HDMC Planning Team_ Community Services Subcommittee Meeting-20250206_140007-Meeting Recording

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1h 42m 25s

Cunningham, Lauren (DBHDS) started transcription

Cunningham, Lauren (DBHDS) 0:03

To get fixed just a minute or two to join the call, and then we'll go ahead and get started.

Moon, Susan (DBHDS) 0:03

Fine.

Cunningham, Lauren (DBHDS) 0:58

All right, 201.

So we'll go ahead and get started.

Season Alabama season Moon would you like to kick things off and then get us started with introductions?

Moon, Susan (DBHDS) 1:11

I'll go ahead and do that.

That would be fine. 'cause. Susan's going to kind of lead the first chunk of our work today.

So thank you, Lauren. Welcome everybody.

To the Community Services subcommittee, Susan, Alabama myself and Eric Williams will introduce ourselves for those who might not have been here last week and may or may not know us as we go around.

But we are the Co.

Try chairs for this subcommittee.

So my name is Susan Moon and I'm the director for the Office of Integrated Health here at DBHDS for general knowledge.

I'm a nurse by background and I will pass this to Susan Alabanza to introduce herself. She can send it on to Eric and then we'll we'll try to have everybody hop in and introduce themselves. So Susan?

Alabanza, Susan (DBHDS) 2:07
Hello, I'm Susan alabamaza.
I'm the clinical director at Hiram Davis Medical Center.
I also wanted to include Amy Loving.
She is another Co lead for this group. So. So Amy, if you'd like to introduce yourself before Eric.

Moon, Susan (DBHDS) 2:17
Oh yes.

Loving, Amy 2:25
Hi everyone.
I'm Amy loving.
I'm with Chesterfield CSB and I will pass it on to you, Eric.

Williams, Eric (DBHDS) 2:33
All right. Good to see everyone.
My name is Eric Williams.
I'm the director of the Office of Provider Network, supports largely focused on D waivers and supporting providers and support coordinators in the community, and I'm currently the acting Assistant Commissioner of developmental services.
Good to be here.

Moon, Susan (DBHDS) 2:51
Great. OK.
So this becomes the the challenge. Cassie. I'm gonna go down my list. If Cassie would like to introduce herself.

Grillon, Cassie (DBHDS) 3:05
Hi, I'm Cassie groan.
I'm the marketing and communications manager at DVHDS.

Moon, Susan (DBHDS) 3:10
Thanks, Cassie and Megan.

McGuire, Meghan (DBHDS) 3:14
Hey everybody.
Megan McGuire, deputy Commissioner for policy and public affairs.

Moon, Susan (DBHDS) 3:19
Thanks, Megan.
McKinley.

Cunningham, Lauren (DBHDS) 3:25
McKinley and I are sharing an office currently, so Mckinley's gonna come around and they're not gonna be able.

Moon, Susan (DBHDS) 3:27
Oh good.

Cunningham, Lauren (DBHDS) 3:33
Hi, I'm McKinley.
I'm with the Virginia management Fellows program and I'm currently working with Cassie and Lauren in communications.

Moon, Susan (DBHDS) 3:41
Thanks, McKinley. OK, Lynette Bartlett.

Bartlett, Lynette (DBHDS) 3:47
Hello everybody.
I'm Lynette Bartlett, admissions discharge manager at Hiram Davis Medical Center.
Nice to see ya.

Moon, Susan (DBHDS) 3:53
Great. Thanks, Kimberly.

DK **Davis, Kimberly (DBHDS)** 4:01
Good afternoon.
I'm Kimberly Davis, the discharge coordinator in southeastern Virginia Training Center.

MS **Moon, Susan (DBHDS)** 4:07
Thanks Aaron.

EH **Erin Harding** 4:14
Aaron Harding.
I'm advocate with the Disability Law Center of Virginia and a member of the supporting Patients Subcommittee.

MS **Moon, Susan (DBHDS)** 4:21
Great. Thanks Aaron.
Markisha.

GM **Green, Markeisha (DBHDS)** 4:30
Hello, my name is Marakisha and I'm a social worker here Davis Medical Center.

JT **Jones, Tanya (DBHDS)** 4:30
Hello.

MS **Moon, Susan (DBHDS)** 4:34
Great. Thank you, Jarvis.

 **Griffin, Jarvis (DBHDS)** 4:38
Good afternoon, everyone.
I'm Jarvis Griffin, the chief executive officer, Hiram Davis Medical Center.

MS **Moon, Susan (DBHDS)** 4:43
Hi, Jarvis, Tanya.

JT **Jones, Tanya (DBHDS)** 4:46

Hi, I'm Tonya Jones.
I'm a social worker at Harmony Davis.

Moon, Susan (DBHDS) 4:50
Welcome Brandy.

Justice, Brandi (DBHDS) 4:54
Hi, Brandy.
Just checking officer at Central State Hospital.

Moon, Susan (DBHDS) 4:58
OK.
Martha Bryant.

Martha Bryant 5:05
Hi, I'm Martha Bryant.
I'm of a son at Harm Davis Medical Center and I'm on Patient Services subcommittee and I'm representing the Family council of Hiram Davis. Thank you.

Moon, Susan (DBHDS) 5:21
Thank you, missus Bryant.
Dee.
Is D She might be occupied.
You're you're off mute.
I can't hear you, Dimitri Morton.

Alabanza, Susan (DBHDS) 5:42
I think it's not working for her, but Dee Morton.

Moon, Susan (DBHDS) 5:44
OK.
That's fine.
You wanna introduce Dee for us, Susan?

Alabanza, Susan (DBHDS) 5:48

Sure, Dee Morton is our occupational therapy manager.
And she works with OT speech and behavioral health techs at Harvard, Davis.

Moon, Susan (DBHDS) 5:59
Great. Thank you, Connie Wade.

Wade, Connie (DBHDS) 6:06
Good afternoon.
I am Connie wade.
I'm the social work manager here and I am in the day room.
We have residents here and we have staff.

Moon, Susan (DBHDS) 6:16
Great. Oh, that's excellent. OK.
So, Connie, you will be tasked with bringing any questions from the day room to this group.
So we're gonna depend on you for that.
I was gonna comment that I think I think Missus Bryant was the only non DBHDS participant on the call today.

Wade, Connie (DBHDS) 6:28
I got it.

Moon, Susan (DBHDS) 6:37
And then of course, our our representative from the Disability Law Center, so that that's good.
So I we will pay particular attention to when your hand is raised.
Ask people in the room not to be shy and for everyone we really we really want to encourage people to put on your advocacy hat today and feel free to bring up any questions, any issues or ideas you will see at the end of the meeting that we.

Wade, Connie (DBHDS) 6:51
OK.

Moon, Susan (DBHDS) 7:05

Are trying to log and create a work plan for all those ideas.
We're not planning to have answers just to continue to collect data, ideas, questions, suggestions.

Morton, Demetrie (DBHDS) 7:13
I don't get this error.

Moon, Susan (DBHDS) 7:17
And so raise your hand if you can. If you can't, please feel free. As Susan Al Banza reminded me earlier today, feel free to interrupt us if, if you have a question and you're you need to be recognized, come off mute and and just say excuse me and.

Morton, Demetrie (DBHDS) 7:17
This all the children.

Moon, Susan (DBHDS) 7:35
We will, we will stop and and gather your thoughts for our notes.
Beyond that, we did not take a break last time, but I think when we get an hour in here, we'll add.
Ask if folks would like a break 'cause.
I don't recall that we took a break and it it can be a lot of information and we truly are hoping that today we do bring.
Some data and some some actual information from both from Hiram and from the community services on the developmental disability side.
So with that in mind, does anybody at this point have any questions?
OK, seeing no hands and no hands from the room either with Connie public comment.
Is there an official public comment you would like to make? Will we?
We plan to listen to those now, but for anybody that has a public comment, we will take those throughout the course of the meeting. But officially, do we have a public comment?
OK, seeing no official public comment and I do expect public comments from our non DBHDS participants here today.
I'm going to pass the agenda to Susan, Alabama.
'Cause she's been working with the team at Hiram.

To pull some data about Hiram Davis, Medical Center ignitions and usage by the community, and so Susan, the floor is yours.

