

DBHDS Update:  
Training Center Closures &  
Implementation of  
DOJ Settlement Agreement

**James W. Stewart, III**  
Commissioner

Virginia Department of Behavioral  
Health and Developmental Services

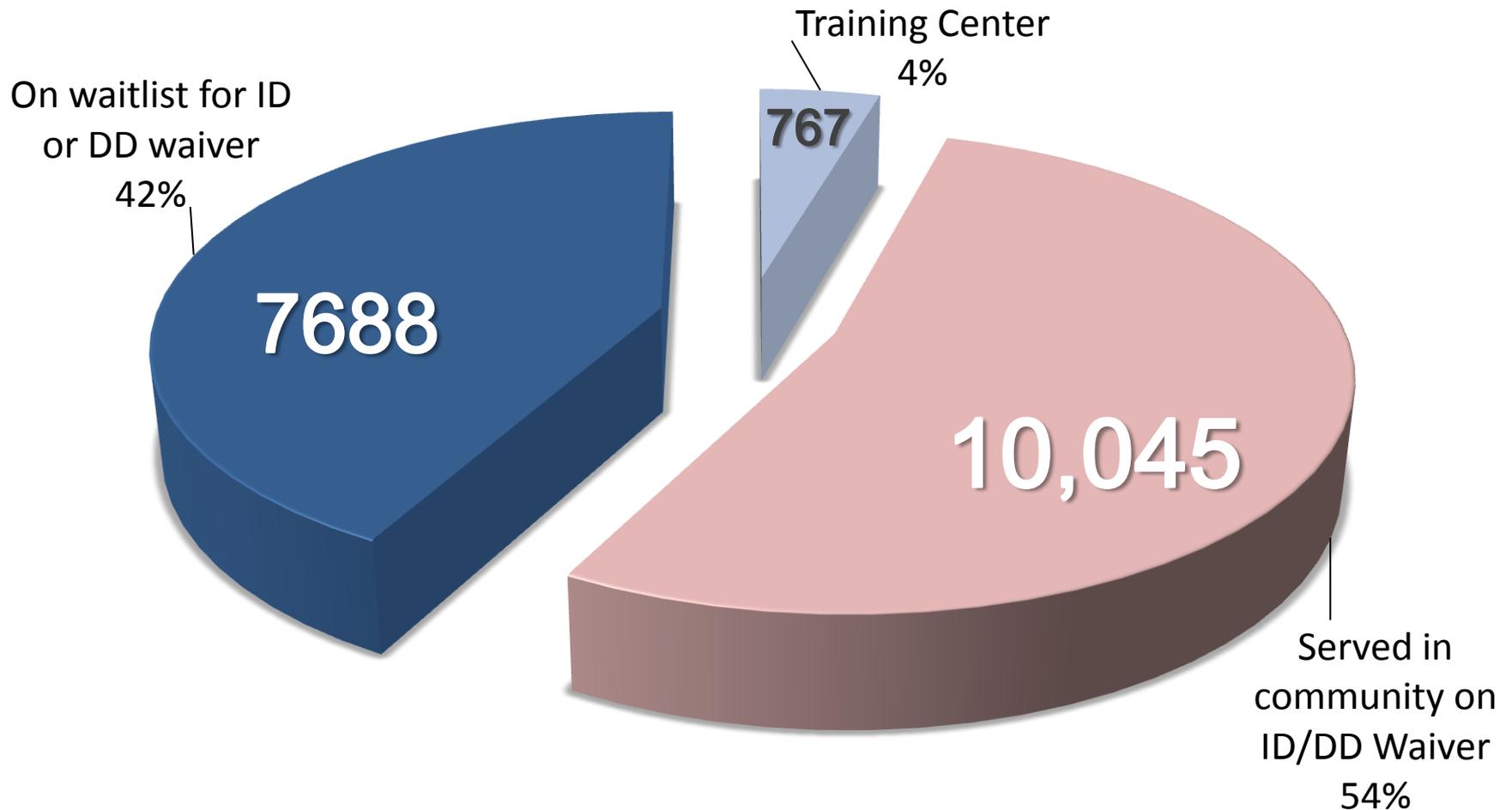
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# Virginia's Five Training Centers

