DBHDS
Virginia Department of Behavioral Health and Developmental Services

Frequently Asked Questions Related to Training Center Closures

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1. What is the discharge process?

In January 2012, Governor McDonnell announced that four of Virginia's training centers will close by FY 2020. That same month, the Commonwealth signed a 10-year settlement agreement with the US Department of Justice that agreed to improve Virginia's overall developmental disability system by providing more community-based services and supports for individuals, including those in training centers. As part of this agreement, DBHDS must conduct a consistent discharge process at each training center based on the premise that all individuals, with sufficient supports and services, can reside in the community. As part of this discharge process, DBHDS is committed to ensuring that each individual residing at a training center is served in the most integrated setting that is available and appropriate to meet his or her needs in accordance with his or her choice.

To fulfill this commitment, DBHDS has implemented an improved discharge process to support consistent discharge planning activities that will ensure individual choice and safety. This process includes:

- Developing a discharge plan before an individual moves that addresses the individual's developmental, behavioral, social, health, and nutritional status, and personal preferences;

- Providing reasonable time to plan for and prepare the individual and family or AR for the discharge;

- Ensuring that all essential support needs will be met in the community;

- Providing a post-move plan of care that will assist the individual in adjusting successfully to his or her new home; and

- Providing post-move monitoring to ensure the continuation of supports and services as identified in the pre- and post-move process.

The discharge process will help families understand the living options that are currently available or can be established and make the choice that is best for the individual's successful move to the community. It has been our experience with the individuals who have already successfully moved from training centers that once an individual actively begins the discharge process, which begins on the date of the initial pre-move planning meeting, the process takes approximately 12 weeks to complete.

The following is an overview of the process that may be further refined to meet the unique needs of each individual.

Week 1: The personal support team (PST), also known as the interdisciplinary team, will hold a pre-move planning meeting to identify the services and supports needed for successful living outside of SVTC consistent with the choice of the individual and his or her authorized representative (AR).

Based on this meeting, a discharge plan is developed/revised that identifies all of the essential/health and safety support needs of the individual, the equipment the individual will require, the training the provider will receive regarding the individual's specific support needs, and outlines a specific plan for transition.

Week 2: Based on Personal Support Team discussion, feedback from individuals/ARs, and CSBs who have explored potential providers, providers are identified for the individual and AR to visit.

Weeks 3, 4, 5 The individual and AR will tour potential provider homes and employment or day supports.

Potential providers will go to the training center to observe individual and staff at the training center.

Week 6: The individual and AR will identify a potential home based on options explored and input from the PST. A provider pre-move planning meeting

will be held with the PST and the provider to share information and confirm additional visits.

Week 7: Individual will complete a day visit to the home and supported employment/day support provider with assistance from training center staff.

Week 8: Individual, with assistance from training center staff, will visit the home during the evening. The Training Center will provide individualized training to the potential provider during this time period.

Week 9: The individual will visit the home for a weekend and overnight experiences.

Week 10: Individual and AR will confirm choice of new home and supported employment/day activity, and the PST will participate in a final pre-move planning meeting.

Week 11: Individual prepares to move.

Week 12: Individual moves to his/her new home.

2. ***Why should the individual and authorized representative participate in a discharge process?***

The purpose of the discharge process and related meetings is to identify all of the essential supports an individual will need to live successfully in the community and explore potential options in the community that an individual or family might not be aware. It is designed to ensure authorized representatives are making informed decisions about community placement options.

The individual's Personal Support Team develops the discharge plan and identifies specific options for types of community placements, services, and supports based on the plan. In the event that the individual or authorized representative is concerned with the options presented by the Personal Support Team, DBHDS must take steps to resolve the concerns and document the steps taken to resolve identified concerns so that discharge might occur.

Please note that an individual may remain in a Training Center if he or she chooses. However, participation in the discharge process is encouraged so that the Personal Support Team can understand the concerns of the authorized representative, they are well documented in the Discussion Record, and the Team can try to resolve them.

