

# Brain and Spinal Cord Injury Advisory Council

## Minutes

Date: November 5, 2010

Time: 8:30 a.m. to 3:30 p.m. EST

<b>CHAIR</b>		Thomas R. Kerkhoff, Ph.D.	
<b>ATTENDEES</b>			
<b>NAME</b>	<b>PRESENT</b>	<b>Department of Health Staff Present</b>	
<b>(Council Members)</b>			
Thomas R. Kerkhoff, Ph.D., Chair	<input checked="" type="checkbox"/>	Thom DeLilla, Bureau Chief	
David Kushner, M.D., Vice-Chair	<input checked="" type="checkbox"/>	Suzanne Kelly	
Patricia Byers, MD, FACS	<input checked="" type="checkbox"/>	Jean Kline, Division Director	
Erick H. Collazo	<input checked="" type="checkbox"/>	Victor Johnson	
Casey Haddix, Psy.D.	<input checked="" type="checkbox"/>	Teresa Hall	
Paul Kornberg, M.D.	<input type="checkbox"/>		
Robert G. Melia, Jr.	<input checked="" type="checkbox"/>		
Gregory J.A. Murad, M.D.	<input type="checkbox"/>		
Julia Paul, R.N.	<input checked="" type="checkbox"/>		
Grace Peay	<input type="checkbox"/>		
William Renje	<input type="checkbox"/>		
Bonnie Rice, ARNP, CRRN	<input type="checkbox"/>		
Lester Rice	<input type="checkbox"/>		
Dale S. Santella	<input checked="" type="checkbox"/>		
Karly Schweitzer	<input checked="" type="checkbox"/>		
Michael Sprouse	<input type="checkbox"/>		

### Agenda topic: Welcome and Introduction

<b>Discussion</b>	<p>The meeting was called to order by Dr. Kerkhoff at 8:35 a.m. Dr. Kerkhoff requested that those Council members who had not submitted their vote for the Vice-Chair position, please take a few minutes and complete the ballot form that was provided to them. Suzanne Kelly picked up ballots as they were completed and tallied the votes.</p> <p>Dr. Kerkhoff asked new Council members in attendance to introduce themselves. Dr. Gregory Murad stated that he is the liaison for TBI and spinal cord injury at University of Florida and that he was taking over the seat vacated by Dr. Jacob. Dr. Casey Haddix introduced himself stating he is a neuropsychologist from Orlando.</p>		
<b>Action Items</b>	<b>Person(s) Responsible</b>	<b>Deadline</b>	
None.			

### Agenda topic: Recognition of Departing Council Members

<b>Discussion</b>	<p>Council members Grace Peay, Dale Santella, Bob Melia and Ken Weas were recognized for their contributions to the Advisory Council. Those present were presented with glass plaques as a token of recognition.</p> <p>Dale Santella thanked the Council for the opportunity to serve on the Council. He stated that he has been involved with BSCIP in one way or another for over 15 years and has met a lot of nice people and made some really good connections. He credited his employment with BIAF through a Council meeting held many years ago.</p> <p>Bob Melia stated that it's been a great and challenging eight years. He has seen a lot of</p>		
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	changes, most for the better. Unfortunately, shrinking dollars have made it more difficult and it all trickles down to the patients and their families. He believes this makes the Council's responsibilities even more important than ever before. He stated he will always be available for this program and if there is anything we ever need, to not hesitate to call him.	
<b>Action Items</b>	<b>Person(s) Responsible</b>	<b>Deadline</b>
None.		

**Agenda topic: Review and Approval of Minutes**

<b>Discussion</b>	Dr. Kerkhoff asked if there were any corrections to the minutes. He indicated that on page 23 in the second paragraph that Ms. Seema Eichler was left off the list of individuals who had contributed to the reworking of the psychology standards and requested that the spelling of Dr. Jim Atchison's name be corrected. Ms. Schweitzer requested that her attendance during the July meeting be corrected to show that she was present on the second day of the meeting. (Note: after review of the recorded transcripts, it was found that Ms. Eichler's name was not mentioned during the meeting in July. In addition, Ms. Schweitzer's attendance on the second day was reported in the minutes on page 10.) Dr. Kerkhoff made the motion to approve the minutes. Dr. Kushner seconded the motion. A vote was not called.	
<b>Action Items</b>	<b>Person(s) Responsible</b>	<b>Deadline</b>
None.		

