Transcript

April 17, 2025, 5:00PM

Cunningham, Lauren (DBHDS) started transcription

Cunningham, Lauren (DBHDS) 0:11
Alright, 1:00 PM.
We'll go ahead and get started.
Thank you to everyone for joining us today.
You know, we've got a lot to cover, so we will get right into some quick introductions.
I'm Lauren Cunningham, communications director at Dbhds.
I'll turn that over to you. Our Co leads, Heather.

Rupe, Heather (DBHDS) 0:29
Hi, I'm Heather roop.
I'm the director of Clinical services at DBHDS.

Cunningham, Lauren (DBHDS) 0:34
And Nicole Russell.

Russell, Nichole (DBHDS) 0:36
Good afternoon.
My name is Nicole Russell.
I'm the physical therapy director here at Harm Dave's Medical Center.

Cunningham, Lauren (DBHDS) 0:41
OK. And then I'll just go down our list quickly.
We've got Robert.

Johnston, Robert (DBHDS) 0:47
Good afternoon. Robert Johnson, director of Environmental Care Facility Services division of Central office.

Cunningham, Lauren (DBHDS) 0:53
Megan.

McGuire, Meghan (DBHDS) 0:56
Hi everybody.
Good afternoon.
It's my name is Megan McGuire.
I'm the deputy Commissioner of policy and public affairs.

Cunningham, Lauren (DBHDS) 1:04
Angela.

Harvell, Angela (DBHDS) 1:06
Good afternoon, Angela Harvell, deputy commissioner for facility services.

Cunningham, Lauren (DBHDS) 1:12
Kimberly king.

King, Kimberly (DBHDS) 1:15
Hello everyone.
I'm Kimberly king.
I'm a Community integration manager with the Office of Clinical Services and I support Hiram Davis Medical Center in Southeastern Virginia Training Center.

Cunningham, Lauren (DBHDS) 1:27
Susan alabanza.

Alabanza, Susan (DBHDS) 1:31
Hi, I'm Susan Alabama.
I'm the clinical director of Hiram Davis Medical Center.

Cunningham, Lauren (DBHDS) 1:36
Vicky.

Brewer, Vickie (DBHDS) 1:41
Good afternoon.
I'm Beth rora.
I'm the admin of assistant with Medical Services Academy this month.

Cunningham, Lauren (DBHDS) 1:51
Brandon.

Charles, Brandon (DBHDS) 1:53
Good afternoon Brandon Charles, senior human rights manager for facility operations.

Cunningham, Lauren (DBHDS) 2:00
Tony.

Davis, Tony (DBHDS) 2:02
Greetings, Tony Davis, human rights advocate with the Office of Human Rights.

Cunningham, Lauren (DBHDS) 2:08
Eula.
OK, Tanya.

Henderson, Tonya (DBHDS) 2:22
Good afternoon.
My name is Tanya Henderson.
I'm director of pharmacy at Haramdagis Medical Center.

Cunningham, Lauren (DBHDS) 2:29
And Tanya Jones.

Jones, Tanya (DBHDS) 2:33
Tonya Jones, I'm so short here.
I'm Davis.

Cunningham, Lauren (DBHDS) 2:37
Sorry for that, Tonya.
I.
I saw you come off mute when I said the other Tanya's name and I I should have known.

Jones, Tanya (DBHDS) 2:41
No problem.
Thank you.

Cunningham, Lauren (DBHDS) 2:43
Miss Brian.

Martha Bryant 2:50
I am Martha Bryant.
I'm mother and guardian of sun and skill nursing with ID at Hiram and I'm from Amherst County.

Cunningham, Lauren (DBHDS) 2:59
Thank you, Dimitri.

Morton, Demetrie (DBHDS) 3:04
Hi this is D Moore.
I'm an occupational therapist. Hello, everyone.

Cunningham, Lauren (DBHDS) 3:12
Nicole Derose.

Nicole Durose, dLCV 3:17
Hello I am one of the advocates here at Disability Law Center and I'm just covering today. I think Aaron normally participates in these meetings and couldn't attend this one. So thank you.

Cunningham, Lauren (DBHDS) 3:27

Thank you, Nicole.
Sheila Sneed.

Snead, Sheila (DBHDS) 3:31
Hello. I'm shigla Sneed with Dbhds community integration support specialist with facility services.

Cunningham, Lauren (DBHDS) 3:42
Dominique.
Connie.

Wade, Connie (DBHDS) 3:59
This is Connie Wade.
I'm the social work manager.
Dominique is in the day room with the patients residents.

Cunningham, Lauren (DBHDS) 4:07
Got it.
Thank you, Connie.

Wade, Connie (DBHDS) 4:08
You're welcome.

Cunningham, Lauren (DBHDS) 4:10
And Denise.

Webb, Denise (DBHDS) 4:13
Hi. Denise Webb, Chief operating officer at Southeastern Virginia Training Center.

Cunningham, Lauren (DBHDS) 4:19
OK.
And with that, I'm gonna turn things over to to our our Co leads Nicole and Heather.
Do you want to say a few words before we get into the first presentation?

Russell, Nichole (DBHDS) 4:37

I don't have anything prepared to say.
I just want to say I appreciate everyone's time and attention and your willingness to be able to participate in this discussion for today.
So I thank you for that.

Rupe, Heather (DBHDS) 4:50
That's it.

Cunningham, Lauren (DBHDS) 4:51
Great. OK.
Well, our first presenter, we had had some questions I think at the last meeting.
About the the cost for for renovating the current Hiram Davis facility.
Robert Johnson from our division of facility services is here to talk a little bit about that. So I will turn things over to him.

Johnston, Robert (DBHDS) 5:14
Hello. Good afternoon everyone.
Good to be here.
If you see the screen I'm sharing, I'm going to go through a few slides to speak to the cost and the cost estimates we have.
Specifically, 94,000,000 is the current renovation cost for Hiram Davis and 145,000,000 for a full new replacement.
Wanted to speak a little bit to the background of history of Hiram Davis and and how we got here. And then I will jump right into.
The cost estimates and the basis behind the numbers that we have.
I'll try it this way.
So history and background on Heron Davis, Hiram Davis was built in 1974 and has had no major renovations. All building systems are nearing.
If not already exceeded their end of estimated life and we have had significant, we've experienced some incidents over time with sewage pills, HVAC, environmental control issues, Legionella and other the plumbing system.
Within the building is an advanced stage of deterioration.
It experiences frequent and numerous leaks that are increasingly difficult to repair due to the poor condition of the primary piping system, the sanitary system piping is cast iron.

