HDMC Planning Team_ Supporting Patients Subcommittee Meeting-20250203_145719-Meeting Recording

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1h 29m 44s

Cunningham, Lauren (DBHDS) 0:13

The one that just joined, we're going to give folks another few minutes to join the call and then we'll go ahead and get started right at 3:00.
All right, 3:00 PM.
We'll go ahead and get started.
Nicole, I'll turn things over to you.

Russell, Nichole (DBHDS) 2:52

First of all I want to say good afternoon to everyone and thank you for your participation this afternoon. We will get started with A roll call or have everyone introduce themselves so we know who is all participating today.
Again, my name is Nicole Russell.
I'm one of the Co chairs for the committee and I'm the physical therapy director here at Ham Davis Medical Center.
So in what direction do we want?

Rupe, Heather (DBHDS) 3:16

I'm Heather roop.
I'm Oh yeah, sorry.
I'm the director of Clinical services at DBHDS Central Office and facility services.

Russell, Nichole (DBHDS) 3:18

Time.

King, Kimberly (DBHDS) 3:27

Hello, I'm Kimberly king.
I'm a Community integration manager with DBHDS.

Davis, Kimberly (DBHDS) 3:37
Hello, I'm Kimberly Davis, the discharge coordinator in southeastern Virginia Training Center.

Cunningham, Lauren (DBHDS) 3:37
But.

Bartlett, Lynette (DBHDS) 3:44
Hello, my name is Lynette Bartlett.
I'm admission discharge manager at Hiram Davis Medical Center.

Elsie Coleman 3:53
Good evening. My name is Elsie Coleman.
I'm the interim executive director at Crater District Area Agency on Aging.

Fisher, Heather (DBHDS) 4:03
Good afternoon.
This is Heather Fisher.
I'm the facility director at southeastern Virginia Training Center.

Cunningham, Lauren (DBHDS) 4:16
Good afternoon. Lauren Cunningham, communications director at DBHDS.

Jones, Tanya (DBHDS) 4:23
Good afternoon.
I'm Tonya Jones, social worker at Harambe's.

Moon, Susan (DBHDS) 4:27
And hi, good afternoon.
I guess I'll go next.
My name is Susan Moon.

Green, Markeisha (DBHDS) 4:30

Good afternoon.
My name is Marakisha Green and I'm a solicitor. I'm David's medical.

Cunningham, Lauren (DBHDS) 4:38
Susan, do you want to go ahead next?

Moon, Susan (DBHDS) 4:41
Oh yeah, that's fine.
I'm sorry, I wasn't sure the order.
I'm just visiting today.
Hi, my name's Susan moon.
I'm the director for the Office of Integrated Health at DBHDS. What?
I'm a Co lead of another planning team under Community services, so I'm just here to listen and learn.

Erin Harding 5:02
My name is Aaron Harding.
I'm an advocate with the Disability Law Center of Virginia.

Alabanza, Susan (DBHDS) 5:10
Hi, I'm Susan alabazza.
I'm the clinical director at Hiram Davis Medical Center.

Griffin, Jarvis (DBHDS) 5:31
Hello, I'm Jarvis Griffin.
I'm the facility director at Hiram Davis Medical Center.

Rupe, Heather (DBHDS) 5:44
Good begin everyone.

Cunningham, Lauren (DBHDS) 5:44
Hi miss.
Yes, go ahead, Miss Bryant.

Martha Bryant 5:48

I'm Martha Bryant.
I'm a parent of a son with intellectual disabilities, skilled at Hiram Davis Medical Center, and I've recognized Nancy, Crohn's name up there without a photo.
But she's also a parent who's probably listening in.

Russell, Nichole (DBHDS) 6:10
'Cause everyone had an opportunity to introduce themselves.
All right.
Well, we're gonna get started with clarifying some of the questions that came up during the last meeting. I wanted to go over.
The levels of care we have here at Hiram Davis as well as the services that we do provide and let me see if I can share my screen here.
2nd.
Can you all see the screen?

Nancy Crone 6:52
I'm here.
I can hear you.

Alabanza, Susan (DBHDS) 6:52
What?

King, Kimberly (DBHDS) 6:52
No, not yet.

Cunningham, Lauren (DBHDS) 6:53
Not yet, Nicole, no.

Russell, Nichole (DBHDS) 6:54
OK.

Nancy Crone 7:05
Replay.
Replay.

Cunningham, Lauren (DBHDS) 7:21
Nicole, if you like, we can do public comment 1st and then if you want to send me what you were trying to share, I can try to share it from my screen.

Russell, Nichole (DBHDS) 7:26
OK, OK.
Thank you.

Cunningham, Lauren (DBHDS) 7:32
Do we while Nicole's doing that?
Do we want to open the floor to public?
Comment If anyone has comments they want to share. We ask that you try to limit it to two minutes, but but the floor is yours. Just raise your hand and we'll go in order.
OK, not seeing anything. We'll move on to the next item.
Nicole, did you have any luck or do you want to jump ahead in the agenda?

Alabanza, Susan (DBHDS) 8:16
You muted Nicole.

Cunningham, Lauren (DBHDS) 8:21
Nicole, you're muted if you're.

Russell, Nichole (DBHDS) 8:31
Sorry about that.
I was trying to find the document soon as I you wanna move to the next thing and I'll I'll send it. Send the e-mail to you.

Cunningham, Lauren (DBHDS) 8:38
Sure that works.

Nancy Crone 8:41
OK.

Cunningham, Lauren (DBHDS) 8:44

Give us one second here.
I know we had talked about kind of looking, do we want to get this out of the way while we have a moment up front in terms of looking at our next schedule meeting.
I know this group had had opted to meet monthly, so this would be a March meeting.
I did want to check and see if Mondays work for people in terms of scheduling.

King, Kimberly (DBHDS) 9:16
Yes, Monday's like this time on Mondays are generally good for me.

Cunningham, Lauren (DBHDS) 9:22
OK.

Russell, Nichole (DBHDS) 9:23
Wendy's are fine for me as well.

Cunningham, Lauren (DBHDS) 9:30
Give me one second.
I'm gonna try to share.
Screen from Nicole.

Russell, Nichole (DBHDS) 9:44
Thank you.
So I'm going to just review the services that we currently provide here at Hiram Davis, General Medical or acute care skilled nursing care and nursing facility or long term care for our General Medical care.
That's the same level of care provided in medical and medical hospitals on a General Medical unit for acute medical needs. The 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 care skill level of care. In addition, as a cost savings measure to

D bhds and taxpayers, Haram Davis can accept patients from from community hospitals through a hospital to hospital trans.

Nancy Crone 10:49
Yes.

Russell, Nichole (DBHDS) 10:51
To reduce special hospitalization costs.
In General Medical, that's where we provide intravenous therapies as well as to supporting those folks who have.
Drains and things of that nature.
For our skilled nursing care, there are two types of skilled nursing services provided here at home.
Davis the 1st is the typical type of skill care found in most nursing and rehab facilities. That requires the skills of a nurse or therapist with the with the expectation of improvement in their condition.

Nancy Crone 11:20
Repl.

