BSCIP Advisory Council In Person Meeting - Save the Date-20250306_090820-Meeting Recording

March 6, 2025, 2:08PM

3h 6m 14s

Casavant, Robert started transcription

Casavant, Robert 0:10

OK.
Good morning, everybody.
Thank you for joining us.
I just want to let everyone know that Kim was unable to join us today, so I'll be filling in.
Give me a little grace.
Do you hear?
Just hit that new button here.
Here we go.
Oh, thank you so much. OK.
So we're gonna be working on the standards this morning, but before we get started, I'm gonna have Jeremy do roll call for us to see who all we have here.
Good morning, everybody.
Here's the roll call, Don Chester.
Kevin Mullen.
Patty Lance.
Daniel Nicholson.
Michael fader.
Gianni present.
Doctor Adriana.

Valbuena Valecillos, Adriana D 1:21

Here.

Casavant, Robert 1:22

Doctor Brian Higdon here. Doctor Howard is.
Harry Rayborn and Ruth Ann Tattersall.

All right, I think Patti Lance came in.
OK.
He can verify for the roll call Patty Lance is in now.
She was in the lobby. I'm sorry.
OK.
So that should be our forum to vote if we need to vote on anything.
OK.
So doctor Hickden, I'll let you let us know where you want to get started on the standards from last time.
So we had marked page where we'd left off, but I have some questions and also suggestions as reviewing the document before, but I know this conversation may be limited because Kimberly isn't present. But I asked that the previous meeting.
Whether.
A.
Bskip Rehab Center would be.
Recommended to to patients and families when they're in acute care, wondering whether.
When like a case manager is talking to them, whether they'd be directed to attend directed not sorry direct.
Direct is not the word, but educated on which centers were B skip centers in. In the process of deciding which rehab center to attend.
So not directing them to go, but just notifying them.
This is AB Skip center on your list of options.
Do do you?
Do you have a conversation with Kimberly about that?
No. Again, I think that would be up to the facilities. If they it's not a matter of.
For us, we we're not involved in that, but if the facilities want to advise them that this is AB skip center.
That that's up to the facilities, OK, is, is that a conversation that you are committed to had with legal or that your recollection of the yeah, I'm not decision or I I'm not sure if she's had that conversation yet, but I can make a note of that to.
Get back to you guys after this meeting.
OK, have a similar like thought. Trying of thought would be skip publish the list of rehabilitation centers that are certified through them in some way so that it was like on record for people to look at.

Do you know about that? OK.
I'm I'm not sure if there's ever been a list, but I can find out OK.
Yeah, it the one thing we can't conflict with this is, you know, giving patient choice. But I I would agree it'd be nice if the case managers at the facilities were provided that list to be able to say these are, you know, state of Florida be skip designated facilities.
For consideration as well.
Yeah, there's so many factors that go into that.
So direct was not be the right word, but just to add to information they have. But I think there's an important question because there's no kind of financial incentive for rehab centers to be be skip centers.
It's not like we're getting a check from the state or anything, but if there if if we want participation from the rehab centers to kind of beef up their beef, beef up their programs, there's not. But this is something that's associated with manpower and and investment there there.
Be some.
Mark of a quality that goes along with that mm hmm.
I have one suggestion for addition to the.
To the acute care standards, I wanna take some time to go over.
I noticed there was standards on rehab, nursing and psychology, but there was not any standards mentioned physi or Pmnr consulting course that stuck.
But Doctor Val Bueno's Forte is.
But if you read the recommendations for trauma care for both brain injury and spinal cord injury, both of them recommend physiatry consultation, and I think that would belong in in the Q CARE standards is that there is a physiatrist as part of this part of the case manage.
And and part of the interdisciplinary team, I thought there was. I thought I remember reading that that we had recommended that.
That that be entered, that they have to.
Have pmnr consults.
It is on the list of doctors that need to be available for consultation.
It's alongside, you know, OB joint venture and things like that.
But as a separate standard, so just like there's a whole listing of nursing standards and whole listing of psychology standards, that there be a separate listing for PHYSIATRY standards to put them in forward in the that it be included.

So are you saying that they're certified in brain injury?
Specialty designated for brain injury and spinal cord specifically.
Not that there.
Not that their specially trained or or board survived, but their but their board certified in in PMNR yeah.
Part of the team, yes.

Valbuena Valecillos, Adriana D 7:25
I agree with that.

Casavant, Robert 7:28
I did write some language.
It goes along with this, but maybe some of you may want to fill this out more.
Is there a way I can e-mail it and it be like pulled up on the screen for people rather than me just reading through it?
Yeah, Jeremy katland.
Yeah, you can e-mail to Jeremy one second.
Could you just type in the e-mail address?
That'd be faster.

Kevin Mullin 8:20
And.

Casavant, Robert 8:40
Oh, I do realize I could join the teams.
Share it there, but I did e-mail it to you.
Mm hmm.
Can you guys see it right?

HIGDON, BRIAN 9:44
You guys see my browser?

Casavant, Robert 9:45
Browse it.
Yeah. All right, so.

HIGDON, BRIAN 9:50
Right, so for zytree.

Casavant, Robert 9:55
Yeah, I mean, OK.
Besides, she's physics standards.
This starts here and it copies some language from the psychology standards.
But the purpose of standards applicable to acute treatment setting by physical medicine rehabilitation physicians is to provide minimum practice guidelines regarding physiother.
Apy Rehabilitation management of secondary conditions, patient family communication and determinate post acute rehabilitation needs staffing.
There's a board certified PM and R physician with experience in neuro trauma consultation common to see disabilities should be coming at assessment severity TVINSCI using structured assessment tools.
Those are listed here.
Management of secondary conditions, including acute traumatic neuropathic pain, spasticity for the static hypertension near Jain bound bladder near neurogenic restrictive lung disease, disorders of consciousness, agitation and distorted sleep.
Talking about brain, are there any that you would add to that?

Valbuena Valecillos, Adriana D 11:07
Rancho del Sol setting is run up and.
No.

Casavant, Robert 11:16
Is the Asia exam for the mm hmm the update you want?

Valbuena Valecillos, Adriana D 11:20
Yeah. No, I think that's pretty complete.
I yes, I think this is a nice addition too.

Casavant, Robert 11:29
All right.

Valbuena Valecillos, Adriana D 11:30
Like add lines.

Casavant, Robert 11:33
And then clinical procedures, consultation, physiotherapy consulted within 24 hours of admission for TBI and SCI and be part of the on the 24 hours.
I'm just wondering if that's within it of admission. That would be the only thing that I would say in there, considering if somebody's there on a Saturday, you know, admitted on a Saturday or a Friday night.
Yes. So the the evaluation is to be completed within 72 hours down below. Oh consulted within 24.

Valbuena Valecillos, Adriana D 12:06
Yeah, what we do is, yeah, what we do is usually we add it in the power plan.

Casavant, Robert 12:07
Hours.

Valbuena Valecillos, Adriana D 12:14
You know the standard standard orders of every admission that come with that diagnosis.
So PM and R Consultation is part of the check.

Casavant, Robert 12:23
Yep.

Valbuena Valecillos, Adriana D 12:23
Preset orders, but we we, I I rescheduled the console as the patient is still too acute to be assessed, but we'll get the referral as soon as the patient get admitted with that diagnosis.

Casavant, Robert 12:32
Shakti.
Yeah, great.

Thank you.
Sorry, I should have read further and no worries, I can just throw this in front of you the and this is in line with the recent recently published ACS guidance on TBI.
And forget about the timeline for the spinal cord injury ones are, but the obviously it's easier to have it similar for both the evaluation be completed with 72 hours of mission and to include, but not limited to prefunctional status characterizing severity of TBI and or SCI manage.
Plan for secondary conditions and identify barriers to acute care and eventual home me discharge.

Valbuena Valecillos, Adriana D 13:16
Excellent.

Casavant, Robert 13:17
Yep.
Did you follow those little changes I made?
You want me to resend?
But if you change I made there. Yes, OK.
Any additions that people may consider or recommend?
No, I think that's great.
I think it's great.
Any other recommendations people have?
I'm going backwards on on on territory that that we've covered.
Gonna stop sharing my screen.
OK, you wanna share your screen again?
And then there's one note right above the area that we restarted.
That that we're gonna restart.
Basically question those ourselves.
Do we want to add preferred neuropsychologist for Ibrance research, credentials for boards, you find neuropsychologist.
I would say I I would say yes to it being preferred but not yes. Required yes, agree.
And if it's just a a recommendation, but not a requirement, I don't think we need to dive into to board certification.
Exactly. Yeah, alright.
Anything else before we move on, move forward.