3. ***Why are social workers contacting me to discuss the discharge process and our willingness to consider community placement options?***

Social worker calls are an essential component of the discharge process as many families have long-term trusted relationships. Social workers will continue calling regularly to report on the individual's activities within the training center as well as to talk about options for moving to the community. Social workers are able to talk to families on an ongoing basis about any questions or concerns they have. Under the settlement agreement, DBHDS is obligated to continue to work with families to ensure they have the information needed to make informed decisions about placements. Therefore, our social workers will continue to make these calls to authorized representatives.

4. ***What are my placement options in the community and can I continue to reside in a training center?***

You have several placement options in our communities. They are outlined in the Table below:

Setting	Description
Sponsored Residential Services	Sponsored residential services are supports provided in a person's or family's ("sponsor's") home. The sponsor is evaluated, trained, supported and supervised by a provider agency that is licensed by DBHDS. Only one or two individuals may receive sponsored residential services in one home. Sponsor homes must meet the requirements of the State Licensing Regulations. The physical environment, design, structure, furnishing, and lighting of the home must be safe and appropriate. The provider agency must conduct an assessment to identify physical, medical, behavioral, and functional preferences and needs of each individual it serves through a sponsor home. This information is used to create an individualized services plan that must be implemented to provide the medical, behavioral, and other supports required for the individual's success in the community. Other plans that must be in place include plans for emergency preparedness and food provision. In addition, the sponsor must make reasonable efforts to prepare meals that consider cultural background, personal preferences, and food habits and that meet dietary needs. The provider agency must also develop and implement emergency response training for all sponsors and their employees. There must be at least one person at the home who holds a current certificate, issued by a recognized authority, in standard first aid and cardiopulmonary resuscitation, or emergency medical training. Finally, both the provider agency and the sponsor home must comply with State Licensing and Human Rights Regulations.
Group Home Residential Services	Group home residential services provide 24-hour supervision in a community-based, home-like dwelling operated by a provider agency licensed by DBHDS. Group homes typically provide services to four to eight individuals. The provider agency requirements are essentially the same as those listed under sponsored residential services. The individuals must be provided the medical, nursing, and behavioral supports required to live successfully in the community. In contrast to sponsored residential services, the group home provider employs persons to work in the group home instead of contracting with sponsors to provide services in their own homes.
Intermediate Care Facility (ICF or ICF/ID)	ICFs/ID are another example of residential services providing 24-hour supervision to individuals in a community-based, home-like dwelling operated by a provider agency. ICF/IDs typically provide services to four to 12 individuals. An ICF/ID community home is different from a group home because it is not only licensed

	by the DBHDS, but is also certified for Medicaid funding by the Virginia Department of Health. There are additional specific Health Department requirements for medical care and staffing. The ICF/ID provides or contracts directly for all the services the individual requires.
Family Home	When consistent with their needs and informed choice, individuals may live with the proper supports in their own family homes or even in their own apartments. This option includes an agreement with the individual, authorized representative, and case manager on the types of supports that are needed for the individual to live there successfully.

Placement in another training center or a nursing facility are other options. These two options are not considered community placements in an integrated setting.

Per the Settlement Agreement, DBHDS conducts a discharge process that is based on the assumption that, with sufficient supports and services, all individuals with complex needs can live in an integrated setting. In accordance with Virginia Code § 37.2-837(A)(3), if an authorized representative does not consent to discharge from a training center, the individual will not be moved to the community; however, if an individual and authorized representative choose to remain in a training center, the individual can be transferred to another training center, as determined by the Commissioner pursuant to Virginia Code § 37.2-840, when a training center closes. We encourage individuals and families to actively participate in the discharge process in order to understand the options available to them in the community.

Participation in the discharge process enables DBHDS to understand the barriers and essential support needs of individuals so that community capacity can be developed in the locality or region where the individual would like to reside. Without the active participation of the individual and authorized representative in the discharge process, it is difficult to understand at the regional and state level exactly what supports are required in our communities to serve individuals who currently reside in our training centers.