Russell, Nichole (DBHDS) 11:22
Individuals are typically eligible for this type of care for 100 days after 30 after a three day qualifying stay.
Hospital stay, which is paid for by Medicare.
Part A, the second type of skilled nursing care is a long term skilled nursing care that is paid by Medicaid.
This type of care and community nursing homes is only found if the daily rate is increased from a typical long term care bed.
Requirements for these services includes the need for increased direct care services, such As for long term.
Feeding tubes and tracheostomies.
These residents can have more fragile medical issues that need close monitoring for for safety and health and for nursing facility. A long term level of care that 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, this level of care is typical in many community nursing facilities.
If you could Scroll down for me, Lauren, I also here at Hiram Davis, we do have.
A minimum data set which is commonly known as Md's.
We do have Md's nurses here on site to determine the level of care and individual qualifies for in a nursing facility.
The Md's is managed and completed and submitted by the MBS coordinators who are registered nurses.
The the minimum data set is part of the federally mandated process for clinical assessment of all residents.
In Medicare and Medicaid certified nursing homes, this process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems, the car or the care area assessments are part of this process and provide the foundation upon which a resident's individual care.
Plan is formulated, Md's assessments are compiled 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, as well as on discharge.
All assessments are completed within the specific guidelines and time frames and you can find that additional information on cms.gov.
The following are the population that we currently serve here at Hiram Davis.
The intellectually disabled and developmentally delayed.
Dementia and those folks who have been diagnosed with neurological disorders.
And for those folks who have mental health diagnosis as well, the current supports and services provided by Hiram Davis on site, we have dental services. We have respiratory therapy services, we have radiology.
We have pharmacy, we have laboratory services.
We have rehabilitative services which is inclusive of occupational therapy, physical therapy.
Speech, language pathology and recreation therapy.
We also provide wound care services through our wound care nurse and we also provide clinic services not only to our residents that reside within her home, Davis, but also to our outpatients. And those services include Podiatry surgical clinic, gynecological as well as optometry.

We also provide behavioral health training and that is through therapeutic options to help to manage our individuals that we serve with mental health.
Diagnosis.
As well as we also have our central medical supply where we have on site medical supplies.
So I just wanted to do an overview. So those people who may not be aware of the services that we do provide as well as the residents that we do serve, are there any questions regarding any of the any of the information that we that was just present?

King, Kimberly (DBHDS) 15:13
This is Kim king.
I had a couple questions I guess.
First of all, as far as the respiratory therapy services, is there a respiratory therapist there at Hiram Davis?

Russell, Nichole (DBHDS) 15:25
Yes, ma'am. We do have a respiratory therapist on site.

King, Kimberly (DBHDS) 15:26
Yes, OK, I thought so. OK.
And then I just wanted to clarify and I don't want to confuse things. But as far as the types of care, I know we there are individuals in certain bed types quote UN quote.
Versus the type of care.
So for example, someone could be in a bed that is a skilled bed, but the actual level of care that they're receiving is long term care. So for the.
What you just described are those the bed types or cause GM is the bed type, right?
And then.

Russell, Nichole (DBHDS) 16:10
I kind of sort of put the two together, General Medical and acute care and then for skilled the two types of skill we had the long term skill and then you had the.

King, Kimberly (DBHDS) 16:10
Bill. OK.
OK.

Russell, Nichole (DBHDS) 16:20
I'm not looking at my actual document, but there were the two different types.
The ones one more suited to which you typically find in regards to a nursing and rehab facility and then the other one is more of the type that you would see in a Community nursing facility.


King, Kimberly (DBHDS) 16:30
OK.
OK.
Thank you.

Russell, Nichole (DBHDS) 16:37
You're welcome.
Miss Bryant, you have a question or comment?

Martha Bryant 16:49
I believe we had talked about telehealth that we're able to do telehealth with air providers, doing virtual visits with specialists.
I know we're using that with my son we're doing.
We've done three different specialists.
Where where the, say the nurse practitioner is in in my son's room and.
He.
He can. He or she can visualize my son, and then we can talk about neurology or pulmonary or that type of thing.
So telehealth is coordinated there. So then you're being being able to pick up specialty service without transport.

Russell, Nichole (DBHDS) 17:38
We will add that to the list.


Rupe, Heather (DBHDS) 17:38
And I think that's an important distinction.
It's the coordination of the telehealth.
So Hiram Davis isn't necessarily providing telehealth, but I think what you're saying is

that they are coordinating the telehealth to have other providers.
Come in. Is that correct?

Martha Bryant 17:54
Correct, which is a cost savings. In other words, it's both infection control benefit and cost benefit.
And then you're able to maintain your medical home model.
So I've talked before about our coordination with VCU.

Russell, Nichole (DBHDS) 18:18
OK.

Griffin, Jarvis (DBHDS) 18:19
I think you signed that up perfect together.

Martha Bryant 18:21
Also see things like Chaplain, we have an on site chaplain.
So there's.
You know, family support. I know we're doing some end of life support.
For individuals and families. So I'm just trying to think back to that list that we submitted from the Family Council, the first meeting.
We I think Susan Alabanza had submitted our unanimous list that we had created and.
So that was previously submitted and I'm trying to think through everything that we listed there in terms of dental, you know, I mean.

Rupe, Heather (DBHDS) 19:09
I'll. Yeah, I'll pull that up really quick.
I think I have it so.

Martha Bryant 19:15
So we talked about.
Dental sedation and recovery.
One of the populations that I don't see that that's listed on who you serve, the vcbr dropped off.

And also that we're serving central state in our clinics.
So while they're not residents there they are, Potter bear cost cost accounting because of the outpatient services they come to.
Whether it's dental or another service or a lab or an X-ray, we have shared cost savings with Central state.
And when you're saying under #2 population served, you're not including that. We are serving some central state residents and I believe we are in the past we've served some Community residents. In other words, they're coming for dental there and maybe Jarvis or somebody can correct me, but.
I think we have a broader population than the three listed under #2.

Griffin, Jarvis (DBHDS) 20:18
Yes, Miss Brown, we have served a community, residents and patients on an outpatient basis. And you know, as a safety net, sometimes through our General Medical.

Rupe, Heather (DBHDS) 20:26
Yeah.
And I I appreciate that. I do think, I'm sorry, Jarvis.

Griffin, Jarvis (DBHDS) 20:29
More so rate COVID.
That.
Or so pre COVID then.
Now, but yeah, that's still a consideration is for security.
Baby, the Bcbr central state in other states facility patients that we serve, I think we can capitalize and capture them under mental health.
They do have some type of mental health diagnosis.
They have problem mental health facility. So I think yes, a great point, Miss Brad, about community.
I'm sorry, he said. Our relationship.

Martha Bryant 21:03
Thank you for the.

Thanks for the additional information and please correct it in the in the Minutes or the transcript.

Rupe, Heather (DBHDS) 21:18

I'm gonna copy and paste in the the chat or the the services that you that you all listed from.

From the Family council.

RN

Russell, Nichole (DBHDS) 21:32

Thank you.

Any other questions?

Rupe, Heather (DBHDS) 21:33

So that everybody has the ability to see that.

RN

Russell, Nichole (DBHDS) 21:42

So the first question, I guess we want to look at what options are available currently in the Community to help support the needs of our residents of residents and patients that are currently residing here at home, Davis.

MB

Martha Bryant 21:57

None.

King, Kimberly (DBHDS) 21:58

OK.