Online space in my notes here.
The next note I had was line X.
Or or part X.
It says refutation center must have a formalized agreement with it'll be part of the acute care hospital within its pension area.
I just didn't understand what this means.
That full line's agreement.
And it's really vague for for stand alone centers. I met a stand alone center.
We do have some.
We do have many agreements with with in here hospital, but I'm not sure which one of those fits this requirement.
It's just like a transfer agreement or.
Like I don't know.
I don't know what this entails.
I had the same question.
I mean, we are fortunately affiliated with acute care hospitals, but there are many rehabs that are standalones that, yeah, OK.
I mean, if we don't know what it means, I just recommend just taking it out.
Yeah, I'll. I will research and find out if there's a clear answer to that and or recommend removing it.
Yeah, there's no clear answer.
I just remove it.
I mean, just as a hospital, you know, any hospital is gonna have some plan for if they have to transfer particles out and yeah.
What was your guys understanding of point why below that?
The not sure who exactly these people are.
Are these like the typical admissions liaisons or?
Or is this some other type of staff?
I feel like it was the liaisons that are going out and you know talking about bringing patients to reassessment.
I don't know if the the intent was for something else or not, but I agree.
All right, I'm. I'm fine with Cuban language as it is.
Any other suggestions there?
My next note is at .88.
The so it says the Rebootation center's medical director of the position who needs.

There's been some back and forth at the federal level about who medical director. My stance is that this should be a physiatrist, especially for neurotrauma patients. But I do want to acknowledge that there's some some historical back and forth on that point. During my committee, members want to step into the step into that conversation.

Valbuena Valecillos, Adriana D 17:57
I agree it should be up to that physiatrist.

Casavant, Robert 18:02
Yeah, there's the challenge is that in some facilities, I know that they have been grandfathered in that maybe weren't physiatrists and so.
Yeah. So so typically somehow sometimes this can be grandfathered in if someone has experience working at a sniff level.
Care as a rehabilitation director and then that qualifies them for having the experience via rehabilitation, medical director at A at Rehab Hospital, even though they're not a physiatrist.
My specifically for.
My my sense is that physically for neuro trauma, physical have a lot more neurological background then someone who's an internist or an anesthesiologist or or other specialty.
I guess you could argue that there are some neurologists that sometimes function as a primary attending in rehab hospital, but I think that's gonna be pretty exceptional.
And then there's some things that neurologist isn't gonna be able to deal with.
And honestly, neurologists don't deal with neurotrauma that much.
Anyways, that's more of a neurosurgical specialty.
I'm wondering if we just, I don't know if we leave the I don't feel like we should leave the terms meet carf criteria for training. I feel like it should be.
Maybe.
What you were just referencing for the neuro, some of the neurospecific training and leave it at that?
I don't know.
I would motion that.
That, that, that the language for this document says Physiatrist specifically.
I didn't realize that there could be medical directors that weren't physiatrist.

So yeah, that was litigated.
The federal federal level about 4-5 years ago. OK, the AP and R had a whole white paper on that.
They're the head of AP MNR test, testified before the Senate.
But for this specifically for treatment of of Neuro Trauma, I think it should be even a step up from that.
The the my only feedback would be and or maybe a physiatrist on staff who has the specialty training because like if we have a spinal cord designated physician who's treating those patients, OK, so it's not the medical director, but it's the, it's the direct team physician. I'm, I.
OK, with that?
Yeah, I think that just allows a little bit of, OK.
Maybe for those programs that have that Grandfather, but they have a specialist also.
Yeah. So can we add a note in on a A?
You wanna say it one more time?
So that OK then.
No. To add that language.
Alright, the rehabilitation centers medical director Shelby A.
Physiatrist medical director or direct treatment position for these patients shall be a physiatrist.
With and skip the card criteria with feign knowledge and experience and rehabilitation of neuro trauma.
And then continue as written.
That is specialized training experience TV and yeah.
What do you guys think of this next list at AB?
How many of those do you guys have at your at your rehab hospital?
So I'm saying just because.
The presence of surgeons at a rehab center is gonna be scarce.
So the I made a a different list of ones that I would expect would be at AB Skip Coopers Center.
So I said in addition to physiatry have internal medicine in pulmonology, neurology, Pediatrics for pediatric centers.
And then below that say process in place for consultation and coordination care with general surgery, urology, neurosurgery and interventional radiology.
Anything. Let me other services that aren't.

I'll drop this in the comments.
Yeah, 'cause. Not everybody's gonna have.
I mean, I agree, yeah.
But we just need to have a process to be able to get those consoles.
Yeah. Obviously the any other specialists I like, I could have included like cardiology or I think we can just leave things like that but like pertaining to like spawn according to specifically these are ones that that are most pertinent.
Oh, Kevin just dropped in a comment, I think.
Oh yeah.

Kevin Mullin 23:14
Just just stating that if we did roll call this morning, I was 11 minutes late. I apologize.


Casavant, Robert 23:20
No worries.

Kevin Mullin 23:21
Good morning, everyone.


Casavant, Robert 23:22
Got you.
Thank you.

Valbuena Valecillos, Adriana D 23:25
ENT.
It's often consulted for brain patients to.


Casavant, Robert 23:33
I mean, I'd be fine with that again sometimes.
The searchable specialties are are hard to bring in. My center does have that, but I don't know how widespread that is.
Sometimes, like pulk, knowlists are the ones that that can manage to trace themselves.
Then sometimes there's they're just copying and things like that that need to be done.

That'll just may not be doing.
How about other necessary care providers?
A process for other necessary care provider to access other necessary care providers or something like that.
Mm hmm, we can add that for for the list of process in place for consultation according to care and add ENT mm hmm.
So just so I understand, are we replacing the one through 17 with what you've suggested in the comments, correct, OK.
It makes me chuckle.
That OB guy is listed there.
And Placid surgery and have trouble getting a plastic surgeon in the whole right Jacksonville for outpatient.
They're all doing cosmetics.
I didn't make any.
Oh for A/C, the point below that.
Provision of the bond services.
Dentistry to remove that mm hmm.
And then vocational services conditionally, that's when Bskib is involved.
Vocational services in some ways is deferred.
Yeah, I would say or referral to April for something like that.
If we don't want to remove it, but dentistry definitely needs to be removed, that's giving somebody.
What about the education to local school boards and homebound teachers? Does to a lot of people provide that on a regular basis?
I mean that for the school boards, I don't.
I don't understand the school boards, but our pediatric program does have yeah, program in place for.
For continuing education or returning to education, OK.
So if they're in inpatient, they have to have some education requirements.
So OK.
I work with adults so.
Yeah, but please remove local school boards.
Let's have the 1st I I imagine someone going and like I don't know. I I didn't think about children.
I have to think broader.

Yes.
Anything else for A/C to change?
For ad, your dynamics is listed there.
That's usually not done when patients are in acute rehab. It's usually done afterwards.
There are a few instances where this happens, but.
Wouldn't say the hospital would have to be required to have a referral system in place for aerodynamics.
Remove your dynamics, OK?
But I'm not sure if it belong here somewhere else.
But they I would recommend that you do have a referral pathway for a urologist after.
After rehabilitation, say for urologist that would perform a urologist Prasad just that would perform.
Your your URO dynamic testing.
But.
It's not that important.
We can move on.
I got it.
The.
Didn't write anything for AE.
Was there anyone that any comments on AE?
It's pretty standard, yeah.
Yeah, for AF for the and this is. This is specified for first 72 hours.
And most of those make a lot of sense.
But sexuality is not something that my center, I think, assesses within them for 72 hours. We usually let them get settled in before we get into those details, right?
I agree.
And I just am asking for recreation and leisure time skills.
We have the the privilege of having ATR, but not everybody does. So as I think occupational therapy also assesses recreation and leisure within their evaluations. If there's not like think we're both doing it. Yeah, I know in our intake we come and ask them what their hobbies are.
And try to integrate that with our.
Familiarity, yeah.
Yeah, our our RT is definitely not there at that side within 72 hours, yeah.