It is severely corroded over time by cleaning agents use for infection control and for removal of organics from traps and drains.
That deterioration and corrosion is from the inside out throughout the system, throughout the extent of the piping, which makes proper repairs.
Very challenging.
The bathrooms and bathroom layouts throughout the facility do not comply with American with Disabilities Act, current code requirements and patient management requirements for private toilet accommodations as required by current standards, the electrical distribution system has reached the end of its useful life and lacks code compliance the entire.
System from primary switch gear to distribution and sub panels and circuit Breakers need replaced.
Due to age and lack of current code compliance, parts for much of the primary system are not readily available due to the manufacturing of the equipment or the age of equipment no longer being produced.
An emergency response responses system failure will be difficult. The number of outlets that are provided are not adequate coverage for the electronic devices currently in use, and this includes lacking ground fault protection. The elevators are beyond their useful service life. The original equipment manufacturer's is no longer. In business and replacement, parts are repeatedly are are consistently very hard to come by.
Our recent repair operation, we basically had to fabricate new parts.
From scrap to facilitate the repairs.
While the building is currently functioning, it does not need current codes and has antiquated systems.
The greatest risk is an event occurs that requires evacuation of residents and staff for an extended period of time, or that will require new certification. Under current codes, code read the triggers for code recertification could include CMS changing the conditions of participation and updating the minimum code stand.
To a more.
Building before it can be reoccupied or the building official for us, that's the division of engineering building from the Department of General Services.
The building determining that a proposed renovation or system update that we do try to undertake is of a magnitude that must meet the current building code.
So the current capital needs to renovate harm. Davis would require 94 million and a

two year evaluation of the building. Due to the nature of its construction, how the systems are integral to the infrastructure of the building enclosures itself. In addition, adding on to the new central.
State Hospital was explored.
This is not feasible because federal regulations state that an institution that is primarily for care and treatment of mental diseases cannot be a skilled nursing facility or a nursing facility.
Additionally, internal and external physical space and access needs for the new hospital building cannot fully accommodate the skilled beds that would be Co located on this site.
So that's history and background and if you will statement of need.
So now these are the assessments and cost estimates to date.
For Hiram Davis, Ficus is what does that stand for.
That is facility condition, facility condition, inventory.
And assessment system.
It is managed through the Department of General Services.
It basically assesses the buildings as an asset, what their value are and scores them on on need and and age.
So we had two FICO score score, we had two ficas scores done in 2015 and in 2017, the cost there is simply the asset evaluation of that of the hospital as a building that is not cost to repair.
Place. That's an evaluation of the physical asset of Haram Davis.
With those two findings, we then commissioned a professional consultant A&E firm, Architects from engineering firm, that would be Virginia A&E, who is Virginia A&E.
Our our agency has four different term contracts with professional consulting, architecture and engineering firms that were procured through an RFP that we renewed over 40 years.
Virginia, 80, is one of four they have a lot of experience in this type of work, specifically with Hiram Davis, and also they have experience with skilled nursing. They have done a lot of additional work for the agency over the years.
So we contracted Virginia A&E to do an assessment of the HVAC and plumbing systems cost replacement and that is the value you see there for 6,000,000.
That was a straight system replacement cost.
It did not include also what are called soft costs.
I'm going to speak more to what soft costs.

What that means, but for a total project cost you basically as we put together what we estimated to be, you have the actual construction cost for the construction and then you have the additional cost of soft cost to get to the total project cost.
Again, if you'll bear with me, I'll speak to it in a minute.
To what those soft costs are, we had another study done same year, same firm for what?
The full building renovation would entail that's not just simply the HVAC and plumbing system replacement, but ADA compliance.
Innovation and more and that with total project costs is at 43.5 million.
These are from 2017.
And these spoke to the capital budget requests that we would then proceed to submit.
To the administration by the capital budget request could submit from our agency to HHR administration. From there, the governor does or does not include that in the budget recommendations he makes the General Assembly every year.
So this these values from 2017 spoke to the capital budget request we initiated for funding.
This is the history of funding requests we have made.
For higher data, starting in 27 for 14,000,000 renovation cost, that was going back to trying to capture the HVAC and plumbing system replacements as well as a few ligature and maybe incidental items.
Then a year later, it balloons the cost increases because we were looking at a full renovation.
And.
We were otherwise doing it under the current code at that time, which will come into play with these increased costs over time. As of July 2021.
The central state, the new replacement hospital for Central State, had been funded and design is underway and we explored the option of an additional beds to Central state.
We submitted this request two years ago to add capacity there that could pertain to the current that could replace the current Herham Davis capacity.
I spoke to how that could not move forward because it is not really permitted by federal regulations for skilled nursing to be on same site and additionally the pod design for expansion for Central state was configured to be. I have all the shared services for that new hosp.

Administration, physical plant and whatnot and we are required for skilled nursing to have standalone separate administration program and support spaces for those beds.
And that made the space bigger than could be accommodated on the site. In addition to not being permitted fairly to do so.
In 2024 and again in 2025, we submitted to replace and provide for boiler heating and hot water for Harem Davis moving forward and also for the existing central State Building 94.
This was because the schedule for Central state is to open in early of 2027 and at that time.
The rest of the existing central state campus goes offline.
That includes the existing power plant.
Existing borrow plan and all the existing utility and support that are connected to Harem Davis.
So this this funding request is to stand up an independent boiling plant or boiler configuration that will continue to support Harem Davis and one of our existing central state buildings.
Then end of this year we submitted budget funding request for conversion of some units at some homes at our existing SE Virginia Training Center.
The part of the bottom is the snapshot of the beginning of what the capital budget request we submitted looks like. That's the actual form and format we fill out and submit to DPB.
That's the Department of Planning and Budget.
And this is where I will speak more to soft cost and how we got to these numbers.
So this is a project estimate sheet extracted and if you see over on the top left the bases of estimate, these are the assumptions made that got us to a $60 million cost estimate and the assumptions made were 1200 or 1200 square feet.
Bed for 94 beds for a footprint of 112,800 square feet. That's new construction.
This is from 2018.
And it's also the cost.
The cost values we use were based on at that time we were funded and underway for expanding Western State hospital. We added 56 beds to Western State Hospital in Stanton.
So the cost values are based for what we were seeing in the market under contracts at that time and also reviewed and approved by Deb.

The site cost was based on separate project, the new replacement.
Vcbr Center that is now complete but was underway.
Also at the same time.
We inflated to 5% / 5 years for midpoint construction value and these forms the basis of that 60 point million construction value over here if you add if you add that 60 million that I'm trying to circle with my cursor to the value of the site develop.
Cost.
At for Hiram Davis, that was an initial 5.9 million.
So there's your construction cost 66 million at this level?
These next lines comprise the soft cost that add to and come up with the total budget. So at the time of 2018, not today, we had a new replacement cost of $94.4 million for a new hospital. It was going to be a larger.
Footprint with more beds.
And we instead submitted. At that time the capital budget request for 45,000,000 for renovation.
So I was speaking to soft cost on the left side.
This is same as I showed you on the previous slide, but highlighting the soft cost items which are design services, inspection and testing, project management and contingency.
Contingency for us is anywhere from 2 to 5% of the total construction estimated cost and that adds up to the the total of the 94.4 million for replacement hospital.
At that time in 2018.
So from there moving forward.
We have basically the hospital continue to operate. The systems have continued to age out. So we have simply added market escalation by year on these values on these assessments and on on the, on the data we had.
So looking at the renovation costs, we originally put forward at 45.5 million you see at the top each year and underneath that is the percentage of market escalation we use a year over year, typically a 4.5%.
There have been three years recently, with exceptions. I will speak to, but we got from 2018 at 45.4 for renovation to current day cost of 94.2.
That's for renovation and that does also include the fact that we would have to vacate staff from the building for up to two years while that construction is going underway. So in 2021 there is the pandemic, there is an overall contraction and supply of Labor avail.

