with the growing older population, this situation is not sustainable.

Recommendation 1

Do not pursue Medicaid nursing facility certification for HGTC. The BHPC Team's assessment is that despite the fact that HGTC was able to achieve and maintain Medicaid nursing facility certification over decades, the CoP assert that a nursing facility may not be an IMD, which HGTC is. Whatever factors allowed HGTC to maintain its nursing facility certification previously

are less likely to be a successful path forward now that the question has been called by the 2015 decertification, and given the new federal nursing facility regulations. Further, the demand for beds at ESH and HGTC for non-nursing facility services and populations has increased significantly creating pressure on the system for rapid access to beds at the state psychiatric hospitals. Certification of beds at HGTC as nursing facility beds would eliminate their use for satisfying that need. Because of the complexity of the IMD regulations and longstanding misunderstandings, if the Commonwealth chooses to attempt to overcome the IMD issue and explore the apparent contradictions in statute, we recommend that before making further investments, the Commonwealth engage CMS' Central Office for formal guidance designed to protect against future audit as well as provide support in a future certification action.

Recommendation 2

Leverage existing privately owned nursing facility capacity or support the development of new privately-owned community based nursing facility capacity that is capable of meeting the needs of stable geropsychiatric residents and individuals with neuro-cognitive conditions with behavioral issues. In doing so, DBHDS should work with the Department of Medical Assistance Services to ensure that any such nursing home capacity is not developed in such a way that it meets the definition of an IMD- it must not be for the primary purpose of providing diagnosis, treatment or care of persons with mental diseases if larger than 16 beds.

Consider developing and providing supports to incentivize the development and operation of this community capacity such as enhanced rates, technical assistance to help the nursing facility operator develop a model of care appropriate to the population and train staff to implement psychiatric models of care designed to address aberrant behaviors, offer medication management, maximize the least restrictive methods for the individual's functioning, provide specialized interventions to assist the nursing facility with managing acute behavioral events that introduce the risk of a resident having to be discharged and placed at HGTC, and develop programming to support the transition from HGTC to the nursing facility such as the RAFT program that operates in Northern Virginia with the support of the Area Agency on Aging.

RAFT stands for Regional Older Adult Facilities Mental Health Support Team, and it is a grant funded program that provides evaluation, care planning, case management with physicians and agencies, medication monitoring, therapy, 24-hour consultation to facilities, and mental health training for nursing facility and assisted living facility staff. RAFT provides these services to help individuals who need assisted living or nursing home level care and are ready to be discharged from a state psychiatric hospital transition to those settings, and to help prevent those who are at risk of going to a state psychiatric hospital from going there.

Work with DMAS to leverage the possibility of the Commonwealth Coordinated Care Plus program Medicaid Managed Care Plans' participation in identifying ways to develop new and use existing private nursing facility capacity.

Recommendation 3

Develop community based long term services and supports capacity other than nursing facility capacity that is capable of meeting the needs of stable geropsychiatric residents and

individuals with neuro-cognitive conditions with behavior issues. Similar to the IMD caution related to developing nursing facility capacity, this same caution exists for other forms of congregate housing such as Assisted Living Facilities. DBHDS has separately engaged HMA to create a Virginia Geropsychiatric System of Care Report that will present a comprehensive plan for the publicly funded geropsychiatric system of care in Virginia including the appropriate array of community services including the costs and revenues for each option. The BHPC Team recommends that the Commonwealth consider the options and recommendations in the forthcoming report for developing community based long term services and supports.

Recommendation 4

Consider pursuit of Medicare certification as a psychiatric hospital at HGTC. Whether or not to pursue such a certification needs to be considered in the context of the larger system, but such certification would have the benefit of allowing billing to Medicare for Medicare covered services. Achievement of such certification should also have the benefit of improving quality of care (i.e. active treatment) and documentation. There is already an effort underway at HGTC to solve the problem of having mixed populations within a unit in order to focus the model of care and staffing within a unit to meet the needs of the population. This effort would need to sustain in order to ensure clinical quality and to meet certification requirements. If ESH attempts recertification as a psychiatric hospital, there is an option to include HGTC within that certification.

Recommendation 5

Develop end of life planning and care capabilities at HGTC including palliative care and hospice options. Irrespective of certification, there is a need for these services at HGTC based on the age and complexity of the population.

Recommendation 6

Regardless of certification related decisions, implement repairs and improvements to HGTC as recommended by the facility condition assessment and detailed in Appendix A. Similarly, complete a self-assessment of compliance with the Life Safety Code, and remediate identified gaps.

Recommendation 7

Ensure current planning regarding moving patients out of HGTC to an Assisted Living Facility takes into consideration IMD provisions. During interviews with key informants at ESH, we learned that DBHDS plans to purchase an assisted living facility (ALF), and to move HGTC residents ready for discharge to this assisted living setting with the belief that the facility will receive Medicaid funding for the services for these individuals. While IMD status for an assisted living facility is not a barrier to any required federal certification (CMS does not have CoP for ALF), individuals under the age of 65 who reside in an IMD are not eligible for any Medicaid reimbursement. The discharge of HGTC patients to an ALF will relieve congestion at HGTC, but care should be taken if the state desires Medicaid funding for individuals served in the ALF. In addition, an ALF that is an IMD might face challenges in meeting other Medicaid requirements (e.g., characteristics of home and community based settings of care for HCBS waiver services) or might

face challenges under the Americans with Disabilities Act and the *Olmstead* Supreme Court decision regarding unlawful segregation of individuals with disabilities. The BHPC Team recommends consultation with the Medicaid program and other experts to ensure that alternative strategies maximize the likelihood of financial viability.

Conclusion

As outlined in this report, the Commonwealth's ability to achieve Medicaid certification of HGTC as a nursing facility may be severely jeopardized by its status as an IMD. Further, the current population of HGTC is not wholly comprised of individuals who have a nursing facility level of care, and there is a competing demand for HGTC beds. The recommendations in this report focus on options that will result in getting HGTC patients with a nursing facility level into appropriate settings that will allow Medicaid to participate as a payer, and which may have the further effect of easing the pressure on HGTC and ESH for bed availability. None of these recommendations provide any immediate relief, and require planning and investment. HGTC is part of a larger system, and its capacity and use affects that larger system. In assessing this report and making any subsequent decisions about HGTC, we recommend consideration of the impact of those decisions in the context of the broader system as a means to ensure that state resources, both facilities and funds, are aligned with the Commonwealth's goals and priorities for serving the geropsychiatric population in Virginia.

Appendix A: Facility Condition Assessment Deficiencies Report on Hancock Geriatric Treatment Facility

OLSHESKY DESIGN GROUP, LLC
212 SOUTH HENRY STREET, THIRD FLOOR
ALEXANDRIA, VA 22314
703.548.0179,PH 703.548.2734, FX
ODESIGNGROUP.COM

IV. Deficiencies Report on the Hancock Geriatric Treatment Center, Building 1, Hospital

October 31, 2017

Eastern State Hospital
Williamsburg, VA

The Hancock Geriatric Treatment Center, HGTC, was built for Geriatrics in 2008, and it is the newest Geriatric facility out of the four hospitals that were assessed. It is 116,000 sf. The hospital was designed for 150 geriatric patients. Changes have been made to accommodate space for Temporary Detention Order patients, TDO's. Currently, as of 7/17/17, there were 80 geriatric patients in Pods 2 and 4 only. Temporary Detention Order patients are now in Pods 3 and 5. As TDO patients need a different physical environment than the Geriatric patients this has posed some issues for Hancock Geriatric Treatment Center. In some cases TDO patients reside in the Geriatric wings temporarily, which can cause a disturbance to the Geriatric patients.

This hospital is one -story. Geriatric patients can easily access the outdoor courtyards, which are surrounded by hospital wings. HGTC won an Architectural Design Award when completed.

Based on RS Means and an HHS Study[1], done in 2014 the price per square foot to rebuild this facility is $339.10 per sf which includes an escalation to 2017 dollars. This does not include equipment, furnishings or land. The Replacement Cost to rebuild this facility would be $49,976,631. This includes 5% demolition added to the cost, 10% for Architecture and Engineering fees, and 10% for site work. The total deficiencies are $277,242. If an additional $100,000 is added to the deficiency cost for two items needing a Comprehensive study the total Deficiencies Cost is $377,241. The Facility Condition Index is 0.005 or less than 1% and the Hospital is considered in good condition.