Alabanza, Susan (DBHDS) 9:23

Thank you.
Give me just a minute, if you will, to pull up my share. My screen for everyone.
Everyone see that levels of care Davis levels of care, OK.
So I wanted to review this.
We also reviewed it in the last subcommittee meeting for supporting patients, but just to try to give an overview of the different levels of care that we have at Hiram Davis.
So we have 3 levels of care, General Medical or acute care, skilled nursing care and nursing facility or long term care, General Medical acute care is the same level of care provided in a medical hospital on a General Medical unit for acute medical needs.
Medical providers such as physicians and nurse practitioners determine whether the patient's needs are acute enough to warrant General Medical or acute services.
These services include diagnostic testing such as radiologic and laboratory testing and treatment that requires the care of a nurse and closer oversight than skilled care.
If the person continues to require additional medical care before discharge, they can step down to a skilled level of care. In addition as.
A cost saving measure to DBHDS and taxpayers, Hiram Davis can accept patients from community hospitals through a hospital to hospital transfer.
To reduce special hospitalization costs.
Currently, Hiram Davis only bills room and board for those services, but with the acute medical surgical certification, Hiram Davis could bill for specialized services such as four strings, pharmaceuticals, therapies, etcetera for inpatients and outpatients.
But that's basically what you would find in the same level of care that you would find in your local hospital, like Southside Regional or Chippenham, or in kind of local hospital.
We have two types of skilled nursing services.
The first is the typical type of skilled care found in most nursing or rehab facilities that requires the skills of a nurse or therapist with the expectation of an improvement in their condition.
Individuals are typically eligible for this type of care for 100 days.

After a three day qualifying hospital stay, which is paid for by Medicare Part A.
And that is what you hear of refer to as skilled care in community nursing homes when they're referring to a skilled level of care. That is what they're referring to typically, is that 100 days after the three day qualifying hospital stay, the second type of skilled care.
Is a long term skilled nursing care that is paid by Medicaid.
This type of care in community nursing homes is only found if the daily rate is increased from a typical long term care bed requirements for these individuals.
For these services include the need for increased direct care services, such As for long term feeding tubes and tracheostomies.
These residents have more fragile medical issues that need close monitoring for safety and health.
Nursing facility or long term level of care is provided for individuals who have stable medical problems and are unable to take care of themselves or need assistance in daily care or adls. And this level of care is found in many community nursing homes.
Also, as a nursing home, we use the minimum data set, which is also known as the Md's to determine the level of care and individual qualifies for in a nursing facility.
The MD S has managed, completed and submitted by Md's coordinators. The minimum data set is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes.
The process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems, care area assessments, or cause are part of this process.
And provide the foundation upon which.
Residents individual care plan is formulated Md's assessments are completed for all residents and certified nursing homes, regardless of source of payment for the individual resident.
Md's assessments are required for residents on admission to the nursing facility periodically and on discharge, and all assessments are completed within specific guidelines and time frames, and that information can also be found on cms.gov.
That's kind of an overview of the different types of care that we provide.
Does anybody have any questions on that on those definitions or that section?
Yes, Miss brown.

MB **Martha Bryant** 14:36

As we pointed out in the patient services subgroup, we're serving central state ancillary services and clinics, particularly in our dental and.
We have used community referrals as well and I believe we're doing outpatient services as well as on site.
In other words, say someone from Danville could come up for a clinic.
Or for for dentist. I know when I did a board meeting at in Danville, they said that they have used Hiram Davis as a medical Resource Center.
So mental health is bringing people into Hiram.
For non residential service.

Alabanza, Susan (DBHDS) 15:31
That is correct, yes.

Martha Bryant 15:31
Thank you.

Alabanza, Susan (DBHDS) 15:33
Thank you for pointing that out.
You're right, we do have outpatient services just as typical hospitals have.
And we do offer those for the DBHDS facilities, the facility that uses those services most often is central state.
But we have had people from Piedmont and Vcbr, and sometimes the other other facilities. If they feel that they can be better served coming to one of our clinics.
And you are correct, Miss Bryant, that people have been coming.
From community placements, primarily from IDD community and primarily for dental, but occasionally we have had people.
In in other clinics, but most of that is an area that possibly.
Is needed more.
I should say, sometimes the advantage of when people have wanted other services is because we can take more time, especially if somebody really has trouble going to an outpatient doctor or clinic and they have not been able to get a certain medical service. Sometimes they've been able to.
Come here because we can if we know that ahead of time we will take all the time they need to make them comfortable.
And so that their staff can work with them.

As well, so that they can get whatever kind of medical.
So thank you for bringing that up.
Anything else?
I will pull up my next.
Document and share my screen again.
Can you all see this chart?
OK.
So this is just from the last.

Moon, Susan (DBHDS) 17:26
Susan, can you make it as a little bit bigger for folks?
I think you have more room on your screen than that might make it easier.
If not, that's fine.

Williams, Eric (DBHDS) 17:41
Yeah, there's also a plus sign down by Susan's name that you can Click to make it larger for yourself if you like.

Alabanza, Susan (DBHDS) 17:50
Thank you.
'Cause, I don't know why I'm having trouble right now finding this.
None.
Here we go.
Is that better?
This is just for the last five fiscal years.
The number of admissions that came from different facilities and from the community.
And if you notice.
The highest number have come from the community in the last five years. We saw a real spike in 2023, fiscal year 2024.
It dropped off primarily because of things like.
We did have.
Both admission and discharge coordinators out on medical leave, but also we had issues with Legionella and significant construction projects that had us delaying admissions for eight months or more.

So it we were getting referrals, sometimes people found other places to go.
Some people did wait and come later.
But that is really why we have had the decline right here.
The increase in in Community referrals has really come from people finding out about what we can offer.
It's also been from a lot of times discussions with the Office of Integrated Health or Community Integration managers and trying to work through what can people get in the Community and if they're not getting that, being able to come to Hiram for whatever they whatever they need.
I will say that.
Almost everyone who has come to us from the community returns to the community or has a plan to return to the community.
There has been one person who, between the community, the Community integration manager and ourselves, we realized, was really too fragile to go back to a Community placement.
And there have been a few people who have come.
For comfort care.
Or their medical decline has ended up that they needed to have comfort care and they chose Hiram Davis for that rather than an outside Hospice agency.
Any questions on anything on this chart?
Yes, yes, miss Brian.

MB **Martha Bryant** 20:27
Umm.
And their families.
Case when CBT, CS skilled nursing facility closed in 2017.
There were a number of skill nursing transfers to Hiram, which was represented to be a training center transfer.
Can you pull in your data?
How many people?
Came to Hiram when CBTC skilled nursing unit closed.
So CBTC skilled nursing was unique in the system.
The.
No other training center had skilled nursing, and I think if we just look at 2020, we're not going to capture the skill nursing population.

Alabanza, Susan (DBHDS) 21:23
So we can pull those numbers for you and and present those.

Martha Bryant 21:27
Thank you.

Alabanza, Susan (DBHDS) 21:28
Figures. You're welcome.

Loving, Amy 21:32
I just have one question.

Alabanza, Susan (DBHDS) 21:32
Anyone else?

Loving, Amy 21:33
This is this is full admissions, not kind of the outpatient things we were talking about, correct.

Alabanza, Susan (DBHDS) 21:39
That's correct.

Loving, Amy 21:39
OK.

Alabanza, Susan (DBHDS) 21:41
These are however you do make a good point, so I can pull the outpatient as well.
Anything else?
OK.
My next document.
Hey, can you all see this this document?
This is kind of a rough chart.

McGuire, Meghan (DBHDS) 22:26
Yes, ma'am.

Alabanza, Susan (DBHDS) 22:26
This is just OK.
Great. This is just a real, excuse me, a starting point again. In the same time period, those five years and these are admitting diagnosis for individuals from the community.
And I separated them in general, the first column is the total number with that diagnosis and then this.
These columns are where they were admitted to what level of care.
General Medical skilled or NFL long term care?
So we had dental surgery, fever, plural effusion on the right, seizure control, diabetes with hyperglycemia.
Adult failure to thrive, which you see is a large one.
Recurrent aspiration pneumonia, open wound of the right hip.
The cubitis ulcer of Coccygeal region kidney disease.
Chronic stage 3 abnormal weight loss, surgical aftercare, major neurocognitive disorder.
And I apologize.
I didn't finish that one, but major neurocognitive disorder, decubitis ulcer, right.
Hip Stage 4, neuromuscular scoliosis. Acute cystitis.
Anemia, acute respiratory failure with hypoxia, congestive heart failure, aspiration syndrome, chronic idiopathic thrombocytopenia, Gray matter, heterotopia status post osteo, epilepsy, sepsis, diabetes mellitus type 2, tuberous sclerosis, dysphasia, generalized weakness.
Unspecified orthopedic aftercare, decubital ulcer, bilateral edema of lower extremities.
Left fibular fracture communicating, hydrocephalus, esophageal dysmotility, intellectual disability, and strabismus.
Rectal hemorrhage due to ulcerative coli.
History of bilateral hip replacements.
Acute tetraplegia UTI. Other fracture, right, lower leg, impaired mobility, altered metabolism due to diabetes.

