Transcript

April 22, 2025, 5:31PM

Cunningham, Lauren (DBHDS) started transcription

Cunningham, Lauren (DBHDS) 0:03
131 will go ahead and get started.
Thank you all for joining us this afternoon.
We have a pretty packed agenda, so we're going to get right into things with some quick introductions and then we'll do public comment and then we'll start our presentations.
I'll go ahead and kick things off. I'm Lauren Cunningham.
I'm communications director at the Virginia Department of Behavioral Health and Developmental Services.
We'll just go around real quickly as I see people on the screen.
Robert, do you want to go next?

Johnston, Robert (DBHDS) 0:34
Broad Johnston.
I'm the director of Environmental Care facility services at PBHTS.

Cunningham, Lauren (DBHDS) 0:40
And I I should have started with the with two of our Co leads. Susan Moon as one of our Co leads.
Would you like to go?

Moon, Susan (DBHDS) 0:46
All right, that's fine.
We can just go around the room.
Yes, my name is Susan Moon.
I'm the director for the Office of Integrated Health here at DBHDS.
We're registered nurse by background and welcome everyone.

CL **Cunningham, Lauren (DBHDS)** 0:59
Great. Our other Co lead season Alabamaza.

AS **Alabanza, Susan (DBHDS)** 1:04
Hello, I'm Susan alabanza.
I'm the Cliff.
Sorry, chief. Clinical officer at Hiram Davis Medical Center and my background.
I am a social worker and an occupational therapist.

CL **Cunningham, Lauren (DBHDS)** 1:18
Great Amy loving.

AL **Amy Loving** 1:27
Hi, can you hear me?

MD **Morton, Demetrie (DBHDS)** 1:28
Hello.

CL **Cunningham, Lauren (DBHDS)** 1:28
Yes, we can hear you.

AL **Amy Loving** 1:30
Amy lovely.

MD **Morton, Demetrie (DBHDS)** 1:31
I'm trying to see if my mic is working.

CL **Cunningham, Lauren (DBHDS)** 1:34
Oh, hi.

AL **Amy Loving** 1:35
Do what?

Cunningham, Lauren (DBHDS) 1:35
Yes, Steve, we can hear you.

Amy Loving 1:37
Hmm.
Hi, Amy. Loving.

Cunningham, Lauren (DBHDS) 1:43
Hi, thanks Amy, doctor Griffin.

Griffin, Jarvis (DBHDS) 1:49
Hello, I'm Jarvis Griffin.
I'm the chief executive officer at Hiram Davis Medical Center.
My background is in quality and risk management.

Cunningham, Lauren (DBHDS) 2:00
D Morton.
Oh, Dee, you're muted.

Moon, Susan (DBHDS) 2:15
Modern technology at its best, it's always a struggle.

Cunningham, Lauren (DBHDS) 2:17
Dee, we can, we can.
We'll come back around to you. No worries.
We'll come back around to you, Christina Gleason.

Gleason, Christina (DBHDS) 2:25
Hi, I'm Christina Gleason.
I'm a registered nurse.
I'm the community transition nurse with dbhds.

Cunningham, Lauren (DBHDS) 2:31
Great. Heather Norton.

Norton, Heather (DBHDS) 2:34
Heather Norton, deputy Commissioner, community services, dbhds.

Cunningham, Lauren (DBHDS) 2:39
Todd McDonald.

Mcdonald, Todd (DBHDS) 2:45
Hi, I'm Todd McDonald.
I'm a Virginia management fellow working with Dbhds for the next eight months.

Cunningham, Lauren (DBHDS) 2:54
Cassie girl on.

Grillon, Cassie (DBHDS) 2:58
Hi, I'm Cassie grillon.
I'm a marketing and communications manager at Dbhds.

Cunningham, Lauren (DBHDS) 3:04
Brandon.

Charles, Brandon (DBHDS) 3:06
Hi, Brandon.
Charles, I'm the senior human.
Sorry, I got cut off.
I'm the senior human rights manager for facility operations at DBHDS.

Cunningham, Lauren (DBHDS) 3:16
Thanks Brandon. William rose.

Rose, William (DBHDS) 3:20
Hi go by Paul Rose.
I'm the emergency manager at Hiram Davis.

Cunningham, Lauren (DBHDS) 3:25

Great. Thank you, Paul.
Taneka, Goldman.

Goldman, Taneika (DBHDS) 3:29
Good afternoon. Taneka, Goldman director for the Office of Human Rights at DPHDS.

Cunningham, Lauren (DBHDS) 3:34
Thanks taneka.
Hallie Pence.

Pence, Hallie (GOV) 3:38
Hi, I'm Holly pence.
I'm in the governor's office as his executive director for help right now.

Cunningham, Lauren (DBHDS) 3:44
Thanks, hallie.
Tony Davis.

Davis, Tony (DBHDS) 3:47
Greetings, Tony Davis, Office of Human Rights and Human rights advocate for Hiram Davis.

Cunningham, Lauren (DBHDS) 3:53
OK.
Madeline went.

Lent, Madelyn (DBHDS) 3:58
Hello. I'm Madeleine Len, public policy manager, Dbhds division of policy and public affairs.

Cunningham, Lauren (DBHDS) 4:04
Thanks and Megan McGuire.

McGuire, Meghan (DBHDS) 4:07
Megan McGuire, deputy Commissioner for policy and public affairs.

Morton, Demetrie (DBHDS) 4:10
A very separate.

Cunningham, Lauren (DBHDS) 4:14
All right.
Anyone that I forgot before we move into public comment?
All right. We're gonna do public comment up front. If there's anyone that would like to speak, we're we'll give you about two minutes.
Per person, just raise your hand virtually and we're happy to happy to get to you.
OK.
Well then we will move right into our first presentation from Robert Johnson in the Dbhds division of Facilities Services.
Central Virginia Training Center, which I know has been a topic that we've covered a couple times and had some questions about.
So Rob is here to to talk us through. So I'll turn it over to you, Rob.

Johnston, Robert (DBHDS) 5:11
All right.
Thank you and good afternoon.
I'm gonna talk about a little bit of background and the current status of Central Virginia Training Center.
Excuse me.
Some of the 386.5 acreside is located in Madison Heights on James River.
It is immediately across from the river, immediately across the river from Lynchburg entrance to the site is via Colony Rd. From the north or top of the page of the slide.
You're looking at. Colony Rd. is accessed from Route 210 Old Town connector.

Morton, Demetrie (DBHDS) 5:47
Old Town connected.

Johnston, Robert (DBHDS) 5:50
This main road, I'm not sure why I'm echoing here.

Morton, Demetrie (DBHDS) 5:50
Main road. I'm not sure why I'm a second later.

Johnston, Robert (DBHDS) 5:56
Excuse me.
Not sure what's going on there.
There are two cemeteries on campus.
I'm sorry, the main road through the campus, which is Colony Rd. is maintained by B dot and is the primary access for the trailer park, which is located to the southwest of the campus via Carolina Ave.
There are two cemeteries on the campus, and if you allow me, I'm gonna pivot to a Google map which gives you a little bit further outlook.
So on the right, if you're following my cursor, this is the top portion continuation of what you're seeing on the left.
So you've got the main campus of Central Virginia Training Center, which includes the lower Rapidan buildings and to the top is the entrance of Colony Rd.
Colony Rd. is highlighted in green. Goes right through the middle of the campus and then turning it becomes or Carolina Rd. Ave. feeds off of Colony Rd. continues down southward.
This cemetery is hard to see from Ariel.
It is fenced in in a wooded area as you saw.
The other cemetery is up here to the top right and then at the bottom you see the beginning of the trailer park development.
Over here this is again the top of the campus showing Route 210 and 29, where you access Colony Rd. to enter the campus.
Facility includes 89 numbered buildings.
One swimming pool and two water towers.
The building.
The buildings are color-coded for the three areas. The three primary areas, Aras excuse me of development and growth or expansion that would be pre 1946 from 1946 to 1966 is shown in yellow or beige.
And then in green is post 1966 development utilities provided and available water services provided from the city of Lynchburg.
Services from Amex county.