So there are of course just regular nursing facilities.

There are also specialized nursing facilities that receive a higher rate because they can support individuals with a higher level of medical needs.

There are community intermediate care facilities.

And then, of course, there are Medicaid waiver funded residential options as well.

Some who have 24 hour nursing support, some who contract with physicians to come to the homes and serve the individuals as well.

AS

Alabanza, Susan (DBHDS) 22:46

Excuse me, are those homes?

That have the skilled services.
And the ones that have the physicians come are those only offer within the IDD system.
Or are they in the other systems as well?

King, Kimberly (DBHDS) 23:04
Right. Thank you, Susan.
I'm sorry, but yeah, those are as far as I know, those are only for the.
Idd system.
I know that.
There's currently and there have been some ongoing development of specialized group homes for people with mental illness.
And that the facility services team is continuing to just look at you know what the gaps are and care or you know being able to support various types of needs so.
So that process is ongoing, but I'm not sure right now.
I know there was discussion about developing one that could support individuals with more medical needs, but I'm not sure where that is in process.

Russell, Nichole (DBHDS) 24:10
So if our individuals were to be adamant placed out into the Community, would these supports the ones that were just mentioned? Would they be able to serve the needs of our residents, or would we need to have some additional supports put in place for them for them to?
Be successful.

Erin Harding 24:34
Hi, this is Erin with the Disability Law Center.
Something that is pretty common for us that we see, especially when we get copies of the.
Discharge or like eviction notices from community or private nursing facilities is people who are being basically forced to leave their facility because they may have like behavioral support. Behavioral health support needs that aren't well.
Addressed in the private system or the private system doesn't think like the cost benefit analysis is to their advantage to keep somebody who has those more intensive needs.

So I think you know, even though for people who want to say in a similar institutional level of care, that's one big consideration is like whether the private system is going to be willing to support them long term, right?
And if we know that they're not going to based on like historical information.
Of what we've seen in the system, are there supports that maybe DBHDS could put in place on the front end like through DAP or some other kind of funding stream to ensure that there's a higher level of behavioral support needs available in those place?

Rupe, Heather (DBHDS) 25:56
That's a great point. Thank you.
I mean, I think we all know that that is an issue. And I I agree with you having some sort of model where there's some enhanced supports available if somebody's just going to transition to a Community, placement is going to be necessary.

Russell, Nichole (DBHDS) 26:15
In the past, when I know that the training centers were closing, they had the REACH program available just in those instances to provide that extra support.
Does that not exist any longer, or is it under a new name? Can someone speak to that?

Rupe, Heather (DBHDS) 26:34
It does still exist.

King, Kimberly (DBHDS) 26:34
Yes, we.
Yeah, we still have rage.
So just to make some distinctions, as far as the.
Individuals with intellectual and developmental disabilities.
From what I know, there are definitely more residential options.
And additional ones coming online that can support both behavioral and medical need. I think from my.
Experience what has been the most challenging is for the individuals with dementia or mental health concerns to find placements that can do both.
I don't know, Aaron.

You know, based on what you're seeing that that's the population, I think that.
We need to probably build up more capacity for. I'm not saying everything exists for ID, but they're definitely seems to be a lot more options.
With those specialized levels of care for ID and DD individuals.

Alabanza, Susan (DBHDS) 27:43
Right. And I I would also add that it becomes particularly difficult for people who have been at vcbr or may be on the sex offender registry or have that label of being a sexually violent predator, even if they have not re offended for years.
And have a medical decline. It can be really difficult for them to find care.
Even recently have had another admission just because they could not find care anywhere in the community. Because of that label.
So that is another concern. And I know just for the people who are currently at vcbr, but people who have discharged from our system through the Community as as they age and as they have medical declines, it is a big issue.


King, Kimberly (DBHDS) 28:29
Yeah, definitely.
And again, that's for.
More so for someone with mental health or mental illness and dementia, because again on the waiver and ID side that typically has not been an exclusionary criteria, we're currently working.

Alabanza, Susan (DBHDS) 28:40
Correct.


King, Kimberly (DBHDS) 28:51
With someone from vcbr that we recently discovered had an intellectual disability and he.
Already has a residential option with a nurse that's interested in supporting him, so.

Alabanza, Susan (DBHDS) 29:06
Good point.
Thank you.

Russell, Nichole (DBHDS) 29:16
Concerns in regards to options being available in the Community.
In reference to, especially our IDNDD population receiving those services, if indeed they are in the Community.

Alabanza, Susan (DBHDS) 29:32
You know, the one thing I would, oh, I'm sorry, Miss Brian. Go ahead.

Martha Bryant 29:38
OK.
What I was going to say is I've been following a North Carolina story about someone who has lived at a hospital with autism and behavior because of the of a waiting list of a lack of capacity in North Carolina.
So when when facilities are under capacity?
You can.
You can't get in.
You might live in a hospital or I think, actually in this case, this person lived in an emergency room for about two months in a in a Can you imagine living in an emergency room Bay and then has moved up to an admission room.
Basically not because of medical acute care needs because of lack of placement, and that is so autism with behavior, particular ambulatory or physical size of harm to environment or elopement risk.
I know it when we look at some people who have died in residential placements.
It's been elopement risk of being hit by a car.
Wandering away and snow storms being found dead in snow.
So.
The even something like.
You know comorbidity?
You're wandering risk your behavioral risk.
Make it more challenging.
I know one of the things that we have talked about among non ambulatory families is air Protective devices.
So people with cerebral palsy may need seatbelts or chest belts so that or shower trolleys that have sides on them as opposed to a bath chair where you're expected to

sit up independently. So sometimes it's comorbidity of cerebral palsy or autism or. Epilepsy that makes a provider reject us.
Or cost of equipment.
I know I have an expensive skills son.
So earlier.
Kimberly King asked about bedtime versus need or something. So I can say.
My son has been consistently skilled without that hundred day rule of a post acute care thing, and he scores by the MDS and by by physician order.
He is in skill based.
Needs so he's not just parked in the bed space. That's considered skilled. It's individual consideration.
But that also raises the recent alarm that my son had a misdiagnosis on.
A discharge document without my participation.
So when when someone can go in and presume community and give them a diagnosis.
That's doesn't exist.
It's discriminatory.
It's very, very dangerous to misdiagnose someone or to not allow participation.
So they know that's something that our families are very concerned about retaining, and that's our legal rights to the individualized diagnosis and our care planning, participation and decision making.

Alabanza, Susan (DBHDS) 33:27
That's correct.
And to to try to, in an effort to try to ease your fears.
You know that instance was an error and it has been corrected and so there is no planning at Hiram Davis for individuals without AR consent. We talk amongst ourselves to update each other where people are in the discharge planning process.
But we don't do active discharge planning and make decisions for anyone.
Without the family or the AR legal guardians input.

Griffin, Jarvis (DBHDS) 34:05
Susan, if you don't mind if you could touch a little bit more about our discharge process and kind of what that would look like for individual with that iddt diagnosis.