Antibiotic reaction and fluid aspiration.
Abnormal gait due to muscle weakness.
Aspiration pneumonia.
Unspecified intellectual developmental disability and palliative care.
Susan.
So if you notice some area, some diagnosis were for a couple of types of levels of care, but overall we had in those five years.
At least 19 admissions to our General Medical beds, 29 to sniff and or skilled and seven for an F for long term care.
So I know there is a need for for skilled, but we do see people really utilizing even though there's only four GM beds. We do see people really utilizing those beds as a way to come and and get services.
Talk a little bit about.
The reasons for admission for those who may be familiar with some of those those clinical diagnosis.
I know some of them sound pretty stable, however.
There, there could be a reason that somebody is admitted, even if they do have some medical stability. And so these are some of the reasons that people have been admitted that aren't part of the diagnosis, not receiving appropriate care from community medical providers.
So some examples of that would be people who have been in nursing in community nursing homes, they might be developing de cubitous ulcers.
That the family or the Guardian do not feel are healing appropriately, or that they're getting the right care for them.
Also, sometimes they feel that they're not getting.
The rehab that they need for their issue, which is slowing down their progress also.
A lot of times in nursing homes there for rehab, there are productivity rates.
And they want you to make a certain amount of progress and a certain amount of time, or you're really not eligible for rehab.
At Hiram Davis, we don't have productivity rates.
We are able to spend more time and we are able to revisit somebody who may not be actively participating in therapy until they get used to us.
So we're able to accommodate for those types of things.
OK, another reason would be medical. The medical community not finding reasons for a person's decline and needing a comprehensive interdisciplinary medical work

up.
So sometimes you will see we've seen people coming because they'll say this person keeps bouncing back and forth to the Ed or they keep going to the hospital, they're discharged, and then they're back within a couple weeks. And this has happened three or four times.
And nobody seems to be able to figure out what's going on or why this keeps happening.
Sometimes they might have a decline where they keep getting, for example, recurrent aspiration pneumonia would be a good example of that, or failure to thrive. They might be going back and forth to the hospital.
The Ed and might even be going to other medical specialists in the community. However, there's really nobody who is case managing that, so to speak.
The advantage of coming to Hiram Davis is our PC PS will case manage all of that even if they are going to a specialist, our PCP will look at the whole picture and will be able to work with that specialist to see if their recommendation is going to.
Work. Or if maybe it needs to be discussed more because they have these other issues going on.
And we've also seen that work very, very well where we've been able to get people back to.
Their prior level, or to a very stable level to where they're not having a recurrence of whatever the issue is, and many times it has to do with medication management.
You know this can happen to us too.
But when you can't speak for yourself, it can be a little bit harder.
But if you start going to many specialists for different issues.
Sometimes they're looking at their one specific thing, and it's not that they're trying to provide poor care, but they're just not used to looking.
At that whole picture and without somebody doing that, if you kind of add medication after medication, after medication, you can end up with some pretty significant medical issues. And once those are ironed out, people, we've seen several people stabilize.
Another reason is rehabilitation.

Martha Bryant 29:22
It's really.

Alabanza, Susan (DBHDS) 29:24
Yes, ma'am.

Martha Bryant 29:30
One thing that I think has to be noted in the five year look back or the COVID protocols and length of stay per diagnosis so.
For some of those years, we were in 14 day isolation protocols and say an aspiration pneumonia.
A hospital might give you a three day length of stay, which your COVID protocol required. A 14 day quarantine.
Quarantine period or we picked up people who needed oxygen, which has not been available at scvtc.
So I think there's got to be some.
Looking components of care such as oxygen or recognizing we were in a COVID a major COVID pandemic which which prolonged length of stays and prolonged the whole.
Before you could return anywhere.
Does that make sense?
You know you got locked into a 14 day.
I do have a question about out of state. I'm aware from family council.
Of at least One North Carolina case.
So the fact that the Petersburg area is along the North Carolina border as well.
Are we having out of state people who are having difficulty returning to their homes?
Thank you.

Alabanza, Susan (DBHDS) 30:59
Sure. That's a good question.
It honestly depends on the state.
So North Carolina has been a difficult state.
To be able to get into their programs due to how their Medicaid works and the length of waiting lists on there, we do have another individual who is looking at Maryland and Maryland appears to be a little bit easier to navigate.
But I think it depends on the the type of services they need. The type of system that they're going to need to go into and in the state itself. So.

Right now we only have two people who are looking to go to another state.
But that is a good question.
It does play into what the needs are and where they can be found.
Returning to close to be close to family members.
OK.
All right, another reason for admission is rehabilitation. As I talked about a little bit before.
We can take more time with people sometimes as, as we have had more community admissions, we found that some providers, sometimes some CSBS.
And sometimes people like guardianship programs have realized that we can provide a more individualized service and take our time.
So sometimes we've had people referred for rehabilitation just.
Because they had a previous experience that they felt was really good for that particular population.

Morton, Demetrie (DBHDS) 32:35
OK.

Alabanza, Susan (DBHDS) 32:41
Adult Protective Services.
We have had a few cases of adult Protective Services. I think I can think of four at least.
And typically it's because somebody is being neglected in a certain situation and they need a safe place to land.
Often they've had medical issues that have gone unaddressed.
And so there's a plan put in place for them to come to Hiram Davis, APS and Department of Social Services works out whatever is going to go on as far as.
Their safety and who's going to be able to be guardian and and works out all of that while we address the medical needs and then at that point we figure out where the discharge plan as far as the discharge plan, where they should go, if they can return.
Home.
Or if not, where they will go and we do all of the individualized training and meetings that we typically do for others who have gone to community placements similar to what the training centers did, there's also.
Follow up and post move monitoring with those placements.

So we are going and making sure that everything is safe and that those medical needs that they had before are all being addressed.
Another reason is no appropriate placement is available or needing a temporary placement.
And again, this goes to some of what some of the family members have brought up previously.
You know, sometimes if somebody's in the hospital, they've had a medical decline and they're not able to return to their previous home because people can't manage their current medical needs.
Sometimes it might be environmental that their bedrooms on the second floor. Now they're in a wheelchair.
And we've even had sometimes where group home is closing and there's an emergency situation at the last minute and we have to have somebody again needs a safe place to land. So we're able to provide that and we again work on whatever medical issues they have and then.
We are able to put together an individualized, comprehensive plan and provide training and post move monitoring as they discharge to a Community placement.
Any other comments or questions on those reasons for admission?
From the community for it's right now we only admit people from the community who have a primary diagnosis of iddt.
OK. And then I just wanted to go over the reason for admission for Bcbr residents.
And I think this is significant too, because even though several people have been admitted from vcbr, they have on a permanent basis, they have been people who were originally discharged to the community, had a medical decline and no, no other place would take them.
A lot of nursing homes will not accept people who are on the sex offender registry.
And it is a huge barrier. Just a few weeks ago, we admitted somebody from the community through who had to come through vcbr because they had a medical decline and VCU could not provide find any place for them to go.
They had.
They have a long, long list of places they tried.
Usually these people, these individuals, have.
The type of medical needs that makes it unsafe for them to live on the units at vcbr, and there's a lot of concern from Vcbr staff.
With them having to stay there, we have had some people accepted for comfort care

because they have a terminal illness.
And again, it can just be very difficult to find a Community placement as people have a medical decline for people who are on the sex offender registry.
So as we talk about Community services, I think that that's a one of the other areas that's really, really significant.
You know, people are having real medical issues and they are really, really.
Like having a hard time finding a place to go.
We've even had, and I know I I titled this as Vcbr residents, but we've actually had a couple of admissions from state facilities for people on the sex offender registry.
You know the other state facilities I can think of one from Catawba, and he had a terminal illness and was not able to find a nursing home in the community and had no family. But he was able to come here. A similar situation for somebody from Eastern state.
So that is that that is an issue for several people.
Any questions on this area?
That is all of the data that I have have right now and Susan Moon, are you presenting presenting data next or is that Eric?

MS **Moon, Susan (DBHDS)** 37:54
I am not presenting data yet.
I'm not.
Eric will actually be next, but I just want to take a minute and check in with our group at Hiram with Connie.
And to see if there are any questions from that group.
Or anything they would like to know more about at our next meeting about Hiram, where they are working and living the data.
I mean, we have a lot more data. We intend to pull.
And look at to present at the next meeting.
We have lots of ideas and misses, Bryant has added a few to the list here today.
So I just want to check in with Connie.

WC **Wade, Connie (DBHDS)** 38:37
Thank you. So far there aren't any questions, but thank you so much for asking.

MS **Moon, Susan (DBHDS)** 38:42

OK.
Alright, very good.
I will pass this off to Eric.

