Transcript- Generated By Microsoft Teams

December 12, 2024, 5:58PM

Cunningham, Lauren (DBHDS) started transcription

Cunningham, Lauren (DBHDS) 0:40
Welcome to everyone. That's just joining.
We're going to give folks one more minute to to join the call. If you can just sit tight.
Ready to get whatever you are.

Rupe, Heather (DBHDS) 1:33
Alright.
Hi, welcome everybody.
So this is the supporting patients subcommittee.
Hopefully this is where you're supposed to be.
And you registered and got in OK.
I'm Heather roop.
I'm the director of Clinical Services and one of the Co leads for this project.
We're going to start out with introductions and so if it's OK, I'm just going to go down the list and call and say your first name. If you want to come off mute and introduce yourself, I'm going to start with my colleague Nicole.
Call. You might be on mute.

Russell, Nichole (DBHDS) 2:15
I apologize.
Good afternoon.
My name is Nicole Russell.
I'm the physical therapy director here at Hiram Davis Medical Center.

Rupe, Heather (DBHDS) 2:24
Angela.

Harvell, Angela (DBHDS) 2:28
Angela Harvell, deputy Commissioner for facility services with DVHDS.

RH **Rupe, Heather (DBHDS)** 2:35
Susan.

AS **Alabanza, Susan (DBHDS)** 2:45
Is it this season?
Season Alabama Hiram Davis Medical Center clinical director.

RH **Rupe, Heather (DBHDS)** 2:51
Emily.

E **Emily Schabacker - Cardinal News** 2:56
I'm Emily Shaw backer.
I'm a reporter with Cardinal News.

RH **Rupe, Heather (DBHDS)** 3:01
Thank you for being here, Erin.

EH **Erin Harding** 3:08
Hi, I'm Erin Harding.
I'm an advocate with the Disability Law Center of Virginia.

RH **Rupe, Heather (DBHDS)** 3:13
You're in, Heather.

FH **Fisher, Heather (DBHDS)** 3:18
Good afternoon.
I'm Heather Fisher.
I'm the facility director at southeastern Virginia Training Center.

GJ **Griffin, Jarvis (DBHDS)** 3:30
I'm Jarvis Griffin.
I'm the facility director at Hiram Davis Medical Center.

JT **Jones, Tanya (DBHDS)** 3:40

I am Simon Jones.
I'm a social worker here at Harrah's Davis Medical Center.

Rupe, Heather (DBHDS) 3:45
80.

Cunningham, Lauren (DBHDS) 3:50
I know Katie said in the chat that she's in the car, so she's on on mute. But Katie is from Bacup, yeah.

Rupe, Heather (DBHDS) 3:53
OK.
Thank you, Katie, Kimberly.

King, Kimberly (DBHDS) 4:01
Hello everyone.
I'm Kimberly king.
I'm a Community integration manager with Dbhds facility services.

Rupe, Heather (DBHDS) 4:09
Bryant.

Martha Bryant 4:11
More to Bryant, mother and guardian of a son in skill nursing with ID and Hiram Davis Medical Center.
And I'm from Amherst County.

Rupe, Heather (DBHDS) 4:23
Again.

McGuire, Meghan (DBHDS) 4:25
Good afternoon.
I'm Megan McGuire, the deputy Commissioner for policy and public affairs at D bhds.

Rupe, Heather (DBHDS) 4:32

Shell.
And maybe at a place where they can't come off mute and introduce themselves.
So thank you all for that.
I know.
That's tedious, but it's nice to know everybody that's here and sort of what your role is.
I appreciate that this is the first of our subcommittee, so I wanted to take a minute to kind of talk about ground rules or just sort of how you know, expectations of the meeting.
And this list is not all inclusive.
So if you all want to add some things, we certainly can do that.
But what I wanted to start with is that we asked that everyone be respectful.
And encouraged you all to listen to each other.
You know, assume positive intent to assume that that we're all coming in here for the good of the individuals.
And we're going to engage in some constructive dialogue and in order to be efficient with our time, let's make sure that we're respectful of the many topics and viewpoints that come up.
And so we may have to parking lot some things and if we do or you have some further discussion you want to have, there's always the e-mail, the.
Hdmc planning team at Dbhds Virginia Gov.
And we can stick that in the chat if you have additional comments that maybe we're not able to cover in our time.
We are very thankful for the people that are here today.
We have to spread the word about this, so if you know of other people.
That would like to join, you know.
Please make sure that you let us know, but but we do appreciate you taking the time today to come and join us.
We are going to have a time for public comment, so I'm going to pitch it over to Nicole to facilitate that.

RN **Russell, Nichole (DBHDS)** 6:39
We're going to open up the floor for public comment.
Please be aware that we will not be addressing each comment individually. However

comments will be reflected in the meeting minutes, so we will open up the floor for public comment at this time.

Rupe, Heather (DBHDS) 7:35
There's no public comment.
I assume we can move on.
I think we wanted to take an opportunity to review the code section for this committee and for this process. And so Lauren's gonna share that.
Nicole will run through that with us.

Russell, Nichole (DBHDS) 8:04
OK.

Cunningham, Lauren (DBHDS) 8:05
Nicole, are you able to see my screen?

Russell, Nichole (DBHDS) 8:07
Yes, I can for the purpose of considering restructuring of the system of the mental health services involving an existing state hospital, the Commissioner shall establish the state and Community consensus and planning team consisting of department staff and representatives of the localities served by the state hospital, including local.

Martha Bryant 8:23
OK.