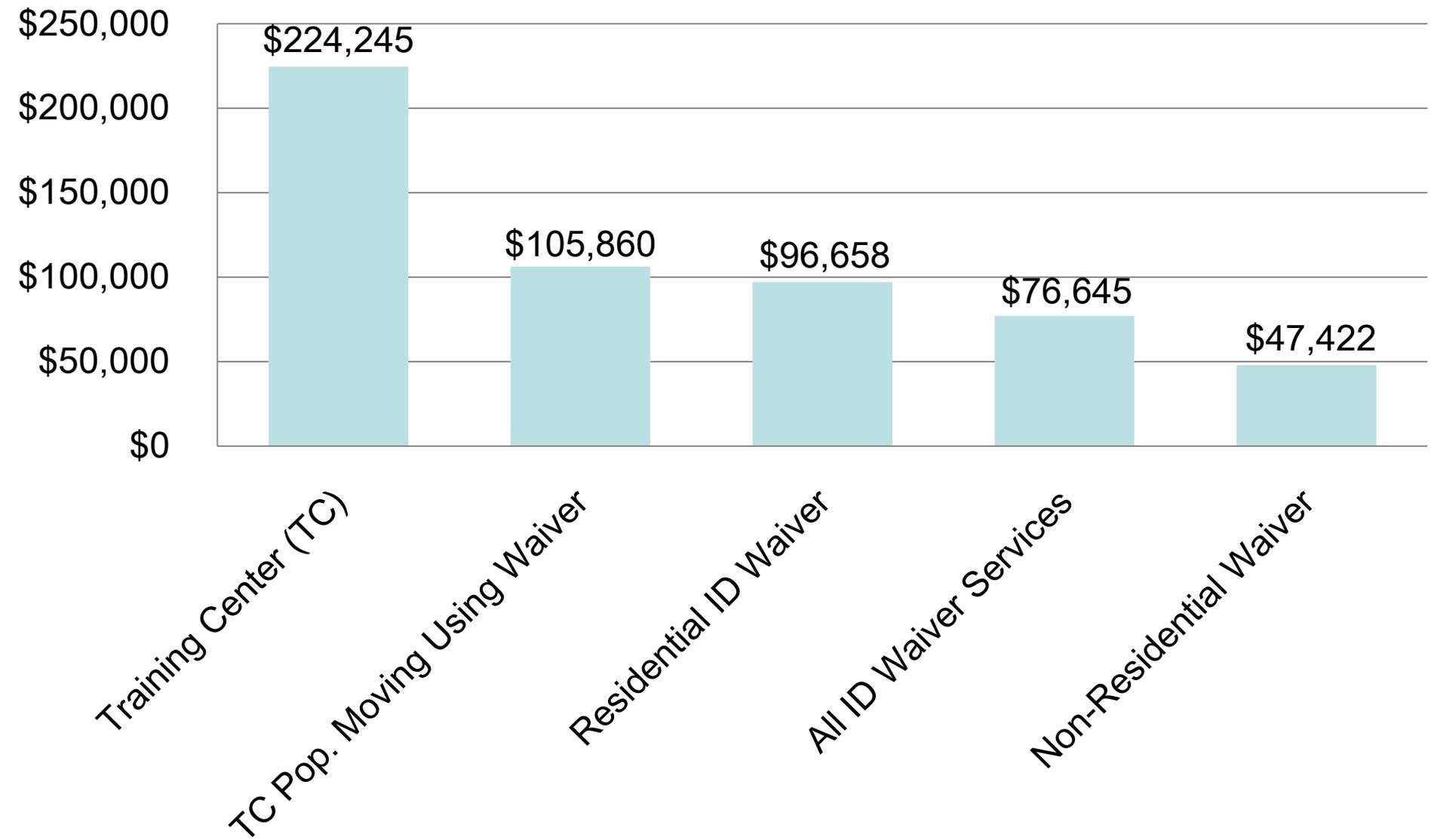
## September 1, 2013

Name	2000 Census	March 2010	June 2011	June 2012	Sept 2013	% Decrease 2000 - Present
<b>Southside (SVTC)</b> Closure date: 2014	465	267	242	197	98	79%
<b>Northern (NVTC)</b> Closure date: 2015	189	170	157	153	132	30%
<b>Southwestern (SWVTC)</b> Closure date: 2018	218	192	181	173	157	28%
<b>Central (CVTC)</b> Closure date: 2020	679	426	381	342	296	56%
<b>Southeastern (SEVTC)</b> Remains open at 75 beds	194	143	124	104	84	57%
<b>TOTAL</b>	<b>1,745</b>	<b>1,198</b>	<b>1,085</b>	<b>969</b>	<b>767</b>	<b>56%</b>

