# E10

# Designing Care Spaces with Our Future Selves in Mind: Jane Rohde

# —Transcript—

(*"Skip to My Lou" by Neal Caine Trio plays.*)

## Sponsorship

[00:00:02] **Bridget McDougall:** This episode of *Between the Lines with FGI* is brought to you by the Facility Guidelines Institute: The keystone to health care planning, design, and construction.

(*"Skip to My Lou" by Neal Caine Trio fades.*)

## Opening

[00:00:14] **Jane Rohde:** We weren't born and raised in a double-loaded corridor. Even an apartment has a house layout. But if you're sharing a room with one other person and [the only other thing] you have is a bathroom and a curtain, that's an acute care setting made to be where someone ends up living.

(*"Skip to My Lou" by Neal Caine Trio plays.*)

## Intro

[00:00:31] **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 in 1965, pickleball was invented. . . [Do] you play pickleball, John?

[00:00:53] **John:** No, but I used to live down the street from where it was invented.

[00:00:56] **Bridget:** Uh-uh.

[00:00:57] **John:** Another fun fact is pickleball is not named after a fermented vegetable. It's actually named after the family dog.

[00:01:04] **Bridget:** Oh, here, Pickle!

(*Dog barks.*)

[00:01:06] **Bridget:** Anyway, along with Pickle, we've got FGI's very own John Williams, vice president of content and outreach and chair of the 2026 Health Guidelines Revision Committee.

[00:01:16] **John:** And coming to you live and in person from St. Louis, Missouri, which instead of being named for a dog was actually named for King Louis IX . . .

[00:01:23] **Bridget:** That's King Louis IX of France. Bonjour!

[00:01:27] **John:** . . . is Bridget McDougall, associate editor with FGI. And we are here because we love the conversations around health care-built environments and all things related that we do to make those spaces safe.

[00:01:39] **Bridget:** Today, we are going to be joined by Jane Rohde, who is known as the mother of the Residential *Guidelines* document.

[00:01:48] **John:** Jane was the tri-chair for the residential document group until 2022 and participated in the creation, if not the birthing of, the residential document.

[00:01:59] **Bridget:** Jane is principal and founder of JSR Associates, and she has over 30 years of senior living, health care, and sustainability consulting and design experience.

[00:02:10] **John:** And [Jane is] such a key figure in the FGI world. She received the Pioneer Award from FGI in 2020 for all of her efforts in being a visionary in leading us into this residential space. It's such an honor to have her here with us today. Ready to go between the lines of the residential document, Bridget?

[00:02:29] **Bridget:** I'm ready. I think you're ready. Pickle the dog is ready. King Louie's ready. Let's do it.

(*“Skip to My Lou” by Neal Caine Trio fades.*)

## Guest welcome

[00:02:38] **Bridget:** Welcome to you, Jane Rhode. Thanks for joining us today.

[00:02:40] **Jane:** Thanks for having me.

## What facilities are covered in the residential *Guidelines* document?

[00:02:43] **Bridget:** So, much like its hospital and outpatient document siblings, the residential document is separated by chapters addressing specific requirements for particular facilities. To help folks get a big picture view here, I’m going to name each facility type that’s in this document, and I’m hoping you can say a sentence or two that can briefly explain what each facility is—kind of where we would see this facility and what patient population it serves. So, nursing homes?

### Nursing homes

[00:03:09] **Jane:** Nursing homes would be your long-term care. Sometimes we also see rehab as part of that because nursing homes are usually licensed for both. The care population is usually a certain number of ADLs that cannot be handled or maintained through assisted living.

[00:03:25] **Bridget:** ADL, Jane, help me. ADL?

[00:03:27] **Jane:** Oh, sorry—activities of daily living; things like bathing, toileting, changing your clothes, feeding, that kind of thing. But basically the care population is a higher frailty, either mobility-wise and/or cognitive-wise, depending on the resident themselves.

[00:03:44] **Bridget:** OK. Hospice facilities.

### Hospice facilities

[00:03:46] **Jane:** Hospice care is really for those who are terminally ill and working through the process of passing to the next world. It’s basically to allow someone to pass with ease, and you want that to be in the most comfortable, amazing setting possible. Services can come to your home, services can come to assisted living, but then there’s also dedicated hospice facilities. Those are usually licensed under nursing homes, depending on the jurisdiction. So, it really depends on like everything, as we know, John, right?

[00:04:12] **John:** Exactly.

[00:04:13] **Jane:** Everything depends on the jurisdiction.