Alabanza, Susan (DBHDS) 34:18

Sure we have.
We have a A A.
It's a very lengthy process and it's a modified process from the training center closure and the settlement agreement with the Department of Justice.
But basically we would we work with initially the a couple of individuals can speak for themselves and if so, we let them do that of course. And otherwise we work with families to see what part of the state they would like their loved one to.
To move to and then we do a thorough assessment of what their needs are.
What services are they receiving here?
So we look at every single discipline, the environment, nursing, medical, OTPT speech.
Their finances.
Their their recreational involvement, any respiratory needs, their dietary needs, any kind of support that they're getting. We also go through all their equipment.
And supplies, you know, down to do they need 4 by 4 gauze and syringes.
We look at everything and then we make a list of what we call essential supports, which means what is it essential for this person to have when they discharge and we go through that list, much of it may be the same, and sometimes it might be slightly differe.
Just because some things might be done here a certain way and you would do them slightly differently.
In a community setting, but we do not risk any kind of safety or care for that.
But once we go through once we develop all of that, we have a very lengthy meeting with the family, the individual, the provider, all of the Hiram Davis team, the CSB, and we go over all of that.
What they're getting here, what they would need for a safe discharge and then we talk about what would be needed, you know, can the provider provide these things and what do we need to move forward?
So if the provider says that they can meet everything and the legal guardian or ar is in agreement, then we move to excuse me. Then we move to doing things like setting up training with the provider where they actually come to the facility. They train in detail in.
Each of those areas.

And they can either. They can then go back and train their staff on how to work with the individual.
So many times they actually bring several staff to train at the facility as well, and if they need to come more than once, that's fine too.
We order all the equipment and all the supplies, make sure transportation is set up for the person, and then we have a trial visit. So the person goes, it can. We've done sometimes one overnight, depending on what the person needs.
Sometimes we've had as many as 4 overnights.
And then we come back together and talk about how they did during the visit.
During that visit, we are available at any time for any kind of questions. If we needed to come out and do any additional training, we would be available.
But once we come back together and the person doesn't have to come all the way back to the facility if they've done well, we have a discharge planning meeting or a final discharge planning meeting.
We talk about how the visit went.
Are there any other things that need to be clarified?
Or changed. Do they have any questions?
And if all has gone well, we discharge the person that day, and then we set up times to do post move monitoring.
So we do a post move.
The CSB does a monitoring within seven days.
We do a monitoring within 14 days of discharge within 30 days of discharge and those are in person.
And then we do calls at three months and six months.
So it's a very lengthy process for somebody with mental health.
Or dementia. It can really vary depending on where they're going. If they're going to a nursing home.
That's similar to ours a lot of times it's sharing the information of what they need as far as their care and their medication. Again, if they're certified just as we are, we do give them.
Those other details, like if they eat a certain way or have any kind of specialized behavior strategies, we go over all of that.
And then they are discharged there.
Hope that it anybody have any questions.

Erin Harding 39:15

I don't have a question, but I do think it's imperative as we're moving forward with this and especially as maybe folks who are going to have more barriers to discharge are moved out of the facility, whether their primary diagnosis is developmental disability, mental health, dementia, another neurological cond.
I would really want to advocate for the pre and post move planning process.
That is, I mean, it's been recognized as a national model, the independent reviewer.
For the settlement agreement, you know was really pleased with what Virginia put together for the training center population.
Like, I don't see that.
Like I don't know why we can't do that for everyone.
I recognize it might need to be modified a little bit depending on like the population, but I would really like to see a commitment from the state that they're going to do post move monitoring and following up with people regardless of their diagnosis, to ensure that they're in.
The the right setting that they're safe, that their needs are being met in this process.

Alabanza, Susan (DBHDS) 40:14

I think I think I also, as you mentioned to the pre planning I meant to add that for people with mental health or neurocognitive disorders. We also do have an assessment that we use for them as well discharge planning assessment to make sure we go over all those.
That needs that.
They have, whether it's medical or behavioral or environmental.
So there is a detailed assessment.
It's not the exact same document, but it is a detailed assessment that we do for that and that we talk to the.
Provider that they would be working with as to whether they can meet those needs.
So that is part of it. But you are correct, we don't have a post move.
We don't have a a, a post move process for people.
Who are discharging in those ways?

Griffin, Jarvis (DBHDS) 41:05

I appreciate the the overview, Susan detail and Erin that that's a great point you're making.

Alabanza, Susan (DBHDS) 41:08
Welcome.

Griffin, Jarvis (DBHDS) 41:11
I think that is a a great consideration as we kind of work through the discharge process. I think some type of post move monitoring for those individuals that are not already and associated with that DOJ process that we mimic that and modify incorporate that into our.
Our discharge plan.

Rupe, Heather (DBHDS) 41:33
That feels like a pretty solid recommendation that as we are preparing our report in a little in a few months, that was something we should definitely put in there and consider, I agree.
Miss Bryant.

Martha Bryant 41:54
Earlier, Susan said that an error occurred and it had been corrected.
I'm still waiting for correction of errors from November on equipment and I think part of that is a software problem between a team meeting document and another document.
So you can have errors out there that misrepresents you for months.
I would just like to say from personal experience that my one son.
Was forced out.
We had post mood monitoring and that the independent reviewer, because he went from a training center to Hiram, the independent reviewer had no role at all and given that he was dead in less than 60 days, post mood monitoring did not protect him at all.
One of the.
Issues for him was restricted formulary both at Hiram Davis and at the hospital. I had to personally fill prescriptions.
Sorry, in retail pharmacies and take them back to the hospital.

His FDA exempt drug was abruptly terminated.
So abrupt terminations of multiple drugs definitely contributed to his death.
So in that pre plan document, even though that was identified as a need.
The abrupt terminations were.
Contributing factors to his death. And then he became homeless in a hospital.
So I I feel for this North Carolina family and one of the questions to this team is how within a 5 month period.
In one meeting in December.
Was it determined that there should be 10 beds at southeastern for training center transfers and only $3,000,000 investment for renovations?
So at this point, with my son's false document unresolved, he's probably excluded from those 10 beds, even though I don't choose community for him.
So when you have under capacity and we talked about the data.
Points we needed about youth aging out, chronic change in health conditions, and how many people choose.
Training center.
The department is already given a testimony that they need 10 beds.
So there is a hidden process here that we are not participating in and then we hear archive testimony that it's already been pre determined how many beds are needed and how much money is needed.
So I've said from the beginning this is flawed.
Where this families who want training center transfer transfers as opposed to waivers and settings that don't meet the needs.
Needs. How do we participate?

King, Kimberly (DBHDS) 45:08
Miss Brian, I want to speak to that. We can definitely at any point.
A family is ready begin the planning process.
It doesn't have to wait.
It doesn't mean that this process of trying to explore what all the options are for Hiram stops, but it can be something that's occurring now.
So you know, we could start having.
Meetings to, you know, make sure we have accurate information.
Information listed about the specifics of his support needs equipment. All of those things.

Sooner rather than later, just to allow as much time as possible and to ensure that if planning or additional planning needs to happen for southeastern, should that be the option you choose that we're already pulling in the team from Southeastern so that they can be a part of.
Those discussions again, it doesn't mean a a date.
Has to be set or anything and at any point in the process you can change your mind and select something else.
But given you know some of the things you raise and some of the concerns, we would definitely be happy to go ahead and have just an initial meeting to lay out all of his support needs, discuss things, talk with the team at Southeastern to look at, you know.
Exactly what it would take to support him there.
So that can happen at any point you would like.