Williams, Eric (DBHDS) 38:49
OK.
Thank you, Susan and Susan.
Appreciate the data review. So what?
I'm here to talk about today is to talk about the framework, the tools, the resources and the processes that we use on the Community side to support the development of the provider community and also to help individuals and families become more aware of and make it easier for.
Them to locate and access services that meet their needs.
So I'm going to start with a a review of our provider data summary, which we've been doing since 2018.
We do it every six months and we look at a lot of data from across the department. Related to the location where services are provided, information about the wait list, information about the increases and decreases we see in terms of who's offering services and how many individuals are receiving those services.
We look at support needs as part of this, so I'll go ahead and start and I'll pull up the report 1st and just kind of explain that to you. But I think what I'd like you to have in mind is I'm going to be showing you some of.
The ways we go about it on the Community side and if you see visualizations, dashboards, things that you think would be helpful for you to have related to the data that we're discussing in this work group, we have data analysts on staff who have expertise in developing differe.
Kinds of data solutions.
And we can certainly work with them to see what they can bring in terms of development of any kind of dashboard resource that you might find helpful.
All right. One of the things I've learned too is that as we develop.
Visualizations, or even the structure of the data summary you know, you start where you start, and then you refine it and you get better over time.
So you know, in my mind the idea is just to get started.
And then we just refine it as we work together and make it better.
So I'm going to share my screen.

And we'll go ahead and start with whoops.
Sorry, Lauren, I'm showing your thing.
Hang on, here we go.
So we do this report every six months.
This is the most recent report, which is from November of 2024.
This has just been finalized.
It has not yet been posted on the DOJ library or sent out to the provider community yet.
Typically what we do is a webinar after each report and the reason we do that is because we want to bring providers in and teach them how to use the data that we make available so that they can make smarter decisions about where they offer services.
One time I had a group home.
Contact me and say you know it's I haven't had anybody in my program for a year and I'm about to lose my license. And I said, well, tell me about your thought process around developing that group home. And they said, oh, well, I just wanted a group home.
At the beach. And so I that's where I opened one.
But there's a lot of saturation right in tidewater, around group home services, at least at this time.
And so that really wasn't the best decision for that provider to make.
There should have been a little bit of leg work.
In terms of understanding who is already there and what is the Community need. So I think that the data we're making available helps providers make better decisions about where they offer services.
So this report talks about the activities that we carry out through the Office of Provider Network supports.
We do have an online dashboard that I'll show you in a moment that providers have access to that they can use and search and filter for information about the availability of services.
It talks about the activities within within our office that focus on meeting certain measures that we have to meet under what was the terms of the settlement agreement.
Now we're under permanent injunction. That's where these originate from, but they're there, measures that we care about to as a department and as a system.

So we're focused on those.
We talk about activities we do.
How many providers do we talk about developing services?
With and which services or providers interested in developing peer mentoring? We have contracts kind of out there with other entities and we rely on reports from those vendors to help us build out the story about the system.
But once you get down a little further, you start to get into visualize data and we use things like line graphs, bar charts, online dashboards.
To make this information, you know easy for people to understand.
So I'm gonna go down to the measures section 1st and just say you know, we have a lot of like I was saying line graphs, we can produce these as individual reports that come out as PDFs that you can kind of hold in your hand and look at.
And then we have the online options where people can just have a link and they can go in and see all this information online.
One of the things we do we look at the 133 localities in Virginia and we actually are paying attention to how integrated those localities are.
So we have of course a spectrum of services.
We have services that are, you know, much more integrated with much smaller groups. And then of course, we have larger services as well.
And so this looks at the level of integration across all the localities.
Further, we look at some of the some of the data we look at, for example, this measure data continues to indicate that at least 90% of individuals new to the waivers, including individuals with a supports need level six or seven since FY16 are receiving services in.
The most integrated setting, and that's based on their their preferences and their needs.
So support needs level 6 and seven under the supports intensity scale, which is the assessment we use.
Under the DD waivers, Level 6 is complex medical supports, and Level 7 is complex behavioral supports.
So when we look to track progress with this measure measure, we use the this top table right here.
So 90, we're targeting for 90% of the individuals coming onto the waiver and overall we have a 97% success rate with integrated settings under the waivers. And then the second chart for level 6 and seven.

Is there just to demonstrate that we pay attention to people with complex health and complex behavioral needs and that they are not forgotten in our numbers, that we are paying attention to them also having the same opportunities that others have.
And so for folks with complex medical and.
Behavioral needs.
You'll see that we are at 96%.
Integration following enrollment in the waivers.
Here's another trend graph we're trying to trend our data over time.
Again, we use bar charts.
Look at increases in providers or decreases in providers.
Increases like within a locality. Maybe they had five types of integrated services and next quarter they have six types.
So we track that kind of increase in the options that are available to people.
We also look at direct support, professional competence. We're trying to achieve a success rate of 95% and that is both for having documentation in place to prove competence, but also through on site reviews through our quality service review, vendor observing DS, PS, interviewing DS, PS making.
Sure that they understand the needs of the people they support.
And how to offer and provide that support so we have a whole competencies process around that.
For documentation, right now we're about 78%.
And for observed competence, there are certain things that reviewers look at and ask.
And for the observed piece, we are at 86.6%, so 87% success with DS PS being determined competent through observation. We look at things like employment, how many people participate in choosing jobs in the community.
We look at things about choice around where people.
People live who?
They live with what?
Whether or not they decide their daily schedule.
Also, whether or not they develop their own Service plan.
OK.
So we look at day services, not just residential services. We look at people and their opportunity to be involved in different types of day services and employment services and we track increases or decreases in that.

We have a lot of demographic data, so a lot of the things that Susan was talking about earlier around.
The minimum data set or you know some demographics about people who live in Hiram Davis or people with complex needs. You know, we can develop visualizations around demographic information.
So for example, here we have wait list data.
This is the level of need people have on the wait list and what region they reside in.
We look at how old people are and how long they've been waiting for waiver.
And we pull all this data from our waiver management system.
This is related to living situations. So for example you can see that for sponsored residential we started with 15113 individuals in 2016 receiving sponsored residential and then as of September 30th we have 2083.
So you can see the increases in people using different types of services.
We have some data around ICFIID placements as well as nursing facility placements.
We do trim these up and down. So for example, number of adults residing in ICFIIDS, excluding training centres for this report as of November, we have 344 that are just indicate indicates a slight decrease from last quarter or.
Last report, last semiannual report.
Number of adults residing in nursing facilities.
Number of individuals in training centers.
So we do look at also independent housing. We look at licensed services and and how many providers are there of different types of licensed services.
So as I go through this, I mean there are probably gaps in this data or information in this data that we could strengthen based on the work of this group.
So there might be.
You know you're not thinking about these, this category of complex needs or or this kind of information would be helpful because I think we want to build.
Out our system to support all people, right?
We wanna be able to support more people, so I think that the work of this group will help us contribute information into our process and make it better so that we can serve more people.
We look at service authorization data to tell us how many individuals in each region are receiving different services, and then you'll see that SYS level 6 and seven again.
So sys level 6 here is the complex medical supports.
So you'll notice that for group day support, there are 364 individuals in the

Community receiving Group Day support services, and they've been determined to have complex medical needs.
We have 282 individuals with complex medical needs living in integrated group residential, which means 4 Bed group home or smaller or a sponsored home which is no more than two people.
We also have like the larger group homes we have 123. So you can kind of see the numbers here and a total of 1464 people with waiver and complex medical needs.
We also track the number of therapeutic behavioural consultation providers in the Community and I'm going to pull over another resource real quickly that we have.
So we have a behavioural services office and they've developed a searchable database of behavioural providers.
So anyone in the Community support coordinators, families can come in and actually use filters to identify and locate.
Providers of behavioural services.
So if you just wanted to look say.
In region one, you would check that it would give you all of region 1.
Maybe you're looking at a specific CSV area?
Look at Blue Ridge and that filters down to that.
Funding types accepted.
Let's say you know DD waiver, CSA languages supported and then the credentials of the staff.
So this is just one way that we can can kind of help families find providers of of needed services, especially around in this example complex behavioral supports.
Alright, so that we do.
Go a little bit faster.
We also spotlight different things in our reports.
So national core indicators is a national report and process that we participate in to understand our disability system.
We look at children's services, specifically children and youth residential. The other thing I would say is we we rely on Community partners to read these reports and say, you know, we want to know more about.
Children, we wanna know more about youth and so we work with our data analysts to kind of incorporate information as respect as requested by the Community.
So just like I'm saying today, if you see things that you would like to develop for our work together, we can do that as well.