### Question about skilled nursing facilities/SNFs

[00:04:15] **John:** So, I want to jump in here with another question because I think in the same space, there's this term floating out there that I hear in a lot of context and it confuses people. So, *skilled nursing facility,* or SNF, or like I call it: sniff.

(*Person sniffs rapidly*.)

[00:04:30] **John:** Where does that fit?

[00:04:31] **Jane:** So, that would fit under nursing homes. And the reason we utilize the more generic term *nursing home*, instead of using SNFs or skilled nursing facilities (because that's what we started with)—the reason being is that there are many jurisdictions and one that I happened to be working with at the time that actually, they licensed nursing homes, but they had a different licensure for skilled nursing facilities because it had a higher level of staff requirements and some other things that they required. So, we thought nursing homes was the most generic terminology that we could use. Most states do license to the skilled nursing facility level, but the criteria is the same, so if somebody adopts the *Guidelines* to use it as code and licensing code in their state, we would say that the skilled nursing facilities would fall under nursing home.

## Other facilities covered in the residential *Guidelines* document

(*Soft bossa nova music plays.*)

[00:05:18] **Bridget:** Hey, everybody! It's Bridget of the future talking to you all of the present. OK, so when we were doing this interview, I started off by asking Jane to tell us about each specific facility that's listed in the residential document book, and then we all got so into the conversation, we kind of just let it naturally go on some twists and turns, and while we got to them all, I didn't want to leave you all hanging with thinking that you were getting a list. So here it is. There are nine different facilities that are covered in this document. We talked about nursing homes and hospice facilities. Coming in at number 3: assisted living settings.

(*Ding!*)

[00:05:55] **Bridget:** Number 4: independent living settings.

(*Ding!*)

[00:05:58] **Bridget:** Number 5: long-term residential substance abuse treatment facilities.

(*Ding!*)

[00:06:04] **Bridget:** Number 6: settings for individuals for intellectual and/or developmental disabilities.

(*Ding!*)

[00:06:11] **Bridget:** Number 7: adult day care/adult day health care facilities.

(*Ding!*)

[00:06:15] **Bridget:** Number 8: wellness centers.

(*Ding!*)

[00:06:18] **Bridget:** And rounding it out is number 9: outpatient rehabilitation therapy facilities.

(*Ding!*)

[00:06:25] **Bridget:** Back to your regularly scheduled podcast!

*(Soft bossa nova music fades.)*

[00:06:31] **Bridget:** Is there a way that you can help folks understand kind of the totality of what's in this document and how, what kind of spaces are broken down into what pockets?

## Evaluating based on the continuum of care

[00:06:42] **Jane:** So, how we evaluated it was to look at the continuum of care, putting together the different pieces and parts. So, that's why we have nonresidential support facilities that are also included. That's things like adult daycare, adult day health care, what we call P.A.C.E.—programs for all-inclusive care of the elderly, and why we also evaluate, outpatient rehab.

[00:07:04] **Jane:** I think that there's a thought missing: usually we look at it by diagnosis, not by demographic. So, we try to encourage people to look at it from a demographic perspective because who's using most health care? Older adults and older staff. When you start to get into the 45 to 65 is your average age for a nurse, you also start having some of the same issues, whether those are mobility issues, those are site issues, acoustics, or hearing issues. So, that's kind of the bigger bucket.

(*Upbeat jazzy-funk music plays.)*

[00:07:43] **Jane:** Then we tried to figure out, OK, so how does that bucket get divided? And that's how we ended up with residential health facilities. So those are places where

specifically health care is needed because of a, basically a diagnosis or your activities of daily living not being able to be met. So, that has more of a clinical focus, and nursing homes and hospice both have those; they're just at the opposite extremes.

(*Upbeat jazzy-funk music continues.)*

[00:08:16] **Jane:** And then residential care and support facilities, some are licensed, some aren't, right? So, assisted living can be unlicensed or licensed depending on the scale, size, how many people, how many residents, in what state, county, and township you're in.

(*Upbeat jazzy-funk music continues.)*

[00:08:34] **Jane:** Independent living [is] not licensed; however, if it's going to be for affordable housing, a lot of times it's age-restricted. So, then we want to look at the independent living and the components of that, and what are the congregate care or the potential other services that might be adjacent or part of that.