Griffin, Jarvis (DBHDS) 46:43
And let me add on that you'll be on site on Wednesday, Miss Brown. And I think we have a touch point that day that we're gonna make sure that we.
Go review all of the needs during that team meeting and make sure that we have an accurate accounting now the how we captured that moving forward with that technical issue that we having with the EHR, we're gonna.
I'll, I'll put a lot all of that information onto a Word document or tracking form that we will use to kinda get that Bay.

Martha Bryant 47:19
I feel like there have already been presumptions of placement, and of course the budget is not passed in the General Assembly, in the House and the Senate sides don't agree.
So on the House side, there was the $3,000,000 and the 10 beds I believe on the Senate side, it's language that I haven't been able to read yet, even though I call Senator Deeds office this morning.
So I appreciate that we're going to have a meeting, just a regular quarterly.
Umm.
What I'm saying is my quarterly from November had errors and we're still not corrected to this point.
So until we get through the budget process and we see what the governor vetoes

and what.
Makes it to to budget.
Wouldn't proceed with planning, basically, but what I'm concerned about is this.
I have seen a four year to get the discharge planning document template.
And the training for that, because definitely against my consent and agreement, my son was listed as community discharge with support services and it was stated he was on a ventilator, which he is not.
So we're we're getting major flawed airs in this hidden process.

McGuire, Meghan (DBHDS) 48:45
Could I talk about the House and Senate budget with maybe clear some things up there that could be helpful for you?
I agree with you like we're still kind of combing through those budgets and understanding what they are.
The one budget? The House budget.
Would create that skilled nursing space for just 10 patients in the and it would be.
Too upgraded homes to the skilled nursing level and they would be.
$1.5 million each.
But I think what is really important in that place is that should not be considered at all. The final recommendation of the planning team, and that's what you just said.
I I agree with you there.
The reason that that went forward was so that we could start that.
Process of getting the home upgraded because it's a lengthy, lengthy state process.
For procurement and inspection.
And if we can get those two homes started, we're in a lot better standing if there happens to be a system failure at Hiram Davis, which is our big concern about people having to move out quickly.
But if everything moves slowly, the first of those two health or homes should be ready in a in a little over a year, and then the next one would be late next spring.
What?
You know you would recognize quickly in this, Miss Bryant.
Is that those budgets don't include the cost of upgrading staffing and getting certified and that would need to be a next step there and it would need to be handled separately.
So we know that there are a number of people that have the ID diagnosis and that

have.
Of were former training center residents and all of those individuals have the right to continue to choose the training center care.
So even we'll get those issues corrected.
But you choose the the care.
So we'll we'll make sure that November is corrected, but.
There would never be any question in my mind of you've you've been very clear.
And what you would choose for your son?
And we don't know for sure if the number of people who would choose SEVTC would be greater than 10 or less than 10.
We just don't know right now, but this safeguards us in getting the process started at scbtc.
Otherwise we might not get it done in time.
So whatever choices people make, we will make sure that they are accommodated and the planning team ultimately.
And I'll save this and I'll stop. But the planning team may want to recommend to upgrade additional homes beyond just those two homes.
And then, of course, we're going to have a lot of recommendations for the other populations there, well as well.
So I hope that helps a little bit.
It's not predetermined, it's it's a safeguard because the process is very lengthy because of the procurement laws.
I hope that helps some.

AS **Alabanza, Susan (DBHDS)** 52:08
I I have a question about some of the information that was in one of the presentations last summer from the Commissioner and it was estimated that.
To to renovate Hiram Davis, I think was 90 some $1,000,000 and to replace was about 150 million, so.

MM **McGuire, Meghan (DBHDS)** 52:25
We built.
Yeah, that's what I remembered.

AS **Alabanza, Susan (DBHDS)** 52:29

Right. So one question I had was because we do have a new central state being built with all of those ancillary services.
That are going to be brand new. Does that $150 million include all of those ancillary services being in a new Hiram Davis or does it and does it in is that for 94 beds?

McGuire, Meghan (DBHDS) 52:51
I do believe it's for the whole 94 beds, but I don't know about the ancillary services.

Alabanza, Susan (DBHDS) 52:54
OK.

McGuire, Meghan (DBHDS) 52:56
So we can check on that.

Alabanza, Susan (DBHDS) 52:58
OK.
Thank you.

Russell, Nichole (DBHDS) 53:04
Mr. Fisher.

Fisher, Heather (DBHDS) 53:07
This is not my question, but it's one from our families that I told them that I would bring to this committee.
They're aware of SPTI think it's cvtc.
I'm sorry that had a renovation that would include skilled nursing beds and they wanted to know why that's not being put under consideration as an option.
For Hiram Davis.

McGuire, Meghan (DBHDS) 53:37
I don't have an answer for that.
At this time I can check for sure.

Fisher, Heather (DBHDS) 53:43
I will let them know. Thank you.

McGuire, Meghan (DBHDS) 53:45
Course.

Russell, Nichole (DBHDS) 54:00
Thank you, Miss McGuire, for clarifying the 10 bids and the other information. Because I was going to ask you to do that as well. So I do appreciate you providing that information for us.

McGuire, Meghan (DBHDS) 54:08
Of course.
I hope it helps and I'm I'm happy to answer any more questions that Miss Bryant or anyone else has about that. To the extent that I know right now and I will always be happy to get more information if I don't have it in my fingertips.

Russell, Nichole (DBHDS) 54:25
Thank you.
Any other questions or concerns?
Miss King, were you going to say something?


King, Kimberly (DBHDS) 54:39
Oh no.
Thank you.

McGuire, Meghan (DBHDS) 54:47
Miss Brian, is that a hand raised?

Martha Bryant 54:50
Yes.

McGuire, Meghan (DBHDS) 54:51
OK, good.

Martha Bryant 54:55
Well, I know the budget's not final yet, but there was new spending for mental health

and crisis and phone lines and postpartum depression.
So there are a lot of budget lines that were favorable.
If if passed and not vetoed.
There were pay raises. There were new investments in higher education for nursing.
So.
There was a lot of of good in these budget lines.
I think one of the concerns with my friends at Southeastern and we've maintained friendships, is there concern about displacement so.
67 of 75 beds being occupied. And then you're going to renovate 2 cottages. That's going to require some displacement and even your determination of which home gets renovated. I think within skilled regs.
That the.
Skill building has to be close closest to administrative support, so the whole look at capacity.
At southeastern the physical layout the you know what has to be.
Come on board for skilled is is a major concern and I certainly would like to participate in it as well as their other families who are contemplating going there.
What what I was found interesting. What in some of this question was it said.
What region would you like to go to?
And that was the number one consideration. So certainly in my county of Amherst County, when we've got an empty training center, fully renovated fully 88 that we were forced out of, we could save $20 million and reoccupy that so.
No, I would.
I would love to stay in Amherst County and have my son in those fully.
Renovated heat pump.
Modern, beautiful buildings.
So I think when this predetermined 10 beds on the other end of the state is very concerning and then we have to look at the national picture of what could happen to Medicaid.
Actually I put in ACMS diversity search today.
And I've sent some attachments to legal sites.
And that type of thing.
So the link to diversity in CMS, which is a has been a disability standard.
Is is now says no page found.
So somehow we are are losing disability rights.