A. SUBSTRUCTURE: Foundations and Basement Construction
Foundation: Appears in Excellent Condition. It was built in 2008. The foundation is concrete block with a life expectancy of 50 years and on a concrete footing, life expectancy of 75 years. If well maintained it could last longer.
On Grade Slab: Slab on grade appears in excellent condition. It was built in 2008. It has a life expectancy of 50 years. If well maintained it could last longer.

[1] HJR 16: State Operated Institutions, Building *and Operating a 16 Bed Inpatient Facility*, Prepared by Sue O'Connell, Research Analyst for the Children, Families, Health and Human Services Interim Committee, May 2014

A value of Deficiencies: $0.00

B. EXTERIOR ENCLOSURE:
B10: SUPERSTRUCTURE:
Roof Construction:
Excellent Condition. It was built in 2008. The roof construction, metal joists supporting a metal deck with rigid insulation on top has a lifespan of 30 years. If well maintained it could last longer.
Structure: Structure appears to be in excellent condition. It is metal joists supported by steel I Beams. The structural system has a lifespan of 75 years. If well maintained it could last longer.

B20: EXTERIOR ENCLOSURE: Exterior Walls, Windows and Doors:
Generally in very good or excellent condition.
Exterior Wall: The mortar joints and brick are in excellent condition. The brick life expectancy is 75 years and can last much longer if well maintained. The fiber cement siding is in excellent condition.
Exterior Windows:
Exterior windows are in very good condition.

Exterior Doors:
Generally in very good condition.

B30: ROOFING: Roof Coverings and Openings
Roof Coverings: The roof membrane, rubberized EPDM, membrane flashings and sloped insulation are in excellent condition. It was installed in 2008 and has a 20 year lifecycle.

B Value of deficiencies: $0.00

C: INTERIORS
C10 &C20 : INTERIOR CONSTRUCTION & STAIRS:
Stair to Roof:
Current Roof access stair is a Ship's Ladder without a Safety Cage. The Ship's Ladder should have a safety Cage. There should be standard run and riser stairs to the roof, like the stairs to the roof in most other buildings on campus, including Building 13, to allow mechanic access to the roof. There is mechanical equipment that needs periodic servicing on the roof. Tools, hoses and equipment need to be carried to the roof, which is very difficult to do, if not impossible, with a Ship's Ladder. The round rungs on the ladder are slippery when wet.
There is room to install an inclined ladder with the base at least 5'-0" in front of the ships ladder current location. The inclined ladder would need to include treads and a handrail for safety. This would make access to the roof with tools easier.

C Value of Interiors Deficiencies: $7,678.80

D: SERVICES
D20: PLUMBING
D2013 Plumbing Fixtures: Patient Tubs
The Patient Tubs leak at the door seal.. The Tub seal for the Liberti tubs has failed. The company is no longer in business. Alternative seals have been tried, but have not worked.

RECOMMENDATION: Replace all eight, 8, tubs with RANE, which is in the Adult Mental Health Hospital and are working fine.

D2013: Plumbing Fixtures, Hose Bib:
Hose bibs need to be installed on the roof to periodically clean the Air Handling Unit coils during the year.
RECOMMENDATION: The Humidifiers are no longer being used. A study was completed and it was determined they are no longer needed. The Humidifiers could be removed and the water that is piped to the humidifiers could be used for a hose bib.

D30: HVAC
D30 HVAC Distribution Systems, CVPC Piping
The CVPC piping is sagging and it has warped in some cases, as this is visible in the Mechanical Room.

RECOMMENDATION: Add additional hangers in the Mechanical Room. Hangers should be no greater than 4'-0" apart.

D30 HVAC System
In general we did hear complaints of rooms being either too hot or too cold, and the users of the space have no way of moving the thermostat temperature. We understand that this is controlled by B&G and they can make adjustments to the various offices. To be done in-house.

D30- Nutrition Room Ventilation: There is not enough ventilation in the Nutrition Room, RM 223 in Pod 2, and the similar room in the other three pods. The Nutrition Room is small and has a Kitchenette in it, and heat is generated by the Refrigerator.

RECOMMENDATION: Comprehensive Study to determine if another duct, or a larger duct needs to be added to this room.

D Value of Services System Deficiencies: $119,563.00
NOTE: A Comprehensive Study needs to be done to determine the size of the duct needed for the Nutrition Rooms.

E10: EQUIPMENT
E10 Equipment, Jib Crane: A jib crane needs to be installed to move heavy equipment from the Loading Dock on and off the roof. Currently, the ships ladder is limited access for equipment to the roof. The roof hatch also limits the size of equipment to the roof.

RECOMMENDATION:
There is a base on the roof, near the Loading Dock for the Jib Crane. The jib crane needs to be installed.
Value of Deficiency: Comprehensive Study to be done to determine size of jib crane.

E10 Equipment, Nurses Call System:
The Nurses Call System has not been working. It was explained that there have been shorts in it. Also, the Nurses Call System could be used a ligature device.

RECOMMENDATION: Remove the current Nurses Call System.
Option 1: Install a hard wire system that would be more expensive than a wireless system (based on FICAS report, $300,000 to $400,000)
Option 2: The ESH staff have talked to four vendors and they are in favor of purchasing a wireless system, which would cost approximately $110,000.
Option 2 has been included in the Cost Estimate at the request of the Hospital. A $40,000 contingency has been added.

E. Value of Equipment Deficiencies: $150,000
NOTE: A comprehensive Study needs to be done to determine the size of Jib Crane needed.

Total Value of all Deficiencies: $277,241.80
Note: The two Comprehensive studies need to be completed to determine the cost of ventilation to the Nutrition Rooms and the Jib Crane to be installed.

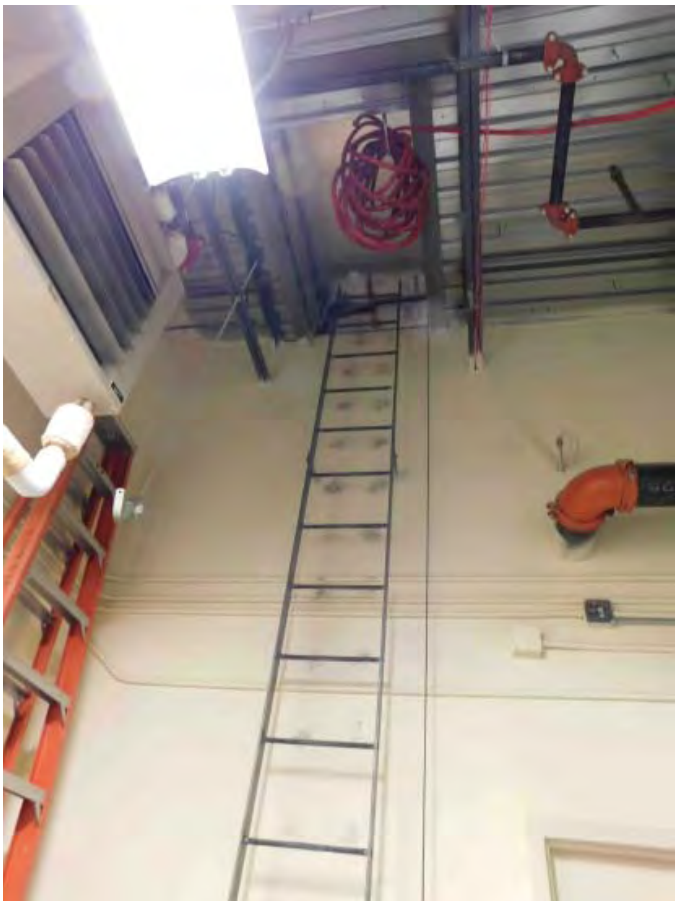
Code	Item Number	Section Name	Install Date	Quantity	UoM	Category (uniformat)	Work type	Priority	Priority Year	EDL	RDL	Deficiency/ Corrective Action/ Detailed Location	Material Cost	Labor Cost	Total Cost *Incl. O&P*	Photo #
C20	R1	Mech Rm	2008	1	sf	C2013 Stair Construction	Replace	**1**	2017			Replace Ships ladder w/0 a Safety Cage, with an inclined ladder w/ treads & a handrail	**$4,488.00**	**$1,200.00**	**$7,678.80**	1401, 1404, 1553, 1578 d
D20	R2	PT Bath Rms	2008	8	ea	D2013 Plumbing Fixtures - Bathtubs	Replace	**1**	2017			replace Liberti tub with a RANE tub. Liberti tubs leak at door seal.	**$80,000.00**	**$3,200.00**	**$112,320.00**	1489, 1494. 2414
D30	R3	Roof	2008	4	ea	D20 - Plumbing Fixtures- Hose Bib	Remove and Install New Item	1	2017			Remove Humidifier & Add hose bib on roof, for each POD.	**$400.00**	**$1,600.00**	**$2,700.00**	1560, 1563
D20	R4	Mech Rm	2008		ea	D30- HVAC Distribution Systems, CVPC Piping	Additional Install	1	2017			CVPC piping needs more frequent hangers every 4'-0" in Mech Rm. It is sagging	**$2,365.00**	**$1,000.00**	**$4,543.00**	1410, 1433
D30	R5	Ktchn-ettes	2008	4	ea	D30- HVAC Distribution System, Nutrition Room, Kitchenette	Comprehensive Study	2	2018			Add ventilation to Kitchenette, Closet Rm 223 & for 3 other Pods. Lacks ventilation				2011, 2012
E10	R6	Roof	2008	1	ea	E10- Equipment, Jib Crane	Comprehensive Study	1	2017			Install LOADING DOCK JIB CRANE to load equip to roof. Size TBD				1556
E10	R7	Patient Rms	2008	25	ea	E10- Nurses Call Station	Replace	1	2017			Nurse Call Systems needs to be replaced. * Speifications TBD by hospital. Wireless			**$150,000.00**	1466, 1468, 1467
R1 - R8 TOTAL COST:													**$110,589.96**	**$89,319.36**	**$277,241.80**	