Appalachian Power provides electrical service and telecommunications were provided by Verizon.
Site contains several buildings of historic character and two cemeteries. As I showed on the MAP, operations began in 1910 as the Virginia State Colony for epileptics. The campus footprint services were expanded significantly in the 1940s and 50s. Resident and staff population peaked the 1970s this.
Facility was closed in 2020 and has been fully vacated and the buildings are unused.
It is anticipated the buildings will be demolished.
For redevelopment.
For new industry.
These next slides, this and the next show you a look at various buildings on campus and from one of the primary areas eras that they were developed in. So the left column on the left side is pre 1945. Building 22 is one of the orig.
First, buildings built in 1910 and then in the middle is when the most growth and development occurred in 1946 and 1966. You're looking at front of building 7 and the front of building 15.
And then to the right buildings since 1966, the next slide will show more.
So the lower Rapidan buildings comprise buildings 8 through 12. They were mostly developed in the 1950s.
The hill buildings, based on their location on the hill on campus, is so named.
Our buildings 14 through 20.
And admin buildings are buildings 495065 and 60.
Excuse me for being out of order there on the numbers. If I go back to the campus map again.
Up here in the right corner, these two lower Rapidan buildings, this middle area comprises if you can follow my cursor. The middle areas area is the hill buildings and then that admin buildings mostly are over further.
The this provides information the lower, rapid and buildings. As I said, dating from the 1950s are in the best shape relative to others on the campus, as they were recent renovations from 2008 to 2015.
And these this slide shows you each building the year is built for the lower raptan buildings 8 through 12 and then the year is renovated. Its current square footage, bedrooms and number of beds.
Building 57. If you do see that in the lower right, that is the chiller plant building that supports the other buildings indicated for the lower Rapidan area.

This slide and the next will show you the current condition or current view inside some of the buildings.
Buildings 8. Excuse me. Let me get back to the map.
Buildings 8911 and 12 have relatively basically the same four out building, 10 up there on the farther right is a little bit different. So you're seeing the left and center pictures are from building 8 the day room view and one of the bedroom views.
And then a common bathroom, also from building 8.
Building 12 day room in Kitchen is on your left in the middle of this slide is the day room at building 11 and then on the right is a shower trolley room in building 11.
I had. If it doesn't convey in these pictures, I would say.
Building 11 finishes might be a little more worn or a little not as good condition as the other buildings that you're seeing the views of.
I stated previously the lower reptilians are in the best shape.
Most equipment is between 10 and 16 years old and is not yet past its estimated useful life.
I can pivot from this slide to an overall 4 plan, but I wanted to speak to some.
Things that would have to happen the buildings share currently common bathrooms for multiple bedrooms and laundry is not configured as it will need to be for today's standards for certification. HVAC capacity would have to be evaluated both for load air quality and again we've been through several it.
Of state code, since even these renovations to these buildings.
So if I pivot again to the to the overall floor plan, I will try to show you over here currently and this is a typical floor plan, I'm on the right side. If you can't see my cursor that is a pot of mill bedrooms and a common bath.
And laundry on the left side, you have basically the same for women. This whole area would have to be.
If you can see this is kind of above, the whole area would have to be reconfigured to by today's standards.
We have to provide private bathrooms for each patient bedroom. We have to confirm the square footage allotment per bed. The laundry would have to be reconfigured to separate, clean and soiled linens.
So these so as good as shape is the inside of the building may be we'd be looking at a full renovation to meet current compliance both for today's building codes and again certification from CMS which we manage through Virginia Department of Health.

So in closing, if renovation and upgrade of the Laura Raptan buildings for conversion to skilled nursing is an option that the consensus planning team would like to include, then a full cost estimate and conditions survey would be required as well as funding for the analysis.
And that concludes my update on where we are with Central Virginia Training Center and its status.
I'm happy to take any questions.

CL **Cunningham, Lauren (DBHDS)** 14:03
Yeah, Susan, Alabama.

AS **Alabanza, Susan (DBHDS)** 14:06
I just have one question about.
Just this whole presentation, I appreciate you doing all this. I I noticed that we don't have.
I don't see unless I hope I'm not missing someone.
I don't see any family members attending today and that that this question primarily came from them.
I I know that they will have access to this, which is great and perhaps we can speak later because they do have a family.
Council meeting in May. Scheduled and perhaps, if available, you could present this again to them at at that point.

JR **Johnston, Robert (DBHDS)** 14:45
I'd certainly be happy to.

AS **Alabanza, Susan (DBHDS)** 14:47
OK.
Thank you.

JR **Johnston, Robert (DBHDS)** 14:50
Absolutely.

MS **Moon, Susan (DBHDS)** 14:52
Yeah, Robert, this is Susan moon.

I really think that one of the most valuable things 'cause we have said to our advocates that have joined our meetings numerous times. We've tried to present some of the sort of environmental and utility challenges of that particular property that we were. We were. I was anyhow well.
Aware of from having been there so many times.
But I think pointing out.
The new the current up to standard building codes and things regarding separation of laundry for infection control purposes.
The individual bathrooms, you know, per bedroom and those kinds of things that are person centered that, you know, actually increase our quality of life and increase our ability to provide safe family like environments for individuals.
So that if they were, regardless of any setting.
We're constantly trying to explain.
We're looking for community settings.
We're looking for settings in general that promote individual choice and increasing access to the community, so even our more institutional like environments need to be person forward, person centered and so the campus, those buildings that I recall.
They're not person centered, they're very old school institutional settings.
And I think remembering that the building code has evolved, as have all of us, right in our idea of what quality care is, I think is really that's very helpful the way you presented that. And I, I do agree with Susan.
I think that if there is a family gathering where they could also benefit from hearing from you, this short presentation that does really focus.
On that, on being person centered and quality.
It's not just about the money or the expense or the idea of a renovation.
It would be extensive in order to bring.
Them to really provide the quality of care we'd want to see and that they probably would want to see.
I don't mean to speak for them, but I'm I'm guessing.
So thank you for that.

JR **Johnston, Robert (DBHDS)** 17:10
Certainly you're welcome if you don't have the cost, but if that were to be pursued, you're right. They would be extensive because of upgrades and person center focus that would be required.

McGuire, Meghan (DBHDS) 17:22
And to confirm, Robert, sorry, this is Megan.

Moon, Susan (DBHDS) 17:24
Absolutely.
Yeah.

McGuire, Meghan (DBHDS) 17:26
In order for it to be certified as the nursing facility, all of those upgrades and.
Code making sure it's up to code would need to be made.

Moon, Susan (DBHDS) 17:38
Absolutely.

Johnston, Robert (DBHDS) 17:38
Yes, yes.

Griffin, Jarvis (DBHDS) 17:41
And I'll add that that's just a physical environment and then we got the licensing piece and the staffing piece and all of the various departments that go that make up those aspects of skilled nursing care and services.

McGuire, Meghan (DBHDS) 17:55
That's true as well. Thank you.

Cunningham, Lauren (DBHDS) 18:07
Any additional questions?

Johnston, Robert (DBHDS) 18:13
All right.
Well, thank you.
I'll remain on the call, but I'll stop sharing.
Appreciate everybody.

Cunningham, Lauren (DBHDS) 18:17
Thanks so much, Robert.
Heather, did you? Since we're on the topic of Central Virginia, did you want to talk a little bit about the Department of Justice settlement agreement and and some of the implications around that?