# Individuals Served By Virginia's Developmental Disability System



# FY12 Average Annual Costs Per Person



# Shifting the Array of Services

## More Integration and Options for Independence



Nursing  
Facilities, ICF,  
Day Support

Group Homes  
Prevocational

Sponsored  
Residential

Family Home  
Group  
Supported  
Employment

Individual's  
Own Home or  
Apartment,  
Individual  
Supported  
Employment

*Current Array of Services*



*Future Array of Services*

# DOJ Requirement for Discharge Planning from Training Centers

- A consistent discharge process was developed for all training centers in 2011.
- Discharge plans in place for all training center individuals.
- Pre- and post-move monitoring processes in place.

**101** Individuals transitioned to the community in FY 2012

**155** Individuals transitioned to the community in FY 2013

**355** Families currently actively discussing discharge

# Moves to Community Homes July 1, 2012 – Present

	FY 2013 7/1/12 – 6/30/13	FY 2014 to Date 7/1/13 – Present
Training Center	Number of Moves	
SVTC	80	16
NVTC	14	3
SWVTC	15	1
CVTC	26	2
SEVTC	20	0
<b>TOTAL</b>	<b>155</b>	<b>22</b>

# Types of Community Homes Chosen

## FY 2013: July 1, 2012 – June 30, 2013

Training Center	Group Home	Sponsored Residential	Intermediate Care Facility	Nursing Facility	Family Home
SVTC	69	1	0	10	0
NVTC	12	1	1	0	0
SWVTC	2	12	0	0	1
CVTC	11	5	9	0	1
SEVTC	3	0	15	2	0
<b>TOTAL</b>	<b>97</b>	<b>19</b>	<b>25</b>	<b>12</b>	<b>2</b>

# Types of Community Homes Chosen

## FY 2014: July 1, 2013 – Present

Training Center	Group Home	Sponsored Residential	Intermediate Care Facility	Nursing Facility	Family Home
SVTC	16	0	0	0	0
NVTC	3	0	0	0	0
SWVTC	0	1	0	0	0
CVTC	2	0	0	0	0
SEVTC	0	0	0	0	0
<b>TOTAL</b>	<b>21</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>

# Locations of Homes Chosen

## July 1, 2012 – Present

	FY 2013 7/1/12 – 6/30/13			FY 2014 to Date 7/1/13 – Present		
Training Center	Returned to Home CSB	Moved to Region of Home CSB	Moved Outside Home Region	Returned to Home CSB	Moved to Region of Home CSB	Moved Outside Home Region
SVTC	22	40	18	5	5	6
NVTC	9	3	2	2	0	1
SWVTC	6	9	0	0	1	0
CVTC	12	3	11	1	0	1
SEVTC	13	6	1	0	0	0
<b>TOTAL</b>	<b>62</b>	<b>61</b>	<b>32</b>	<b>8</b>	<b>6</b>	<b>8</b>

# FY 2013 Census Reduction Goals

Training Center	2013 Goal	2013 Actual	Difference
SVTC	84	80	-4
NVTC	25	14	-11
SWVTC	15	15	0
CVTC	35	26	-9
SEVTC	25	20	-5
<b>Statewide</b>	<b>184</b>	<b>155</b>	<b>-29</b>

# Census Reduction Goals for FY 2014 by Quarter

Training Center	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
SVTC	50	46	22	0
NVTC	20	20	15	5
SWVTC	6	5	6	3
CVTC	8	3	12	12
SEVTC	5	5	5	5
<b>Total</b>	<b>89</b>	<b>79</b>	<b>60</b>	<b>25</b>

## **Positive outcomes related to individuals' moves:**

- Increased skill development
- more participation in community integration activities
- increased family involvement
- reduction in targeted behaviors
- more choices given to individuals