***** E-10, cost of wireless provided by Hopsital at $110,000, $40,000 added for contingency

IV. Eastern State Hospital, Williamsburg, Virginia

Deficiency Report, Hancock Geriatric Treatment Center

Attachment: Deficiency photographs

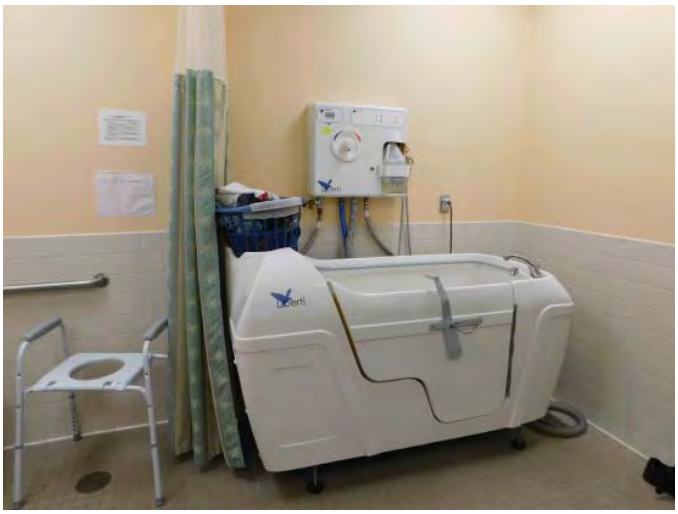


R1: SHIP'S LADDER, NO FLAT TREADS, HANDRAILS OR SAFETY CAGE, DIFFICULT TO CLIMB W/ EQUIPEMENT, Photo 1401

R1: BASE OF SHIP'S LADDER. SUFFICIENT AREA TO PROVIDE A SLOPED LADDER,

Photo 1404

R1: TOP OF SHIP'S LADDER. LACK OF HANDRAIL AT TOP, Photo 1578d



R2: LIBERTI TUB. ALL BATHTUBS LEAK THROUGH THE DOOR CLOSURE SEAL.

Photo 1489

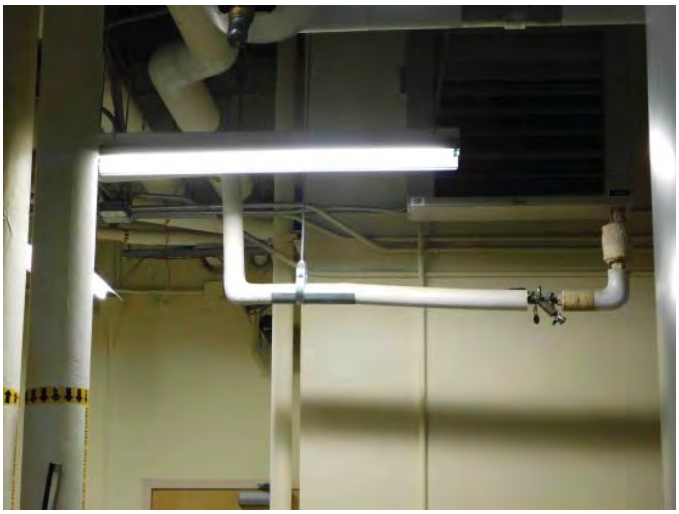
R1: LIBERTI TUB. TUBS LEAK THROUGH THE DOOR CLOSURE SEAL. Photo 2414

R2: LIBERTI TUB. ALL BATHTUBS LEAK THROUGH THE DOOR CLOSURE SEAL.

