[00:00:03.07] - Speaker 3
That's because we're all watching the clock, that's why. Yeah.

[00:00:07.02] - Kimberly Robinson
All right. Well, it is time to start. We'll go ahead and get started. Welcome, everybody. Hope you had great holidays. We can go ahead and start. Jeremy, will you complete roll call for us?

[00:00:21.05] - Jeremy Rutland
Sure. If I mess up your name, bear with me.

[00:00:26.15] - Jeremy Rutland
Don Chester.

[00:00:29.05] - Don Chester
Here.

[00:00:30.03] - Speaker 3
Kevin Mullen.

[00:00:34.11] - Speaker 2
Peter. Patty Lance.

[00:00:40.08] - Speaker 3
Daniel Nicholson. Michael Fata.

[00:00:55.00] - Speaker 1
Jill Arnick.

[00:00:57.03] - Speaker 2
Yeah.

[00:00:59.06] - Speaker 3
Adriana Vabuna.

[00:01:07.12] - Speaker 1
Dr. Brian Hichton. Did I say that correctly? It's Hinkdon. Hinkdon. Dr. Herendez. Kari Rayburn.

[00:01:27.14] - Speaker 2
Present.

[00:01:29.10] - Speaker 1
Awesome. Ruth and Cotter Saul. Present. Awesome. Back over to you guys.

[00:01:41.07] - Speaker 3
We have a quorum this morning or This afternoon, Jill. We have five members from the committee, so you can go ahead and vote on minutes.

[00:01:52.12] - Speaker 4
All right. Can you scroll down?

[00:01:57.05] - Speaker 3
I'm sorry. It's the wrong screen, the screen.

[00:02:00.01] - Speaker 4
That's okay. I keep trying to scroll on my screen. It doesn't work.

[00:02:07.08] - Speaker 3

Patty Lance is just now joining us, just for the record. Oh, great.

[00:02:14.00] - Speaker 4
Welcome. Okay, Do I have any motions to approve the minutes from November seventh?

[00:02:22.15] - Speaker 1
I did notice that they misspelled CARF, like a CARF, but it's C-A-R-F. I think that can be made sense of by someone that knows the terminology. I think I'm okay with still proving.

[00:02:40.13] - Speaker 3
Okay, I'll go back and correct those minutes as well.

[00:02:45.02] - Speaker 4
Great. Do I have a second?

[00:02:47.05] - Speaker 2
I second.

[00:02:48.14] - Speaker 4
All right. Thanks, Kevin.

[00:02:50.01] - Speaker 3
Before we get started, Jill, if I might just interject for just one moment, I wanted to introduce Jeremy to the council members. Jeremy is I'm the newest person that's been added to my leadership team, and he actually replaced Kaitlyn. He is our new Program Services Administrator, and he is just over 30 days old. He started December sixth, and I'm very excited to have him as part of our team. He has a lot of procurement knowledge behind him, and Sal is very organized, has a lot of skill sets needed that is going to be an asset to my team and help to move our Advisory Council along when it comes time to planning our meetings and travel and all of that good stuff. I just wanted to introduce him. When you see his name, you'll get emails from him. You'll know who he is. So thank you for that.

[00:03:48.09] - Speaker 2
Welcome to the team.

[00:03:51.02] - Speaker 3
Jeremy is also going to be our driver today for the document. I'm going to stop sharing so he can share his screen, and then he's going to be our driver today.

[00:04:02.10] - Speaker 4
All right.

[00:04:07.13] - Speaker 3
Where we left off was on page 8 here on letter R is where we left off from November?

[00:04:21.06] - Speaker 1
This is Dr. Higman. There were some points from our previous discussion that I think we're going to circle back on. I'm wondering if we want to do that now or if we want to do that later in the meeting.

[00:04:40.01] - Speaker 3
Are you talking about some of the areas that were highlighted that we were unsure of in the upper half of our document?

[00:04:45.01] - Speaker 1
We're going to look up more information about the current volumes of some of these centers, see if it's reasonable to set a bar for things like that. That was one of the things. Okay.

[00:04:59.15] - Speaker 3

I can tell you I don't think I have any document on some of that. There was another document that was in last month's meeting. Let me see if that is what you might be asking for because we didn't get to the PICU meeting. Let me see what's there. That was the Psychosocial Support System, Case Management, Social Work?

[00:05:32.11] - Speaker 1
I'm trying to find the page here. On page, I guess, number 2, but it might be page 3 on the PDF of the one that you sent out for today's meeting, it said, Request T-quip data, look at B-Skip referral report for Can you pull the full referral reports for reviewing?

[00:06:05.05] - Speaker 3
I do have a referral report that I pulled. Let me find it here for you.

[00:06:14.05] - Speaker 1
Okay.