In this anti de attack so.
We want to retain our legal rights, both state and federal. You know, family decision making.
Participation.
You know, we know each other well.
And you know what?
What I expect and what I'm going to ask for.
So when the timing of getting these false documents.
Decisions that are far beyond what I would agree to have come aboard.
I think it's cooking the numbers, it's.
It it just breaches the trust.
Which is essential for good planning, for for good transition.
Thanks for listening and I have got an acknowledgement of receipt when I will send documents or reference of an article or.
Something that's a standard of care. I do appreciate being acknowledged.

MM **McGuire, Meghan (DBHDS)** 58:51
We're gonna keep working with you.

RN **Russell, Nichole (DBHDS)** 59:00
I'll pose this question to Mr. McGuire.
Is that an option or something?
We should also consider is looking at the facility at CVTC that was renovated prior to the closure.
Is that something we can put on the table or is that something not to be considered?

MM **McGuire, Meghan (DBHDS)** 59:16
And I think that this planning team can look at any options that they would like to the questions that will come back are the feasibility of that. A lot of it is out of our control and in DG s s hands.
Right now.
So you know, if we want to start looking at that as a possibility, we can, we can explore it and then we can bring back the.
The pros and cons or?
The the Yes and no's or how much it actually would cost.

To do in terms of staffing and and all of those other things.
So I actually figured that that would be something that this planning team would wanna look at.
Not knowing what the outcome would be, but it should be.
Everything should be on the table until we determine that it can't be.

Alabanza, Susan (DBHDS) 1:00:15
I wonder if for other parts of the state as well.
If there are any kind of, and maybe even in this area, are there.
Any empty units, any place or you know where that it could be.
A leased situation where you could provide a smaller local service.
For people in the D PhDs system so that you can have it spread around the state potentially.
I don't know if that's something to look at.
It's nice to our own buildings and if that's an option, like at CBTCI think that's great.
But you know, maybe in some other parts of the state, it's really not an option anymore. And maybe there's areas to lease.

McGuire, Meghan (DBHDS) 1:01:05
Yeah. And you think about southeastern is so far for the people in Southwest and Northern Virginia?
So I think this planning team should keep that all of the geographical considerations.
In our deliberations.
Miss Bryant.

Martha Bryant 1:01:33
At one time in the VCE new Children's Hospital, they had shell space.
Which is in the Richmond area, even though that's has been considered to be more acute care model.
C.
Construction out at the short comp area.
I don't know to what degree VCU would be app partner.
When when I was searching and willing to search.
I looked at sheltering arms.

McGuire, Meghan (DBHDS) 1:02:07
Mm hmm.

Martha Bryant 1:02:08
Because that's a good rehab model and it has a partnership with VCU as a medical home.
I think.
I think there's global uncertainty about Medicaid and and this is going to be a tough year or tough time to try to anticipate what's going to happen with Medicaid.
OK.
So if if we lose match rate, if there's some major cut and they have to have a special session, it could throw the state budget into major turmoil.
So it's it's a really hard time to be expensive and need.

McGuire, Meghan (DBHDS) 1:02:52
Understood. I'm going.

Martha Bryant 1:02:58
I am really pleased with delegate cars bill about allowing a caregiver to be with a person at an acute hospital.
Because when you send a non verbal person or a behavioral person into an ER or into a hospital admission alone, you can set up error.
You can set up near fail error as this happened with my son not because he was behavioral, but because he got medications terminated.
So when that non verbal person can't give their medical history and their medication reconciliation and they lose medications.
You can have disaster pretty quickly within within days.
So I'm hoping that that bill passes and.
I think there are potentials for a regional approach.
I certainly don't want to drive to Chesapeake.
I know some people have said, oh, I'll go live there.
But that's not my case.
I help with my 88 year old mother and.
My family is this way.

They're small business owners.
I've got grandchildren in high school.
You know, our whole family's not going to uproot and go to Chesapeake.
It's just going to mean more travel, more expense, but more hotels for me.
As I age and I know some parents are older than me, they're already approaching 80 or in their 80s.
And you're talking about moving people.
For four and five times, it's almost like we're the population that gets.
Gets moved around.
And there have been, you know, wonderful models out there and early, I had talked about St.
Mary's and Albero home. But that's only their own internal group.
You have to age out of St.
Mary's in order to go out to Albaro, but Albero is a good model of.
Of skill care done with a within a medical home model, and I think it's a very complex thing that we need to get right.

Erin Harding 1:05:15
I have a question.
I don't know if this is an appropriate time for Dennis.
It's a little bit off topic of where the conversation has been recently, but I think Miss Bryant mentioned that there was some sort of list that had indicated sort of like her.
Her family's preference for discharge, even though it was like listed incorrectly.
It is that something that is in existence now at Hiram, where they've gone through all the residents and said, you know, this person prefers an assisted living facility. This person prefers a waiver home.
Is there anybody at Hiram or DBHDS that can give some context about what that list?
Stairs.

Alabanza, Susan (DBHDS) 1:05:50
We have asked.
Every everyone or every.
Individual and or their or legal guardian.
When all of this news came out, if they wanted to explore, discharge or not, so we do have it in terms of that. If they do want to explore discharge, than it is individualized.

As to, you know, what their needs are and what part of the state they.
Want to go to and what's available?
So we're working individually that way.
If someone is not actively discharge planning, we have not done, you know, a full detailed assessment, because if we assess them now in that kind of fine, fine detail that could all change. If they decide not to discharge for another year, year and a half. So when when.
The person is ready to discharge.
We have typically done it. If somebody requests to have that assessment done, you know further ahead of time, we are happy to start on that.
But that's where we are.
So we do have an answer from everyone as to what they would like to do for right now.
So for the documentation.
That Miss Bryant was talking about in her son's EHR record. That is not the case.
For most of the people here.

EH **Erin Harding** 1:07:15
I mean, is that information DE identified?
Of course, that would be helpful for this group to be reviewing during our monthly meetings to kind of have our finger on the pulse of like where people or their families are saying they want to go geographically or to the level of care that they're interested in.
To inform our our plan recommendations.

AS **Alabanza, Susan (DBHDS)** 1:07:34
Store and we do have some of that data, a large number of people did not want to address this charge right now.
So I think our census is about 37.
I think close to 30 people do not want to address discharge right now.

EH **Erin Harding** 1:07:50
Got it. OK.

AS **Alabanza, Susan (DBHDS)** 1:07:51

Right. So but we can we can get that information more specifically and we do have what areas of the state people are from originally. However, some people may not have lived in that area, you know for 40 years.
And depending on where their family is now or what services they need, sometimes people are open to going to other parts of the state.
But we do at least have that starting point. We can make that all of that available to you all.

EH **Erin Harding** 1:08:13
OK.
I personally think that might be helpful in recognizing that it is going to change every month.
But just to sort of know where people's minds are at in terms of what they they want for their own life or their substitute decision maker is wanting.

AS **Alabanza, Susan (DBHDS)** 1:08:35
Sure.

RN **Russell, Nichole (DBHDS)** 1:08:44
Does Brian have another?

