HDMC Planning Team_ Community Services Subcommittee-20250325_100109-Meeting Recording Generated by Microsoft Teams

March 25, 2025, 2:01PM

1h 31m 22s

Cunningham, Lauren (DBHDS) started transcription

Cunningham, Lauren (DBHDS) 0:03

The time to join us today, just a quick reminder, we are recording this meeting.
We'll have the recording and transcript available later this week on the Hiram Davis website.
With that, I think we'll probably go ahead and get started with our public comment portion in the meeting season.
Alabianza do you want to go ahead and get us started?

Alabanza, Susan (DBHDS) 0:23

Sure. I just wanna start with introductions.
I am Susan alabanza.
I'm the clinical director for Hiram Davis Medical Center, and we'll just go around and have everybody introduce themselves.
Susan Moon, do you want to go next?

Moon, Susan (DBHDS) 0:41

Oh, hi. Good morning, everybody.
Yes, my name is Susan Moon.
I am the director here for the Office of Integrated Health at DBHDS.
I'm a registered nurse by background, my office.
Houses the community nursing team. We do all technical assistance, education and all kinds of things around nursing services in the Community. We house a dental program.
Essentially, a mobile comprehensive dental program.
And rehab, engineering and assistive technology mobile program service.
So good morning everybody.

Alabanza, Susan (DBHDS) 1:23
Alright, thank you, Eric Williams.


Williams, Eric (DBHDS) 1:26
Yep. Good morning. I'm Eric Williams.
I'm the director of the Office of Provider Network supports.
We provide training, technical assistance and guidance to providers of DD waiver services and support coordination with Csps, and I'm also the acting Assistant Commissioner, developmental services right now.
Good to see everyone.

Alabanza, Susan (DBHDS) 1:46
Hey, thank you, Doctor Moore.

Moore, Brianna (DBHDS) 1:54
Morning everyone.
My name is Doctor Brianna Moore.
I am the director of forensic services at Vcbr where we.
Are provider residential treatment facility for sexually violent predators in the state of Virginia?

Alabanza, Susan (DBHDS) 2:09
Thank you.
Kimberly king.


King, Kimberly (DBHDS) 2:14
Good morning.
This is Kimberly King.
I'm a Community integration manager for DBHDS and I support discharge planning efforts with Hiram Davis.

Alabanza, Susan (DBHDS) 2:25
OK.
Thank you, Doctor Handley.

Handley, Amy (DBHDS) 2:29

Hi, I'm Amy Hanley.

I'm the chief clinical officer at Central State Hospital.

AS

Alabanza, Susan (DBHDS) 2:35

OK.

Thank you, Lynette Bartlett.

BL

Bartlett, Lynette (DBHDS) 2:40

Good morning, everybody. I'm Lynette Bartlett.

I am the admission discharge manager here at Hiram Davis Medical Center.

AS

Alabanza, Susan (DBHDS) 2:49

Thank you.

Dee Morton.

OK.

I don't know if she's able to. D Morton is our OT manager at Hiram Davis Medical Center.

I'm just going through the way people are presenting on my screen, so I'll try to catch everyone, Miss Bryant.

MB

Martha Bryant 3:17

Good morning.

I'm Martha Bryant.

I'm a parent of a son with intellectual disability and skilled nursing at Hiram Davis from Amherst.

AS

Alabanza, Susan (DBHDS) 3:29

Thank you.

Doctor Gupta.

AG

Atul Gupta 3:32

Yeah, Mateo Gupta, representing my daughter, Alicia, who lives at Hiram Davis.

Alabanza, Susan (DBHDS) 3:39
Thank you.
Markisha green.

Green, Markeisha (DBHDS) 3:41
Are you?
Good morning, Mark, Commission.

Alabanza, Susan (DBHDS) 3:46
OK. And Markeisha is one of our social workers.

Green, Markeisha (DBHDS) 3:50
Yeah, sorry.

Alabanza, Susan (DBHDS) 3:52
OK. Sheila Sneed.

Snead, Sheila (DBHDS) 3:57
Douglas Snead, I am a Community integration support specialist and I work with Kim King at Dbhds.

Alabanza, Susan (DBHDS) 4:06
Thank you, Doctor Henderson.

Henderson, Tonya (DBHDS) 4:11
Good morning.
My name is Tanya Henderson.
I'm the director of pharmacy at Harm Davis Medical Center, who also services Central State Hospital.

Alabanza, Susan (DBHDS) 4:19
OK.
Thank you, Tony Davis.

Davis, Tony (DBHDS) 4:24

Good morning. Tony Davis with the Office of Human Rights. I cover all of the region for state facilities.

AS

Alabanza, Susan (DBHDS) 4:32

Thank you.

Eula Seca.

ES

Eula Secka 4:37

Good morning.

You will secure.

I am representing Scaled Haven residential services.

We are community residential provider in the community for people with developmental disabilities and chronic medical needs. Thank you.

AS

Alabanza, Susan (DBHDS) 4:49

OK.

Thank you.

OK, Marissa elimin.

ME

Marissa El-Amin 4:56

Good morning.

My name is Marissa Ellamine.

I'm one of the developmental services supervisors at Richmond Behavioral Health Authority.

AS

Alabanza, Susan (DBHDS) 5:03

OK.

Thank you.

Madeline lent.

LM

Lent, Madelyn (DBHDS) 5:09

Good morning.

My name is Madeline Lund.

I'm the policy manager at the Department of Behavioral Health at and I'm with Warren in the division of Policy and Public Affairs.

Alabanza, Susan (DBHDS) 5:19
OK.
Thank you.
Melinda Mays.
We're not able to hear you.
Miss Mays is one of our lpn's at Hiram Davis Medical Center, and she does primarily works with training, training staff and our CNA program.
OK, Vicky Brewer.

Renata Sharnick 6:01
Good morning.

Alabanza, Susan (DBHDS) 6:02
I think Vicki is having some problems with her microphone as well.

Renata Sharnick 6:04
I'll come back. I'll come back.
After I take an hour and a half OK.

Alabanza, Susan (DBHDS) 6:10
She is.
She is one of our administrative assistants for clinical and quality services.
OK, Tanya.

Jones, Tanya (DBHDS) 6:23
Harambe Davis.

Alabanza, Susan (DBHDS) 6:26
OK.
Thank you, Miss Kamara.

Zainab Kamara Scarlet Haven Residential 6:31

Good morning.
My name is Zainab Kumara.
I'm the director of Nexen for Scarlet Haven residential services.
It's a residential group home for individuals with intellectual disabilities and high medical needs.

Alabanza, Susan (DBHDS) 6:44
Thank you, GAIL. John.

Gail John 6:48
Good morning all.
I'm GAIL, John.
I am part of the developmental services with Rbha and I provide support coordination to a couple of the resident at Hiram Davis.

Alabanza, Susan (DBHDS) 7:03
Thank you.
Rocio, I hope I pronounced that right.

Rocio 7:09
Yes it is.

Alabanza, Susan (DBHDS) 7:09
Sorry.

Rocio 7:10
Hi, good morning, everybody.
My name is Rosia Reyes and I'm the operations manager for Scarlet Haven Residential.
We are residential couple providers for individual tile with abilities and high medical needs.

Alabanza, Susan (DBHDS) 7:23
OK.
Thank you, Robin Johnson.

Johnson, Robin (DBHDS) 7:28
Good morning.
My name is Robin Johnson. I'm the medical.
Services administrative assistant at Harm Davis.

Alabanza, Susan (DBHDS) 7:37
Thank you. And Renata sharnick, I hope I said that right.
I think you're muted right now.

Renata Sharnick 7:48
Yes, I am sorry.
I am executive director of Credit District Area Agency on Aging.