So you see, Council providers, you see, actually we listed who these providers are for children's residential and what localities they're operating in and what region. So support coordinators can come in here and actually see the names of these providers and where they're located very easily and be.
Able to find those providers.
Now this one, I won't spend a lot of time on.
What I'll say is that we go through every waiver service and we do line graphs that show our original baseline date of 2000.
2018 and then we look back six months and then we look at the current time frame and we look for change in provider counts. And we also look for change in individual counts.
So it's really about how many individuals are using the service and how many providers do we have available and what does that look like over time?
All right. So I'm gonna jump now to our dashboard for a second.
So there's a link on the website on the dbhds website that has charts that we use in the written report and providers can come in and leverage this information to understand the DD services system in Virginia.
So we start with just some basic demographic information, but if you click on this of down here at the bottom, you're gonna see there are lots of tabs.
Is available and providers can either use the arrow to click through, or they can use this option. But if you use the arrows, you'll just start going through some of the visualizations that we were just looking at in the report.
So for example, I'm gonna look at, you know, private duty nursing.
You know you can see that we started with 77 providers. We went up to 79.
We got down to 78 and you're going to be able to see where those providers are located. When we get further into this and then you see the number of individuals in both private duty and skilled nursing and changes in those numbers over time.
I'm going to go ahead and jump to the another thing we visualize. For example is we use bar charts to show provider counts.
And regions. So if we want to look at how many supported living providers or crisis providers are there, we can look at May 2018 and then look at the increases or decreases in the availability of those providers over time. So for example, for supported living here you.
See an increase and you see we've struggled with crisis support services.
We do have reach.

Which provides a lot of crisis services.
But there are some services that due to different reasons, we've had to have quality improvement initiatives on and we're constantly working.
To improve access to some of the services.
If you come down to the BMT page, this is really what's available for providers to do some smarter work around.
Where am I going to offer services so we have the population and the top chart, so the count of individuals, how many individuals are in each locality in Virginia and you can Scroll down and you can see how many have which type of waiver. So building independence family.
And individual supports.
And community living and then all waivers and then support needs levels.
Remember I mentioned sys Level 6 was complex medical needs.
You can actually come in and see the distribution of individuals across all the localities. So for example, Chesterfield has 103 individuals who have been identified through the supports intensity scale of having a Level 6 support needs. So providers might say.
Oh, there are a lot of folks with complex medical needs in Chesterfield.
103.
I should reach out to the CSB and see if they need additional support in that area, and perhaps that's a place I would like to open services.
Also down below we track over time the number of individual or or the number of unique providers in each locality.
So yellow means we have 0, so we need to work on developing those.
Green means we have one provider and blue means we have two or more because we want to make sure that everyone has choice. And if you have two providers.
You have the very basics of choice, but once it comes to blue, we're not thinking of that as a as a gap so much as we are the yellow and green.
So if you looked at this visualization since 2018, you would see the color populate more in terms of green and blue. As we've developed services.
But a provider can come in and they can say let's look at skilled nursing for example.
Come in.
And you click on skilled nursing, you're going to Scroll down and you're going to see where the concentration of providers.
Are. So if you're somebody who who really wanted to be close to nursing services,

you'll see like for example, Prince William has five providers.
Northern Virginia, I think.
Give a minute.
Northern Virginia has a lot of providers. I think I saw as many as 24 in one locality.
Well, I have a filter messed up.
Oops.
I looked at this earlier.
I'm not seeing it now.
I apologize.
Well, maybe it was private duty.
Yeah. So a lot of services have moved to private duty.
So for example, Prince William has 24 unique providers offering private duty nursing or long term nursing.
And then there are five providers offering skilled nursing. If you look at some of the other localities, you have Spotsylvania with eight unique providers, right?
Virginia Beach 9 unique providers. You can also look at sponsored residential.
You'll see that Virginia Beach has 35 spot unique sponsored residential providers.
So if I were a provider sponsored residential, I'd pause. If I were gonna open sponsored services in Virginia Beach, I'd have to come back up here and look at the population of Virginia Beach, which currently for waiver services are 989 and there are 30.
5 providers I would definitely call the CSP and talk with them about you know about that.
We also have data in heat.

Moon, Susan (DBHDS) 58:32
Hey, Eric, can I interrupt you?

Williams, Eric (DBHDS) 58:33
Oh, go ahead. Yep.

Moon, Susan (DBHDS) 58:35
Just real quickly.

Williams, Eric (DBHDS) 58:35
Sure, sure.

Moon, Susan (DBHDS) 58:37
Before you move on from the nursing data because I'm, I'm thinking there might be some folks here that don't understand.

Williams, Eric (DBHDS) 58:40
Yep.

Moon, Susan (DBHDS) 58:46
They think they do, but they don't really know what you said about skilled and private duty nursing because Susan spoke about skilled nursing in the beginning does not the same use of the terminology as.

Williams, Eric (DBHDS) 58:54
Right.

Moon, Susan (DBHDS) 59:00
Well, we are using it when you and I are talking about community based DD support services.

Williams, Eric (DBHDS) 59:06
Right.

Moon, Susan (DBHDS) 59:06
And so when Eric's talking about skilled and private duty nursing, he's talking about.
DD Waiver nursing services.
So these are nursing services.
RN or LPN that are authorized by D mass and DBHDS to be provided under the DD waiver.
And so the term skilled and private duty for this data set.
Has nothing to do with the type of nursing care provided.
It's not about the complexity of the nursing care provided or the competence of the

nurse that's providing the care, their competence or certification or licensing level.
It's only about the number of hours.
They receive and the focus.
And so I just wanted to help, we're talking about.
We're not talking about the same thing, and that makes it very difficult for people, so we'll try to say DD waiver, nursing, DD waiver, skilled nursing DD waiver.

Williams, Eric (DBHDS) 1:00:17
Human.

MS **Moon, Susan (DBHDS)** 1:00:17
Private duty nursing a we tend to forget to say that 'cause in our world. That's everybody commonly knows that.

Williams, Eric (DBHDS) 1:00:26
Yeah.

MS **Moon, Susan (DBHDS)** 1:00:26
But I just wanted to draw that line for folks, particularly since we have people in Connie's room also that aren't maybe as.
Sunk into our our DBHDSD mass language. So OK, thanks.

Williams, Eric (DBHDS) 1:00:42
Yeah, yeah, yeah, sure.
And I recognize I'm moving quickly.
It's just a lot of information and my goal today is just to kind of give you a broad overview of how we use data in the community and how we support the provider community. And so as I was saying, some of this the like you might say for.
For our work with this this subcommittee, we might want a dashboard that that tells us something, right?
And then you know me being from.
Provider network supports.
I'd be like, oh, that's a dashboard.
Everybody should see.
Let's let's think about how we can.

Make that information available to more people.
Just, you know, kind of my my personal bend on this.
So anyway, so we have this dashboard.
It does that this, this sort of locality level, but then we also have information that kind of rolls up into a regional level.
So how many providers are there in the different regions of the services and where are the gaps there?
Then we look at distinct providers by region and number of individuals receiving services kind of globally.
And then if we look at the last tab that we use for this, we have a sub regional breakdown, which means for marketing purposes and strategic planning for agencies, if they look in Charlottesville, they should also look in Louisa, right?
They should also look in Nelson County, probably.
So we've created these subcommittee subcommittee Sub regions where we took each region and broke it into four parts. And so that geographically by Rd. localities are close together.
So if I'm marketing my services, I need to pay attention to surrounding localities, because those who might benefit from my services may not be in the specific locality I'm looking at, but maybe the next county over. And so anyway, that's kind of how we help providers do that.
If you're interested in reading any of these reports, they are on the DOJ library.
Whoops, sorry.
Which if you go to the dbhds website you can get there as well.
But all the reports are posted on the.
Website and we can give you the link if you're interested in any of this information.
The last thing I wanted to talk about is something that we've been working on.
It's kind of been a project that we've worked on for some time, so we have my life, my community, which is sort of what we think of in terms of the one stop shop for locating providers and not just providers, but also just Community resources, things like food.
Banks.
Right. DSS offices csbs things that are relevant based on.
Location and so if we go to here, you're gonna see you can just put in a zip code. The type of waiver service you're looking for. Like say we're looking in Richmond.
And we're looking for group day, for example. And then you hit search and it's gonna

pull up, hopefully search results for group day.
So you're gonna get a listing of all the group day providers.
You're gonna understand who your community services board is.
Center for Independent Living, DSS Local health department.
So it's just this is a way to help individuals and families find services, whether they have waiver or not, because you might just instead of putting in Group day.
You might put in, you know food bank, right?
And then if we search for a food bank.
Whoops, maybe Henryko doesn't have a food bank, so we have to appointment.
Yeah, maybe Henryko doesn't have a food bank.
Let's try Richmond.