Anything else for AF?
No.
I didn't have anything for AG.
Es All the requirements for rehab.
Should have that.
My next comment is for.
Eight Ki.
I'm just really unclear on what these transitional residential treatment centers are.
If they exist, they're closely kept secret. That I didn't, that I'm not aware of.
I wish there were facilities like that available in Florida, but.
Yeah.
So I'd remove that language.
Is there, I mean so there is sometimes like Community life centers, right? Where people can go.
It's like a not like almost like independent living, but.
Is that what it means?
I don't know.
We also have a shelter that you can send somebody to that has this a transitional time. If they need a little bit of assistance and then can move on.
So yeah, almost like a halfway house type of.
Like is this like adult daycare or?
No, it's like a community.
I can't think of what the name of it.
There's one in like Central Florida.
I mean there there are places like New York restorative and new life, things like that.
That's right.
Usually not accessible to to. Most patients may not be a pathway.
A lot of that.
The last sentence would follow.
Yeah, I don't think it says you have to. I think it's just saying as appropriate, you can make referrals too.
So if there isn't one available, you obviously make one.
That's the way I read it anyway.
Does anybody else read it differently?
'Cause not everywhere has clinical research centers either or true. True. OK, yeah, we

can just. We can just leave that language and then.
For a skipping down to AW well.
People wanna stand down to that point. Aw, is my next comment.
Text but read over the nursing standards that all seem to be appropriate.
I would have to say on 22 under AP #2.
I don't know if anybody else are. You consistently at least monthly providing in service education for traumatic brain.
I just am concerned about the.
That's more a more strict requirement than even karf.
Yeah, I would say Kourtney is fine.

Valbuena Valecillos, Adriana D 31:57
Yes, I agree.
And at least monthly more than once a month.

Casavant, Robert 32:11
Yeah. Yeah, that's a lot.
I was like, I'm not sure anybody would be in Kapolei.
Just broad.
Just education, right?
I mean, it depends what you mean by in service like is it just during?
I mean, but then you just minimize it to mean nothing, like, right education. Handoff regarding. Yeah, school integration speaking.
Umm.
My next comment is for AW, but I'll let you guys read down to that point.
Let me know when you wanna talk about it.
Just a thought on the nursing plan. You know most at least my experiences is that most nursing plans are really only at the top.
Like 3 things that they're focusing on.
And so this is a pretty extensive list.
I just want to make sure that we're not boxing ourselves in that they have to have a plan of care item for every single one of those, and it might not read like that to anybody. I just.
Is that are you talking about 6?
I'm sorry AQ 3.

Are most pre admission screenings completed by registered nurses?
I feel like.
Not always.
And that's what it says here so.
On AQ1 it says the pre admission screen process assessment shall involve a registered nurse.
So, like our priest screening assessment says, the people that are going out in the community and they're not always nurses.
If you're talking about bullet .1 yeah.
My assumption was that this was after they arrived to the facility, not the prescreening.
Oh, OK.
So should we take out?
What should we change that to then?
Because it says pre admission screening.

Valbuena Valecillos, Adriana D 34:42
But it's under the nursing process.

Casavant, Robert 34:42
Oh.
Yeah. Oh, sorry.
I was at the I I was on page 23.

Valbuena Valecillos, Adriana D 34:54
Yet the pre admission screening looks like they're talking about the PAS that could be filled sometimes for the but it's. Yeah, therapy could be liaisons, but it's it seems to be more of the admissions.

Casavant, Robert 35:01
Sometimes terribly, yeah.

Valbuena Valecillos, Adriana D 35:09
It's just the wording because it's under the nursing process.

Casavant, Robert 35:13
So maybe just take out three.

Valbuena Valecillos, Adriana D 35:14
Unadmissaged. Yeah, I think we just need to remove the pre bar.

Casavant, Robert 35:19
OK.
Thank you.
Square that circle or circle that square.
But the the plan that you're talking about earlier that was AR .3?
Yeah, AQ 3.
Aqi.
Think it should encompass like those things should be.
Should be included in the screening, but not necessarily be like listing the planned yeah.
Just how to change the the language should like that.
Maybe we just say the integrated nursing assessment includes.
'Cause. It's just, yeah, we're kind of duplicating .3 above and .3 below.
Yeah. So I would say the, yeah, I would say the integrated nursing assessment and take out treatment plan includes.
A. Does that look right?
All right next.
And maybe just add on #AR3, the plan reflects the following as appropriate.
Yeah.
And you guys OK with the language regarding incorporating?
Nursing education, I think that makes sense. Yeah. To make that part of the the workforce in training and in the pipeline for rehab.
Nursing, yeah.
Yes, the only question I have is providing opportunities for related research.
Not all facilities have capacity for that.
Could just be like providing information.
So just simply saying, OK, if you're interested in research, this is how you find research.

Not necessarily having it integrate as part of their program. OK, when I read AU two it says.
This real editions shop provide opportunities for the brain and spinal cord injury rehabilitation to participate in research.
That's sorry, I thought it was like page. No, that's OK.
I should have specified where I was at.
You weren't reading my mind.
I would.
I would say related research or clot improvement programming.
Yeah, I would say or quality.
And maybe for the title, for AU, we just add after research slash quality improvement. That way it just kind of ties it.
To.
Just after a research, you can put another slash and say quality improvement.
Feel like for Aw, I'm starting to have amnesia with the previous section. Is this is just me or is this duplicating what's before it?
It's I think it was duplicative of the acute care hospital.
I think we whatever we said in acute, we probably just need to transfer over to this, don't you think?
No, there's this.
I think this is still under rehab.
Adam Q Oh on page 16.
Oh yeah, staffing for psychology. I was thinking this was a QQ.
Yeah, yeah, yeah.
I'll be going back and forth so much, I.
Yeah. Yeah, I yeah, I don't know why we need to have that when we have.
Already it on 16 and all the way through.
Is there anything from Aw that looks like that we need to?
Yeah.
I really didn't like the ratio 'cause that's like then it disincentivizes hiring more staff in certain circumstances.
Oh, you can't hire another masters level cause so. So I really didn't like the ratio.
Yeah. And actually that, that that's a common. I was gonna make about the trauma standards is to remove the ratio requirement for that cause like that they could be hospitalized.

Oh, we can't hire another licensure worker because we don't have enough psychologists agree, and there's just not enough anyway. Yeah, so.
Let me try to find the page for that. If you guys are agreement on that.
More detail.
Yeah, I almost feel like removing a this this section 'cause it's it's got so much detail that I'm afraid we're gonna box box in.
Which section specifically?
Awax and ay.
Because that's all the.
Psychology specific stuff.
Unless there's. Can you help me and give me a page number? Floating 2424. OK. Oh, I'm sorry. 2425 and 26. It goes in the one on page 16 already goes through staffing, orientation and training.
Yeah. And so it's just.
But do we?
I mean, do we need to go into the detail about evaluation includes assessment includes treatment plan includes treatment interventions, discharge summary documentation for psychology related. I mean there's already specifics and how they interdisciplinary collaborate, I don't know.
We don't do that with anybody else.
In the standards, yeah.
Nursing homes, some of the clinical procedures might be worth keeping. That's a why.
Because I don't.
That's gonna be included in the staffing language above.
I think there should be some minimum standards with.
With what the psychologists are actually doing.
OK, actually written some language about this.
So should that be ay be moved to page 7/7?
Then you look at page 17.
For input clinical procedures there.
After orientation and training, yeah.
But I don't.
My personal opinion is, is that we just need 1-2 and three.
We don't need to go into 4-5 and six for.

The all the ones on page 27 that you think?
So so to summarize, it looks like we're removing from 20 page 24.
We're removing aw.
All of ax and then on page 26 for AY we're moving AY 1-2 and three to page.
17.
At the end of a psychological psychology section above, additional standards for comprehensive surveys.
So it just kind of completes the psychology specific standards.
And then deleting everything on page 27.
And we want to keep 20 AZ or not.
Gaz, So what we the the things that are currently on page 27, what was your, what were you proposing to just take that out?
Just take out the treatment.
Take out that section.
I mean, I don't personally feel like we need to detail out what treatment interventions they.
Types of treatment interventions they may provide, because that's part of what they do every day.
Yeah.
Umm.
We don't have a psychologist at our facility, Doctor Higgins.
So do yours do like the support groups and all of these interdisciplinary collaboration tasks so.
Psychologists and and agreed recruiting for psychologists particularly challenged right now. But the.
Some of the assessments done by the psychologists and some of it's done by the.
Speech language, therapist, therapist are doing some of the.
Are doing a lot of the education and the.
An evaluation, but then for our more severe TBI patients, it's like dissipate consciousness and things like that. Then then the psychologists are are more involved in cases like that.
I see but.
A lot of time with TBI, it's such a moving picture that.
It doesn't necessarily make sense to do full neuropsychological assessments in the rehab hospital setting because because they're improving.