[00:06:19.12] - Speaker 3
I pulled it and I have it in my folder for our March meeting. So, Jeremy, I'm going to send this to you and you can pull this up in your screen. The referral report I pulled was from July 2022 to June 2024. It gives the number of referrals from the trauma facilities only. These are just trauma facilities.

[00:07:28.02] - Speaker 1
Yeah. That's a full 12 months?

[00:07:34.15] - Speaker 3
July 2022 to June 2024. That's two years.

[00:07:41.15] - Speaker 1
The question is, I think the time is, okay, there's 50 TBIs and 12 spinal pain injuries. Is that going to rule out some of the larger centers that cover a large geographical area? We don't to do that.

[00:08:09.11] - Speaker 3
Minimum of 50 new traumatic brain injuries. Well, brain injuries is our primary referral. I don't think that even having a minimum of 50 and a minimum of 12, I don't think that that's going to make a big difference in these standards anywhere because the majority of our referrals are brain injured.

[00:08:31.12] - Speaker 1
Okay. Well, the previous language, I'm not sure what this language was, but- T-CIP.

[00:08:42.12] - Speaker 3
T-cip, quick data, I don't have access to that.

[00:08:48.08] - Speaker 1
Okay.

[00:08:50.01] - Speaker 4
I'm wondering if there's a little way to change that language, I think, to your point, Dr. Higdon, that to where it's not hard and fast, but a target number, perhaps, since we don't have access to that data for TQP to know. Because we don't want to... We don't want some facilities to be ineligible because maybe they had 45. That's what you're trying to say, right?

[00:09:22.11] - Speaker 1
Yeah. If they're the major trauma center in the whole region, and if they're not a BC a trauma center than he would be? Yeah.

[00:09:41.09] - Speaker 2
Hi, guys. This is Candice. I can pull up some of the TQP data and show what it says. Are these the

only ones providing for a referral right now? Because there's 36 trauma centers in the state, and then I'm only seeing 20 on here currently.

[00:09:59.12] - Speaker 3
Well, we have other referral sources, but this is what my data analyst pulled back according to our trauma centers. That's a very valid point, Candice, because I do know that, and I'm quite certain that all of our facilities or not ours, but the trauma facilities are referring. I don't think there are any that are not. That's a very valid point, and I would have to go back and ask my data analyst more about that.

[00:10:27.06] - Speaker 2
On this Southeast Health Medical Center is not a trauma center. I don't know who that may be. I can provide you the list of the 36 trauma centers we have currently. Maybe just to look at that and just would like to understand a little bit more what the expectation is from the trauma centers compared to maybe the acute care hospitals.

[00:10:55.10] - Speaker 3
Okay. I'll have to I apologize. I didn't even catch that.

[00:11:03.09] - Speaker 1
I think that's a Florida hospital. Sorry, an Alabama hospital. But they catch Florida patients in their catchment, I think.

[00:11:14.08] - Speaker 3
Let me look on the detail.

[00:11:16.01] - Speaker 1
Yeah, they're in Dothan, Alabama.

[00:11:17.01] - Speaker 3
Yeah, they're in Dothan, Alabama.

[00:11:17.13] - Speaker 2
Yeah, according to the Google, they are in Dothan, Alabama.

[00:11:23.00] - Speaker 1
Yeah. That makes sense why they'd be referring to San Diego. They probably didn't try to get that word.

[00:11:31.03] - Speaker 3
Well, if I look at the data. So, Jeremy, if you click on Southeast Health Medical, double-click that number 2, just the number 2, and it'll take you to the detail of that. This was an external agency. I'll scroll over to the right.

[00:11:53.04] - Speaker 1
Well, let's be careful about putting HBI in public meeting.

[00:11:57.04] - Speaker 3
Well, that's why I scrolled to the right real quick. I got that. I was looking to see where this client was. Well, they're in Sneeds, Florida. The county was Jackson & Gadsen is where those referrals the injuries were. I don't know. I'll look into that, though.

[00:12:28.01] - Speaker 1
Anyways, if they're not looking in Florida, they're not going to be able to be in Florida B-Skip Center.

[00:12:33.07] - Speaker 3
Right. You can close that report, Jeremy.

[00:12:37.05] - Speaker 1
Thank you. I guess the question is, if they're level one in the Food Trauma Center, Should we not worry about the number of injuries that the patients have? Or number of patients with injuries they have?