**Agenda topic: Florida Spinal Cord Injury Resource Center Report**

<b>Discussion</b>	<p>Justin Stark provided a report on the Florida Spinal Cord Injury Resource Center (FSCIRC). In July 2010, FSCIRC was brought under the umbrella and administration of BSCIP as a result of the discontinuation of a contract with the Florida Alliance for Assistive Services and Technology. He believes it is a great opportunity because it provides a huge cost savings, they are now under an organization that focuses on spinal cord injury specifically, and they now have an opportunity to tap into DOH resources from web development to being incorporated into the program's data base system. FSCIRC staffs himself, Anthony Radano who heads the peer mentoring program and Tom Williamson who conducts customer satisfaction surveys for BSCIP.</p> <p>FSCIRC's main services are information, education and peer mentoring. Information services provide individuals with resources that may assist them after their injury to help sustain them in their communities after they have received services through BSCIP. Education services help newly injured individuals "weed" through all the information they have been provided by multiple sources. They continuously provide educational materials that can help prevent costly secondary complications from occurring over the individual's lifetime. In addition, FSCIRC provides education/prevention messages to junior and high schools. Spinal cord injury and disability awareness education is provided to nursing and medical students.</p> <p>The Peer Mentoring Program matches newly injured individuals to a peer mentor who has the same level of injury, sex, age and location. Peer mentors work with individuals to provide one-to-one communication about issues relating to their injury. They serve as examples of what can be achieved after injury and serve as part of the individual's rehab and support team. There are approximately 100 mentors currently enrolled with the program.</p> <p>FSCIRC conducts three different customer satisfaction surveys for BSCIP. One is completed 30 days post closure from BSCIP and evaluates the program's efficiency relating to case management and an overall assessment of the program. A follow-up survey is done one year post closure. This survey checks up on the status of the individual's reintegration into the community and serves as a "safety net" to find unmet needs. The third survey follows progress of BSCIP clients who were referred to Vocational Rehabilitation for employment services.</p>	
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They are recreating a website to serve as a resource tool for individuals with spinal cord injuries. It contains a calendar of events, downloadable information sheets, support group information, and will eventually have a resource database that provides topic related information from a variety of sources.

Dr. Byers asked if there were enough peer mentors to cover the 22 trauma centers. She stated she believes this program would be a valuable resource in the acute phase of injury when patients are just facing their injury and are uncooperative with care because of deep depression. Mr. Stark replied that most areas of the state are well covered, and there are a few issues with some of the rural areas. He believes that peer mentoring is "kind of a tricky thing." Most referrals are received from BSCIP case managers or psychology or therapy health care professionals at facilities. He stated individuals have to be open and willing to participate. At the acute care stage, "it's kind of a tossup", because some may spiral downward to see another person in a wheelchair come into their room and think "that's what I'm going to be like the rest of my life." Mr. Stark indicated most mentoring is done as patients are nearing rehab or entering rehab because this is where "it's time to get practical on what you are needing to do to be able to survive." He stated that if a healthcare professional believes an individual would benefit from mentoring services at the acute care stage, they are certainly open to getting a mentor there. He cautioned however, that if the individual was not ready, it could do more harm than good.

Mr. Anthony Radano discussed that studies show that matching individuals with someone of their own age, sex and level of function is most important. He stated that the biggest challenge is finding people around the state who can fill in the "nooks and crannies." They are looking to develop partnerships with other organizations and facilities to explore ways to get a wide variety of individuals to serve as mentors.

Karly Schweitzer commented that in the acute stage for brain injury, individuals "don't know what's going on" and so having someone there in the early stages would be futile. However, once they begin to comprehend what's going on, the earlier the better.

Dr. Kerkhoff suggested that a pilot project might be implemented to see if the process of peer mentoring could be started in the very acute stage to see if it has an effect.

Mr. Melia discussed that he had worked with Anthony Radano to bring in mentors, not at the trauma center, but at the trauma step down and on the medical floors prior to patients going to inpatient rehab. They served as volunteers for the hospital. He found it very beneficial. The mentors were there to talk to the patients about what to expect at rehab, and that it was okay to have a good day and a bad day, but to push through the bad days.

Dr. Kerkhoff recommended that a written testimony or report be developed based on the success of the program and that the FSCIRC staff distribute it to the designated facility system.

