
Overview of the National Building Bridges Initiative (BBI)
ACRC 2018 Conference
March 27, 3018

Presented by:
Beth Caldwell, Director, Building Bridges Initiative
Top 5 Trends To Expect in the next 3-5 years

1. Expecting less money from local, state and federal governments.
2. Service purchasers increasingly want to buy results and not services.
3. Emphasis on durable results that can be sustained for 6 – 12 months post-residential discharge.
4. Movement from child-centered to family-focused service delivery.
5. Faster moves toward permanency for children not returning home.

* From Tom Woll’s 40 Trends Report, January 2014
BBI Mission

Identify and promote practice and policy initiatives that will create strong and closely coordinated partnerships and collaborations between families, youth, community- and residentially-based treatment and service providers, advocates and policy makers to ensure that comprehensive services and supports are family-driven, youth-guided, strength-based, culturally and linguistically competent, individualized, evidence and practice-informed, and consistent with the research on sustained positive outcomes.
BBI has MANY Partners, including:
Endorse the BBI Joint Resolution

• Go to BBI Web Site (www.buildingbridges4youth.org)

• Read BBI Joint Resolution (JR)

• E-mail Dr. Gary Blau (Gary.Blau@samhsa.hhs.gov) or Beth Caldwell (bethcaldwell@roadrunner.com) or Sherri Hammack (svhammack@sbcglobal.net) that You Would Like to Endorse BBI JR

• Be Put on List Serve to Receive BBI Newly Developed Documents

• Be First to be Invited to BBI Events
Go to BBI Website:
www.buildingbridges4youth.org

Documents & articles to support field (including system of care communities), e.g.:

- *Fiscal Strategies that Support the Building Bridges Initiative Principles*
- *Cultural and Linguistic Competence Guidelines for Residential Programs*
- *Handbook and Appendices for Hiring and Supporting Peer Youth Advocates*
- *Numerous documents translated into Spanish (e.g., SAT; Family and Youth Tip Sheets)*
- *Engage Us: A Guide Written by Families for Residential Providers*
- *Promoting Youth Engagement in Residential Settings*
BBI Web-Based Training Programs Available

https://theinstitute.umaryland.edu/onlinetraining/programcategory.cfm?ottype_id=30

• Best Practices in the Use of Psychiatric Medications for Youth During Residential Interventions (1.5 CEUs)
• Cultural and Linguistic Competence (Part 1): Why Does it Matter? (2 CEUs)
• Cultural and Linguistic Competence (Part 2): Implementation Strategies (2 CEUs)
• Cultural and Linguistic Competence (Part 3): On a One-to-One Level (1.5 CEUs)
• First Steps for Leaders in Residential Transformation (2 CEUs)
• Including Family Partners on Your Team (2 CEUs)
• Pre-hiring, Hiring, Supporting, and Supervising Youth Peer Advocates in Residential Programs (2 CEUs)
• Successful Strategies for Tracking Long-term Outcomes (1 CEU)
• Youth-Guided Care for Residential Interventions (2.5 CEUs)
Recently Released BBI Documents

www.buildingbridges4youth.org

- How-to Guide for Transforming to Short-term Residential (AECF)
- Guide for Judges on Best Practices in Residential (w/ ACRC & AECF)
- Successfully Engaging Families Formed by Adoption: Strategies for Residential Leaders
- Case Study: Leading Innovation Outside the Comfort Zone: The Seneca Family of Agencies Journey
2014 Book: *Residential Interventions for Children, Adolescents and Families: A Best Practice Guide*

There are several options for ordering:
- toll free phone: at 1-800-634-7064
- fax: 1-800-248-4724
- email: orders@taylorandfrancis.com
- website: [www.routledgementalhealth.com](http://www.routledgementalhealth.com) (20% discount w/ web orders using code IRK71; free global shipping on any orders over $35)

Orders must include either: the Title: *Residential Interventions for Children, Adolescents and Families: A Best Practice Guide* OR the ISBN: 978-0-415-85456-6

Note: As a federal employee, Gary Blau receives no royalties or any other remuneration for this book. Any royalties received by Beth Caldwell and Bob Lieberman will be used to support youth and family empowerment consistent with BBI.
BBI Core Principles

• Family Driven & Youth Guided Care

• Cultural & Linguistic Competence

• Clinical Excellence & Quality Standards

• Accessibility & Community Involvement

• Transition Planning & Services (between settings & from youth to adulthood)
Some Of The Critical Issues

Research on Residential Effectiveness

- **Recidivism** — All Categories of Children/Youth
  - 68% in One State (2009) for all Licensed Residential Programs vs. Damar Services (BBI implementer) with ranges from 3-15%

- **Lengths of Stay** — Children/Youth in MH System
  - NYS (Average: 14 months in 12+ years) vs. Florida (<6 months in 3 years)
Many Compelling Reasons To Reduce Overreliance On Congregate Care.

