COMMONWEALTH of VIRGINIA

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COMMISSIONER

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November 21, 2025

To: The Honorable Glenn Youngkin, Governor of Virginia
The Honorable Rodney T. Willett, Chair, Joint Commission on Health Care
The Honorable L. Louise Lucas, Chair, Senate Finance and Appropriations Committee
The Honorable Luke E. Torian, Chair, House Appropriations Committee

From: Nelson Smith, Commissioner, Department of Behavioral Health and Developmental Services

RE: Closure Plan for Hiram Davis Medical Center in accordance with Va. Code § 37.2-316

Va. Code § 37.2-316 requires the Department of Behavioral Health and Developmental Services (DBHDS) Commissioner to establish a state and community consensus and planning team when considering any restructuring of the system involving a state hospital. The language reads:

> *A. For the purpose of considering any restructuring of the system of mental health services involving an existing state hospital, the Commissioner shall establish a state and community consensus and planning team consisting of Department staff and representatives of the localities served by the state hospital, including local government officials, individuals receiving services, family members of individuals receiving services, advocates, state hospital employees, community services boards, behavioral health authorities, public and private service providers, licensed hospitals, local health department staff, local social services department staff, sheriffs' office staff, area agencies on aging, and other interested persons. In addition, the members of the House of Delegates and the Senate representing the localities served by the affected state hospital may serve on the state and community consensus and planning team for that state hospital. Each state and community consensus and planning team, in collaboration with the Commissioner, shall develop a plan that addresses (i) the types, amounts, and locations of new and expanded community services that would be needed to successfully implement the closure or conversion of the state hospital to any use other than the provision of mental health services, including a six-year projection of the need for inpatient psychiatric beds and related community mental health services; (ii) the development of a detailed implementation plan designed to build community mental health infrastructure for current and future capacity needs; (iii) the creation of new and enhanced community services prior to the closure of the state hospital or its*

conversion to any use other than the provision of mental health services; (iv) the transition of individuals receiving services in the state hospital to community services in the locality of their residence prior to admission or the locality of their choice after discharge; (v) the resolution of issues relating to the restructuring implementation process, including employment issues involving state hospital employee transition planning and appropriate transitional benefits; and (vi) a six-year projection comparing the cost of the current structure and the proposed structure.

Enclosed, please find the implementation to close HDMC. Staff are available to discuss the plan should you require additional information.

cc: The Honorable Janet V. Kelly
Sarah Stanton
Mike Tweedy
Susan Massart
Angela Harvell
Meghan McGuire

DBHDS
Virginia Department of Behavioral Health and Developmental Services

Hiram Davis Medical Center Closure Plan

Comprehensive Planning for
Safe Patient Discharges and Successful Staff Transitions

November 21, 2025

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Hiram Davis Medical Center (HDMC) Closure Plan

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Hiram Davis Medical Center, courtesy WTVR

Acknowledgements

The Commissioner of the Department of Behavioral Health and Developmental Services extends his deepest gratitude to the individuals, families, advocates, staff, community providers, legislators, and local government partners who lent both time and expertise to the Planning Team process. The many contributions of all those who participated were invaluable in creating a plan that balanced the needs of HDMC patients, staff, and services in the continuum of care provided by the facility.

DBHDS recognizes that the closure of a facility is one of the most difficult transitions for individuals, families, staff, and the broader community. These changes touch lives deeply, and DBHDS does not take this lightly. The Commissioner reaffirms his commitment that every individual will continue to receive the highest quality care while they remain at HDMC and as they move to new homes that meet their needs and preferences.

Equally, the Commissioner is committed to supporting the dedicated employees of HDMC who have served with compassion and skill. Every effort will be made to retain staff within the DBHDS system, including opportunities at Central State Hospital and other facilities, so that their talents and experience continue to benefit the Commonwealth.

This report is a testament to the shared effort of all who participated in the planning process. Together, we have laid the foundation for a safe, respectful, and sustainable transition that honors the individuals we serve and the staff who have cared for them.

Executive Summary

The Department of Behavioral Health and Developmental Services (DBHDS) has developed this closure plan for Hiram Davis Medical Center (HDMC) under Va. Code § 37.2-316. The plan reflects extensive input from a State and Community Consensus and Planning Team and its three subgroups: Supporting Patients, Supporting Staff, and Community Services. The closure plan will be submitted to the Governor and to the Joint Commission on Health Care (JCHC) for review prior to consideration by the General Assembly. The plan's objectives are to (1) safeguard the health, safety, and choice of every person served at HDMC; (2) ensure a stable transition for the workforce; (3) sustain essential clinical services now anchored at HDMC; and (4) reposition resources to more integrated, community-based settings while maintaining a training-center option for eligible individuals.

HDMC opened in 1974 and now faces multiple end-of-life building systems (HVAC, plumbing, electrical) and design limitations that preclude phased renovations. Major repairs would require vacating the building for up to 24 months and trigger recertification under current Codes. Recent incidents, including persistent Legionella mitigation and a sewage line failure, underscore the risk of an unplanned evacuation. Engineering estimates place renovation costs at approximately $94 million and full replacement at approximately $145 million. Given these conditions, DBHDS proposes an orderly, person-centered closure by December 2027, rather than waiting for an emergency that would force rapid, disruptive placements.

Consistent with Va. Code § 37.2-316, DBHDS led an open and collaborative planning process through the State and Community Planning and Consensus Team and its three subgroups, actively engaging individuals, families, staff, community partners, and elected officials. The resulting closure plan helps ensure successful transitions for both patients and staff, and protects continuity of care.

The plan is organized around three execution pillars. Patient transitions will be individualized and choice-driven. For individuals with intellectual/developmental disability (ID/DD) who prefer a state-operated option, DBHDS is preparing up to 10 skilled nursing beds at Southeastern Virginia Training Center (SEVTC), licensed by the Virginia Department of Health (VDH) and certified by the Centers for Medicare and Medicaid Services (CMS). Renovations at SEVTC (bathrooms, nurse call, oxygen delivery, lifts, ventilation) are scheduled for November 2025 - May 2026, while staff are being upskilled. DBHDS recognizes that SEVTC's location is far from many families and commits to working continuously with any interested family to identify willing, qualified providers closer to home, investing in the complex-care supports those providers need to successfully serve individuals with significant medical and/or behavioral issues. For individuals with serious mental illness or dementia/neurocognitive disorders, the plan strengthens pathways to specialized mental-health residential programs, memory care, and nursing facilities with embedded behavioral supports. Short-term "special stay" needs from other state facilities will be met through contracted sub-acute hospital and nursing-facility partners, with standard referral protocols and holding agreements to prevent delays.

Continuity of clinical services is preserved by moving HDMC-anchored departments to the new Central State Hospital (CSH) where feasible (e.g. dental, lab, radiology, pharmacy, therapies), further supplemented by contracted community providers, mobile services, and telehealth. A Community Services Build & Continuity strategy funds start-up and equipment for complex-care providers, establishes nursing-facility behavioral-health consultation teams, and creates navigation, transportation, and data infrastructure to sustain post-transition stability. Workforce transition prioritizes no layoffs by transferring staff to CSH, Piedmont Geriatric Hospital, SEVTC, the Virginia Center for Behavioral Rehabilitation, and other DBHDS sites. A retention program stabilizes staffing through final transitions, training, certification pathways, and supervisor-to-supervisor handoffs support successful onboarding at receiving sites.

The plan acknowledges that not all subgroup recommendations can be adopted. For example, the HDMC Parent Group urged rebuilding a smaller facility on or near the current campus, but that was not put forward as the recommendation because it would require significant capital and workforce to a duplicative bricks-and-mortar program, delays relief by several years, and risks conflict with national policy direction toward integrated, community-based care. Instead, this plan fulfills the core aims voiced by families – safety, quality, and real choice – through SEVTC for eligible individuals and through strengthened community options closer to home for others.

The closure plan identifies specific community capacity-building investments and provider supports necessary to ensure that specialized medical and behavioral health needs currently met at HDMC can be met in alternative settings across the Commonwealth. The fiscal comparison required by Va. Code § 37.2-316 projects a six-year cost of $285.34 million to continue HDMC operations (including renovation downtime and recertification) versus $115.05 million to close HDMC and build out the replacement service model, yielding estimated savings of $170.30 million (exclusive of any property sale proceeds; a 2017 valuation was $13 million). These savings are redeployed, not removed: funds follow the person to SEVTC and community services and sustain shared services at CSH.

Implementation proceeds in four phases: Preparation and Policy Alignment; Initial Transition Wave; Complex Transitions and Service Re-anchoring; and Final Census Draw-down and Building Closure. These phases would occur under a DBHDS project governance structure with clear milestones, risk management, and monthly public reporting. Across all phases, DBHDS maintains life-safety vigilance at HDMC, preserves patient choice (including Va. Code § 37.2-837(A)(3) training-center rights), and partners closely with families to secure qualified, closer-to-home options whenever possible. This approach delivers safer, faster, and more sustainable access to high-quality care while strengthening the Commonwealth's developmental and behavioral health system for the long term.

While full agreement among a broad array of stakeholders is rare, DBHDS ensured a focus on openness, accessibility, and ensuring voices are heard. The process was designed to create a thoughtful plan that supports safe, person-centered discharges, workforce stability, and system sustainability.

Finally, this closure plan, created with broad stakeholder input, will be submitted to the Governor and to the Joint Commission on Health Care for review and recommendations. The

final determination on whether the plan proceeds rests with the General Assembly and the Governor. If the General Assembly and Governor approve the plan, DBHDS is prepared to implement under the phased schedule and governance model described herein, with monthly reporting on placements, safety, service continuity, and staff transitions.

HDMC Current Condition, Patient Population, and Opportunities

The purpose of Va. Code § 37.2-316 is to ensure that any closure of a state hospital is planned with care, broad stakeholder engagement, and a clear focus on the individuals and communities affected. Although HDMC is not classified as a state hospital, it serves multiple populations whose needs are comparable to those the statute was designed to protect, including former state hospital patients, former training center residents, and individuals from the Virginia Center for Behavioral Rehabilitation. Applying the § 37.2-316 process provides the structure to address HDMC's unique challenges and develop a comprehensive, orderly plan for closure that prioritizes safe patient transitions, supports staff, and preserves essential community services.

The facility's aging infrastructure, decreasing patient population of individuals with complex care needs, and the increasing availability of more integrated care options create both urgency and opportunity. Applying the planning team framework to HDMC allows DBHDS to address serious building and operational risks in an orderly way, while preserving quality of care, maximizing staff retention, and strengthening community services. The following section outlines the current condition of HDMC, the populations it serves, and the opportunities that make now the right time to move forward with a planned, stakeholder-informed closure.

Current HDMC Condition and Reasons for Closure

HDMC opened in 1974 as a 94-bed facility providing acute medical, skilled nursing, and long-term care services to individuals with complex medical, intellectual and developmental, and behavioral health needs. HDMC has never undergone a major renovation, and its systems, including HVAC, plumbing, electrical, and elevators, are at or beyond their expected useful life. When major renovations are made at other DBHDS facilities, residents are typically shifted and condensed to other portions of the facility to allow for phased renovations of a wing or floor. That is not possible at HDMC. The building's design does not allow for phased renovations; major repairs would require all patients and staff to vacate for up to 24 months. Renovating HDMC to current standards would cost an estimated $94 million, and constructing a replacement facility would cost approximately $145 million. Recent incidents, including persistent Legionella in the water system and a sewage pipe failure, underscore the risks of continuing operations in the current building. Planning now for an orderly closure by December 2027 will avoid the risks and disruption of an emergency evacuation and ensure careful, person-centered transitions.