Mr. DeLilla recommended that the FSCIRC staff be invited to present to the Committee on Trauma to talk about the peer mentor program.

Dr. Byers agreed and suggested that Susan McDevitt be contacted for the dates the nurse trauma managers would be meeting.

Mr. Radano discussed that the next steps for the program may be to add a family peer mentoring component. These mentors would assist family members in accessing community programs and would be there to support each other. This type of mentoring could be done through phone calls and would not need to be localized necessarily.

Dr. Kushner asked if there is a formal program or certification process for peer mentors.

Mr. Radano responded that there is a six hour training that covers topics including: state programs, the grieving process, listening skills, how to build trust, how to deal with somebody

if they are being abused or thinking about suicide, situations to avoid and barriers to communication. The training includes role playing. Once they are trained they must pass a background check.

Mr. Collazo asked how many clients are currently being assisted and long are they tracked.

Mr. Radano responded that they average about 20 matches a quarter. They are generally followed on average three to six months, sometimes longer depending on the needs of the client. Following the six months, a report of the contacts between the mentor and client is collected and the client is surveyed to see if they were helped. Sometimes relationships develop between the mentor and client and they continue to interact after the program ends. Mr. Radano reported that several individuals who received mentor services, have come back to the program to serve as mentors themselves.

Mr. Collazo reported that he and his wife had been volunteering in their community to provide parent-to-parent mentoring, but found resistance from several of the institutions due to HIPAA. In his opinion, they were also concerned that he may be recommending other facilities for care.

Mr. Williamson discussed that he conducts satisfaction surveys for the FSCIRC and has never received a negative comment on the Peer Mentoring Program.

Mr. DeLilla thanked the staff of the FSCIRC for their cooperation during the transition to the BSCIP and stated that as a result, BSCIP has reduced expenditures for this program from about \$700,000 to less than \$200,000 annually. BSCIP is working on finding space to house the resource center, it is temporarily housed in the BSCIP St. Petersburg office. The program hopes to secure lease space at Tampa General Hospital, where the center was formerly housed.

Mr. Daniels, the director of rehab services at Tampa General Hospital discussed that they were provided two days notice by FFAST that the FSCIRC would be closed down and that they would be out of the facility. They were not aware of the contract negotiations that were ongoing between FFAST and BSCIP. Tampa General has housed FSCIRC for 20 plus years and found them to be a tremendous asset for their patients and families. He is anxious to have them back.

Dr. Haddix suggested that FSCIRC and BIAF work together to develop some type of standardized educational/mentoring protocol and then provide it to the task force that establishes standards and criteria for designated trauma and rehab facilities to implement into the standards.

Mr. Santella provided an overview of the peer mentoring program that was discontinued by BIAF after six years of operation. The program could not be sustained due to the number of referrals they were receiving, the inability to get an adequate pool of mentors and the nature of the population being served. He stated that they also found the families and caregivers would really benefit from a mentor.

Dr. Haddix clarified that his position was to set it forth as part of an educational plan for both patients and family members within the hospital setting. He found in his experience that patients and their family members would get to outpatient services and would be unaware of what types of resources were available. He suggested establishing a set of educational requirements for the patient and family within the hospital system that would be separate from those that they receive in an outpatient setting.

Dr. Kerkhoff cautioned that every accredited facility is required to have educational components as part of their rehabilitation program and that we don't want to "step on toes or try to intervene when processes to educate patients and families already exist." He stated the issue is to complex to define during today's meeting, but thinks it's worth bringing up in future meetings.

Action Items	Person(s) Responsible	Deadline
None.		