Russell, Nichole (DBHDS) 8:26
Government officials, individuals receiving services, family members of individuals receiving services.
Advocates, State Hospital employees, community service boards.
Behavioral health authorities, public and private service providers, licensed hospitals, local health department staff, local Social Services Department staff, sheriff offices, 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's consensus and planning team for

that state hospital.
Each state and community.
And planning team in collaboration with the Commissioner, shall develop a plan that addresses the types, amounts and locations of new and expanded Community services that we 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.
The development of a detailed implementation plan designed to build community.
Mental health infrastructure for current and future capacity needs 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.
The transition of individuals receiving services in the state hospital to community services and locality of their residence prior to admission or the locality of their choice.
After discharge, the resolution of issues relating to the restructuring implementation.
This, including employment issues involving state hospital employee transition planning and appropriate transitional benefits.
And lastly, a six year projection comparing the cost of the current structure and the proposed structure.
So that is what the code has is presented at and those are our responsibilities.
From the perspective of the Commissioner shall ensure that each plan includes the following components #1.
A plan for community education #2.
A plan for the implementation of required community services involving state-of-the-art practice models and any models required to meet the unique characteristics of the area to be served, which may include models for rural areas.
#3A plan for assuring the availability of adequate staffing. The affected communities, including specific strategies for transferring qualified state hospital employees to community services.
#4A plan for assuring the development, funding and implementation of individualized discharge plans pursuant to the Code for individuals discharge as a result of the closure or conversion of the state hospital to any use other than the provision.
Mental health services #5A provision for suspending implementation of the plan if

the total general funds appropriated to the Department for State Hospital and Community Services decrease in any year of plan.
Implementation by more than 10% from the year in which the plan was approved by the General Assembly.
See.
The screen went off.
You're no longer sharing.
OK, OK.
Thank you.
See at least nine months prior to any proposed state hospital closure or conversion of the state hospital to any use other than the provision of mental health services.
The state and Community consensus and planning team shall submit a plan to the Joint Commission on Healthcare and the govern.
For review and recommendation, the Joint Commission on Healthcare shall make a recommendation to the General Assembly on the plan no later than six months prior to the date of the proposed closure or conversion of the state hospital.
To any use other than the provision of mental health services.
Upon approval of the plan by the General Assembly and the governor, the Commission shall ensure that the plan components required by subsection B are in place and made, therefore perform all tasks necessary to implement the closure or conversion of the state hospital to any use other than the.
Provision of mental health services.
Any funds saved by the by the closure or conversion of the state hospital to any.
Other to any use other than the provision of the mental health services and not allocated to individualized services, plans for individuals being transferred or discharged as a result of the closure or conversion of the state hospital to any use other than the provision of the mental health SERV.
Shall be invested in the behavioral health and developmental Services Trust Fund, established in Article 4.
Nothing in this section shall prevent the Commissioner from leasing.
Unused vacant space to any public or private organization.
So that is the code in its entirety.

RH **Rupe, Heather (DBHDS)** 13:37

Thanks, Nicole.
Are there any initial questions about the code section that comes up?

Martha Bryant 13:45
Begin.

Rupe, Heather (DBHDS) 13:47
I'm not sure I'd be able to answer them.
I'm going to punt them to Lauren or Megan, but I want to open it up for questions. If there are any.
So this subcommittee and the other two are an effort within this code section for us to gather the information needed for the report that we want to turn in. And so this subcommittee is really about the supporting of patients. And so we wanted to spend the the B.
Of the time today really trying to understand.
What are the concerns that we have?
What are the questions that we're trying to answer?
And what data and information do we need?
So I'm gonna stop talking and really open it up to everyone on the committee to kind of get your sense of what you feel like this committee can can do.
What is it that we're looking for?
What is our purpose?

Griffin, Jarvis (DBHDS) 14:49
I'll jump in there.
I'm thinking that our our main objective is to ensure that, you know we are, we have the appropriate supports for each individual as the workout discharge plans for those individuals. So comprehensive needs equipment, services, ensuring that you know they have the the appropriate tasks to specialist in that.
Availability.
I think that is the overarching directive in charge that we have with this component.
So I think and I believe that through the discharge planning process, we were able to annotate and capture what those needs are as we work with those potential providers.
On you know aligning those services and and needs for those individuals as they

make the transition, whether it's now all up into potential closure.
Tore's Daddy and I think you know, it's really heavily dependent on you know, what our our Community integration team is about, what our social work department is working through and what our treatment teams are doing in regards to following up on you know their actual conditions and.
Progress towards their those goals.

Rupe, Heather (DBHDS) 16:21
This Brian.

Erin Harding 16:22
Oh.

Rupe, Heather (DBHDS) 16:23
Oh, sorry.

Martha Bryant 16:29
Well, we have distinct populations that are not covered in that code section. My son has no has intellectual disability skill nursing needs.
And from the prior work of the meeting at the library and the original PowerPoint presentations by the department, we've established that hire of Davis.
Serves people with intellectual disabilities.
Complex medical needs.
So this mental health language.
Does not pertain to Taylor.
So we've understood that there have been 14 people from training centers who are at hiring with intellectual disability.
There were five additional people who had dual diagnosis.
We have a population of sex offenders.
You have long term care, mental health people.
You have General Medical people.
That have been short term rehab and we've had clinics. We have a number of on site services.
That have been misrepresented in documentations as outpatient, meaning that you have to leave to go to the service.

And that's not a skilled nursing practice.
The services are on site and we receive these multiple services without leaving the building or traveling.
For PT or for vaccines or for pharmacy, and we've benefited from telehealth as well.
So we have all these sub populations that are not covered in that code section and I'm aware that other families.
Have asked to participate in this meeting since October 16th.
We asked for it again when we had our Family Council meeting and luncheon at Hiram on December the 10th.
And I don't see them included.
So when people ask to participate, I see a very high number level of staff. What I don't see are families and I don't know all these individuals who were named and and how they, you know, what their title is.
But I see it heavily outnumbered.

Ehrlichmann, Emily (Virginia) 18:57
OK.

Martha Bryant 18:59
A parent or family guardian representation as a as opposed to agency.

Rupe, Heather (DBHDS) 19:08
Make sure there's comments, Miss Bryant. I think I'll defer to Lauren, but I believe if you wanted to be invite, if you wanted to participate in the committee, you had to to register and then get the link.
Am I correct, Lauren?

Cunningham, Lauren (DBHDS) 19:23
He wanted to be a member of the subcommittee and we did. There is an additional family member that is a member of this subcommittee, Miss Crone.
She was unable to attend today because she had a conflicting appointment and she did ask if we could avoid Thursdays in the future.
And for anyone else, just let us know.
And we were happy to add them to the subcommittee, and we also welcome any

members of the public they can register and all they would need to do is register for the meeting and they're welcome to attend.

Martha Bryant 19:55
I'll just. I'll just say that this has been a flawed process from the beginning because it's mental health code and so a bunch of that language that pertains to.
Community education community discharge does not apply when you're skilled nursing and you have a legal right to choose skill facility nursing.
So we're still in the dilemma of being put into an inappropriate course.
And I understand that this was based on harm. David serving mental health individuals.
But we're not all mental health, so.

Rupe, Heather (DBHDS) 20:40
Thanks, Miss Bryant.
I don't want to forget that Erin was getting ready to say something. I believe at the same time.
So I don't want to forget to include you.
Did you have a comment?