All major systems at HDMC, including plumbing, HVAC, electrical, are at the end of or past useful life. Significant building concerns include:

- The HVAC system is well beyond its predicted useful life and in need of replacement. It experienced failure in June 2024 with internal temperatures approaching 80 degrees. DBHDS scrambled to quickly acquire and set up multiple large portable units in hospital patient hallways and administrative areas which are currently still in use.
- Frequent, difficult-to-repair plumbing leaks due to the poor condition of the primary piping. After years of aggressive mitigation, the aging pipes have been mitigated for Legionella bacteria. The risk of recurrence remains, however, and the potential for system failure continues to threaten patient safety.
- Bathrooms throughout the facility do not comply with the Americans with Disabilities Act or current code requirements.
- The entire electrical system has reached the end of its useful life, does not have adequate numbers of outlets, and lacks Code compliance.

Replacement information for these systems is included in the table below:

Project	Description	Budget/Cost	Estimated Project Duration
New Building	**Full Replacement**	**$145,000,000**	4-6 years
Renovation Building	**Renovation of entire building. Includes all major systems listed below. All patients and staff must vacate the building during the work.**	**$94,110,000**	2 years once construction starts; Work cannot be phased - whole building must be vacated
Life Safety Code Compliance	This building is still being inspected under code in effect when the program was originally certified.	$62M for full building renovation to current code	18-24 months; Must vacate to bring HDMC up to current code
Anti-Ligature	Risk components throughout.	$600,000	6 months
HVAC System	Operating but not current code compliant. Highest risk components are air handling units. Spare parts for the most likely points of failure have been identified and stocked by the facility.	$10.5M	12 months; Work cannot be phased - whole building must be vacated
Heating System	Heating system is at risk due to age of the steam and heating water pipe within the building, and the condition of the lines distributing steam from the central power plant. To lessen the risk of steam line failure, a tap was installed to allow connection to a temporary boiler. Distribution pipe failures are repaired as they occur.	$12M	12 months; Work cannot be phased - whole building must be vacated
Domestic Water System	System is 45 years into a 55-to-65-year life.	$1.04M	
Electrical Service and Distribution	Electrical system does not meet current codes. Wiring is at the end of its expected life.	$3.2M	14 months; Work can occur in occupied building with periodic electrical shutdowns
Sprinkler/medical gas/air Systems		$890,000	
Sanitary Piping	Is in poor condition due to both its age and years of having corrosive material poured down the drains.	$1.08M	12-14 months; Cannot be phased - HDMC must be vacated
Building deficiencies that cannot be	Renovate nurses' stations and patient rooms for better patient supervision; Provide on-		

addressed in a simple renovation	suite bathrooms and appropriate bathing facilities to meet patient and CMS requirements; upgrade elevators to accommodate a hospital bed; correct exit and stairway deficiencies.		
Visitation	Private or secluded spaces needed for personal, family visitations.		
Audiology	Demolition of audiology booth for future office space.		
Duress system	Replace existing duress system.	$2M	14–16 months
Window Replacement	Replacement for all facility windows.	$800,000	6-8 months

In its 50 years, major infrastructure renovations have not been possible for two key reasons: 1) HDMC's building design does not allow for phased renovations – patients and staff must vacate for up to 24 months, and 2) extensive renovations will trigger new Code requirements for recertification, leading to the need for evacuation of patients and staff. As shown in the images below, HDMC is working to remediate system failures to the fullest extent possible. For example, the HVAC system failed in summer 2024, and portable units were brought into patient and administrative areas, which have been sufficient so far to cool these areas. The portable units are still required and are currently in place.

In addition, the presence of resistant Legionella rendered the drinking water and ice machines unsafe to use, and patients could not take showers. After aggressive remediation efforts, Legionella bacteria is no longer present in HDMC's antiquated pipes. DBHDS continues to monitor for Legionella to ensure the safety of patients and staff at HDMC.

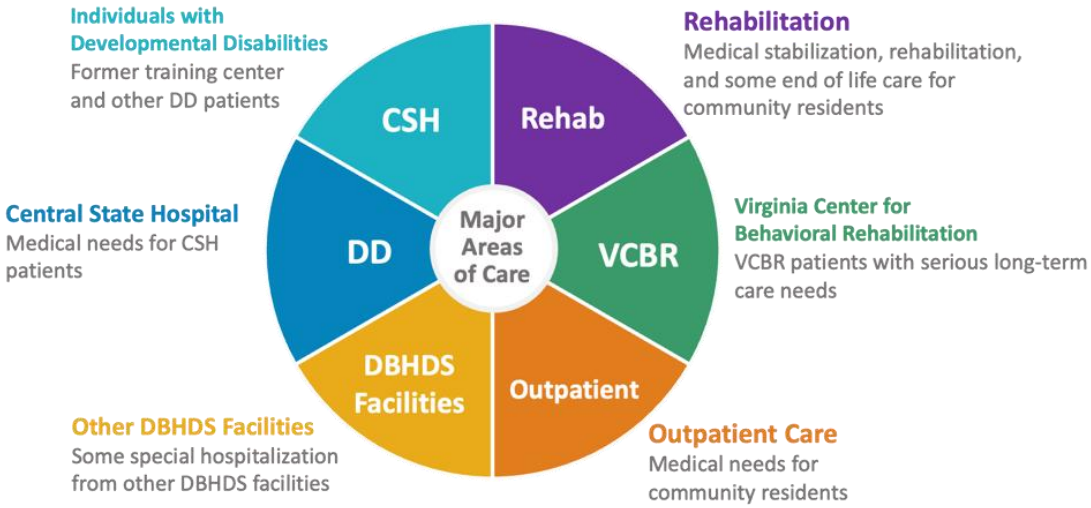
Because the facility's design does not allow for phased renovations, the failure of any major system or any extensive renovations would require the complete evacuation of all patients and staff for up to two years to complete repairs. Such work would also trigger CMS recertification and require upgrades to areas currently "grandfathered" under older Codes, further requiring that the entire building must meet the current Code, adding cost and complexity. As a result, the building would need to be vacated of all patients and all staff for approximately 24 months. It is unknown whether patients who moved to new homes during that length of time would return to a renovated building or if staff would return.

Patient Care at HDMC

HDMC includes 50 skilled nursing facility beds, 40 long-term care beds, and four general medical beds. The facility is unique among DBHDS facilities. HDMC serves a variety of patient populations that have medical needs. Most other states rely on the private sector to provide specialized medical care for those who need it and do not operate this type of medical center or skilled nursing beds. In general, individuals there have either an intellectual or developmental disability, a serious mental illness, dementia, or other neurocognitive disorders. Some individuals may have dual diagnoses.

HDMC serves people with intellectual or developmental disabilities who transitioned there from former training centers or community homes, as well as people with mental health needs from other DBHDS facilities that need long-term care or rehab for medical conditions. For example, HDMC is sometimes used to support the long-term care needs of residents at the Virginia Center for Behavioral Rehabilitation (VCBR) when they face barriers to accessing care due to their legal status as sexually violent predators. Most state hospitals rely on the private sector for long-term medical care, but there are some patients from other state hospitals at HDMC. CSH has historically utilized HDMC as the two facilities share a campus.

HDMC also provides outpatient services such as dental care, internal medicine, OB/GYN, optometry, and general surgery for state hospital patients and individuals with developmental disabilities in the community. Major areas of care are shown below:



HDMC's admissions have declined over time, and occupancy is currently 35 percent. These trends reflect the growth of private-sector options and the preference of families to have loved ones served closer to home. As of August 29, 2025**,** HDMC was serving **33** individuals

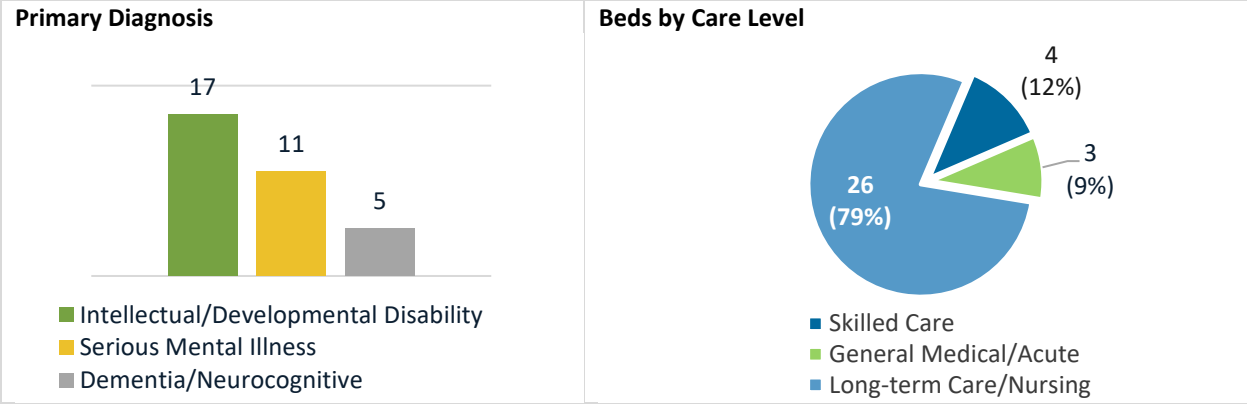
- 17 with intellectual or developmental disabilities (ID/DD)
- 11 with serious mental illness (SMI)
- 5 with dementia or other neurocognitive disorders

Since the closure announcement, the overall census at HDMC was reduced by 10. Currently, six patients are scheduled for discharge and have chosen new home settings. Before the closure date, 27 individuals will need to select new homes in the community, or at SEVTC if they qualify for and choose training center care.

Current Census	33
Current Occupancy	35%
Percent census reduction since 8/2024 closure announcement	26%
Discharges currently planned	6
Average Annual Admissions	
FY 2025	13
FY 2024	31
FY 2023	43
FY 2022	32
FY 2021	33

Patient Populations (September 2025)

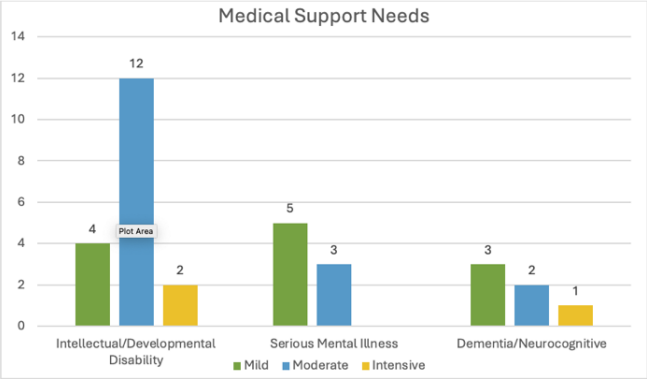
As stated above, HDMC serves three broad populations: individuals with ID/DD, individuals with serious mental illness, and individuals with dementia or other neurocognitive disorders. Depending on their medical needs, HDMC has general medical/acute care beds that typically serve individuals who are planning a shorter stay at HDMC. The facility also has skilled care and long-term care/nursing beds for longer-term patients. The charts below break down HDMC's 33 patients into primary diagnosis and beds by care level.

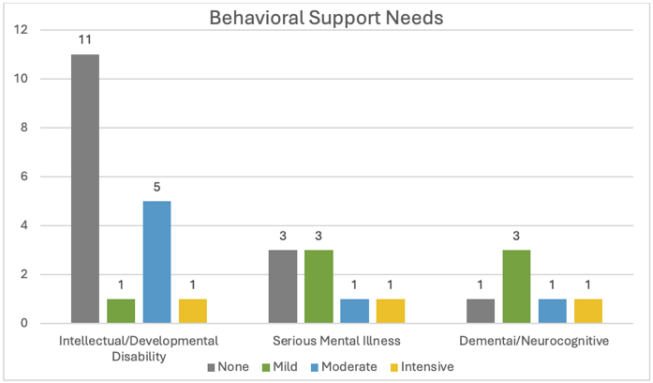


Medical and Behavioral Support Needs (September 2025)

Across the 33 individuals currently at HDMC, medical complexity is concentrated among people with ID/DD, where "moderate" needs dominate and require "intensive" medical supports, as seen below. The medical needs of people with SMI are mostly mild-to-moderate, and there is a smaller cohort of people with dementia/ neurocognitive disorders with one intensive case.