And there were many supply disruptions.
You may recall.
The main port to China was closed for half a year due to COVID. We had some disruption to east and West Coast ports as well.
In 2023, we had additional supply chain interruptions.
We also had a significant impact of ARPA projects.
Arpa is the American relief Plan American Rescue Plan Act that came out in 2020.
Over $500 billion was made available from the federal.
Government to all the states for infrastructure, and I'm sorry for health and mental health of that, I think 500 million.
For more, excuse me, 500 million or more was made available. State of Virginia of 200 million made available to our agency. 50 million of that was specific for capital improvement infrastructure of replacing and repairing utilities, HVAC systems, electrical components.
What that did in a larger picture, all that money going out across the country, there were stipulations and ties to the money that money is available for four years we had two years to get all the money fully obligated under contract, which means get all the design under.
Crack. Get it out the bid.
Get the value of the construction cost that was from 2022 to 2024.
We have an additional any money, any money not obligated at that time is pulled back.
It expires and is no longer available from 2024 to 2026. We have to spend all the money obligated we have to pay all of that out.
So if we have any money left unspent unpaid at 2026 that is retracted, well, that had a big impact across the country.
Because Allstate agencies and all entities that receive this money are now trying to go after infrastructure projects. At the same time, that was an increase in demand on the equipment.
That was increase in demand on limited available labor.
So that is what I mean by our projects. When I say the ARPA project impact the supply chain disruptions continued in the January of that year.
You may recall there was a very major ice storm in Texas that had a severe impact on not only their nfg.
Structure, but pretty much all lamination for all laminated plywood lumber products.

The chemicals and materials for that pretty much comes from Texas.
So there is a large backup and supply that we use in the building industry and then impacts of geopolitical events.
The the HOOFIES firing missiles in the Red Sea have the impact of redirecting some very large mechanical and computer and controls manufacturers directing all of their trade traffic from through the Red Sea.
To around Africa as southern Africa, which increased delivery time, cost and fuel.
So I'll talk you all through that to see why you saw it and unleashing, excuse me, an unusually large spike of 45% in cost just in that year alone. And then this this past year, not currently. The past inflation was significant there continued to be add.
Supply chain disruptions.
And.
The conflict in Ukraine.
Continuing Hoofi missile firing in the Red Sea and other events have had an impact on the availability and cost of the supply chain, so the current value in the far column for 2025 we are assuming for this exercise right now 4.5%, but we.
Cannot speak to what will be impacted before this year is up from the ongoing tariffs in the global market and what their impact will be.
This showed a, so the cost basis of cost estimate from 2018 and the basis on that square footage for 94 beds market escalation got us to 195 million.
That is not what we submitted after.
We instead looked at a straight replacement cost for Harem Davis today, which is 72,787 square feet, 4 storeys and 40 patient bedrooms, with the patient bedrooms sharing more than one patient.
So we got smaller.
We looked at what would you?
What would what was today new?
What would Haram Davidson look like today if we built it like that?
Do slitprint.
That is what I have for you for how we got to the 94,000,000 for renovation and the 1:45 for for new construction and the reasons or items. I'm sorry, the basis behind all those costs.
So that may have been very technical, but that is the extent of the information I have and I'm happy to try to answer any questions.

Cunningham, Lauren (DBHDS) 23:58
Sure, Susan.
Go ahead.

Alabanza, Susan (DBHDS) 24:02
First of all, thank you for providing all of this information.
This is very helpful.
I have a question about the cost for the replacement hospital.
The 195 million and the 145,000,000 did both of those include also building all of the ancillary services with that such as pharmacy lab, radiology, dental. The clinics is all of that included in that.

Johnston, Robert (DBHDS) 24:31
Yes, that would.
Those services would be included in the new hospital either either either example, the new replacement at a larger footprint for 195 or the smaller footprint sized as Aaron Davis is for 1:45.
They would include those services and programs.

Alabanza, Susan (DBHDS) 24:49
OK. Is it?
Is it possible to figure out what it would be to build something new that had the smaller number of patient bedrooms?
Perhaps some a couple.
You know, therapy clinic areas and things like that, but not include those ancillary services. Those will be brand new at Central State and the agreement was going before the announcement, the agreement was going to be that those would be shared services as they are now.
Umm.
So if the consensus planning team wanted to propose.
Building something else on a smaller scale, those would not be needed.
So is it possible to get an estimate for something smaller?

Johnston, Robert (DBHDS) 25:35

I think before I speak to that, I could refer to some coleads here. I think pharmacy and dental care are two examples of services that could be shared. But I think we're required by regulation and certification that the other services have to be provided solely for the skill.
Nursing care.
I don't know if Angela or someone else could maybe speak to that a little bit more further, but I believe that most of the go ahead.

Harvell, Angela (DBHDS) 26:06
Yeah, we are finding out more information even as we broach the skilled nursing facility beds in southeastern. In terms of the separation of services that that are required between 2 entities.
And so that's a conversation that we would have to further Susan in addition to that, the logistics of.
Transporting all of Herron, Davis.
Individuals over to central state for those services is also part of the conversation as well.
And.
You know the feasibility of that comes into question. If we're talking about utilizing the actual footprint to provide those services, pharmacy is a little different because obviously you know medications can be transported and so, so forth.

Alabanza, Susan (DBHDS) 27:03
OK.
That makes sense.
Can I also say that the way that it works now between the two facilities, that could be the case for several things, so.
For example, with the labs most skilled nursing facilities, almost nobody has a lab.
So a phlebotomist comes and draws draws people's labs, draws the blood in the facility, and then it goes to the lab.
That's what's used here at Hiram, with people who are living at Central state or at Central State.
We have phlebotomist in our lab who go to Central state, draw the blood and come over.
It seems that that could.

That could still be utilized again the same with the pharmacy and this actually radiology.
Often has a has mobile X-ray that they go into central state and utilize and then a lot of nursing homes. That is also what they do in the Community is they will have somebody from a mobile X-ray company come and take X-rays.
So that I think that those could be easily set up.
You know, we would have to look at something for a clinic and something for dental, but if you know, those are not necessarily things that are always common and it there could potentially be something where we would.
Have people come in too?
That could be explored, but I just wanted to kind of, yeah.

HA **Harvell, Angela (DBHDS)** 28:27
Yeah, I was just going to say that we can certainly work with Rob if we can share with him a crosswalk of those services.
And he can work with his team to to back those costs out.
I'm not quite sure you know if it'll be a nominal deduction or not, because you would still need programming and clinical and therapy spaces in the new footprint.
And so we may be talking about.
Out some FFE in terms of equipment that's would be duplicated at Central State, but I don't know how that equates to actual.
A reduction in build out of the footprint itself, but we can certainly have that conversation.

AS **Alabanza, Susan (DBHDS)** 29:17
Thank you.

CL **Cunningham, Lauren (DBHDS)** 29:23
Any other questions for Rob before we move on?