Norton, Heather (DBHDS) 18:34
Sure. I think that it's important to note that over the last several years, the DOJ has had an increased focus on.
Well, let's start with Virginia. Was under a Department of Justice Settlement agreement which?
Was focused on the Americans with Disabilities Act and the Olmsted.
Requirements, particularly that we develop Community capacity for individuals.
Regardless of the complexity of their need.
And so we have spent the last 12 years really developing that capacity to meet the needs of individuals with very complex needs in the Community and support of them.
I'll add to that that the Department of Justice has had a a national nursing home initiative that is focused on.
Accountability.
For.
Skilled nursing and and nursing home care fraud and false claims.
Compliance with the Americans with Disabilities Act focus on.
The involvement of individuals.
Who are receiving services through nursing home having choice?
In the community, and moreover, that states have developed appropriate
Community capacity to meet those needs.
Needs elder justice. And then of course.
A particular focus on COVID-19 over 30 states currently have Department of Justice settlement agreements that are focused on nursing homes or nursing facilities in particular, and particularly around assuring that individuals with serious mental illness and developmental disabilities are not inappropriately placed in nursing homes nursing facility.
Nursing facilities and are receiving care in the community and that states have

developed appropriate community capacity to meet the needs of of children and adults with complex medical needs in the community.
So I do think it's important to always keep that in mind in terms of what is the Community capacity that's needed.
For individuals, either with serious mental illness or individuals with developmental disab mental disability.
Because the Department of Justice looks at both.
In terms of compliance with the American with Disabilities Act and has really focused particularly.
On nursing facilities over the last several years.

Cunningham, Lauren (DBHDS) 21:28
Great. Thank you, Heather.
Any any questions specifically around around DOJ for for Heather?
OK.
Well, Heather, thank you for for giving us some important context to the conversation.
Susan moon.
I'll turn things over to you if you want to.
I go ahead and introduce Christina next.

Moon, Susan (DBHDS) 21:53
Much faster through our planned agenda than we anticipated.
So for everyone's information we we may end up ending our little meeting earlier today.
So but first, does anybody? No one has any questions for Heather or?
Robert, at this point I gather, OK.
So Christina Gleason has joined us today and Christina is a registered nurse.
As she said, she's a community transition nurse.
And she works in our pasar office.
Focused on children. And I'm gonna let her explain what children means in this context.
But children who are currently residing in nursing facilities so they're not in training centers, they're not in intermediate care facilities, they're in nursing homes, they're in nursing facilities.

Kind of.
How many there are where they are and the work that goes into.
Ensuring that when possible, they are offered community placements that they're offered choice in community settings and this sort of dovetails what Heather said.
There's a very big focus both Dbhds has and exists in the Commonwealth, and the and the country to reduce the need and for a nursing facility placements where community placements are possible.
So with that being said, I just want to.
I want to give this.
Presentation to Christina.
She might have a slide deck to share.
And then we may be hopefully if we're still here at 2:30, we may hear about the adults in nursing facilities, but.
Christina.

GC **Gleason, Christina (DBHDS)** 23:45
I feel like Susan already touched on all of it.
Thanks for.

MS **Moon, Susan (DBHDS)** 23:47
No, I didn't start at the beginning. Explain the definitions.

GC **Gleason, Christina (DBHDS)** 23:50
Thanks for having me.
Yes. So right, Susan mentioned that I'm in the pass our office which stands for pre admission screening and resident review.
Which is a federally mandated process prior to admission to any nursing facility.
For qualifying diagnosis and a qualifying diagnosis is serious mental illness, intellectual disability, or a category that's unique to passenger, called related conditions.
And that could be autism.
Cerebral palsy.
Down syndrome, traumatic brain injuries, chromosomal anomalies, anoxic brain injuries.
There's a slew of things, and you name it. We have seen it in the past, our office.

So all of those individuals seeking nursing facility admission have to be reviewed.
I do focus on the children, but I do review all idrc adults and children in the Commonwealth.
Susan mentioned the definition of children and I wanna it's important because for my reporting purposes and my counterpart, Lisa Rogers.
22 and under.
Is a child for our reporting purposes, so 18 to 22 is always an interesting realm for us because by the Code of Virginia at 18, you are you are your own, your own person until proven otherwise.
So 18 to 22, we follow those folks admitted.
There's two primary.
Institutions in Virginia that admit children.
So again, that age range is important.
Children's Hospital Brick road.
Their transitional care unit and then Iliff nursing and rehab up in Fairfax, VA.
Those are the two primary facilities.
We have a few folks scattered about.
At the Bryan Center out in western Virginia.
I have one person there on a, on a ventilator.
Umm, she has a she has a terminal illness.
Actually, umm, she's very. She's quite young.
Umm she's 17.
And you know, we follow her for all of her needs.
I'm trying to think of the other facilities, so I review all of their passwords and then write discharge. Susan talk about discharge.
Discharge planning begins at admission.
And it is a lot easier said than done, our families.
Have layers of barriers to bringing their children home, and that is anything from the lack of nursing in the community.
Dme issues like actual being able to actually provide them with what they need as far as equipment goes.
Socioeconomic issues. Parents have parents who are incarcerated.
I have parents without transportation.
Yes.

Moon, Susan (DBHDS) 27:10
Christina, can you offer an example?
I mean, we have a largely dbhds team here who may be able to think on their own of examples, but I know you have examples of some of those categories like adme challenge.

Gleason, Christina (DBHDS) 27:28
So.

Moon, Susan (DBHDS) 27:28
Nursing challenge related to the type of care. You know just some limited examples and in part because we're recording also and I am hopeful that some of our.

Gleason, Christina (DBHDS) 27:33
Yeah.
Oh.

Moon, Susan (DBHDS) 27:40
Family advocates might listen to the recording, find that we all have the notes. Also, as we build out what the what needs to be considered and build upon in Community settings in order to fill some of these gaps.

Gleason, Christina (DBHDS) 27:55
Yes, and I apologize.
I didn't mean to give like specific examples either, since this is being recorded for who we follow.
So.
With the example I sent you most recently be a good example of.

Moon, Susan (DBHDS) 28:09
Yeah.

Gleason, Christina (DBHDS) 28:09
Incontinence wise so.

Is this maybe sounds really simple but.
Folks in the community actually have limited number of incontinence supplies through their DME suppliers and what insurance will cover.
So like briefs that an individual might need to wear.
And that's actually a really big challenge. It sounds so.
Simple, but yet that causes this ripple effect of leaking out onto Tibetan, having to wash bedding mattresses that a person lays on quality of sleep.
Quality of life infection for skin integrity.
Briefs are ripped. They don't fit.
Well, maybe AAG tube leaks and that's not.
It's not even anything that has to do with urine.
But then there's a leak and you have to change them.
And that's just, that's the most.
Recent example I gave to Susan was.
Limited incontinence supplies in the community and how frustrating.
Something as simple as that could be.
I feel like I could ramble, so I might need some more guidance this then about what do you want me to speak on for the kids?

MS **Moon, Susan (DBHDS)** 29:25
No, that.
No, that's fine.
About how many children do you follow?
About how many discharges do you get in a year?
Do they typically go to homes?
Sponsored Homes Group homes. You know, those kinds of things I think are really important to the work of this committee.

GC **Gleason, Christina (DBHDS)** 29:43
Sure.
So the number hovers around sixty children.
A little less, maybe 58.
Children at discharge it don't get too many a year.
A handful at best.
All of the children that I follow have very complex medical needs.