But if there was evaluation that needs to be done regarding disorder consciousness, or if a patient has particularly severe like behavioral problems or agitation that are neuropsychologist will develop treatment plans and and.
Give the staff OK. Inpatient.
Does this you do this?
This is how you respond.
This is how you maintain staff safety in regards to an agitated patient.
But it is more on inventions like that is more on as needed basis.
Behavior plans to that detail with. With all TBI patients when it becomes an issue.
So I guess, yeah, well, I guess it does.
It's worded in a way where it can be him mental health clinicians and only when appropriate.
So I guess it's not saying that they have to do these.
These things on AZ.
If we were wanting to keep that one and move it over so.
I think there is.
We really need an opportunity throughout the whole state of Florida for for elevation of psychological care, for patients with severe TBI.
So I think even centers that.
That are having trouble with this. I think it is a, a an appropriate minimum requirement that that a A.
PhD psychologist, PhD level psychologist.
Be available for consultation for TBI patients.
But that they don't necessarily have to evaluate every single TBI patient.
In the hospital setting, is it warded in here in that way?
I think we did that in the first part.
No, we. That was one of the first things we mentioned. Yeah on 16.
Uh.
I just want to make sure that like the language is the same kind of throughout.
Yeah. So between trauma centers and rehab centers, yeah, well, we're all on rehab, right? Yeah, I thought.
I thought someone said 16, which should be in the rehab, which should be in Q care.
Do you say 16?
Or maybe I misheard. No, they have.
That's why we have this whole, yeah.

So what we're recommending then is AZ stays in, but it it also then gets moved to the back.
And of that 17 page 17 after the.
1-2 and three of AY.
That's moving over.
On AZ, do we want to keep the phrasing? Psychology services must be provided as a part of the integrated interdisciplinary team approach. Or do we want to may may?
Must be available, must be available.
Yeah. OK.
Like as a consultation are just available even as that available as part of an integrated OK.
Did everybody online follow?

Valbuena Valecillos, Adriana D 50:44
Yes.

Casavant, Robert 50:44
OK, good.

Kevin Mullin 50:48
All good here.

Casavant, Robert 50:52
OK. Are we both gonna look at that?
We're moving.
Right.
Into the time do we wanna take a break for a second?
Reading this, I just really wanted to kind of have an accidental conversation about this section.
I raised earlier in the conversation, you know what's the.
What's incentive for programs to to?
Be participate in in becoming AB. Skip does or or remaining as AB Skip Center.
And also at the same time not duplicating car for accreditation and just rubber stamping that. But just then you have to do carve twice.
And.

Also, recognizing for outpatient care that it's very hyper local. So for inpatient rehab, patients may travel or more to to come to inpatient rehab center, but they're not going to be able to do that for outpatient services. You know two to three times a week with a serious.
Disability.
So just I'm not sure what the role or what the what value added is for having outpatient bsip standards for for a place being locate identified as an outpatient, be skip center right 'cause it's most don't even go through the car valuation.
Is it worth the is? Is, is the juice worth the squeeze?
Yeah, yeah. Thoughts on mine.
So our pageant gets. What's your experience from attending outpatient therapy?

Kevin Mullin 52:40
Be worth the squeeze.

Casavant, Robert 52:42
Yeah.
Yeah, I agree.
I don't think we're gonna have, you know, a stand alone outpatient facility that doesn't isn't connected in some way to a rehab center that would go for this separately.
Yeah, you know what I mean.
Yeah. Because, I mean mean like facilities is A is a singular word.
But then right?
I mean multiple centers.
And even in context of Brooks, like, does the does our clinic in Hudson, FL like include as part of our our facility, right, right off campus?
Awesome stuff from sunset exists if we do decide that we don't need umm this portion, which it sounds like we're leaning too. Do we want to add any kind of verbiage to like the inpatient rehab center about, you know, follow up care in any of any kind? Yeah.
I think that's a really good idea.
So like any kind of maybe just a smaller. Yeah. And I I mentioned a small bit about referral to urology services, right.
Do that.

I think maybe we should have this whole section on on, on transition, outpatient, OK, including therapy services, appropriate therapy services.
Or community based.
I mean, overall, they're gonna be transitioning to community based whether it's home or.
I mean, some do go to the sniff, but you know, yeah. How do we?
Where do we wanna put that and how do we wanna word that?
Yeah. I mean, I think it's a statement about appropriate referral services are made, you know for the patient to continue care and progressing and their functional abilities.
It might be easier for me to type out a draft.
And and add things together and then I can send it to to one of the staff members. I have some other things to add to that.
Let me share my screen and start typing if that's OK with you guys for sure.
Do we wanna take a vote about removing the outpatient?
Oh yes, that's that'd be great.
All in favor? We'll just do voice vote.
Say I I I Yup.

Valbuena Valecillos, Adriana D 54:50
Hi.

Casavant, Robert 54:50
As an opposition.
Alright, OK. And then?
You're gonna type the draft of what you of the comment that you wanna add to the end for outpatient. Impatiently most expedient, yeah.
Are we gonna do that now together?
He's gonna type it.
And then we can review it.
OK, right.
Yeah. We just if we do, I think a lot of the existing languages.
Very wordy.
Maybe we don't need to make this sections wordy, yeah.
We're cutting out 10 pages.

Yeah, and. And we cut out a few minutes psychology, but it'll be at the end of the inpatient rehab.
Just so you know, 'cause, it's for the inpatient rehab to closure to to per referral services, yeah.
So when we come back, we'll start on page 39.
Pediatrics.
They have outpatient services for pediatric.
IANS yeah, I don't know what number it'd be sometimes easy.
Yeah, whatever.
We're on at the end after we remove all the others.
Do you wanna take a 10 minute break?
Yeah, that'd be fun. Yeah. OK.
So we'll do the break now.
We have.
It's a 15 minute break so will be back at sorry 1020.
Perfect. OK.
Look at us.
Just go through these mute us, rob and we'll be back at 10:20.
Maybe we can have AI.
Write our containers.
You have an ISO DPT.
You have an IP screen here. Is is offering to help out.
Yeah, I like it.
I do not trust Gemini.
Test testing.
See is still a little low.

Kevin Mullin 1:00:00
I can hear you.

Casavant, Robert 1:00:02
OK.
Thank you.
Just trying out this mic.

Kevin Mullin 1:00:06
No problem.

Casavant, Robert 1:11:55
OK, we're gonna get started again.
We're back from break so.
We were looking at started to look outpatient.
What page do you guys want to pick back up on?
Do you wanna do that first or do you wanna?
Yeah, I can share this.
I I run out of most ideas, so I'll I'll need your guys's ideas to add to this, but I can share my screen here.
So you notice that.
Point AK in the document.
We find the page of that.
It's on page 20.
Yeah, that talks some about outpatient referrals, but not very robustly. If we're gonna be getting rid of the the whole outpatient center outpatient language.
So I think maybe we could add this to AK.
Replace it and make mention of and salvage some of the points from AK.
So this is what I had.
So patients shall be valued by a case manager within 72 hours of mission to begin discharge planning care coordination. I think that's standard of care.
Would you guys agree on that?
There should be process in place to refer patients to following services is indicated, so it doesn't box people in but outpatient or home health, physical, occupational and speech therapy. Referral to outpatient therapy clinics with demonstrate expertise in neurological therapies.
Should be emphasized.
Umm, which may include capability perform body weight, supported gate training.
Functional electrical stimulation.
And then some things for TBI.
So I'd say like cognitive.
Revoltation.

Anything else that would be like hallmarks and of course this is not a requirement.
Anything else that would be hallmarks that that should be part of the programmatics as far as like, what's what outpatient center should be emphasized?
We make referrals to neuro ophthalmologists sometimes, but I don't know if it's worth putting.
Yeah, I I think it's appropriate so.
Be.
That would be under medical, so that would be under therapies.
So vision evaluation by your ophthalmologist or optometrist.
Oh man, I have to spell optimology.
It's harder than you think.

Valbuena Valecillos, Adriana D 1:15:14
What if?
Vocational therapy should be included in this area.

Casavant, Robert 1:15:19
You say?
Oh, crap, yeah, yeah.
Oh yeah, in driver's training.
Or vision. Did you wanna save? Yeah.
Driver's training. Mm hmm. Mm hmm.
And then I think you can just have that kind of caveat as the last one other.
Other services and resources as appropriate.

Valbuena Valecillos, Adriana D 1:15:54
It's appropriate, yes.

Casavant, Robert 1:15:55
That's a catchment.
Uh services and what do you say, sources?
OK. Anything else to add to this section?
Are you guys OK with this replacing AK?
I think we included the.
Possible page again.

Sure. Wait, just add something.
Into the new version about like.
Well, I guess other services could capture all of those, but like programs and services talks a lot about sinners or organizations programs.
Yeah. So since for infant living.
Mm hmm.
Umm. Behavior health? Yeah.
I don't know if you wanna put like support group.
Yeah, patient family support groups. Mm hmm.

Valbuena Valecillos, Adriana D 1:17:14
Customer.