Youth placed in congregate care are less likely to find permanent homes than those who live in family settings.

Youth who live in institutional settings are at greater risk of developing physical, emotional, and behavioral problems.

Current law requires that children be placed in the least restrictive setting possible while maintaining the child’s safety and health.

Congregate care placements cost child welfare systems three to five times the amount of family-based placements, and for poorer outcomes.

Sources: Right sizing. Congregate Care: A Powerful First Step in Transforming Child Welfare Systems, Annie E. Casey Foundation, 2010
Kids Count Data Snapshot on Foster Care Placement, Annie E. Casey Foundation, May 2011
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Critical Elements

Residential-Specific Research Shows Improved Outcomes With:

- Shorter Lengths of Stay,
- Increased Family Involvement,
SOME EXAMPLES OF WHERE BBI IS HAPPENING
Examples of Where BBI/Residential Transformation Work HAS/IS Happening

• Comprehensive State Initiatives (DE, IN, MA, CA - Initially 4 Regions/Pilots – going statewide by county in 2017/2018)

• State Level Activities Happened or Currently Underway (AZ, FL, IL, KY, LA, MI, NH, NJ, NM, NV, ND, OK, RI, SC, VA, WA, WV & Georgia; in CA & MD – Provider Associations Led)

• Current or Previous County/City Level Initiatives (Cities: NYC, Philadelphia; Counties: Monroe/ Westchester, NY; Maricopa, AZ; PA: cluster of six counties NE part of state)

• Many Individual Residential and Community Programs Across the Country
BBI in Massachusetts: Caring Together

• Adoption of BBI framework for reprocurement of all DMH & DCF residential services for youth

• Adoption of interagency restraint/seclusion initiative & Six Core Strategies©

• Commitment to trauma-informed care

• Development / expansion of family & youth roles
  ▫ Parent Partners
  ▫ Peer Mentors

• Development of:
  ▫ Continuum (in-home residential service with team)
  ▫ Occupational Therapy in more intensive programs
  ▫ High intensity community services
BBI in Massachusetts: Caring Together

Flexible Service Models

- Following into community (including support in home schools)

DCF & DMH Jointly:

- Developed standards & outcomes
- Overseeing implementation
- Providing oversight
- Coordinating utilization management
- Engaging in quality management activities
- Developing shared IT (reporting/documentation)
Plummer Youth Promise

The Vision
Adopted 2009
A community committed to providing all children the support necessary to successfully navigate into adulthood

The Dream
Adopted 2015
Every young person has a family unconditionally committed to nurture, protect, and guide them to successful adulthood

The Plummer Home for Boys
Advancing partnerships among residential and community-based service providers, youth and families to improve lives.
Plummer Youth Promise

- Better programming did NOT = better outcomes
- Primary Focus on Permanency
- Focus on Family Search and Engage & Parenting Support/Education
- Focus on Building Community Support Network
Contact Information

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Plummer Home For Boys

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www.plummerhome.org  
jlist@plummerhome.org
California Residential Project

Transformation from long-term congregate care and treatment to short-term stabilization and treatment with follow along community-based services
Vision: LA County RBS Project

The creation of a strength-based, family-centered, needs-driven system of care that transform residential facilities from long-term placements to short-term family driven open therapeutic communities, which are not place-based and concurrently provide for seamless transitions to continuing community care, which support the safety, permanency and well-being of children and their families.
Benefits to Child and Family

- One Child and Family Team Across all Environments
- Care Planning Unifies Residential and Community Treatment (Wraparound)
- Family Search, Engagement, Preparation and Support from Day 1
- Building Life Long Connections and Natural Supports from Day 1
- Concurrent Community Work While in Residential
- 24/7 Mobile Crisis Support When in Community Phase
- Crisis Stabilization Without Replacement (14 days)
- Respite in the Community
Seneca Family of Agencies