Erin Harding 20:51
Yes, I just to piggyback off of Jarvis's comments a little bit about kind of I think what the ultimate goal of this is. You know, he really focused on like the discharge planning piece, making sure that the services are in place for people when they leave the.
Facility, which of course I think is the ultimate goal. The facilities closing like that part has to happen. But I think a concern that the Disability Law Center of Virginia is mindful of and would encourage the committee to be mindful of as well is like the risk of.
Harm that current residents or patients.
Are are gonna be exposed to as the facility approaches closure. And I know that there's a separate group for staff support.
So I don't wanna get too into the weeds of that, but you can't really untangle the two. Like, if staff aren't feeling supported and staying, there's gonna be serious quality of care concerns.

And so I hope we can just remain mindful of that as we move forward as well.
But it's not just like us getting to the end goal of people leaving Hiram, but like making sure that they're safe and supported while they're still there.

Griffin, Jarvis (DBHDS) 21:54
Thank you, Aaron and I and I appreciate that.
You know that reminder?
I know we spoke earlier this morning about, you know, about the transition and those concerns and you know, I I do wanna make sure that we and let you all know that we are mindful and you know, we're gonna be very sensitive as we continue to navigate this.
This this transition.
Particularly, you know, with each individual you know now that we have a finite number of individuals.
I think that's gonna.
You help you know with us, honing in on their unique needs and kind of rallying back to, you know, Miss Bryant.
Yeah, that the code is, you know, very general and we are situated within DBHDS which you know overarchingly, you know in general.
I know the code could be a little bit more specific than identifying you know the unique IDD and the other populations that we serve.
I think the work that we're gonna be doing is really gonna have to focus on, you know, each individual.
And you know, kind of cover those individuals in a individual.
Way approach. So yes, we have to make sure that we always keep the IDD population.
At the forefront, and what those unique needs are recognizing you know the differences, you know, in the medical support needs.
So you know the documentation needs to be accurate.
Needs to be up to date and current with assessments.
You know, whether we have guardianship issues.
The the whole 9 yards.
And so we're gonna work closely with with the integration team, with our team to ensure that you know we have those as much as we can have all of those different areas covered and have it documented.

Rupe, Heather (DBHDS) 23:54
So so far I'm hearing we have concerns about the fact that we have definitely sub populations of folks.
That are gonna have different needs and then we wanna know or one of the the concerns we have is is is what they need available in some other capacity in some other place. Those are two of the and I I'm paraphrasing. So you guys let me know if. I didn't capture those right, but I've heard that as AS2 concerns we have and then the third being, how do we assure that they're safe while they're still there?
In this process.
Else.
Christmas Bryant.

Martha Bryant 24:35
Level of care is non negotiable so.
Currently, the documents recognize that you have skill facility residents there, I believe.
That's recognized, but when you get into the options, the highest level of care is ICF, so there's.
A disconnect between skill level, which is well established and built.

Ehrlichmann, Emily (Virginia) 25:04
Yeah.

Martha Bryant 25:06
And then what?
The options are so right now and DB heads documents.
There is no skill nursing facility option.
And I will speak to the importance of documents being accurate, because my son's last.
You know quarterly.
Was inaccurate. It said that he had four equipment needs and he probably has 10 plus equipment needs and one of his primary needs, which is oxygen, was not listed or interval feeding pump.
So when you don't accurately describe someone that's actually discrimination, it's

called abling. You are misrepresenting someone.
As lust.
Disabled than they are, and the danger, I agree, Aaron.
The danger is you're putting that person at risk by misrepresenting them.

King, Kimberly (DBHDS) 26:17
Another thing, I think it's important for us to.
Gather information on is.
Distinguishing and making sure there's clarification regarding.
A facility or placement type versus a bed type within that facility versus the type of care I know frequently, for example.
We'll say skilled nursing facility or someone's in a skilled bed versus a, you know, General Medical bed versus.
Long term care bed.
And sometimes there's distinct. You know, there's things that distinguish those categories that are really related to billing more so than the actual need that's being provided.
So I mean, I guess that also kind of piggybacks on what Jarvis is saying as far as really ensuring that we are drilling down on the support needs.
That each person has and how that's tied to what type of bed or facility?
That an individual is able to go to because sometimes.
Those terms are used, but they have different meanings depending upon the context and if it's a billing versus a service need.
So I would like for us to be able to really get a clear explanation of those things as we look at the support needs of all of the patients.

Rupe, Heather (DBHDS) 27:46
I appreciate that. Thank you, Kim.
That's it.
That is important.
We do kind of throw those terms around, but they mean different things.

Griffin, Jarvis (DBHDS) 27:53
I'll make just one mention about the documentation piece. We made a modification on how we gonna go about documenting the care plan.

As you all know and I've kinda worked with you as well, Miss Brian, that you know our current DHR is not set up primarily for.
Our level of care and so it's more geared towards behavioral health posture.
As far as the individual care plan.
That's the document that we're gonna be utilizing moving forward from those team conferences and that's gonna be captured in the discharge planning section.
So all of those needs will be listed out, itemized. And you know, kind of elaborated on as appropriate.
So hopefully through that we won't lose anything.

Rupe, Heather (DBHDS) 28:59
Thanks Jarvis.
Other concerns, things we need to and of course this is not an all inclusive. We may leave here and come back to the next meeting and say, oh, I didn't think about this. Can we also look at this?
But any other initial thoughts in regards to the concerns or the questions we're trying to answer?

Erin Harding 29:20
Maybe just. Oh, sorry, Miss brand.

Rupe, Heather (DBHDS) 29:20
Christmas bright.
Go ahead, Miss Bryant.

Martha Bryant 29:30
Well, when this started.
I was very alarmed because I've been through a closure before and that closure was very tragic in our family, my one son.
Was moved nine times in less than two months and did in less than two months, so it transitioned.
Done poorly.
Can be deadly and.
One thing that I've really asked for and have yet to receive is.
Services array comparison of what is available in ICF at Southeastern and what are

the current comparable care needs that are met on site at Hiram Davis Medical Center and I think from our Family Council meeting we had a unanimous list of all the services that we are agree.
That.
Are available at Hiram Davis Medical Center that we would need to.
Have available at our next placement and I will also say as a person who's looked for alternatives that Taylor has been rejected 55 times.
So is gmass in the room or Department of Health long Term care division or?
Or legal representation about levels of care and.
When you when you talk about CMS standards of care, you're into federal code as well as state code.
And it was brought up in our Family Council that.
The General Assembly passed comparable care standard into law.
This was coming off of training center closures earlier that also been a mention about the Trust fund.
So we had two training centers closed.
Clothes that had community investment.
Northern Virginia and the downsizing of southeastern had pretty significant investment in community. However, two training centers, CBTC and Southside, sit empty, and there has not been that.

