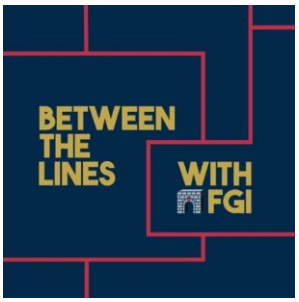

Episode 9

Ding! Ding! A Toast to Residential Care Dining Spaces: Addie Abushousheh

—Transcript—

[Intro music: “Skip to My Lou” by Neal Caine Trio]

Sponsorship

[00:00:00] **Bridget McDougall:** This episode of *Between the Lines with FGI* is brought to you by Specified Technologies Incorporated: Your partner in barrier management solutions.

[Music fades out.]

Opening

[00:00:14] **Addie Abushousheh:** So, if you imagine a fish jiggler, that is lutefisk, and then you cover it in white sauce to try to drown out the taste, [that] is what, more so than any other type of food, carries a memory for me.

[00:00:30] **Bridget:** I might be down with that. We were raised in the 70s, and that was the era of Jell-O with all manner of surprise things inside. So why not? Why not fish?

[Music: "Skip to My Lou" by Neal Caine Trio]

Intro

[00:00:46] **Bridget:** Welcome to *Between the Lines with FGI*, a podcast brought to you by the Facility Guidelines Institute. In this podcast series, we invite you to listen in on casual conversations related to health and residential care design and construction. Coming to you from Washington state, where the official state vegetable is the Walla Walla sweet onion, is FGI's own John Williams, vice president of content and outreach and chair of the 2026 Health Guidelines Revision Committee.

[00:01:15] **John Williams:** And coming to you direct from St. Louis, Missouri, where the state food is the ice cream *cone*—

[00:01:21] **Bridget:** We put ice cream in it. We do.

[00:01:24] **John:** I don't understand why it's just the cone. Why not the ice cream? Bridget McDougall, associate editor with FGI. And here we are because we are just fascinated with conversations about the health care built environment and all the things that we do in the FGI *Guidelines* to make them safe and supportive.

[00:01:42] **Bridget:** Today we're going to be going between the lines of the residential *Guidelines* document with our guest Addie Abushousheh, chair of the residential document group of the 2026 revision committee.

[00:01:54] **John:** And today, Bridget, we're serving up a hot plate of residential care, specifically the importance of food in residential spaces: where it's served, how it's served, and how the built environment plays a role. So, pull up a chair, fill up your glass, and let's get ready to talk with Addie about kitchens and dining spaces. Ready, Bridget?

[00:02:13] **Bridget:** Let's dig in. Ding, ding!

Welcome and get to know our guest

[00:02:20] **Bridget:** Welcome, Addie Abushousheh!

[00:02:22] **Addie:** Thank you so much.

[00:02:24] **Bridget:** Addie, as the chair of the residential document group for this *Guidelines* revision cycle, you are steeped in the subject of residential health care and support facilities.

[00:02:34] **Addie:** I have co-chairs, John Shoesmith and Gaius Nelson, who are absolutely fantastic in terms of thinking through the operational, the care provision, as well as the environmental supports for all of these different facility types. And our residential document group is comprised of the most wonderful, talented, passionate people that we could hope for.

[00:02:58] **Bridget:** They would say the same of you, I am sure. So, you have maintained a faculty position with Kent State University for about seven years. You're also part of the Advancing Excellence in Long-Term Care Collaborative. What is your day job, so to speak?

[00:03:16] **Addie:** I am with The Center for Health Design, and I am the organizational and environmental gerontologist that is part of our research team.

[00:03:28] **John:** Addie, when I think about you, I always think residential care and all spaces around that particular orbit. How did you get involved in residential spaces and residential design and planning?

[00:03:41] **Addie:** It was kind of by accident. I was very interested in the way that buildings support individuals who cognitive and physical frailty. After I finished my first degree in architecture, and had a minor in organizational development, I went to work in a traumatic brain injury unit, and I was able to work with people aged 16 to 86 who had suffered various types of traumatic brain injury. So, I was able to learn the way that individuals who have varying degrees of cognition impairment in different parts of their brain interpret the built environment. It's a pretty intuitive kind of approach. The environment tells you how to use it. You push a button, pull a lever, and turn a knob.

Commented [BES1]: Can you double check the audio and hear if this is who or who've?