Alabanza, Susan (DBHDS) 7:56
OK.
Great. Thank you.
And Todd McDonald, I'm not sure that we you introduced yourself yet.

Mcdonald, Todd (DBHDS) 8:03
Hey, I'm Todd McDonald.
I'm a Virginia management fellow working at the Communications division at DBHDS.

Alabanza, Susan (DBHDS) 8:12
OK, great. And Wendell Walker?
OK.
Is there anyone else that I missed?
OK.

Morton, Demetrie (DBHDS) 8:32
Good morning.

Alabanza, Susan (DBHDS) 8:32
So we just want go ahead.

Morton, Demetrie (DBHDS) 8:33
This is.

Alabanza, Susan (DBHDS) 8:34
Is there somebody who else who was going to introduce themselves?

Morton, Demetrie (DBHDS) 8:38
I'm sorry. Good morning.
Can you hear me?

Alabanza, Susan (DBHDS) 8:41
Yes, we can hear you.

Morton, Demetrie (DBHDS) 8:43
Good morning.
This is Dean Morton, the occupational therapy department manager. Have Davis.

Alabanza, Susan (DBHDS) 8:48
Thank you.

Morton, Demetrie (DBHDS) 8:49
You're welcome.

Wendell Walker 8:52
Sorry, this is delegate Wendell Walker from Lynchburg.
My mic was off at the moment.

Alabanza, Susan (DBHDS) 8:57
Oh, OK.
Thank you. Welcome.
OK. We just wanted now that we've introduced ourselves, I just want to remind everyone that the purpose of this subcommittee is to develop a report for the consensus planning team about the potential closure of Hiram Davis and how the services that Hiram Davis provides to the to the.

Community can be provided within the community.
So first I wanted to allow some time for public comment.
Anybody is welcome to comment on anything they'd like and we may or may not be able to address that in this meeting. And if we are not able to do it today, we can do it next time.
Does anyone have anything that they would like to comment on at this time?

AG **Atul Gupta** 9:55
Mr. Benza, I have a public comment. Can I make it?

MB **Martha Bryant** 9:59
OK.

AS **Alabanza, Susan (DBHDS)** 9:59
Sure.

MB **Martha Bryant** 10:04
It was.

AG **Atul Gupta** 10:05
And as you use the most appropriate word potential closer, it's not written to behavior. Health Commission approves it on these things.
Needs to be clear that the General Assembly has to approve any closure.
Till then, it's all in the planning stages, so we should not create a persona that displays his shutting down. That's not shutting down.
Until the General Assembly approves it and honorable delegate is here, and I know he knows more than anyone of us.

MB **Martha Bryant** 10:29
Say.

AG **Atul Gupta** 10:33
How the procedure works?

Martha Bryant 10:34
Stop.

Atul Gupta 10:35
But having said that, my biggest concern as we move forward is there's a plan to move third floor patients onto the 2nd floor. I've been told all along that the federal code prevents the Commonwealth to mix and match populations. When we were looking for space across the street.

Martha Bryant 10:42
What's this?

Atul Gupta 10:52
In Central State Hospital, So what has changed in terms of those final regulations to move those psychiatric patients to 2nd floor?
Which puts my daughter at risk because many of these people are mobile and their they are have psychiatric issues.

Martha Bryant 11:07
Yeah.

Atul Gupta 11:09
So to me it's a liability issue and I know after the fact when something happens, state can apologize and move on.
But I like to be proactive and.
That should not be the case.
Which should be happening #2 the law of the land is very clear in Commonwealth of Virginia that they the services wherever they go needs to be parallel to what they're getting here currently at and any planning should include all those services as it is transplanted into.
The new place. There's no short changing of this patient irrespective of number of patients. They are here in this facility.

Martha Bryant 11:40

In my place, it's not.
Especially.

Atul Gupta 11:49
But my immediate concern is about the third floor people moving to 2nd floor, which puts my daughter and other many of our roommates at risk of potential, you know.

Martha Bryant 11:59
Oh **** you.

Atul Gupta 12:02
It could be any type of violence, any anything could happen.
Closing a door doesn't prevent an individual from walking around.
I've seen that how that happens on 3rd floor. They're all over the floors. They're moving.

Martha Bryant 12:10
What's up?

Atul Gupta 12:14
They they need least restrictive environment too.
You cannot lock them up in, in in the corridor.
So to me, I don't know who made that decision or the decision has been made, but that needs to be reevaluated.
Thank you very much.

Alabanza, Susan (DBHDS) 12:28
OK.
Thank you, Doctor Gupta.
OK, Miss Bryant.

Martha Bryant 12:36
My son is on 2nd floor at Hiram Davis Medical Center. He's totally defenseless.
He cannot protect himself from harm.
He's at risk because he has oxygen tubing and.

A trach.
So when we have been combined with psychiatric people who are coming into his room without adequate supervision, he's definitely at risk.
I have been hit there.
I have been cursed at.
I've been threatened. We hear screaming.
So mixing psychiatric and intellectual disabilities who were totally dependent is not a good plan.
My request for documents was denied on Friday the 21st from the employees meeting.
So the screenshot of the reduction of staff was on the video screen that.
Plan was not then reflected in the transcript.
Accurately and my request for transparency to get a written document has been denied.
I would also say I'm very concerned about.
Comparable care because we're already seeing proof that.
Services will not be the same as they are at harm Davis, such as pharmacy Lab X-ray.
And then the whole question of state.
What regional gaps that you're forcing people with intellectual disabilities at the skill level to go all the way across the state to Chesapeake as a single place?
So I disagree with the inadequate capacity to decrease ICF beds and only have 10 skilled beds.
So I don't see anyone gathering the data the six year projections.
Which is part of the requirement and now your time.
Frame for a report in August puts us at 12 months from the announcement to the to the report.
So those are my concerns. Thank you.

AS **Alabanza, Susan (DBHDS)** 14:50
OK.
Thank you.
Anyone else? Is there anyone else who would like to make a public comment?
OK. All right. If there's no one else, then we will, we will get started.
First I want to we wanted to start off today with.
Talking a little bit about hybrid Davis and what we provide to the community, if you

can give me just a minute, I will share my screen.
OK.
Can you all see that?

Bartlett, Lynette (DBHDS) 16:30
I can see it, Susan.

Cunningham, Lauren (DBHDS) 16:31
Yes.

Alabanza, Susan (DBHDS) 16:31
OK.

Eula Secka 16:32
Yeah.

Alabanza, Susan (DBHDS) 16:32
Thank you. Thank you.
OK.

Cunningham, Lauren (DBHDS) 16:36
Susan, just FYI.
We're seeing the notes version now.

Alabanza, Susan (DBHDS) 16:39
Yep, I'm trying to.
Having some screen issues here.

Cunningham, Lauren (DBHDS) 16:43
I know that's the danger of teams.

Alabanza, Susan (DBHDS) 16:46
Yes.
OK.

I may just have to go with this 'cause I'm having trouble with my other screen this morning, so I apologize.

Cunningham, Lauren (DBHDS) 16:56
That's fine.

Alabanza, Susan (DBHDS) 16:58
OK.
So we wanted to go over how are the services utilized by individuals who are served from the community.
Hiram Davis certainly does have people who utilize our services for long term residential care, and that's a very, very important component of what we do.
But we also do more than that. Several individuals, even though they consider Hiram to be their home.
There are, of course, other people who are coming to Hiram for temporary placement and temporary needs.
So why do people or their ars or legal guardians choose Hiram Davis?
There's a variety of reasons.
Some are medical workups, where they're not getting answers.
Medical decline safety during APS cases denials due to labels and end of life care.
We'll talk a little bit about each one of these.
S.
So for medical workups individuals in the community may experience repeated hospitalizations.
And or return visits to the emergency departments for the same reason without resolution.
Sometimes they're going to a lot of different specialists who are adding medications and treatments without an overall kind of case management of their case.
There are many people, of course, with intellectual and developmental disabilities who are unable.
To describe their symptoms as they're going through new medication changes and treatments, so they're unable to describe the symptoms that they're experiencing.
And so we may only know some of those declines and effects when we see overt physical issues.
And if no one is case managing that that can lead to further medical decline.