Behaviorally, the majority of people with ID/DD have "no" or "mild" behavioral needs, with only one "intensive" case. The groups of people with SMI and dementia each include a single "intensive" case and small numbers at "moderate." For HDMC transitions, this profile suggests the most challenges for finding quality community housing will be for (a) people with ID/DD with moderate-to-intensive medical needs (e.g., skilled nursing tasks, durable equipment, frequent clinical oversight) and (b) anyone with a combination of moderate behavioral needs and moderate medical needs, because relatively few community providers are set up for both. Priority solutions include seeding complex-care group homes and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) options, contracting nursing facilities with embedded behavioral consultation, and ensuring robust post-placement supports (nursing, therapies, rapid-response) so willing providers can take placements of people with these higher-acuity needs.





When the six discharges mentioned above transition to their new homes, HDMC's census will be 27. DBHDS engages with patients and families on a quarterly and an annual basis to talk about essential support needs and preferences and assess their willingness to consider new community homes. If – and only if – families give authorization, DBHDS can begin exploring community options for them to consider, but they will never be pressured to accept these options.

Based on conversations with family members, DBHDS has anticipated the type of new setting each family is likely to choose. The following sections provide additional details about the 27 patients who will remain at HDMC after the six planned discharges referenced in the Patient Care section occur. These 27 patients have not yet chosen new home settings and need to be included in plans to close HDMC.

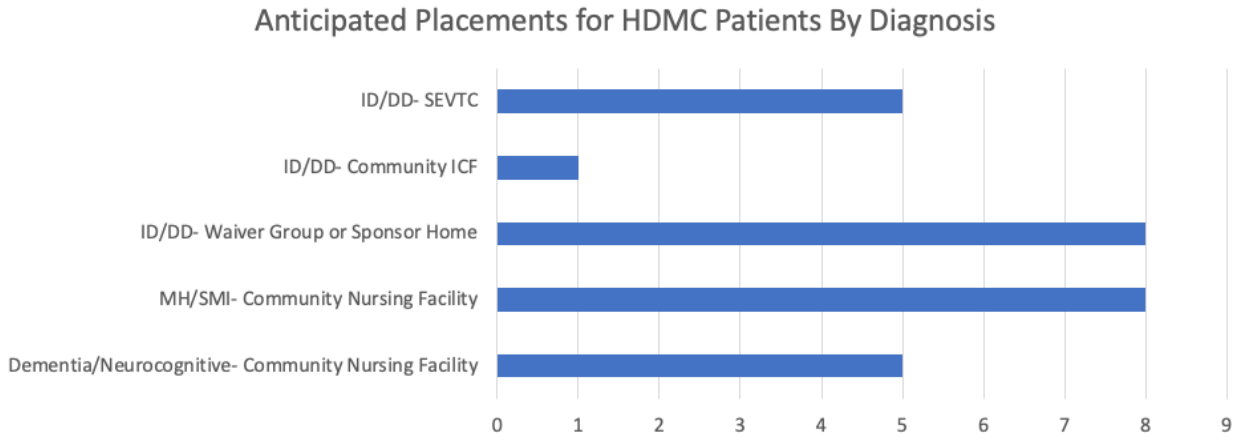
Patients with Intellectual or Developmental Disabilities (ID/DD) Who Have Not Selected New Placements (September 2025)

Of the **14** individuals with ID/DD expected to remain after planned discharges:

- **57 percent** are likely to choose Medicaid waiver group homes.
- **36 percent** are likely to choose newly developed skilled nursing beds at Southeastern Virginia Training Center (SEVTC).
- **7 percent** are likely to choose a community intermediate care facility.

Patients with Serious Mental Illness or Dementia/Neurocognitive Disorders Who Have Not Selected New Placements (September 2025)

Based on the level of care and support needs, it is anticipated that all **11** patients/authorized representatives in these categories will choose to transition to community nursing facilities. Other options for these populations include specialized mental health group homes, and memory care facilities equipped for complex medical and behavioral needs. DBHDS maintains contracts with providers offering specialized supports for this population, including behavioral consultation services for individuals in nursing facilities. Details about the anticipated residential options the 27 patients who remain at HDMC without discharge plans could choose are found below:



Diagnosis	Anticipated Location	Count
Intellectual Disability/Developmental Disability (ID/DD)	Southeastern Virginia Training Center	5
Intellectual Disability/Developmental Disability (ID/DD)	Community Intermediate Care Facility	1
Intellectual Disability/Developmental Disability (ID/DD)	Waiver Group or Sponsor Home	8
Mental Health/Serious Mental Illness (MH/SMI)	Community Nursing Facility	8
Dementia/Neurocognitive	Community Nursing Facility	5
	Total	**27**

Former VCBR Residents & Other Specialized Populations (September 2025)

HDMC currently serves three individuals who previously resided at the Virginia Center for Behavioral Rehabilitation (VCBR). Two of these individuals were admitted with a diagnosis of dementia and one with a serious mental illness. Since 2020, there have been 18 admissions from VCBR for rehabilitation, stabilization, or long-term care. DBHDS is developing targeted strategies to ensure continuity of care for this group once HDMC closes.

Opportunity at SEVTC

DBHDS first explored adding a wing to the new Central State Hospital (CSH) currently being constructed. However, DBHDS learned 1) there is not adequate space in the CSH construction site for a smaller HDMC, and 2) the federal Centers for Medicare and Medicaid Services does not allow for reimbursement for skilled nursing care in a facility that is considered an Institution for Mental Disease (IMD), which is how Central State Hospital will continue to be classified in its new building.

Virginia's last remaining training center, SEVTC in Chesapeake, has capacity to accommodate up to 10 people from HDMC. Two of SEVTC's 15 freestanding homes will be renovated and certified by VDH/CMS as skilled nursing beds to serve medically complex HDMC residents who meet eligibility and who choose to remain in a training center setting under Va. Code § 37.2-837(A)(3).

Southeastern Virginia Training Center (SEVTC)

As of August 10, 2025, there were 65 individuals at SEVTC. The center was built with a capacity for 75 individuals. Each of the 15 homes can accommodate one additional individual, if necessary, but DBHDS prefers for the homes to house no more than five individuals each.

Improvements are planned to meet requirements for skilled nursing certification and to meet the needs of HDMC residents anticipated to choose training center care. These improvements include bathroom renovations, accessibility changes, electrical upgrades for nurse call systems, oxygen delivery, lifts, and ventilation. Staff will be upskilled, and some will transfer from HDMC to maintain continuity of care.

The planned SEVTC nursing beds will provide a training center option for eligible HDMC residents, maintaining compliance with the comparable care and choice requirements of Va. Code § 37.2-837. Staff from HDMC will be trained or reassigned to SEVTC to preserve continuity of care. As shown below, construction for the renovations started in October 2025, with completion and certification anticipated in May 2026.

Renovating and Certifying Two Homes at SEVTC for Skilled Nursing Care

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

Community Services Opportunities

Many families are expected to choose community-based options closer to home, including:

- Medicaid waiver-funded group homes and sponsored residential homes
- Private intermediate care facilities (ICFs)
- Private nursing facilities willing to accept individuals with behavioral health or ID/DD needs

Examples of these types of facilities are included below:

Private Intermediate Care Facility for People with I/DD (ICF/IID)	Residential facility with active treatment, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health/rehabilitative services.
Sponsored Residential Home	Family home that supports 1-2 individuals but has a contractual agreement with a licensed provider agency who provides oversight and administrative services. Some support complex medical support needs.
Group Home	Home providing 24-hour super-vision and support to 3 or more people. Homes may employ specialized staff or utilize the individuals' Medicaid waiver to secure skilled or private duty nursing services and behavioral health and other support.

DBHDS is working to incentivize private skilled nursing providers to accept individuals with behavioral health and/or ID/DD needs and is offering training and resources to support them. The department is also providing training and resources to community providers and may offer one-time funding to develop capacity for medically complex placements. Any transitions of HDMC residents to these settings will follow the proven process DBHDS used to transition 874 training center residents to new homes from 2012 to 2020. This process includes extensive family consultation, trial visits, individualized transition planning, and post-move monitoring.

HDMC Admissions Information

Referrals – In FY 2025, there were 27 people referred to HDMC; 13 were admitted and 14 not admitted for medical, behavioral, or other reasons. Of these referrals, approximately 80 percent come from DBHDS facilities and 20 percent from community settings.

Admissions – The vast majority of individuals at HDMC were admitted from DBHDS state facilities. In FY 2025, 92 percent came from state facilities, and in FY 2024, 74 percent came from state facilities.

Location where admission originated	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Community settings across VA	9	12	20	8	2
DBHDS Facilities	24	20	23	23	11
- Central State Hospital	4	4	6	9	4
- Southeastern VA Training Center	8	4	5	4	1
- VA Center for Behavioral Rehabilitation	3	3	7	1	2
- 7 Other State Hospitals	9	9	5	9	4
Total	**33**	**32**	**43**	**31**	**13**

In FY 2025, 29 percent of admissions (9 individuals) occurred. Medical acuity at Central State is consistent with other state hospitals; admissions are primarily due to proximity and convenience. HDMC residents come from across Virginia: four transferred from Horizon Behavioral Health when Central Virginia Training Center closed (Region 1, Western Virginia). Most current residents are from Region 4, Central Virginia.

The length of stay varies greatly, with some admissions only staying a short time for rehabilitation, while others are considered permanent patients.

DBHDS Guidance on HDMC Referrals and Admissions

Current DBHDS guidance on referrals to HDMC is as follows:

- **Community referrals** – Reviewed and accepted when clinically appropriate.
- **Referrals from state facilities** – Permanent transfers are paused to avoid multiple disruptions if closure advances. This supports discharge planning requirements in Va. Code § 37.2-316(B)(4) and Va. Code § 37.2-505, ensuring services match individual needs and preferences. Instead, individuals who would have transferred permanently to HDMC are being connected with appropriate community providers.
- **Temporary/short-term admissions** – May occur on a case-by-case basis.

This guidance is consistent with Va. Code § 37.2-316's emphasis on orderly planning and transitioning individuals to community services if and when a closure proceeds. These decisions also reflect the desire to avoid the unnecessary emergency placement of any individual should the building fail before any final plan is approved by the General Assembly and the Governor.

In August 2025, HDMC employed 144 staff, as shown in the table on the left, below. Entire departments, totaling 36 HDMC positions, will transfer to the new Central State Hospital (CSH), preserving therapeutic, lab, dental, and pharmacy services for state facilities and the community. The table below on the right shows these positions.

HDMC Classified Staffing (July 2025)	Filled
Administrative Staff	15
Clinical Staff	20
Therapy	6
Healthcare Compliance Specialists	5
Direct Service Associates	53
LPN	22
Nursing	23
Total	**144**

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

Additional staff may also transfer to CSH. Staff will receive preferential recruitment for comparable roles at CSH or other DBHDS facilities. Substantial completion of the new CSH is expected in January 2027 (renderings below).

Clinical roles at HDMC include counselors, laboratory and pharmacy staff, dentists, and physicians. These positions are in high demand in the private sector and within DBHDS. Other staff will have opportunities at DBHDS facilities within a 50-mile radius. The goal is not to have layoffs, with retention bonuses modeled after training center closures to maintain staffing levels until all patient transitions are complete. Current new work location preferences of HDMC are found to the right. Of note, the unaccounted for/ remaining staff (56 people, 40 percent) represent those who have not yet been allocated or expressed preference placement or have different plans. As of August 2025, only four have stated a preference to retire, though many are eligible.

In addition, DBHDS continues to speak to HDMC clinical staff about the possibility of transferring to the new nursing beds at SEVTC to continue to care for the individuals they cared for at HDMC. So far, as shown to the right, one full-time nursing staff member has stated an intention to relocate to SEVTC.