MB **Martha Bryant** 29:29
Yes.

CL **Cunningham, Lauren (DBHDS)** 29:32
Yes. Oh, yes. Go ahead, Miss Bryant.

Martha Bryant 29:36

Umm.
This is the first time I've seen 6,000,000 for the Southeastern 10 beds because I think in the General Assembly the budget amendment was for 3 million.
For 10 beds and there it's not comparable on site services. So I would like more explanation about that.
In the central in the Hiram rebuild.
Thing there are several disappointing things that I see.
One is to have 40 bedrooms with four patients per room.
That's an outdated model that population density per room is not modern healthcare thinking.
It's certainly not optimal living situations.
I know you're used to thinking about square footage and cost per square foot and building materials and what out, but from a nursing point of view, that's an unreasonable expectation to have.
40 bedrooms with four people per room. Even at Hiram Davis. Now we have.
A separation of psychiatric of ambulatory of vcbr. We have a number of isolation rooms with attached bathrooms as opposed to just a bathroom and a shower on the hall that like 20 people use.
So I don't see the modern.
Modern concept of delivering intellectual disability health care. I will say that southeastern at least you have some private bedrooms.
You have some more living space. You have all first floor egress.
This is the first time I've heard about building 94.
We have heard about building 93 as.
A potential evacuation site, both for Hiram Davis and Southeast.
In terms of a hurricane evacuation plan, so, so I just want more detail.
On how these things were arrived at, I mean basically said were these cost estimates adjusted over time for the for the decrease in census?
So my son's arrived in 2017 when the census was in the 60s.
It has decreased and part of the decrease has been mandated.
When you're saying no major renovations, I have to say we've done a lot of work on water.
We finally achieved Legionella mitigation.

We've just moved every hallway to do smoke compartments.
We've had roof replacement since we've been there, so about every six months my son has moved for some renovation project.
So I don't know what to grade these.
Things already achieved have been calculated in there.
At one point, we weren't taking admissions of of long term care.
We're only doing short term because we were in this constant construction and having one hall closed on a rotating basis.
To do these fire Marshall citation upgrades, so I appreciate all the work Rob and.
I just.
It just generates more questions. I guess. The other thing I would say is in this calculation.
You know, did you maintain the same licensure footprint so that you had four General Medical beds? You had, however, many skilled nursing beds which require things like oxygen and suction?
You have so many nursing facility beds, you have how many program spaces?
You know how much staff space?
So it just it just opens up more Pandora's box of questions. Thank you.

JR **Johnston, Robert (DBHDS)** 34:03
Thank you for those questions. And I can try to speak to each of them as best I can.
As for the 6,000,000 versus 3 million, the six million was the budget request we submitted.
The 3,000,000 is what came out from the governor's budget and the proposed funding we typically on any project funding request. The funding we request, we will get back either no funding or partial funding.
They do.
Not always fully fund us for the amounts we asked for.
So that's the difference in the six million and the 3 million.
On the configuration that's based on the existing.
Footprint. But the the current existing Hiram Davis has four floors and a capacity of 96 beds.
This configuration, proposing 40 patient bedrooms.
These would be much, much larger bedroom suites and they would be configured to current certification standards, meaning there would be bath and toilet within each,

which within each bedroom that would be private and closed off.
But we have today we we are grandfathered in a lot of the ways we're operating currently at Aaron Davis.
And today we'd have to have a dedicated toilet and sync for each patient.
So a four patient bedroom would be a much larger room with its own dedicated bath and sink for that room, and the layout would not be a simple a simple duplicate of the current Davis layout. It would be 4.
It would be 4 floors, much less patient bedrooms on each floor because they would be physically much larger in space and size.
As for the projects you referred to.
We have mitigated the Legionella, the smoked damper, the smoke Damper project was a installation of dampers in existing ductwork that we were able to do as well as the roof replacement.
What all those projects that are major in the sense of what they entailed and what they cost have in common is those are projects that we are able to do while the facility continues to operate as those projects go on.
The replacement of the pipes, the.
Expansion.
In the bathrooms to make them ADA compliant.
The reconfiguration of patient bedrooms.
The all of those things would require vacating the building to to design. Today, we would have to design today's codes and we've been through no less than three code revision, new editions since 2017.
Things that would be impacted are efficiency and air quality from the hphc system and also capacity and pressure.
The plumbing system, so we cannot reuse existing ductwork.
It's embedded inside the framework and infrastructure of the in the architecture of the building, so we'd have to vacate the space to pull out and replace the ductwork.
The equipment would have to be removed and what we were able to do the smoke damper project is that was.
A2 to four hour window each day where the unit's operating one unit was shut off while that side of the hospital was operated on.
We had temporary cooling in place, but that was resumed each day.
And resumed full service.
It's also interconnected in that we have two units with two zones, but the central feed

of those units is connected so that when we shut off one unit to work on one side, the airflow and capacities at the other side are reduced. And that's where we ran into. A problem with heat and temperatures last summer, doing the smoke damper project.
The roof replacement project is a project we are able to undertake without closing or vacating the hospital, so that's why we proceeded with those projects.
They were needed.
We were able to address.
We cannot replace the entire mechanical system with new units, new ductwork. We cannot remove all of the piping that is deteriorated.
Replace it with new piping.
We cannot build new compliant bathrooms without evacuating the space. That's why the costs are higher and different.
It's to reflect code compliance to to today's standards and the conditions and type of the systems that were replacing.
I don't.
I don't I.
Notes Mrs. Brian.
I don't know if I hit all your questions, but I was trying to speak to how we got to.
What we have envisioned.

Cunningham, Lauren (DBHDS) 38:14
Go ahead, Miss Bryant.

Martha Bryant 38:16
All right, the this building 94.
That's the first I've heard of anything about building 94.
Because both Hiram and Southeastern have had an evacuation plan that uses a central State Building. So.
And I understand that that that is not a skilled nursing facility, that it's a mental health.
Bed. So can you speak more about this building?
9094 and one thing I didn't hear addressed was the different licensure levels that we have at Hiram. Now the four General Medical beds, the skilled nursing facility, beds, nursing facility and then we have clinic spaces.

So in this rebuild, rebuild.
And then we have distinct populations, we have vcbr.
We have psychiatric, we have people with dementia, we have ambulatory and non ambulatory people.
We have outpatients.
We have on on site. When we asked earlier, we were told that this was for all the licensure levels at full full census.
So you were still looking at having the 94?
Beds.
By the four different licensure levels.
Is that accurate?

JR **Johnston, Robert (DBHDS)** 39:48
I would like to.
I would like to speak to the first part about building 93 versus building 94 on campus, and then I'm gonna defer to the other leads for your skilled nursing certification questions.
We are using building building 93 right now is mostly vacant and not in use and right now today it is our evacuation shelter plan for Hiram Davis and Southeastern Virginia Training Center. It is not.
It is not set up.
Never has been.
Everybody out of the building, we would take them to building 93.
What the funding is going forward moving forward, building 94 is in use and is in better condition right now today than building 93. So in building 94 as a part of the rest of the campus gets vacated into the new Central state hospital, we would.
Prefer to have building 94 as the available swing space evacuation space that I just described.
Moving forward, it is in better condition, better upkeep, and so instead of.
Sort of fixing up and improving 93 and connecting it to continuing service for boiler heat and hot water we would connect instead to building 94 as well as keeping harm Davis running.
But with that said, with that said, we are looking at right now in real time at keeping building 93 and building 94, but that has been developing in the past year or longer.
Angela, I don't know if you want to speak to that, but.