So at Hiram Davis, the the model that we use is the PCP manages all care.
Including recommendations from specialists.
So they basically are looking at what the specialists are asking for and if they think that that's going to cause some sort of decline.
They can talk to the specialist about it and try to tweak it or find something else to do so that so that that can be teased out.
As far as medical decline, including rehabilitation, people can experience all types of medical decline that prevents them from going back to their home.
Some of the we've seen a whole host of issues that would fall in this category, but some of the examples are getting a gastrostomy tube when you used to eat by mouth or perhaps a fracture or multiple fractures that lead to the person being non ambulatory, meaning they.
Can't walk anymore.
There are a lot of people with IDD who need more time to recover and or rehabilitate.
And sometimes it's just a matter of not understanding why they're in a different environment.
Who the people are that are working with them and they're just not comfortable.
So typical nursing homes are unable to provide that additional time they often have.
They always in in the private model have productivity rates.
That can lead to an individual being discharged from therapy early and not reassessed later.
Hiram, we provide as much time as needed to develop a therapeutic report and work with the individuals at the pace they're comfortable with.
We don't have any kind of productivity and.
It's not based on insurance payment at all.
Everyone gets whatever they need, no matter the.
Insurance. And so that is different when we're when somebody has an issue and needs a little more time. We've seen people who come in for therapy.
They're not really ready, they're not comfortable.
But we continue to build that rapport, even if it's going and talking to the person every day, just doing little things so that at some point, when they feel more comfortable with us.
They'll start to participate, and that's been useful and successful.
OK, safety and care during APS cases, we've had people come to us when they have

been experiencing neglect in their home and we are a safe place basically for them to come and land and we can address any kind of medical needs the person has.
We're we're a safe place.
So that if there are issues with.
The the people who have been providing doing the neglect or perhaps abuse, we can ensure their safety.
At our facility, there's no time limit on the person's stay, so the guardians and social workers can work to determine what the safest discharge plan is, and then with that discharge plan, we'll talk about this a little bit more. But it is very comprehensive and provides 6.
Months of oversight for safety and additional support is needed.
OK.
I think I skipped 1.
So denials due to labels, so individuals who are required to register with the Virginia State Police as a sex offender can have difficulty finding services and congregate residential settings such as nursing facilities and group homes, even for end of life care.
Individuals have returned to Vcbr due to the inability to find community services due to their label, and several have been admitted to Hiram Davis for services. Due to this reason.
Often when this is the case, you know, due to their medical decline.
They're having to return to Vcbr, and it's not necessarily safe for them in in the milieu at times.
So we have been able to provide a safe place for them to get their medical care and at times end of life care.
So also end of life care in general, some individuals or their ARS or legal guardians have chosen Hiram for the their end of life services.
Especially since we have extensive experience with the IDD population.
And again, people who have certain labels and certainly sex offender are being on the sex offender registry.
This can be difficult if they don't have a family that has a home that.
Will accept them into their home for end of life care and getting Hospice services there.
It can be really hard to find.
A facility that will accept them.

And that can be for people who are at vcbr. It can also be for people who are within the behavioral health system that are on this on the sex offender registry and needing to find end of life care.
That can be difficult for both.
OK, what would be required to provide these services in the Community?
Facilities and providers familiar with individuals with IDD that will provide close medical management of all aspects of the person's care. As I had said before, what's really been successful with our model is that the PCP is really case managing everything that's happening with the person so there.
Would need to be some sort of model set up.
With providers.
That they would be case managing that that can be difficult in the way the private sector is structured right now.
That's not really very typical for PC PS to be managing all of that. Some of them probably do that unofficially, but in general people are are going to their PCP and then they're going to specialists and they're kind of having to speak up for themselves. So it can.
Be a little.
Bit difficult. Sometimes the pcp's may pick up on it and sometimes it may be a little bit more difficult to tease out.
We would also need services provided without productivity levels. As I mentioned, you know this is the case in therapy and that can be where some people don't progress or don't progress very fast and so they're discharged from therapy without productivity levels, they and people getting used to who.
They're working with.
There is a potential that they could come further in their rehabilitation.
Also, agreements for care for individuals who are required to register with the Virginia State Police and are on the sex offender registry, including end of life care.
And facilities and homes willing to take individuals who are being relocated from their home by APS and provide comprehensive medical care.
And also providing care regardless of insurance source, that's huge in the private sector and that can really lead to whether or not you get certain types of care.
Is your insurance at Hiram Davis?
We provide whatever care you need, despite insurance or whether you even have insurance.

Also, for people with IDD, currently we provide a really comprehensive discharge planning with six months of oversight.
OK.
So we've we've talked a little bit about this, but case management by apcp there would really need to be additional education to Community pcp's that could improve overall care, but it could also move very slowly on an outpatient basis because you have to parcel out testing and.
Referrals. You also need agreements with local hospitals or community health providers to provide these services as an inpatient.
Education would need to be provided to hospitalists since.
Hospitals typically look at resolving issues quickly and discharging quickly, and in our experience, sometimes people need a little more time really to tease things out. Even if the original reason that they're there and that people.
May be theorized that they're experiencing this once they get results that say, oh, for example, everything's OK with your liver.
Well, maybe there's something else going on with another part of your body that needs to be teased out.
I don't.
I don't want to say that no one does that in the community, but we have seen several people who get discharged for a particular issue when there's actually probably something else going on that isn't picked up on.
But again.
Hospitals don't tend to keep people for very long, and they certainly don't tend to keep people very long to really try to explore what's going on and watch the person, especially if they're nonverbal and can't tell you exactly what they feel is going on in their body.
Agreements with nursing facilities to provide these services when the person may need an extended stay for a medical workup that would need to be some sort of agreement and potentially in monetary incentives.
Rehabilitation without productivity levels there would definitely need to be education to rehab professionals about working with individuals with IDD, and there would need to be some sort of monetary incentive in whatever way is needed for community nursing homes to provide additional services at a slower pace when needed.
For optimal results.

You know, the private sector is geared toward making a profit and people.
When they, you know, don't meet those productivity levels, they don't get as high reimbursement.
Services for individuals registered as sex offenders, so there would need to be agreements with residential providers who can provide care for those with increasing medical needs that are registered sex offenders.
And that goes for end of life care as well there is.
A lot of hesitation in the Community as far as nursing facilities accepting people.
Those regulations tend to be very strict.
And the fear is that if if somebody who is considered to be a registered sex offender reoffends, the nursing home would be held liable.
So, especially if the person is ambulatory.
Even if they are end of life, there's a real hesitation to accept them for any type of care, and that is that's something that we've experienced as well.
We've had people.
Who are?
Registered on the on the registry and they want to go someplace else for their end of life services and we've been unable to find someplace that would accept them.

Cunningham, Lauren (DBHDS) 30:13
Susan, I was just going to flag that Doctor Moore has her hand raised.

AS

Alabanza, Susan (DBHDS) 30:16
Oh, I'm sorry, Doctor Moore.
Sure, go ahead.