5. ***How will DBHDS develop community capacity to support individuals leaving the training centers?***

DBHDS and the Department of Medical Assistance Services (DMAS) are taking the following action steps to develop these supports:

- DBHDS and DMAS have worked together to ensure that we are maximizing coverage under the current waiver program for behavioral supports and 24 hour nursing. Examples include:
    - Nursing services for extensive medical supports on a 24/7 basis;
    - Nursing services at employment or day support programs;
- DBHDS is providing Bridge Funding to support individuals moving from SVTC and NVTC. Examples of Bridge Funding include:

- BCBA and ABA supports directly with an individual;
- Home modification, DME, and assistive technology for individuals moving to group homes (current waiver only provides this for individuals moving to their own home);
- Nutritional supplements currently not covered by DME provisions in the existing Medicaid program;
- Specialized intensive training for community provider staff on individualized medical and behavioral issues and needs prior to an individual's transition;
- Room and board supplements; and
- Behavioral supports during day support or employment activities.

- DBHDS and DMAS working to obtain approval of the 25 percent exceptional rates for congregate residential services from CMS, anticipated February 2014;

- DBHDS and DMAS partnering with Human Services Research Institute (HSRI) to study how to modify the current ID waiver, as well as other waivers supporting individuals with developmental disabilities. The *My Life, My Community* study will recommend changes to better support individuals, with the most complex medical and behavioral needs, in our communities. The study is focused on ensuring there are adequate services and supports for individuals moving from training centers to the community. The earliest date recommendations will be implemented from My Life, My Community is Fiscal Year 2016. DBHDS intends to use Bridge Funding to support individuals until these waiver changes occur.

- DBHDS is working to close on the sale of some of its facility properties so funds can be deposited into a revolving trust fund to be used to develop community capacity to support individuals moving from training centers (Item 314. C. of the 2013 *Appropriation Act*). The recent sale of surplus property at the Southeastern Virginia Training Center (SEVTC) in Chesapeake is one example.

6. What if the community is not ready to provide for our family member? Will the closure timeframes change?

DBHDS is working closely with individuals, authorized representatives, CSBs, and community-providers in each region to identify homes and day activities for every individual who wishes to move from a training center to the community. To facilitate capacity for these individuals at SVTC and NVTC, which are the two centers that will close first, DBHDS has obtained Bridge Funding to support individuals and develop capacity in collaboration with providers as described above. It is also working to obtain federal approval for exceptional rates, close on property sales to support community capacity development, and undertaking *My Life, My Community* study to transform waivers.

- DBHDS does not intend to transfer individuals who have chosen to move into their home communities from their regional training center to another training center far away from family and friends.

- DBHDS has stated that it will re-evaluate the impact of these actions on expanding capacity in the Northern Virginia region in the spring of 2014 and move to modify the current closure schedule for NVTC accordingly. DBHDS will conduct similar capacity analyses at SWVTC and CVTC within 12-24 months of their proposed closure dates.

7. ***How does DBHDS ensure the quality of community providers?***

DBHDS has almost doubled the number of licensing specialists they have on the ground. Investigating specialists grew from 19 to 35 specialists, and the number of human rights advocates that visit with individuals and providers also increased since 2012. The following other steps have been taken to improve oversight and enforcement:

- The Settlement Agreement requires case managers to provide enhanced oversight of individuals who meet certain high risk criteria, including individuals who have lived in training centers and moved to the community. In addition, we have put in place rigorous post move monitoring process with visits from licensing, training center staff, human rights, and the CSB within the first days, weeks, and months after an individual moves to the community to ensure his or her health and safety;

- Under the Settlement Agreement, licensing is also required to conduct additional visits to individuals at risk and has been conducting these visits since March 2013; and

- DBHDS is monitoring and collecting data concerning individuals in the Settlement Agreement target population using a web-based reporting system. The system has been in operation since April 2013. It is an enhancement of the same system used for years at training centers and other DBHDS facilities. This system has enabled DBHDS licensing specialists to go on site and investigate any problematic situations much more quickly than before.

8. ***Can my family member move to a private nursing facility or will DBHDS move my family member to a private nursing facility?***

Private nursing facilities, unless they are chosen by an authorized representative, are <u>not</u> appropriate placement options for individuals leaving training centers. DBHDS believes that individuals can be served in the community regardless of need and will use recommendations from *My Life, My Community* to ensure those requiring nursing facility care can be supported in our communities.