EE **Ehrlichmann, Emily (Virginia)** 32:01
Are you gonna walk?

MB **Martha Bryant** 32:12
Similar community investment and I believe during the recession or during this downturn of the economy at some point.
That what was supposed to be trust fund from from closure of training centers, went into general fund. So if there's some magical pot of money out there, that's a trust fund.
Please tell us.
I will say that Senator Kane said that he believed that there could be federal match money.
And absolutely wouldn't turn down any federal money, so you know.

Ehrlichmann, Emily (Virginia) 32:46
You want.
You want me to choose you wet?

Rupe, Heather (DBHDS) 32:54
Karen.

Erin Harding 33:00
Just so I don't forget.
I mean, these aren't really concerns necessarily, but just two things that are kind of on my mind at this moment. New to this group.
One, I think it's great that we're going to try and get some more families involved if they're interested in joining, but it might be nice also to have some current residents involved if they're able and willing.
I know I was briefly on site this morning and I had a couple of people I didn't even bring up discharge planning with them like they brought it up with me.
And so those are examples of people who, if they had the will and interest in time.
To join one of these meetings might be good representatives to include.
I do think they probably were more on the behavioral health side. I'm not sure, but I think they probably were.
So that's just one suggestion or idea and maybe that can be brought to the Patient Council or the I think it's called the Resident Council.
And two, I mean, I think myself.
DLCV, I'm sure, Miss Bryant.
Like, I'm just gonna be, like very mindful of sort of the intersection of this process and the ongoing the winding down us for V Virginia settlement agreement.
Sort of like the target population within that and like sort of the they're not like clear, established rights, but sort of the model practices and things that have been developed for those folks over the last decade plus, like what can be learned from that and apply to this?
Process and perhaps even be applied to this process, not just for like the folks with developmental disabilities at Hiram, but maybe best practices we can pull out of that to benefit all of the residents, whether they have dementia or some sort of.
Mental health support need.

Rupe, Heather (DBHDS) 34:34

I appreciate that.
Yeah. Thank you for reminding us of that, 'cause. You're right. There's lots of lessons learned and things we can apply, and we should definitely be mindful of that.
I appreciate those comments.

Zainab Kamara 34:45

Hello. Good afternoon everyone.

Griffin, Jarvis (DBHDS) 34:48

Hello.

Zainab Kamara 34:48

I was unable to introduce myself earlier.
My name is Zainab.
I'm the director of Nursing for Scarlet Haven residential services.
It's a provider in Northern Virginia that.
Support individuals with disability with high medical needs.
Up company organization have.
Involved in the discharge process from Nvtc and CVTC and some individuals from around Davis.
So I was happy that we were asked to be part of this committee, at least, to see what support we will be able to provide in what area of our needs that is there, since our individual going back towards midbrain was seen, we are specializing individuals with medical.
Needs not mental.
What I did with medical, so we do have eye respiratory tricks and vents and **** tubes and feeding tubes.
So we're here also to support in that area and help with the process, because we've done that successfully and most individuals from around Davis, Cvtc and Nvcc, they do thrive through the support that we provide medically.

King, Kimberly (DBHDS) 36:07

Just to follow up on your last and thank you Kamara for being here. Aaron, just to

follow up on your last statement regarding some of the processes that were put in place under the DOJ settlement agreement and that transition process, Hiram Davis already utilizes a slightly modified version.
Of that transition process that we use for the training center.
Discharges for the individuals with developmental disabilities.
But I do.
You know, like and agree with your idea of looking at those other populations at Hiram to see what additionally, you know what we can take from those to add to support the other individuals with transitioning.
I know believe the clinical director has already started some work with the social workers on looking at that and you know the level of detail planning and identifying support needs and everything that goes into.
Transitioning the individuals with DD.
I know there's already been some conversations and collaboration about that.
So yeah, I just want to say that I agree.
That's a good idea.

GJ **Griffin, Jarvis (DBHDS)** 37:30
It may not be as.
Relevant, but I I think it may be.
But I I did wanna bring it out as a output from the Family Council meeting.
This last one is, you know, looking at projection of the Asian population as well.
We need to make sure that we consider, you know, the individuals that possibly ageing out within the next two to six years out of the children's facilities and possibly other facilities that may be serving.
No, this population at third, we don't wanna make sure we leave those individuals out in our projections and and planning.
So just to kind of take note of, you know.
The the quantity the types need that they may possibly have so that we can ensure that we have sufficient capacity to continue to serve those individuals.

RH **Rupe, Heather (DBHDS)** 38:27
Thank you, Doctor Griffith.
You're right.
I mean it's it's about the individuals who live there now, but it's also about the

function that Hiram Davis serves in the community and the in the broader spectrum of the continuum. So I appreciate that.
So to answer these questions or to make some decisions or some recommendations, what is it that we would need?
What? What do we need to see at, say, the next meeting to help guide some of this work and discussion?
What? What's the data?
What are the reports?
What are the lists?
What are those kinds of things that we would need to gather for the group?

Erin Harding 39:10
I'm kind of going back in my memory ways to when the CBTC downsizing enclosure was being planned.
But I feel like at that time there was maybe like at least monthly communication with substitute decision makers about the level of care that they were interested in and what part of the state they were interested in.
It it may be that the social work staff at Hiram Davis already has this data available for the current folks, but perhaps a DE identified version of that report might be helpful for us in some way.

Rupe, Heather (DBHDS) 39:47
Thinking the same thing like I think first what I wanna know is what are the subpopulations and how many folks are in them?
And I know Doctor Griffith's team is working on sort of the individualized plans, but kind of from the broader perspective of providing a report or or recommendation, we'd like to know what that is.
So if we could get that, that would be great.

Griffin, Jarvis (DBHDS) 40:13
I don't think that'll be a problem.

Rupe, Heather (DBHDS) 40:13
I know, Miss Bryant.
I'm sorry, Doctor Griff, go ahead.

Griffin, Jarvis (DBHDS) 40:16
I was just affirming that that shouldn't be a problem.