[00:04:28] **John:** And that really speaks to something that we talk about a lot, within the *Guidelines* revision committee and this podcast: being that interpretive bridge between people who speak different languages, but you just opened my eyes to a whole new way of thinking about how people interpret the visual cues in the environment as well.

[00:04:47] **Addie:** Yeah, absolutely. Because a lot of times whenever you're talking about varying degrees of cognition impairment, especially when you're talking about frontal lobe impulse control, certain features in the built environment might look like a bathroom, and therefore they promote that kind of behavior in areas that are not intended to be used toilets.

[00:05:07] **John:** Or a button that's just begging to be pushed, perhaps.

[00:05:10] **Addie:** I do love to push buttons.

Changes in the "legacy language"

[00:05:12] **Bridget:** Yes, we do appreciate that about you. Addie, you mentioned to us that much of our legacy language in the residential *Guidelines* has undergone pretty radical changes. Can you tell us a little bit about what you mean?

[00:05:24] **Addie:** Yeah, absolutely. So, in long-term care kind of settings, you know, we have gone from thinking about the physical plants as "wards" and talking about those who are receiving care as "inmates" to really gaining a different kind of credibility or financial foothold as an extension of acute care services where we started to characterize people as patients think about our buildings as extensions of acute care. And in response to this shift in what we would call our legacy language, we're seeing some really significant shifts in the way that we characterize and capitalize upon building types as well as support services that are taking place within the buildings.

[00:06:16] **John:** And, you know, that makes a lot of sense. I think the very first lesson that I got when I started going through residential care facilities and trying to understand the codes and standards was, "We don't call folks in these spaces *patients*; we call them *residents*." And it's more about understanding how you provide care to a person who is in, effectively, their home, and that substantial layer of personal rights and autonomy, and choice, self-determination, around that space that is really your home.

[00:06:48] **Addie:** Absolutely. This year is the 50-year anniversary of the first community that was designed to support individuals who have dementia. It was based upon evidence-based design standards that were coming out of care settings that were providing care for individuals who had schizophrenia. We started to see that the individuals who are receiving care in traditional skilled nursing settings were . . . jealous maybe isn't the right word, but we were observing [individuals asking] why can't I receive that kind of care? Why don't I qualify for the kind of empowerment and self-determination and autonomy that we're providing to individuals who have cognition deficits just because I don't and because I have physical frailty?

Food as an extension of autonomy and choice

[00:07:37] **John:** You and I, Addie, were at a conference not so long ago, and we started talking about autonomy and choice and things like that inside of residential care spaces and you brought up the concept of food, which is fascinating to me. And it totally clicked when you said it. If I want control over my own environment, one of the main things that it's about is food and my choice of where food is delivered, what food, how it's prepared, do I get to help—all of those things.

[00:08:06] **Addie:** The primary complaint that comes into the Centers for Medicare and Medicaid Services, CMS, is about dining. There's responding to the agency of individuals for

decision making and not assuming that somehow just because a person has experienced deficits or impairments that they are disabled for making decisions on behalf of themselves.

If they aren't able to convey preferences verbally, they will convey those behaviorally. There's also additional emphasis being given to the autonomy and the functioning, not just of individuals who are receiving services, but those who are providing services and the local areas where care and services are being provided.

Can those function as autonomous units in small house models, in subunits, or small business units of a larger organization? Do they have decision-making control? And that is something that very much we're looking at with subject of dining. We took this on in a food preparation kind of capacity.

What to expect in the 2026 draft document

[00:09:16] **Bridget:** And when you say, "We took this on," you're referring to the residential document group, right? The part of the 2026 Health Guidelines Revision Committee. So, in what way did you do it? How'd you take it on?

[00:09:28] **Addie:** So, nursing, for example, you could have a traditional institutional building with a central commercial kitchen, or you could be using household kitchens. You could be using warming, serving kitchens. So, we not only revisited precisely what these kitchens were, how the food was being prepared, and by whom the food prepared; we shifted all of that language into the common elements chapter [of the 2022 Residential *Guidelines* document], and consolidated it such that each one of the chapters could reference, and designers and organizations that are providing services could have a little bit more control in that regard.

Kitchen choices are up to the facility

[00:10:09] **John:** So, I'm looking at page 93 in [the] common elements [chapter of the 2022 Residential *Guidelines* document], and there's this whole section on food service facilities, and it almost looks like there is an á la carte approach. You've got commercial kitchens, retail kitchens, household kitchens, of those things. And if I'm hearing right, you've made it a choice for the facility to choose how they want to deliver care, and you're just laying out, "OK, if you want to choose item one and four, here's how you would build them." Is that right?