Mark Nickels, Regional Executive Director
Who Is Your Loneliest Child?
LIGHTING THE FIRE OF URGENCY
FAMILY FINDING AND THE WRAP-AROUND PROCESS
Additional RBS Resources

Information on the California RBS Reform Coalition project and other County models can be found at:  www.rbsreform.org
Los Angeles County

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Resource Management Division
425 Shatto Place, Suite 303
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San Francisco/Santa Clara County

Mark Nickell, Regional Executive Director
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The Children’s Village

- CEO, COO and all VPs/Directors required to have open door policy to *any* family member
- Hired Parent Advocates (full-time, salaried and with benefits)
- Provide evidence-based parent education in English and Spanish
- Trained and launched Family Team Conferences (FTC)
  - Since some parents could not attend, developed mobile FTC Conference Centers
- Developed a variety of successful short-term (21-day, 28-day, 40-day, 100-day) residential models to provide stabilization and crisis respite for teens
- Beginning in 2005, secured “flex funds” for family support (available to all staff and Parent Advocates)
- Outcomes:
  - Overall median, annual length of stay for teens drop from over 24 months to under 6-months
  - Last year, over 800 teens were discharged in under 40-days
The Children’s Village

Outcomes for MST Intervention for 15% at “highest risk” (who previously consumed 75-85% of all aftercare/flex resources)

<table>
<thead>
<tr>
<th>Outcomes 2008 – 2010 6-month treatment</th>
<th>MST/WAY Treatment 25 youth and families</th>
<th>Comparison 23 youth and families</th>
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</thead>
<tbody>
<tr>
<td>In School</td>
<td>19 (76%)</td>
<td>10 (43%)</td>
</tr>
<tr>
<td>Arrests</td>
<td>4 (16%)</td>
<td>12 (52%)</td>
</tr>
<tr>
<td>Failure to remain at home</td>
<td>5 (20%)</td>
<td>16 (70%)</td>
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</tbody>
</table>

CV privately funded specialized MST teams to provide these families with the intensive support they needed.
Contact Information

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## Long-Term Outcomes (Recidivism)

- Data dynamically collected to 5-years post “discharge”

<table>
<thead>
<tr>
<th>Year</th>
<th>Recidivism Rate</th>
<th>Year</th>
<th>Recidivism Rate</th>
<th>Year</th>
<th>Recidivism Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>4%</td>
<td>2011</td>
<td>9%</td>
<td>2012</td>
<td>6%</td>
</tr>
<tr>
<td>2006</td>
<td>11%</td>
<td>2013</td>
<td>11%</td>
<td>2014</td>
<td>12%</td>
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<tr>
<td>2007</td>
<td>9%</td>
<td>2015</td>
<td>15%</td>
<td></td>
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<td>2008</td>
<td>3%</td>
<td></td>
<td></td>
<td>2016</td>
<td></td>
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<tr>
<td>2009</td>
<td>8%</td>
<td></td>
<td></td>
<td>2017</td>
<td>12%</td>
</tr>
<tr>
<td>2010</td>
<td>6%</td>
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- Recidivism typically occurs within the first 12 months post discharge
Damar: Practice Improvement

Definition of “Recidivism”

During the 5-years post “discharge” from the residential care setting, the youth is not placed in a similar or higher level of care.
Critical Incident of Primary Concern

If 24 hours goes by and a youth is not with his/her family and/or in his/her home community, it is considered a Critical Incident for the Agency and a plan of action/correction must be submitted to the COO*. (Note: Phone calls do not count.)

*Internal Quality Plus Threshold is 95% for Agency. If it's not measured, it's not managed.
Damar: Now We Know!!

Our Job is not to cure kids but rather to help kids and their families negotiate the basic tasks of everyday life.

“Residential treatment” should be oriented not so much around removing problems kids bring to care but toward establishing conditions that allow children and families to manage symptoms and crises more effectively at home and in the community.
COULD YOUR RESIDENTIAL PROGRAMS DO THIS?
2009 >>> Guaranteed Outcomes!

If a youth requires re-admission post “discharge,” it is FREE.