Rupe, Heather (DBHDS) 40:19
OK.
Miss Brian, I know you'd asked for sort of the the side by side comparison, but I'm wondering if it sounds like the Family Services Council started or has a list of what you all feel like it happens at Hiram?
I'm wondering if you'd be willing to share that as the as the starting point for us to kind of compare these other services.

Martha Bryant 40:46
Susan Alabanza can probably.
Because their meeting minutes had people's names and we don't have consent to.
Release names without consent.
That the.
List of services we certainly can share.
I woke up this morning thinking of things that we didn't have on the list that come with licensure, such as.
Md's MD SRNS infection control are in wound care, are in quality management compliance.
We have a central supply.
We have to have a clean utility room, a dirty utility room.
We certainly have clinic services on site.
I know Miss Crohn was particularly interested in the dental services on site.
With sedation and recovery.
So my son uses.
Is PT and OT five days a week?
On site it is not outpatient, he uses Podiatry.
He's seen GI in the past.
We've seen orthopedics in the past and that they didn't get that contract renewed, but we're interested in doing.
Orthopedics, I think there's gyne.
Cology.

4th floor egress and 88 bathrooms and accurate equipment list.
And.
We we have respiratory therapy, we have lab on site.
We get X-rays on site.
Taylor's had an illness recently.
He got lab X-ray same day antibiotics on site.
We didn't have to go out anywhere.
He was diagnosed.
He's being treated. He's doing very well. So when you get early recognition of illness and you can.
Treat on site. You're saying you're really saving a lot of money? Vcu.
Is this medical home?
I really don't want to have to start him all over or go through formulary issues or go with the contract pharmacy which I have to say that medication disruption just was abrupt.
Termination was heavily involved in my other son's death.
So this continuity.
Important and when you get abrupt termination you can get unrecoverable outcome.
Certainly one of the things I brought up earlier was.
The.
For profit bad outcomes and two recently have been highlighted in Wtv art articles.
One of an intellectually disabled person who died in another family of a veteran who had dementia.
She moved in within 19 days because of his poor quality care, his hygiene, his weight loss, his unexplained injuries, and right now Virginia's really behind a nursing home inspections or response time.
Complaint. So it was taken, you know, like Hiram's last inspection is March of 2022.
And some of these nursing homes have not been inspected for over two years.
So that oversight piece, that continuity, one thing I would like to say, and it's kind of hard to measure, but that's expertise you don't want to lose people who are who choose to work with these populations.
And the ratio is the nursing ratios so often in hiring we have an or in every shift we have an LPN ratio of of sometimes one to seven, sometimes 1:00 to 8:00.
We have CN as instead of direct service professionals. We have our own CNA

education program.
So we're building.
This career pathway within the facility, so licensure level really gets into expertise.
And the the kind of the hard to say, but very essential is love. Are your workers committed?
Dedicated do they love their individuals?
Are you getting holistic care or are you getting task oriented high ratios in bad care?

Rupe, Heather (DBHDS) 45:37
So, Susan, do you have the initial list that maybe they drafted and I understand for Miss Bryant that maybe we need to add some additional things as we think about it, but I'm wondering if that would be a starting point to bring to the next meeting or to.
Share beforehand.

Alabanza, Susan (DBHDS) 45:54
Sure, I can send that out to you all to distribute.

Rupe, Heather (DBHDS) 45:57
That'd be great.
What? What other data points or?
Pieces of information. Do we need to bring?

Martha Bryant 46:09
I think you look on your six year projections of how many people are in in Children's Brook Rd. Long term care, how many are at Saint Mary's?
I even call St.
Mary's because I'd heard about the Albaro pump so.
I've been willing to look, and I was told that that Albaro adult home, which I think is a 12 bed model, only takes people.
Who were originally at St.
Mary's so sometimes they're this aging out.
You hit a bed shortage because.
They only take self referral.
So in other words, you can't get into a St.

Mary's pathway because.
They they have too many people.
I did research gateway since that has been discussed recently and Gateway's website says that they have extensive waiting list that they are short term only.
Their goal is independence, with six within 16 weeks.
So when you look at people who have long term disability, who were not on that independence 16 week pathway, then Gateway is less of an option.

King, Kimberly (DBHDS) 47:34
What I would say to, and I don't know who would be the best person or how we would get this, but this that information again about the facility type license certification type versus the support need and what can be provided.
Miss Brian.
I'm familiar with Albero house and like you said, you're right. It stays full with individuals who've aged out of St.
Mary's Children's ICS side and move over there, but Albara house is an ICF and we know the love.
Medical support needs that St.
Mary's provides.
So again, just looking at, you know what are truly the options versus the needs and what does the regulations surrounding that I think would be really, really helpful as we look to evaluate what additional capacity is needed.
In the community or at you know, Southeastern or the facilities we have to be able to meet these needs.

Rupe, Heather (DBHDS) 48:39
Envision like a matrix almost of.
Here's all the things Hiram has here are the providers and you know who has what.

King, Kimberly (DBHDS) 48:49
Mm hmm.

Rupe, Heather (DBHDS) 48:51
It would take some work and I'm not sure I'm the person to do it, but I it almost gets out.

I think what you're saying.
Like, what does a service need?
Service type versus what is a level of care and.

King, Kimberly (DBHDS) 49:01
Right, right.

Griffin, Jarvis (DBHDS) 49:04
A good starting point as far as the deliverable would be for us to supply, you know that subpopulation breakdown.
That includes, you know, locality preference.
And the needs list.

Rupe, Heather (DBHDS) 49:19
That'll be perfect.

Griffin, Jarvis (DBHDS) 49:19
And from that, I think we could, you know, at some at at least whatever cadence that we need to have this meeting we can.
Review that at some frequency.
I'm not the individuals in particular, but you know we can code EM out in such a way that we deserve, you know, their privacy.
I think another deliverable would possibly be just some type of report of the agent populations within. You know our current system so that we can, you know review that and address that as needed.
Definitely will be inviting the residents you know to these meetings. So we we can facilitate, you know, those that would like to participate in will start to plan around that for the upcoming meet.
And as Miss Price said, you know that that children's concern with that six year projection, I know that's being worked through.
Buy another subcommittee, so if you know we can have some kind of annotation there and then proposed plan, document report, you know that takes into account that piece.
We can work definitely on, you know, facility type versus support need. And as you said Heather, you know kind of correlate that into some type of matrix.