Commented [MOU2]: Is this 'of' or 'all' in the audio?

[00:10:38] **Addie:** Absolutely. In certain communities, it's not necessarily a choose between [different types of kitchens]. It might be combination of all of the different types of kitchens. So in, again, lifespan communities or continuing care retirement communities that have the continuum of independent living, assisted living, nursing, as well as memory care/rehabilitation, you might actually end up with *all* of these types of kitchens and be working to extend your

services to the community by providing opportunities for those who live in and around your site to come in and take advantage of special kinds of food options and restaurant options.

[00:11:20] **John:** That makes perfect sense. And I could see that; even an outpatient training kitchen for helping people in the community learn about how to provide food or cook food or what have you.

[00:11:29] **Addie:** Absolutely.

[00:11:30] **Bridget:** Can you help wrap my head around some of these different kitchen types and what they mean? So, John mentioned the commercial kitchen, which I think is what we think about when we're thinking about a kitchen for a facility like this. But what's the difference between that and a household kitchen?

The household kitchen

[00:11:46] **Addie:** The household kitchen really gets back into that functional autonomy kind of concept where we're seeing smaller self-contained households that are typically between 10 and 20 individuals who are receiving services in a particular setting have a full kitchen, pantry, and dining area where they can prepare food from scratch that responds to the preferences of the individuals who live there and involve the individuals who are living there in the selection, menu planning, and preparation and serving. It really is so meaningful for the way in which we live our everyday lives, that to remove it diminishes the personhood and the meaning for living on a daily basis.

[00:12:37] **Bridget:** Everybody in our generation probably can call up their grandparents' recipe box and everything in there and that those recipes told stories and were passed down from generations or from neighbor to neighbor and what that means to be able to carry that into your living setting, to be able to create food and prepare and provide food.

[00:12:57] **John:** Or the option to cook seasonally.

[00:13:00] **Addie:** Seasonally, culturally, spiritually, we take them for granted when we're living in our own private residence, but it's something that if that is one of the only retainers for your individuality and your connection to where you previously lived and the people that you previously associated with, it's so powerful.

[00:13:21] **Bridget:** Food and smells are the kind of thing that I think do wonders for memory, correct? Like, it can just really transport somebody right back to a certain time and place.

Dementia and the negative impact of the commercial kitchen approach

[00:13:34] **Addie:** Absolutely, Bridget, and that is so key to part of this evidence-based design process for having the cooking that's localized where individuals are living closer to resident rooms because when a person develops certain types of dementia, sometimes there's a lag in recognition from a sensorial perspective to the smell of food or the appearance of food.

So, whenever you have food that's been centrally prepared in a commercial kitchen, plated, sent in on trays, and then delivered in front of an individual who's been sitting at a dining table for an extended period of time waiting for the food to arrive, and it's revealed to them, they actually don't recognize the food as something that they're hungry for because they haven't had time to have that smell.

[sound of person smelling]

[00:14:29] **Addie:** They haven't had time to hear the sound of the cooking . . .

[sound of food sizzling]

[00:14:35] **Addie:** . . .to hear the conversations that accompany the preparation of the food.

[sound of conversation]

[00:14:44] **Addie:** So, there's a lack of responsiveness. Not only is an individual not prepared to eat, this is where we see a lot of the weight loss, and the unintended side effects of that kind of service result in excessive supplements, weight loss, and loss of strength.

[00:15:06] **Bridget:** Such a good point about how those associated senses all factor into somebody's experience of identifying food. That's incredible. I've never thought about that before.

[00:15:18] **John:** So, you've got the commercial kind of production kitchen. You've got this household kitchen. What is a social activity kitchen?

The social activity kitchen

[00:15:25] **Addie:** So, this is something where, as the name implies, literally this might be something where it is intended for social activity for the individuals who are living in the care setting, for them to together to have a hand in the preparation and turn it into something that is an extension of an activity program. As opposed to playing bingo, we might make cookies.

We might shuck corn. We might do any number of things where we are going through the process of doing something that meaningfully contributes to enjoyment at the end of that process.

[00:16:05] **John:** And an outpatient therapy kitchen, is that like a training kitchen for people living out in the community?