(*Upbeat jazzy-funk music continues.)*

## Long-term substance abuse and treatment, settings for individuals with intellectual or developmental disabilities

[00:08:54] **Jane:** And then the other two chapters that came up in 2018 and then in 2022 were the ones for long-term substance abuse and treatment. And that was because we realized that any age can have these issues, but it's really considered a long-term setting because it's longer than even a week, or three days, or two days, or whatever.

(*Upbeat jazzy-funk music continues.)*

[00:09:16] **Jane:** So, we worked on that using different protocols in different states, and it's the same with settings for individuals with intellectual or developmental disabilities. Typically the terminology used state-wise is group home, but a lot of times we use that for older adults too, because it fits the criteria better.

(*Upbeat jazzy-funk music fades.)*

[00:09:39] **Jane:** You're trying to push and pull between zoning and licensing and the building code. This is probably the only group where we actually use the single-family IRC. . .

(*Bubble pop!*)

[00:09:48] **Bridget** (Inserts)**:** International *residential* code.

[00:09:50] **Jane:** . . . versus the IBC. . .

(*Bubble pop!*)

[00:09:52] **Bridget** (Inserts)**:** International *building* code.

[00:09:44] **Jane:** . . .which is more commercially based. And then the nonresident support facilities, looking at how do you help people who are in those vulnerable situations?

## An á la carte approach to designing

[00:10:03] **John:** That's a really good way of describing it. So, if I can try to put it in different words, it's like you're asking us to focus on community and really try to understand who are the people in that community. And you've given us almost an á la carte approach to say here are all the different types of communities that exist and understanding that many of them can be on one particular campus. So, you might have a skilled nursing facility along with a[n] assisted living-type community along with an independent community and how do those coexist and sort of play together on that same campus? And how do we calibrate requirements and minimum safety kind of considerations to each of those different communities?

[00:10:45] **Jane:** That's right. And we always think of it as a community, and if you talk to some of my more advocacy-based folks, if you see the word *facility* and older adults are vulnerable populations, they call it the "F-word."

(*Laughter*.)

[00:10:56] **Bridget:** Oh, dear.

[00:10:57] **John:** [That's] good to know.

[00:10:58] **Bridget:** Why?

[00:10:59] **Jane:** Because a facility has a clinical connotation.

[00:11:01] **Bridget:** Mmmm.

## Nursing homes, assisted living, and reimbursement

[00:11:03] **Jane:** And so, you know, these are places where people live, and nursing homes were never designed for someone to live for 10 or 15 years in a nursing home bed, in 80

square feet, right? Nobody was ever intended for that. It was really meant to be an extension of the acute care setting where someone went for a short period of time and then generally passed away. Like, it gave them a transitional place or a step down. And what has happened over time is that that didn't work anymore. So, people who couldn't afford assisted living when the assisted living market came in, just as context, when that became something that was viable, it was really meant to just assist people who were living independently a little bit. That was really why it started.

[00:11:40] **Jane:** Then assisted living became a business, and then assisted living became a facility, and then it became licensed. And so, when that happened, it meant that people who had means could stay in assisted living longer; people who had no means ended up in a nursing home.

[00:11:55] **Jane:** It also changed the modeling of how you reimburse a nursing home. You used to have private pay, you used to have your Medicare public pay, and then you used it for rehab, and then you had Medicaid. So, it was a balance. It was kind of a rob Peter to pay Paul, but you could balance it out to give the higher level of care for everybody. That no longer exists. Nursing homes right now are struggling and they're struggling desperately, and COVID didn't help that. The pandemic didn't help that.

[00:12:18] **John:** Yeah, and you talk about reimbursement driving a lot of different creativity, and even over the past 20 years, I've seen so many different iterations of people trying to figure out a way to balance reimbursement in the needs of the community and make it work. And it takes a really interesting, almost mishmash of different settings and different communities sometimes to make that work. And I think that's what this document is engineered to do is help you understand that and go, all right, you want to create anything that exists today or anything you can imagine in the future, here's a way to parse through it on a community or setting-by-setting kind of basis and come up with that solution.

[00:13:00] **Jane:** Yes. My practice right now is very much in the intergenerational living model. We started a nonprofit specifically to look at that. So, as a result of that, though, all these different pieces and parts come to play. So, we might have assisted living or even nursing in a small house model, coupled with independent living, that's actually intergenerational instead of only dedicated to older adults because again, anyone can be vulnerable at any point in time.

## Asking the right questions during the functional program process

(*First 3 bass notes of "Skip to My Lou" by Neal Caine Trio play*.)