Casavant, Robert 1:17:22
I think that's good.
Yeah.
Yeah. Do we want to be specific in what those organizations are or leave it, just leave it.
Yeah.
I think that looks good. And yeah, I think it should have just replaced K and I think so AK.
Yeah. So let me drop this.
The chat I'm not sure if it's gonna.
Convert or if I need to e-mail it OK OK, I think it'll probably need to be.
Emailed. So it's all nice and bulleted.
Let's see how it goes.
Oh, second kept it.

Valbuena Valecillos, Adriana D 1:18:22
Yeah.

Casavant, Robert 1:18:25
So he put in the chat.
We're gonna replace AK with the language he dropped in the chat.
On page 28 K on page 20. I'm sorry.

All right.
And we've always stricken the outpatient section.
What's below that?
Is it straight to Pete after that?
Yep, mm hmm.
Yeah. And I'd just like to propose that we don't have necessarily separate pediatric center standards that perhaps we keep that first paragraph minus the the very last sentence and then.
Section B that just talks about the volume, just like we did with the other with the adults for brain injury and spinal cord and that be it cause the rest is all already incorporated in my opinion.
In in the what we just worked on and maybe we change it from adult brain and spinal cord injury, inpatient rehab center standards to just inpatient.
I mean brain and spinal cord injury, inpatient rehabilitation center standards. I like that.
And then we get rid of the rest and get rid of the outpatient.
Repeats. That's my proposal.
I generally agree with mine.
Maybe we can.
I haven't had enough time to to read through some of these things, so to read through it and see if there's anything else we wanna salvage from it.
So you wanna repeat?
The recommendation is to change the title of the inpatient rehabilitations section to instead of adult.
Yeah, just say brain and spinal cord injury.
And patient.
Rehabilitation center standards.
I think you mentioned that we're gonna keep the keep the volume requirement or keep a volume requirement eBay volume requirement.
Let's discuss what's written down here.
Yeah. So right now it says 30 pediatric admissions per year with average daily senses of four to five.
Yeah, I don't keep 4:00 to 5:00.
I don't how you.
I think maybe just wanted just to sign on a number for per year and not do a new

census.
I agree from a little experience on that. Sometimes the census can can vary quite a bit month to month. For Pete's programs, definitely.
Do do.
I'm not sure if the language is included here or not, but would you guys agree that there should be like a separate treatment spaces?
Specifically available for pediatric patients, yeah, I think that's actually required by law, isn't it?

Valbuena Valecillos, Adriana D 1:21:41
Definitely yes.


Casavant, Robert 1:21:43
I yeah, alright.

Valbuena Valecillos, Adriana D 1:21:44
It's required I believe.


Casavant, Robert 1:21:46
Yeah. Then we won't duplicate that.
I think it says that in if it's by law, then then we won't duplicate it.
That would consent.
Yeah, and it says it up at the top too.
I've got a good note that I can tell you about later, but it's not pertaining to this to this document.
But regarding that.
So what does everybody else think? Minimum of 30 pediatric patients per year and just leave it at that?
Similar to the previous conversation we had regarding T quip and in acute care centers, I'm I'm I'm just curious what what volume for the for the existing pediatric centers, what volume they typically see?
If this is a reasonable amount.

Valbuena Valecillos, Adriana D 1:22:34
You're talking about inpatient service?

Casavant, Robert 1:22:36
For yeah, for in inpatient.

Valbuena Valecillos, Adriana D 1:22:39
Three patients a year.

Casavant, Robert 1:22:41
Yeah, 30 patients a year.

Valbuena Valecillos, Adriana D 1:22:43
36.

Casavant, Robert 1:22:44
Yeah, I mean, so it's like less than one a week.
So that's not really that high.

Valbuena Valecillos, Adriana D 1:22:47
Yeah, that, that.
Yeah, it's it we have in, in, in my situation we have 6 beds. The average census is 3:00 to 4:00 and they are like like right now. We just went down to one.
So it's it's hard to get the numbers.

Casavant, Robert 1:23:04
Mm hmm.

Valbuena Valecillos, Adriana D 1:23:05
But I think 30 patients is reasonable a year.

Casavant, Robert 1:23:09
Yeah. Yeah. Just I understand what Doctor Valpini is saying. But for for me the the the other non non clinicians online here the.
The insurance for Pediatrics generally has shorter lengths of stays, oftentimes because so many patients are under under Medicaid in the in the pediatric population, OK.

Should on the very first part paragraph where it says the following standards have been developed with this goal in mind. Should we reference something about following the standards like previously mentioned that we went over for the adult? Or is that just kind of assumed?
We want them to know that we still want them to meet the criteria already listed, right?
Say that again for me and and and point to me where you're talking.
Yeah. So in the on page 39, there's the last sentence where it just says the following standards were created with this goal in mind.
I don't know if we want to reference that.
We're still expecting them to meet the standards, even though we're just listing that caveat of 30 patients.
Because the verbiage need to be there that, yeah, it was just like we assume that's good. But well, we assume that like the program will go based off of all of the things already listed.
You know what I mean?
We still want them to have that standard of care, yeah.

Valbuena Valecillos, Adriana D 1:24:37
Yes.

Casavant, Robert 1:24:38
It's just not repeated separately.

Valbuena Valecillos, Adriana D 1:24:41
Yes.

Casavant, Robert 1:24:50
So something like all.
All all standards previously.
Identified in this.
Standards manual or whatever should be followed for pediatric and then the piece about there should be a volume of admissions sufficient to support.
Under B, the specialist professional expertise necessary to operate a comprehensive designated pediatric rehab program, it's expected that a minimum of 30 pediatric

admissions per year.
In order to create a rehabilitation environment adequate for pediatric designation.
We've just taken out that and in the average daily census will be maintained.
So in section B.
We're going to remove.
And an average daily census of four to five patients will be maintained.

Valbuena Valecillos, Adriana D 1:25:54
Yeah, that's tough.

Casavant, Robert 1:25:56
Yes. Yeah, really tough and difficult to quantify.
Is like the mm hmm.
So she's talking mean or median? Would it quite typical here.
On sorry, on page 45.
AB there.
Our quality assurance, things that were not mentioned previously, do we want to keep that or include it into the previous standards? It talks about the disability rating.
Vocational status.
Academic status.
I don't know if we need to mention education again like we did previously.
Yeah. I mean, I think we already mentioned education. So but if we.
Need to include the specific QIQI piece about that.
I'm assuming it's talking about the disability writing scale there.
Yeah, which is interesting that it's there and not in the other 'cause you right.
You typically do that after and outpatient, so.
Are you sure? Are you?
I'm not familiar with the scale, right?
Yeah, I mean I I've done it only in outpatient.
So yeah.
But there was language previously about.
That having like a school liaison right person, and I think that covers a lot. Like if there's get school aids on person working, then they're gonna be valuing where they're at in school and and involving that.
So I think that'd be difficult to.

Pull up one.
You guys can help me remember did we have anything about data collection previously?
Yes, because it's a part of the Qi, right?
I just.
I don't remember reading it, so I just wanted to make sure there is language that talks about evaluating and tracking functional outcomes. OK and we had a previous conversation about.
Oh no, I forget the old name, but the caret tool is basically being, yeah, the present one in the versus Keras.
Yeah, we OK.
So that had been discussed previously.
I do remember that.
And also karf requires all of these things.
And since we're saying that you have to be karf, right?
Brush in my brush.
So it's the recommendation.
I'm sorry. Yep. So.
I think what we're saying and please correct me if I'm wrong if anybody hears differently, we're we're just keeping this first paragraph and that section B with that.
One part of the line removed out and everything else under Pediatrics is going away.
We don't have to have a separate pediatric section.
There's language in here regarding the qualifications of the pediatric medical director.
I think it may be important to preserve that perfect one.

Valbuena Valecillos, Adriana D 1:29:12
Yes.

Casavant, Robert 1:29:12
Find which page that is, because I don't think that was mentioned earlier.

Valbuena Valecillos, Adriana D 1:29:14
Yes.

Casavant, Robert 1:29:17
Yeah, we just talked about from the brain and spinal cord perspective specifically.
Trying to find saddened. Yeah, so it's letter O on page 42.
I think it it gives options as far as that.
Perfect. Yeah.
So it's just question of prior to put that language do people agree with this language, these four, these four options?
What? So just the documented long term follow up of 30 PDF. That means they have to have an outpatient practice.
So. So they had.
They have to have at least one of these, umm, or at least one. OK, perfect.

Valbuena Valecillos, Adriana D 1:30:16
Yeah, I think that's appropriate.

Casavant, Robert 1:30:19
OK, the .4, it just seems to be sound.
Who's trained in meds? Pete the Med PEDs, but not pertaining to rehabilitation.

Valbuena Valecillos, Adriana D 1:30:31
Which point?