[00:13:01.08] - Speaker 2
Well, so here's what I am aware of, and I've worked at a pediatric trauma center and a level one trauma center for the past 20 something years in Florida. From my understanding of the process, once upon a time, in order to be a B-Skip center, so not all at the time, not all trauma centers were B-Skip centers. And what differentiated the two, any hospital should be referring patients to the process and the referral of resources. But to be a B-Skip Center, in addition to just doing initial evaluation or treatment, to be a B-Skip Center, you had additional resources such as neuropsychology, advanced rehab support, and dedicated education hours for your nursing and therapy team, specifically to brain and spinal cord injury. During our Florida trauma verification visits, we would have a neuropsychologist or somebody from neurosurgery looking at specifically the brain and spinal cord injury care. And that's what deemed you a B-Skip Center. Now, recently with Florida trauma drama and legislation and other things, because in the state of Florida, to be a trauma center, you You've never required, so this will cover B1, you've never needed joint commission, you've never needed certificate of need.

[00:14:38.10] - Speaker 2
There's a whole actual legislative written rule on how you can become a trauma center. And B-Skip, because they had their own rules, we just went along with it. But however, with the trauma drama, they said, No, B-Skip is not in legislation. Trauma is, we're just going to call everyone a B-Skip center. I think that's created some confusion because if that's the case, we need to incorporate some of these additional requirements into the Florida trauma standards, which are being revised currently.

[00:15:20.12] - Speaker 1
Yeah. I had to look... I thought you were just throwing that around the term trauma drawing, but I guess that's a term that was used, at least in media, to describe some legislative changes. I'll have to read that later. But my point was just the volume, to not get lost in the volume. But I think all the other comments about having a neuropsychologist, having those other things are still important, but not getting caught up in the volume. Because if a center is going to invest in those services, then they probably have a volume to match.

[00:16:00.09] - Speaker 2
Well, yes and no. You say admission. Now that becomes tricky in the trauma world because if they come into the hospital and are seen and evaluated, is that an admission or did they stay overnight or did they stay to get their traumatic brain injury truly cared for, meaning they're seen through surgery and all the way through rehab. So we'd have to be very clear on what the definition of admission is, because there may be some trauma trauma centers that stabilize the patient, but then do truly send the patient to a higher level trauma center or a trauma center that has more complex abilities to truly care for the traumatic brain injury. Back to what is this? Are we holding the trauma centers to a higher level of care? If so, there should be a minimum because if not, you can't be good at something if you don't do it well and you don't have the volume to do it.

[00:17:12.00] - Speaker 1
Yeah, it's challenging. I've been talking about what other people think.

[00:17:26.09] - Speaker 4
I just... Looking at One, before we get into the nitty-gritty of two, since this is where we started, are you saying we need to remove one because all of the facilities, they don't have this requirement to be a trauma facility?

[00:17:46.09] - Speaker 2
So for one, I would take off accredited. They must be designated by the Florida Department of Health as a trauma center Or if the B-Skip program for Florida is truly back around, we used to have a dedicated coordinator, and we would get a separate certificate from the B-Skip program saying, Hey,

you follow our standards. We've reviewed your patient care, we're getting things we need from you, and we're telling you, you meet the B-Skip standards. So I don't know what the resources are for the Florida B-Skip program to do that. But if we're saying a minimum, you have to be a trauma center, then I would say must be designated as a Florida Trauma Center.

[00:18:41.14] - Speaker 3
Well, I think that's where B-Skip is going, and that's why about a year ago now, through legal, they came back and decided, because of the current standards that trauma has, and I never can remember which page it is and paragraph it is in your standards, that is where B-Skip fell under for designated facilities, and we were following trauma standards according to what was written there. That's why we're revisiting all of this because these standards didn't apply anymore. And so there was the big question on, well, how does B-Skip designate facilities and legal came came back, and this is when Kate was there. And we had discussions, and it was, if you are a trauma center and you meet all the criteria according to your standards, then you're automatically a B-Skip designated facility.

[00:19:48.02] - Speaker 2
Say that again.

[00:19:50.11] - Speaker 1
I don't fully understand it.

[00:19:53.05] - Speaker 3
It's a mouthful.

[00:19:55.09] - Speaker 2
I hear what you're saying. Essentially, because of the different legal challenges that were happening at different trauma centers and non-trauma centers, and people wanting to become a B-Skip Center, because there used to be a verification, a survey visit process, US. Correct. They came down to the nitty-gritty that said in legislation, there's rules on what it takes to be a trauma center, and a trauma center cares for patients with injury, and brain injury and spinal cord injury are some of those. Therefore, you are automatically a brain and spinal cord injury center because you're a trauma center. It seems like we should just make sure the Florida trauma standards match these if we're saying these are one in the same Correct.

[00:21:02.01] - Speaker 3
Then we have to go to rule in order to enforce the B-Skip standards because currently there's no rule.

[00:21:09.03] - Speaker 1
Okay.

[00:21:09.11] - Speaker 3
That's why we're rewriting.

[00:21:12.01] - Speaker 1
Got you. That helps me understand better. Whenever we formalize with this when we get through this linky document, then Then I'd go back to the trauma committee, then they would have to incorporate it in the way.