MB

Moore, Brianna (DBHDS) 30:20
Thank you.
I did call around to both DSS and VDH and.
They were very explicit, one of the staff members was saying that she had worked in 42 States and that it's not, you know, something that's exclusive to Virginia in terms of having issues of placement with elderly or medically compromised patients.
So she very blatantly said they're just not going to do it.
And I also spoken with our discharge department.
And they have. This had been having the same problem, so I understand that you

know.
People forget the humanity of other people who have made terrible decisions in their lives, but I really do appreciate that Hiram has been like nobody wants.
We don't want people to believe Hiram. Nobody wants to go anywhere else for the end of end of life care.
But sometimes you know things do take place where they're not able to stay at Hiram. I think just in one particular instance, but we.
We definitely need those services for our population.

Alabanza, Susan (DBHDS) 31:26
Right. Thank you, Doctor Moore.
I I completely agree.
We've had and we've had that experience for people from Vcbr and also individuals, like I said from some of the other state behavioral health facilities who are on the registry and they really want to go someplace else.
Usually it's it's to the location that's a little bit closer to their family.
Sometimes they want to go there.
And they just can't.
But even if the family can't take them in, they're not able to find someplace. So.
And it's unfortunate, but it is true.
We do provide end of life services and we will even.
Help with the funeral if needed.
So we have a chaplain who is very, very sensitive to everyone's needs and really often provides a lot of those services.
And helps people kind of work through if they're not able to go someplace else, along with our social workers.
But I agree, Doctor Moore, it there is something to be said for the humanity at the end of life.
And so those, those are really important services.
OK.
I will go on to the next one.
We do do comprehensive discharge planning as far as we do it for anyone who is discharging. However, for people who are have an intellectual or developmental disability, we do have to provide.
A modified version of the settlement agreement with the Department of Justice.

And it really does kind of dot all the is and cross all the T's.
It's comprehensive and it it has very, very specific details of the care that's being provided and what would be need to be provided in the new home for the person to be safe and successful.
We also do extensive training with the new residential provider.
We do a trial visit to ensure that their safety and problem solved through any issues.
If needed, we do multiple visits.
And after the person discharges, we do in person.
Post move monitoring by Day 14 and by day 30 post discharge we do.
Phone follow-ups at three months and six months of discharge and then we do additional monitoring's and support is needed for issues that arise.
So if this model were to be used in the community, it would definitely require.
Providing some sort of monetary incentive, because when you do, it's really very, very detailed. It's very time consuming.
And honestly, we have to drive all over the state to do it.
So we've discharged people pretty much everywhere.
We'll drive to Winchester, VA Beach, SW, Virginia, all across the state to wherever the person is discharging to for those post move monitoring.
So they are quite intensive.
So that's something that we don't find in other in the private sector.
Again, we provide care regardless of insurance source.
Most individuals have Medicaid, but some may not. So insuring services are equal, despite the funding source would would be a challenge, but something to explore for community services.
And private providers may need additional money to provide for equal services, even within Medicaid, the MCO coverage varies among those MC O's.
So there might need to be new agreements with each MCO and we would probably need to examine the coverage provided for each MCO and whether that would that would work.
And then just to bring up the elephant in the room, how will the potential cuts in Medicaid affect the services individuals receive in the community?
Some federally funded funded clinics in rural areas have already closed, so that will already be limiting services, and I don't think anybody.
Any of us really know at this time how you know what's gonna happen? But certainly.
Most of the individuals we serve in in you know, in any way, most of them have

Medicaid and so that will have a huge impact on what they're able to access in the Community and perhaps what Medicaid is willing to put additional monies to in the Community.
So just want to open it up for any kind of ideas or suggestions. Comments.
On any of that on on how to provide those types of services in the Community or other aspects to look at.
There's no other comments there.
Susan Moon has go ahead, sure.

Cunningham, Lauren (DBHDS) 36:50
Oh, Susan, real quick.
Miss Bryant has her hand raised.

AS

Alabanza, Susan (DBHDS) 36:54
Oh, I'm sorry. I didn't see you, Miss Bryant. Go ahead.

MB

Martha Bryant 36:58
One issue that came up was a General Assembly session was the concept of pharmacy deserts and I think delegate Walker has been involved with this and delegate watchman as well. And in your area.
So basically pharmacies are closing and we have areas.
Without pharmacies, a number of counties and localities without pharmacies.
So a number of our populations.
Whether it's psychiatric populations, dementia, aging with chronic diseases or intellectual disabilities, pharmacies, a big piece of the puzzle to get reliable, consistent medications, and some of my friends who are aging even in retirement communities.
Once it snowed and they were used to mail order or delivery pharmacy, that didn't work in a snow storm.
One thing that you also have to think about that I've become more aware of in the last couple of weeks is about hurricane evacuation plans.
So we know hurricanes can affect Virginia weather, weather. It's the Tidewater area and their plan is to come to central State Building 93 or it's for southwest that we just had Hurricane Helene.
Where a hospital had to evacuate and it's gonna permanently close.

Or you have flooding and you have roads out.
Those whole MOU concepts of what happens in disaster.
So Central State has has or the pharmacy or the evacuation plans. That's that's a central state plan. And has anybody considered with this new building of Central state, what are all these centralized?
Us location evacuation plans.
Particularly.
Watching the pharmacy piece and in terms of comparable care, the pharmacy at Hiram Davis is supposed to go exclusively to Central state for the so for people with intellectual disabilities, we lose pharmacy services, we lose the dental clinic, we lose the the therapies. So a bunch of things.
That are on site now.
Are slated to be mental health only, so I think they're you're creating gaps.
Thank you.

AS **Alabanza, Susan (DBHDS)** 39:38
Just to kind of piggyback on that, Miss Bryant.
If Hiram were to stay open even with those ancillary services moving to Central state, the plan was that they would still serve Hiram Davis Medical Center so there wouldn't be any lack of care in that way.
They would.
They would still be able to get the care that they needed right there.
OK anyone else?
OK, I will turn it over to Susan Moon, who has.
More information on services that are in the community now.

MS **Moon, Susan (DBHDS)** 40:27
Juan, hello.
Just a second.
So Full disclosure, everyone, I've been having some technical difficulties this morning and thanks to Lauren, she's been muting me periodically as I try to navigate.
I don't know what's happening.
I it's like my computer has become possessed in some strange way.
It's the IT bugs.
I don't know dust mites that have little it weapons in them.

Anyhow, good morning everyone.
So Susan Alabanza and Eric Williams, who will kind of pick up at the end here today and I are have been kind of try chairs here for this subcommittee and we have been diligently trying to make sure that discussion topics that are brought up at each meeting we.
Try to bring back.
Data and facts and information and share some of the research that we do ongoing here at dbhds.
And then drill it down to be able to have this subcommittee produce a report with some good recommendations.
And so I took on for this meeting, answering some of the data related questions dealing with workforce and a few other questions that had come up in our previous meetings.
So I'm going to do my best to bring you some information from the Department of Health Professions, largely.
About the workforce.
Person health care workforce in Virginia.
The workforce that largely is currently supporting people with developmental disabilities and in some cases, mental health conditions also.
Across the Commonwealth and I do have a slight, you know, I lean toward DD since that's where the largest part of my work is.
But as we build this out, we will equally be looking at.
Healthcare professionals.
And and and their status serving the mental health community in the Commonwealth so.
Level setting.
Here we created some slide decks. As you can see this time also as we try to figure out how to present this information to multiple audiences going forward.
I like to level set by looking at what our mission is.
And this is just a placeholder slide that actually talks about the code.
Lauren and Susan, you know, clarified.
And it's been clarified that our mission here is to look at the potential closing of hiring Davis Medical Center and what currently exists in the Community and what needs to be built out in order to support people in the absence.
Of hiring were to close and so this is just level setting. I always need to go back to