[00:13:26] **John:** We've spent two episodes earlier this season talking about the importance of functional program and how just imperative it is to the success of a project and having the right people at the table for those initial discussions before a facility takes shape. Let's say I want to open one of these intergenerational kinds of models, or I'm a designer that's

working with that kind of facility, who are the right folks that should be at the table during that functional programming process?

[00:13:52] **Jane:** So, I'm going to talk community first and then I'll go down to building-level. When we look at the community, we do this on a very grassroots way because we believe that unless you understand the services that are provided in the community at large, you have no way of understanding what should be programmed. So, if we want to talk to people, we would call the local senior center; we would talk to the area agency on aging; we might talk to the state; we may talk to the local home health care provider. Who has physical therapy available? Is one of the colleges involved? Who is the health system? How does a health system work? And what are they providing? What we look for is commonalities and then gaps.

[00:14:30] **Jane:** So, let's take this down to the building level. In my work, I always look for the disconnect. We call it the 60,000-foot functional program. It's not the part of the functional program that you submit to your regulator or to your AHJ, but this helps us format what a community may want to look like.

[00:14:46] **Bridget:** It's a pregame.

[00:14:47] **Jane:** That's a really good way to put it. It's a pregame show. And so, when we do that, it really helps people position their mindsets. And then a lot of times my clients will use that document throughout as the go-back-to, and it's like, "Oh, wait a second. We've made this change, but didn't we need that for something?" So, we try to get people to use that document throughout the design process. So, it's almost like a tool. When we get into the specific functional program, that's my nitty gritty that I love the most, and that's how we structured the one in the *Guidelines*.

(*Jazzy swing music interlude plays.)*

[00:15:29] **Jane:** That's why we do the who, what, where, when, and how throughout, and that is to understand every operational flow that comes in and out of the building. So, if I have food delivery, where is it being delivered? I don't want it at my front doors. Particularly if I'm doing a smaller model; I want it to come into the side kitchen door or I want it to come into the back door where my loading dock is. So, am I going to do a loading dock? Am I going to do personal laundry for my residents because that makes them feel more like at home and family members can participate or am I going to send all that out and have it, you know, the accidental Mr. Jones gets Miss Smith's bra. So, you know, trying to make sure that the clothing is going back to where it's supposed to go.

[00:16:06] **Bridget:** Unless Mr. Jones likes to wear a bra, in which case go for it, Mr. Jones, but get your own.

[00:16:11] **Jane:** Get your own.

(*Jazzy swing music interlude plays.)*

## Getting the staff on board when change happens

[00:16:21] **Jane:** When we do functional program, we meet with every department group. It's all about a matter of what they understand and what they don't understand and then how that applies. And then when they see it, they're like, it's best to go do a journey—we call it learning journeys—but taking somebody off to the learning journey to go, this is what it would work like.

[00:16:38] **Jane:** Think about an elevator being centrally located in the building, when you get off that elevator, what if instead of you getting off that elevator, you actually went into 3 front doors, and those front doors then became the household for into the kitchen and then into the dining room and then into the living room space, and then your bedrooms are a little bit further away. That would be the process of what you would have to think. Getting staff who are used to working in a departmental-vertical way. . . "Oh, so I don't have to take my housekeeping cart to every household and to everything?" Nope. We put a housekeeping cart right there for you. And then the nighttime staff will restock it for you. "OK, I can do that. I can do that." But they need to think through it.

(*Jazzy swing music interlude plays.)*

[00:17:25] **Bridget:** It's funny because if you were to ask me to draw a nursing home, I'm sure I would draw those long double-loaded corridors, you know, and I can just still picture my sweet little grandma in her wheelchair with their little sock feet, just pedaling herself all the way down the hall, and I wonder if this document isn't in some way helping and assisting with that shift, that understanding. We're all going to be there one day, if we're lucky, needing some sort of care and living space, and I would want to live in a space that looks like a home and reminds me of a home and has that type of design. I would.

## The mobility and transfer risk assessment

[00:18:04] **John:** Yeah, absolutely. And I'm beginning to see the way that the document supports that concept because we've, got this á la carte sort of menu of settings and we've got the functional program that helps us understand that. Also, in Part 1, we've got a series of safety risk assessments, and that's really helping us understand individual risk, but there are some that are pretty unique to the residential document. And the first one I'm thinking about is this residential mobility and transfer risk assessment. Can you talk about a little bit and, and describe what it is and maybe the harm of not doing one?