Mostly ventilators.
Management.
We have kids, young adults, I should say, who do go to group homes, Medical Group homes.
Typically.
We see that as the discharge plan going to a Community group home versus going home.
We have had some children go home and then end up having to readmit because of a lack of staffing nursing.
Call outs or they can't find someone qualified.
You know, vent trained individuals in the community is incredibly challenging.
Nurses aren't meant trained.
So it's it's a big there's a deficit there.
It's also challenging cause the number of kids that I have their their parents, are not their legal guardians.
There's a like. There's a lot of family dynamics, so we have a lot of children in custody of furious DSS offices, foster care situations.
And so again, just trying those, those families are. They're always trying to get the child back with the the biological family. And you know, there's obviously a lot of barriers there.
Training parents have to be trained.
You might have.
You know, nursing coming in, but in the hours that you don't have a nurse there, mom and dad need to be trained to care for the individuals.
So right now I think I only have I have one active discharge.
So working on getting that that one to a Community group home, we do occasionally have.
Folks go to an ICF, we have actually that happening in just a couple of weeks.
Someone whose level of care has changed a little bit and it looks like an ICF will be able to fit their needs, but they still can't go home.
Mom and dad.
Are unable to provide care.
So about 60 kids, give or take.
It flexes only a little bit as soon as someone discharges, there's a wait list.
For children's and Iliff.

Now.
Anything else?

Moon, Susan (DBHDS) 32:50
Does anybody have any questions for Christina?
Lisa Rogers has joined us and I believe.
We'll be able to continue to talk about the pass our process in regards to adults in nursing facilities. So we will keep Kristina here as they are a Dynamo team. But does anybody have any particular questions for Kristina?

Gleason, Christina (DBHDS) 33:08
Yeah.

Moon, Susan (DBHDS) 33:15
Regarding the kids at this point.
Oh, Lisa Rogers, are you able to speak?

Rogers, Lisa (DBHDS) 33:35
Yeah. Can you hear me?

Moon, Susan (DBHDS) 33:36
Yeah, absolutely.

Rogers, Lisa (DBHDS) 33:37
OK, it turns out I wasn't on mute this one time.

Moon, Susan (DBHDS) 33:38
So I think you you'll need to introduce yourself since you weren't here at the very, very beginning. And I think you were able to hear a lot of what Christina was chatting about.
And so I think this group would benefit from a little more about pasar a little bit more about the resident review process and since your work bridges into our mental health population, that is also.

Rogers, Lisa (DBHDS) 33:54
Yeah.

Moon, Susan (DBHDS) 34:03
Residing in nursing facilities, I think some insight there.
Would also be helpful.

Rogers, Lisa (DBHDS) 34:08
Sure thing.
I'm Lisa Rogers on the registered Nurse Community integration consultant.
In the past, our team lead.
So the work we do with adults, children, well, ID adults and children, and then the serious mental illness population in terms of the pass, our process is the same.
With a, a few little caveats in in there, the adults are considered anybody age 22 and up we see.
And we see the gambit.
We see all the way. I think the oldest I've seen is 95, I think.
So we see every every aspect of life.
I think I don't know how many of you know much about the the pass our process, but the goal of the program is to just optimize their placement success, their treatment success and their quality of life when they're in a nursing facility. It's federally mandated for all those.
That.
That have a diagnosis of an intellectual disability, serious mental illness or related condition, or some sort of combination of all three, two of them, whatever it may be.
So there's a level one process within the pasar process and that's typically done at the hospital or the their community setting. The Health department will do that if they are in the community as opposed to a hospital.
Any any results from that?
That will either confirm that there needs to be a level 2 for them to go into nursing facility level 2 evaluation, or.
It'll say Nope, they don't meet.
Pass our criteria, but that doesn't necessarily mean they can't go to the nursing facility.

That just means they don't need the passenger, which stands for. By the way, pre admission screening resident review.
I should have gone into that original so that level 2 screening will do two things.
It'll either confirm or discredit the results of that level one.
For example.
Sometimes we'll see.
Yeah, they have this, this intellectual disability diagnosis. However, they were diagnosed after the age of 18, so that takes them out of the pessar population.
That doesn't say they don't have the diagnosis and that they can't go to the nursing facility.
It just says they don't fit past our criteria and they can move along to the nursing facility without a pre admission screening. And the other thing is.
For a related condition, as Christina mentioned earlier.
They have to be diagnosed prior to the age of 22 for that for them to fit past our criteria.
That's just another little piece and then that Level 2 screening. The other thing that we'll do for those with a confirmation of the serious mental illness, intellectual disability, or related condition that will determine if the placement is appropriate and identify any recommended services.
To help help them while they're in that nursing facility.
When somebody needs a level 2 assessment, that level one will be completed by either the hospital or the the community.
Health Department and Dbhds has a contracted company currently that's through MAXIMUS.
So the level 1 assessor will then send that.
Level 1 assessment to the contracted company, along with a current history and physical that was completed within the last 12 months.
Including like physicians, orders, treatments and medications.
They'll ask for contact information and names and addresses for family or guardians, if that's applicable.
Admitting nursing facility, if that's known.
That's not always known.
A current psychiatric evaluation also completed within the past 12 months, if if the person is being admitted for a serious mental illness.
IQ testing if they have that also if that's applicable and any other additional clarifying

mental.
Or physical information that will help us get a better.
Full picture of that person.
Like a well-rounded, holistic approach type.
So once that is completed, Maximus will then send us through a portal that we have called Assessment Pro.
They'll send us that whole package.
You know, and then wrapped up in a little bow with a level 2 assessment that's completed by an independent contractor that they have.
Through Maximus and they do this level 2 assessment and it's a full history of their social standing, their medical standing, their adl's their iad LS their any psychiatric.
Background IQ testing if that's applicable as well.
And just a full picture of of who they are and where they are and what they are dealing with.
Once that's all completed for the pre admission screening, they send that all to us.
And we, Christina or myself, or Navya, who is our mental health coordinator, will write a summary of findings, which is essentially just taking all of the information in that beautiful package that they've delivered to us and summarizing it to the best of our abilities. We recommend any Serv.
That are needed.
And then any specialized services that may be necessary to help meet their goals.
In the nursing facility.
The It's a similar process for the resident review, however, obviously that person is already in a nursing facility, So what is sent to us instead of the UAI is the MDI. The most recent Md's that's completed, as well as all the other information that's been that I.
Discussed and then the only difference with that is MAXIMUS will write that summary of findings.
And we go through and review.
You edit, make changes that as we see fit. If something doesn't add, right we.
Will ask Maximus and for some clarifying questions and then.
Whether it's a pre admission screening or resident review that then gets sent back to the referral source, whether it's you know, the the hospital or the health department or the the current nursing facility, whether it's past our or pre admission screening or resident review.

I know I spent a lot of information at you before I move forward.
Is there?
I know there could be Gray area and there's tends to be a lot of questions, so if anybody has any please feel free to raise your hand.
Throw it in the chat or however you guys like to handle that.
And then if there's nothing, I'll keep going.
I don't mind.
So just just to give a little bit of numbers, I don't have all of them in front of me at the moment, but I do have some we did in quarter two of fiscal year 25, we had 112 adults go through the ID pass.
Our side.
Pre admission screening. So 112 people in three months were screened.
To go into a nursing facility and all these individuals were found to have met the level 1 criteria and the level 2 criteria to be admitted.
Now, the caveat with that is that doesn't mean they were admitted.
That means they went through a process.
Some of those people will go home.
Some of those people, unfortunately, will end up passing away before they move out of the nursing or the hospital.
Some of those individuals end up in a group home instead.
It just depends on on what happens.
After after they go through that screening process.
The other numbers I currently have right in front of me we had.
In that same quarter, we had three individuals that were diagnosed with a serious mental illness and or well and an intellectual or related condition, intellectual disability related condition.
So that was actually a lower number than it typically is.
We typically see about 5 or 10 per quarter of individuals that are duly diagnosed.
Going through the pre admission screening process, as far as children in quarter to fiscal year 25, we had five children go through that pre admission screening process.
One of those children passed away prior to admission and the other four were admitted to a nursing facility.
So you know that that number, especially with children, tends to ebb and flow quite frequently.
I've seen it where we've had one or two.