Casavant, Robert 1:30:32
Letter #4 under O says a combined adult and pediatric residency training.
Basically, sound who's who's Med P boarded or trained?
I don't think that's appropriate for rehabilitation.
I think the other three are more pertinent to be a medical director, yeah.
So strike four and keep the 1st 3.

Valbuena Valecillos, Adriana D 1:30:55
Yeah, yeah, I agree.

Casavant, Robert 1:30:59
So for a lot of B, that'll be better a.

OK, AE talks about.
Prevention and education. Do we want to keep any of that? I don't remember.
That being clear, some language about that earlier.com what that exactly means.
But but it is included OK yeah.
It is.
I honestly did have a question about like to what extent rehab centers are expected to do like school presentations.
I don't know if you guys wanna revisit that now, but I don't think that it should be in a requirement. I don't think so either. I think that is too dependent on the school's policies and what they're welcome to. Mm hmm. They're welcoming into the facility.
Let's find.
That language and strike it.
It's.
J. Let me find a page number of that.
It's gonna be adult rehabilitation like J.
What's this song previous?
Jay, which one is that? J #2.
Or you can be scheduled traumatic TBR SCI programs with implemented in local elementary middleware high schools.
I was.
I'm proposing just removing this section.
Because it could fall under letter one.
So you I guess you could change .1 to say ongoing.
Community, public or school based arrange programs.
14 page 14 yeah.
What are you guys seeing about changing letter? One to say to include school and then striking 2?
Just one second only.

Valbuena Valecillos, Adriana D 1:33:43
I'm not sure what.

Casavant, Robert 1:33:43
4.

Valbuena Valecillos, Adriana D 1:33:44
What is that bar?

Casavant, Robert 1:33:47
So, page 14 under letter J.
It's what we're trying to do is make sure that it reflects that there's, you know, promotion of health and community public awareness and because of some of the. Rules in the schools and things like that on who can come in and present and different things like that.
The recommendation is is that we just add to #1.
That may include the local media to target specific prevention concerns and education.
Is that what you're saying? Education. Facilities?
Yeah. And then remove the 2nd.

Valbuena Valecillos, Adriana D 1:34:29
OK.

Casavant, Robert 1:34:30
Entire circuit.
One entire second section #2.
Because you may or may not have the opportunity to do that, given your area.

Valbuena Valecillos, Adriana D 1:34:46
OK. Yeah.

Casavant, Robert 1:34:53
Hopping back and forth quite a bit here.
Back to the pediatric session.
Just let us know what page will do.
We've already gone over it.
It it's kind of interesting that vocational services is listened under uh. Pediatrics.
Umm, yeah, yeah.
So that child labor, disabled children, umm, the only other thing under Pete.

Sorry 'cause I I know I made the recommendation that we just remove but I was looking at Jay and I I think maybe we should state that obviously I mean it to me it's obvious you have to have competencies and things like that education.
Staff trained in Pediatrics specific and you do if you're a carf certified for speeds, but I don't know if we want to leave any portion of that.
That you know, if you're designated, you have to have the appropriate pediatric staff trained.
I agree and could include child life specialist.
So I think that's a yeah, their beauty rec or and or child life specialist.
I just have to find where that goes and then previous document maybe right below the the piece that we're adding about the medical director.
So we're on page 41 now, correct. Sorry.
So the relevant section in the adult the quote UN quote Adult section is letter A/C on page 18.
So I propose the language on that.
At the top it would say the realtor should have her be able to perform permission to find services.
And when ethical rule, these services should be appropriate for the pediatric population.
You guys see where I'm talking?
Yeah. And then add child life specialist. Yep, Yep.
Very fine.
Can you repeat that?
So we so on .18.
So and after services say.
And when applicable.
These services should be appropriate for.
Should be appropriately trained for pediatric care.
Should work.
Should I never.
Hmm.
Match island.
Repeat everyone.
How about just type it into the chat?
It's gonna drop it in the chat.

Can you scroll up just a little bit?
Or the down, sorry.
Thank you.
So, right, right. So services.
Interactable these services shall be trained in pediatric care.
Do you guys agree in that mm hmm. And that's on A/C, right?
Yeah, the heading of A/C. OK, yeah.
And then #8 will be child life specialist mm hmm. Slash recreational therapy.
Yeah, that's fine.
Oh, is RT not included or not? That RT.
The other rttr yeah. Guys can arm wrestle over that, yeah.
Life. LIFE.
Sorry, I should've sounds very similar.
And or recreational therapy.
Facial therapist, I guess.
Yeah. Perfect.
Thank you.
You may have mentioned something about the ongoing contact with third party payers. Is is there anything from that we need to?
All into the larger document, I think this is letter M.
Yeah, I think we covered that. When we put other services, OK, on the referral section.
So I think we're OK, OK.
So much of this is just copy and pasted from the adult, yeah.
The narrative from letter Y is there anything we wanted to take from there?
OK.
So what page number are you looking at?
Page 44.
Letter Y.
44 letter Y.
No, I feel like that.
Didn't we talked about family centered care in the adult?
I mean that's that's part of car requirements.

Valbuena Valecillos, Adriana D 1:42:06
What do you want to train on that?

Casavant, Robert 1:42:06
Could you?
I mean, so. So I'm wondering if if if this language in letter Y should be pulled into larger document and kinda salvage from from the section before we mm HMM I was looking back.
I don't see it.
Yeah, in anywhere in the adult section, actually.
Does anybody else see it?
I'm not be missing it.
Yeah, I don't see it.
So I think it's a good idea. Good catch.
It's a little bit wordier than I would write it, but but I think everything couldn't could pertain just question of where to put it.
Could we put it? Just I think we're taking some of the heading from from the town document the right where we added like the medical Director qualifications.
Yeah, but alongside that.
So you wanna take the language from Y and put it with the heading you said? Yeah.
So I think there should be a subsection dedicated Pediatrics include the the language that's in.
On Page 39 and then we're going with the the volume of admissions, yes, so the the language at the top of page 39, the language regarding the volume of admissions without the average census, the medical director language and then this and then the.
That'll be C.
It'll become section C under PSP, the address.
We're probably gonna need to go through and say which exact sections you guys want stricken. OK. And then that way whenever we recreate this document, we'll we can format.
Yeah, OK. Yeah. OK.
But we're essentially saying everything but these, these ones that were specified. OK, so it would be really currently OK.

B and.
Mm hmm, with those that we proposed.
Bony we're keeping.
Art.
Let's go from.
Why? Is there anything?
Well, let's just start after. Why?
Are we keeping our striking?
Half after that, after why I'm I'm reading through it.
Haven't seen it anything else to keep.
I haven't either.
Trying to think, are there any hospitals that are do purely P's rehab?
I don't.
I'm I'm not aware of any in the country.
I know of a couple, but I don't know that in Florida.

Valbuena Valecillos, Adriana D 1:45:35
And Children's Hospital.


Casavant, Robert 1:45:39
Is in Miami, New York.

Valbuena Valecillos, Adriana D 1:45:39
But they don't have.
Yes, but they don't have like an inpatient unit rehab unit.


Casavant, Robert 1:45:46
Oh, OK.
Yeah, specific inpatient rehab unit.
I can't think of anybody.

Valbuena Valecillos, Adriana D 1:45:52
I think in browser we have Joe Demoji Joe I has Joe DeMar. Yes, I think they do have an invasion rehab unit.

Casavant, Robert 1:45:52
In.
Joe DiMaggio standalone. OK, OK.

Valbuena Valecillos, Adriana D 1:46:04
I have to double check with Bart to go over the Pediatrics rehab.

Casavant, Robert 1:46:08
I thought that was, you know, for some reason. I thought that's part of Memorial Health care.

Kevin Mullin 1:46:15
Someone can correct me if wrong this check Nicholas had the Children's Hospital also.

Valbuena Valecillos, Adriana D 1:46:15
It's part of the memorial, I think.

Kevin Mullin 1:46:21
I don't know if that's stand alone or not, but I thought there was a pediatric inpatient rehab, but I'm not 100% sure.
Anybody in the Palm Beach area that might know that answer?

Valbuena Valecillos, Adriana D 1:46:31
Which which one?

Kevin Mullin 1:46:33
It's Jack Nicholas children's.

Valbuena Valecillos, Adriana D 1:46:36
I'm gonna ask my my friend right now.

Kevin Mullin 1:46:41
And I'll see what I can even just do a quick search online, see what I can find out.