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

Establishing the Planning Team Process

Background on Va. Code 37.2-316

Va. Code § 37.2-316 was enacted in 2003 in direct response to an attempt by the department to close a state hospital without a structured public process. The General Assembly's intent was to create a clear, orderly, and transparent framework to ensure that any proposed restructuring of the state hospital system would be accompanied by a comprehensive plan and meaningful stakeholder engagement before a closure could proceed.

The statute requires the Commissioner to establish a State and Community Consensus and Planning Team when the restructuring of the system of mental health services involves an existing state hospital. The Planning Team must include a broad array of representatives: individuals receiving services, family members, advocates, state hospital employees, community services boards (CSBs), local government officials, local health and social services departments, law enforcement, area agencies on aging, private providers, and members of the General Assembly representing the service area.

The process must allow for public input, ensure that all affected stakeholders have an opportunity to be heard, and produce a plan that is reviewed by the Joint Commission on Health Care and approved by both the Governor and the General Assembly before implementation.

Commitment to Stakeholder Engagement and an Inclusive Process

Consistent with Va. Code § 37.2-316, DBHDS has convened the Planning Team with broad stakeholder representation. The process is structured to:

- Maintain openness and accessibility through in-person and virtual meetings;
- Welcome and incorporate public feedback;
- Create subgroups to focus on Supporting Patients, Supporting Staff, and Ensuring Community Services; and
- Develop a comprehensive plan that emphasizes orderly, safe discharges, sustainable community capacity, and workforce stability.

DBHDS has prioritized making the planning process accessible to the public through in-person and virtual meetings, public comment opportunities, subgroup work, and ongoing communications with patients, families, staff, legislators, advocates, and providers. Stakeholders have been encouraged to share ideas, voice concerns, and propose alternatives. Every piece of input has been considered in the development of this plan, even though not all recommendations can or will be incorporated into the final version.

Balancing Stakeholder Input with Systemwide Considerations

While the closure plan reflects the recommendations from the Planning Team's subgroups, it must also account for the health of the entire service system and the Commonwealth's long-term

obligations. Proposals to build a new congregate facility, for example, could raise concerns under the Americans with Disabilities Act (ADA), U.S. Supreme Court ruling in *Olmstead,* federal settlement agreements, and potentially invite U.S. Department of Justice scrutiny. In contrast, the addition of 10 skilled nursing beds at SEVTC to support former training center residents is expected to be consistent with federal expectations. The closure plan, therefore, may differ from some subgroup recommendations to safeguard both individual care and the stability and sustainability of Virginia's developmental services system. However, this report includes links to all of the subgroup reports for the Governor and General Assembly's consideration.

Transition Goals and Outcomes

DBHDS's goal is to complete the closure of HDMC by December 2027, or earlier if all residents have been safely transitioned to appropriate settings. The plan emphasizes individualized, orderly discharges, continuity of essential supports, strong workforce transition strategies, and preservation of critical community services. Through this approach, DBHDS will honor the needs of current HDMC residents and staff and strengthen the Commonwealth's capacity to provide high-quality, integrated care into the future.

Statutory Framework and Approach to "Consensus"

While § 37.2-316 describes the group convened to guide this process as a "State and Community Consensus and Planning Team," uniform agreement among such a broad and diverse array of stakeholders with differing goals, priorities, and concerns is rarely achievable. The true purpose of this statutory requirement lies not in achieving unanimity but in ensuring that every voice is heard, every perspective is considered, and that the planning process is comprehensive, thoughtful, and transparent. DBHDS has approached this responsibility by making the process open and accessible to the public, maintaining publicly available materials, and actively inviting and receiving feedback throughout. The Department's priority in this work is to create a process where stakeholders understand their input is valued, and where that input informs a plan that ensures safe, orderly, and well-supported transitions for every individual served.

Va. Code § 37.2-316 Application to the HDMC Closure

While Va. Code § 37.2-316 was codified over 20 years ago, the closure of HDMC marks the first time this process has been implemented. From 2012 to 2020, Virginia closed four of its five training centers, but Va. Code § 37.2-316 did not apply because the training centers were not state hospitals. HDMC is not a state hospital, but it serves many populations, including state hospital patients, so Va. Code § 37.2-316 must apply to HDMC's closure process. As a result, DBHDS applied the Va. Code § 37.2-316 process broadly, encompassing all populations served at HDMC, not solely those who came from state hospitals. This ensures that each person's needs are considered in the planning process and that every affected population benefits from the same deliberate and orderly approach envisioned by the General Assembly when the statute was created.

Commitment to an Inclusive Process

Stakeholders and Membership – The Planning Team includes representatives required by Va. Code § 37.2-316 and relevant HDMC stakeholders: DBHDS staff; local officials; individuals receiving services and family members; advocates; state hospital employees; community services boards; private providers and hospitals; local health departments; social services; sheriffs; area agencies on aging; interested members of the General Assembly; and other interested persons.

HDMC Planning Team

Full Planning Team

- October 16th, 2024 at 3pm
- June 5th, 2025 at 10:30am
- September 4th, 2025 at 2:30pm

Supporting Patients Subgroup

- December 12th, 2024 at 1pm
- February 3rd, 2025 at 3pm
- March 11th, 2025 at 2pm
- April 17th, 2025 at 1pm
- May 15th, 2025 at 2:30pm
- June 17th, 2025 at 11am
- June 30th, 2025 at 3pm
- July 7th, 2025 at 11am
- July 21st, 2025 at 12pm

Supporting Staff Subgroup

- December 17th, 2024 at 9:30am
- January 29th, 2025 at 9am
- March 17th, 2025 at 3:30pm
- April 28th, 2025 at 12pm
- May 29th, 2025 at 3:30pm
- June 13th, 2025 at 12pm
- July 21st, 2025 at 3:30pm

Community Services Subgroup

- December 16th, 2024 at 10:30am
- February 6th, 2025 at 2pm
- March 25th, 2025 at 10am
- April 22nd, 2025 at 1:30pm
- May 16th, 2025 at 12pm
- June 12th, 2025 at 3pm
- June 30th, 2025 at 12pm
- July 11th, 2025 at 12pm
- July 22nd, 2025 at 2:30pm

Structure, Subgroups, and Timeline – DBHDS convened the first meeting in October 2024, following the August 2024 announcement regarding the start of the Planning Team process. Full Planning Team meetings were held three times: once to kick off the process, an update mid-process, and a final time to review the closure plan and provide feedback. DBHDS also established three subgroups to provide expertise on specific areas and develop tailored plans: Supporting Patients, Supporting Staff, and Community Services. The subgroups were tasked with developing plans to provide to the Commissioner by August 1, 2025. The meeting schedule is found to the left.

Transparency and Public Engagement – DBHDS has emphasized open, ongoing engagement since the closure announcement, including direct outreach to families and staff, presentations to the Behavioral Health Commission and JCHC, and public meetings of the Planning Team. Full Planning Team and all subgroup meetings were open to the public, recorded, and posted on the HDMC website. Public comment was accepted at meetings and in writing via email at: hdmcplanningteam@dbhds.virginia.gov. DBHDS maintains a public webpage for all information and comment submission.

How the Subgroups Inform the Closure Plan

Supporting Patients - assess placement options and person-centered transition planning for all HDMC populations and identify any specialized capacity required.

Supporting Staff - develop strategies to minimize layoffs, align staff with vacancies across DBHDS (especially at Central State), and as needed, use retention incentives to ensure care continuity during ramp-down.

Community Services - identify services that must exist in the community before closure e.g.,

nursing facility partnerships, behavioral supports in nursing homes, memory care, and other capabilities to meet complex medical needs, plus community education.

Importantly, while stakeholder input is critical, not all subgroup recommendations will be incorporated into the closure plan. For example, building a new congregate facility could raise concerns with the U.S. Department of Justice, while the SEVTC nursing beds are expected to meet both state and federal requirements. The closure plan balances individual needs with the long-term stability and sustainability of Virginia's developmental services system. A summary of each subgroup's recommendations are found below and a link to each subgroup's full report is included at the bottom of this section.

Supporting Patients Subgroup Summary

The purpose of the Supporting Patients Subgroup was to identify and recommend strategies for safely and successfully transitioning all HDMC patients to appropriate, high-quality care settings in advance of the facility's planned closure by December 2027. The subgroup focused on ensuring individualized planning, preserving patient choice, and maintaining or improving quality of life during and after the transition. The subgroup included representatives from DBHDS leadership, HDMC clinical and administrative staff, community services boards (CSBs), private and public care providers, patient and family advocates, and specialists in developmental disabilities, serious mental illness, dementia, and medical care. The composition ensured expertise across the patient populations served at HDMC.

The subgroup met regularly to review detailed patient data, evaluated available placement options, and discussed service gaps. The group engaged with families, guardians, and care teams to understand patient preferences and needs. Lessons learned from previous training center closures were incorporated, and recommendations were coordinated with the Workforce and Community Services subgroups. Major subgroup recommendations included:

- **Individualized Transition Planning** – Develop a personalized transition plan for each patient, including medical, behavioral, and social support needs. Plans should be created with input from the patient, family, or guardian, and reviewed regularly until transition is complete.
- **Preserve Patient and Family Choice** – Ensure all patients and their authorized representatives are offered a range of placement options that meet their care needs, including the choice to transfer to the Southeastern Virginia Training Center (SEVTC) for those with intellectual or developmental disabilities.
- **Expand Placement Options for All Populations** – Increase availability of specialized nursing facilities, Intermediate Care Facilities, Medicaid Waiver group homes, sponsored residential settings, and mental health group homes with medical support. Ensure placements are geographically dispersed to maintain community ties.
- **Consider Rebuilding HDMC Services on a Smaller Scale** – Several family members and guardians strongly recommended that DBHDS rebuild a smaller facility in or near the current HDMC campus, maintaining the medical and rehabilitative model of care in a state-operated setting.

- **Provide Specialized Supports for Complex Medical Needs** – Develop contracts and partnerships with providers capable of supporting individuals with intensive medical needs, including tracheostomy care, ventilator support, IV therapy, and wound care.
- **Address the Needs of Non-I/DD Populations** – Secure placements for individuals with serious mental illness, dementia, or neurocognitive disorders in specialized group homes, memory care units, or nursing facilities with behavioral support services.
- **Maintain Continuity of Care During Transition** – Ensure uninterrupted access to therapies, medications, and specialized medical services during the transition period through coordination between current and receiving providers.
- **Use Trial Visits and Gradual Transitions** – When feasible, allow patients to visit prospective placements and engage in gradual transition activities to reduce anxiety and improve outcomes.
- **Monitor Post-Transition Outcomes** – Track and evaluate patient well-being, safety, and satisfaction after placement to ensure services meet the intended goals and to address any emerging concerns promptly.

Community Services Subgroup Summary

The purpose of the HDMC Planning Team Community Services subgroup was to identify and recommend the types, amounts, and locations of community services needed to support the closure of HDMC by December 2027. The subgroup's work focused on ensuring that adequate and sustainable community capacity is in place to serve current HDMC residents in alternative settings while maintaining quality of care. Membership consisted of members representing state and local government officials, community services boards (CSBs), private service providers, advocacy organizations, family members of individuals receiving services, health professionals, and representatives from relevant state facilities. Membership ensured diverse perspectives and expertise in planning for the transition of HDMC residents into community-based care.

The subgroup met regularly and included presentations from DBHDS staff, review of current HDMC patient data, examination of available and needed community services, and discussion of barriers to community placement. Public comment and stakeholder engagement were incorporated throughout the process. The subgroup coordinated closely with the Supporting Patients and Supporting Staff subgroups to align recommendations. Major workgroup recommendations included:

- **Expand Community Residential Options** – Develop and increase availability of Medicaid Waiver-funded group homes, sponsored residential homes, and private Intermediate Care Facilities (ICFs) with the ability to meet complex medical needs. Ensure geographic distribution to support placement close to individuals' home communities.
- **Enhance Specialized Medical and Behavioral Support Services** – Establish contracts and provider capacity for skilled nursing facilities, memory care units, and specialized mental health group homes that can support individuals with serious mental illness, dementia, or co-occurring disorders, including access to behavioral support services in nursing facilities.