MB **Martha Bryant** 1:08:47
When we started this, we talked about sub population identification.
So when we talk about 30-7 people there.
And this goes back to the slides from August and then again in October.
We when we had a census of around 42 in August, there were 23 people with ID.
Five of those had mental health comorbidities.
Then we had 14 from training centers.
Then there was announced to Senate Finance Subcommittee that you needed ten beds at Southeastern.
So my concern is when I do the math and I know two people are choosing community, I see 11 people left left behind.
In other words, have.
And how many? How many?
How did we arrive at the 10?

And what are the identified goals of the 11 left behind?
And I would think that my son having that false document, it would not have been in the 10 beds calculation for what you need at southeastern.

McGuire, Meghan (DBHDS) 1:10:12
It was more about getting two homes.
5 builds each to start the process.

Martha Bryant 1:10:23
Well, and this is a beginning.
We may may need more homes.
What what I haven't done is I'm not.

McGuire, Meghan (DBHDS) 1:10:30
Right.

Martha Bryant 1:10:32
I've never been boots on the ground down there.
I've never looked at your how landlocked you are at.

McGuire, Meghan (DBHDS) 1:10:39
Mm hmm.

Martha Bryant 1:10:39
You know, I did send a FOIA.
For you, I haven't heard the FOIA process is is slow and bulky.
You have to get a a paper, pay the bill, pay by check, wait for your answers.
But I will.
I will eventually get answers and willing to pay for the answers, but I mean Heather's boots on the ground of what's what's available there.
And you know, I mean you've had high occupancy of your.
I see.
Yeah, you don't have a lot of capacity there from my understanding.

Fisher, Heather (DBHDS) 1:11:21

We have 75 beds, Miss Bryant. So we've got 9 open beds at this time with one empty home.
So you know we have.
Continuously declined since we took some of the individuals we opened up.
Expanded to 10 beds to 85 in 2020 to help with the transition.
The final transition of cvtc so we do have that CAP.
Acity capabilities, I should say.
OK, let me say if needed.

Erin Harding 1:11:57
I I recognize that the vast majority of people on this call work for DBHDS.
And so my comment is not super relevant to you all, but for those of us who aren't state employees, I personally would hope as an advocate that people are not having to do FOIA requests to get information that's relevant to this plan development process.
You know Miss Bryant, obviously you know many things that are sort of.
Separate from this as a parent.
Working with an adult child in the system, but I would hope that like if I think she had said she requested some of the OR was thinking about requesting some of the the planning forms, I would hope that there might be a way that we could just bring.
Those requests to this group and have access to that information during one of our monthly meetings. I would hope people wouldn't have to pay pay for that.

McGuire, Meghan (DBHDS) 1:12:50
We are not charging her.

Erin Harding 1:12:53
OK.

McGuire, Meghan (DBHDS) 1:12:54
But I think it makes a lot of sense for it to come to this group.
I'm not.
I'm not familiar with that request being made before.
Before the FOIA request was sent.
So I think that is been a process that Miss Bryant has used before and has been able

to get the information that she was hoping for. And I think it's a good, you know, it's a good tool.

Erin Harding 1:13:11
And.

McGuire, Meghan (DBHDS) 1:13:24
But I agree with you, it would be nice to be able to bring it to this group.
Unless there's something that's very specific for her that it doesn't make sense, in which case I'm very open to that.

Erin Harding 1:13:38
OK, wonderful.
Thank you.

McGuire, Meghan (DBHDS) 1:13:40
Yeah. Thank you for saying that.
I agree.

King, Kimberly (DBHDS) 1:13:43
Just to circle back to the numbers.
Just hopefully to provide some clarification, I guess about where we are right now with the iddt population, there are currently 21 individuals that hire them with that diagnosis. Five of those individuals have selected a placement and were actively in the discharge process, leaving 16 of the 16.
That remain 5 are open to exploring.
Community now and we're just gradually getting our documents and everything ready and we'll be starting that. But all of those five are interested in exploring community as well.
That leaves eleven of those 11/2 of the individuals are receiving care via judicial consent because of of a loss of a guardian.
Guardians who've passed away and are currently on the wait list.
For us to try to get them public guardians to be able to make a decision, and so that just leaves nine individuals right now with families, you know, that are wanting to see this process.

To fruition so.
Just wanted to break those numbers down, you know, for everyone.

Martha Bryant 1:15:15
I can just say that.
When I explored.
My options? We got 55 rejections and one facility was in immediate jeopardy from a death and could not take admissions.
So what I've discovered both in touring and exploring and calling is.
No good solution so.
Umm.
I'm not sure how you update your willingness to explore community. I was.
I was there at one point, exploring.
With with no good solutions earlier in the last meeting, Aaron had brought up participation about verbal people of the Resident Council.
Or whatever, and I see no one who was a resident participating.
So I thought that was going to at least be an offer and be some accommodation that a person.
Who could speak and participate would be offered the opportunity.

Griffin, Jarvis (DBHDS) 1:16:31
Miss White, can you follow up on what we've done about that since the last meeting?

Sturgeon, Dominique (DBHDS) 1:16:42
Doctor Griffin, I'm not sure if Miss Wade was had her laptop hooked up for the residents to watch the meeting on the third floor.

Griffin, Jarvis (DBHDS) 1:16:53
OK.

Sturgeon, Dominique (DBHDS) 1:16:53
So I'm not sure if she has access to her microphone right now.

Griffin, Jarvis (DBHDS) 1:16:53
So we did.

So we did meet with the Resident Council and went over, you know, our results from gave them updates on the work that we've done thus far about the, the consensus, the Planning Committee meeting. And we have offered it to them to sign up, to participate where they would.
Like to.
I'm assuming I could be wrong that we didn't get any.
Any sign ups this time around?
But we do make it a point each month as we meet with the Resident Council to.
Offer that offering and make it available to them.

Wade, Connie (DBHDS) 1:17:37
Hello, this is Connie.

Griffin, Jarvis (DBHDS) 1:17:38
Doesn't he have any additional?

Erin Harding 1:17:38
Thank you.

Wade, Connie (DBHDS) 1:17:40
I'm. I'm sorry.
Hello, this is Connie Wade.
We do have a resident that's watching.

Griffin, Jarvis (DBHDS) 1:17:44
OK.
Thank you, Miss white.

Wade, Connie (DBHDS) 1:17:45
You're welcome.

Griffin, Jarvis (DBHDS) 1:17:52
So we have done that Miss Brian and I participate.

Russell, Nichole (DBHDS) 1:18:09

We have about 15 more minutes before the meeting concludes.
Are there any other concerns or burning issues anybody wants to bring to the table for us to kind of sort of research and bring back to the table for the next meeting?

Martha Bryant 1:18:24
I had to ask about.
Trying to anticipate your capacity.
And and we talked about.
Aging out at St.
Mary's and at Children's Hospital in Richmond. And I'm not sure if there's a children's facility in Northern Virginia with an over. Whatever. Where you're going to have basically more tech skilled nursing facility use that are going to age out as well as you're anticipating.
Did populations with chronic health conditions, who are currently at ICF, but when they need to go to skilled nursing facility capacity, particularly of of oxygen users, so?
In the past, Hiram Davis has.
Received people needing oxygen at Hiram, and we've talked about trying to preserve short stay or.
Having people age in place.
It's southeastern. So as their chronic conditions are, their aging occurs. They're not forced out.
So have you collected any data on on those data points?