Photo 1494

R3: REMOVE HUMIDIFIER NO LONGER IN USE. INSTALL HOSE BIB USING EXISITNG PIPING, Photo 1560

R3: HOSE BIB WOULD BE ADJACENT TO AHU'S. HOSE BIB NEEDED TO CLEAN ADJACENT COILS PERIODICALLY, Photo 1563



R4: SAGGING CVPC PIPING
Photo 1410

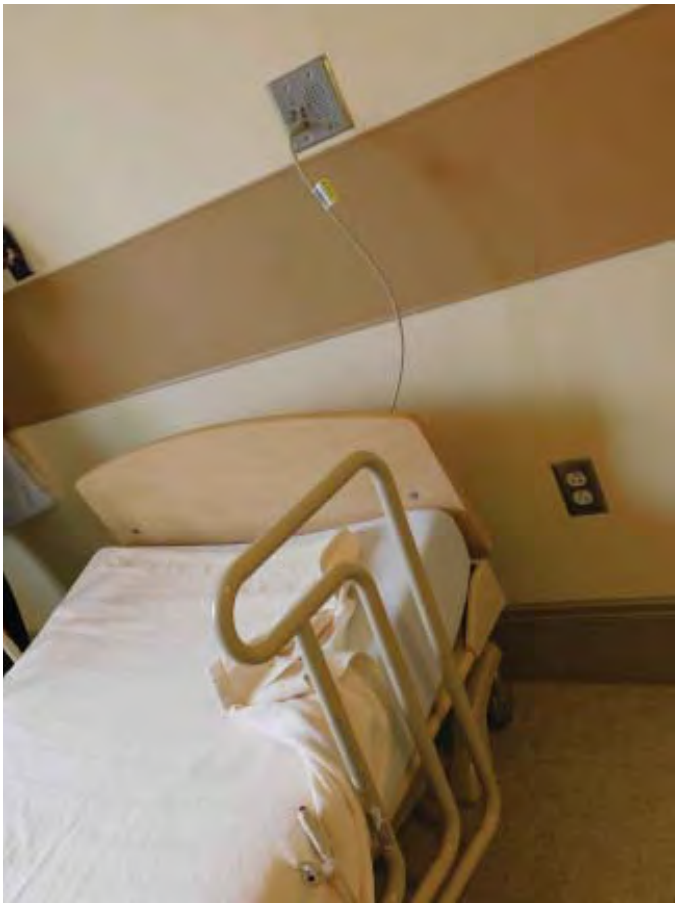
R4 SAGGING CVPC PIPING
Photo 1433

R5 NUTRITION ROOM NEEDING ADDITION COOL AIR, Photo 2012

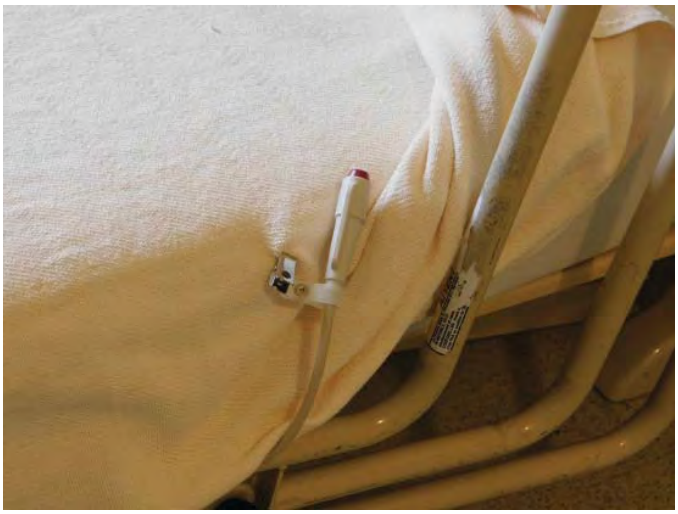
R5 NUTRITION ROOM NEEDING ADDITION COOL AIR, Photo 2011

R6: JIB CRANE BASE ABOVE LOADING DOCK, Photo 1556

R8: NURSE CALL STATION, INOPERABLE & NEEDS TO BE REPLACED WITH ANTI-LIGATURE, Photo 1466



R8: NURSE CALL STATION, INOPERABLE & NEEDS TO BE REPLACED WITH ANTI-LIGATURE, Photo 1467



R8: NURSE CALL STATION, INOPERABLE & NEEDS TO BE REPLACED WITH ANTI-LIGATURE, Photo 1468

OLSHESKY DESIGN GROUP, LLC
212 SOUTH HENRY STREET, THIRD FLOOR
ALEXANDRIA, VA 22314
703.548.0179,PH 703.548.2734, FX
ODESIGNGROUP.COM

IVa. Deficiencies Report on the Kitchen/ Dining Room, Building 13

October 30, 2017

Eastern State Hospital
Williamsburg, VA

This Kitchen and Dining Room Facility is used for the Geriatric Patients. The Substructure, Superstructure and Exterior Enclosure are in very good condition and expected to last into the foreseeable future. While the Substructure, Superstructure and Exterior Enclosure were built to last well beyond 100 years the Systems in the building have a shorter lifespan. Some systems in this Facility need immediate attention and are critical to maintaining the mission of Hancock Geriatric Treatment Center. If this Kitchen/ Dining Room facility shuts down, it would have an impact on the Geriatric Patients. Meals would become much more expensive.
This Deficiency Report does not include all of the Deficiencies in this building. It has focused on those that need immediate attention. The deficiency costs are estimated at $1,627,401.18 with significant comprehensive studies to be done.

A. SUBSTRUCTURE: Foundations and Basement Construction
Is generally in Very Good Condition. It was built in 1954. The substructure was built to last well beyond 100 years. If well maintained it could last for the foreseeable future.
Basement Slab: In very good condition

Value of deficiencies : $0.00.

B. EXTERIOR ENCLOSURE:
B10: SUPERSTRUCTURE: Floor and Roof Construction:
Is generally in Very Good Condition. It was built in 1954. The superstructure was built to last well beyond 100 years. If well maintained it could last for the foreseeable future.
Structure: Structure is sound and in very good condition.
Roof Structural System: The roof structural slab is in very good condition.

B20: EXTERIOR ENCLOSURE: Exterior Walls, Windows and Doors:
Generally in good condition.

Exterior Wall: The mortar joints and brick are in very good condition. The brick vents need to have the plastic covers removed. The brick vents are there to ventilate the structure and are essential to serve that purpose. If they are not removed, significant decay could occur.

Exterior Windows:
Generally exterior windows are in good shape, with the exception of the monitor windows, which need IMMEDIATE replacement. The monitor windows were installed in 1954 and have a lifespan of 45 years. They have exceeded their useful life by 18 years.
The window frames are bent in some cases and not all the windows shut completely.
The Monitor motor does not operate. The shaft and extension arms need to be replaced. This needs immediate attention, to assist in keeping the Kitchen cooler in the summertime.

B30: ROOFING: Roof Coverings and Openings

Roof Coverings: The roof membrane, rubberized EPDM, membrane flashings and sloped insulation are in **CRITICAL CONDITION** and need immediate replacement.
The roof membrane was installed in 1991 and has a 20 year lifecycle. It has exceeded its useful life by 6 years. The current condition has slightly sloped insulation, in some places, no slope in some places and a reverse slope (or sloping to ponding) in other cases. In some cases bubbles have formed on the roof.

B Total Value of deficiencies : $461,740.27

C: INTERIORS
C10 &C20 : INTERIOR CONSTRUCTION & STAIRS:
Are generally in good condition.
C30: INTERIOR FINISHES:
Floor finishes are generally in good condition, with the exception of the replacement tile in the Kitchen. It was not grouted properly and there are hollow cavities below it. This is a high priority item, as if it fails, the kitchen service would be difficult to provide with carts. A comprehensive study needs to be completed to determine which tile's have hollow cavities below them and quantity of tile replacement needed.

Ceiling Finishes: Several Ceiling Tiles have been replaced with plastic in several rooms, primarily Room 103, Diet Manager's Office; 103A, Conference Room; Room 102, Patient Dining Hall/ Cafeteria and 101A Office. The tiles have been replaced with plastic due to the roof leaking because the roof membrane has exceeded its useful life.
Once the roof membrane is replaced, the ceiling tiles can be replaced. This is a dependent replacement item and as such is a lower priority.

C Value of deficiencies : $568,960.65

D: SERVICES
D20: PLUMBING
D2030 Sanitary/ Storm water Waste piping.
The sanitary waste piping, cast iron, in the Basement crawl space, that runs from the first floor fixtures and rain water leaders, needs to be replaced. It was installed in 1954 and its useful life is 30 years. It has exceeded manufacturer's useful life by 33 years. It is in need of CRITICAL replacement and is a high priority item and needs IMMEDIATE replacement. The basement has been flooding when there is a large rainfall. This occurred prior to the three new boilers being installed.

D2030 Sanitary Waste:
Drain for three new Boilers
When the three (3) new boilers were installed in 2016, their drains were tied into an existing floor drain. The existing floor drain and its pipe size were not modified. The existing floor drain was designed to handle only its load, not the increased boiler flushing load. Due to the increased load on the existing floor drain, flooding now occurs in the basement North-South corridor, and in the far East-West Corridor and in nearby rooms.

The three boilers flush water two times a day. If the water is flushed at a typical speed, they will overwhelm the drains and water will come up out of the floor drain, closest to the three boilers.
If there is a heavy rain, (not a slow rain) water will come up from the floor drains, as explained by B&G staff. Water at the closest drain has come up about 1.5 feet. Water will come up at the two intermediate drains along the Hall, as well and come up a maximum of 6" at the end of the Hall drain, to the south.

There is a Sump Pump but it is insufficient for even average rainstorms.
THE ODG team removed the Sump Pump cover and found a disconnected pipe to the sump pump. It has since been connected. The water will be pumped out at a quicker rate from the basement Hall, however, the flooding will still occur and needs immediate attention.

Recommendation is to run the boiler drain pipe to daylight.

D2023 Domestic Plumbing
The domestic plumbing, copper piping, in the Basement crawl space that runs to the first floor fixtures, needs to be replaced. It was installed in 1954 and its useful life of 20 and 25 years has exceeded. It should have been replaced approximately 40 years ago. It is a high priority item and needs to be replaced in the next 12 months; at the latest. The insulation for the piping needs to be replaced also.

D30 HVAC
D3043-R12 The four Air Handling Units, or Heating and Ventilating Units, H-1, H-2, H-3 and H-4, located in the basement that serve the building need to be replaced IMMEDIATELY. This is a CRITICAL item and needs IMMEDIATE attention. Water sits in many of these units and the air being blown from them may not be healthy.