[00:18:42] **Jane:** The resident mobility and transfer risk assessment is really evaluating your care population. Like, who are you caring for and what does that look like if you're aging over time? The other piece is the study that Jon Sanford did at Georgia Tech—and Maggie Calkins worked on that extensively as well—amongst other people who've worked on the *Guidelines* over time: grab bars for transfer and mobility were designed for veterans

returning from Vietnam. So, the dimensions are too high, and the placement isn't right because you always notice that there's that grab bar that's behind the toilet and it's like, whoever uses that, you know? Usually, there's like a towel hanging from it. And the reason is it was meant for people who have upper body strength to do a side transfer out of their wheelchair, and older ladies, we're not positioned to be able to do any kind of transfer that would actually take that kind of upper body strength.

[00:19:35] **Jane:** So, what we were able to do is provide an alternative grab bar scheduling, so even if your local authority is going to require certain ADA compliance in a certain number of rooms or whatever it might be, the rest of the rooms could all go along toward the resident mobility. So, for example, we would look at how are you going to be transferring people? Where are you going to be transferring?

[00:19:56] **Bridget:** I'm sure when we're talking about transferring and risk assessment and fall risk that bathrooms are one of those spaces that need a lot of attention. What are some of the design considerations around these spaces, with showers, particularly?

[00:20:11] **Jane:** Where we really see it is when people don't have the vertical grab bar coming out of the shower because that's the one that they hang on to as they step out and reach for their towel.

(*Shower runs, water is turned off, shower curtain is pulled back.*)

[00:20:29] **Jane:** And so, if you put a hook there, then they're reaching for the hook, or they're reaching for the towel, and then they use the towel as the grab bar, and then they go down. So, it's like a fall process. So, the reason that's important is that it really tells you about the care population, how much mobility issues you have, and it forces people to actually look at it.

(*First 3 bass notes of "Skip to My Lou" by Neal Caine Trio plays*.)

## The resident dementia and behavioral health risk assessment

[00:20:50] **Bridget:** Another aspect of the safety risk assessment in this document is the resident dementia and behavioral mental health risk assessment. Can you talk about what that particular assessment is?

[00:21:01] **Jane:** Yeah, so, this was a little bit different because, you know, we have all these mental health issues, and we have all these different things in the health care market at large. So, when we look at resident dementia and evaluating it, we did it as an overlay. The idea of the overlay is that you can have dementia and be in any setting. Right? Independent living, for example. So, if you have two spouses living in one apartment and one has dementia and the other does not, what are some of the features or factors that you may want to consider? So, do you have a[n] elopement risk? Do you have things that happen in

terms of getting lost in queuing? Those are things that help people stay independent longer. So, those are different pieces and parts that you want to look at.

[00:21:40] **Jane:** There's all these different kinds of dementia as well, [and] there's certain things we can do in the physical environment that helps them. And so that's why we did it as an overlay so that it can be referenced back, no matter what the setting. So, that was the goal behind that, which I think is a good way to do it.

[00:21:55] **John:** Absolutely. You know, a full menu of options and those overlays that help you look at, different populations within each of those options.

[00:22:04] **Jane:** And the smaller the environment, the better it is for folks with dementia is what we've found.

(*First 3 bass notes of "Skip to My Lou" by Neal Caine Trio plays*.)

[00:22:10] **Bridget:** I went back on to the Facility Guidelines Institute YouTube channel and watched some of your videos from 2018 where you were talking about the residential document. I really did my homework, right? I went deep! You were saying that the number of people who build these spaces that don't have any experience building these spaces is higher than we'd expect. Like, we'd be shocked, basically. What are some of the common errors that people would make building these facilities because they don't know any better?

## Common errors when designing and building residential health, care, and support spaces

[00:22:42] **Jane:** The one I see a lot is the architectural need to be lofty and big and tall because most people need to be in smaller spaces where there's some decent acoustics so that you can hear each other and you can also still be able to have a dialogue or, you know—we love open kitchens. Everybody loves open kitchens. However, the larger the population, the larger the open kitchen, [and] the less people can hear. So, that's one area that we see quite a bit.

(*Upbeat slow-tempo jazz plays*.)

[00:23:12] **Jane:** Also, the lighting. So, you're in your community spaces, people are starting to tone down for the day. So, you start to tone down from blue lights into amber lights. Then they go out into the corridor and it's all blue light. So, by the time they get back to their nice little resident unit, whether it's an apartment or their room, and it's all calm light again, they're all wound up again because the circadian lighting got, you know, it kicked them back up to daytime instead of going down towards sleepy time. So, there's things like that, that people don't know.