And I've also seen where we have, I think the most I've ever seen in 1/4 is 8 in the 8 years I've been here.
So that's kind of fun.
The mental health population for us is quite similar.
I mean it is the same process.
I will say we tend to see more people more frequently or the same people more frequently.
You know, unfortunately that can be a bit of a revolving door.
I don't like that term.
Term, but it's it kinda explains that we tend to see a lot of the same people.
Any questions?
No. Well, if you think of any, feel free to reach out anytime. I don't have the rest of the numbers in front of me and I apologize.
But I can get those to you if you would like some.

MS **Moon, Susan (DBHDS)** 43:49
That's OK if you send the numbers, I can get the numbers from you and we'll get the numbers about kids, adults and Deedee and mental health.

RL **Rogers, Lisa (DBHDS)** 43:50
Susan yeah.

MS **Moon, Susan (DBHDS)** 43:59
And then we can add it to a slide deck that we started to build and and will be presenting again next week with some additional slides.
So we can add those slides to my slide deck and then we'll have a comprehensive picture to kind of walk people through to give everyone an update.

RL **Rogers, Lisa (DBHDS)** 44:08
OK.

MS **Moon, Susan (DBHDS)** 44:17
I think at the start of our next meeting.

Rogers, Lisa (DBHDS) 44:17
Great.

Moon, Susan (DBHDS) 44:20
Does anybody have questions?
And Lisa?
Just curious, do you have insight as to why nursing facility is chosen?
When you do, the resident reviews for pasar, what's some of the like?
Why the nursing facility settings would be chosen versus?
Other community based settings, even an ICF setting.

Rogers, Lisa (DBHDS) 44:51
I I feel like that's the $1,000,000 question in some senses, specifically with the kids.
I think some families.
Some families just get very comfortable with that nursing facility setting, even if they are educated and know that there are other placements.
I think sometimes it's the fear. I do think sometimes people don't know.
You know, I think.
I don't know.
I I wish I knew the answer 'cause then I'd try and fix it and change it.

Moon, Susan (DBHDS) 45:24
Yeah. So even with the adults that are in currently residing in nursing facilities, you find the same. Their families are comfortable with their residential stay in the nursing facility and it's the fear of change.

Rogers, Lisa (DBHDS) 45:24
But yeah.
Mm hmm.
Yeah.

Moon, Susan (DBHDS) 45:40
Is that what you're referring to?

Rogers, Lisa (DBHDS) 45:42
I think a lot of times it does have to do with that.
You know the the conversations that happen just in some of the assessments we see, they're like well, no, they've been there before.
I'd like them to go back there, you know, and even. And especially for a lot of the kids. But I see it with adults, that their families put them there and leave them there.
And that's, that's where they're going to be.
And they're happy with it.
And that's that.
They don't want the they don't.
They don't want them at home because they.
Unfortunately, and this is some of the saddest things we see is where you know, having an individual at home doesn't fit their lifestyle.
They don't want to have to take care.
They don't want to have to deal.
I see that and I hate that and I know Christina can attest to that as well.
And I think they know that they're in a place where there's medical staff that can take care of them and and they know that they're taken care of.
And I think you know, it's that fear of, well, I don't want to do wrong by them, but I don't want them.
I don't want them to be my burden.

Moon, Susan (DBHDS) 46:47
Right. So you still have a question and I don't remember the answer to this question.
So I'm gonna ask a question.

Rogers, Lisa (DBHDS) 46:48
Yeah.
Yes, ma'am.

Moon, Susan (DBHDS) 46:52
I don't remember the answer to.
Not a very good attorney.
Attorneys never ask questions they don't know the answers to.

So I do know and I think this is accurate, that when a child is living in a nursing facility and they would like their their guardians.
They'd like to choose a community setting.
The support coordination services from the CSB can become involved.

Rogers, Lisa (DBHDS) 47:19
Mm hmm.

Moon, Susan (DBHDS) 47:21
I want to say it's 180 days in advance of the discharge date.
Does that exist?
Is that still true?
And does that exist for adults?

Rogers, Lisa (DBHDS) 47:31
So yes, so?
We for for children when when we get a pre admission screening. Christina typically I I help when I can or when she needs me. We'll send what we call an awareness letter. So the CSB knows that there's a child from their catchment area that is either going to a nursing facility, has been screened to go through the nursing facility, whatever it may be and and they are probably going to need services at some point.
Services assistance of some sort at some point.
So the CSB is fully aware of the children.
They are also aware of adults that go through. John Clay is our program specialist.
He sends the ISP S.
No, no, not ISP S.
He sends an individualized plan of some sort, and I don't think it's it's it's not the same as the other ISP stuff. He sends something.
To the Csps, letting them know, hey, these individuals are also in your catchment area and may need services at some point.
So the CS BS are aware and can get involved at any point.
For children specifically, when they're when we are notified of their potential discharge, children and young adults.
When we're notified, Christina.
When Christine is notified.

The goal is to get the CSP involved as soon as possible.
We do send an action letter.
When they are Christina, correct me if I'm wrong.
Is it 180 or 120 days out?
I think it's 120 days out from discharge to make sure that they are involved and to make sure that they're ordering the equipment and doing all the things to help educate the family or guardian, whoever may be in place and to ensure that they get.
The services to be successfully discharged in the community.
So Long story short, yes, support coordinators are aware that these individuals are going into facilities and may need their assistance at some point from the point of.
Pre admission screening being completed.

MS **Moon, Susan (DBHDS)** 49:42
OK.

RL **Rogers, Lisa (DBHDS)** 49:42
Did I answer it or did I go round about? I feel like I went round about.

MS **Moon, Susan (DBHDS)** 49:45
No, I think you did.
I think that the threat I was the threat I was pulling on is a thread that.

RL **Rogers, Lisa (DBHDS)** 49:46
It's been a long 2 days.

MS **Moon, Susan (DBHDS)** 49:52
When Pasar was in the Office of Integrated Health, we spoke about frequently and that is that having support coordination with the through the CS BS more actively engaged even with the adults in when they express a desire to explore community options and discharge planning could be valuable versus.
Depending solely on the social workers.
In the nursing facilities to to provide all of that guidance.
So I was just sort of exploring some of those ideas in my brain that we've talked about in the past as to how to a educate nursing facilities a little more about the community options and also to bring for bear some of the resources that exist in our.

Rogers, Lisa (DBHDS) 50:23
Mm hmm.

Moon, Susan (DBHDS) 50:37
Community service boards to kind of help with that kind of as a transition philosophy and we do more of that.
Transitioning when we're talking about children and we use that word more also than we do when we're talking about adults. We don't necessarily talk about it as much as a transition as it's a, it's a discharge from one point of care to another.
So I was just mulling that over in my brain in terms of recommendations for this this committee's work.

Rogers, Lisa (DBHDS) 51:02
Mm hmm.
Right.

Moon, Susan (DBHDS) 51:08
Cool. Thank you.
Does anybody have questions for Lisa or Christina?

Alabanza, Susan (DBHDS) 51:14
I have a question and this is this is just more kind of subjective but.
We do have a lot of families who are comfortable with the care that they've received at Hiram Davis and don't want their loved one to move. And I know that that's what a lot of families are experiencing in, in community nursing homes too, which is very understandable when.
You feel like you have caretakers who are reliable and providing.
The proper care.
I just was curious if you've seen an increase in the number of families who want their children to stay in nursing homes.
Also, because of just the the lack of staffing in so many areas.
You know, in healthcare, of course has been hit really, really hard.
And one thing we've heard from families is what if I take my child or my loved one?
On home or someplace and they have, you know, a shortage of staffing. Then I can

have.
I could really be in a bind and have difficulty providing the right care in general.
I know there's lots of different situations, but I was just wondering especially we saw the the staffing concerns really increase with COVID-19 and have you seen an increase in the number of families with children that are are making those kind of assessments?