This the capital budget request typically go in a year or two.
You out and sometimes get resubmitted each year when they're not funded, and so building 94 is better situated for us in the timing of our submission.
I'm gonna defer to my teammates on the rest of that.

Harvell, Angela (DBHDS) 41:42
Yeah. I I I don't.
Thank you, rob.
I'm not quite sure if I'm really clear on what the question is about 93 or 94, but those buildings are buildings that are available to us as a system. If we need an immediate shelter and they're not necessarily, they wouldn't be used for any type of.
You know long term.
Care.
And So what we've attempted to do is to maintain that availability in some respect so that we can have some control if an imminent failure occurs.
But we're talking about a matter of hours, not a matter of weeks or a week that we would like to have our individuals served in that bill in the either one of those buildings because.
They're old and obviously they're not built for that population.
And then in terms of the services that would be provided in a new footprint for Heron Davis, that would all be a part of the design work that would be yet to come should we receive.
The go ahead and the funding to begin to work on a renovation or a new build work very closely with.
The Harem Davis staff, as well as stakeholders, you know residents.
Family as to what we would like to see in a new bill for Heron Davis or renovated building, and that's all a part of the design.
Work that takes up to 24 months.
And you know, would be inclusive of those services that we determined.

Cunningham, Lauren (DBHDS) 43:44
Oh yes, Miss Bryant, go ahead.

Martha Bryant 43:47
Umm.

I've had a conversation with Heather and Jarvis in the interim since their last meeting and I was told if there's a hurricane that's going to have greater than 120 mph, that there's an evacuation plan.
And there, you know, in the old southeastern.
You know that there were evacuations. That and I don't know how many people moved for what?
Duration, But a hurricane evacuation.
Is a possibility.
And then you'd be looking at how many people you move or what duration. And that that comes into your hurricane?
You know, or your category three or four or five, you know, are we going to be a direct hit to Virginia or or or that type of thing?
But I appreciate that you have contingency planning and.
I just think there's so many unknowns right now.
I have submitted different things.
Different documents I've submitted private equity.
Negative study from the United States Senate.
Presented more local stories on the impacts of private equity and local nursing facilities.
Just just this week.
We've had the new CDC autism prevalence update.
So when we start to predict how many beds we need by what type?
I don't see the 10 beds and for skilled southeastern is the right number or go into 65 beds in ICF is the right number.
Or the right distance that that we are only going to one statewide facility of limited capability.
And.
I personally want my son in a modern first floor.
Egress building not in some, you know, upstairs.
Sharing a room with a bunch of people.
And I appreciate all the work that's been done in the interim to keep Hiram go going.
Appreciate what we had cooling towers and all the persistent Legionella work.
So it's it's been quite a journey.
I would like an update in your census and in your subcategory populations so that the planning keeps on track with.

What the numbers are?
So can somebody from Hiram tell us the numbers? Thank you.

Alabanza, Susan (DBHDS) 47:03
I can pull that up and and give it to you in a few minutes.

King, Kimberly (DBHDS) 47:06
OK.
Susan, would you like me to?
To do that.

Alabanza, Susan (DBHDS) 47:11
Sure, sure. If you have it already, that would be great. Thank you.

King, Kimberly (DBHDS) 47:12
OK.
Yeah, as of Monday of this week, there were seven individuals that Hiram with dementia or other neurocognitive disorder.
19 with intellectual and developmental disabilities and eight with serious mental illness.
So the total census was 74.
I mean, 34. Sorry about that.

Cunningham, Lauren (DBHDS) 47:47
And.
Any additional questions before we move?
Yes, Miss Bryant.

Martha Bryant 47:52
So are you still serving vcbr?
Are you still doing admissions?
I haven't visited this week, so.
In my last visit, we had had two admissions that week and we did have vcbr people still there.

Alabanza, Susan (DBHDS) 48:11

Yes, we have vcbr.
We have one, one person.
They are originally from Vcbr, but they are.
They have been a permanent resident at Hiram Davis for a few years.
However, they are on the sex offender registry. The we did have one additional admission on Tuesday from Piedmont.
Again, a temporary admission.
All admissions right now are temporary.
But yes, we've had one more. So that would bring it to.
35 Since Tuesday and we are accepting admissions, yes.
A lot of admissions have have.
Slowed.
It slowed incredibly since the announcement.
A lot of people in a lot of different places across the state believe were already closed or that a definite decision has been made to close.
And so when they find out, we can still accept admissions.
We've had several people who are actually surprised because they they were under the impression that.
Again, we were closed or could not accept anybody so, but we let people know we are still taking emissions on a temporary basis.

Martha Bryant 49:36

So what's the we had to ask about aging out data and I'm aware of St.
Mary's and Children's Hospital in Richmond, so in the Norfolk and Richmond area and I'm less familiar with Northern Virginia about Pediatrics, pediatric nursing facility and skilled nursing facility long term care.
So previously.
This has been a training center.
Service availability. Now both Hiram and Sebtc.
Are adult only.
So will somebody address the Pediatrics and have you obtained any aging out data?

Cunningham, Lauren (DBHDS) 50:33

Miss Bryant, I can.
I can speak to that aging out data, the Community Services Subcommittee was going to be the one that was going to look generally at data.
I can speak with them about having that for maybe their May meeting, but that was the subcommittee that was going to look at at demographic data.

Rupe, Heather (DBHDS) 50:54
Yeah, correct. I think our focus is a little bit more on the patients that are there now, whereas that group is looking at kind of the bigger impact about patients that may have come to Hiram.

Martha Bryant 51:07
So the when when we say that we have 19 people with intellectual disability now.
And we're planning to have 10 beds at southeastern.
How do you go from 19 to 10?
At the time of the General Assembly, my son's discharge plan was inappropriately listed as community.
We are not.
Bring any choice form.
Right now.
We should have choice forms we should have.
Right to facility based care and.
Well, could somebody please explain the math? Thank you.

King, Kimberly (DBHDS) 51:59
So at this time out of those nineteen, five of the individuals with ID are actively in the discharge process.
With identified homes, I'm already have discharge dates.
Additionally of that 19, there are only ten of those 19 with families that are not interested in looking at any discharge options.
At this time.
So based on that and.
The other nine that are open, they're they're interested to exploring any options.
So that's how the initial.
You know, I think estimates were arrived at and also some of the 10 families who are

not interested in pursuing anything right now have made comments such as, you know, when the time comes, I'd like them to move to places closer to me.
Some are open to community options, not just dbhds facility options.

Rupe, Heather (DBHDS) 53:21
OK.

Cunningham, Lauren (DBHDS) 53:23
Yep, I was just gonna throw it to you, Heather.