Casavant, Robert 1:46:46

Yeah, there's what about Wolfson's in Jacksonville?
So they don't have their own.
It's their, their.
Those patients are at Brooks, are physically located at Brookside.
So partnership and then I think there's one in Orlando.
So I guess there should be language that.
I'm looking locations.
But I guess under the under the combined standards.
There should be separate designation for, you know, brain injury, spondane injury or or pediatric, yeah.
I'm done.
We're done.
Yeah, I think that's how we changed the title at the top right.
Bring final cordon and Pediatrics between brains.
Spinal cord. Is that separation or it's just you have to be 1 to the other, one to the other, right?
I think.
Is that correct?
At least that's how it used to be.
Let me say it that way.
Do you know what is it?
Is it separate designation when it's brain and spinal cord Injury program designated?
You have to have just one or you have to have or are they separate?
Think we're talking about this when you're talking about minimum patient volume.
I I know before, at least for us, it was one designation, right?
And spinal.
Yeah, it was.
Yeah. At the top of the pages on the screen it says spinal injury cord program.
And I don't know if that's just that one page typo. Yeah, OK.
One one thing that I noticed on page 44 when it talks about the interdisciplinary treatment team next to sexual functioning education, it just says age appropriate.
For where we have it on page.
In the other standards besides sexuality on page 19, should we put in parentheses

age appropriate or with parental consent?
Yeah. Good catch, Gary.
It actually says sexuality on AF and I think I like the sexual functioning.
I I agree.
Yeah. So if we could change on page 19 AF.
#15, if we could change it to sexual functioning education.
Basically taking #13 on page 44 and putting it there.
OK.
He's on page 19, so if you can say page 19 AF, OK, we took it out there.
Do we want to add it or keep it out?
I say add it.
I think I think that's because we didn't like the term, but I think this term is OK.
So let's if we could add it to 16. OK, sexual function, but sexuality, sexual function, sexual functioning, education.
They're just sexual, not sexual function and not education.
Just OK, sexual function, sexual function.
And then in parentheses, but age appropriate with parental consent as needed, yeah.
With age appropriate comma.
With parental.
And then consent.
You just need to remove the extra T in there.
And just end parentheses.
There you go.
Of course, we're gonna strike the I think outpatient section.
I think that yes, we removed it from there because that was within the initial evaluation.
Is that still appropriate in that section or should it be moved to?
I'm so sorry.
So I remember now that this is during initial evaluation and you said that you did not evaluate.
That's right.
I didn't see much of that.
Yeah, on that one. But I think we need to put that somewhere.
So let's look where so you can copy #16.
That's right. Sorry. Good catch. Good catch.

Maybe under AG just copy. I would say cut.
Yeah, cut and then we'll paste it somewhere.
Yeah, we're gonna see gone to retty can put it.
So what were we just showing?
Look in Ag and see if it can go there AG.
Or you just put it as a separate point. OK, maybe.
Yeah.
A/C or AJ?
Look at AJ, let's say JC.
Obviously going back.
Ah, seems to be redundant with the the language that we created regarding discharge planning.
Mm hmm. So we just take out. Ah.
I yeah, I agree.
And I think under AJ is where we can put the sexual function.
OK, AJ #4 is where you can paste the section. You are cutting the sexual function.
Evaluation comes in regarding sexual functioning.
Like that.
Like, say you're doing a good job over there catching up.
I appreciate all all your systems.
You're doing great.
You usually get to speak things into existence like this at 4:00. If you can top evaluation and, well, what's what did you mean? Let him delete that first, like education?
But it wasn't education.
It was evaluation and counseling.
Counseling. Yep. And vouching just in front of sexual function, yes.
In front of the word sexual function, yeah.
Could do.
And counseling.
Would it be related to sexual function?
How would you word that evaluation and counseling regarding regarding?
Thank you.
But we were getting another audience member.
And then do we get, ah, deleted? We did OK, yeah.

OK.
Right, I think my pages are all out of wack.
Yeah.
There's a pediatric outpatient.
Can we remove it twice?
Yes. Yeah, we we don't need pediatric outpatient.
No, that's that's came through in.
We're salvaging, but probably not.
OK.
So we're on page 47.
Thanks for keeping us. You and my brain.
Can you see where it's going?
Thank you, Ben.
You're doing great. OK. And we're just scanning for the people online, scanning through to see if there's anything that we need to salvage or if we're gonna strike the entire section.

Kevin Mullin 1:56:08
No problem.

Casavant, Robert 1:56:14
Oh, this is completely out of order.
But the the section that we wrote regarding outpatient service coordination that should also include physiatree follow up. I just took that for granted.
But Oh yeah, coordination and referral to for physiatry follow up.
I don't know for that where we put that, but do you know what?
What section that's in it was hang on.
We put it.
We added it at the very end and we mm hmm in inpatient.
Maybe.
Pitched roughly around page 28.
Yeah.
Excuse me.
Yeah.
So number wait no, keep going. Scroll down.

Is that the last on that and did you copy?
So maybe it's up.
We put it somewhere else. If you search for the word.
I think I think Optometry you'll probably find it.
OPTOM.
Oh M.
As in Mary.
Optometry. Yeah, whatever.
Ophthalmology. Yeah. Click on that.
It's gonna be all those sections.
Next one.
Click forward on your search bar.
Oh, it's it's just above there, I think again.
The reason that I dropped in the chat.
Yeah. Did we?
Did we get that thrown in yet? Yeah.
Goodness, search for gate training. That should be there.
GAIT.
Search that.
Oh, there it goes.
Yes, so under.
I think it should be 8K. Look for AK.
Oh yeah, I don't think we can include that language yet.
Yeah, it doesn't look like it's it's. Yeah, that's the one I'll like it in the chat.
So one I just liked.
We wanted to replace it with AK, right?
We wanted to put it there.
AK with it.
Yeah, this should include.
Discharge and playing care coordination and.
Under the the sub bullet points you can say physiatry physiatry.
We're replacing everything in AK with what's in the chat.
I think you might have sent it to you an e-mail too, right?
Yeah, it's in the chat.
I just liked it.

OK, just posted at 10:26.
So replacing AK with the comment made at 10:26.
In the chat, I'm sorry.
I keep wanting to tell.
Just reach out and do it.
I know I keep wanting to help.
It was a lot, yeah.
You have to work on the formatting later.
It's not going to give you enough space.
I mean all the languages there, if you just yeah, work on the formatting later.
But yeah, yeah, just one line.
Just add the physiatry so we have it.
Sorry, yeah.
And then maybe leave a note inside here that says like replace with.
And then this is this feels kind of picky to mention, but can you make AJ where it's not double spaced?
It isn't anywhere else.
Thank you.
Nice.
And suddenly we find ourselves at the end of the document with 20 minutes left.
I feel like we should dance it out.
Oh, that's awesome.
It I've got a little smaller things to address if we have time, yeah.
My notes and this is I I I didn't cover these things because it was. It was this ground that we had already covered by main notes about it, you guys.
Does anybody have anything else?
And then online.
Sorry, I didn't know if they had anything on outpatient or whatever they wanted to say.
Turn on this.
Message. Great work everybody.
Kim is gonna be so proud.
She is gonna be really impressed.
Did you say did the child say or did you?
Were you able to e-mail?

Oh, perfect.
Yeah. Perfect.
So this this next comment will be for.
For page 9 on psychology for acute care services.
The wording at the oh, this is actually very bottom of page eight. I was reading this, but I was copying the language from it but.
So it says the purpose the. So the first sentence. If you read it just doesn't make sense.
The purpose of it stands out will look treatment setting is to provide minimum clinical and but doesn't mention psychology in it.
So I would say it says acute treatment setting by psychologists is to provide minimum clinical and programmatic practice guidelines for to facilitate management of cognitive behavioral.
Et cetera, et cetera.
Does that make sense, you guys?
It does, except for. I think that we had, if I'm remembering correctly, I thought we went through and changed this because.
Acute care facilities didn't always have the psychology at that point to, and that's why it it said at the end by the medical team to promote favorable outcomes versus.
A designation of a specific person. Am I not recalling that correctly?
It very well could be that way. It's been awhile.
So under V staffing, we still have it that says.
Minimum one doesn't need doctor levels.
Clinical psychologist or doctor level licensed psychologist.
I think we still have that right underwear.
Letter V oh under that heading.
The copy I have still mentions that there's a doctor level clinical or doctor level license psychologist.
Hmm. True.
So I think that requirement's still in there.
OK, I was gonna actually. My next comment was that the three years requirement experience, I don't know if that was necessarily.
Needed or not, the the three years of experience.
Yeah, I thought we changed that too.
So I don't know if I. I'm clearly not remembering things correctly.

Valbuena Valecillos, Adriana D 2:04:57
Yeah, I think we suggested to change it 'cause. It's difficult by itself to find the psychologist.