D3043- R13 & R14, The steam and condensate lines in the crawl space and on the first floor need to be replaced IMMEDIATELY. They are in critical condition and have corroded very badly. While we were there one line broke. The pipes have a useful life of 75 years, but have corroded so badly they need immediate replacement.

D3040- R15, The AC units for the Reimbursement Department need to be replaced with a rooftop Air Handling Unit. The Roof top unit will cool the Offices more efficiently and provide more comfort throughout the suite.
Two of the air conditioners are located on an interior wall and putting additional heat into the Kitchen Storage which is open to the Kitchen. This is exasperating the hot air in the Kitchen already.

D3053 Heating and Ventilating Units in the Kitchen, and their associated piping need to be removed. The four units no longer operate and water drips from the piping. This is an IMMEDIATE NEED.
A new Root Top Unit, such as a Heat Pump, would replace these inoperable units. The Roof top unit would provide the needed cool air for the Kitchen that gets very hot in the summer time, including temperatures in the Kitchen into the 90's degrees if not above.
The other option for cooling the Kitchen would be provide circulating air with fans and operable monitor windows.

D+F Value of Services (includes demolition) deficiencies : $596,700.26
NOTE: A comprehensive study needs to be done to determine the size and cost of the four AHU's in the basement that need to be replaced.

Total Value of all deficiencies : $1,627,401.18 (sum of A-F)
A comprehensive study needs to be done to determine the size and cost of the four AHU's in the basement that need to be replaced. A Comprehensive Study needs to be done to replace the motors for the monitor windows in the Kitchen.

Code	Item No.	Install Date	Quantity	UoM	Category (uniformat)	Work type	Priority	Priority Year	EDL	RDL	Deficiency /Corrective Action/ Detailed Location	Material Cost	Labor Cost	Total Cost *Incl. O&P*	Photo #
B20	R1	**1954**	**0**	**Ea**	**B2013 Remove Brick Vent Cover**	Remove	1	2017	**45**	**-18**	**brick vent 5" x 8" (no sz shwn)**	**$0.00**	**$1,911.68**	**$3,099.27**	897, 910
B20	R2	1954	64	Ea	**B2023 Replace Operating 3-9" x 5-6" stl frm wndw (5'-5" x 71%= 3'-6")**	Comp Renew	0	2018	45	-18	**Repl Stl Wndws & screens**	***$78,940.16***	***$14,016.00***	***$122,112.00***	804
B20	R2a	1954	64	Ea	**B2023 172 1030 Replace Steel Screens**	Comp Renew	0	2018	45	-18	**Replace Steel Screens for Windows**	***$3,379.20***	***$9,320.96***	***$20,096.00***	810
B20	R2b	1954		Ea	**B2023, Replace Wndw Operator: Motor, shaft & bear-ings, arms**	Comp Renew	0								1152
B30	**R3**	**1991**	**389.15**	**Sq**	**B301002 Low Slope Membr Systems**	Comp Renew	**0**	2017	20	-6	**Replace EPDM Roof. It exceeds its Estimated Design Life**	$85,383.00	$114,737.00	**$316,433.00**	780, 784, 785, 776, 784, 803
C30	**R4**	**1954**	**37439**	**SF**	**C3023 Tile Floor Finishes**	**Compreh ensive Study**	1	2018	15	-11	Repair Quarry tile floor, (2% of flr)	**$2,246.34**	**$256,457.15**	**$409,957.05**	2476
C30	**R5**	**1991**	**193.2**	**C.S.F**	**C3033 Ceiling Finishes**		2					**$66,654.00**	**$46,561.20**	**$159,003.60**	822, 823, 826, 739, 744, 835,
D20	R6	2016	150 x 2'	LF	**D203001 Pipe & Fittings**	Intsall new	0	2017			Saw cut, remove concrete, & pour concrete for 3 new boiler drains & pipes	$4,400.00	$6,900.00	$12,300.00	1121, 1212, 1212, 1201
D20	R6a		150 x 2'	LF	**D2033 Sanitary Waste**		0	2017			**Install 4" sanitary pipe in slab, 300 SF**	$4,725.00	$3,600.00	$11,910.00	1203
D20	R6b		2	Ea	D2033 Sanitary Waste		0	2017			Install new floor drain	$361.00	$1,580.00	$2,550.00	
R1 - R6 Total Cost:												**$246,088.70**	**$455,083.99**	**$1,057,460.92**	

Code	Item No.	Install Date	Quantity	UoM	Category (uniformat)	Work type	Priority	Priority Year	EDL	RDL	Deficiency/ Corrective Action/ Detailed Location	Material Cost	Labor Cost	Total Cost *Incl. O&P*	Photo #
D20	R10	1954	800	LF	D2023110 Domestic Plumbin	Replace	1	2018	35	**-27**	Remove old & Install new domestic piping below kitchen: 1/2" copper. Add 15% for confined space	$ 6,000.00	$ 10,472.00	$ 23,880.00	851
		1954	800	LF	D2023110 Domestic Plumbin	Repl	1	2018	35	**-27**	3/4" copper	$ 6,000.00	$ 10,472.00	$ 23,880.00	852?
		1954	300	LF	D2023110 Domestic Plumbin	Repl	1	2018	35	**-27**	1" copper	$ 3,780.00	$ 4,269.00	$ 11,400.00	
		1954	300	LF	D2023110 Domestic Plumbin	Repl	1	2018	35	**-27**	1.5" copper	$ 5,325.00	$ 5,790.00	$ 15,600.00	
D20	R10a		800	LF	D2023160 Insulation, Pipe	Replace	1	2018	15		1/2" copper insulation, add 15% confined space	$ 680.00	$ 4,656.00	$ 8,272.00	
			800	LF	D2023160 Insulation, Pipe	Replace	1	2018	15		3/4" copper insulation	$ 736.00	$ 4,808.00	$ 8,592.00	
			300 LF		D2023160 Insulation, Pipe	Replace	1	2018	15		1" copper Insulation	$ 276.00	$ 1,803.00	$ 3,222.00	
			300	LF	D2023160 Insulation, Pipe	Replace	1	2018	15		1.5" copper insulation	$ 345.00	$ 1,932.00	$ 3,507.00	
D20	R11		680	LF	D2030 Sanitary / Stormwater Waste	Replace	0	2017	30	**-33**	Remove old & install new 4" cast iron piping below kitchen, add 15% for	$20,400.00	$38,250.00	$85,204.00	
			190	LF	D2030 Sanitary / Stormwater Waste	Replace	0	2017	30	**-33**	3" cast iron	$4,275.00	$10,070.00	$21,280.00	
			100	LF	D2030 Sanitary / Stormwater Waste	Replace	0	2017	30	**-33**	2" cast iron	$1,655.00	$4,960.00	$9,780.00	
D30	R12	1954	1	cfm	D3043 Distribution Systems - AHU	Comprehensive Study	0	2017	15	-48	Remove old & Install new basement H&V, Unit H-1,				164, (163 ?)
		1954	1	cfm	D3043 Distribution Systems	Comprehensive Study	0	2017	15	-48	Replace basement H&V Unit, H-2,				165, 166, 167
		1954	1	cfm	D3043 Distribution Systems	Comprehensive Study	0	2017	15	-48	Replace basement H&V Unit, H-3,				169, 171