Rupe, Heather (DBHDS) 53:23
No, I was just going to say, Lauren, if if you think are we ready to move on?

Cunningham, Lauren (DBHDS) 53:27
Yep, if we don't.
Any additional questions?
Heather, I think you're up next to present.

Rupe, Heather (DBHDS) 53:36
Gonna steal the screen from you, Rob.
All right, so I was asked to come and talk about.
Our long term care partnerships.
Our nursing home partnerships that we've developed as a result of our state hospital discharges.
So I I know that this may not be completely applicable, but I think the idea was to hear what we have done to see if in recommendations there was an ability to replicate or expand on.
So I'm just gonna go through it.
Briefly, happy to answer any questions that you guys have.
Can you all see my screen, Lauren?
OK, great. So I'm Heather robe, director of clinical services and this nursing home we call it we we affectionately call it the nursing home project. But there are long term care partnerships.
Our office works with the state psychiatric facilities primarily on admission.
Active treatment and discharge. So we're involved in in your other hospitals outside

of although we do some work with Hiram and Vcbr and but we're working mainly with the adult hospitals. And so this is sort of my team.
It takes a. It takes a team of us to kind of make these things work, but we're looking at individuals from admission through discharge and trying to get them to the least restrictive, most appropriate community resource for them.
So the brief history of how this came about is pre pandemic.
We had our hospitals operating at a really high bed census over 100%.
And in 2014, we had the bed of last resort legislation that that sort of directed the state psychiatric facilities to accept TD OS if we could not find another appropriate placement for the individual and it sort of changed the dynamic in the state facility.
Sort of unintentionally.
And so we had more admissions coming through our our psychiatric hospitals.
At the same time, we maintain an extraordinary barriers list.
So it's individuals who are ready to discharge from a psychiatric hospital, but they're they have not found a placement and we call those sort of extraordinary barriers.
We've tried all kind of all the normal.
Available resources and we just can't. Can't get anyone to accept them.
And then at the same time you have community services boards and you have nursing homes and typically they did not always work together primarily because a lot of the services that community services boards bill are not able to be billed in a nursing home facility. And so you.
Just didn't have a whole lot of collaboration that was happening in those areas. And so all of those things were kind of going on at the same time.
And.
In our world.
The the Community Services Board is responsible for discharge planning and so the treatment team kind of determines the level of need for the individual.
The CSB, as part of that, as well as the the hospital social workers.
And all you know that is done kind of through our collaborative process.
OK.
So all that to say, we knew at in 2020 that we needed some nursing home beds that we had individuals waiting on our extraordinary barriers.
List and what they needed was a nursing home placement and when I looked as of the list I ran yesterday, 23% of the individuals we have on our extraordinary barriers list need a nursing home bed. And like I said, traditionally CS BS did not provide a.

Whole lot of services.
So we were able to get people into nursing homes who just needed the traditional nursing home level of care. But if there were any behavioral or mental health interventions required.
Nursing homes were usually kind of saying no. I don't think that's that.
This is the right patient for us.
So.
We kind of came up with a plan and it it morphed, but what it did was it looked at us as dbhds and our state facilities.
And it said, hey, if we are able to come up with both a model and some funding that we're able to work with the Community Services Board and find a nursing home partner, we might be able to discharge some of these folks.
So it takes all three of these levels kind of working together to make this work. And what we did was we were able to provide some funding. We sort of as dbhds oversight of the plan implementation, we kind of control referrals and controls, not the right word, but.
Direct referrals to these programs and then we're doing monitoring and mediation and outcome reporting.
The Community services boards then provided a nursing home liaison, which was a staff position.
Some qmhp or direct staff that supplement the nursing home care.
But not in the sense of traditional nursing services.
They are supplementing the staff that are at the nursing home, but they're doing behavioral interventions and then you have the Community Services Board really kind of be in the review and the approval of the invoices. And so the money flows from us to them.
We then looked at the nursing home and said what we'd like you to do for these specialized units is hire a dedicated quality of life manager or an activities director that has some experience in behavioral health.
So that we are developing activities and interventions that are that are directed towards this population.
We ask them to hire a specialized mental health social worker.
We ask them to sort of create a unit or some bed capacity for these patients and then?
We ask them to come up with some creative solutions to staffing and environmental

barriers, and so that's kind of what we went in with and we said alright, let's let's see how it works.
Our goal was to reduce the number of individuals on the EBL who were waiting for nursing home care, reduce the length of time they're waiting to get into a bed and to maintain a 30 day readmission rate of 7% or below. And at the time that we.
Started this, the state rate was 8% readmissions.
So we have two current programs. We have Valley health and rehab, which is in Shelby, VA.
We have about 40 to 48 beds in that program and it's been operating for three plus years.
We partner with Mount Rogers CSB to do that and so.
They have been really, really successful. This program is sought after they stay full.
We do not have a problem getting people into those beds and staying in those beds.
Beds.
They have had a readmission rate for that project of like less than 1% I think for both projects combined it's like a 2% readmission rate that we're looking at for all the individual served. And at this point we've served probably well over 100 individuals in.
Those programs that we have.
The second one we have that we started was Waverly Health and Rehab.
It's been going for about two years.
We partner with Western Tidewater CSB.
We have 15 beds in that program and also they have.
Been stateful and been successful.
The other benefit to both of these is that these are just certain beds in the facility.
It's not the full facility, so we're able to move people through other parts of their facility. So if we get them in from the psychiatric hospital to valley and they stabilize, they're doing well. They really don't need the behavioral health.
Component anymore.
More than valleys able to move them to a different unit, creating bed capacity on that unit. For us, the other flexibility that they have is that both of these programs have both skilled nursing and long term care beds.
And so they have the flexibility of kind of bringing them in at the level that they feel that person needs. When we make that referral.
So Waverly usually tries to bring them in at skilled nursing.

Kind of stabilize them before getting them to to the long term care.
Like I said, we're meeting all of our metrics less than 2% readmission rate.
For for both of those programs over the time that they've been operational.
Questions.

Cunningham, Lauren (DBHDS) 1:02:35
Yep, Susan, go ahead.

Alabanza, Susan (DBHDS) 1:02:38
Just have a quick question about.

Rupe, Heather (DBHDS) 1:02:39
Yeah.

Alabanza, Susan (DBHDS) 1:02:41
For people who are on the sex offender registry.

Rupe, Heather (DBHDS) 1:02:44
Mm H.

Alabanza, Susan (DBHDS) 1:02:45
Have you found a lot of?
Have you found home?
Are either of those facilities willing to take people who are on the registry if they're still ambulatory?

Rupe, Heather (DBHDS) 1:02:54
It's a great question.
So Valley is not and that is specifically because they are very close to a school.
Waiverly is more likely to look at that.
I mean, like, literally valleys in the backyard of the school.
Waverly is willing to look at them on a case by case basis.

Alabanza, Susan (DBHDS) 1:03:15
Thank you.

Rupe, Heather (DBHDS) 1:03:18
That was a lesson learned, Susan.
You know, Valley is the one who came to the table willing to kind of be our first partner.
But that was one of the things we figured out as we started as man, they're so close to the school.