9. ***How is DBHDS ensuring adequate staffing and quality of care at training centers as they downsize?***

DBHDS remains committed to quality. It has increased the level of oversight and reviews since the signing of the Settlement Agreement. DBHDS completes annual programmatic audits of its training centers. DBHDS also monitors staffing, overtime, and turnover, very carefully. It has established a DBHDS Quality Improvement Committee to examine data regarding deaths and serious injuries for facilities and community providers. This data is also shared with five Regional Quality Councils, and they examine the data.

All five training centers continue to be in good standing with federal surveyors (CMS). The CMS surveyors look very closely at facilities to ensure there is adequate staffing, sufficient safety for residents, and that the overall quality of care is appropriate.

10. ***What is the current closure schedule for the training centers?***

Southside Virginia Training Center will close on or before June 30, 2014. Northern Virginia Training Center will close on or before June 30, 2015. Southwest Virginia Training Center will close on or before June 30, 2018, and Central Virginia Training Center will close on or before June 30, 2020. Southeastern Virginia Training Center will remain open with a maximum capacity of 75 individuals.

11. How will individuals who have selected Training Center as their placement option be moved to another training center?

DBHDS will not transfer an individual to another training center until it has exhausted all options available in the community where the individual wishes to live and the AR has indicated a choice for a training center placement. If an individual and his or her AR want to move to the community, DBHDS will ensure appropriate supports, regardless of how extensive, are in place to make that happen within the closure schedule timeframes.

If an individual chooses to remain in a training center, two things will happen: (1) social workers will continue to contact the AR at least quarterly to determine if the AR still wants that option and ask about what barriers to a community placement, and (2) three months prior to facility closure, DBHDS will work with the individual and AR to make the transition to another training center. This process will include specialized training for the new staff at the training center and identifying and obtaining all appropriate equipment.

12. Can the training centers be repurposed to have a mix of residential supports, day support, and RCSC-type supports for individuals that live in one location?

The Commonwealth is moving toward a system of community-based services where individuals are fully integrated into community life with other non-disabled individuals of their choosing. A campus model would not support this vision.

13. ***What actual services does waiver cover and what are the rates? What is the real difference in what we will get under waiver vs. ICF now?***

ID Waiver Services Available in Virginia

Assistive Technology	**Rates based on specifics of service and differential of NoVa and ROS**
Specialized medical equipment, supplies, and appliances, which are not available under regular Medicaid; also includes items necessary for life support, ancillary services.	Individual Consideration and limited to $5,000.00 per yr.
Companion Services	
Support and companionship provided to adults (age 18 and older) in their homes or at various locations in the community.	$8.86 to $15.20 per hour
Crisis Stabilization Services	
Clinical services and other supports provided to avoid emergency psychiatric hospitalization, institutional admission or any removal from home.	$24.02 to $101.67 per hour
Day Support Services	
Center-based and community-based programs offered during the day and evening hours that provides opportunities for learning new skills and, being active and involved in the community.	$26.19 to $42.87 per unit (up to 3 units per day)
Environmental Modifications	
Physical adaptations to an individual's home or vehicle, and in some instances, his or her workplace.	Individual Consideration and limited to $5,000.00 per yr.
Personal Assistance Services	
Direct support in the home and community with personal assistance, activities of daily living.	$12.91 to $15.20 per hour
Personal Emergency Response System (PERS)	
Electronic device enabling individuals to secure help in case of an emergency.	$29.70 to $87.62
Prevocational Services	
Services aimed at preparing an individual for paid employment	$26.19 to $42.87
Residential Support Services	
Supports provided in and individual's home and community.	$15.10 to $22.59

Respite Services	
Services designed to provide temporary, substitute support, which is normally provided by the family or other unpaid, primary caregiver.	$8.86 to $11.47
Services Facilitation (SF)	
Supports from a Services Facilitator (SF) for training and help on hiring, training and dismissing employees who provide Companion, Personal Assistance or Respite supports through the Consumer-Directed model of service delivery.	$178.31 to $231.67
Skilled Nursing Services	
Nursing services ordered by a physician for individuals with serious medical conditions and complex health care needs.	$22.29 to $31.19 per hour
Supported Employment	
Employment and on-the-job training and support in jobs in which persons without disabilities are typically employed and alongside people without disabilities.	$35.48 to $40.81 per
Therapeutic Consultation	
Training and technical assistance to family members, caregivers, and direct support professionals in providing Psychology, Behavior, Speech, and Language Pathology, occupational Therapy, Physical Therapy, Therapeutic Recreation and Rehabilitation Engineering.	$54.58 to $62.77 per hour
Transition Services	
Direct purchase of goods and services for anyone receiving the ID Waiver services and moving into a private residence, such as a family member's home, one's own apartment or home, adult foster care, sponsored residential, and, to a limited extent, a group home.	Individual Consideration Costs are limited to a one-time cost of $5,000 and only apply to MFP.