[00:21:37.13] - Speaker 2
We could. If you give us these, because we're still currently rewriting our draft of an updated trauma standards. I happen to also be the President of the Trauma centers and the Trauma Program Manager Group. We can take this draft and give it to all of our Florida trauma centers to look at and just get some additional input, that would be great.

[00:22:02.15] - Speaker 1
Then some centers would be just trauma centers, and then some centers would be trauma centers, and then some centers would be trauma B-Skip centers, but under the heading of the trauma center.

[00:22:10.02] - Speaker 2
Yes. Ideally, we should keep everybody accountable. I'm going to share my screen very quickly just to show... Let me see if I can make this a little bigger. This is the Florida T-Quip Collaborative. T-quip is Trauma Quality Improvement Program. My screen is not giving me the tools to... Currently in Florida, according to the fourth quarter, this is a year and a half worth of data for severe traumatic brain injury. In Florida, it's telling me there's 2,295 severe traumatic brain injury patients. This is public data, so I can share this with the group. But basically what this report shows is all of the trauma patients from 2023 in the first quarter of 2024 This benchmarks the state of Florida against all other trauma centers across the nation. Here's how many patients there were, and then where we fall for severe traumatic brain injury, among many other categories. Then it gives us ratios of how good our care is and then complications and different things related to it. This is Florida compared to others. I can send this with the definition of what severe traumatic brain injury is or any of the data, but clearly the referral patterns and the numbers may not be matching, or we definitely have some work and opportunity Because there is sometimes some significant changes and turnover with trauma program managers or different trauma centers to just reeducating them on the process of referring for brain and spine, and what does that mean.

[00:24:14.14] - Speaker 1
My understanding is correct, the TQIP data identifies spine, but not necessarily spinal cord injuries. Is that right?

[00:24:26.02] - Speaker 2
Correct. I can send you the definition file. They look at more severe traumatic brain injury. I'll send you the reference document, which defines what each inclusion cohort is. Here, I can actually pull it up. Share that with you real quick. And I apologize, they just changed my PDF, so it doesn't let me make it bigger, so you can read it bigger than this. So These are the different cohorts. They have an epidural hematoma category, and in order to meet that, they must have documented a GCS less than 13 or at least one basically, injury coding for epidural hematoma. That's considered one of the severe traumatic brain injury. Let's see what else. Well, that's epidural hematoma. Then severe traumatic brain injury is injury coding of more severe brain injury, and then GCS 8 or less, GCS motor 4 or less, and initial EDGCS of four or less for motor. There is one in there for spinal cord injury. Blunt traumatic injury, and they have to have a severity of six. It's excluded if it's a severity of six, which is like a severed spinal cord. If it's a complete spinal cord injury with a lot of other things, I think that's excluded.

[00:26:21.09] - Speaker 1
Okay. Because they have more other bodily injuries.

[00:26:25.12] - Speaker 2
Yeah, because I think once you have a complete injury that you can't rehab or improve anything on, I can read more of this document to see if there's any other reasons why there's an exclusion to it.

[00:26:44.12] - Speaker 1
More that they don't survive to rehab. Is that the indication?

[00:26:47.15] - Speaker 2
Yeah, could be. There's a little bit there on spinal cord injury.

[00:27:05.05] - Speaker 1
Okay. But to the definitional thing that you pointed out about, just because they pass through their door doesn't mean that they are taking charge of their care. How does a TQP data deal with that? Do they exclude patients who are transferred to a different trauma center?

[00:27:27.14] - Speaker 2
Yes. The inclusion to T Quip is not only transferred to trauma center for their care, but admitted and truly cared for beyond the initial day.

[00:27:39.11] - Speaker 1
Okay. But for actual verification process, we're going to If we were to write this report to tie in with the trauma standards, we should probably just use the same definitions that are already being gathered for severe TBI and it's spinal cord injuries on there, too.

[00:27:59.15] - Speaker 2
Yes. I can email this benchmark reference report that shows the definitions of the cohort, so you can include that.

[00:28:11.10] - Speaker 1
Yeah. Even if there's some different... Because there are going to be some different differences between that numbers and the B-scope numbers, even with reporting because of resident status in terms of that.

[00:28:23.06] - Speaker 2
Yeah.

[00:28:26.06] - Speaker 1
If they don't survive to rehab and stuff like that. Okay.

[00:28:31.14] - Speaker 4
So back to the document. Yes. For one, we're going to just say that it's trauma designated by the state. Then for two, a line wording to reflect the same as the T-quip for the brain and spinal cord? And do we want to stay with the 50 and 12 or say something like, ideally a minimum of?

[00:28:59.09] - Speaker 1
Well, this As a standard, I don't think you can say ideally. It's just... Yeah.