Alabanza, Susan (DBHDS) 1:03:31
Right. And what I've also been told by people who have, you know, lengthy experience working in nursing homes at an administrative level is that, you know, the excuse me, the general feeling is if people are still ambulatory, they're not willing to take a risk and they will not.

Rupe, Heather (DBHDS) 1:03:46
Yeah.

Alabanza, Susan (DBHDS) 1:03:47
Accept people.
So, but we even had experience with one person who really was not ambulatory anymore and had.
Needed end of life care and between us and their guardians.
And they were trying to find someplace to go and no place would still accept him. So anyways.
Those are some of the.

Rupe, Heather (DBHDS) 1:04:07
Yeah. No, I I think that's a great point.

Alabanza, Susan (DBHDS) 1:04:08
Other barriers?

Rupe, Heather (DBHDS) 1:04:09
I think one of the benefits to this program specifically is that we we always try will tell

you we always try.
And so we have our community transition specialists.

Alabanza, Susan (DBHDS) 1:04:17
Play.

Rupe, Heather (DBHDS) 1:04:19
We have the Mount Rogers like so Valley specifically of a Mount Rogers liaison. And then we have the nursing home and they're meeting every week and talking about referrals.
So it's not just a piece of paper that's coming through. One of the benefits here is we're really trying to say no, just like meet the person, you know, kind of spend some time.
With them, you know, and really trying to.
I don't want to say sell the individual, but really kind of be more than just what that what's on that piece of paper. And that has been how we've gotten some of those exceptions through.

Alabanza, Susan (DBHDS) 1:04:47
That's good.
OK.
Thank you.

Cunningham, Lauren (DBHDS) 1:04:57
Any other questions for Heather?
Yes, M's Bryant, go ahead.

Martha Bryant 1:05:03
When you're talking about percentage of people on the extraordinary barriers list, and you said 23%, what's that number?

Rupe, Heather (DBHDS) 1:05:13
Yeah.

Martha Bryant 1:05:13
I mean number of people as opposed to percent.

Rupe, Heather (DBHDS) 1:05:16
Yes. No, it's a good question.
I was updating that statistic because this was an old slide. We only have 74 individuals currently on our extraordinary barriers list and I think 17 were waiting for a nursing home.

Martha Bryant 1:05:29
Umm.
I noticed that you just have like 2.
Models. One of the things that came to mind would be you talked about environmental modification and particularly in dementia care, you have to think about elopement and wandering.
And I mean are we talk?
I mean.

Rupe, Heather (DBHDS) 1:05:53
Yeah.

Martha Bryant 1:05:53
Can you talk more about how how the reimbursement changes and what kind of environmental things you change?

Rupe, Heather (DBHDS) 1:05:55
Yep.

Martha Bryant 1:05:59
Thank you.

Rupe, Heather (DBHDS) 1:06:00
So now it's a good question about the the reimbursement, because at this point we are not able to supplement the Medicaid rate, right?

We can't do that.
And so all of our support to the nursing home comes in the in the view of either staffing or we've given them some additional money like specific for Valley, there's a period of time when they were struggling to find staffing to work on that unit. So we so.
They wanted to offer, like, a dollar more an hour or some sort of incentive, and we helped fund that. But by patient, we can't supplement the rates.
So it's whatever the Medicaid rate is.
The environmental modifications.
Vary by whatever the facility needs, so the I'm and I'm glad you brought up the thing about the dementia. So for Valley, this is on the 2nd floor. We did give them some funding to sort of create some doors.
They have some delayed egresses they were able to re arrange some rooms, create some capacity for kind of staffing at the end of the hallways that would be able to watch.
So some different things to try to make the.
Make it more secure.
And so those are the kinds of things we are offering them were there, you know, were there some upgrades that they needed because the building was old or some things that would be specific?
So one of the things like we wanted was a a activities area.
For this unit.
And so we were able to fund kind of some construction to do that. Some quiet spaces are for those individuals who kind of get overwhelmed and in crisis.
So we wanted to fund some of those.
They didn't have that.
That type of thing.
We are pretty flexible with that in the sense of you know, what do we think we would need for this population and and what do you already have and how can we how can we make that work.

Martha Bryant 1:07:48
Do you consider if they are for profit or non non profit?

Rupe, Heather (DBHDS) 1:07:54

At this point, we have not been picky. I'll be perfectly honest because we we wanted to get this off the ground and so and I sort of skimmed over that a little bit. But honestly, Valley came to us and during the pandemic and said we we have a.
Lot of open beds. Is there something we can do?
And that's sort of where the idea was born.
So we will talk to and entertain any kind of nursing that comes that comes to us and kind of pitch the idea.
So there is really no consideration for that.
They just know that we're not supplementing the rate and we're not paying, you know.
So either the person pays the private rate, or they reimburse through Medicaid.

MB **Martha Bryant** 1:08:34
I've been following the lawsuits coming out of the colonial Heights Fiasco's in the Westport stories, and.

RH **Rupe, Heather (DBHDS)** 1:08:44
Mm hmm.

MB **Martha Bryant** 1:08:51
Lack of oversight. I think one of the most troubling things that I read about this medical facilities of America is that one physician had 31 nursing facilities, not 31 patients, but 31 facilities.
And so by regulation.
They're they're not required to see someone within so many days of admission or.
I think they're only.
Required to see within 30 days and again within 90 days.
So the physician to patient ratio?
Or the the oversight is very lacking.
And the other thing that just was revealed in one of the wtv our stories was also that a real estate company charged rent.
And so a lot of the funding that would have gone for care paid exorbitant rent and so.
They claimed a loss even though the the equity firm claimed a profit.

So you have to look at financial exploitation.
Of care delivery based on the for profit motivation of the ownership. Thank you.

Rupe, Heather (DBHDS) 1:10:11
And I I mean I appreciate that comment.
I will say part of the benefit of these programs is they do have additional layers of oversight because now you have a Community services board who's in there serving those patients as well as dbhds going in regularly to look at these two programs.
So we do try to take that into account. The other thing about these two programs is that both Mount Rogers and Western Tidewater who are the partner Csbs have what we call geriatric teams. So they have.
Of psychiatric nurse practitioners who are serving the folks in those units as well. And so it we're not relying solely on whatever the nursing home practitioner is.
So we're also serving them through additional external resources, which adds that layer another layer to that.

Cunningham, Lauren (DBHDS) 1:11:09
Any additional questions for Heather?

Rupe, Heather (DBHDS) 1:11:15
The thing I will say about it is I believe that the model is probably like you know, we've based it on behavioral health and behavioral health needs. But I think it's it's modifiable, right?
So if we had other population needs who had something similar, I think you could take the model and kind of create what you needed for that population.

Cunningham, Lauren (DBHDS) 1:11:41
Great.

Martha Bryant 1:11:42
So are you planning to grow the program?
I mean, are you recruiting additional nursing facilities?

Rupe, Heather (DBHDS) 1:11:46
Yes. Yeah.

Martha Bryant 1:11:48
I mean, only two out of the whole state is a very limited.