RL **Rogers, Lisa (DBHDS)** 52:34
Mm hmm.
I mean, we've had families even before COVID say.
Well, I mean, there's a specific example in my head, you know, and the exact family that they had him at home and he was doing great and then nursing didn't show up.
Nursing didn't show up.
Nursing didn't show up.
They couldn't maintain, so he had.
He got admitted to the nursing facility and they wanted to bring him home but they couldn't get any any nursing and they were in a fairly populated area.
They couldn't get somebody to stay, stay on. And, I mean, I've met them. I had talked to the. It was the grandma and Grandpa raising the child and they were wonderful.
I mean, their house was Immaculate, everything, and it was just they couldn't keep the nurse position for them staffed.
So I mean that was even before COVID Christina.
I don't know if you've heard of anything.
More since COVID.

GC **Gleason, Christina (DBHDS)** 53:39
So I would say, Susan, your question was what?
What are we seeing as far as parents wanting to bring their children home but don't feel like they can?

AS **Alabanza, Susan (DBHDS)** 53:52
That's part of it.
Or if they you know if they're scared, if the staffing levels even at group homes might be.
More scarce than what they are experiencing in a nursing home.

Gleason, Christina (DBHDS) 54:04

100%.
So, so many of our password children are ventilator dependent.
If you've never worked with an individual who is dependent on a ventilator, that can be very intimidating.
So that's intimidating. As a parent who has learned all of the things there is to learn about your child's condition.
And has researched it to the nth degree. It's it's still.
Intimidating. So then you couple that with known challenges in the community.
So many of our parents did try to bring their children home.
We also have a number of children who went from the delivery room to the NICU to long term care because their needs are so complex, coupled with family dynamics such as things I mentioned before, parents incarcerated parents with their own serious mental illness.
Or conditions that.
Affect their ability to provide care.
Yeah.
So I see.
I feel like yes, there are families who who want to bring their children home, but it it is incredibly scary right now. You have an attending, you have nurses, you have cnas, you have staff, you have rec therapy, you, you have everyone there to just fully wrap around.
Your child and you know.
That they're going to be safe.
And our families are spread out, the Commonwealth is.
Rather interesting from the mountains to the beach and everything in between, and the different types of hospitals that go from, you know, border to border.
So I hope that answers it.
I would say it's not just the families are comfortable.
It is.
It is a fear of what will happen specifically. We have so many event dependent.
Children and that is rightfully an intimidating scenario to take a child home on a ventilator.

Moon, Susan (DBHDS) 56:17
Yeah, Susan Albanza, that was a great.

Gleason, Christina (DBHDS) 56:17
I hope.
I hope that.

Alabanza, Susan (DBHDS) 56:18
Thank you.

Moon, Susan (DBHDS) 56:19
That's a great question and much like Robert's conversation about Cvtc and some of the ADA requirements and some of the environmental and regulatory things you need to consider are families that are taking children or adults home from hospital that are that require ventilator support either 24.

Alabanza, Susan (DBHDS) 56:21
Thank you.

Moon, Susan (DBHDS) 56:42
Hours or even.
For limited hours, if ventilator support is required at all.
There's a need for household generators and backup equipment and lots of additional tubing and equipment in terms of maintaining tracheotomies and and trache tubes and trache sets and respiratory therapy consultation to the home and things. And so there are a lot of.
Additional safety.
And household modifications that often need to be made that that complicate your discharges.
Right, Christina.

Gleason, Christina (DBHDS) 57:19
Sure. And again you add in all of the variables of the families that we interact with socioeconomic status.

Do you own your own home?
Do you rent?
Are you even able to make those modifications? 1 financially or two through a landlord?
Is it suitable?
The ventilator dependent children are supposed to have their own rooms. Is that feasible?
For what the family can afford.
There's so many layers, and the ventilators really are a tricky scenario.
For for getting the equipment.
For getting your tubing, getting those orders placed is your order going to come in on time?
Was it shipped on time?
Was it delivered on time?
It was it missing pieces of the order.
There's so many things for just that one. One family to, to have to consider.
For their.
For their child.

MS **Moon, Susan (DBHDS)** 58:20
Thank you very much.
So we're we're happy to welcome, if you don't mind, I'll just enter.
I'll just introduce and welcome Mrs. Bryant, who's a family advocate and the mother of a young man who currently resides at Hiram Davis Medical Center.
Took a little liberty to introduce her.
I understand that she has joined Jarvis Griffin in his office at Hiram and has a question.
So, good afternoon, Miss Brian.

GJ **Griffin, Jarvis (DBHDS)** 58:50
Good afternoon.
I have lived experience with two sons who've had trachs.
They didn't have trachs at the time they were at home. However, when we left neonatal after 10 and 11 week.
Discharge as we came home with oxygen with apnea monitors.

While they were still at home, they had gotten.
Surgeries we came home with orders for 24/7 nursing supports in that realm of CSB, case management and.
Waiting to be on waiver, which at the time didn't exist for children.
We did family only care for two years.
Their pediatric ICU was two hours away.
We did a lot of transports in the car with somebody would have to drive. I'd be in the back seat with oxygen, with somebody having a seizure or asthma attack trying to get to Richmond.
So.
We're very fortunate to be in excellent facility care here where I'm not the cook, the bottle washer, the nurse, the mother, the transport, the bill payer, the educator.
I will say case management is weak in terms that a case manager just has to have a college degree.
They don't have to have any healthcare degree, so we have many.
Liberal arts case managers, who would rapidly turn over if they got assigned the Bryant case.
I would just say that even when we were facing CBTC discharge the most we were ever offered was to rent A basement apartment.
So we're not in a rental apartment situation and I remember.
What the neonatal discharge?
We actually saw a 2 year old still in neonatal at UVA because she was going to be a trauma event and couldn't live in like Bristol.
So rural.
Rural Healthcare is definitely a barrier. Even though I live 45 minutes from a city, you have to think about where the pediatric medical centers and a lot of times that's not even in your local hospital.
And I will say some several things are disappointing if you're not at that high medical technology point of view.
I have met a mother through the Mac Medicaid Volunteer Group who's done a facility admission.
For a teenager, and she said she can't get staff to her home when you're paying wage of like, $12.00 and something like that to take on an incontinent person.
Who's ambulatory with behavior in a rural setting?
So I'll St. you know when we look at what is minimum wage, we had a veto on the

$10 million for additional nursing facility staffing.
So this is not a nursing friendly.
Administrative environment.
I'm very pro nursing it and one of the things nationally that we're working on with VOR net, which is a national advocacy organization, is to get the federal Department of Labor.
To understand that a direct support professional should not be a minimum wage reimbursement and then when you have a nurse in your home hired through an agency, they are on hourly wages. They don't have benefits like insurance, retirement, paid days off.
So I will say an air home setting of 30, some nurses who came through our door, only three were considered regular if we.
Out of hospitalization, that meant they got no work, no pay.
It's hard when you have intermittent hospitalizations to retain staff.
You have to have staff who are willing to travel.
They eventually did get mileage reimbursement because of the distance that most of them lived in a city and were commuting out to the county.
But like I said, it's unequal employment environment for the for the employee point of view.
Why would you go from a facility based job where you get vRS retirement Anthem insurance?
You know, paid holidays, sick leave, whatever. To be an hourly employee of a nursing agency that's under contract. And then for three days, a sign per week that.
We're going to be staffed despite what the physician order said.
24/7 we got Tuesday, Wednesday, Thursday.
So when these nurses pick their schedule, they're not picking Friday, Saturday, Sunday holiday weekend, Snow Storm, Tornado watch, hurricane.
And primarily had to use a nurse for us to even go up to UVA specialty appointments.
Because I was the driver in a wheelchair van.
And they had to be in the back.
To be able to suction or whatever, and I recently told a story about at one time we actually transported in a bus like a wheelchair bus and the pass the passenger seats for the bus were in the front, the wheelchair tie down was in the back and my.
Son had a seizure way to pull off on the side of Route 29 to work on this child in the