[00:29:05.06] - Speaker 4
Yeah, I get what you're saying.

[00:29:09.15] - Speaker 1
But if a sender only sees one spinal phenology a month, even if they are To put my clinical hat on, even if they are geographically remote, like or something, if they see less than one spinal phenology a month, then the patient might be better off transferring to It's a place that has more volume of care, depending on things. But I won't make a judgment on surgery, but it probably would make sense for them as much as possible to... My clinical hat says that there should be... Like Hannah is just saying, should be a minimum.

[00:29:50.01] - Speaker 2
Looking at this number, I think most all trauma centers would meet that. The only exclusion to that would be maybe pediatric trauma centers. This doesn't say severe traumatic brain injury, right? For B-Skip program, traumatic brain injury could be a more mild TBI. Or are we only looking at true severe injury came in with a GCS list in eight that have an epidural or subdural?

[00:30:22.11] - Speaker 1
Jessica, do you know what the cutoff... Jessica is a case manager that works with me. Do you remember what the cutoff is for brain injury?

[00:30:29.11] - Speaker 2
The cutoff or is it the Rancho score? Yeah. I believe that was... I think it's four. You have to be above four.

[00:30:42.06] - Speaker 1
Correct.

[00:30:43.04] - Speaker 2
But below below you don't meet criteria.

[00:30:47.10] - Speaker 1
Okay. All right. That was my opportunity to introduce Jessica, who works at Go to Clean.

[00:30:53.13] - Speaker 2
Hi. Hi, everyone.

[00:30:55.13] - Speaker 1
But they do have to It would be rather severe to be in to be scared. But like I said, I think it makes sense to use just the T-Camp definition here.

[00:31:19.00] - Speaker 2
Most centers, I would say, meet that because I know their total volume. I think the lowest center volume of just patients with injury are around a thousand patients a year for adult centers. So I would say if you have a thousand patients, there would be at least 50 that have a traumatic brain injury. But for pediatric only centers, that may be a very high number. So at least most trauma centers, and there's only one, two, three pediatric only trauma centers.

[00:31:59.15] - Speaker 1
All right. Yeah, I haven't even reviewed the pediatric standards because I understand those are way below on the document. But I'm fine with these numbers. I don't know what other people think about these cut-offs, but I'm fine with just keeping them the way they are for now.

[00:32:30.01] - Speaker 2
And just so you're aware, for the TQIP reference document I'm going to give you, those numbers that I quoted is age greater than or equal to 16. Maybe if you say a minimum of 50, whatever, and if we put somewhere in here for patients ages 16 and older, then that should cover... That should be pretty achievable for all trauma centers.

[00:33:00.04] - Speaker 1
Yes.

[00:33:01.07] - Speaker 4
Age 13 to 18 can use the adult range of scale.

[00:33:12.03] - Speaker 1
That's That's per B-Skip. That's on our...

[00:33:18.05] - Speaker 3
That's in our...

[00:33:20.15] - Speaker 2
Just to let you know.

[00:33:23.14] - Speaker 4
I'm sorry, this is Fallon Moore, the Regional Manager for Region One.

[00:33:58.04] - Speaker 2
Is everyone present?

[00:34:00.05] - Speaker 3
I think I am.

[00:34:01.12] - Speaker 2
I thought it went like, silent for a minute. Are we able to make edits on the document again in this

meeting?

[00:34:09.02] - Speaker 3
Yes. Absolutely. Yes.

[00:34:11.02] - Speaker 4
I apologize. I was on mute and didn't realize I had muted myself. What I'm hearing is, is we're good with these numbers. The only question is, is do we want to add anything relative to age?

[00:34:23.11] - Speaker 3
Yeah. That's what Candice was suggesting we add patient age, language to say patient aged 16 and older to this. Am I correct, Candice? Is that what you were referring?

[00:34:37.15] - Speaker 2
Yes.

[00:34:39.00] - Speaker 3
Okay. So, Jeremy, in number 2, we need to We can take the red off the 50 and 12 because the council agrees that those numbers are okay. I'm sorry.

[00:34:55.02] - Speaker 2
Dr. Higdon's computer died, so he's trying to log in again.

[00:34:59.12] - Speaker 3
I thought he froze. I thought it was me. I'm like, Did I freeze?

[00:35:06.14] - Speaker 2
Yeah, it was weird. I could only see Jeremy moving and everyone else was paused.

[00:35:12.13] - Speaker 3
Adding the language in there are required annually- For ages 16 and above.

[00:35:23.06] - Speaker 1
I'm back. I jumped off my tablet.

[00:35:26.14] - Speaker 3
So, Jeremy, after the word annually, we're going add for ages 16 and above. Then do we all agree we can remove the note that's highlighted there, or do you still want to look at that data?