my mission when I'm doing work like this.
And then I think it's important.
As we start to talk about things like pharmacy deserts.
Thank you, Miss Bryant.
I actually added that to a slide while you were speaking.
So we don't.
We don't lose it.
And you'll see it come up. But it wasn't there before you brought it up today.
But we do need to look at regions and what's available across the Commonwealth.
We have dramatically different needs in different parts of our state and for everyone's information, and this can be difficult.
Usually we're talking about dbhds regions.
The Health Department has their own regional lines. The Department of Health Professions. You're going to see as I go through some slides, have their own unique regional lines. The way they look at different regional geographic areas in the Commonwealth.
And I'm largely going to be trying to drive toward the DBHDS regions, unless the larger work when we get ready to write the report lends itself to use.
Some other regional breakdown, but so.
So I wanted to include this slide going forward so that when we need to level set what regions we're talking about, we have a frame of reference.
So if anybody ever wants to come back to this, we can.
There are some different kinds of slides, pictures of regions that I will add. Some maps show different elements of the regions better than others.
I selected this one today.
Because it specifically pulls out here.
The what we call region.
Two or Northern Virginia, our utmost northern regions.
And so it pulls it out into this nice graphic here so you can see Arlington County, Fairfax Falls Church in Alexandria.
And then it also pulls out our southeastern corner a little more clearly with Hampton, Newport News, Western Tidewater, Norfolk, Portsmouth, Chesapeake and the Virginia Beach area.
And so it just kind of helps.
So again, this is all level setting so we can try to make sure.

Speaking the same language.
We focus a lot on community services boards and so it is the first point of entry for most people with mental health challenges, substance use disorders, early intervention and developmental disabilities entering our support system in Virginia.
And so again, this is in case we need to reference back and the topic comes up and we want to reference back to which Csps are in which regions. And it does become important in a lot of our work.
To make sure we know what they are.
So this is here also if we need to reference that.
So super big conversation all the time is. Do we have enough people to support individuals in the community?
And you could you could actually debate that one way or the other.
Typically we end up with no because we know there are workforce challenges in the Health and Human services arena across Virginia across the United States.
But it's really important to take a little bit of a deeper dive. So these next few slides are going to look at physicians a little bit.
We are going to look at pharmacists in particular.
Mrs. Bryant, this is where, as you were speaking, I added these elements so we will come back to that data at our next meeting for sure and we will. I do not have this information for you today and we'll talk first a little bit about dentists ultimately.
What we need all of your help with and what we're going to be looking to answer are is this question in red.
What does all of this data ultimately tell us about community based services? In the absence potential absence of hiring Davis Medical Center?
So this is a lot of information and Lauren will make these slides available to everyone for us and I am not going to talk about all the data points on this slide. I think it's interesting.
This particular slide to note this is about physicians, not physicians assistants, not nurse practitioners.
This is specific to physicians and so we do have about 51,000 people licensed as physicians in Virginia and there's a little over half who are currently in the workforce.
And a little over half actually, that are also working full time.
You will also find that most of them are currently.
That are working full time are working in the profession profession. As a medical doctor.

The median age is another very important factor here. In our work, and that would be at the median age is 51, which leads us to this particular graphic and this is a map. And again, this brings us back to my discussion about regions. The Department of Health Professions uses different regional breakdown. So as we move forward, we're going to be looking at.
Trying to break these things down more by county and city and less by region, but that takes a little bit of effort in slicing and dicing our data.
It's still important to take a high level look at the Commonwealth here and you can see that the largest intensity of.
Physicians, the largest number of physicians, live in what they call Northern Virginia. Here, slightly bigger land mass than what DBHDS uses.
And then this particular area that they call West Central, it's important to note that over 1/3 of all physicians do expect to retire at the age of 6511% of that workforce expects to retire in the next two years, and half of that workforce is.
Expected to retire by 2042.
OK.
We'll move on to pharmacists, as Mrs. Bryant brought up.
We currently have about 16,000.
In just under 17,000 licensed pharmacists in Virginia, we also have a little over half that are currently in the workforce and just under half that are working full time in our workforce.
The median age for our pharmacists is 44 years old.
And that leads us to the important information about how long they expect to stay in the workforce and what their retirement outlook looks like.
This map is the same Department of Health Professions map, but it's pharmacists and it does show you that we tend to have the largest number of pharmacists down here in Southwest Virginia and West Central Virginia.
I don't know the where's or the whys, and we can slice and dice the data to try to tell a little bit more of that story, but I think for this group right now.
A lot of the focus has been on expected retirement.
How strong were our workforce be as we move into the next 5-10 and 15 years?
And how can the Commonwealth position itself to plan to support the folks that might otherwise be supported at Hiram? And in this case, 47% of pharmacists expect to retire by the age of 65?
7% of the current workforce expect to retire in the next two years.

And half of them expect to retire by 2048.
We will lay on top of this the number of pharmacies as best we can.
We will try to do an overlay for our next meeting.
Dentistry is a major focus of my work every day and so there are about 8000 licensed dentists in Virginia.
Just over half of them.
I'm are working full time in the Commonwealth. The median age for our dentist is 47 years old.
And when you look at retirement and where they live, where they are serving our Commonwealth, the largest number of dentists here are served in Northern Virginia, UP along the northern I-81 corridor and then.
Here along Eastern Shore.
Tends to be where we see the largest number of dentists here circling this part of the Commonwealth that is consistent with information from Medicaid when they did their analysis in 2022.
You do find the largest number of licensed dentists in 2022 in Northern Virginia, and the largest number of dentists participating in Medicaid.
I am not going to drill down into more information about dentistry today.
But just point of reference.
That is consistent with other data sets that we often look at here at tbhds. It is important to note that only 27% of the workforce expects to retire in the next decade, so a large majority of our dens report that they expect to continue working into.
The next 5 over the next 5 to 10 years, while half do expect to retire, ultimately in 2043.
We do, as I've said, look at other data sets.
It's really important that we determine our validity and reliability of data and in doing so we pull from other reliable data sources to try and see if we're getting consistent feedback. All right, so one of the things we did look at, we do look at is our C.
Report this.
Is still.
Really useful information that since the census was just drawn in 2020.
21 We're not quite five years out and we will see a lot of aligning of the data.
This was important for a lot of our work because again, as I said earlier, we look at CS BS as entry points and as really good sources of support and information about

supports in the Commonwealth.
For people with varieties of disabilities. And so the 2021 census.
Did show us that there were five counties in Virginia that did not have a dentist.
In the county, so it doesn't matter whether you're a typical adult, a child with or without insurance, with or without a disability, there was not a dentist in these five counties in 2021 that could serve you, and that also speaks to Mrs. Bryant's comment about.
Where are the deserts that exist for different?
Types of support services.
Nursing. So nursing again is a hot topic just about everywhere.
And building our nursing workforce. So the same questions.
These are the questions that this group presented to us in previous meetings, and so there are 130,000 registered nurses licensed in Virginia.
3/4 of them are working in the workforce.
The median age is 44 and I think you're starting to see a consistent trend.
Where the median age of a lot of our professional healthcare workers that are licensed in Virginia is in the is within their 40s.
I will get back to their retirement.
There's going to be a special slide for Lpns and RNS on retirement.
This is kind of where those nurses are living.
The information on this slide talks a little bit more about the types of settings they work in for profit.
Not-for-profit settings, income of nurses and whether they're currently satisfied with their work in the location that they're currently employed. And so the health professions, the Department of Health Professions is really looking at job satisfaction as they look toward in the Commonwealth looks toward how to RET.
Nurses in the workforce and so this.
Again, this map shows you that the largest concentration of licensed nurses.
Is in central Virginia and West central Virginia. So right in the heart of our Commonwealth is where we tend to see the largest number of of licensed folks and then SW Virginia and Hampton Roads.
This is lpn's.
Lpn's are critically important to the delivery of healthcare services in community based settings and the the work and collaboration between an RN and an LPN is often how healthcare.