- **Increase Capacity at Southeastern Virginia Training Center (SEVTC)** – Renovate two existing homes to provide skilled nursing-level care for individuals with intellectual and developmental disabilities (I/DD) who choose SEVTC. Expand capacity as needed to meet demand without exceeding the beds allowable under current legal agreements.
- **Rebuild or Develop New HDMC Services** – Some stakeholders emphasized that, alongside community service development, Virginia should invest in rebuilding HDMC on a smaller scale near the current campus, to preserve a state-operated medical center option for individuals with high medical or behavioral complexity.
- **Support Transitions with Individualized Planning** – Use DBHDS's established discharge planning process, including engagement with families and authorized representatives, to ensure all placements meet individuals' needs and preferences. Provide trial visits, transition supports, and follow-up to ensure stability after discharge.
- **Strengthen Community-Based Health Services** – Expand access to outpatient medical services, rehabilitation, therapies (physical, occupational, speech), dental care, and specialty medical care to replace services previously provided at HDMC. Consider mobile and telehealth models to improve access in rural or underserved areas.
- **Ensure Sustainable Funding** – Secure ongoing funding for the development, staffing, and operation of expanded community services, including potential use of carry-forward funds for one-time development costs and Medicaid reimbursement adjustments to sustain operations.
- **Workforce Development and Training** – Coordinate with the Supporting Staff subgroup to ensure adequate training for community providers in supporting individuals with high medical needs. This includes recruitment initiatives, retention strategies, and specialized training programs. Partner with the Virginia Department of Health to provide a "a targeted training and consultation program for community nursing facilities and service providers" given Governor Youngkin's August 11, 2025 Executive Order 52 on *Strengthening Oversight of Virginia's Nursing Homes.*
- **Monitor and Evaluate Outcomes** – Implement a structured process for monitoring placements post-transition to ensure safety, quality of care, and satisfaction. Use outcome data to make adjustments to services and supports.

Supporting Staff Subgroup Summary

The purpose of the Supporting Staff Subgroup was to develop recommendations to ensure the successful transition of HDMC employees as the facility prepares for closure by December 2027. The subgroup focused on retaining essential staff to provide quality care until the final transition, offering pathways to new employment within the DBHDS system, and minimizing layoffs. The subgroup was composed of DBHDS leadership, human resources representatives, facility administrators, representatives from Virginia Works, and staff from HDMC and neighboring facilities. The membership included individuals with expertise in workforce planning, recruitment, retention, and employee benefits to ensure a broad approach to transition planning.

The subgroup met regularly to review staffing data, vacancy rates, retention needs, and lessons learned from prior state facility closures. They assessed the availability of comparable positions at other DBHDS facilities, identified skill transfer opportunities, and discussed potential incentives to retain staff during the closure process. Feedback from staff, families, and other stakeholders was incorporated. Major workgroup recommendations included:

- **Implement a Retention Bonus Program** – Establish a progressive retention bonus system to encourage key staff to remain at HDMC until their positions are no longer needed. Bonuses should be paid quarterly or in lump sums based on role and length of continued service.
- **Prioritize Placement at Central State Hospital (CSH) and Other DBHDS Facilities** – Offer affected employees comparable positions at CSH, Piedmont Geriatric Hospital, the Virginia Center for Behavioral Rehabilitation, or other DBHDS locations within a 50-mile radius. Relocation assistance should be available for moves over 50 miles.
- **Facilitate Skill Transfers and Career Development** – Provide training and professional development to help staff transition into new roles within DBHDS or in the private sector. This includes cross-training, certification programs, and career counseling.
- **Use Attrition to Reduce Layoffs** – Manage workforce reductions through natural attrition when possible, avoiding layoffs where comparable positions can be offered.
- **Support Retirement-Eligible Employees** – Offer counseling and information on retirement options for the 48 full-time staff members eligible for service retirement, ensuring informed decision-making.
- **Communicate Frequently and Transparently** – Maintain ongoing communication with staff through meetings, newsletters, and direct outreach to provide updates on closure timelines, job openings, and transition support resources.
- **Coordinate with Other Subgroups** – Ensure alignment with other subgroups to synchronize patient transitions and staffing needs.

Utilizing Subgroup Recommendations to Create the Closure Plan

As stated above, not all subgroup recommendations are included in the closure plan because the statute requires a single, executable course of action that is clinically safe, financially responsible, and achievable on a defined timeline. The subgroups were asked to surface the full range of ideas, including proposals that conflict with one another, so some were expected to be screened out against feasibility, cost, workforce, and alignment with statewide strategy. DBHDS has provided a link to all subgroup reports below.

For example, the HDMC Parent Group strongly endorsed rebuilding the facility on a smaller scale in or near the current campus, and subgroup recommendations include this option, but the closure plan does not support this option. Since the current HDMC building must be closed, investment in community capacity has to be made to accommodate. As a result, rebuilding HDMC would be a double investment: funds in community capacity and then again in a new or renovated facility to serve the same populations. In addition, HDMC must be completely renovated to continue operating the facility. As described above, the aging infrastructure of HDMC will not support patient operations for much longer. All major systems are at the end of their useful life. It is unlikely that the lengthy process to receive capital funding, design and plan for a new facility, and complete construction could occur before a major system failure would cause the evacuation of the building. Finally, demand across Virginia for institutional services provided by HDMC has significantly decreased over the years as described above, and it is

unknown how many patients would return to a new building if one if built after a system failure causes a lengthy evacuation.

DBHDS recognizes, sincerely, that SEVTC is far from many families' homes. DBHDS is committed to choice and to working continuously with any interested family to identify willing, qualified providers closer to home and to investing in the quality, complex-care supports those providers need to say "yes." For families who do prefer SEVTC, DBHDS will maintain robust medical, behavioral, and quality oversight. For families who do not choose SEVTC for their qualifying loved one, community options and post-transition supports will be emphasized that advance the Parent Group's goals for safety, stability, and access, without the delays, concentrated risk, and long-term costs of rebuilding a hospital on the HDMC campus.

Links to Subgroup Reports and Public Comment: DBHDS recognizes the Governor and the General Assembly may want to reference the subgroups' full reports. These reports are very well crafted, provide thorough details, and were critical in the development of the closure plan. In addition, DBHDS presented a draft of the closure plan, posted it publicly on the Hiram Davis website, and opened a two-week public comment period to receive feedback on the draft. During this time, three comments were submitted concerning the draft Closure Plan from parents expressing concerns about closing the facility. All feedback from the public comment period and comments received throughout the public comment period are posted online. **The complete reports for each subgroup, and all public comments are posted on the HDMC Planning Team webpage at: www.dbhds.virginia.gov/facilities/hwdmc/hwdmc-planning-team.**

Closure Plan for HDMC

Guiding Principles for the Closure Plan

The development of this plan has been guided by clear priorities:

- **Patient care first** – safe, individualized, high-quality care in the most appropriate setting.
- **Workforce stability** – goal of no staff layoffs, with placements in other DBHDS facilities and retention incentives.
- **Improving community services** – a focus on growing and improving safe and quality medical and long-term care services in the community for individuals with developmental disabilities and serious mental illness.
- **Stakeholder inclusion** – open, transparent process inviting a broad array of stakeholders to participate, ensuring methods to provide feedback, and making meeting details publicly available.
- **System sustainability** – responsible use of taxpayer funds, alignment with best practices, and compliance with federal expectations for integrated care.
- **Legal obligations** – full compliance with § 37.2-837(A)(3), ensuring that former training center residents have the option to remain in a state training center setting and receive comparable care.

As a result, the closure plan reflects the overarching goals of patient care, workforce stability, and stewardship of Virginia's behavioral health and developmental services system, and it balances stakeholder input with systemwide responsibilities. As a result, not all subgroup recommendations will be incorporated in their entirety. First and foremost, the plan prioritizes patient health, safety, and choice, with an emphasis on individualized, high-quality care in the most appropriate setting. It also pursues the goal of avoiding staff layoffs by identifying placement opportunities across DBHDS facilities. At the same time, the plan must account for the long-term sustainability of the entire system and the responsible use of taxpayer dollars.

These considerations include awareness of broader federal policy trends, such as the U.S. Department of Justice's (DOJ) increasing scrutiny of states that rely heavily on institutional nursing facility beds, and the national push toward integrated, community-based care. While DBHDS is confident that the creation of 10 new skilled nursing beds at SEVTC for former training center residents aligns with federal requirements and will not trigger DOJ concerns, proposals to construct a new facility could raise questions about compliance with the Commonwealth's settlement obligations and the direction of system transformation. Accordingly, the closure plan will reflect a careful balance of stakeholder input, legal and policy considerations, and the long-term health of the system as a whole.

Closure Plan Details

1. Current State Snapshot

This section summarizes the current operating context to anchor transition planning. The graphic below is explained in more detail in the following text.

Facility Profile

HDMC is a state-operated medical and skilled nursing facility that has historically served individuals with complex medical needs from DBHDS facilities and the community. Major building systems are at end-of-life, and extensive repairs would require full evacuation for up to 24 months, so as a result, the plan proceeds to closure.

Closure Date

In August 2024, the Commissioner announced the start of the HDMC closure process and proposed the date of closure to be by December 2027. The closure plan recognizes closing HDMC would impact patients, staff, the local community, and the larger system of services and **maintains the recommendation to close HDMC by December 2027**. This date will allow the process of closing HDMC to be gradual so DBHDS can help individuals move into safe placements of their choice and ensure that their needs are appropriately met and can transition staff who would like to stay in the DBHDS system into new positions.

Patient Populations

In August 2024, the Commissioner announced the start of the HDMC closure process and proposed the date of closure to be by December 2027. The closure plan recognizes that closing HDMC would impact patients, staff, the local community, and the larger system of services and maintains the recommendation to close HDMC by December 2027. This date will allow the process of closing HDMC to be gradual, so DBHDS can help individuals move into safe placements of their choice and ensure that their needs are appropriately met and can transition staff who would like to stay in the DBHDS system into new positions.

Patient Populations

Individuals served at HDMC include: (a) people with intellectual or developmental disabilities (ID/DD); (b) people with serious mental illness (SMI); (c) people with dementia or other neurocognitive disorders; (d) individuals admitted for short-term medical stabilization, wound care, or rehabilitation; and (e) a limited number with a history at the Virginia Center for Behavioral Rehabilitation (VCBR).

The following was provided earlier in this report about the population at HDMC as of September 2025 and what settings individuals and authorized representatives are likely to choose.

Current Census	33
Current Occupancy	**34%**
Percent census reduction since 8/2024 closure announcement	**26%**
Discharges currently planned	**6**

Diagnosis	Anticipated Location	Count
Intellectual Disability/ Developmental Disability (ID/DD)	Waiver Group Home	8
ID/DD	Southeastern VA Training Center	5
ID/DD	Community Intermediate Care Facility	1
Mental Health/Serious Mental Illness	Community Nursing Facility	8
Dementia/ Neurocognitive	Community Nursing Facility	5
	Total	**27**

Workforce Overview

As shown below, HDMC employs a multidisciplinary workforce including nursing, direct care, pharmacy, laboratory, radiology, dental, rehabilitation therapies, and support staff. Neighboring Central State Hospital (CSH) and other DBHDS facilities have comparable roles and vacancies that can absorb HDMC staff through transfer and attrition. Several clinical departments are slated to move to CSH to preserve service continuity. Preferences for new work locations of HDMC staff are included below.

HDMC Classified Staffing (Aug 2025)	Filled
Administrative Staff	15
Clinical Staff	20
Therapy	6
Healthcare Compliance Specialists	5
Direct Service Associates	53
LPN	22
Nursing	23
Total	**144**

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

Services Anchored at HDMC

Services delivered on the HDMC campus have included: internal medicine; pharmacy; laboratory and radiology; dental (including sedation dentistry); physical, occupational, and speech therapies; podiatry; selected surgical consults; palliative and end-of-life supports. The plan below details how these services will be maintained through CSH and community partners.