## **Positive outcomes related to individuals' homes:**

- 95.8% of the 24 individuals with identified need had been provided all needed supports for adapted environment and equipment
- 96.9% of their homes were free of any safety issues
- 100% of their homes were clean and had adequate food and supplies
- 92.3% of their homes were located near community resources

# Readiness for Transition Regional Variation

- **Tidewater region** – Residential capacity expansion has enabled SEVTC to downsize successfully
- **Capital area region** – Availability of excess licensed residential capacity in region has resulted in meeting census reductions targets at SVTC
- **Northern Virginia region** – Limited capacity for residential and day support services and high service/development cost has slowed NVTC transitions to community significantly
- **Southwest region** – Availability of sponsored residential capacity has enabled SWVTC downsizing to remain on target; limited availability of licensed congregate care will slow progress in future
- **CVTC (serves statewide)** – Residential capacity expansion has facilitated significant transition

# Assuring Provider Capacity

- **Challenges**
  - Waiver structure
  - Waiver rates
  - Limited resources for development
- **Solutions**
  - Exceptional rates - Earliest implementation end of 2013 due to pending CMS and regulatory review
  - Waiver structure/rate study – Earliest implementation July 2014

# SVTC Layoffs

	Total Classified	Wage employees separated	TOTAL
<b>ROUND 1</b> 1/25/13	15	3	18
<b>ROUND 2</b> 5/25/13	25	23	48
<b>ROUND 3</b> 7/25/13	65	2	67

# Workforce Development and Outplacement Services

- Progressive retention bonus plan implemented July 2012
- On-site guidance about employment opportunities and career building.
- Employee forums held monthly.
- Programs to improve employability: skill-building workshops, resume assistance and career counseling.
- Held career fair in June with CSBs and private providers.
- On-site placement assistance from other state agencies, other hospitals within DBHDS, CSBs, and private providers.
- VRS assists with counseling and other needed information.
- Linking employees with private providers and equipping them with information to learn how to become providers themselves.

# Four Main Areas of Settlement Agreement

Serving individuals with DD in the most integrated setting and building quality community-based alternatives for individuals, particularly individuals with complex needs

Transitions from training centers

Quality and risk management system, including monitoring and evaluating services, and implementing quality improvement processes at an individual, provider, and state-wide level

Supporting independent housing and employment options for individuals with DD

# DOJ-Required Medicaid Waiver Slots

Virginia will create 4,170 waiver slots by June 30, 2021:

State Fiscal Year	Individuals in Training Centers to Transition to the Community	ID Waiver Slots for Individuals on Urgent Wait List	DD Waiver Slots for Individuals on Wait List
2012 <sup>1</sup>	60	275	150
2013	160	225*	25**
2014	160	225*	25**
2015	90	250*	25**
2016	85	275	25
2017	90	300	25
2018	90	325	25
2019	35	325	25
2020	35	355	50
2021	0	360	75
<b>Total</b>	<b>805</b>	<b>2915</b>	<b>450</b>

1. These FY2012 slots have already been funded and assigned to individuals.

\*25 slots each year are prioritized for individuals less than 22 years who reside in nursing homes or large ICFs.

\*\*15 slots each year are prioritized for individuals less than 22 years who reside in homes or large ICFs.

# Crisis Services

- Settlement Agreement requires 24/7 mobile crisis response and at least 5 regional crisis stabilization programs by June 30, 2014
- Systemic Therapeutic Assessment Respite and Treatment (START) program was selected to provide majority of these services for adults
  - 5 regional programs
  - 24/7 mobile crisis support online in all regions January 2013
  - 3 of 5 crisis stabilization units in operation as of February 2013
  - Each START program will receive funds in FY14 to meet terms of Agreement by adding staff and resources
- Children's crisis funding plans under discussion

# Case Management

- Online Case Management training curriculum was developed in FY12 and required to be taken in FY13
  - As of September 5, 2013, 4,056 have completed the first 6 modules and 3,421 have completed the final module
- In March 2013, CSB and DD Waiver case managers were required to begin enhanced case management visits for individuals meeting certain criteria
  - Face to face visit required every 30 days
  - Visit in their place of residence at least every other month
  - CSBs are collecting type, frequency and duration of these ID case management services