Code	Item No.	Install Date	Quantity	UoM	Category (uniformat)	Work type	Priority	Priority Year	EDL	RDL	Deficiency/ Corrective Action/ Detailed Location	Material Cost	Labor Cost	Total Cost *Incl. O&P*	Photo #
		1954	1	cfm	D3043 Distribution Systems	Comprehensive Study	0	2017	15	-48	Replace basement H&V Unit, H-4,				171-172
D30	R13	1954	80	LF	D3043 Steam Distribution Systems, Steam	Replace	**0**	2017	75	12	Replace steam piping (steel) from basement boiler/CR/basement and 1st floor 8", Steam lines, steel pipe flanged, add 15% for confined space	$8,240.00	$11,360.00	$28,400.00	853
		1954	55	LF	D3043 Steam Distribution Systems	Replace	**0**	2017	75	12	6", Steam lines, steel pipe flanged	$3,410.00	$5,857.50	$13,585.00	872
		1954	243	LF	D3043 Steam Distribution Systems	Replace	**0**	2017	75	12	5", Steam lines, steel pipe flanged	$15,066.00	$25,879.50	$60,021.00	
		1954	450	LF	D3043 Steam Distribution Systems	Replace	**0**	2017	75	12	4", Steam lines, steel pipe flanged	$14,400.00	$30,150.00	$66,375.00	
		1954	55	LF	D3043 Steam Distribution Systems	Replace	**0**	2017	75	12	3", Steam lines, steel pipe flanged	$1,361.25	$2,777.50	$5,885.00	
		1954	65	LF	D3043 Steam Distribution Systems	Replace	**0**	2017	75	12	2", Steam lines, steel pipe flanged	$1,020.50	$2,122.25	$4,680.00	

Code	Item No.	Install Date	Quantity	UoM	Category (uniformat)	Work type	Priority	Priority Year	EDL	RDL	Deficiency/ Corrective Action/ Detailed Location	Material Cost	Labor Cost	Total Cost *Incl. O&P*	Photo #
D30	R13a		80	LF	D3043 Pipe Insulation	Replace	0	2017	5		Remove old & install new 8", Steam lines insulation in crawl space mostly, add 15% for confined space	$480.00	$1,280.00	$3,136.00	
			55	LF	D3043 Pipe Insulation	Replace	0	2017	5		6", Steam lines, insulation, add 15% for confined space	$162.25	$544.50	$1,078.00	
			243	LF	D3043 Pipe Insulation	Replace	0	2017	5		5", Steam lines insulation	$716.85	$2,405.70	$4,762.80	
			450	LF	D3043 Pipe Insulation	Repl	0	2017	5		4", Steam line insulation	$1,116.00	$3,573.00	$7,132.50	
			55	LF	D3043 Pipe Insulation	Repl	0	2017	5		3", Steam line insulation	$102.30	$363.00	$709.50	
			65	LF	D3043 Pipe Insulation	Repl	0	2017	5		2", Steam line insulation	$99.45	$386.10	$744.25	
D30	R14	1954		LF	D3040 Steam Water Distribution, Steel Pipe, Condensate	Repl	0	2017	75	12	8", 6", 5"4", 3" Condensate lines, 5", 3" & 2" black steel, add 15% confinsed space				
		1954	420	LF	D3040 Steam Water Distribution, Steel Pipe	Repl	0	2017	75	12	Remove old and install new 5" steel iron threaded pipe	$14,721.00	$31,605.00	$46,326.00	
		1954	34	LF	D3040 Steam Water Distribution, Steel Pipe	Repl	0	2017	75	12	3" steel iron threaded pipe	$765.00	$1,635.40	$3,502.00	
		1954	740	LF	D3040 Steam Water Distribution, Steel Pipe	Repl	0	2017	75	12	2" Steel Iron threaded	$9,287.00	$20,091.00	$42,661.00	
D30	R14a		740	LF	D3043 550 Distribution Systems, Pipe Insulation	Repl	0	2017	5		Remove old and install new 2" pipe insulation for condensate lines, add 15%	$1,132.20	$4,395.60	$8,473.00	
			34	LF	D3043 550 Distribution Systems, Pipe Insulation	Repl	0	2017	5		3" pipe insulation	$63.24	$224.40	$438.60	
			420	LF	D3043 550 Distribution Systems, Pipe Insulation	Repl	0	2017	5		5" pipe insulation	$1,239.00	$4,158.00	$8,232.00	
F20	**R15**	1991	**9**	**EA**	**F201006 Mechanical Systems- AC window units**	CR	1	2018			Remove existing AC units from Windows in Reimb.		$100.00	$900.00	928

Code	Item No.	Install Date	Quantity	UoM	Category (uniformat)	Work type	Priority	Priority Year	EDL	RDL	Deficiency/ Corrective Action/ Detailed Location	Material Cost	Labor Cost	Total Cost *Incl. O&P*	Photo #
D30	R15a	2018	5	TONS	D304001 Air Distribution, Heating, And Cooling	R	1	2018			Add RTU to replace window AC unit cooling capacity and supplemental heating/R/Reimbursement Area at south side	$7,500.00	$4,000.00	$15,525.00	
F20	R16	1954	**4**	**EA**	**F201006 Mechanical Systems- H & V Units**	CR	0	2017			Remove four , 4, Heating & Ventilating Units from Kitchen			$8,100.00	637, 751, 633
D30	R16a		10	tons	**D3053 Heat Pump - New RTU**	R	0		20		Add New RTU Unit for Kitchen, to replace existing 4 Heating & Ventilation units	$6,275.00	$4,275.00	$14,525.00	
R10 - R16 TOTAL COST:												**$145,179.94**	**$271,770.48**	**$569,940.26**	

R1 - R6 COST:	$246,088.70	$455,083.99	$1,057,460.92
R1-R18 GRAND TOTAL:	**$391,268.64**	**$726,854.47**	**$1,627,401.18**

IVa. Eastern State Hospital, Williamsburg, Virginia

Deficiency Report, Building 13

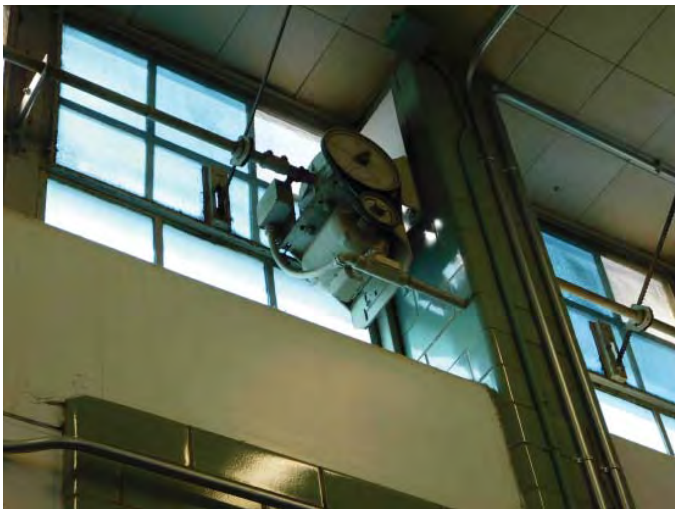
Attachment: Deficiency photographs

R1: BRICK VENT, WITH PLASTIC COVER, NOT ALLOWING VENTILATION Photo 897

R1: BRICK VENT COVERS, ALL AROUND STRUCTURE, Photo 910

R2: REPLACE STEEL WINDOWS, SOME NO LONGER CLOSE, Photo 804

R2 & 2A: REPLACE STEEL WINDOWS & SCREENS, WINDOW FRAME BENT, OPERATOR ARM DETACHED, SCREEN RIPED
Photo 810



R2B: REPLACE MONITOR MOTOR, SHAFT & ARMS, INOPERABLE, Photo 1152

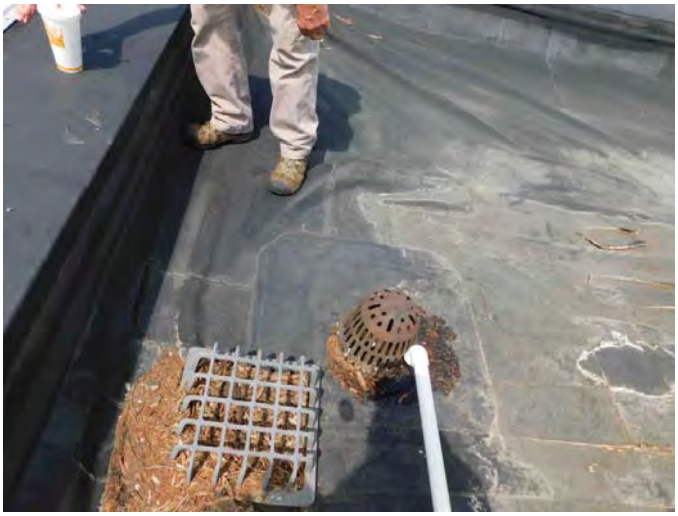
R3: LOW SLOPE MEMBRANE SYSTEMS, VIEW TO NORTH, EVIDENCE OF PONDING WATER, Photo 780