What if you guaranteed your outcomes?
Damar Contact Information

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www.damar.org
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jimd@damar.org
Family Adolescents and Children Therapy Services Inc (FACTS)/MN
Key Elements of Practice Model

Collaborative Intensive Bridging Services℠ – CIBS

- **Builds Collaborative Partnerships between:**
  Case Manager, Family Therapist, Child and Family, and RTC

- Ecology is the target of intervention not just the family

- CIBS is a 3 Phase Intensive Systemic In-home Therapy Model Integrated with a 30 day Residential placement
  - **Phase 1:** Initial engagement and assessment of family and child in-home, 2 to 4 weeks
  - **Phase 2:** Intensive RTC services, continuation of intensive in-home and RTC therapy 30-45 days, child has home visits so family can practice skills being learned in RTC
  - **Phase 3:** Intensive in-home therapy with child home
Key Elements of Practice Model

- CIBS is not RTC as usual – RTC focus during Phase 2 30 days is on:
  - Skills Practice not Mastery
  - Intense Family Focus
  - Frequent Home Time
  - Co-Therapy with Child and Family with Family Therapist and RTC Therapist
  - 3 Staffing within 30 days with all partners and child and family.

- Same Family Therapist stays with the family from beginning to closing through all 3 phases of CIBS, Family Therapist has 5 to 7 weekly contacts

- Family Therapist has small case loads between 4 to 5
Key Elements of Practice Model

- Focus is on building skills of children to better manage their emotions and behavior and to increase parents’ capacity to manage their child’s emotions and behaviors

- 2014 Dakota County MN Data Evaluation 24 months after RTC 30 day placement to compare CIBS Youths with Youth in Residential Placement.
  - **CIBS youths – 58**   **Comparison Youth – 34**
    - Subsequent RTC Placements 24 months after RTC:
      - CIBS 76% youth had no further placements
      - Comparison youth 35% had no further placement
    - Costs for additional services during 2 years post RTC placement
      - CIBS (14 youth) $236,928.10
      - Comparison Group (22 youth) $689,780.89
    - **Cost Savings of $452,852.80**
  - Services are paid through Insurance and County
Contact Information

• Lynn Van Blarcum, MA, LMFT
  Executive Director
  (651) 379-9800 x204
  lynn@facts-mn.org
As You Can See There Are Big Steps and Small Steps Being Taken

- All Steps Count
- A Number of Family-Driven & Youth-Guided Practices Have Been Identified That Support Better Outcomes
The Voices of Family and Youth

- Deborah Fauntleroy, Family Advocate
- Matt Anderson, Youth
Examples of A FEW FDC Practices

• Hiring of Family Partners/Advocates
• Mission/Values emphasize FDC as primary focus
• Orientation/Training/Supervision on FDC Commitment
• Use of Family Finding/Search & Engage; focus on permanency
• Sibling Support
• Clinical/other expertise in engaging/working w/ families (e.g., MST; FFT; Wraparound)
• Clinical/staff work in homes to support problem-solving real issues (not residentially created challenges)
• Families welcome 24/7
• Lose words ‘home visits’/’home passes’ – time w/ family and in home community begins at admission (not privilege)
• Staff/youth call families frequently
Examples of A FEW YGC Practices

• Hiring of Youth Advocates/Peer Mentors
• Mission/Values emphasize YGC as primary focus
• Meaningful Youth Advisory Council
• Orientation/Training/Supervision on YGC/TIC Interface & Commitment
• Understanding Impact of Trauma (e.g., use of sensory; repetitive/rhythmical; NO/VERY LOW restraint/seclusion/AWOLs/Police calls
• Individualized (truly) approaches (safety/soothing plans – PREVENTION/ TEACHING applicable at home/school)
• Eliminate points/levels/focus on consequences and behavior management (compassionate inquiry vs praise)
• Major staff focus on youth voice/choice
• Youth engaged/supported in community activities matching individual skills/talents/passions
• Youth have cell phones (w/ filters)/call family/approved friends often
• Focus on youth leadership/advocacy skills
• Education flexibility/creativity
“You never change things by fighting existing reality. To change something, build a new model that makes the old model obsolete.”

- Buckminster Fuller
Strategies to Address Challenges

Dr. James Whittaker: “I have more faith in a whole cloth approach where we start with a set of principles, change theory, structure and then select a limited array of key interventions to implement it .... This seems to me more consistent with what successful non-TRC EBP’s such as Multi-systemic Therapy and Multi-Dimensional Treatment Foster Care have done, than simply an approach that aggregates ever greater numbers of EBP’s in a residential setting.”