[00:35:52.10] - Speaker 1
Can we specify what set of data is specified according to TQP data?

[00:36:02.14] - Speaker 3
Yes. So after above, you want to put per TQIP data?

[00:36:07.14] - Speaker 2
I would put maybe Florida Trauma Registry.

[00:36:12.12] - Speaker 3
Okay.

[00:36:14.04] - Speaker 2
That gives them even more wiggle room.

[00:36:16.15] - Speaker 3
All right. So there you go, Jeremy. Take the per out and put four per. Okay, never mind.

[00:36:28.15] - Speaker 4
Then, yes, we can remove the note.

[00:36:37.01] - Speaker 1
That was a whole sidetrack, but hopefully it was worthwhile.

[00:36:41.14] - Speaker 2
Can we also change one, Jeremy, to be designated? Designated? Yeah. Designated. So must be designated by Florida Department of Health as Trauma Center.

[00:36:59.15] - Speaker 4
I think it's as a trauma center, correct?

[00:37:20.00] - Speaker 3
Yes. No, it's Florida Department of Health as a trauma center. Then you can remove the rest of that line. We are driving.

[00:37:46.10] - Speaker 4
Yes, and the word by in there. The... Jeremy, I can appreciate how difficult this is with everybody watching as you make changes. All right, fantastic. C, hospital And then the level support capability.

[00:38:21.05] - Speaker 1
I think we were just going through past comments that we're describing. There were things that we were going to follow up on.

[00:38:29.01] - Speaker 4
Oh, thanks. Thanks. I don't think we got... You don't have any information on this, do you, yet? Kimberly?

[00:38:41.10] - Speaker 3
I do not. No, I do not.

[00:38:46.11] - Speaker 4
I don't know if there's any others. I don't recall. Sorry, it's been a minute.

[00:38:54.06] - Speaker 1
There's a note further down where we're discussing board certification for neuropsychologist.

[00:39:03.04] - Speaker 2
Oh, yeah.

[00:39:04.14] - Speaker 1
Yeah, I did talk to a colleague here that is a board certified neuropsychologist, but it seems like being board certified is a pretty high benchmark that is not fairly common. It's not like among doctors where 95% of us are board-certified for the But just the majority of them are not board-certified, but of course, they should be licensed. But then you have to go back to the clinical question, And of the assessments that they're going to be doing, is their value to having them board certified if they're going to be making important judgment calls regarding if someone in a vegetative state or someone is starting to emerge from TBI, these are life and death conversations. So that's the other side of the coin that should be made. That they should be able to demonstrate as being able to assess patients with severe brain injury.

[00:40:28.04] - Speaker 4
It's going down to find that yellow note?

[00:40:33.06] - Speaker 1
This is on page... Numbered as nine on the document. But to talk as we're reading this. So there's... I

actually was just talking to a brain injury doctor the other day about this, but trying to determine if someone has immersed or not from a coma or a vegetative state is very difficult because there can be very subtle differences that most professionals would not pick up on. So there's a scale called the Coma Recovery Scale, revised, and that's the standard care to be used for determining if someone is likely to further emerge from a vegetative state or not. I'm sure my brain injury colleagues would be able to say this better. But even though it's the standard of care on a high level, it's not very broadly used or it's not as broadly used as it should be. That oftentimes patients and families are informed, Okay, they're in a coma. They're really not showing any signs of recovery. And then they withdraw life support when they might have more signs that were not noticed by their clinicians. Other people's thoughts or feelings?

[00:42:15.04] - Speaker 2
I think I understand both sides. I feel like, clinically, of course, we would want to set the highest standard that we could, but I don't know if B-Skip isn't going around and making sure that they're able to assess this appropriately, then I don't know how we I would say that that's a standard of ours, I guess. If it's limited to have boards, if it's not as well known or there's not very many board-certified neuropsychologists, do we want to limit the amount of facilities that can be part of the Biscuit program because they don't have that? It goes the same discussion with the numbers if we're limiting them, if they don't meet that criteria. I guess it would be Yeah. Because in the wording above, it doesn't say neuropsychology, it just says psychologist.

[00:43:12.12] - Speaker 1
I'm trying to think about it now. If I as a family member of someone with a severe brain injury in this situation, I would absolutely want them to be assessed by someone who can perform those tests, like the co-increvery scale, to be able to do that. Absolutely. Yeah. Right now, I'm leaning towards that we should include this language in some way that they should have the expertise to evaluate the severity of someone's severe, severe brain injury.

[00:43:45.08] - Speaker 4
I think maybe we could say something along those lines, but has had the training, but not necessarily that they're board-certified, because I think there's probably... Maybe they're not board-certified yet, but there's certainly neuropsychologists who have have the training to do so and have the experience as indicated for three years. Does that make sense?