The outpatient therapy kitchen

[00:16:12] **Addie:** Not necessarily living out in the community, but we've got a lot of folks who have certain types of rehabilitation, therapeutic goals that are coming post-op, or that for a period time just need to strengthen certain aspects of their body, what have you. From an outpatient therapy kitchen perspective, we're looking at really learning to reuse our physical strength to function within a residential kind of setting; to use the stove, to have that range of motion for reaching into cabinets, for microwaving meals, for stooping down to get something out of the oven. So, we're really looking at that as another mechanism to facilitate therapy.

[00:16:59] **John:** OK, so these kitchens are going to look almost like an occupational therapy kitchen where it's got a residential range, a residential refrigerator, microwave at normal counter height to help them understand and learn how to get back into that food preparation at home kind of business.

[00:17:15] **Addie:** Absolutely. And, you know, really there, safety is the name of the game to rebuild capacity so that additional services aren't required once they get back into their own home.

The warming and serving kitchen

[00:17:28] **John:** And then finally, that warming and serving kitchen, it's kind of like the full spectrum down from production down to just a place where food lands and you're able to reheat or break apart and distribute that out to any type of setting. Is that right?

[00:17:43] **Addie:** It can be. It can be a combination of a central kitchen and almost like a household kitchen where you have different kinds of strategies. You could have a steam table. You could have one of the flash-freeze, rapid reheat ovens where you have that delivery process that's an intermediary kind of service component between the actual preparation and then the service of the food, but gives the individuals who are living in a particular care setting again, access to that final finishing touch where you are plating, where you can smell the preparation of the food, and have the appearance of a kitchen that is familiar from a residential character perspective in the home that they're living in.

Centralized and decentralized kitchens

[00:18:30] **Bridget:** Another thing that the *Guidelines* mentioned is centralized and decentralized kitchens. Can you speak to that?

[00:18:37] **Addie:** So that was in large part some of the older language that was present in the 2018 edition [of the Residential *Guidelines*]. And some of this is, you know, us picking up on things of what is there versus what's intended, but I think what you're seeing there is a difference between the centralization and then the decentralization on the household, the warming/serving kitchen, certainly outpatient therapy kinds of opportunities where food preparation is taking place in smaller-scale settings on more of an individual or small group basis.

[00:19:12] **John:** And as a designer or a planner, how would you broach that conversation with a facility who's planning on building a new building, a new campus?

The importance of the functional program process

[00:19:21] **Addie:** So, I send folks to the functional programming process first and foremost because we have to have absolute clarity from a design perspective on the way in which services are intended to be provided, the kinds of capacity that an organization intends to have with regard to preparation, before we can dive in and support that from an environmental design perspective. We're trying to make sure that we engineer the glove to fit the hand, as opposed to the other way around.

[00:19:56] **John:** I'm guessing that there's importance not only to how people cook and how people experience food preparation, but where they eat, too.

[00:20:06] **Addie:** This is something that we are actively engaging in right now in preparation for the 2026 *Guidelines*. We have been responsive to or tried to be responsive to both shifts that we've seen within the industry as well as the food preparation kitchen kinds of strategies that we were able to introduce in the 2022 *Guidelines*. Not only that, but we've had an eye toward enforceability; the square foot allocations and clearances that we're trying to introduce to really make it the most functional space possible, especially when you have individuals who in long-term care increasingly use mobility aids.

Dining areas—size considerations

[00:20:53] **John:** We pay a lot of attention to numbers in the *Guidelines* because those are things that we can count and those are pretty clear finish lines that people can cross. I know that there's been some conversation around the size of these dining areas, especially when we

think about mobility aids and the extra space that you need around those. Are we looking at the numbers, like 28 square feet, at all? Are we moving that up, down, sideways?

[00:21:21] **Addie:** Yeah, so that's a really good question, and it is something that we have responded to in the 2026 [revision] cycle. So, one of the proposals is to move language that has previously been in the appendix—a recommendation—of 28 square feet per occupant into a requirement, and this is accompanied by a minimum dimension of 14 clear feet between walls.

To have individuals seated on two sides of a table, as well as individuals who are providing services, you really need that 14-foot clear. Now, to your point, in terms of mobility aids, if you have a population that is fully ambulatory, everybody can walk around on their own, 25 square feet typically is enough, and we left room for approvals by authorities having jurisdiction based upon care populations. If you move, however, into a situation where you've got about 25 percent of the population that's using mobility aids, you really need to think more about 30 square feet. And if you've got 50 percent of your population using mobility aids, you have the best functionality at 40 square feet per person.