Moon, Susan (DBHDS) 1:04:11
It's probably not called a food bank, so it hasn't been captured.


Williams, Eric (DBHDS) 1:04:13
Right.

Moon, Susan (DBHDS) 1:04:15
It hasn't been captured by the search.
That's that's one of the challenges with search engines, but right?


Williams, Eric (DBHDS) 1:04:17
Yeah, but.
Yeah, but, but trust me, you can find things here that aren't way for services.

Moon, Susan (DBHDS) 1:04:24
Right you can.


Williams, Eric (DBHDS) 1:04:25
And information as well. So, but under find a provider. This is the portion of my life and my community that my office works with and what we do is we've developed a mechanism for providers to secure a badge and that badge can be in autism behavioral supports complex.
Health supports or accessibility.

So we have a survey that providers can come in.
And choose to take and if they score high enough on the survey, the questions within the survey are weighted.
So they have to get a high enough score in order to pass it. If they pass, they have the opportunity to submit evidence 2D BHDS to demonstrate that they meet the sort of fundamental basic program features that we would consider necessary to award this.
Badge. But once they are confirmed by us as having those features.
We then kind of give them a badge that shows up on the database, and then we also add them to a list of providers.
So if you were looking for example of behavioral supports provider, you could click this list and you would be able to see providers who have been confirmed by dbhds to have the minimum program features and at least one service location, which means they have the capacity to build.
It in additional service locations.
That you can explore and reach out to and say I understand you have this badge.
Do you have this?
All of you know. Do you have this option in Spotsylvania?
If not, is that something you would make available?
So it's a way to incentivize providers to one.
Let us know if they support complex needs and then for us to recognize and promote them as a provider of those services.
So in a nutshell, that's really what I wanted to share, just kind of how we use data and how we might use it in the subcommittee and then how we might inform the larger community about.
Out gaps in our system related to complex needs.
OK.

Moon, Susan (DBHDS) 1:06:25
Phew.

Williams, Eric (DBHDS) 1:06:26
Sorry, I know it was a lot.

Moon, Susan (DBHDS) 1:06:31

OK.
Everybody take a deep breath.
And questions for Eric comments and questions.

Loving, Amy 1:06:45
I I do have one, just since we're talking about, you know, complex medical support needs potentially for folks. I know there's been.
OTPT speech that's also been available at least a little bit more in our region, is that something that you can tease out in that data?
I know you talked about therapeutic consultation, at least in the behavioral aspect, but.

Williams, Eric (DBHDS) 1:07:09
Yeah, I think we would have to do some work to be able to get there because I believe right now they all use the same coding and we have to rely on the code.
Yeah, we have to rely on the coding to be able to tease it out.
So we'd have to work with the Medicaid agency to set up those codes and be able to do that.
But yeah, that's a good idea, yeah.

Moon, Susan (DBHDS) 1:07:29
Susan.

Alabanza, Susan (DBHDS) 1:07:31
I had a question. If I know you have data on people who have significant medical needs and then significant behavioral needs, do you have data on people who have both?
I know sometimes that's where we have referrals and it can be tough.

Williams, Eric (DBHDS) 1:07:48
So I I can't say that those syscores are a clean medical behavior.
We know people are unique and if you have behavioral, you may have medical.
If you have medical, you may have behavioral, I think 7.
Seven is probably the well we just recently redone the sys.
So those those references have changed and we need to update our dashboard.

But if you're at A7, I mean it, there is a good chance that you may also have complex medical needs.
We're just.
We're just recognizing that you've achieved the highest level of support, which is really around the behavioral issues, the the medical issues without behavioral would be the medical. But we don't say they're isolated or you don't have more than one thing that you need support with, yeah.

Alabanza, Susan (DBHDS) 1:08:33
I see. OK. Yep. Thank you.

Williams, Eric (DBHDS) 1:08:36
OK.

Moon, Susan (DBHDS) 1:08:38
There's lots of questions for Eric.
He's a wealth of information on this document.

Williams, Eric (DBHDS) 1:08:47
Well, I appreciate everyone's patience as I went through all that. Thank you.

Moon, Susan (DBHDS) 1:08:51
Yeah, we we certainly appreciate it a lot.
OK.
So not to Amy.

Wade, Connie (DBHDS) 1:08:58
For long distance.

Moon, Susan (DBHDS) 1:08:58
Not to put you on the hot spot but. And you don't have to answer now. But coming from the communities, the Community Services Board perspective and we did not give, we did not ask Amy to bring us any data or information direct from the experience of the support.

Wade, Connie (DBHDS) 1:09:05
Thank you.

Moon, Susan (DBHDS) 1:09:15
Coordinator in the Community Services Board.
So Amy, sometime between now and when we end.
If you have some like sort of observations and thoughts about how the CSP has used Hiram and so forth, feel free to bring those. Bring those up and to bring those to light. We were highly focused on bringing some of this data to the group, so.
We'll give you a half an hour or so to think about it, and then you know, then you can bring some of those things to us if if you'd like to.
Sound good?

Loving, Amy 1:09:50
Yep, sounds good.

Moon, Susan (DBHDS) 1:09:51
OK.
All right.
The other thing is I I did mention the beginning.
We're at an hour.
Does anybody anybody want to break the next part of this? Will not be data heavy? We wanted to share what we're working on in terms of an approach to organizing some of this information.
Does anybody want to break and don't feel bad if you're the only one? If you're only one, we'll all take 5.
No. All right.
Going, going, gone.
All right, let me see if I can share.
So.
There's an awful lot of information that we talked about in the last meeting. We had a very really robust conversation. If you weren't here with us last time, the the transcript's available and Lauren will happily send it to you.
To you, but there was a lot. And then, as Susan and Amy and Eric and I have been

talking over the last couple of weeks, we've gathered just a little bit of what's out there to share with you.
Today we've gathered a lot of other information we will bring to you as we get organized here to bring it in the most in, in, in a way that everybody can digest it and we can start to look toward.
The result with the result here needs to be.
A subcommittee report with everything we learned and recommendations.
And so here in developmental services, we do a lot with work plans and.
This is a lot of this is born out of our work around the settlement agreements.
We like to leverage what we've learned to do.
And so this isn't this is not a complete document by any stretch of the imagination.
This is like 24 hours old. OK, but we endeavor here to have a work plan.
And that will capture the questions people have, the suggestions people have, the ideas, the concerns that you have everything.
Down this column for right now, it's called strategies and actions.
Right here.
These titles are going to change before you see this again, because that's not exactly what's in this column.
This these really are comments, thoughts, questions.
We're gonna change this.
And then the responsible party. So one of us will probably volunteer to address that issue.
Question concern.
Gather that data when we think we can have it by status would be kind of the update.
What did we learn?
Where is the report that we found that we brought to show you where you where can we find that status like and then that can be any actions taken, anything learned, any document identified?
And current actions and results will probably change this title to be recommendations.
You know, actions and recommendations.
Ultimately, we're supposed to have recommended actions for the Commonwealth to take to mitigate whatever the barrier is or to develop programs and services to meet a need right that that's ultimately where we want to go.

So the goal here is to research and write the Community Services Subcommittee report for the overall community census and planning section of this overall report.
The objective I have just taken this stuff right from Virginia code. Lauren went over all of this in our first meeting.
I'm not going to read it to you.
It's the high level bullets of the six things that all the subcommittees are supposed to kind of be working on.
In order to send a report to the to the Commissioner.
The focus for us really is types and amounts and locations of new or expanded services that would be needed to successfully implement the closure or conversion of the state hospital, Hiram Davis Medical Center.
Etcetera. So I thought I would kind of Scroll down here.
Now remember this is only about 24 or 48 hours old.
So I we are attempting.
I attempted to categorize these things so that we had some categories. They're not in any particular order.
These notes have been kind of pulled from the transcript thanks to Susan Alabanza for helping to pull high level questions and things from the transcript.
So there's sort of the directive about what we're supposed to do.
We will endeavour.
To develop a section of definitions.
We refer to DD waiver a lot, but what does that mean?
So we will build out a definition that's usable for everyone.
I talked a little bit about these issues about defining skilled nursing.
We will define what that means in different settings, right?
For different population groups also it is different.
Sadly, we use the same terms to mean lots of different things.
So that's a disadvantage for work groups like this one.
We're going to talk about the different kinds of beds. We'll define those for everyone.
So when new people join us, they will be able to have this document and they'll be able to know what we've talked about.
We'll define all the different providers, the different populations, some of the different settings, group homes and residential, some of the large system entities like community services boards.