Location Preferences of HDMC Staff	# of staff	%
CSH Preferred	39	27%
CSH Transfer of Services	28	19%
Piedmont Geriatric Hospital	5	3%
Virginia Center for Rehabilitative Services	1	1%
Central Office	3	2%
Southeastern Virginia Training Center	1	1%
Eastern State Hospital	3	2%
Retiring	4	3%
Unaccounted for/Remaining	60	42%
Total	**144**	**100%**

2. Operational Posture During Transition

Admissions Policy Aligned to Closure

Cease new permanent admissions. Limit temporary admissions from DBHDS facilities to time-limited, clinically necessary cases approved by a centralized review, with a preference to stabilize and discharge to community settings. Communicate policy to referring facilities, CSBs, hospitals, and families.

Life Safety and Infection Control

Maintain rigorous life-safety practices and infection control for remaining residents; continue required monitoring, mitigation, and contingency planning while census declines.

Placement Data and Progress Management

Track and report monthly: census, individual transition status, barriers, and anticipated discharge dates. Use a central dashboard to drive case conferences and unblock barriers.

Communications

Issue regular updates to families/guardians and staff; maintain a public-facing webpage with timelines, FAQs, and meeting materials; provide a single point of contact for transition questions.

Patient Transfers

Safely transitioning patients to new placements that meet their care needs and preferences

3. Patient Transition Plan (by Population)

Cross-Cutting Standards

- Individualized Transition Plan (ITP) for every person, covering medical, behavioral, social, communication, and mobility needs; developed with the individual and their authorized representative.
- Pre-move planning: records transfer, medication reconciliation, durable medical equipment (DME) and supplies, transportation, staffing handoffs, and benefits/billing readiness.
- Choice and trialing: offer a range of qualified providers and, when feasible, trial visits or virtual tours to support informed choice.
- Care continuity: align prescribers, pharmacies, therapies, and specialty clinics before moving dates; schedule post-move follow-ups.
- Post-transition monitoring: intensive check-ins at 72 hours, 14 days, 30/60/90 days, then quarterly for one year; rapid response supports to address emergent issues.
- Offer trial visits and gradual transitions whenever feasible, allowing patients to experience new settings prior to full discharge to reduce anxiety and improve outcomes.
- Ensure continuity of therapies and specialty medical services (physical, occupational, speech, dental, behavioral health) during transition, alongside medication and pharmacy continuity.
- Expand post-transition monitoring to include not only health and safety outcomes but also patient and family/guardian satisfaction and quality-of-life measures, with follow-up case conferencing if concerns arise.

As of September 2025, there were 27 patients who needed new residential placements.

Individuals with ID/DD

Placement pathways include Medicaid Waiver Group Homes, Sponsored Residential homes, community Intermediate Care Facilities (ICF/IID), and community Nursing Facilities when medically necessary. For those who elect state facility care, Southeastern Virginia Training Center (SEVTC) will be readied to accept individuals with enhanced medical needs. Additional actions:

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

Based on conversations with families, DBHDS anticipates the 14 patients with ID/DD will choose Medicaid Waiver group homes (8), SEVTC (5), or community intermediate care facilities (1). Once families choose a new location, DBHDS will work with families to identify providers and carefully plan safe transitions.

Individuals with SMI and Dementia/Neurocognitive Disorders

Placement pathways include specialized mental health group homes with medical supports, memory care units, and community Nursing Facilities that can support behavioral needs. Additional actions:

- Maintain/expand contracts with providers operating specialized mental health residences and memory care settings.
- Provide behavioral consultation services for individuals residing in community nursing facilities to reduce disruptions and hospitalizations.
- Establish crisis linkages (mobile crisis, step-up/step-down) for stabilization during and after transition.

DBHDS anticipates the current 13 patients with SMI and dementia/neurocognitive disorders will choose community nursing facilities. DBHDS has contracts with providers who can support HDMC patients with serious mental illness, dementia, or neurocognitive disorders.

Special Hospitalization Alternatives (for other DBHDS Facilities)

Replace HDMC 'special stays' with contracted community stabilization and rehabilitation options for individuals from state hospitals, the training center, and rehabilitation center who require short-term medical care (e.g., wound care, IV therapy, tracheostomy, or oxygen management). Develop referral protocols, acceptance criteria, and holding agreements with hospitals and nursing facilities to ensure timely admissions.

Individuals with VCBR Histories

For individuals with a VCBR history, identify providers with appropriate safeguards and competencies. Provide technical assistance to receiving facilities regarding risk management, care planning, and coordination with legal and public safety partners. Ensure contingency arrangements in case of denials or unexpected placement disruptions.

Post-Transition Monitoring and Quality

Implement a structured follow-up schedule and a rapid-response protocol. Monitor health outcomes, behavioral stability, incidents, emergency department usage, and family/guardian satisfaction; resolve issues promptly through case conferencing and provider technical assistance.

Community Services Build

Ensure continuity of the HDMC safety net for individuals in the community

4. Community Services Build & Continuity Plan

Replace Services Formerly Anchored at HDMC

To maintain continuity for individuals formerly relying on HDMC, the following services will be covered through CSH and community partners: pharmacy; laboratory; radiology; dental (including sedation dentistry); physical, occupational, speech, and recreational therapies; podiatry; internal medicine; general surgical consults; gynecology; and palliative/end-of-life supports.

DBHDS will retain core HDMC community services at the new Central State Hospital. The Community Services subgroup provides a plan to contract with community providers, use mobile/telehealth, and coordinate referrals to ensure community providers serve complex medical and behavioral patients who may have gone to HDMC.

Delivery Channels

- Move entire departments where appropriate to Central State Hospital (e.g., dental, laboratory, radiology, pharmacy, and therapies) to sustain access across the region.
- Contract with community providers to deliver specialty and ancillary services close to where people live.
- Use mobile and telehealth models to extend reach in rural or underserved areas and to support post-placement stability.
- Expand outpatient clinic capacity (dental, rehabilitation, specialty medical, and therapies) through community providers, supplemented by mobile and telehealth services to reach underserved areas.
- Implement a nursing facility training and consultation program in partnership with the Virginia Department of Health, consistent with Governor Youngkin's Executive Order 52 (August 2025) to strengthen oversight and quality in nursing homes.

- Incorporate long-term sustainability measures, including Medicaid rate adjustments and use of carry-forward funds where permissible, to ensure expanded community services remain viable beyond start-up grants.
- Establish a workforce development strategy for community providers, including specialized training, recruitment, and retention supports, developed in partnership with VDH and provider associations.
- Incorporate community education and technical assistance sessions for families, CSBs, and providers to ensure clarity about new service pathways and how to access supports.

Capacity Development & Funding Approach

Provide one-time development supports (start-up grants, equipment, and specialized training) to providers that commit to serving individuals with complex medical and behavioral needs. Utilize Medicaid reimbursement mechanisms, single-case agreements where necessary, and targeted contracts to ensure operational sustainability.

Access and Coordination

- Coordinate referrals through CSBs and facility services; set clear service standards (access times, care coordination, documentation) and monitor utilization and outcomes.
- Provide transportation supports where needed.
- Implement a formal evaluation framework for community service capacity, including defined outcome measures (e.g., health/safety indicators, placement stability, family satisfaction, and provider readiness). Report results publicly on a quarterly basis.
- Require regional capacity mapping to ensure that services (group homes, ICFs, nursing facilities, outpatient clinics) are geographically distributed so individuals can transition closer to their home communities.

Staffing Plans

Retaining HDMC staff expertise in the DBHDS system and ensuring adequate coverage to meet patients' care needs as the facility downsizes

5. Workforce Transition & Retention Plan

Objectives

Preserve safe staffing for remaining residents while enabling timely placement of HDMC employees into comparable roles across DBHDS; minimize layoffs through transfers and attrition; retain critical skills within the state system.

Retention and Stability Measures

- Implement a progressive retention bonus program tied to quarters of continued service, with enhanced amounts for hard-to-fill clinical roles.
- Offer scheduling flexibility, access to training, and recognition incentives to stabilize key teams through the final transitions. Also support staff through Employee Assistance programs like counseling and work/life support as needed.
- Consider flexible hiring practices, such as "restricted positions," that allow employees to be hired for a year or another set time period but receive the same benefits as full-time employees.
- Structure the retention bonus program to allow either quarterly payments or lump-sum incentives, modeled after training center closures, with progressive increases for staff who remain through later quarters.
- Establish a standing internal staff communication channel (e.g., weekly email updates, intranet postings, town halls) to provide transparent, frequent updates on closure progress, job openings, and transition resources.

Placement Pipeline

- Provide certification and career development opportunities (e.g., dementia care, respiratory supports, wound care, behavioral supports) so staff can qualify for comparable or higher roles within DBHDS or in the private sector.
- Prioritize placement at Central State Hospital (same campus), with additional opportunities at Piedmont Geriatric Hospital, the Virginia Center for Behavioral Rehabilitation, Southeastern Virginia Training Center, and DBHDS Central Office. Provide relocation assistance for moves over 50 miles. Use a priority hiring mechanism so eligible employees receive preferential recruitment to comparable roles.

DBHDS anticipates staff attrition but will be transitioning staff as well. Of 146 FTEs, 6 departments (36 staff; 25%) will go to the new CSH, 48 are retirement-eligible, and others will receive preferential recruitment to comparable roles at other DBHDS locations.

Department Moves to Central State Hospital (CSH)

Move certain whole clinical departments to CSH (dental, pharmacy, laboratory, radiology, and therapies) to maintain regional access and preserve team cohesion. Where full movement is not feasible, transition staff individually through the placement pipeline.

Training and Career Development

Provide cross-training and credentialing pathways (e.g., tracheostomy/respiratory supports, complex wound care, dementia care, and positive behavior supports). Offer career counseling, resume and interview support, and supervisor-to-supervisor handoffs to ensure successful onboarding at receiving facilities.

Retirement-Eligible Staff

Offer benefits counseling and clear timelines to retirement-eligible staff to support informed choices while maintaining adequate coverage until transition. Deliver

individualized retirement counseling sessions for retirement-eligible employees to support informed decision-making and continuity of care until closure.

Minimizing Layoffs and Supporting Well-Being

Use attrition and transfers to avoid layoffs wherever possible. Provide EAP services, wellness supports, and reasonable accommodations during the transition period.

DBHDS will aim for no staff layoffs and will use retention bonuses to ensure enough staff are available to provide services to remaining residents as HDMC downsizes.

6. Implementation Timeline & Milestones

The following phased timeline provides a structured path to closure by December 2027.

Phase 1

August 2024 – December 2025 – Preparation and Policy Alignment – Finalize admissions posture; establish dashboards as needed and case-conference cadence; initiate provider development and SEVTC readiness; announce retention program; begin department-level transition planning with CSH. Reduce permanent admissions to reduce risk to residents in the event HDMC is approved to close.

Phase 2

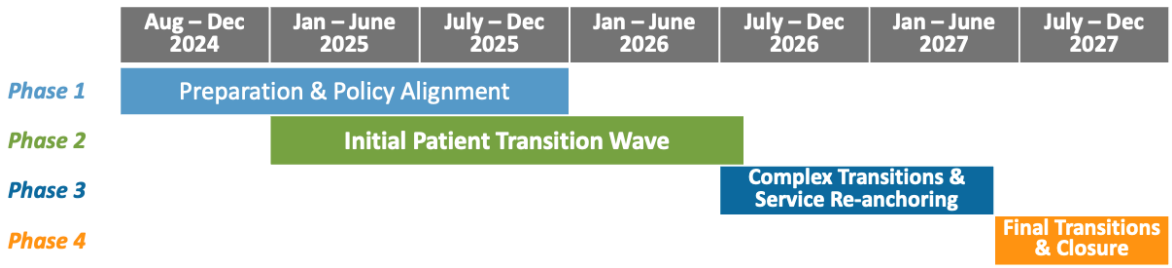
January 2025 – July 2026 – Initial Patient Transition Wave – Transition individuals with identified placements and lower transition barriers; scale post-placement monitoring; expand provider capacity where gaps are observed. SEVTC nursing beds are expected to be online in spring 2026.