# Quality Assurance & Oversight

- Increased licensing specialists from 19 to 35
- Number of licensing visits have increased similar to the case management changes
- Additional data collection required
- Providers must monitor risk triggers and thresholds and take action to remediate risks
- Real-time, web-based incident reporting system required

# Regional Support Teams

- Regional Support Teams have been established to help resolve barriers to the most integrated community setting consistent with an individual's need and informed choice.
- Members include individuals with diverse ID/DD experience including medical professionals, CSB and DD case management professionals, human rights advocates, and licensing specialists.
- Referrals are made to the teams for individuals having difficulty finding a placement, those that move into congregate settings of 5+ individuals, ICFs, or nursing facilities, and those that have a history of being removed from placements.
- Since January 2013, there have been 22 referrals from the community to the RSTs and 67 from training centers.

# Regional Community Support Centers

- As community-based services continue to grow and the training centers downsize and close, these supports will be shifted to the community and become Regional Support Networks
  - One or more community-based locations
  - Core team of professionals to provide services to individuals living in the community, including those discharged from training centers
  - Provide outreach and education to providers in order to serve the ID/DD population
- Anticipate transitioning SVTC, NVTC, and SEVTC support services to community in FY15

Discharge Process:  
Resources for Individuals and ARs

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# Discharge Process

Week	Process Step
1	Initial Pre-Move Meeting with Individual, Authorized Representative (AR), and Personal Support Team (treating professionals at the training center and the CSB case manager)
2	Individual, AR, CSB reviews potential residential and employment/day support providers that could meet individual's essential support needs
3-5	Pre-tour requests and Provider tours of potential providers
6	Provider Pre-Move Meeting
7-8	Day and Evening Visits
9	Provider Training and Overnight Visits
10	Final Pre-Move Meeting
11-12	Preparation for Moving and Moving
12 +	Post-Move Monitoring

# Discharge Process Goals

- Best life with right supports
- Move occurs once all supports in place
- Share info—inclusive process, not exclude, input is critical
- Rumors—raise them with Jae or CIM for more information
- Open and honest communication

# Support/Education for Individuals/ARs

- Review what is important to/for individual
- Discuss Essential Supports
- Review training center move Process
- Provide education about the different types of Residential/Support Employment/Day activities in the community
- Discuss specific concerns, develop plan to address concerns
- Provide at least 3 options, whenever possible
- Tours, visits

# Support/Education for Individuals/ARs

- Provide resource materials at pre-move, annual meetings
- Offer referrals to Family Resource Consultant
  - Additional Support and information
  - Opportunity to speak with other families who have loved one with similar needs living in the community
  - Family Mentor
  - Peer Mentor

# Post Move Monitoring

Training center staff work collaboratively with the CSB, provider, and Community Integration Manager to:

- Ensure essential and non-essential supports agreed upon in the discharge plan/discussion record are being provided.
- Monitor the individual's adjustment to his/her new home and supportive employment or day program.
- Offer additional support services to the individual, AR (where applicable), provider, and/or CSB.
- Provide necessary recommendations to the community provider and CSB to resolve identified concerns, and document steps on the post-move monitoring action plan. Recruit others who may assist (e.g. CRC and Human Rights).

# Post Move Monitoring

Training Center	<ul style="list-style-type: none"><li>• 3, 10 and 17 day visits</li><li>• Contact AR to assess satisfaction</li><li>• Complete two visits in home and one at day services</li></ul>
Licensing	<ul style="list-style-type: none"><li>• Within 2 months of move.</li><li>• Follows enhanced licensing visit guidelines</li></ul>
Human Rights	<ul style="list-style-type: none"><li>• Visits within one month of move</li></ul>
CSB Case Manager	<ul style="list-style-type: none"><li>• Day 7 and monthly visits for 12 months</li><li>• Follows enhanced case management guidelines</li></ul>
Community Resource Consultant	<ul style="list-style-type: none"><li>• Between 75-90 Day Visit</li><li>• Meet with individual in home setting</li><li>• Review provider Individual Support Plan</li><li>• Provide technical assistance as needed</li></ul>

# Questions & Answers

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