The code is pretty clear on what ICF is and how it functions.
Regulated and the same is true for skilled nursing facility, level of care. Now as we extrapolate that out to the other providers.
We can look at who's licensed within, you know our locality and the localities of preference and kind of start there with some type of dot matrix.

King, Kimberly (DBHDS) 51:17
Did have a question for this group as we look at data regarding.
Support and care needs.
As someone referenced before you know with some of the closing training centers, we really got down into lists of all diagnosis, all support needs.
It was really pretty overwhelming, however.
I think our initial run at taking a look at that with Hiram started really for by creating.
Categories of mild, moderate and intensive need and then defining what those may mean so that we could, you know.
You would be able to easily take a look and wrap your head around what the support level really is based on established.
Definition. So just from the group, you know just interested to know what level of documentation and data you know do we think is most appropriate for us to to pull together where it really can tell you know an accurate story of what the needs.
Are versus information overload?

Griffin, Jarvis (DBHDS) 52:36
That's a great distinction, and I think as we move forward, I think having you know a definitional reference type of number collection that can help us.
Easily.
Encapsulate you know a majority of the unique needs, at least in general sense. You know every individual's gonna have unique needs and you know we can specify that out at the granular level.
But as far as conversation of planning purposes, I think.
Having you know those definitional terms of categorization, we can really.
Make our work a lot more efficient.

Erin Harding 53:20
I don't know. Oh, sorry.

Rupe, Heather (DBHDS) 53:21
Go ahead. Go ahead, Ian.

Erin Harding 53:24
I don't know if this group would have the capacity for it, but it may also be helpful to not limit ourselves to the existing care models in Virginia.
Like certainly we're not the first state to wrestle with this type of facility closure and it might be good to just do like a national level review to see what sort of care options have been developed elsewhere that we might be able to adopt.
And I know that's easier said than done because it costs money to come up with those options. But.
You know, we have in Virginia a very innovative program of our own, the DAFF program that's used in the mental health.
Side of DBHDS to fund often times like very integrated innovative long term placements for folks with very complex care needs. And so it would seem that.
If resources allowed, like, there's no reason we couldn't have our own type of DAP model for the Hiram folks that are coming out.
Virginia also already has a nursing facility level of care, Medicaid waiver for any of the folks who are particularly interested in living in an integrated community setting when they leave the facility like that waiver exists.
But the problem with that waiver is you have to be able to afford and have your own home or a family member with their own home to live in.
It doesn't have the residential piece like the DD waiver does.
But again, that's maybe a way that we could use adapt type model to supplement.
Existing Medicaid waiver for the folks that that want something like that and could use something like that, I know that doesn't address everybody's needs, but for some people it certainly would.
So that was sorry, that was a couple of things all at once, but best practice models from other states. And then also how can we leverage our own best practice models that we have in Virginia like DAP and sort of like modify that for the Hiram folks as?
They're thinking about community placements.

Rupe, Heather (DBHDS) 55:29
Brian.

Martha Bryant 55:32

I think there's a lot of uncertainty at the national level as we change administrations about what happens to Medicaid and what happens to.
Medicaid expansion in Virginia.
So if national Medicaid changes, that's going to have a ripple effect into Virginia funding. And then?
The whole.
Regulatory structure.
So we've had an election, we'll have a gubernatorial election next year.
This change is gonna come about during the change of an administration.
So likely we're gonna hit a new governor, a new Commissioner, and we're in transition and.
It's highly important to get the planning right, but also have some contingency concerns.
I'm concerned when Kimberly says 3 levels of care, mild, moderate, extensive.
That that doesn't isn't enough.
Capture.
I personally, with Taylor having a trick and oxygen, he's always been skilled and in terms of availability in the state.
Part of his 55 rejections is that he's under 65, and even though he has Medicare, he isn't coming off of a hospital.
Stay where you get so many days of payment.
So I think you also have to look at mixed payer people.
You know.
Like Taylor has survived Social Security survivor benefit, which helps him pay for care, he has Medicare that helps pay for medications and specialty visits and equipment.
But not everyone has those payment models. So.
And geographically, as I said earlier, Northern Virginia and Tidewater had more community investment whereas the Lynchburg and the South side area or rural Virginia.
Has had under investment in community so.
My CSV which is horizon in the Lynchburg area, does not have a waiting list and they only have one ICF home that has a nurse 24/7.
So when we're looking at people who truly need 24/7 staffed nursing.

There's very limited availability, so in this matrix that you're looking at, it's not just that it's an ICU.
The staffing model and then.
Do they have?
And I'm not opposed to nonprofit.
Basically look at is there investment there Albero and St.
Mary's it's been a good model, but it's very limited and you have to have that history of having been a St.
Mary's resident in order to even get into their pipeline.

RH **Rupe, Heather (DBHDS)** 58:53
Other thoughts?

MB **Martha Bryant** 59:03
I'd like to hear from Heather Fisher.
What's what's the latest going on at South Southeastern?
Because we're hearing some.
Consideration of converting 3 cottages or increasing capacity or having a different licensure level there. But it's all kind of what if?

FH **Fisher, Heather (DBHDS)** 59:31
Well, that has been part of the discussion.
Nothing is final at this point. I was listening to the conversation in terms of the services and.
We have we serve a population that is very diverse as well.
Here we're serving the IDD behavioral health and several of our individuals have complex medical needs as well.

AS **Alabanza, Susan (DBHDS)** 59:59
It's fine.

FH **Fisher, Heather (DBHDS)** 1:00:03
So we have a lot of services already in place.
Whether they be there directly on campus or if we contract like such as our pharmacy, but we have things in place as far as how quickly we get our medications.

You know I can't speak.
I don't have enough familiarity with the folks at Hiram to say that they could easily.
Slide into our facility.
We certainly have to evaluate each person.
Individually to see how that would, how that would work. You know that converting beds or converting houses, that's a higher level conversation, but that that's an idea to help support the needs of the individuals.
Like you said, some of the things we don't have oxygen continuously that we don't have it at this point.
It's not saying you can't have it it, you know with enough.
Funding and reconstruction. It can be done.
So.

GJ **Griffin, Jarvis (DBHDS)** 1:01:12
I'll just add that you know, I've had a recent discussion with bcbr this morning and we'll talk talking about, you know, building up their capacities and kind of some models by which you know, we can further help strengthen, you know, core competencies in around some of the unique.
Aspects of care that we provided, but they're able to provide at their facility.
So I would imagine that we could do the same thing here.
There is, you know.
Now as far as some of the unique character that we do and don't provide those policies, procedures, training and you know references and citations to you know equipment needs and you know.
Supply needs that would come along with certain aspects of care.