floor of a bus.
So you know, some lessons learned are ambulance transportation.
With professionals, we're going to do an office visit to VCU tomorrow.
We will have to have suction and oxygen from the office because the office doesn't have the oxygen in the suction even though we're going to transport.
By ambulance, we're going to take a Hiram nurse with us so that we get nursing care in the office setting.
And you know, still for a transport between Petersburg up to downtown Richmond.
We're allowing an hour for the pick up the load the unload, get to the 11th floor on time, which VCU has a very tight window. If you're late, you don't get seen.
And I was really surprised this year in terms of ADA, we went to a VCU Broad Street office where we had to be seen in a lobby because there wasn't stretcher accommodation.
And on a particular floor.
So Ada, even in a modern building, we're not there yet for a structure so.
I have a lot of lived experience and I choose facility, DB heads care. I would say that most people coming into training center admission enter as children.
My son's admission was at age 2 when their father had his second heart attack like he had his heart attack on a Friday. I did a Saturday morning admission, having three sons at home and a a husband and ice with his second heart attack.
Because I was the the the nurse for everything but Tuesday, Wednesday, Thursday and.
Used to be.
I need some sleep.
They have to have awake nursing, not just training, not just a consult to teach you what to do.
But parents can't stay awake 24 hours a day.
Even you know with high caffeine.
Too, to be the provider.
I really think you're facing an aging out tsunami and it would be worth looking at when is the average age of entrance to a training center.
What's your length of stay?
OK, my son's entered at age 2 in 10 months. Taylor's 31.
But if we look in in the CSB window, we entered CSB.
World at neonatal discharge.

Because then they were eligible for early intervention, which was is federally mandated. And even at that, even though you're coming into a federal mandate, we had to wait nine months until the new fiscal year began.
They were born in January. The fiscal year began in July.
Then we only were offered one service, like they said I could choose either OT or PT. No nursing.
And I will just say the logistics, we use 5 pharmacies, OK, in order to get the supplies, we need it.
We actually sometimes got mail order supplies, but we used five pharmacies to just get what we needed.
Logistics.
Logistics.

AS **Alabanza, Susan (DBHDS)** 1:08:11
You bring up a lot of good points, Ms. Bryant and.

GJ **Griffin, Jarvis (DBHDS)** 1:08:13
I would like to.
I've submitted a lot of documents and I want to highlight a couple.

AS **Alabanza, Susan (DBHDS)** 1:08:16
I.

GJ **Griffin, Jarvis (DBHDS)** 1:08:19
I'm sorry I'm a little late joining.
I wanted to see Taylor when I first got here.

MS **Moon, Susan (DBHDS)** 1:08:24
Now, Mrs. Brian, it's fine. Lauren and I had a chat in the background.
So you don't, don't worry.
And had said we wanted to provide an opportunity at the end today also for public comment and we only so everyone knows we only have one more item today that Susan, Alabama has some numbers related to the vcbr.
Residents at Vcbr and she gonna offer that information in closing today, so.
So the floor is yours. We we're hoping that that our family advocates would arrive

today and we would benefit from some of your thoughts. So we can structure our agenda for next time.
So the floor is yours.

Griffin, Jarvis (DBHDS) 1:09:09
Yeah, we made it a point to get you down here, OK there.

Moon, Susan (DBHDS) 1:09:12
Yes.

Griffin, Jarvis (DBHDS) 1:09:15
There was the United States Senate.
Study and I believe it was released in December of 2022 talking about the negative effect of private equity in nursing facilities and the bad quality of care.
And unfortunately, some of those sided cases are Virginia stories.
And there have been additional stories even this week.
Again, both from the long Term Care Ombudsman, Jenny Latimer, about poor quality in Virginia nursing homes.
So when you start looking at ratio of providers or the difference between private, private for profit equity firms who own facilities and DB heads operated facilities, this is.
A quote. And there's Melissa Hippolett and Wtbr have done wonderful.
Work on investigative journalism, but basically one position has 31 private for profit equity caseload. OK.
So most nursing homes or 100 beds or more. So now you're talking about one physician who has over 3000 patients.
There's no way the quality is equivalent to a DB heads operated skill.
Nursing facility or training center.
I've long touted that training centers are unique populations. I've recently read an article. All of it, also about dementia.
Saying that Ers are so poorly equipped for dementia, with particularly with dual diagnosis to mental health, to where people are having delusions or paranoia.
Yeah, and people are boarding in Ers.
There's also been a tragic suicide of a 10 year old.
With bullying in Roanoke and and and that investigation.

They were saying a 75 day wait for a pediatric psychology psychiatric intervention and also what is the best practice for a school for bullying and suicide awareness? Even in younger, she's an elementary school student at age 10.
So often we think about mental health in schools as teenagers.
But when you have a suicide of a 10 year old and you've waited 75 days.
You know, unfortunately, we have this tragic death.
So whether you're on the pediatric end of things with these technology kids or the autism wave, I also submitted the latest thing the Rob Kennedy junior.
A press conference from CDC about autism is now one in 20 males, one in 31 females. That tsunami of autism is out there, and I understand that autism has a whole continuum of care.
You can be mild.
You can be adult ADHD.
But when you get that mix of profound intellectual disability and autism.
Then you have a population that's gonna need to be served.
And I actually have my former students and I was I'm a retired nurse educator. When I'm in the Walmart parking lot, I have people coming up to me telling me that they can't get services for their, for their children, and they're trying to turn to me as a.
Resource. What should I do?
How do I get service on one of my nursing students?
Cannot work 12 hour shifts. As a nurse, she's had to change careers.
Because her son can't be without her.
For her to even go to a 12 hour shift job.
Oh, and I will just bring up pace.
Pace is long, you know, program of all inclusive care for the elderly, but usually pace has a morning pick up and a afternoon drop off. That's not even an 8 hour day. If you're taking care of somebody who's elderly because they're only going from home maybe six hours.
A day. So when you look at day support on the community model versus.
A facility model.
It's not.
Equivalent.
I don't know. I I have to say I spent part of the weekend in an emergency room with my mother and she was in for a medical issue, but we had a psychiatric young adult next to us, and I heard the F bomb a lot and this this.

Toxin toxic environment of behavioral and medical in the ER, side by side. I was very grateful to get up to a floor and get my mother in a private room.
So we could get some sleep and get away from the ER environment.
And our city really had little to offer on on a Easter Sunday or even the next day because.
In the Lynchburg Environment, Easter Monday is a holiday.
We got a lot of people off.
I will say this is a true story of the VCU pediatric ER.
For me to take a child to a bathroom, I had to search floors to have a da bathroom to get a wheelchair of the child and me in the same bathroom.
So the main lobby, I learned, has ADA bathrooms. The er left ADA bathrooms.
I mean.
Ada is very vital and turn radius when you're talking about typical homes. Turn radius in your hallways.
Turn radius in your doors.
We just had tornado, you know, planning. OK, so homes that don't have basements or don't have egress that whole slope issue of what is a ramp.
We had a one story house.
With two steps to an entrance.
We we could.
We ramped our ranch style house and bought a bought a van.
But.
I can say.
For US, facility based care has been the miracle.
For them, for for the individuals as well as the family.
And.
On site services major, this whole concept of we've had lived experience with that. I think I reported that on one lab that was sent out, it took six days to get the result.
OK, people can't wait six days to figure out what their lab result is.
So.
It's challenging, it's very challenging.
It's very challenging and the dynamics are just as unique as they are per individual.
Clearly, do we have some opportunities I think in the Community.
Well, then, I think integrative health has done a lot of work on.
High risk conditions. What?