[00:44:12.09] - Speaker 1
Yeah. I think there's some metrics. We've named a couple of scores in here. One is the Asia score for spinal quinegia that I'm very familiar with, and of course, Glasgow's score, but in Rancho. But maybe it would be worthwhile to include the coma recovery scale among the ones that they should be able to assess on patients.

[00:44:40.05] - Speaker 4
Okay. Yeah, that sounds good.

[00:44:46.14] - Speaker 1
Is that language further up in the document? I mean, switch over and scroll.

[00:45:02.11] - Speaker 4
It's right there. That's psychology-specific standards, if I'm not mistaken, and that's where it starts.

[00:45:11.06] - Speaker 1
There you go.

[00:45:14.03] - Speaker 4
Maybe right before it says We talk about third-row evaluation assessment, that sentence. Before we get to the purposes sentence, we can put in there expectations that the I'm really skilled in administering the coma. Wow, I just lost the word.

[00:45:59.08] - Speaker 1
Coma Cree scale.

[00:46:00.12] - Speaker 4
Thank you. Revised. That's the word I was looking for. Yeah.

[00:46:04.08] - Speaker 1
So CRS revise is the most recent one.

[00:46:19.11] - Speaker 4
I think we're trying to say the provider is trained in administering Is it competent?

[00:46:32.08] - Speaker 1
Yeah.

[00:46:34.10] - Speaker 4
Yeah, competent, whatever, however you want to say it. The coma The recovery scale, the revised coma recovery scale or whatever?

[00:46:48.14] - Speaker 1
Yeah. What is the word?

[00:46:58.09] - Speaker 4
Coma Recovery Scale. Coma, C-O-M-A. Recovery. Scale. Dr. Higdon, did you want to add anything else right there?

[00:47:28.10] - Speaker 1
Revised. The name is Comer's Recovery Scale Revised. Okay. It revises at the end of the word. Yeah. Crs-s, I think is the acronym.

[00:47:59.15] - Speaker 4
Anything else you want to put in there?

[00:48:06.13] - Speaker 1
Not this time. I'm circling back with my neuropsychologist colleague, and next meeting, I might have more.

[00:48:14.04] - Speaker 4
Okay. Anybody else have any other thoughts right there? I think as we scroll down to the staffing part where it had the yellow, we can take that particular piece off. All right. Keep scrolling down, if you will. I don't remember any other yellow pieces after this. Where did we stop? Oh, of course, there is.

[00:49:15.03] - Speaker 1
Right there. Let me jump in here with an anecdote. I know we're waiting on hearing back from legal as far as how much we can encourage families to go to B-Skip Rehab centers. I know we had talked about that back in November. I think there's a note that we're waiting to hear back from legal. I just saw a patient yesterday in my clinic who had gone to, to be honest, one of our competitors in Jacksonville for her complete spinal cord injury, and she's just having a rough time of it. It just wasn't appropriate care. She's just trying to catch up two, three months later after her injury from not having gone to a spinal cord injury center. Kimberly, if you could keep touching base with legal about that language, about whether patients can be informed, Okay, this is a B-Skip Center, this is not a B-Skip Center, as you make your choice of your rehab destination.

[00:50:17.10] - Speaker 3
Okay.

[00:50:18.13] - Speaker 1

Thank you. Jill, are we moving on? Yeah.

[00:50:38.04] - Speaker 4
Yeah, sorry. The yellow comment there, we just wanted to reference back to that, refer We're back to...

[00:50:46.07] - Speaker 1
There you go.

[00:50:50.12] - Speaker 4
Removing the requirement of accreditation in one or both specialty areas. I have to apologize. I do not remember the conversation at all around this. Obviously, it's right above. It says that we want the facility, that rehab center, to be accredited by CARF. Then in addition to the general CARF the specialty programs for one or both. Any thoughts around that?

[00:51:30.03] - Speaker 2
Jill, do we know any idea how... My facility is a brain injury specialty program, but do we know how common that is throughout the state for rehab facilities to go that extra step?

[00:51:44.03] - Speaker 4
Quite honestly, many facilities are moving away from CARF accreditation in general, from what I understand. I mean, obviously we are and we have it and we're going for it for Spinal Port also. But Anybody else have thoughts on that? I think we'd be eliminating access to many facilities if we say they have to have CARF and at least one of these.

[00:52:19.02] - Speaker 1
I mean, it's the question of why are facilities going away from it? Is there a competing one? Are they being mean to owners or something, or is it just because there's more administrative burden or they don't meet the criteria anymore, and that's why they don't do that. If it's because they simply don't meet the criteria and their standard of care has fallen, then that's not acceptable.

[00:52:50.13] - Speaker 4
Sure. Yeah. You want somebody who's meeting criteria, but I think it's administrative burden of keeping up with it. Quite frankly.