Services are sustained successfully in community settings.
The licensed Practical Nurse workforce is significantly smaller.
There are lots of reasons for that.
We don't have time for today, but we have 28,000 licensed lpn's the Commonwealth.
Nearly all of them are currently in the workforce.
And the median age for those nurses is also 46.
Again, they're about 40 years old.
So this is the map.
Reflecting where nurses are, the lpn's are currently licensed and this also talks a little bit more about where they're employed. The amount of money that they're paid and whether they are satisfied with their current work circumstance and 63% of LP NS currently report feeling sat.
Again, this speaks to work around retention.
So when do they expect to retire?
Our Lpns expect to retire by age 65.
Among Lpn's who are 50 years and over 22% expect to retire by age 65.
They did not drill down.
Oh, it does say here. I'm sorry, Lpns.
Expect 21% expect to retire in the next 10 years. By 2049, we expect 21% of the current workforce.
Course to move into retirement with RNS. If you look over here, 42 expect to retire by age of 65 and 28%. This says here on this side that 21% expect to retire by 2049.
So we're looking at, you know, a loss of just under 1/4 of the workforce over the next 10 years.
Direct care professionals, so we call direct care professionals in the developmental disabilities.
Services model, direct service professionals and that is the terminology that you'll see across the United States.
There is movement.
To create certifications and job career pathways for direct service professionals to grow in that role and in management and other roles in direct service to individuals with disabilities.
So we wanted to take a little look here.
There's a good organization called the American Network of Community Options and Resources and Core.

They do a lot of surveys and research and they did a recent workforce review in 2024. It's one of the more current ones, so I just brought some information from their work.
And so some of the high level information from their work shows that 90% of experienced moderate.
Of of providers.
I'm sorry, I should clarify.
So they surveyed providers.
So those are the small and large businesses across the country that.
Provide residential and day support services for individuals with developmental disabilities, largely so in serving. Surveying those providers, they did find that 90% of them are experiencing staffing challenges. They're having difficulty finding direct service professionals to work.
69% reported turnover.
And and that they had to turn away new referrals, right?
So when they're getting referrals for people that need supports, they're having to turn them away.
They just don't have the staffing to provide those services. 39% of those providers were discontinuing one program or service within their business model, 64% intended to delay.
The launch of a new program.
While they look to hire, hire and trained staff, 34% were considering some cuts in the future if recruitment and retention programs that they're trying to initiate failed, and so there are a lot of really creative retention programs on ideas out there and organizations working on RET.
But a lot of the providers, about a third of them are considering.
Further cuts in the.
Programs and just to cut back on some of the services they provide.
45% were experiencing more frequent reportable incidents and so we work a lot on looking at where there's potential risk for an adverse event, an injury or a fatal outcome and looking at ways to reduce those risks. And a lot of that speaks to training direct service.
Professionals and educating folks about where those risks exist, both health and safety.
50 risks and some social risks throughout communities.

And so providers report that they start to see more incidents as they have staffing concerns as staffing concerns rise 57% of case managers struggled to connect people with services.
And so we do have folks with us from rbha I think today and so our support coordinators.
Often referred as case managers.
Really do struggle and they reach out to dbhds pretty frequently to get help finding services and so providers are reporting that yes, the case managers that work with them really struggle to connect people.
57% reported delivering services in areas where few or no other options exist.
And so we work really hard to promote the growth and development of provider services in underserved areas in Virginia.
Yeah.
There are particular teams and people here to be HDS focused on just that mission.
And so this would be why we really do have 50% of the of providers struggling.
OK, you can read the other side here.
There's a lot of other information in the Ankar report if you're interested.
It's not a long report.
It's very well constructed and easily written.
And so I do highly recommend people check into that.
We will bring other information about workforce data related to direct service professionals and what some of those retention programs and a workforce development programs are that are out there.
A lot of those programs are focused on these three areas and this is what ancore is taking some deeper dives into.
They're looking.
At what they call enhanced fmap, this is a federal medical assistance program assistance percentage. It has to do with the home and community based services rules, and this would allow states to increase currently inadequate reimbursement rates.
Offer additional opportunities for DSP training.
This is a big focus of our.
Work here in developmental services at dbhds.
Developing a sense of professionalism for the profession of direct support professionals.

Supporting innovative approachments to recruitment and retention and advancement of that workforce.
Another area and recommendation they make is to establish standard occupational classifications for direct service professionals that does not exist currently in Virginia.
It is a movement across the country.
And again there is.
In the Commonwealth, a lot of work around training and empowering direct service professionals to do their work.
Establish systems of access monitoring and so this means looking at ways that the system can compel regular review and adjustments to reimbursement rates, which is actively the Commonwealth of Virginia is always seems to be in a rate study.
Around different different areas of the workforce.
And services that are provided in our underserved communities.
So these are some of the high level recommendations from ancor from this particular report.
Round workforce in direct care.
Susan has already spoken a good bit about Hiram Davis Medical Center and the data there.
I am not going to talk about this.
It is a placeholder though for additional data related to Hiram Davis Medical Center.
And these are.
Maybe some points of information we still need to gather.
For Members of this committee in the past have asked for other information about.
History. Historical data from Central Virginia Training Center, et cetera.
Nursing facilities so.
How do we know how many nursing facilities serve people with developmental disabilities or underserved populations?
Or serve our mental health populations.
Etc. It's hard to identify that it really can be difficult to slice and dice.
Which nursing facilities have the capability to serve different kinds of complex needs?
One of the ways we can do this is looking at the pre admission screening.
And resident review process called Pasar and so this is a federally mandated process that if an individual with a severe mental illness or developmental disability related conditions also falls here if they're seeking admission to a nursing facility, there is a formal review process.

And once they're there, admitted to a nursing facility, there's a formal review process. It's all federally mandated, but it gives us a little bit of insight.
We can look at.
At the data from those reviews and so one of the things that our current data around Pasar tells us is.
There are right now about 136 nursing facilities serving at least one individual with a developmental disability.
We know this because we are conducting resident reviews in those facilities to kind of see how those folks are doing.
We also know that there's about 368 individuals.
In those 136 facilities receiving nursing facility level supports from that data.
So that's our current view.
Into.
For the developmental disabilities population, I did not pull mental health, which we can. We can do that. Also we can look at the mental health side.
One of the things that came up, this is a lot of information. I'm sorry.
But one of the things that came up last time was House Bill 2253.
So there was an effort in this last legislative session to add some more structure around.
Sanctions when surveys are conducted in nursing facilities and problems are identified by the surveyors, particularly surveys done by our Department of Health.
And so the bill specifically looked at sort of empowering.
Those surveyors to offer additional sanctions. The bill was identical to another bill offered in the House Bill 1383.
And proud to say that my I checked this.
Sean, so that I'd be sure that we had the accurate information, but House Bill 2253 was signed by the governor on March 19th, 2025. And so that will empower the Department of Health and our health, Health and Human Services secretariat to begin to.
Look at other ways to increase or improve the sanctions process when nursing facilities.
Are identified with health and safety related.
Deficits. And so I mean that's good news for being able to monitor and ensure that the Commonwealth is looking at ways to reduce the risk of adverse events and potential injuries and and improving the quality of care in the institution's where we

have folks residing, OK, that.
Was good news and.
Intermediate care facilities.
I do not have information today.
We do have access.
I will bring that next time.
We're hoping that in the we'll have a good list from all of you.
Of what other information we might bring at our to our next meeting and this will be on the list taking a little bit of a look at our icfs.
Group homes and sponsored homes.
Eric Williams spoke a little bit about those last time.
He might have a tad bit more information today, but we will be pulling.
Information from our last meeting into this slide deck so that it contains a comprehensive view.
We did speak already this morning about some about Vcbr and some of their needs and challenges when trying to access and utilize community based services for the folks that are have received treatment at vcbr or are currently being supported there.
And that is the end of my slide deck, Lauren, this morning it was a lot, I I apologize to everyone.
Does anybody have questions, comments, things you'd like to know more about?