What are the complications for a person?
Whether it's aspiration pneumonia, whether it's pressure ulcers, where it's whether it's.
Constipation, whether it's elopement.
Recognizing symptoms in the nonverbal person.
You know what is early intervention?
I just this today I've heard of a story of a person who went to standard nursing facility pressure ulcers within a week. When people sit in soiled.
Things, or they're put in a wheelchair in the morning and they're not put down to be changed and they sit in soiled clothes for hours.
You can get pressure ulcers within days.
It doesn't take long for.
Deterioration, right.
And then then then you can get a septic depth.
That's always a challenge for non inventory folks and if particularly more so with nonverbal as well.
Well, and one of these wtvr stories.
Had quotes from the nurse's cell phones about if you were nonverbal, you didn't get expletive.
And then they also talked about stealing drugs.
On the tax, what drugs they were stealing, I guess for.
Use and we have based near death experiences with termination of drugs, lack of available drugs, often on a for profit, hospital admission or even nonprofit. They they just reimburse on that primary admitting diagnosis and you can lose your drugs for your other chronic conditions. OK, so drugs that.
We get omitted seizure drugs.
Hypo. My son takes potassium.
Replacement drugs, metabolic drugs.
So he needs Synthroid for hypothyroidism.
They all dropped so within three days of being in hospital, he's getting complications of seizures and low potassium because those standard maintenance drugs got dropped because of the DRG.
So.
I mean.

Moon, Susan (DBHDS) 1:19:19

So Mrs. Bryant, this is Susan.
Lauren is flagging us that we have 10 minutes and so I wanted to capture, though I think that you have hit a topic we have not talked about in the subcommittee really yet and that is the challenges in reimbursement.
I mean, we've touched on it, of course, as I think that every public comment has touched on this issue. But I just made a little list.
That maybe next time we will take a section of our agenda.
And actually break out some of the community concerns.
And take a little bit of A twist to reimbursement.
Take it a little bit away from rate structures and rate studies and look at reimbursement related to the drg's and drugs related to specifically to some of the metabolic drugs and some of the supplemental drugs like potassium and other things that can be overlooked in different setting.
We discussed earlier prior to you joining incontinence care supplies.
You joined.
We were talking a little bit about some of the challenges in reimbursement around oxygen equipment.
Trach, supplies and so forth.
So I think that.
And I know Susan Alban has been messaging me in the background also that we can build out. I think some of these topics for our next discussion.
And may even reach out to you in the interim here to ensure that a lot of these topics that families.
Have have experience then we are also reading in the news. We kind of organize into a an agenda so we can hit them in a in a well thought out sort of pragmatic deliberate manner.
If that's makes sense.
Yeah.

Griffin, Jarvis (DBHDS) 1:21:21

Even even even if they wanna open, they're getting D mass denials.
We've had two denials within the last 18 months, I would say where I'm paying out of pocket. I brought in a supply that I saw with my mother.

Moon, Susan (DBHDS) 1:21:32
Mm hmm.

Griffin, Jarvis (DBHDS) 1:21:39
That is a upgraded supply.
That.
That would be beneficial.
And well, and I think you also have to look at.
All these D mask cats, and if we think the caps are something now, just wait. When we when we pull tariffs into it.
So actually I said to somebody that one of my son's supplies is made in Puerto Rico, Puerto Rico's got electricity issues.
A lot of PPE is China.
America doesn't have redundancy or manufacture of a bunch of these supplies.
Us, we're we're importing all this stuff, so supply chain is.

Moon, Susan (DBHDS) 1:22:26
Mm hmm.

Griffin, Jarvis (DBHDS) 1:22:32
Is a problem and and I think there at one time I think there used to be a $2000 DME cap for Dmas.
All right, so 11 wheelchair is more than $2000.
I mean, for an adaptive that you know, a custom fitted mode or something. I mean so like when I look at, I told the legislator when we were in Taylor's room, I said look at this room.
This is probably $15,000.
Of equipment.
One thing I do want to bring up is with the southeastern move. There's right now, there's no incentive for anybody to relocate.
There's no recruitment, no. Basically, I feel like the expertise is undervalued.
I have heard that there are staffing accommodations that Catawba Mental Health Hospital.
Or.

So if if you accommodate staff at one facility and you're going to have a major relocation but you're not offering that for different population and a different thing. I think I think we can't afford to lose all this expertise and I want my son to have continuity and on site services.
So I mean, I don't.
I don't see the department stepping up.
I don't.
What I read is we're going to go to contract this and contract that. I've lived through contract and I know how bad it fails.
Just like like like formulaies of drug stores like, OK, so like vaccines. OK, that's on a contract.
OK. If if Hiram Davis, if we need a something, it's here in our pharmacy.
It's it's not like a two day clinic and you only get 2 opportunities in a year to get something that's not a reasonable model for people who are being admitted over time and and if you look at system wide capacity.
You're the only hospital system that I know of that's reducing capacity.

MS **Moon, Susan (DBHDS)** 1:24:46
That's a good question.
I don't know the answer to that.
That'll be another data point that will pull up Mrs. Bryant for our next for our next meeting. I really hate to.
We have 4 minutes.
Lauren's gonna start bringing an actual.
Bell, she'll start.
She's gonna start to have sound effects.
Here and I do wanna ask I wanna pass this back to Lauren, but I'll. I'll pass this to her with an open question to everyone. If anyone here has a question.
Or a topic they'd like to add.
To the agenda for next month, in addition to the ones that I have made a list, I know other people.
Lauren's probably making a list of topics that Mrs. Brian has presented, so back to you, Lauren.

CL **Cunningham, Lauren (DBHDS)** 1:25:36

I was gonna say while people are kind of thinking through any topics they wanna cover, I'm gonna drop into the chat. The link to the planning team page on the Hiram Davis website, you'll be able to find a recording of this meeting up there later this week. A.
Transcript but I also wanted to remind you all we have the planning team e-mail address that you can find there. If you think of something after this meeting between meetings, if you have a question you wanna reach out about between meetings.
You can reach us through that e-mail.
Address as well.
Did anyone want to share anything before we?
Wrap up.

Griffin, Jarvis (DBHDS) 1:26:16
No, but I just want to let Miss Bryant know that we're planning to have the piece of the presentation that we that you missed out on as far as the training center possibility and infrastructure needs.
We're gonna hopefully get that on the agenda for the next Family Council.
So then we can kinda cross populate and we can get that feedback back to Susan and team.
As far as families input, I have one final data point that I've read while I was.
Awake at night in the hospital, and that was the.
Mortality Review committee.
This was by Doctor Bob Anthony.
So he's he's done. Different submissions through federal court.
But basically.
When people transitioned in the closing of the training center, we had a 7 to 10% mortality problem.
And.
With Hiram Davis transfer coming from CBTC to Hiram, we had a six ton death rate risk.
The transitions.
Changing providers going to a different environment with different expertise.
That's something to avoid that those are scientific.
Studies. He's an analyst.
He was part of the settlement agreement in our court efforts.

It's expert testament.
There's also Susan earlier had talked about.
Reimbursement for maintenance, what is skilled nursing reimbursement?
And there's a Supreme Court case, I think it's called Jim old or something.
Anyway, I sent that link, it's.
You Medicare will reimburse for maintenance.
You don't have to make progress.
So that's kind of a misunderstanding, but there's a Supreme Court precedent.
So you can reimburse for maintenance PTO T.
Thank you.
Thank you, Miss Bryant.
Appreciate you.
Well, I think you heard it from our end.

CL **Cunningham, Lauren (DBHDS)** 1:28:35
Thank. Thank you, miss Bryan.
Thank you, Doctor Griffin and season and season. Thank you both so much for for Co leading the subcommittee.
We'll be in touch very soon with our May meeting date.
I think you have that link in the chat.
As I said, if you have any questions or things you want to share between meetings, hdmc planning team at dbhds.virginia.gov is the e-mail.
Thank you all so much.
Hope everyone has a good afternoon.

GJ **Griffin, Jarvis (DBHDS)** 1:29:02
Thank you.

AS **Alabanza, Susan (DBHDS)** 1:29:03
Thank you.

MM **McGuire, Meghan (DBHDS)** 1:29:03
Thank you.

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