Rupe, Heather (DBHDS) 1:11:49
Yeah, it's a great.
So yes.
So yeah, thank you for that question.
So yes, we are always looking for new partners. We've had one who's come to the table down in the.
In the southern region.
And so we'll be talking to them.
Additionally, there was at one point.
This has gained some traction and so there was at one point a budget.
Amendment, that sort of directed us to expand, to assure we had one in each region.
So yeah, I think.
I think the idea is always to grow it.

Cunningham, Lauren (DBHDS) 1:12:33
Alright. Well thank you so much, Heather.
That was a great presentation.
I want to be conscious.
I think we usually do public comment up front and I forgot to get into it after the introduction. So I do want to leave a moment for if there's any public comment, please feel free to raise your hand and then we'll go in order of of hands being.
Raised.
Yes, M's Bryant.

Martha Bryant 1:13:09
Martha Bryant, from Amherst. I'm really concerned about the impact of the federal cuts across all kinds of things.
Medicaid.
There, there are known disparity areas in Virginia.
South side is one.
Southwest is another you can actually go into Kaiser Family Foundation. They have

Medicaid utilization.
In Congressional District.
Of course, tariffs, imports, supply chains.
Cost of of many things or uncertain whether it's building materials or steel or medical supplies or devices.
That's that's a whole unknown. Hopefully by May we'll have the governor will have reviewed the budget and we'll be.
Clear on what was funded and what was struck.
I would like more.
Cost implication.
Predictability.
Today I saw that Puerto Rico didn't have power.
My son uses something that's only made in Puerto Rico.
So when we look at supply chain and we only depend on one source to manufacture it.
We we really haven't solved the redundancy of supply chain.
So.
We're in a whole new economic and health care environment.
You know several things. When I think about what patients or what people need, even something like vaccines, preventative care on site services versus contract.
Underfunding something so it's it's alarming to me if D be heads ask for $6 million and they were funded at $3,000,000, you know where.
What can you achieve when you get 50% of your ask and that was pre tariff and presupply chain disruption?
So how valid is that?
3,000,000 gonna be to achieve anything.
By the projected end of patient care in 2026.
So my level of worry has increased. Thank you.

CL **Cunningham, Lauren (DBHDS)** 1:15:53
Thank you, Miss Bryant.
Do we have anyone else that that would like to make a public comment?
If not, all right, Nicole and Heather, do you all have anything you want to cover before we kind of look ahead to our May meeting?

Russell, Nichole (DBHDS) 1:16:16
I don't have anything to add at this time.

Rupe, Heather (DBHDS) 1:16:18
I don't either.

Cunningham, Lauren (DBHDS) 1:16:20
OK.
Well, we will wrap things up a little bit early.
We will have a May meeting scheduled hopefully in the next week or so, and we'll share that widely.
So please, if you have any questions or things you want to submit to the committee, you can reach us at Hdmc planning team at Dbhds dot Virginia Gov.
If there's anything that you know you you have didn't haven't heard information today or you wanna go back and review.
Information that was shared. We will have a recording of this meeting and a transcript available on the Hiram Davis planning team website.
Which I will drop into the chat in just one second.
I do want to make one quick reminder that there are two more subcommittee meetings. Oh, I'm sorry.
Yes, you go ahead please.

Eula Secka 1:17:20
Sorry, turning it off mute.
Sorry about that.
I know I came in maybe about the second or third meeting and there were a few questions I had.
I went back and reviewed like the actual law that we're using to guide this whole planning and things of that nature, just to see what the expectations are. And I'm not certain about the time frame that we're supposed to have our findings or recommendations completed by. I Don.
Know if there's a working document that's out there that we're working.
I don't have any access to any of that.

Cunningham, Lauren (DBHDS) 1:17:50
Sure. So the, the, we are working towards an August 1st deadline of having the draft plan into the Commissioner, so that will be all three of the subcommittees, the Subcommittee, the supporting Staff Subcommittee and the Community Services Subcommittee. Having each of their parts to the plan to the.

Eula Secka 1:18:05
Right.

Cunningham, Lauren (DBHDS) 1:18:08
Commissioner, by August 1st.
That sits with him and then it's due for its submission to the.
Jchc and the General Assembly.
On November 1st.

Eula Secka 1:18:21
And who's actually putting the findings together?
Working on the document is there one that all committee members, members get a chance to review? Or is it something that's just happening in a background based on the outcome of our meetings?

Cunningham, Lauren (DBHDS) 1:18:34
It's having to the Co leads are taking the lead on on submitting it based on what's discussed at these meetings and there will be a chance then before it's submitted to the jchc for the entire planning team to review and make comment.

Eula Secka 1:18:47
And we don't have OK to and make comment. So we don't get to see it in the process. But when it gets to a certain stage, we will be then get a chance to review it, OK.

Cunningham, Lauren (DBHDS) 1:18:50
Yep.
Yes, yes.

Eula Secka 1:18:56
Thank you so much.

Cunningham, Lauren (DBHDS) 1:19:04
And I should mention there, we're working on scheduling as well a meeting of the full planning team. It'll be a virtual meeting coming up hopefully in May or June.
So just something to stay tuned for.
There'll be more information about some of the logistical aspects at that meeting, too, and it'll be a chance for all three subcommittees to come together.
If there's nothing, yes M's Bryant, please go ahead.

Martha Bryant 1:19:35
We're already seeing reduction in force impacting weekend staffing.
This is a hidden process.
I will say my son was able to be diagnosed. Have the pharmacy have access to a medication on a Saturday and begin treatment on a, you know, on a weekend.
But reduction in force, I will say.
We have to protect people from harm as the census decreases.
My son's needs don't change because it's Saturday or Sunday or a holiday.
His needs are the same, and sometimes he just happens to have a a incident where his need is increased on a Saturday morning or on a, you know, on a on a night so.
When I look at the projected.
Staffing. It's not comparable care and this reduction of force right now is not transparent at all.
Thank you.

Cunningham, Lauren (DBHDS) 1:20:49
Thank you, S Bryant.
If we don't have any additional comments, we will go ahead and wrap the meeting up early. As I mentioned, we'll get that next meeting date out to everyone as soon as possible and we'll have a recording and a transcript of this meeting available on the Hiram Davis website.
Later, later, hopefully, by the end of the week.
Nicole and Heather, anything to add before we wrap up?

RH **Rupe, Heather (DBHDS)** 1:21:16
No, I just appreciate everybody. And Lauren, I very much appreciate you keeping us on track.

RN **Russell, Nichole (DBHDS)** 1:21:22
Thank you, Lauren.

CL **Cunningham, Lauren (DBHDS)** 1:21:24
Thank you all.
Hope everyone has a good rest of the week and we'll talk soon.

RH **Rupe, Heather (DBHDS)** 1:21:28
Bye.

ES **Eula Secka** 1:21:28
Thank you so much.

MM **McGuire, Meghan (DBHDS)** 1:21:30
Thank you.

RN **Russell, Nichole (DBHDS)** 1:21:30
Thank you.

CL **Cunningham, Lauren (DBHDS)** 1:21:30
Bye bye.

ES **Eula Secka** 1:21:31
Bye bye.

SS **Snead, Sheila (DBHDS)** 1:21:32
Thank you.

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