MB **Moore, Brianna (DBHDS)** 1:10:51
I do.
I have a thing that I would like to know more about.
I would like to know I'm in opposition of the closure of Hiram Davis, but I don't know.
I I haven't heard the reasons why people are supporting the closure of Hiram Davis or planning to support the closure of Hiram Davis.
I would like to know what the other thought processes are.

AS **Alabanza, Susan (DBHDS)** 1:11:20
I'm sorry.
A lot of it has to do with the actual building.
So the the building has had several problems with the environment.
In terms of the, the pipes are old and sometimes they burst.

Martha Bryant 1:11:33
In terms of.

Alabanza, Susan (DBHDS) 1:11:37
We have not had any burst in a while and they've not.

Martha Bryant 1:11:40
Personal.

Alabanza, Susan (DBHDS) 1:11:41
There's no real pipes in most resident areas where it would, you know, say, you know, the ceiling open up on somebody.

Martha Bryant 1:11:43
Not wanting to spend.

Alabanza, Susan (DBHDS) 1:11:51
It's typically in other areas of the facility.
There's also been issues with the elevators at times that can happen anywhere.
It's not common that we have issues with the elevators, but there's just a sense that.
The building has some real issues and if we had to evacuate, there's no really good area to evacuate to without having.
To disperse everybody within 48 to 72 hours.
Internally, we've been talking about is there anything else we could do as far as an evacuation plan?
But for right now, we have had a lot of work done to the building we have.
New elevator project we just had all of our smoke dampers.
Corrected and approved and we have had.
Legionella mitigated.
So we've had a lot of improvements, but that is basically what led to to potentially closing the facility.
And I think part of that had to do also with expense, the expense of fixing the facility.
Would be close to $100 million building a new facility would be estimated at about $150 million.

However, we did, we have asked for some additional information as to the specifics of those numbers as some other people have mentioned, a lot of the ancillary services.
Will go into the new Central state hospital building so you know they they will have a new radiology department, a new laboratory, new pharmacy, new dental suite.
So there's a lot of things that are already going to be brand new.
Our census has been well, it's much lower now since the announcement. However, it had been hovering in the 50s and about a year ago, before some of the major projects we were heading up to about 60 people.
So there could be an argument made that perhaps we wouldn't need 94 beds.
But some of the things that have been brought up is are there places?
To potentially lease.
Is there someplace to?
Is there a way to have another building built on a smaller level that could still be on the same campus with?
With all of the services at Central State.
We do hold certifications.
As an acute care facility and as a nursing facility.
So we're able to build under both of those, which does bring.
Revenue in.
And not not all facilities are able to do that.
We are Medicaid certified facility.
And you know there, there have been some people who have brought up in in some of the other subcommittees, and perhaps this one as well, you know, looking at places like the old cvtc and issues.
I'm sorry, issues with having traveled so far to go to SEVTC.
But of course that those those types of facilities apply to if they were to remain a training center, apply to individuals with intellectual and developmental disabilities, they would not apply to people with behavioral health needs, dimension needs and or who are registered as sex offenders.
So that's, that's where it came. That's where the proposal came from, basically.

MS **Moon, Susan (DBHDS)** 1:15:49
Yeah. And Lauren Cunningham is supporting all of our work here and she is working on getting somebody from facility side from the facilities people here at Central

Office to answer and speak to all that that information and a lot of those questions, since it's not the expertise of.
Any of us.
And Susan did a great job there, giving us a high level overview.

Alabanza, Susan (DBHDS) 1:16:13
Correct.

Moon, Susan (DBHDS) 1:16:16
So please send us specific questions.
Regarding building facility possibilities so that we can like send that to the facilities team and and have them be able to like bring the information we want to know to the next meeting.

Moore, Brianna (DBHDS) 1:16:33
Thank you.

Cunningham, Lauren (DBHDS) 1:16:34
I'll say what just real quick to add on to that one. I know one of the things that's come up across this subcommittee as well as the supporting patients is the idea of using Central Virginia Training Center.
That's something we're working on for our April meeting to have someone either from facility services or the Department of General Services come and you know, we know there's some challenges.
So we wanna know what is the current status.
What would it look like to use Central Virginia training Center?
What would need to go into it?
So we're hoping to have that for our April meeting.

Alabanza, Susan (DBHDS) 1:17:03
Thank you.

Moon, Susan (DBHDS) 1:17:03
Mrs. Bryant has a question.

Alabanza, Susan (DBHDS) 1:17:08
You're muted, miss Bryant.

Moon, Susan (DBHDS) 1:17:11
Yeah.

Martha Bryant 1:17:15
Sorry.

Moon, Susan (DBHDS) 1:17:16
There you go.

Martha Bryant 1:17:18
OK.
Sorry about that.
I would like more information about your census breakdown now.

Alabanza, Susan (DBHDS) 1:17:20
Thank you.

Martha Bryant 1:17:25
Like of your skilled, how many are IDD? How many?
Vcbr how many acute care? How many?
Serious, mentally ill, I continue to object that a single code section is being used when 37.2 dash 837.
Is the code section relevant to us? And according to Medicaid?
Code sections we Medicaid should have statewideness we should have choice.
So basically I would like a breakdown of your.
Population.
And I have to say, we just went through passer on Friday.
This is an out of state contract.
A psychologist is hired from a Tennessee company called Maximus.
This is the first time I've met him.
It was his third year to review my son.

He's coming as a independent.
Basically validate that he's disabled and what therapies he gets and what's the medical status.
That's what kind of equipment I think this would be a cost efficiency in the future that we don't need to look at someone every year or pay out of state travel.
So.
I'm sorry, I've got to take a call. Thanks.

MS **Moon, Susan (DBHDS)** 1:19:02
Thanks, Lynette.
Hi, Lynette. Good morning.

BL **Bartlett, Lynette (DBHDS)** 1:19:06
Hey, good morning.
I just I wanted to help Miss Bryant.
I do have yesterday's breakdown of our census.
I can break down the IDD, neuro COG and mental health. Would that be helpful?

MS **Moon, Susan (DBHDS)** 1:19:16
And that's yes, that's great. Thank you.

BL **Bartlett, Lynette (DBHDS)** 1:19:19
OK, so yesterday our census was 34.
We have a total of 19 IDD residents here, 7 Neuro COG residents, which would include dementia, and then we have 8 mental health residents here in this facility.
I keep up with this all the time so.

MS **Moon, Susan (DBHDS)** 1:19:37
That's great.
Thank you.

BL **Bartlett, Lynette (DBHDS)** 1:19:38
Store.

MB **Martha Bryant** 1:19:39

You do.
You have any bcbr?
Do you have any acute medical this yesterday?

Bartlett, Lynette (DBHDS) 1:19:47
We had three GM patients in our which are acute medical, but two of those are ours. One of them is an ID person from another facility. We do have in our long term secure site.
We do have some.
I don't have that total breakdown.
I'm sorry, I just had the diagnosis breakdown for you.

Alabanza, Susan (DBHDS) 1:20:10
I do know we have at least three people.

Bartlett, Lynette (DBHDS) 1:20:12
In GM.
In GM.

Alabanza, Susan (DBHDS) 1:20:14
Right. We have at least three people who are from vcbr.

Bartlett, Lynette (DBHDS) 1:20:20
And that's true.
We just had two admits this week. One of them was from southern Virginia Mental Health Hospital.

Alabanza, Susan (DBHDS) 1:20:21
Right.