**Agenda topic: Brain Injury Association of Florida – Contract Overview**

<p><b>Discussion</b></p>	<p>Mr. DeLilla provided an overview of the Brain Injury Association of Florida contract with BSCIP. The contract budget is \$1.2 million, of this \$711,330 is funded through General Revenue appropriations. Mr. DeLilla referred the Council to page 28 of the BIAF contract in their folders. Under the new contract, BIAF will continue to provide a toll free help line. They will maintain a staff of five to eight resource facilitators (previously called family community support coordinators). The resource facilitators will be trained on resource facilitation best practices. They will develop a series of frequently asked question sheets and checklists that identify service provider's best practices. BIAF will develop and update a resource directory of service providers. They will continue membership in Brain Injury Association of America and will subscribe to appropriate industry journals. They will design and maintain a web-based data collection system to track those served and the services provided. They will maintain and distribute a TBI materials inventory. BIAF will provide presentations to service providers. It will publish and distribute email newsletters during the third week of each month and will publish and distribute a biannual magazine (<i>BrainWaves</i>). BIAF will conduct teleconferences once every two months for brain injury support groups leaders and will provide technical assistance and educational materials to develop and maintain support groups statewide. They will communicate via email monthly with support groups about educational opportunities and address care giver needs.</p> <p>In addition, BIAF will develop and conduct three specific workshops for the annual BIAF Jamboree and Family Forum to foster the development of community-based leaders who will provide advocacy and support to survivors in their community. They will also work with county veteran service officers to ensure referral between the VA and BIAF. BIAF will plan and conduct teleconferences to train its resource facilitators about eligibility criteria, rules and regulations to obtain veterans' benefits and will provide training to county veteran services officers about provider services and supports. A checklist will be developed to assist in identifying and referring veteran survivors to providers for services and supports. BIAF will begin developing a plan to create a statewide Family Support and Advocacy Network.</p> <p>Mr. DeLilla turned over the discussion to Ms. Breen who discussed the contract deliverables in further detail. There will be a minimum of two people answering the 800 line. Any family in Florida will be able to access the TBI resource and support center portal (<a href="http://byyourside.org">byyourside.org</a>). All of BIAF's websites are being condensed into this portal. The portal will contain a resource directory that will be searchable geographically.</p> <p>She discussed that BIAF is changing the way it does business. They are moving from the family support model where staff worked one-on-one with clients. In the past, staff would meet with clients to help them apply for social security, go through their bills, put post it notes on cabinets to help them find things, etc. A low number of people were served with a high intensity of services. With funding cuts, they needed to look at a different way of providing services. They will begin using a best practice model called resource facilitation. They are applying the model from the state of Minnesota. This model limits contact. Resource Facilitators will meet clients at support groups, will have to be creative in talking to them by phone and connecting them to resources. The model depends a lot on funded resources and providers in the state, which is lacking, but they plan to be as creative as possible to get support to the families when they need it most.</p> <p>She discussed that the last part of the contract is developing a family network. The goal is to build a family-to-family support system.</p> <p>Mr. DeLilla spoke about the website. The idea is to have information and resources at the community level available at one site for survivors, family members and professionals to</p>
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access. This website will be the same website the resource facilitators are going to use to provide services to individuals, families and professionals. Their job will be to help people navigate the information.

Dr. Kerkhoff suggested that central office go through the administrators or the management team for each designated facility and ask them to develop within their case managers and discharge planners a way to access the website before the family leaves the rehab facility so that they have actually seen the website. Mr. DeLilla responded that this may be the responsibility of the resource facilitators to link up with key people at each facility to make them aware of the website and how to navigate it. Dr. Kerkhoff added that he thinks it's important that these kinds of key discharge planning issues be written into policy and procedure within the designated facilities and that with encouragement from the program, this can be done uniformly. Dr. Kushner recommended adding a requirement to the administrative standards that are currently being reviewed and updated that states prior to discharge or at some point during the hospitalization that case managers should inform families of the availability of the website.

Ms. Breen stated that although the department has not officially adopted the five-year strategic plan on TBI, this is the department's way of meeting the first obligation of an information, referral, planning, and advocacy center.

Ms. Alice Hearn commented that she agrees that for inpatient, it really is the family that needs to be addressed and that you have to repeat it over and over. She asked if the website was up and running.

Ms. Breen responded that they will be beta testing it in December and plan to have it up in January or February.

Action Items	Person(s) Responsible	Deadline

**Agenda topic: Brain and Spinal Cord Injury Program Budget Update**

**Discussion**

Victor Johnson provided a report on the Brain and Spinal Cord Injury Program's current budget status. He reported that total revenues for the period July 1, 2010 through September 30, 2010 were \$6,004,784. Of this, \$58,531 was from the red light running camera bill and is "pass through" to the University of Miami. He expects this will steadily increase as more cameras are installed statewide. He then compared revenues for this first quarter to last year's first quarter. Overall, there was a decrease of \$233,857 or 9% for traffic-related civil penalties. There was an increase of \$60,469 or 25.75% for license tag surcharges, a decrease of \$3,720 or 18.76% for motorcycle specialty tags, and a decrease of \$48,762 or 48.78% for subrogation. Mr. Johnson reported that the program provided funded services to 554 clients through the Medicaid Waiver, Consumer Directed Care, Nursing Home Transition, the General Program and Children's Medical Services at a cost of \$2,298,766 for the first quarter.