Russell, Nichole (DBHDS) 1:19:40
I have not personally collected any data.
I don't know if anyone else has any information they're willing to share with us in regards to that matter, or we can definitely.
Make sure that we have the that information available for the next meeting.

Rupe, Heather (DBHDS) 1:20:01
I think we can look at getting that information.
I'm not sure how difficult it'll be to to get that, but we can certainly look at what the process would be for gathering that for the next meeting.
I don't wanna make any promises that we will definitely have it, but we can certainly look at that.

Martha Bryant 1:20:22

When we talked about partners for information.
I know when our family had an issue, the Shriver Center was University of Massachusetts was brought in as experts.
And then if we look at other states reporting University of Kansas does state by state comparisons.
Unfortunately, their data ends.
And so I just looked at it again.
Today ends at 2021, so at 2021 we were in the pandemic, but that gave you a state by state comparison to other states as well as looking at your census reduction and of course when we hit the pandemic and the demand of staff and.
Cost went to acute care.
Then cost spending for developmental disabilities dropped off.
It was almost like a clip effect.
I so I think there we need more current data at least maybe to 2024 and.
You know, just looking at a systematic way of trying to estimate capacity, I do know that the waivers have come online and they're at a quarterly distribution to allow provider development for those who wanted waivers.
That instead of being this lump sum of, you know, taking everybody off the waiting list, it was in a quarterly fashion, so.
And then in terms of localities, if you look on the mental health side?
I know.
I listen to the House Appropriations.
Health and Human services budget presentation there is more invested in crisis in what was called Marcus Alert Co occurring responder teams, more investment in the crisis line.
So I'm trying not to just look at capacity and demand on the intellectual disability side.
Or the training center side, but also to look at the mental health investment that may be coming online and what people.
'S What the resources are going to be.
If funded.

King, Kimberly (DBHDS) 1:22:48

I was also wondering is there an opportunity to form any type of partnership with a Community nursing facility that would be open to expanding their services or you know, delving into any type of specialized care maybe for some of the?
Residents that you know are are experiencing more challenges as far as being, you know, us being able to find options for them and that could be you know.
Idd as well as mental health and dementia.
Just wondering if there's an opportunity for that.

Rupe, Heather (DBHDS) 1:23:23
OK.
Hey. Hey, Kim, this is Heather.
Actually I think there is a budget amendment and that looks at expanding some of the pilot success we've had now. Ours has traditionally been around dementia, but I think we've shown success with that, that very model.

King, Kimberly (DBHDS) 1:23:28
OK.

Rupe, Heather (DBHDS) 1:23:41
And so I do think there's opportunity and room there for that in the future.

King, Kimberly (DBHDS) 1:23:46
Great. OK.

Erin Harding 1:23:53
Would it be possible for us to get a little more information in a future meeting about what that sort of pilot program has entailed, even if it's just like kind of a high level?

Rupe, Heather (DBHDS) 1:24:00
Yeah.
Absolutely. I will talk about it all day long.
It's my favorite thing to talk about, so I will be happy to do it next meeting at the top of the meeting.

Erin Harding 1:24:05
OK, great.

McGuire, Meghan (DBHDS) 1:24:06
You got the right person.

Erin Harding 1:24:09
Thank you.

Martha Bryant 1:24:18
Nursing facilities got a investment amount to raise rates.
In in general.
I don't know how that plays out across.
Profits for profits and non profits. I am well aware that the people dying in nursing facility care, especially those highlighted in the WTVR arrest stories.
Are the most vulnerable.
They they are cognitively impaired.
Or they can't speak for themselves and call call bells.
So we've had gross negligence of people in standard nursing facilities to the point of death and abuse investigations and arrests of multiple employees in nursing facilities, so.
I think one of the most alarming things to me in the henrika neonatal fracturous case was that there was no expectation of health professionals to report suspected abuse and neglect.
I know both as a nurse and a teacher. Part of my license and my yearly annual start up school or start the job again as we had to do an abuse neglect.
Annual reporting signs of abuse. Neglect.
Remind and do a competency check that you know that you have to report suspected abuse and neglect as a mandatory reporter so.
That's that's the potential growth area to set up expected competencies that all health professionals.
Know to recognize abuse and neglect and that their mandated reporters.

Russell, Nichole (DBHDS) 1:26:23

Are there any other comments, concerns, questions that you wanna bring to the table for us to try to gather information in preparation for the next meeting?
That has not already been discussed.

Erin Harding 1:26:43
Appreciate that you know the facility has facilitated the option for people who live at Hiram currently to participate in these meetings if they want to. But I also recognize and appreciate that this is like a weird forum for sharing your personal experiences. And so I guess I would just put it out there that if the Resident Council wants to do something like the, it sounds like the Family Council has done.
Where they come up with a list like how they would most feel supported in this process.
Yes, like I would love to hear that and get that in some way and it doesn't necessarily have to be a resident coming to these meetings if this doesn't feel like a comfortable place to share that. But if there is a mechanism for facilitating that information, I would.
Really appreciate it because ultimately that's what we're supposed to be doing is supporting the the residents or the patients.

Griffin, Jarvis (DBHDS) 1:27:39
I think we can have a conversation around that and and facilitate that, that information flow back and forth.
So we'll put that on the agenda for our next Resident Council when I'll see what we can come up with and we'll return it. Feedback, whether you know it's a list of items or things that you know are important or if there's nothing at this time.

Erin Harding 1:28:01
Thank you.

McGuire, Meghan (DBHDS) 1:28:04
Thanks Aaron.
That's a great suggestion.

Russell, Nichole (DBHDS) 1:28:24
If there are no other comments, questions or concerns we have about 5 more

minutes.
I do want to just take this time to say thank you for all the input and the suggestions and the information that was shared in this meeting this afternoon.
We definitely will review all of the information, making sure that information that we are able to gather that will be presented at our next meeting.
Lauren, did you have any final closing remarks, concerns or questions that you'd like to share?

Cunningham, Lauren (DBHDS) 1:28:57
Sure. I just wanted to remind everyone, if you have something you want to share with the Co leads or certainly other members of the planning team between our next meeting, I think we all know how to reach each other. But we also have that Hdmc planning team at.
Dbhds.virginia.gov e-mail.
We will try to acknowledge receipt to Miss Bryant's point every time that we.
Receive a message, but feel free to use that to send information and we will always pass it on to the Co leads.

Russell, Nichole (DBHDS) 1:29:32
Well, I thank everyone for their time once again. And you all have a wonderful afternoon.

Rupe, Heather (DBHDS) 1:29:38
Thank you all. Thank you.

King, Kimberly (DBHDS) 1:29:38
Consider by everyone.

Fisher, Heather (DBHDS) 1:29:38
Thank you.

McGuire, Meghan (DBHDS) 1:29:39
Thank you.

Russell, Nichole (DBHDS) 1:29:39
Bye bye.

Sturgeon, Dominique (DBHDS) 1:29:39
Thank you.

Snead, Sheila (DBHDS) 1:29:41
Thank you.

Alabanza, Susan (DBHDS) 1:29:42
Thank you.

Griffin, Jarvis (DBHDS) 1:29:43
Take care.

Cunningham, Lauren (DBHDS) stopped transcription