Bartlett, Lynette (DBHDS) 1:20:26
And then we had one from the community. That was ID last week.
So we've had two, it's two week two admissions in the past two weeks.

Alabanza, Susan (DBHDS) 1:20:35

The one from the community the the CSB made a special request for Hiram Davis, even though the person had been approved for admission at another private nursing home.
The the CSB had noted that they would probably get more more personalized.
Care for what they needed and would considering their IDD, and so that person was able to come to Hiram.
And again, when people come from the community to hybr.

Martha Bryant 1:21:07
In the eyebrow. It's not as specific one, but we are looking at.

Alabanza, Susan (DBHDS) 1:21:09
ID time limit. But we are looking at what is the discharge plan so that they can return to the Community at some point once in a while we've had somebody have a a much longer stay or permanent placement but that's pretty rare.

Martha Bryant 1:21:14
What is the distraction plan so that we can return to the at some point in?
Time. But that's pretty rare.

Alabanza, Susan (DBHDS) 1:21:31
Go ahead, Miss Bryant.

Martha Bryant 1:21:32
That's Bryant.
My sons came to Hiram Davis in 2017 as part of the settlement agreement, when the skilled nursing facility at CBTC closed. That it been a wonderful.
Excellent care in our home county.
So I'm certainly an advocate for close to home care.
We choose training centers because.
Of the multiple on site services there, I prefer a Central Virginia location.
I don't agree that southeastern is going to be the right model.
And the staffing proposed of not having a nurse in the home where Taylor resides is unacceptable to me so.
Some people need training center care.

These forced relocation.
Further and further from home or or not preferable? Thank you.

Moon, Susan (DBHDS) 1:22:41
Thanks, Mrs. Bryant. Real quickly.
Eric Williams is another one of our Co leads here and Susan and I had so much information. We have barreled on through.
He may have some updated.
Information to share. So I want to give him an opportunity to comment here.

Williams, Eric (DBHDS) 1:23:01
Thanks Susan.
So last time we did a pretty extensive overview of our gap analysis in Virginia and how we identify where services are available and where they're needed.
One of the things that my focus is I think within the group is to kind of bring it down to the organizational level and think about what would a model of service look like that could parallel or approximate.
The services individuals receive at Hiram Davis.
And so for me at least personally, the best way to do that is to think about an individual, somebody you know with very complex needs and then think about what it would take for them to be successful, safe and successful in the community.
So thinking about things like what is needed in the environment where they will be, what is needed in terms of equipment.
So for example, do they need accessible settings and do they need a generator or do they?
What kind of equipment needs?
Be there or your lift, etcetera.
What's needed on site in the home versus what's needed in the near community around that person that they need to have quick access to.
Also thinking about specialized staff and the accessibility of different therapies that they may need and do we need any kind of system changes around?
You know, developing medical case managers that specialize in medical support needs.
Do we need to think about? And Susan mentioned earlier that idea of agreements with nursing facilities for some of the care.

You know, certainly bringing in some of those things or changing regulations around transfers, for example.
Transfers happen in the community, often by choice, sometimes because a provider isn't able to meet someone's needs. But for somebody who is in a a critical place with very complex support needs, maybe regulations need to be.
Around what that transition process looks like to ensure the person's needs could be met in a new location.
And perhaps it needs to be extended or approached differently.
So thinking about different rules and regulations that need to change, we've spent a lot of time at 40,000 feet and so just bringing it down to the person and thinking about what it would need for each individual or in general, could we get to a model is?
Something I think might be helpful.
To meet to meet the objectives of the group and you know, I'll continue to think about that.
I don't know if that's something that Members would want to contribute to, whether it's in the full committee or subcommittee or just through submission of ideas, but I'll try to work on that as well.

Martha Bryant 1:25:40
Yes, that's well.

Williams, Eric (DBHDS) 1:25:43
OK.
Yep, miss Bryant.

Martha Bryant 1:25:50
Equipment has been a barrier for us and also.
The.
The dma's process of being denied and having to pay out of pocket.
So if I looked at Taylor's room and all the things that he needs, it would probably be about $15,000. I will say as Hiram has downsized and you're thinking about a possible smaller model not at 10 beds, but what is realistic?
Like do you need 40 beds?
Do you?

Do you?
Would you change the licensure and the title of a CBTC to be a Medical Center or to build on the Hiram campus?
A smaller modern facility.
That's first floor ADA oxygen. That type of thing.
I think equipment is a big barrier and when we look at a southeastern training center bed that maybe.
Uses just standard like OK, a a full size bed and a dresser.
It's far different than what Taylor needs.
And the cost?
So it's been suggested that I buy equipment.
No, I'm not gonna buy his equipment when it's reimbursable. And I did see that the appeal process by law, will change from 30 days to 90 days.
So by the time you get a denial and you start to try to do an appeal.
You know, it takes it could take 10 days to get the letter or your vendor in air case or vendor demanded upfront payment.
So I had to pay over $1000 for something and then it got denied.
So we're out of pocket over $1000. So I think when you have even a downsizing and there's equipment available, I think in the past when CBTC closed, a lot of the equipment was.
Offered.
To mental health hospitals, some mental health hospitals could come get dressers or hospital beds, but I don't think that's the appropriate model that you, I mean wood equipment, be able to go to to a non DB heads facility or work with Dmas about, OK, what is your equip?
Reimbursement model, so those are.
Certainly, I'm glad you talked about.
Umm.
Equipment and I will say that Taylor needing oxygen and southeastern in the past not allowing oxygen, has been a barrier even for ICF people that if you needed oxygen you got shipped to an ER and a hospital and then to Hiram only because of oxygen. Thank you.

Williams, Eric (DBHDS) 1:28:46
Yeah. Thank you.

That kind of detail is very helpful to understand.
So thank you for that.
But that's really all I wanted to say.
We'll continue to look at it and see what we can bring back in terms of options. I'm even thinking down to the home like setting, figuring out how close we can approximate services and supports even in in the very smallest of settings. So thank you.

Martha Bryant 1:29:09
Thank you.


Williams, Eric (DBHDS) 1:29:19
That's right.

Martha Bryant 1:29:19
No, it's fine.
I will talk just a second about contract failure and.
When Hiram was going through some renovation, we lost on site lab services particular things for a few days, but we've had a recent success story with my son who has a full time nurse practitioner there.
So he was diagnosed dead.
All of his lab there had X-ray.
There had vascular services come in.
He got IV antibiotics there. God all saves money. Whereas when lab had to be sent out, it was run in Burlington, NC. It took three, five and six days to get his diagnosis, and so contracts failed.
So you were talking about regulatory change and transfer of service to nursing facilities and I would just say beware of contract failure.
Our onsite services were great and we just we just had a lived experience.
Thank you.


Williams, Eric (DBHDS) 1:30:25
OK.
Thank you.
It looks like we might have run out of time.

So thank you.
I guess I don't know, Lauren.
Do you wanna close up?

Cunningham, Lauren (DBHDS) 1:30:39
Yeah, I was just gonna wrap up with a couple notes we mentioned earlier.

Williams, Eric (DBHDS) 1:30:39
OK, OK.

Cunningham, Lauren (DBHDS) 1:30:42
We're working on a couple things for next month, including exploring the the option of Central Virginia Training Center.
We'll have slides as well as a recording of today's meeting and a transcript up later this week on the Hiram Davis website.
We'll also try to finalize a date for our April meeting and communicate that out.
Hopefully this week, if not early next week.
So thank you all for taking the time to be with us.
Thank you to season season and Eric for being our Co leads and hope you all have a good rest of the day.

Eula Secka - SHRS 1:31:15
Thank you so much.

Alabanza, Susan (DBHDS) 1:31:16
Thank you.

Moon, Susan (DBHDS) 1:31:17
Thanks, Lauren.

stopped transcription