Phase 3

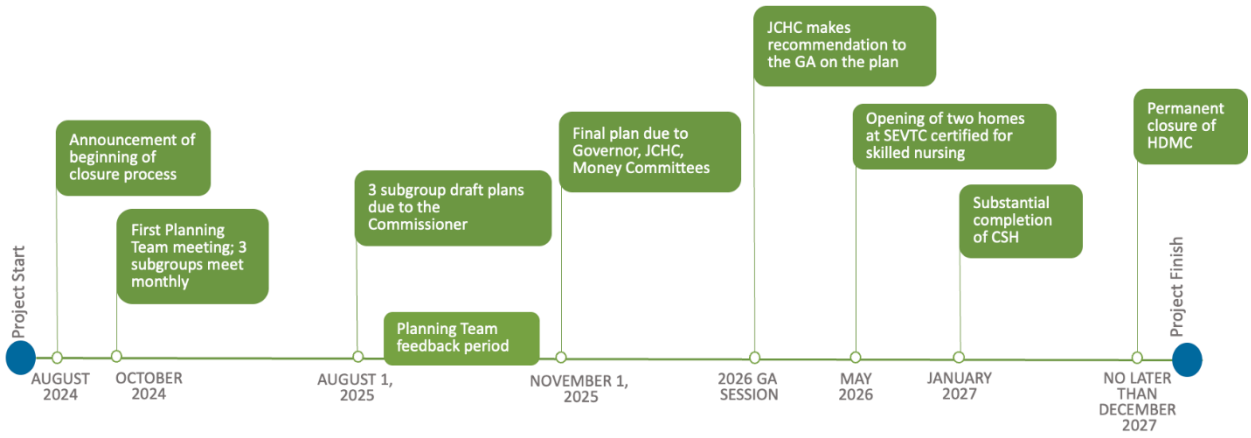
July 2026 – May 2027 – Complex Transitions and Service Re-anchoring: Complete moves for individuals with high medical or behavioral complexity; move designated departments to CSH; ensure all community service contracts are active and meeting standards.

Phase 4

May 2027 – December 2027 – Final Census Draw-Down and Building Closure Activities: Complete remaining transitions; secure records, equipment, and inventory; finalize staff placements; execute building closure procedures.



A timeline marking milestones in broad strokes from start to finish is included below:



7. Budget & Financing Overview

This plan contemplates only closure-aligned investments and operations:

- One-time costs: SEVTC home modifications and equipment; provider start-up supports; transition supports (transportation, DME set-ups); retention bonuses.
- Ongoing costs: contracted specialty services; behavioral consultation in nursing facilities; rate differentials for complex care; mobile and telehealth operations. Funding approaches will prioritize appropriate Medicaid reimbursement, targeted general fund supports, and other allowable sources to sustain services.

8. Quality, Safety, and Risk Management

Establish provider qualification standards for accepting individuals with complex needs; conduct readiness reviews; and require incident reporting, root-cause analysis, and corrective action plans when indicated. Maintain contingency placements for denials or provider disruptions. Safeguard civil and human rights, including grievance processes and independent advocacy access.

9. Governance, Reporting, and Accountability

Create a DBHDS-led project management structure with executive sponsorship and a multidisciplinary implementation team. Manage an integrated workplan spanning patient transitions, workforce, and community service build-out. Report monthly on: placements completed, time-to-placement, readmissions, critical incidents, staffing levels and placements, and service continuity metrics. Publish regular public updates.

10. Stakeholder Engagement & Communications

Engage families/guardians through recurring meetings, transition liaisons, and individualized planning sessions. Provide staff with HR clinics and a live vacancy bulletin. Convene provider readiness sessions and technical assistance. Maintain regular briefings with legislative partners and local government stakeholders.

Fiscal Analysis

Va. Code § 37.2-316 requires a six-year projection comparing the cost of the current structure and the proposed structure; in this case, that means comparing the cost of continuing to operate HDMC and the cost of closing it.

The Cost of Continued Operations

HDMC must be completely renovated to continue operating the facility. As described above, the aging infrastructure of HDMC will soon no longer support patient operations. All major systems are at the end of their useful life. It is unlikely that the lengthy process to receive capital funding, design and plan for a new facility, and complete construction could occur before a major system failure would cause the evacuation of the building.

In addition, demand across Virginia for institutional services provided by HDMC has significantly decreased over the years as described above, and it is unknown how many patients would return to a new building if one if built after a system failure causes a lengthy evacuation.

The cost of **continued operations at HDMC is shown below, allowing for the construction of a new facility.**

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

Several assumptions were made to calculate these figures, as explained below.

HDMC Budget – The FY 2026 budget for HDMC is $28.6 million, and both scenarios are built on this assumption. This analysis does not forecast any reduction and assumes the census at HDMC remains stable.

Inflation – A three percent annual inflation increase is assumed.

Closing and Reopening of HDMC – Year 1 and Year 2 of the continual operations assume the facility is completely devoid of patients, with patients placed in community settings while renovation work is completed. A 35 percent reduction in operations is assumed, as some staff leave employment and non-personnel costs are minimized to utilities and security during the renovation. It is assumed that the remaining positions would remain in state employment; however, these employees would be temporarily reassigned to other facilities, such as Central or Eastern State, until HDMC is reopened. If more staff leave state employment than assumed, there will be additional hiring costs required to staff back up to allow residents to return.

HDMC Renovation Cost – The cost for renovating HDMC was provided as an overall building renovation study prepared by Virginia A&E in April 2017. A link to this document is provided in this report's Appendix. This renovation cost assumes a replacement of all 94 beds at HDMC; however, HDMC is currently only at 34 percent occupancy, and this number of beds is not needed. Of note, in order to get an accurate cost of a smaller number of beds, a consultant would need to conduct a full analysis of factors like a land survey and costs for the new footprint, including patient areas, administration, and treatment areas that are not going to Central State, etc. Typically, it costs about $5,000 for an initial evaluation to get a cost proposal created because the consultant needs to get preliminary information to understand what it will take to develop the full analysis. Depending on the cost proposal, the full analysis should be under $1 million.

The Cost of HDMC Closure

The second scenario is a **six-year cost for closing HDMC and building additional community services** as shown below:

HDMC Closure

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

Several assumptions were made to calculate these figures, as explained below.

HDMC Budget – The FY 2026 budget for HDMC is $28.6 million, and both scenarios are built on this assumption. This analysis does not forecast any reduction and assumes the census at HDMC remains stable.

Inflation – A three percent annual inflation increase is assumed.

Medical Needs – State Facilities – Many state facilities rely on HDMC for the care of medically complex patients and for training staff to manage such cases. Funding is projected to support state facilities in acquiring equipment and hiring staff to continue serving this population. This includes the ability to provide care involving PICC lines, tracheostomies, and feeding tubes.

Shared Services – Shared services include funding for Dental, Pharmacy, Lab, Radiology, and other therapies. Currently, patients at CSH receive these services through HDMC. Funding is needed to retain these staff as CSH employees. Additionally, this funding assumes partial reductions of CSH operations that HDMC had been funding, including finance, procurement, transportation, food service, and housekeeping. The analysis assumes proportional reductions; however, some areas will not see full reductions due to the inability to split existing staff. Shared services also include funds for record retention services shared between HDMC and CSH.

Community Services – The community services estimate reflects projected costs for 28 individuals transitioning to community placements. Estimates are based on each individual's level of need and include a combination of waiver placements, ICF placements, extraordinary rates, nursing home placements, and state-funded community residential plans. This analysis assumes that five individuals who qualify for training center and nursing care will transfer to SEVTC and will not be discharged to the community. These figures can be adjusted should more qualifying patients decide to transfer to SEVTC.

Retention Bonus Plan – DBHDS' staffing goal in closing HDMC is to have no layoffs. However, DBHDS anticipates needing a retention bonus plan to ensure existing patients continue to receive quality care as the census decreases. The estimate provided is based on previous plans during 2012 – 2020 when DBHDS closed four of Virginia's five training centers.

Staffing with Closure – The closure scenario assumes the facility will close within one year, with all staff either transferring to other DBHDS facilities or leaving state employment. The analysis includes estimated Workforce Transition Act (WTA) costs, though final estimates will need to consider leave balances and retirement options.

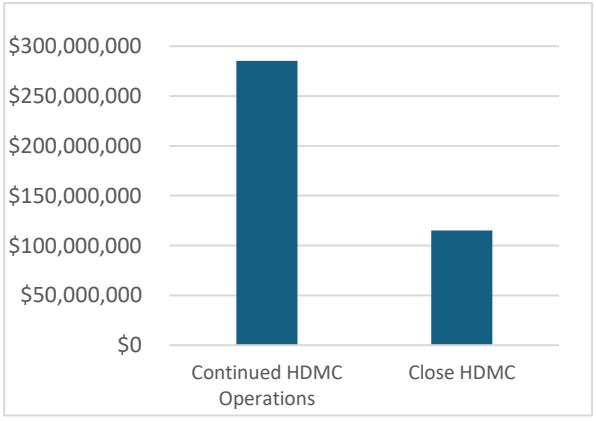
Capital Costs – No additional capital costs are assumed at SEVTC over six years other than the $4.5 million already included.

HDMC Value – The provided value of HDMC is based on a 2017 estimate, which is the most recent available from the agency. It is likely this estimate has decreased due to ongoing facility infrastructure issues.

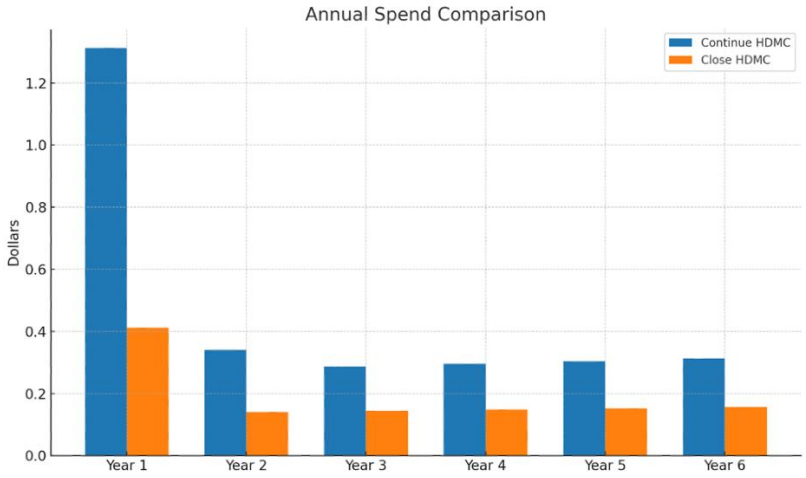
Key Findings

The six-year total cost to continue HDMC operation is $285,344,888. To close HDMC and add nursing beds at SEVTC and other community services is $115,049,249.

As a result, the six-year savings from closure (excluding any property sale) are $170,295,639. If the 2017 property estimate of $13 million is realized, the savings will increase accordingly.



The image below details the annual spend comparison between these two scenarios.



The closure plan results in $170,295,639 in savings across six years, driven by avoided renovation ($94.1 million) and lower run-rate thereafter. Importantly, savings are redeployed, not removed: dollars follow the person and the service, including SEVTC readiness, community capacity, shared services at CSH, and workforce transition. The closure path reduces Year-1 cash exposure substantially and improves the structural spend by approximately $14-16 million per year thereafter.

Conclusion

The HDMC Closure Plan delivers a single, executable path that protects individuals, honors family choice, stabilizes the workforce, and modernizes how care is delivered. It replaces an antiquated, failure-prone building with a distributed model: SEVTC skilled-nursing capacity for eligible individuals who elect a training-center setting, expanded community placements for those who prefer to live closer to home, and shared clinical services anchored at the new CSH and in community networks. DBHDS is mindful that distance to SEVTC poses challenges for many families; we therefore commit to working continuously with any interested family to identify willing providers closer to home and to invest in the complex-care supports needed to make those placements successful.