We don't get into operations. We say this repeatedly. However, we do recognize that in dining environments, there are different seating times. So, you might not have the entire occupant population that is using the dining room at one particular time. You may have a rise-to-dine kind of opportunity, where as people get up as they would like to, that's when they make their way to the dining room. So again, you're not trying to seat everyone at one time. It's these moments where you have holiday or special event or activities that you really do need a room to be functional, to at least get everyone in and everyone out safely and efficiently, where you need to have these clearances.

[00:23:30] **Bridget:** How do you account for the space needed for visitors and families?

[00:23:35] **Addie:** That is an excellent question. So again, I'm going to talk about some legacy language here. Historically, when we have been talking about traditional institutional care settings, we didn't necessarily make room for companions, for visitors, for volunteers. We had feeders and assistants. So, you could have one assistant providing food to four individuals, sometimes six individuals, around a feeding table that needed assistance with dining. What we have transitioned into and what we're seeing more and more of is that we have better outcomes when you have individuals who are accompanying those who are dining where there's that relationship to capitalize upon. There's the conversation to capitalize upon. So, we want to make space for dining companions, for volunteers, for visitors.

Four types of dining spaces in the 2026 draft document

[00:24:34] **Bridget:** So, you mentioned the work of this current committee and what's going to go into the 2026 draft, and by the way, folks will be able to find that 2026 draft available for

public comment starting July 1st all the way through September 30th—you can check out our website. But there's this whole section in the residential draft that came about that's about dining area types. And I was really fascinated about this going back to John's mention of autonomy, breaking it down between four spaces: private dining, outdoor dining, in-room dining, and kitchen associated dining area types. Tell us a little bit about the process of landing on those four spaces.

Private dining

[00:25:17] **Addie:** Dining really is the workhorse of long-term care because you are not using dining areas as single function kind of spaces. There are a host of activities that take place in dining spaces, and from a private dining space that you mentioned, Bridget, I think that this is really very important for us to consider because we're not only providing services to the individuals who are living in or receiving care services; we're providing services to their companions, to their family members, to individuals who provide their life meaning and whose relationships we need to still be able to support. So, private dining rooms is something in that regard where if there's a special family event, or a birthday, or something like that, we want to make sure to give them an opportunity to have that experience separate from the . . . a larger dining space that could be louder, it could be just a little bit more chaotic, but to give them the intimate kind of dining experience.

[00:26:24] **Bridget:** In the episode before yours, we interviewed Mandy Kachur, an acoustic engineer, and one of the things that she was talking about was residential dining spaces and how important it is to get those acoustics right because it can be really isolating for folks who have a hard time hearing to be in an environment that's loud and noisy and chaotic and you're there to socialize and can't do it.

[00:26:46] **Addie:** Absolutely. I am a huge fan of Mandy's, and she has done so much work with the acoustics group to try to inform and put performance parameters on dining spaces. Her work, which has been exploratory in the 2022 [revision] cycle, really took a deep dive into the performance of large-scale dining settings and what we can do to try to improve the performance.

[00:27:11] **Bridget:** OK, so take us from private dining to outdoor dining.

Outdoor dining

[00:27:15] **Addie:** This is something that is really exciting to me, especially, as a result of my own research. I was looking at the sequencing of food preparation to service and found that in the most successful communities that I was going into, not only was the food service taking place in dining rooms, but there was this extension of that dining space into outdoor areas where a person could take their coffee and read the paper in the morning, where you could do

some growing of vegetables that you could grill. You could invite people from one household over to another household. So, just like in our own homes where we use the patio or something like this as an extension of our food preparation and service, these outdoor dining areas really are pretty important.

[00:28:01] **Bridget:** Oh my god, absolutely. A little dining alfresco. That is the best.

Commented [MOU3]: Should this be alfresca?

[Sound of descending marimba bells]

[00:28:09] **Bridget:** [Post-interview interjection] OK, my Italian-speaking friends, if there are any of you out there, I am fully aware and embarrassed that I said alfres*ca,* [laughs], the sparkling soda, and not alfres*co*, [Italian for] dining outdoors. Anyway, enjoy! Where's my [language learning program] Rosetta Stone?

[Sound of descending marimba bells]

[00:28:28] **Bridget:** OK, so now in-room dining.