[00:53:02.15] - Speaker 1
Yeah.

[00:53:06.15] - Speaker 4
I just wonder if there's another alternative to be able to say CARF with a designation or outcomes of something, but we'd have to go into a lot more detail of that. If we were looking at even this, compare websites or whatever.

[00:53:30.13] - Speaker 1
Yeah. Well, I mean, referring to CARF is outsourcing that administrative thing, but it shows that they are meeting certain criteria for having a programmatic system of care.

[00:53:53.11] - Speaker 4
Yeah.

[00:53:55.06] - Speaker 1
So I think it'd be reasonable to keep CARF because the alternative to that would be to rewrite this whole thing to include most of what CARF is already saying.

[00:54:05.13] - Speaker 4
Do you think we can remove the area, though, designating at least a specialty, if it's just comprehensive for the CARF program?

[00:54:14.04] - Speaker 1
Or do you want to see that they need to be designated in one? I think at least designation one would be reasonable.

[00:54:28.01] - Speaker 4
I think we just removed that highlight if everybody's in agreement. Do I Are there any non-agreement?

[00:54:49.12] - Speaker 2
No, I think we're in agreement.

[00:54:52.02] - Speaker 4
Okay, let's go ahead and remove that. It is 159. Kimberly, I don't know if you want to talk about February, and if we have somebody to lead that Committee?

[00:55:16.13] - Speaker 3
I have nobody to lead that committee at this time, so that would be great if somebody can take on that chair for the PQI committee meeting.

[00:55:29.15] - Speaker 1
I would be the default one, but if someone else wants to step up and do it, I'd welcome that.

[00:55:47.03] - Speaker 4
Otherwise, my recommendation would be maybe we don't meet in February because we've got the in-person in March, and perhaps then we can identify somebody if there isn't.

[00:55:58.08] - Speaker 3
That's fine. If the If the council agrees to that, that's fine.

[00:56:09.02] - Speaker 1
Yeah, I'm fine with that. With this document, it's just such a long slog. I'm part of the problem. I admitted that we didn't move forward at all with this, but I would like to finish our job somehow. So Then removing one more hour of discussion about it doesn't help with that process. I don't know how much time we can block aside during the March meeting on this document. If we can do multiple sessions or somehow structure the session around that to make more progress on that meeting.

[00:56:54.09] - Speaker 3
What I would recommend is like we did for November, the morning session would be this document length, because that's typically when our committee meetings are.

[00:57:04.12] - Speaker 1
Yeah.

[00:57:05.05] - Speaker 3
That goes from 9:00 to 11:30. Okay.

[00:57:11.13] - Speaker 1
All right. Yes, we can- Is this section right here where we are?

[00:57:20.12] - Speaker 3
Yeah, I took a snippet, so I'll know exactly where we stopped.

[00:57:24.15] - Speaker 2
Okay. How many pages altogether?

[00:57:28.10] - Speaker 3
Fifty-three.

[00:57:30.04] - Speaker 2
Okay.

[00:57:33.03] - Speaker 3
If everybody reviews it ahead of time, if everyone reviews it ahead of time and have your questions posed, that'll help move it along as well.

[00:57:44.03] - Speaker 1
Okay.

[00:57:50.12] - Speaker 3
That meeting in March, that will be our second biannual council meeting. I have it on the agenda. That's going to be in Tallahassee at the Betty Eastley Convention Center. We had it there one time before, Room 152. Jeremy is getting our quotes Right now, he needs one more quote for our hotel, so we have that secured, and then we're going to start routing our folder. Then be on the look out if you're going to be traveling to this meeting. There's going to be an email coming out asking who is traveling, the same one I send every time, who is traveling, and do you need a rental car? Because we have to put your travel authorizations in. There's going to be the standard questions that are going to be coming in the email to you all. Everybody should still be active in our STMS system. If you traveled before, if you've never traveled, then there's more information that we'll need in order to put an account in for you. The state has to enter the travel request and the travel reimbursements for you. That's not something that you all can do. If you need a rental car, the state has to reserve a rental car on your behalf.

[00:59:15.15] - Speaker 3
Just be looking for that email.

[00:59:25.08] - Speaker 4
All right.

[00:59:27.04] - Speaker 1
Motion to join.

[00:59:29.04] - Speaker 4
Yeah. Do we have? That's my motion, yeah.

[00:59:34.06] - Speaker 2
A second. I have a second. I have a second. I have a second. I have a second.

[00:59:35.05] - Speaker 4
Have a great afternoon.

[00:59:39.05] - Speaker 2
Thank you, guys.

[00:59:40.11] - Speaker 1
Thank you, everyone.

[00:59:41.15] - Speaker 3
Good job, Jeremy.