That serve almost everybody in these populations.
And lots more definitions. We'll keep adding to that.
Then there's the data issue.
We know we need a lot more data and a lot more data exists.
There's data out there to tell us where we don't have enough primary care doctors.
I can pull that up.
We'll have that data to share with you probably at the next meeting that already exists.
Thanks to the Department of Health, Professions and other research entities, so they'll be other data sets, and I've started to make that list of data that people have asked for.
We'll be looking at what are group homes and what are sponsored residential homes like and that will be.
Those will be defined in definitions.
Eric's already started to talk about those homes.
Some of them serve complex medical needs.
Some do not serve complex medical needs.
What is the difference between a group home and a sponsor home?
These are typically developmental disability.
Service options. Do these exist in the mental health, on the mental health side?
How do they exist?
What do they call them?
How available are they?
So we'll be looking at those residential settings and right now this is just titled Group Home and sponsored Homes.
Intermediate care facilities.
Again, we tend to live in the DD world.
There are intermediate care facilities that serve lots of type, different types of people.
So what are they?
Where are they?
Many intermediate care facilities do not serve people with complex medical needs.
That's not their intention.
They have a specific purpose in in achieving certain goals.
The people have established some are medical, some are behavioral. Most and many are.

Activities of daily living and self-care goals.
So we'll try to build this out.
What are our resources in the Community that can help to fill the gap in the absence of of Hiram Davis Medical Center?
Nursing facilities will be the same thing.
There are lots of issues and challenges around nursing facilities.
They don't serve behavioral needs.
Hiram Davis Medical Center can't serve.
Of all types of behavioral needs, there are constraints for those types of facilities and serving folks with high behavioural needs.
This is where our folks that are on the sexual predator registry are challenged.
They just can't support people that present with high risk behaviors of any kind.
Productivity rates. What does that mean?
Why is that a barrier admission criteria?
So we'll be pulling some of that information. It is already available.
In the pasar process, in a medical datasets, those are fairly concrete data points definitions we'll put into this spreadsheet that everybody can have.
There was a lot of conversation about provider regulations and practices.
For example, what could be done to prevent arbitrary discharge from a community setting when a provider's accepted you?
And they they just decide they can't serve you anymore, you know.
And now you don't have a a home, right?
You're being told you have to move.
You have 30 days to find another place to live.
Those what are seemingly arbitrary discharges are very, very difficult for the individuals in the system and their families.
So there there was some conversation last time about this.
Arbitrary discharge.
How does that happen?
How can it be prevented?
The impact of the Virginia Code, established in 2014, and I apologize, I don't have the code number.
But there was a lot of conversation in our last meeting about.
The the code that that provides for individuals being discharged from state facilities, in particular to receive the same or parallel care in their next placement.

That they must receive equal to or better care in essence than they are currently receiving in terms of type and quantity and availability of service.
I need to get better at explaining that and get the actual code here, but but that's on here so that we're sure we address it and build out.
The facts around this and and what some of the answers might be.
Infrastructure.
That sort of self-explanatory.
That's what we're talking about. I made it its own category coming up.
It's in the notes talking about the need for inpatient psych beds.
How does that affect this?
Our job is not to deal with the need for inpatient psychbeds we're focused on community services.
But how does this need in the Commonwealth impact our recommendations?
Adult Protective Services. What do they need?
Why do they come to hire and Davis Medical Center for assistance?
What do we need to know about that in making our recommendations?
Reduction of risk that came up in our last conversation in a variety of different ways.
What are the current actions and initiatives around preventing and reducing risk, and what are those actions in all the various settings across these populations in the Community?
That's a massive focus of the work we do in our division here at DBHDS.
So we will do our best to fill that in here for all of you.
Specific needs of individuals.
So this subcommittee is not supposed to focus on the needs of of individuals.
Specifically, there's another subcommittee for that, and I attended that this week. I think it was this week.
We'll pass a lot of that feedback to them.
The subcommittee's crossover, each other, and I think we can communicate also between subcommittees.
We're going to focus on the community addressing the needs, not the specific needs of individuals. It's.
It's kind of a dance, but we will keep this here permanently as a sub note and gather our thoughts about the specific needs of individuals.
But it's not supposed to be our focus.
Parent identified wrap around services.

There is a list that the parent group and Hiram developed and Susan presented it at our last meeting.
We will be entering that onto this spreadsheet so that we make sure we address.
Each of those services, for example pharmacy services, are available at Hiram and they don't exist in an ICF on site or an on site at a group home.
That's something we all know and we need to address the Community availability of pharmacy consultation and services. So we'll add that list here.
And some of those issues may get their own their own row as we move along.
Rural areas have come up and they they are.
We're in our last discussion and so we need to address the rural areas of Virginia.
And as Eric showed you, we have a template for doing that on the DD side. And and we can adapt that together. The other information for our other populations.
Plans for those who choose to stay in a state facility.
That again.
And I believe also is the there's enough that the individual serving individuals committee is also.
This is a focus they are serving.
There is a subcommittee kind of just for this, but it's a big concern of this subcommittee and meeting the needs of individuals and individuals. Having choice is a big focus of developmental services.
So although this is not.
Our focus how to choose to stay in a state facility.
Because we're supposed to focus on community, we will continue to keep this row and add our thoughts and concerns here again so that it can be shared with the other subcommittees.
Fiscal issues we are supposed to deal with the fiscal impact of our recommendations.
And so this column will grow significantly as we look at the costs that could be associated with filling gaps and identifying barriers and filling gaps.
Apps in those services.
We might come back to that because I think there wasn't going to be a question about that, about fiscal.
So we'll we'll come back to that before we close out today.
Plan for education came up last time.
What type of education is needed in the community?
Who needs the education?

We're all keenly aware that there's a lot of education needed in the community about people with.
Various types of disabilities and unmet needs.
Community services. This is why we're here.
These are all of the items.
We need a plan for assuring the development and funding of individualized services.
What does that look like?
What are the gaps?
What types of skills or equipment might be needed?
Some of this is direct cut and paste from the minutes from the last meeting.
Types and amounts and locations of potentially newly expanded services.
Again, the wrap around services list applies here as well as its own standing topic.
Mental health structure.
You know, we need to look at the mental health structure for supporting people in the community and where those gap where gaps are in those services and then all the other healthcare needs.
We will be bringing data and information about the other types of healthcare needs that exist at harm Davis Medical Center, but we need to be replicated or we need to identify where they are replicated. If they are in the community, such as dementia care primary care.
Various other challenges.
So there's system capacity.
What types of DD services?
What types of mental health services some of this?
Feels repetitive again.
I only started to organize it yesterday.
Talking about the actual skilled beds, those are those nursing facility skilled beds, OK, that have a specific definition of admit admitting criteria and what's required by a facility to be called a skilled bed facility.
So we'll address those.
Elements here and where they exist and if they serve.
People with complex needs that are in our populations.
Community beds Eric started to touch on community beds.
Those are the assist level 4, Tier 6 and seven folks.
For our DD population, we'll talk more about DD waiver nursing and home health

nursing as community supports and how those are accessed and look at barriers to accessing home health and DD waiver nursing discharge planning was a topic that came up.
In our last meeting.
There lot of the folks, particularly families that have lived through discharge planning processes in the past, presented some issues and concerns about discharge planning and how that flows and making sure individuals complex needs are met.
In the discharge planning process.
And then, of course, there's a section last section to state facilities in general.
Transitioning to other state facilities, which would not necessarily be our focus, but came up in our last meeting. And so it will live in this spreadsheet ongoing.
So we continue to capture those things as there are some folks that may be choosing southeastern Virginia Training Center, another state facility as a discharge as their discharge plan.
In the future.
And so we'll leave that here, forsake of being trying to be complete.
I'm sorry, that was a lot.
But we just wanted to present.
And next time we'll have this ready that you could actually have a copy.
It's it's not really useful in its current format.
We need to change columns titles and clean it up.
But we wanted to present a way that we'll begin.
To like use this as an agenda.
As we move forward.
OK, questions, conversation issues, concerns, ideas.

AS **Alabanza, Susan (DBHDS)** 1:29:44
Thank you for putting all of that together in that way.

MB **Martha Bryant** 1:29:45
Together in that way, you're welcome.

MS **Moon, Susan (DBHDS)** 1:29:51
Missus Bryant, your screen is blinking.

Martha Bryant 1:29:53
It.

Moon, Susan (DBHDS) 1:29:54
You might wanna offer us some ideas here.

Martha Bryant 1:29:55
It's very comprehensive, well done in 24 hours.
When Eric had his.
Presentation me being from a rural area of the state, I was looking at all those zeros of no service.

Moon, Susan (DBHDS) 1:30:16
Hmm.