The next steps follow the process set out in § 37.2-316: transmittal to the Governor and JCHC, opportunity for review and recommendations, and final consideration by the General Assembly. While that deliberation proceeds, DBHDS will maintain life-safety readiness at HDMC, continue transparent stakeholder engagement, and execute preparatory activities that do not presume the outcome (e.g., workforce retention, provider readiness, and SEVTC certification work). If the General Assembly and Governor approve the plan, DBHDS is prepared to implement immediately under the phased schedule and governance model described herein, with monthly reporting on placements, safety, service continuity, and staff transitions. If a different policy direction is chosen, DBHDS will adjust course promptly.

Of note, DBHDS understands the uncertainty that exists among patients, families, and staff at this stage of the planning process and that stakeholders are eager for clarity. The sooner the plan is approved with any needed adjustments, the sooner HDMC patients and staff will have clarity on the next steps.

Proceeding with this closure plan avoids the risks of an emergency evacuation, moves people into safer and more integrated settings on a predictable timeline, preserves critical clinical services, and saves an estimated $170.3 million over six years of funds that are reinvested in people and services.

Appendices

Reports

All subgroup reports can be found at: www.dbhds.virginia.gov/facilities/hwdmc/hwdmc-planning-team. Direct links to each subgroup report are included below:

- Community Services Subcommittee Final Report
- Supporting Patients Subgroup Final Report
- Supporting Staff Subgroup Final Report

Hiram W. Davis Medical Center Overall Building Renovation Study, prepared by Virginia A&E: Hiram W. Davis Medical Center Overall Building Renovation Study

Public Comment

Two Week Public Comment Period on Draft Plan: September 5th-19th, 2025

Following the final Planning Team meeting in Petersburg on September 5, 2025, DBHDS shared the draft plan on the HDMC website and offered a two-week public comment period. Two public comments were submitted during this time and are found below:

September 5, 2025

https://dbhds.virginia.gov/facilities/hwdmc/wp-content/uploads/sites/6/2025/09/2025.09.04-HDMC-DRAFT-Closure-Plan-Presentation.pdf

Good afternoon everyone,

Safety concerns about the slides from September 4 mtg at Petersburg library about Hiram Davis proposed closure.

1. Inadequate shared bedroom space including beds 4ft apart and lack of space for respiratory supplies and daily care per person. Hiram Davis medical center beds are 6ft apart safety for 2 wheelchairs in use at the same time. [Son] has a roommate diagonally across with 10ft apart respiratory droplets separation. Son has custom wheelchair including custom armrests. He uses a large ARJO lift, not a ceiling mount Lyft. Shower trolley requires turn radius also.

2. Infection control space including droplet zone separation. COVID CDC guidelines 6ft Occupants are not expected to wear masks.

3. Presentation omits measurements. Fall risk location in the shower room water zone pathway to the toilet. Known pattern of fall in bathrooms.

4. No therapy spaces and equipment storage. No walk oxygen in therapy or other living areas than the bedroom.

5. No staff break room. I see lockers and a staff bathroom

6. No sight line from nursing station to bedrooms. Sight line to living room unclear if solid door.

7. Window one per bedroom to match other houses. Limited natural light. Son currently has 3 bedroom window.

8. Limited front porch with railings. Hiram Davis has a covered canopy and benches. Outdoor space planned.

9. Medical and pantry storage documents as a single room.

10. Statement about continuity and closer to home care. This is totally disruptive and far from homes. Parents in public comment live in Amherst, Lynchburg and Goochland. A brother in family council is from Richmond. Another family is from Northern Neck

11. Statewide safety net serves as far as 8hr.

12. Off site services with excessive time for star lab run at a hospital and expected results in 4 hours. Does not meet 1hour Sepsis guidelines, not comparable to onsite lab services at Hiram Davis
Routine labs may be sent to Burlington NC for delayed results days later.

13. Quality reporting non-specific. What qualifies as rapid response? Mortality missing. Severity scoring or raw numbers? No sentinel event

14. DME purchase and supplies unclear how Person centered and reimbursement caps

15. Off site services, how delayed are the new appointments and accepting new Medicaid and Medicare recipients

16. Contracts for multiple services now onsite

17. $ 4.5 construction costs, Appropriations $3

18. Non emergency ambulance transportation. Hiram Davis uses H2H including oxygen and stay onsite at appointment..

19. Revenue source, increase in Medicare and Medicaid base rate annually.
Why is Hiram Davis not billing all services rendered for CSH outpatient cost codes?

20. No connection between the cottages.

21. Cook chill tetherm? Included in protective space?

22. How are medications and supplies delivered to retain licensed nursing in cottage 24/7? There is no operation and staffing plan? What is redundancy staffing plan?

23. Assuming about MH psychiatric hospital adding new services not allowed in license such as PICC IV, tracheostomy and wound care?

24. Lack of clarity and financial accountability for start up funding one time and ongoing? Per person acuity scoring? Capitated?

25. Son has environmental allergies and uses fragrance free products including laundry detergent and hygiene products. Sharing close space has led to allergic reactive airway. No aerosols.

26. VCU and Bon Secours Southside specialists are his medical home.

SEVTC uses 2 hospital systems, Chesapeake General and Sentara. This would totally disrupt his care and electronic health records. Hiram Davis uses Cerner electronic record. What does SEVTC use? Is it compatible with the two hospitals? How many health information professionals are onsite?

27. Son requires multiple generator power outlets. How many outlets per bed are proposed at SEVTC?

I looked at the Sheltering Arms room graphic better space, light, visitation in bedroom with full ADA bathroom and shower all private rooms. VCU affiliated.

Oxygen consumption rates vary by size of tank and liter flow rate. Tanks are less safe than wall and require refills. My son uses 5 liters per minute. A transport tank lasts about an hour and the EMT must have backup. Son takes rolling E tank from the facility to an appointment with an assigned nurse and a portable suction machine and tracheostomy travel bag.

I have no current mapping for DBHDS operated skilled nursing facility care for ID. I understand the state MH psychiatric facility map. I don't know an updated crisis service map. Does SEVTC have an onsite crisis center staff and therapeutic space? Regional response?

Has DMAS approved new rates for discharge to contract community providers for ID , Psychiatric, dementia and VCBR discharges? Is there an ongoing staffing ratio support onsite? Hiram Davis has onsite security cameras, rounding, and behavioral health staff including 1:1 assignments.

How does SEVTC Chesapeake provide end of life care onsite?

I disagree with the plan to close Hiram Davis by December 2026. I support the less than $1 million cost for the study of rebuilding the Same services as currently available on the shared CSH.

I'm happy to discuss solutions. I have participated in 28 meetings and have made many documents submitted.

The current draft proposal doesn't meet my son's needs for safety. I will not consent to unsafe environments.

Thanks,
Martha Bryant, mother and guardian
5675 Lexington tpke Amherst VA 24521
434-851-4933
msbryant724@gmail.com

Emotions run high as state nears deadline for recommended closure of Dinwiddie hospital

The state Department of Behavioral Health & Developmental Services has until Nov. 1 to officially recommend closure of Hiram W. Davis Medical Center.

Check out this story on progress-index.com: https://www.progress-index.com/story/news/2025/09/05/families-of-patients-at-hiram-w-davis-medical-center-plead-to-keep-it/85979655007/

Good afternoon everyone,
Please include this in the public comment and archive.

Thanks,
Martha Bryant
Amherst
434-851-4933
msbryant724@gmail.com

September 9, 2025

Residency: Hiram Davis Medical Center, Virginia

First let me start out by saying I strongly support new construction or extending operations at Hiram Davis in Petersburg!!!!!

[Son] is a 48-year-old Male that was born prematurely spending three months in MCV /VCU prenatal unit having a brain hemorrhage when he was two weeks old. Son suffered significant Brain Damage at birth and is severely and profoundly disabled. He is Blind, Nonverbal, Non-ambulatory, Epileptic and a severe Spastic Quadriplegic with significant muscle wasting in his lower extremities. Son is fed with a G-Tube. Over the past several years Son has been

hospitalized and treated for a range of disorders including surgery for Hydrocele, Oxygen depredation, G Tube complications and constipation among others. Son's current adaptive assessment measurement is 3 months old. Son clearly needs Skilled Nursing and remains dependent on others for his medical, personal and daily care. He has a shattered fractured femur and has to be placed in wheelchair by PT only with a brace on his leg.
Son has recently been treated for an obstructed bowel blockage as well as UTI and was in General Medical for 18 days for recovery at Hiram Davis. While there he was able to get labs, x-rays, EKG, rectal tubing, and IV. Ratio for nursing 4 to one in General Medical. This kept him from having to be transported numerous times for tests and avoided having to go out to the hospital. Also, he was able to see the GI doctor at Hiram Doctor. This was a huge cost savings. Specialists come in monthly and are available when needed. Hiram Davis provides in house dental care, PT, OT, pharmacy, dietitian, speech, oxygen availability and recreation. Doctors are available Monday thru Friday and one on call on weekends 24/7plus two Nurse Practitioners. Contract with vascular specialists. Superior ratio and expertise not available in community. Son has NEVER needed wound care in 36 years which makes a statement in his care.

Son has received and requires intensive, comprehensive, individualized programs of active, and precise nursing treatment and care that is designed by an interdisciplinary team of qualified professionals that are trained to provide for Skilled Nursing Care for clients such as presently being provided for him at Hiram Davis. His mother is legal guardian and visits Son regularly and confident that Son's complicated personal and medical needs are being addressed and met at Hiram Davis. His father deceased on February 17, 2024.

Son has had to move from St. Mary's Infant Home to Southside Training Center, from Southside Training Center to Central Virginia Training Center, from Central Virginia Training Center to Hiram Davis Medical Center because of closures. It is time that the fragile clients stay at Hiram Davis where the necessary services are provided. Hiram Davis is proximity to home for visiting and responding to appointments and meetings.
These are lives we are talking about!!!!

Nancy B. Crone
9000 Avery Point Way Apt. 208
Goochland
Cell 804-833-5707

June 5th, 2025

DBHDS encouraged meeting participants at the June 5, 2025 Planning Team meeting to share any additional public comment via email that they were unable to share during the meeting. Below are the comments received:

Object to plans to worsen care ratios for Hiram Davis medical center Petersburg residents. My son's acuity scoring had increased not decreased. This is unreasonable reduction. Please add this to your public record.
Thanks,

Martha Bryant, mother and guardian, RN Amherst 434-851-4933
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https://dbhds.virginia.gov/facilities/hwdmc/wp-content/uploads/sites/6/2025/06/HDMCSupporting-Staff-Subcommittee-v255-Read-Only.pdf
Good afternoon everyone,
My son's acuity needs are currently increased as a general medical needs return from ICU. His tracheostomy, medication administration and oxygen needs don't indicate lower acuity scoring.

Hiram Davis has different types of care needs spread across 2 floors and 4 hallways. Having a single nurse per hallway is inadequate. Reducing RN hours also ill advised.

Let's focus on safety and not assumptions.
These individuals are not needing less care or lack of coverage for lunch, clinics and out of audible range.

Many of you have seen for yourself the building layout with long hallways and profound Intellectual disabilities and complex needs.

Thanks,
Martha Bryant, RN, mother and guardian Amherst 434-851-4933 msbryant724@gmail.com

References Shared with the Subgroups for Review

DBHDS encouraged subgroup members to share information to help improve the quality of the recommendations across the three subgroups. References submitted during the subgroup process are found below:

12 On Your Side. (2025, 06, 27). *Virginia Hospitals Closely Watching Lawmakers Debate Federal Spending Cuts.* 12onyourside.com.

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Budget Senate. (n.d.). *Private Equity In Health Care Shown To Harm Patients Degrade Care And Drive Hospital Closures.* budget.senate.gov.

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