R3: LOW SLOPE MEMBRANE SYSTEMS, VIEW TO EAST, EVIDENCE OF PONDING WATER, Photo 784

R3: LOW SLOPE MEMBRANE SYSTEMS, VIEW TO NORTH, EVIDENCE OF PONDING, Photo 785

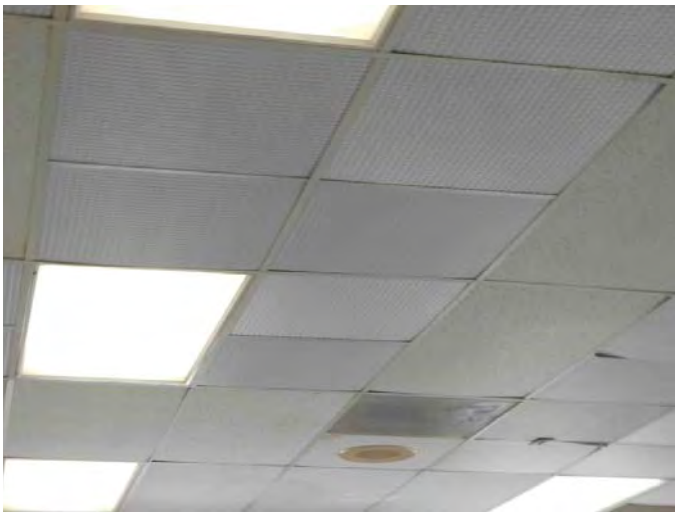
R3: LOW SLOPE MEMBRANE SYSTEMS, VIEW TO NORTH, EVIDENCE OF PONDING, (ABV RM 103 CEILING LEAKS) Photo 776

R3: LOW SLOPE MEMBRANE SYSTEMS, VIEW TO EAST, EVIDENCE OF PONDING, ABOVE ROOF LEAKS Photo 784



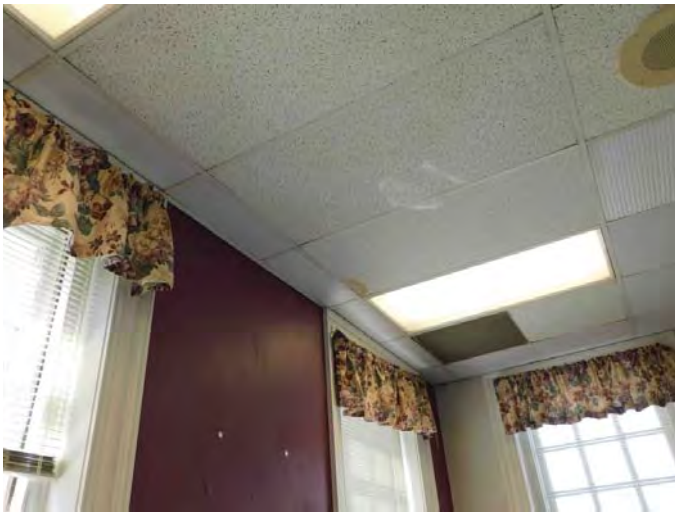
R3: LOW SLOPE MEMBRANE SYSTEMS, ROOF MEMBRANE DETACHING, ABOVE RM 101A CEILING LEAK Photo 803

R4: TILE FLOOR FINISHES, KITCHEN,REPLACEMENT TILE NOT GROUTED PROPERLY, HOLLOW BELOW, Photo 2476

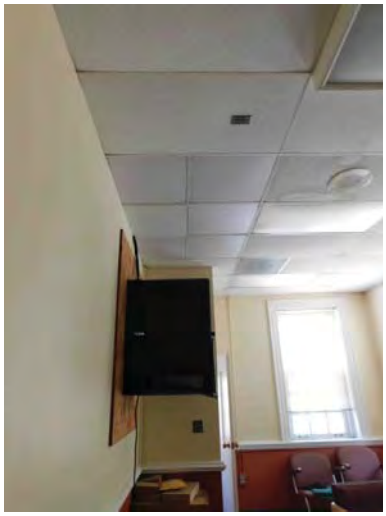


R5: CEILING FINISHES, RM 101A, REPLACEMENT CEILING TILES DUE TO WATER INFILTRATION, Photo 822

R5: CEILING FINISHES, RM 101A, REPLACEMENT CEILING TILES DUE TO WATER INFILTRATION, Photo 823



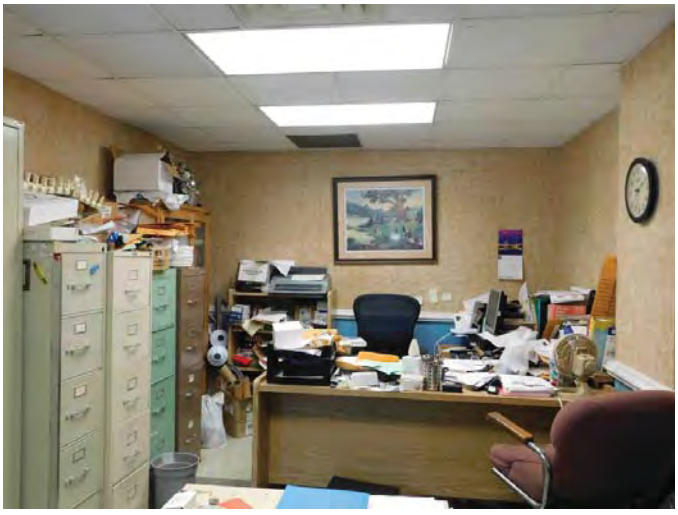
R5: CEILING FINISHES, REPLACEMENT CEILING TILES ALONG WALL AND IN FIELD, DUE TO WATER INFILTRATION, Photo 826



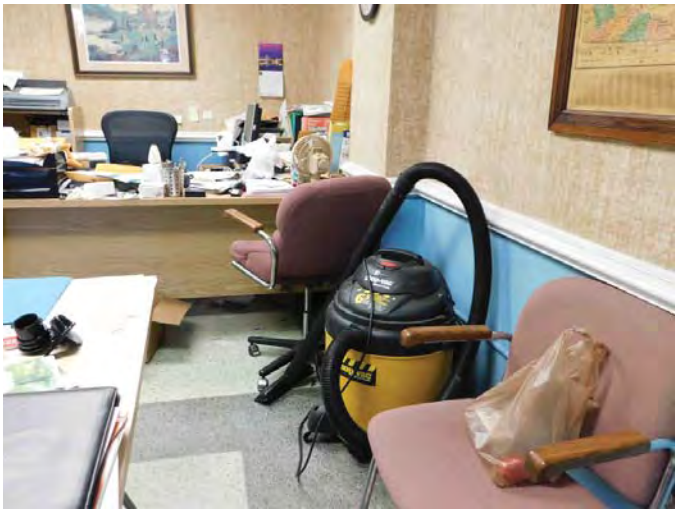
R5: CEILING FINISHES, CEILING TILE REPLACEMENT, DUE TO WATER INFILTRATION ABOVE AUDIO VISUAL EQUIPMENT, RM 103A, Photo 739