(*Upbeat slow-tempo jazz continues*.)

[00:23:47] **Jane:** The other one we see is the lack of color and/or contrast used in the right way. So, if you don't know a handrail's there, because the handrails white and the walls white, they don't use it because they don't know it's there. We also perceive space by the edges. Say you use a dark border and then a really light middle. People think the middle is either a hole or a step-up or something else, and can be perceived—again, you stop, and in that pause of not being sure is when often falls can happen.

(*Upbeat slow-tempo jazz continues*.)

[00:24:22] **Jane:** Those are some of the errors that we see that are very common. It doesn't have to be that way because most of the fixes are actually just a little bit of planning. There's not a lot of cost in it. It's just understanding who's using it and how are they using it and how can we help them use the space better.

(*Upbeat slow-tempo jazz fades*.)

[00:24:40] **Jane:** Sometimes we'll do mock-ups where we actually lay it out. And then the staff will run a wheelchair through it because they can't necessarily picture what it means on a drawing. Drawings don't mean anything to someone who doesn't read architectural drawings.

[00:24:53] **Jane:** We had one session years ago, it was a greenhouse project-esque type model, and I just, I can still see the elderly gentleman. He was a part of the architecture team. He's 86 [years old] and most of my client base was, like, in their later-70s, and we mocked up the bathrooms, and we mocked up an entire household using tape. And they're like, "We can take some room out of this. Let's put some more room in the bathrooms," or "Let's put some more room in the resident rooms." Right? And that was like, a day period of time to develop a functional program around what would work and what won't work.

[00:25:20] **Jane:** So, for us, the functional program is very, very important because it talks about how you're going to do it and how you potentially *could* do it. Typically, when we do culture change processes about 95 percent of the people who you work with are all for it because they're only there—it's their heart. I mean, who else works in long term care unless you have a heart, you know what I mean? It's just like, it's so heartfelt. I had one staff member, she was a housekeeper and she made it all the way through COVID. And I said, "Well, it's part of your heart." And she burst into tears, and I was like, "Yes, it is part of your heart. It will always be part of your heart."

(*"Skip to My Lou" by Neal Caine Trio plays.*)

## Wrap-up

[00:25:55] **Bridget:** You're very missed Jane. Your heart is all over the pages of this document and to think of the reach that you've had because of the passion that you have, it's special.

[00:26:06] **Jane:** The work that the *Guidelines* committees do and the volunteers and the amazing passion and strength behind all those volunteers and all the calls and the amazing staff and everybody else that's involved in it, I couldn't match it in any way, shape, or form. I mean, it was just one of the most amazing things in my life.

## Outro

[00:26:29] **John:** Thanks for joining us! Today's episode wraps up season one of *Between the Lines with FGI.*

[00:26:33] **Bridget:** Hey, we have had a great time interviewing guests and having you along with us for season one. We sincerely appreciate all the positive feedback we've received. If any of you are keeping those good thoughts to yourself, please share them with us. We'd love to hear it. Head on over to Apple podcast and leave us a review.

[00:26:51] **John:** Also, we're developing a schedule for season two. So, if you have ideas for topics or for guests, please get in touch with us by writing to us at podcast@fgiguidelines.org, and you know, Bridget, I was just thinking if we had a list of guests, we could even ask our listeners what kind of questions they might want to ask.

[00:27:11] **Bridget:** Sure could. And if your company or your organization is interested in sponsoring an episode or a series of them, get in touch with us and find out how you can hear *us* give *you* all a shout out at the beginning of our episodes, reach out to podcast@fgiguidelines.org for more information.

[00:27:30] **John:** Many thanks also 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.

[00:27:38] **Bridget:** Bye, everybody. Have a great summer!

[00:27:40] **John:** Have a great summer, folks. Bye, Bridget.

[00:27:41] **Bridget:** Bye. Bye, John!

[00:27:44] **John:** Bye.

[00:27:45] **Bridget:** I had to give you another bye because that first one was like, "byyyyee."

[00:27:49] **John:** Bye, Louis.

[00:27:50] **Bridget:** Bye, Louis. Bye, Pickle.

(*Dog barks.*)

[00:27:53] **John:** Bye, Skip to My Louis.

[00:27:59] **Bridget:** For this season-ender, Neal Caine and your trio, take us out all the way to the end, would you?

(*"Skip to My Lou" by Neal Caine Trio plays until end.*)