Martha Bryant 1:30:18
So definitely there's a rural and small town.
Gap that.
For years, we've known about the gap.
We know the service sitting there and then we talk about the success of Prince William and Virginia Beach.
So for for a veteran who has a 31 year old son.
But it's the same conversation in a way that that we've had for decades.
So I do want to say that right now I don't see.
The transparent process for those of us who want to go to skilled nursing, and I'm aware that both on the Senate side, on the House side, there's new budget language and.
Funding and budget that has to be worked out. So coming out of session at the end of February, there'll likely be legislative.

Moon, Susan (DBHDS) 1:31:13
Thank you.

Martha Bryant 1:31:14

Legislative language and things, and I would like to have a subgroup for those of us who do plan.
Facility level transfers when you're talking about what are specific gaps within a home or whatever, I believe in the last meeting at some meeting we had a provider tell us that they were getting equipment denials.
Equipment has been a a barrier for for our family as we've looked for where to go and part of that is D mass caps and maybe individual funding.
If I looked at my son's room and what he would require to go somewhere where at over $10,000, sometimes there's an annual cap. Sometimes there's a per item cap.
We had a denial. Well, actually had two Medicaid denials this year that I just just at.
It we just, we just paid out of pocket.
So you know, there are definite barriers there on the individual level.
When I look at where a home is or what happens with people.
Well, look, man is an issue for for people who like to wander one population. I haven't heard much about is autism ID.
And sometimes that can get into specific.
Sensing types or distance to a safe Rd.
We've also had people.
We had one family who had a trailer that they would get a notice like pick them up within some.
They actually had a trailer, so they could.
Get to the home to pick up their son, who had destructive behavior because he would be evicted. Not in 30 days notice, but it like in like get here in two hours.
So I'm gonna call the police.
So we definitely have that behavioral ID DD Co occurring.
Risk behavior.
Some set fire, some break furniture, some need.
Glass that doesn't break.
You know, like, I mean, it gets really detailed into the types of even windows that you have type of furniture you have.
I really appreciate the work. I did pick up some data points there and one thing that Virginia is not doing and I sent a link to Lauren today, there's an organization called Nord National Organization of Rare disorders. Virginia is does not have an event right now and I.

Moon, Susan (DBHDS) 1:33:47
Mm hmm.

Martha Bryant 1:33:50
Don't think we have an executive order or a legislative order to recognize that as.
A day in Virginia. But the Nord National Day is February 28th.
And so there are many disorders within Nord that are coming to the IDD umbrella.
There's free webinar that's coming up and that's going to have state to state comparisons, so one of the data points you had was about children in nursing facilities, which said 58.

Moon, Susan (DBHDS) 1:34:08
Mm hmm.

Martha Bryant 1:34:22
So we had on the patient services, we had looked at anticipated.
Anticipated.
Development. What is their capacity that we're going to need in the future?
So when we look at aging out and we identify.
Service gaps. One of my concerns is that we're just not planning for people at Hiram.
Now we're looking at who would usually come to harm or we're looking at aging out of St.
Mary's or aging out of children's my sons came to care.
Young in their life and I had two very complex people.
So intellectual disability in the severe complex category your need for service can be earlier than age 18. So I think we have to be sensitive to when you enter.
One of the things I've heard from Senator Deeds and others is it that in the whole mental health concept of how that's licensed, there are no nursing facility beds.
Or skilled nursing facility beds and within.
Their facility structure, how are you going to build in more medical services for aging or non ambulatory people?
And when I was in Danville, they had actually had an empty building.
They were talking about, so I think.
That's just something to look at if you don't have harm.

And southeastern can't take mental health.
Then where is this medical service need going to come from?
And previously I had mentioned that wtbr people who are dying in nursing facilities and they are cognitively impaired.
So we definitely don't want to set up.
A inadequate care system.
I listened to the testimony of Jenny Latimer and of the state Health commissioner about delegate woksman's bills about nursing facilities, sanctions and citations.
Two bills passed.
Out of the house, 99 to 0.
But basically they identified that there's a quality gap.
There's definitely a quality, so within this process I don't see vdh and D mass involvement or considerate. Considering this new legislation that's coming down.
Thank you.
Maybe we needed to add a cooperative agency.
Thought thought process as a work group.
And also this pending legislation. Thank you.

Moon, Susan (DBHDS) 1:37:17
Thank you, missus Bryant.

Martha Bryant 1:37:18
Mr. Bryant.

Moon, Susan (DBHDS) 1:37:20
Is Megan here still?
Megan may not be still here with us.

Cunningham, Lauren (DBHDS) 1:37:28
I think Megan had to jump off the call, but I can if we have questions, yeah.

Moon, Susan (DBHDS) 1:37:30
OK.
I just wanted to.
I wanted to give her an opportunity if she wanted to talk about any of the legislation,

but that's fine.
I just didn't want to miss.
We are aware, Missus Bryant, of that piece of legislation.
I can't speak to it.
Because I'm not prepared to, but we have had internal conversations and are watching that and I I know that if Megan was here, she'd probably be able to give us a little bit of an update with that. But we are D bhds is watching it and we are.
Aware of the need, of course. And.
The concept of a cross agency collaboration around nursing facilities and so forth.
It it it's been a conversation on the table that has nothing to do with the legislation.
So I really appreciate you mentioning that here today and we'll Add all these comments to this work plan regardless of whether they end up in our subcommittee report.
We can capture them.
Amy, any thoughts from support Coordination Universe here and you can say no said I didn't ask you in advance.

LA **Loving, Amy** 1:38:55
Well, I I really was gonna talk more about, like, just the experience that we had working with Pam Davis and how helpful it's been for especially our complex folks in the interest of time. I won't, you know, necessarily get into those specifics. But a couple of the, OK.

MS **Moon, Susan (DBHDS)** 1:39:10
Well, we have time.
We have a couple minutes.

LA **Loving, Amy** 1:39:13
A couple of the the big points that I think were super helpful is.
I think the the commitment to the discharge planning.
Is has been really, really great because they go that extra mile to do the training with the staff and make sure everybody gets what they need.
And that helps it to be the most successful transition.
That's always been a super, super helpful thing. We've had situations where you know, maybe sort of what Susan was saying in terms of reasons people might come,

but we've had care teams that are just like we don't know what else to do for this person. They might even.
Put them on Hospice care and then you know, I'm like, hey, I'm Davis. Hey.
And you know, they're able to kind of work with their whole team.
And figure out you know what needs to happen for that person.
Really help them get stabilized.
We've had that happen several times where then they've come off of comfort care and gone back into the community and been very successful.
So those were a few of the things that I I felt like I really wanted to highlight that at least from the Community side, it's been really good in terms of, you know, using those services and using the interdisciplinary team that you guys have and all the res. That you have so.

Moon, Susan (DBHDS) 1:40:26
All right.
Thank you, Amy and Eric reminded me we're supposed to end at 3:30. So we're 10 minutes over. My little brain had 4:00. Don't ask me why.

Loving, Amy 1:40:28
Yeah.
Hmm.

Moon, Susan (DBHDS) 1:40:37
And that would be bad.
All right. So we're couple minutes over.
Lauren, do you want to wrap up and send us off?

Cunningham, Lauren (DBHDS) 1:40:42
I do.
And I've got just a couple kind of housekeeping notes. So I dropped some links in the in the chat, one takes you back to the Hiram Davis website.
We're posting transcripts and recordings and and meeting information there, but I also wanted to flag if you have anything you want to share. As Miss Bryant has done with the subcommittee Co leads or or members of the subcommittee, or you have questions.

We do have that Hdmc planning team at dbhds.virginia.gov.
E-mail of course.
You can also reach out to myself season Moon season Alabama Amy or Eric.
And then in terms of our next meeting.
We'll work to get that scheduled with the Co leads pretty quickly.
We have a list serve I believe of of people that have attended previous meetings or expressed interest and we send that out to make sure that you have ample notice.
We also posted on the website and we also post it on the Commonwealth calendar.
All that being said, if you have, you know whether it's Co workers, community partners, other families.
Staff at Hiram Davis residents please, please.
Spread the word and make sure they know about this. If this is something that they're interested in participating in, we want to make sure that all parties are at the table and we'll make sure to to get any information they're looking for to them.
I'll turn it back to you, Susan.

MS **Moon, Susan (DBHDS)** 1:42:06
Oh no, I think.
Thank you very much everyone for joining us and we will we'll come prepared with lots more information and answers to some of these questions next time.

AS **Alabanza, Susan (DBHDS)** 1:42:21
Thank you.

BL **Bartlett, Lynette (DBHDS)** 1:42:22
Thank you.
Thank you much.

Cunningham, Lauren (DBHDS) stopped transcription