Casavant, Robert 2:05:02
Yeah, I thought we did too.
Yeah. So just.
Maybe just change that sentence to a minimum of ongoing education.
Do we want to identify how much education?
I don't really want to get into weeds.
Yeah, I think we really made it broad and if we could go back and look because I'm pretty sure it should be in our minutes, somewhere else on how we just.
Reworded that.
Notes. I don't know if it was in that one or yeah. And in the heading, but this is the edit document because it does under under the large kind narrative.
Under psychology standards, it does include the language regarding the color recovery skill revised, but in retrospect I I think that should belong somewhere else and and kind of has too much emphasis here at the heading.
But there should be a different section that does talk about.
Umm, you know using.
Using you know.
Objectives. Probably not the word, but establish standards to evaluate TBI patients.
To include this crsr the recovery scale revised.
But it's sort of kind of out of place in this in this narrative on the topic of page 9.
So.
OK.
Another change there's so under.
V it says VI.
Sort of like you're doing Roman numerals. That should be.
WI think.
Do you see that?
Yeah. So the VI should be W.
Of section one. I think this language shows up somewhere else, but like I don't the the whole Section 1 like oh you have to know who your colleagues are.

That seems sort of redundant or unnecessary, so I I just under VI or not WI just proposed taking out that whole section about knowing your neighbors or your colleagues or you guys agree with that?
Yeah, I was actually looking. I feel like we did that in the take me to training.
Take out the whole W section.
No, not the whole W section, but the whole one under W OK. Seems kind of so it goes on to the next page.
OK. Yeah.
But then under .2, which will of course become .1.
That's where I wanted to put the language regarding using established metrics.
Including the recovery scale revised but.
Including a broader range.
So let me type this out last night.
Yeah, I'm wondering.
I I think what you're referencing is is similar to what we had already done and made suggestions on in the inpatient rehab.
So I'm just not really sure that.
This little granularity is going to be present in our prior minutes, so we might just have to redo this work.
Yeah, yeah, I what I meant was, is we have it today in this on page.
16 where we start with psychology specific standards, we had already reduced it, so maybe it's just a copy and paste to the acute section for that. If you look at it, that's just a I typed it out. Let me I just put my list of of metrics I.
Put that.
In the chat OK, copied too much, but it would start with. Come on recovery scale revised. That would be the the typical metrics.
Yeah. For that assessment, I was still on the orientation and training piece that we had reduced in the rehab section.
And so I was just recommending we make that change also in the acute section, yeah.
So that'd be under, umm, probably around letter R.
On on page 17, yeah.
But I think there's new language that we need to see.
Mm hmm. Could you Scroll down to our? Yeah.
I don't see the language there regarding the actual quantitative assessment.

Call Taylor assessment.
We listed all those out somewhere.
We put them.
I remember.
I don't think we listed them per southeast.
I remember that Rancho. And yeah, if you if you'll type. If you search on the document for Rancho.
We'll see where that appears.
Can you see what the note is right there on R Jared?
That's just the that's just where we started. Oh, OK.
Never mind.
RHNCHORANCH.

Valbuena Valecillos, Adriana D 2:11:24
Yep.

Casavant, Robert 2:11:35
Yeah, under the data collection and evaluation which is page.
Or in which one?
I guess if you D or one number one, so it's listed OK.
Oh, that. Yeah. Emergency. We gonna be in favor of adding a few more of those metrics there and then copying it to acute care as well. Mm hmm.
That is a page four is acute care.
This.
Under data collection and evaluation, not under psychology specifically. OK. OK.
And and I think that's a good point. That doesn't have to be done by the psychologist.
I I told one of my colleagues psychologists about how the how the psychologists in Miami do do Asia exams.
And they they shuddered over.
They they laughed.
So do you want to?
Put from the chat over to this what we're looking at now.
Yes, OK.
I don't think my chat meant mentioned the.

Oh, it does.
On our existing language includes Asia, but my chat didn't mention Asia exam.
But basically take that list of of measures and include that under DD #1.
Separated.
Oh, it is separated by brain and spine, brain and spine brain.
So we'll need to identify which ones of these will go under, so they're all brain except for the Asia mm hmm. Mm hmm.
So the chat can go into two.
Yes.
Perfect.
And they don't have to do all of these to be clear.
But they should be capable of.
Of performing these as clinically indicated.
Yes, that's an important thing to say.
'Cause it says we must use the Glasgow coma scale and then.
It just came up.
Did you have that in your chat language?
No, I can type it in chat.
What is all that that just became yellow?
I think that that's the other one that, yeah, go into all of that can, like just hit the back button.
Like the little hook arrow up there on the top.
Maybe it'll take it back to where it was.
OK.
And then.
Oh no.
It kept it in there.
I think it's old page.
No, but we don't need.
I don't know where.
Like if you know how it says traumatic brain spinal cord injury patients shall be evaluated like none of that should have been been there. So like started discharge planning and care coordination. I think that was an accidental copy. Do you think that belongs in a different section? Yeah.
Yeah. And then now we wanna add.

Yeah. So there's a chat.
The doctor hadn't posted the one at 11:17.
The last one in there and we want to copy that into #2 behind the design standards.
No. Mm hmm. The part that starts with. Let me let me write the whole language. OK.
He's gonna rotate a new one for you, but it'll just go there at #2.
And we can actually, would you?
Would you agree, Beth, that we can just change the note?
'Cause, he's going to he's about to include the Rancho Los Amigos scale.
So you want to delete the note.
Yeah, like we can.
I think we can take that out because we're about to do it.
Apps. And then he's gonna provide.
So these would be bullet points.
Perfect. And did you say Doctor Higdon you wanted to?
Expand in rehab also in the rehab section and include more of the metrics.
Yeah. Once I get to rehab, there would no longer be actively assessing the GCS.
Typically we don't do that, but they'd be using.
Typically, they'd be actually managing either the O log, the goat for amnesia testing, and then.

Valbuena Valecillos, Adriana D 2:18:12
Dhiranjan.

Casavant, Robert 2:18:13
For patients who are still in amnesia, and then the the ranch Los Amigos and then.
But you just say as clinically indicated for these?
Each have the role.
Do we wanna include?
The Ace run with the Aces, the acute concussion scale. If it's a if, it's concussion out.
Think it'd be used in the using the rehab hospital setting.

Valbuena Valecillos, Adriana D 2:18:38
Not in the kit setting, yeah.

Casavant, Robert 2:18:41

We do.
We use it.

Valbuena Valecillos, Adriana D 2:18:41
Oh, they they skipped the Montreal Cognitive assessment on the bullets part.

Casavant, Robert 2:18:49
Oh, sorry.
Thank you.
So just where where it starts with Montreal, just make it its own line.
Go back to remember.
I guess we're using the ice on people that are coming in for different diagnosis other than brain sometimes for spinal, but it's more for like you know, our hips that fall.
And then I also have a concussion.
So I would take the all those tests and the phrase above it that says.
Assessment may also include the following metrics.
I would take that language and then.
We need to find a home for it in the. Yeah, we wanna rehab centers doubled.
And then we're gonna.
On the phone.
Note that we have two minutes.
Can you do another search for? Like if another Rancho comes up?
That might help us narrow down.
Where it is in the rehab.
It's only on page 4.
I didn't mention it.
I don't think it necessarily belongs under psychology because it could be a lot of these can be assessed by by 9 psychologists.
So I think it belong under.
So like page 14.
Where it says F at the top, all rehabilitation centers are required to track functional outcome measures.
Then you can put another comment under that.
Rehabilitation centers rule track.
I.

Cognitive status using.
These following assessments.
To go back and renumber them.
So it'd be another heading. So being, you know, letter G.
But of course bump the other ones down.
But.
Well, actually, let's throw it in under F.
So all track functional outcome measures.
As well as.
Cognitive status for brain injury patients.
Yep.
Cognitive status.
And then hit paste there for that section and we'll mesh the words together.
Seeing say in including.
Metrics such as.
And then just leave the list itself.
Mm hmm.
Right. OK.
Any other things that we need to follow up in the future for? I don't.
I have some other supplements down, but they're they're lower priority to be honest.
Yeah, I have a question about the process.
So all of these are gonna be compiled, and then we'll be given like the new version to kind of like adds on it and see how things that'd be good for the next meeting, OK. And we can talk about that during the during the Advisory Council, OK.
And I know some of these will be handed off to the T Equip Advisory Council to review as well.
I think there's a conversation before that trauma.
The trauma would trauma's gonna that. These are some of these may be integrated into trauma standards.
OK. Yeah.
Is this technically yours or am I doing this by motion to adjourn?
I'm moved to adjourn. All right.
Yeah, OK. And we'll reconvene at 1:00 PM for the full Council meeting.
All right.
Sounds good.

Thank you. Sounds good.
Yeah, I finally.