In-room dining

[00:28:30] **Addie:** I think especially where individuals who are receiving rehabilitation services are concerned, they are just exhausted by the end of the day, and going to a group kind of dining setting is just more than they can actually manage. And there are a lot of people who choose to eat in their rooms, in private.

[00:28:52] **Bridget:** I was gonna say you could call that in-room/introvert dining and I'd be there.

Kitchen associated dining

[00:28:58] **Addie:** Absolutely. And then as I mentioned, we have these kitchen associated dining area types where you're never going to do away with the large scale dining areas, but none of us want to do away with those. We go to restaurants on purpose. This is where we want to be in the company of others and have that kind of entertainment value associated with dining.

And, you know, from a food preparation perspective, we're seeing the display kitchens that are visible to these areas more and more, or the brick oven kind of preparation. But we've got, you know, the retail dining that's associated; if you think Starbucks, I mean, you're going to go, you're going to buy your cake pop and your double soy latte, and have a seat right there.

From a household dining perspective, this is directly responsive to that household kitchen, where the food that has been prepared for small groups of individuals is then going to be shared by that same small group of individuals. And that's really about relationship development. We're seeing not only the individuals who are receiving care, but those who are providing care participate in that dining process and having dinner and lunch and breakfast together.

[00:30:15] **John:** So, is that proposal kind of a similar approach to the kitchen approach where you have a set of options and the facility itself has the autonomy to choose which option they want to design in?

[00:30:28] **Addie:** Yeah, they can choose between or a combination thereof. And so our dining à la carte becomes, in essence, a kit of parts that you can choose between to support your care strategy in your building type, regardless of the level of care that may be provided.

One of the things that we've tried to do within this particular setting is recognize that where a person dines is not the only kind of consideration associated with dining. For a lot of older adults who have physical frailty, there's an associated component having to do with a toilet room, toilet facilities, and that you need to have access in pretty short order quite frequently, and hand washing stations. So, it's clearances, it's service provision types, it's those associated support areas. Really, this cycle we took the deep dive on dining.

[00:31:28] **Bridget:** With that deep dive, [have] there been any surprises?

Folks want happy hour!

[00:31:32] **Addie:** I have to say that in long-term care, increasingly, we are finally responding to the desire for happy hour. You know, nobody wants to give up their mixologist kind of approach to living, and that's something that I think is gaining a foothold where hadn't seen one before.

[00:31:52] **Bridget:** Absolutely. Let me tell you, if my husband and I live long enough to be in a retirement community, there better be really good coffee. I'm talking good Italian espresso machines. None of this cheese and crackers situation. No apple juice.

[Music fades in: "Skip to My Lou" by Neal Caine Trio]

[00:32:10] **John:** We've been designing these spaces for so long and trying to do it so intentionally, and we're just now getting to this concept of this core function to being a human, to living. The concept of eating is such an important consideration in a place where somebody lives.

[00:32:28] **Addie:** It's a core component in both living there as well as I think providing services.

[00:32:34] **Bridget:** Absolutely.

Wrap-up

[00:32:35] **John:** Addie, this has been fascinating. Thank you so much for being here and sharing with us how we're being really intentional about evolving these *Guidelines* and providing a lot of options for facilities to support the communities that they're in.

[00:32:49] **Addie:** Absolutely. My pleasure and my privilege.

[00:32:52] **Bridget:** I hope to catch you all in about 40 years in the social activity kitchen. I'll bring the brownie recipe.

[00:32:59] **Addie:** . . . a.k.a. "bar."

[00:33:01] **Bridget:** Whatever you need there, we'll have it.

[00:33:03] **Addie:** We're aiming for special brownies, Bridget.

[00:33:06] **Bridget:** Not those kind of brownies! But I don't know, maybe they can toss something in. Who knows what the laws and the fun will bring years from now?

Outro

[00:33:17] **Bridget:** Thanks for joining us for another episode of *Between the Lines with FGI*. Do you have an idea for an episode or a question that you'd like us to answer? Please get in touch by writing to us at podcast@fgiguidelines.org.

[00:33:32] **John:** Also, if you're interested in becoming a sponsor for one or a series of episodes, you can reach out to us at the same address. It is podcast@fgiguidelines.org.

[00:33:41] **Bridget:** Many thanks to Neal Caine and the Neal Caine Trio for the use of his song "Skip to My Lou." You can find it on the album of the same name.

[00:33:50] **John:** Join us next time as we go between the lines with FGI. Bye, everybody.

[00:33:54] **Bridget:** See you next time.

[Music fades out.]