R5: CEILING FINISHES, CEILING TILE REPLACEMENT & WATER STAIN, DUE TO WATER INFILTRATION ABOVE WINDOW, RM 103A, Photo 744

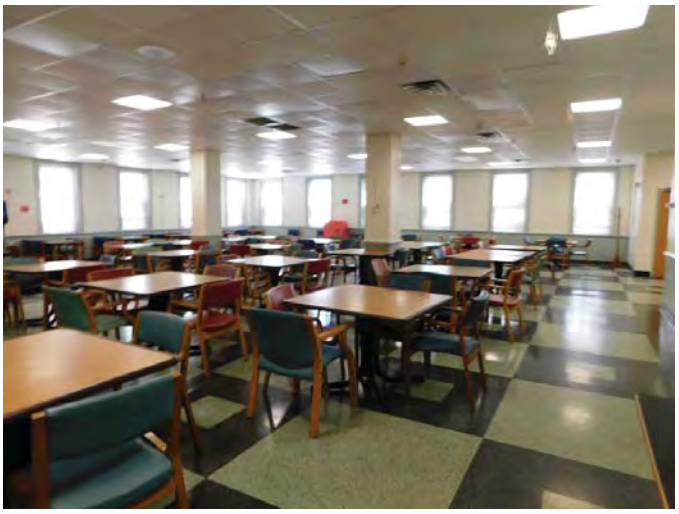
R5: CEILING FINISHES, CEILING TILE REPLACEMENT & ITEMS ABOVE FLOOR, DUE TO WATER INFILTRATION, RM 103, LEAK OCCURED RIGHT BEFORE OUR ARRIVAL, Photo 835



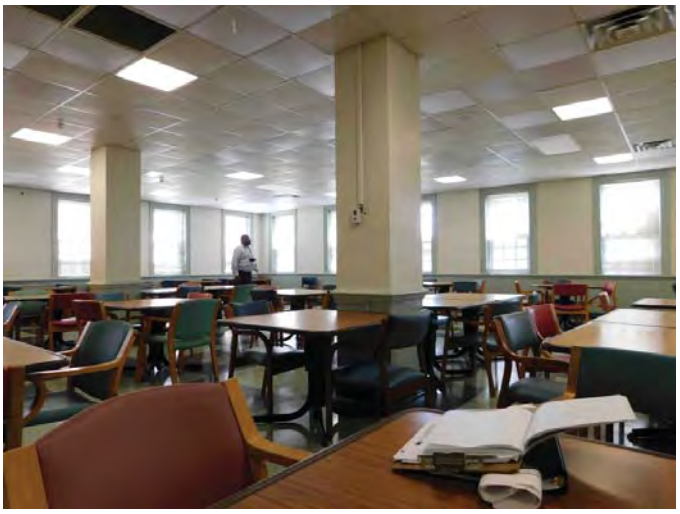
R5: CEILING FINISHES, CEILING TILE REPLACEMENT & ITEMS ABOVE FLOOR, DUE TO WATER INFILTRATION, RM 103, BUCKET ON FLOOR TO CATCH WATER, Photo 836



R5: CEILING FINISHES, CEILING TILE REPLACEMENT & SHOP VAC DUE TO WATER INFILTRATION, RM 103, LEAK OCCURRED RIGHT BEFORE OUR ARRIVAL, Photo 837



R5: CEILING FINISHES, CEILING TILE REPLACEMENT DUE TO WATER INFILTRATION, RM 102, Photo 724



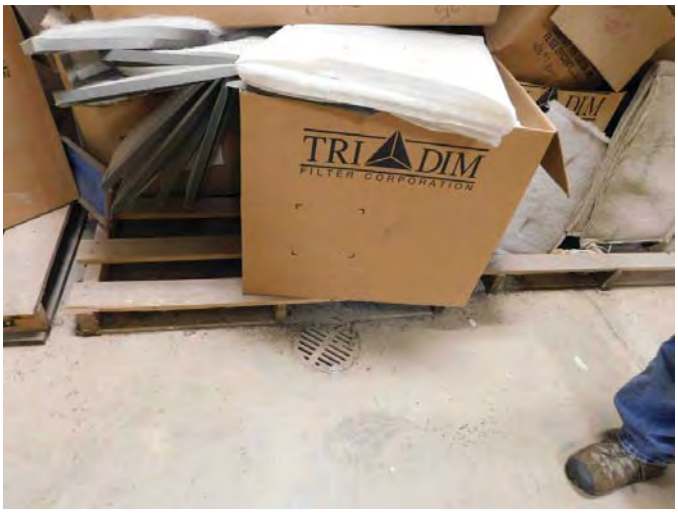
R5: CEILING FINISHES, CEILING TILE REPLACEMENT DUE TO WATER INFILTRATION, RM 102, Photo 731

R5: CEILING FINISHES, CEILING TILE REPLACEMENT DUE TO WATER INFILTRATION, RM 103A, LEAK ABV AUDIO VISUAL EQUIPMENT, Photo 1158

R6a: BOILER DRAIN FOR FLUSHING, SEDIMENT ON FLOOR DUE TO FLOODING

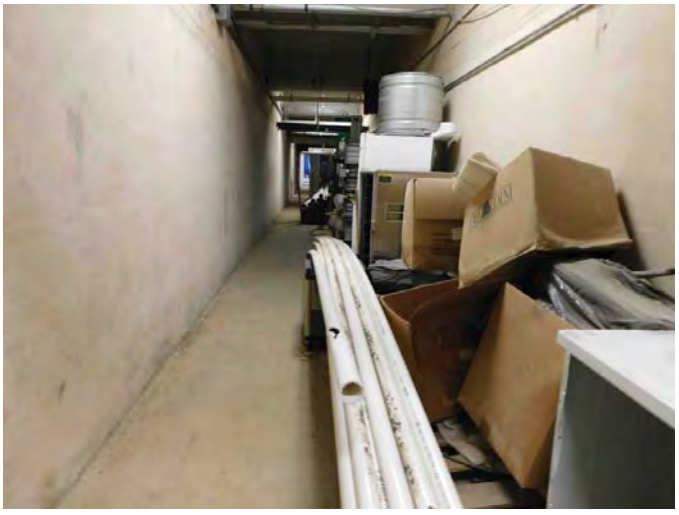
Photo 1211

R6a: BOILER DRAIN FOR FLUSHING, RM B15, SEDIMENT ON FLOOR DUE TO FLOODING, Photo 1212



R6a: BOILER DRAIN FOR FLUSHING, N-S CORRIDOR, DRAIN, ELEVATED BOXES & SEDIMENT ON FLOOR DUE TO FLOODING

Photo 1212



R6a: BOILER DRAIN FOR FLUSHING, N-S CORRIDOR, DRAIN, ELEVATED STORAGE & SEDIMENT ON FLOOR DUE TO FLOODING

Photo 1201

R6a: BOILER DRAIN FOR FLUSHING, N-S CORRIDOR, DRAIN, LOWER SHELFS REMOVED, SEDIMENT ON FLOOR DUE TO FLOODING, Photo 1203

IVa. Eastern State Hospital, Williamsburg, Virginia

Deficiency Report, Building 13, Items R10-16

R10 & R10A: DOMESTIC PLUMBING IN CRAWL SPACE, Photo 851

R11: SANITARY WASTE PIPING IN CRAWL SPACE, Photo 850

R12: BASEMENT H&V UNIT COILS, H-4
Photo 164

R12: BASEMENT H&V UNIT, H-4, COILS DAMAGED, BEYOND USEFUL LIFE, Photo 165

R12: BASEMENT H&V UNIT, H-4, COILS DAMAGED, BEYOND USEFUL LIFE,

Photo 166

R12: BASEMENT H&V UNIT, H-4, COILS DAMAGED, BEYOND USEFUL LIFE,

Photo 167

R12: BASEMENT H&V UNIT, H-3, COILS DAMAGED, BEYOND USEFUL LIFE,

Photo 169

R12: BASEMENT H&V UNIT, H-3, COILS DAMAGED, BEYOND USEFUL LIFE, Photo 171

R12: BASEMENT H&V UNIT, H-4, COILS DAMAGED, BEYOND USEFUL LIFE, Photo 172

R13 & 14: STEAM & CONDENSATE PIPING, BADLY CORRODED, BEYOND USEFUL LIFE

Photo 853

R13 & R14: STEAM & CONDENSATE PIPING, CORRODED PIPE & MISSING INSULATION, Photo 872

R15: WINDOW AC UNITS ON EAST SIDE, NEED CENTRAL AIR Photo 928

R16: HEATING & VENTILATING UNIT, NO LONGER OPERABLE, LEAKS WATER, Photo 637

R16: HEATING & VENTILATING UNITS, N LONGER OPERABLE, LEAK WATER, Photo 633

R16: KITCHEN HEATING & VENTILATING UNIT, NO LONGER OPERABLE, LEAKS WATER, Photo 751