FH **Fisher, Heather (DBHDS)** 1:02:03
Right.

RH **Rupe, Heather (DBHDS)** 1:02:05
But I think you know that is part of this process is determining where are the gaps that are out there.
Are they something that we can fill easily?
What do we need to fill those?
So I I think that's kind of looking at the training center in comparison to Hiram.

You know what, and who might want to go there?
What do we need? If that was the choice?

Russell, Nichole (DBHDS) 1:02:28
Also to to piggyback on that statement, would we be able to set up like trials once those supports are put in place?

King, Kimberly (DBHDS) 1:02:29
What?

Russell, Nichole (DBHDS) 1:02:34
Can we do the trial visits to see if they are going to be beneficial for the resident or if there's some pieces that we need to revisit?
Is it going to be a viable option?
So we would need to also establish those things almost now so that we can make sure if it's not going to work out in their best behavior, we need a backup plan.
So that would need to be established sooner versus later.
Such as those possibilities for those trial visits to go in and see how we can support those visits so that they are successful and if not, what will be the backup plan for that?

Griffin, Jarvis (DBHDS) 1:03:13
And then on the back end that that post move monitoring after discharge, you know that we do when we discharge in quarters with the DOJ settlement agreement.
So that's a very relevant point, Miss Russell.
Thank you for bringing that up.

Russell, Nichole (DBHDS) 1:03:33
Also too, I'm going to.

King, Kimberly (DBHDS) 1:03:34
I know that. Oh. Oh, go ahead.

Russell, Nichole (DBHDS) 1:03:37
Just I just wanted to clarify with the outpatient that we services that we do provide

here at home, Davis for me as as a physical therapist, I do provide the outpatient services for Central state. They do not have a physical therapist over there.
Yes, I also provide services for our inpatients as well, but I just wanted everyone to understand that we do provide outpatient services and the folks do come here prior to vcbr having a physical therapist. Those folks would come here for therapy services.
So I just want to make sure everyone understands that.
We do provide a dual service inpatient as well as outpatient.

Martha Bryant 1:04:23
I think you need more sub population descriptors and way back when there was ASIS scores and I think sometimes.
Reimbursement is set by DMS.
Change of licensure often requires ACOPN process.
Virginia Department of Health is licensure.
So there are lots of multi agency components of this.
If you're, if you're gonna have facility based beds elsewhere.
I definitely don't wanna go through a trial and fail.
I I feel like I've lived a trial and fail.
Ed. Failure at all costs.
So I mean basically we know that when you change licensure level, it changes your staffing level and.
Your ratios and your expertise and your competency and my concern by moving it that far away.
Is that you'll have a a lot of new hires and you're not gonna get continuity, not continuity in your physicians and your nurse practitioners and your R NS and your basically your expertise. You're gonna lose expertise.
I am a legal guardian.
I'm required to visit every one to 120 days for me to travel.
Even a day trip and spending minimal amount of time.
OK.
That's 10 hours on the road.
I asked one of my friends. I talked to two friends from Southeastern families yesterday.
I'm like, where is a safe hotel, you know?
I think we need to think about family values and having a regional approach. And

just because there is limited capacity there doesn't mean that's the best option. Trying to force everybody into an existing empty space and in some places you're going to potentially displace people there who are entitled to that ICF placement. So I've heard some rumors about you're going to take a visitation room in the cottage and make that be a bedroom. And that's how you're going to change capacity at the ICF level.
We know we have skill things that aren't ICF like my son is not ICF.
So and when I walked down the hallway on 2nd floor, I see significant disability.
I don't really see ambulatory ICF going to a workshop going to a community outing it.
It's a different population so.
I'm worried.
I just have to say I'm very worried and I have been because I think we've had a flawed process.

Rupe, Heather (DBHDS) 1:07:39
Other last thoughts not to shut down the conversation, but around what we need to bring to the next meeting or questions that we wanna answer.

King, Kimberly (DBHDS) 1:07:48
I think it'll be important as we look at projecting into the future, looking at the numbers and needs that were being supported for a lot of the temporary specialized hospitalizations and stabilization stays to see what those needs are and then be able to evaluate how they could be.
Met, you know, somewhere other than Hiram.

Rupe, Heather (DBHDS) 1:08:13
Thank you for that, 'cause. I think that is a big concern of the state hospitals certainly. Weird.

Erin Harding 1:08:20
Christmas Bright was talking about like the need to focus on sort of like a regional approach. It did make me wonder, like, where are the CS BS and this? And I apologize if I missed that during the introductions, but are are the CS BS a part of

this?
Should. Shouldn't they be if they're not?

Rupe, Heather (DBHDS) 1:08:38
Great, great thought.
Lauren, did we have any csbs interested.

Cunningham, Lauren (DBHDS) 1:08:45
We have CSB representation on one of the other subcommittees, but I can I will reach out again and see if we can get someone for the subcommittee.

Rupe, Heather (DBHDS) 1:08:59
I thank you for this conversation. I think it's a great place to start.
I I know we've got lots more to have and and we have to have a report done, I believe by August.
Is that right, Lauren?
August 1st. So we have some time to continue to meet.
I think the recommendation is we get together at least monthly to start and then kind of evaluate the cadence at that point to see if there's more or less work to be done.
So, Nicole, do you wanna kind of take the reins on on?
Talking about the next meeting.

Russell, Nichole (DBHDS) 1:09:34
Sure. I will do that so.
Looking at.
Best times in reference to schedule for the next meeting. Does anybody have any suggestions?

Rupe, Heather (DBHDS) 1:09:52
I think specifically the only thing I heard was Miss Krone wanted us to try to avoid Thursdays if possible, so maybe looking at a different day of the week.

Russell, Nichole (DBHDS) 1:10:04
Is Oh no.

Martha Bryant 1:10:05
Wednesday mornings are normally ID teams that hire him.
So.
Wednesdays tend to be meeting heavy at Hiram.
I will say the governor's budget comes out next week.
We'll see if there's anything.
In that, and by then, we'll look at whether we have.
Executive branch investment.
Or direction or from General Assembly members. Whether we have budget amendments or budget language that will be going through their committee process.

Russell, Nichole (DBHDS) 1:10:53
Do we want to go with a Tuesday for the next meeting?