For a more in depth explanation of services please refer to *My New Home In the Community* available at http://www.dbhds.virginia.gov/ODS-default.htm.

ICF Medicaid reimbursement is based on a "per diem" rate, which is established by the state Medicaid Authorities. Each provider's per diem rate varies dependent on multiple factors. At the end of the year the provider submits a cost settlement report, which is reviewed by DMAS, and the payment is adjusted based on allowable costs. DMAS will only pay for approved costs. The end of year cost settlement determines the following year's "per diem" rate.

Waiver services are Medicaid reimbursement is based upon an individual model of support determined by assessment of identified needs. Services are selected from the menu of 15 service options (as listed above) according to the individual's assessed need. Standardized service rates are set by the state for each service in the menu. Providers of services must operate within the funds made available for each person in the program (available funds per person will vary according the individual's needs as delineated in his/her individual support plan).

14. What are Regional Support Teams?

As part of the Settlement Agreement (SA), Regional Support Teams (RST) were designed for supporting individuals with intellectual disability (ID) or developmental disabilities (DD), who live in training centers, meet the ID or DD Waiver waitlist criteria or live in a nursing home or intermediate care facility for individuals with ID. The RST provides recommendations in resolving barriers to the most integrated community settings consistent with an individual's needs and informed choice**.** Referrals by support coordinators (SC)/case managers (CM) and social workers (SW) at the Training Centers are made to the Community Resource Consultants (CRC) or Community Integration Managers (CIM) with the Department of Behavioral Health and Developmental Services (DBHDS) under certain circumstances as described in the SA. The CRC or the CIM will refer to the RST when barriers to most integrated settings for individuals still exist.

15. Is the same level of care available in a community ICF that is available at the training center? Is there an official procedure regarding the physician's involvement in the discharge process?

ICF Services/Supports are provided based on assessments of the federally required areas, known as the "Comprehensive Functional Assessment" (CFA). All needed medical care must be provided, regardless of whether a DMAS billable service or not (e.g. dental). If a service is not billable (DMAS or third party), the provider is responsible for providing the service(s) out of the "per diem" rate (i.e., adult dental, preventative medical care, podiatry, etc.). Any approved Medicaid Waiver service is made available to the individual if it is identified as a need by the assessment. Services are tailored to the individual needs. Individuals have a choice of providers of Waiver and other Medicaid funded (e.g., medical) services.

16. What if a provider shuts down? What will happen to my loved one? Who is responsible?

The Community Support Team serves the same role in the community as the PST does in the TC. They assist in making decisions with the individual and their family for identifying supports for the individual. The CSB Support Coordinator will coordinate all needed services through

Person Centered Planning meetings where options will be identified for consideration. The community team typically consist of the Individual, their AR/Family/Guardian, a representative from their residential program, their employment/day support program and any other person they wish to have on their team. The CSB SC will also work collaboratively with the CRCs, OLS and OHR to ensure continued supports are provided for the individual. Temporary arrangements can be made until a permanent solution is determined. We continue a thorough process for reviewing potential providers and involve START for supports to assist with maintaining an individual in their choice of community home. Our goal is to avoid additional moves after choosing a community option, but if it becomes necessary the person will be cared for until the best supports are identified. The TCs are still accepting admissions when needed and have accepted some individuals while alternative supports have been considered.

17. *What is my role as an AR? Will I have to take my loved one if something goes wrong? Am I financially responsible?*

Your role will remain the same as it has been as the current AR. If a change in status is required to support your loved one, the CSB Support Coordinator will help with coordinating a Person Centered Planning Meeting to address the concerns and arrange for the changes that are required to meet his or her needs. Your loved one will continue receiving Waiver reimbursement for services while living in the community.