Operating budget expenditures totaled \$3,106,951 and includes salaries and benefits, temporary employment services, expenses, operating capital outlay, contractual services, Medicaid Waiver and purchase client services, risk management, research funding, and transfer to the Department of Management Services. Non-operating budget expenditures totaled \$4,197,202 and includes the transfer to AHCA for their state share reimbursement and transfer to general revenue of the required 8% of all revenues from fines. BSCIP has an outstanding debt to AHCA for state share of \$1,314,115. The program is steadily paying this off monthly as it can.

Mr. Collazo asked if there was \$1.8 million in reserve somewhere based on the total revenue and expenditures reported. Mr. Johnson replied, no. The cash balance for the program as of the day before was approximately \$650,000. As of September 30, other expenses have been paid.

Mr. DeLilla asked Mr. Johnson to update the Council on the program's Legislative Budget Request (LBR). Mr. Johnson discussed that the program had submitted a request for \$4 million in General Revenue. Of this, \$3 million would reimburse the trust fund for the state match for the Medicaid Waiver and it would provide an additional \$1 million to expand and serve more individuals on the waiver. Mr. Johnson reported that the LBR did not make it through the next step to be included in the department's annual legislative budget request.

Dr. Haddix asked what alternatives have been looked at in terms of generating new sources of revenue. Mr. Johnson replied that the attempt to submit the LBR was one way of requesting additional revenue. In addition, the program has been looking at ways to reduce expenditures. It has contacted all of the clerk of courts around the state to ensure that we are receiving the funding that we're supposed to and will be doing this again. Dr. Haddix asked about being included as an option to receive \$1 contributions on license tag renewals. Mr. DeLilla responded that the number of organizations receiving this type contribution has increased and as a result has diluted the contributions to nothing, as with the Motorcycle Specialty Tag. He stated that initially the tag was for BSCIP, the Centers for Independent Living and the Personal Care Attendant Program. Then another program for the Blind, so the percentage keeps going down. Now he thinks there are six organizations sharing \$20 for each tag. Another group, In God We Trust, would like to have a specialty tag. This would reduce revenue more. He stated we are trying to work with Highway Safety and Motor Vehicles to limit the number of specialty tags that are out there. He doesn't believe we would generate many dollars with a check box on license tag renewals. He stated that one area of potential is through the motorcycle specialty tags. There are more than a million registered motorcycles in the state, but only about 300,000 plates being sold. He stated we need to encourage people who drive motorcycles to buy a specialty tag. Mr. DeLilla stated to serve the needs of this program's population, we need significant amounts of money. The program has been trying to bring expenditures in line with the massive reductions we are facing. We were not expecting to lose 20 percent or more of our revenue within a year or year-and-a-half period. A lot of costs have been tied into the Medicaid Waiver program and built into the care plans and providers. Trying to "put the brakes on that without putting people at risk was a real challenge." Expenditures are under control, in line with the revenue, and the revenue seems to be stabilizing at this point. The program was hoping for support for the LBR of \$4 million that would have been used as match, but it's not going to happen this year. He discussed that the program had hoped to be able to utilize \$1 million from the Trauma trust fund, but the legislative language would not permit it.

Ms. Porter asked if information was available on the amount of trust fund money that was spent for spinal cord vs. brain injury, what the specific services and average costs for services are, and if this information would be included in the annual report. Mr. DeLilla responded that the annual report will be available in March and would include this information.

Action Items	Person(s) Responsible	Deadline
None.		

**Agenda topics: Election of Advisory Council Vice-Chair**

<b>Discussion</b>	Dr. Kerkhoff announced that Dr. David Kushner was elected by the Council to fill the Vice-Chair position. Dr. Kerkhoff thanked Erick Collazo for volunteering to be a candidate.
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Action Items	Person(s) Responsible	Deadline
None.		