Elements of Effective Practice for Children and Youth Served by Therapeutic Residential Care | Research Brief/Casey Family Programs (2016)
Consistent Challenges Faced

- Most state agency documents/regulatory oversight (e.g., contracts; licensing; Medicaid) do not have best practice expectations and often have practices contra-indicated for effective outcomes
- Different systems (e.g., probation officers; child welfare workers) not supportive of focus on reunification/working w/ family in home/community
- Many residential programs have not had opportunity to learn/understand/implement effective practices to engage families/promote family-driven care
- Permanency Practice Models (e.g., Family Search & Engage/Family Finding /Expanding Support Network): no urgency
- Insufficient community based resources & supports
- Residential programs still struggling with coercive interventions and high # of incidents (e.g., restraint/seclusion/police calls/runaways/aggression)
### BBI Contact Information

**www.buildingbridges4youth.org**

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March 27, 2018
Association of Children’s Residential Centers
62nd Annual Conference
Successful Residential Transformation Strategies that Support Sustained Positive Outcomes for Youth and Families

Presented by: Carlene Casciano-McCann, LMHC
Executive Director, St. Mary’s Home for Children
About St. Mary’s Home for Children

- High-end residential treatment services and aftercare
- Acute residential treatment services
- Assessment and Stabilization program
- Outpatient services
  - Office-based
  - Home and community based
    - Enhanced Outpatient Services (EOS)
    - Outpatient Support Program (OSP)
    - Child & Family Trauma Team (CFTT)
    - Supporting Teens and Adults at Risk (STAAR)
    - Supporting Adoptive & Foster Families Everywhere (SAFFE)
- Special Education School
Why BBI?

- Wanted better outcomes for youth
- Research proved what we saw anecdotally
- Same youth cycling through
- Youth experiencing multiple placements
- Recognized need to better engage families
  - Parents NOT the enemy
- Youth in care too long
- Liked the framework because it wasn’t prescriptive
  - Allowed for creativity and flexibility in service of BBI values and principles
Preparing:

- Examined the outcomes for youth who had extended stays in residential
- Learned from another agency
- Created program design and logic model based on BBI framework
- Read BBI materials
- Brought BBI training to the agency
- Connected with Parent Partner agency
Making the Commitment

- BBI implementation is a significant component of our strategic plan
- Policies and procedures re-written to reflect BBI language/philosophy
- Job descriptions include commitment to BBI values and principles
- Parent Support partner embedded at the agency
- Added Family Liaison positions
- Ongoing training and support
Parent Partner Role

- Promote engagement of parents to fully participate in their youth’s treatment.
- Parent’s are involved in everyday decision-making about their youth’s care.
- Provide ongoing support and education opportunities
- Promote self-care and nurturing parenting skills
- Encourage communication between parents, St. Mary’s, DCYF, and other community based providers and natural supports involved.
- Provide aftercare services
Family Liaison Role

- Works in both the residential houses and family’s homes
- Facilitates family time between youth and family
- Supplemental parent coaching
- Provides aftercare services
- Coordinates youth’s involvement in community “normalizing” activities
Leading with Family Engagement

- Intake and admissions process is family-friendly
  - Meet family at venue of their choice
  - Interpersonal strategies to engage
    - empathy, validation, respect for cultural and religious beliefs, expression of hope for the future
  - Family is in charge of decision-making regarding replacement
  - Tour of the agency involves not just staff in the house. But kitchen, maintenance, nursing, teachers, etc.
  - House staff members meet with family to discuss activities, routine, allowance, transportation grant, etc.
- Residential Without Walls
- Commitment to EVERY youth having a connection
Beyond Family Engagement to busting barriers

- Daily contact with families via phone, home pass, or family time on campus
- Transportation provided when it is a barrier
- Community activities with families
- Family finding
- Treatment plans emphasize achievable gains, reinforce positive change and address the entire family’s needs - not just the child’s
- Education to families, DCYF, Child Advocate’s Office, CASA, and judges regarding research that supports shorter lengths of stay
- Interventions address interpersonal & practical barriers
- High levels of empathy and validation, cultural competence, case management, advocacy, motivational interviewing, and TFCBT
Aftercare

- Discharge planning begins at admission
- Parent Support Partner, Family Liaison, and home-based trauma clinician makeup the team from admission through aftercare
  - Some members of the team stay involved based on individualized needs
- Family receives six months of aftercare services
  - Home-based, weekly
  - Services based on family’s needs
  - Monitor family for up to one year
- Psycho-ed, case management, parent advocacy & support; individual, couples, and family treatment, and referral
Contact Information

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