Martha Bryant 1:10:59
I think that's gonna require a record record.
Coordination with Lawrence to not hit the other subcommittee groups. I know that one subcommittee's Monday and one subcommittee's Tuesday.
So just so they don't conflict.
And you have the opportunity.

Cunningham, Lauren (DBHDS) 1:11:19
I'm happy to help coordinate between the subcommittees to make sure we're not overlapping days.

Russell, Nichole (DBHDS) 1:11:23
OK.

Martha Bryant 1:11:25
I did ask Jarvis that cost comparison was listed as a subcommittee with no ability.
To.
Basically that seems to be hidden.
That seems to be hidden work, so we expect a transparent process with the ability to

comment.
So what's going on with that cost comparison subcommittee?

Griffin, Jarvis (DBHDS) 1:11:51
I'll share that information and we'll get back to you, Miss Brian, on that.

Martha Bryant 1:11:56
Thank you.

Rupe, Heather (DBHDS) 1:12:00
I wonder, do we aim for the 13th or 14th that Monday or Tuesday of January?
That'll be about 30 days from now.
And we'll just see if Lauren can double check the other groups meeting then and send us an invite for one of those days.
Do you mind doing that, Lauren?

Cunningham, Lauren (DBHDS) 1:12:20
Cut it off. Yep.

Rupe, Heather (DBHDS) 1:12:20
Thank you.
Thank you.
And I and Nicole will work on the request for some of the information and trying to make sure we pull that together.
It's not stuff necessarily. I have readily available, but I did see that Susan has already sent up the list, so we'll try to pull some of that together as a talking point. And like you mentioned, Miss Bryant, the budget comes out. So there may be some discussion we.
Wanna have at the next meeting around anything that is related?
So we'll certainly look at that.
If you all have other ideas for topics for the agenda or things we need to cover, things we haven't thought about, please make sure you share them with us.
This is this is our group.
We're just helping facilitate it.

So I want it to be as useful to everybody as possible.
Yes, ma'am.

Martha Bryant 1:13:09
D mass sets rates.
So rate is a barrier to discharge. When we were looking at placements, equipment cost was barrier to discharge some of that.
Cost per year or our equipment limit is a buried or discharge, and another family told me that restraint or what is considered a protective device in DD.
World what is protective like a like a seat belt or?
A.
Something to prevent injury is being refused by the private sector because they're calling it a restraint, so I think we have some language barrier there and some cost limits.
That that's why people aren't.
Being accepted.
And and also one thing to look at in the General Assembly, we were told that Medicaid.
Is.
Lower than Medicare.
So if we get a Medicaid equity bill this year, then that's also, you know, when you're competing for a bed and Medicare is going to pay 10% more than Medicaid you, you lose the bid on dollars alone.

Rupe, Heather (DBHDS) 1:14:44
Did you have another point?

King, Kimberly (DBHDS) 1:14:48
No, I'm sorry. That was a mistake.

Martha Bryant 1:14:49
It's.

Rupe, Heather (DBHDS) 1:14:50
OK.

No, I just wanted to make sure you.
I thought you'd come up and I didn't wanna miss you before.
We sort of wrapped up any last thoughts. We still have a a few minutes left, but I'm happy to to wrap up early if we feel like we're winding down.
But any last thoughts before we head out?

Cunningham, Lauren (DBHDS) 1:15:12
Oh, that's actually a great point.
I was just gonna chime in and say so.
The Hdmc planning team e-mail, which I'll drop again in the chat, is where you can if you have questions or comments, people that you want to direct to us, that's the best e-mail address to use. I think most of you also have my e-mail address.
You're always welcome to reach out to me, and I'm happy to pass anything along to the Co leads. And again, I wanted to put the call out that if there's individuals that you know that want to be part of this process.
Please please send their information my way and I'm happy to reach out.

Rupe, Heather (DBHDS) 1:15:48
Thank you so much, Lauren.

King, Kimberly (DBHDS) 1:15:51
Yes, Kamara, I don't mean to put you on the spot, but as someone who's currently supporting individuals with intensive medical needs in the community, are there any barriers or specific challenges that you all face?
As you're trying to make sure needs are met, just as we're trying to assess, you know, overall capacity outside of facilities.

Zainab Kamara 1:16:16
Well, the the only barriers that we do face sometimes is the licensing process because we do have the homes and and make sure the homes are ready for licensing and also the Sence Marys as you guys mentioned earlier of also like the the organization that I work for.
They've already chimed in with us, so they're we're receiving some of their individual that outgrown their population.
So we are right, currently we are.

And the process of getting more homes, you know, making sure that their ADA compliance and see how much we can facilitate the process of licensing you know. Giving us the licensure in order for us to start the process of bringing the individuals, but other than that, except the authorization process and the denial of equipment, when it comes to the nursing aspects, we also provide 24 hour nursing, both LP, NS and RNN, so.
In our area, we are we are OK.
It's just those little kinks, yeah.

King, Kimberly (DBHDS) 1:17:21
OK.
OK.
Thank you.

Rupe, Heather (DBHDS) 1:17:37
OK.
Well, we'll look for the invitation.
Will it be the same again to register Lauren?

Cunningham, Lauren (DBHDS) 1:17:45
Yes. So as soon as we confirm a date, I'll this group is all on a listserv that will receive. It will also post that to the Commonwealth calendar and the hire of Davis website, but you'll receive an invitation and it'll be the same process where you need to. Register.

Rupe, Heather (DBHDS) 1:18:01
Hey.

Martha Bryant 1:18:01
We had short notice this time.
I hope that will improve so people can reserve dates.

Griffin, Jarvis (DBHDS) 1:18:13
As soon as those texts, as soon as those dates are are are available, we'll make sure

to push those out to the Family Council as well so that we can have maximal exposure for that availability.

Cunningham, Lauren (DBHDS) 1:18:13
Go ahead, Doctor Griffin.

Rupe, Heather (DBHDS) 1:18:29
Thank you guys again for your time and for your interest and for your comments and I look forward to continuing to work with you all. I think together collectively we have some good ideas and some good thoughts and we'll be able to come up with a report that.
Is comprehensive, so I appreciate you all and we will talk to you next month.

Griffin, Jarvis (DBHDS) 1:18:49
Thank you all. Thank you.

King, Kimberly (DBHDS) 1:18:49
Thank you.
Bye everyone.

Rupe, Heather (DBHDS) 1:18:50
Thank you.

Cunningham, Lauren (DBHDS) stopped transcription