**Agenda topic: Legislative Issues**

<b>Discussion</b>	Ms. Jean Kline reported on legislative issues affecting the department and the program. House Bill 5311 which was passed and signed into law last year requires the department to take a
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	<p>“very hard look at ourselves and determine whether we can eek out more efficiencies.” The division staff has worked very closely together and has already done some consolidation within the Office of Emergency Operations and the Office of Public Health Preparedness and created a Bureau of Preparedness and Response. The Office of Trauma and the Brain and Spinal Cord Injury Program have discussed how they could work better together in terms of not only the diaphragmatic pacing and ventilator dependent patients, but across other fronts. EMS and Injury Prevention have made strides to work more collaboratively together. At this point, our recommendations have moved through the department. The department will consider these internally and then will work with an external body to make final recommendations. The report is due to the Legislature March 1.</p> <p>Ms. Kline also discussed that with the election of a new governor, a new transition team will be named and the department will be working with them very closely.</p>	
Action Items	Person(s) Responsible	Deadline
None.		

**Agenda topic: Government in the Sunshine Law**

<p><b>Discussion</b></p>	<p>Mr. Michael Greif discussed the Sunshine Law and used a handout as a reference. He began by stating that Advisory Council members are subject to the Sunshine. He discussed definitions that the Council needs to understand. The definition of a meeting is “when you are speaking to another member of the Board about matters on which foreseeable action might be taken by the Board.” This means the Council must be very careful when having conversations with each other outside of a meeting. He stated, “When you speak to another member of the Board, you need to be aware, am I going to speak about things that are matters on which foreseeable action might be taken by the Advisory Council. If you are, then you better be in a meeting.” Meetings must be open to the public, which means a place easily accessed by the public. Meetings can be held electronically, for example, a teleconference, but you must still have a location so the public can come in and listen to the conversation. The concept of openness also includes the idea that those who come in have an opportunity to give input as to what’s going on. There also must be reasonable notice of the meeting given. He asked how the Advisory Council meeting was noticed. Ms. Kelly responded that a meeting notice was sent to those who’ve requested to be placed on a distribution list and the meeting was also noticed in the Florida Administrative Weekly. Mr. Greif asked how much lead time was given. Ms. Kelly responded six weeks. Minutes must be taken of public meetings. Mr. Greif stated they can be literally transcribed or they can be simple.</p> <p>He discussed that if two Council members have a conversation that includes discussion that should have been noticed as a meeting, they can “essentially replay the conversation at the next meeting.” As long as you operate in good faith, say you made an error and restate the conversation in the next meeting so everyone can hear it, you can correct Sunshine Law errors. Ms. Kline discussed a case where two elected officials were investigated and charged for violating Sunshine Law.</p> <p>Mr. Greif then discussed proxy voting. The Advisory Council cannot vote by proxy. The reason is that to vote by proxy, two members would have to discuss an issue and that would fit the definition of a meeting. He discussed that members present at meetings may not abstain from voting; however, members with a conflict of interest must follow procedures. “Conflict of interest is where a matter might inure to the private gain of the member, the principal to which he is an agent, a relative, or a business associate.” The procedure would be to not speak on the topic unless you have disclosed your conflict. You may also choose not to disclose a conflict, but you have to follow the procedures referenced in his handout. It is expected that as a member of a state board, you will have conflicts of interest. Dr. Byers asked if the required 15 days notification applies whether you vote in favor or against your conflict. Mr. Greif responded that the language does not specify either way.</p> <p>Several other questions were raised by Ms. Kline. She asked if Council members can use staff as a conduit between board members. Mr. Greif responded that they cannot. Ms. Kline asked</p>
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what about networking among the board members? Is it appropriate to share an e-mail or a paper on an issue that has come up and may come before the board as a vote as long as it goes to all of the board members? Mr. Greif responded, no, it fails one of the requirements of a meeting, which is that it must be open. Dr. Kerkhoff asked if task forces should have only one Council member so they wouldn't inadvertently collude to solve a problem and generate a report. Ms. Kelly responded that task force meetings are being noticed. Mr. Greif responded that as long as the meetings are noticed, the task force can have as many people as it wants. However, if members go off to work independently, two Council members should not work together. Dr. Kerkhoff asked if survey teams containing more than one Council member are a violation. Ms. Kelly responded that Council members are subject matter experts for site surveys. They are not serving on the survey team because they are Council members and so would not be violating Sunshine Law. Mr. Collazo asked about the transfer of information (drafts for example) between Council members in the course of doing research and needing an opinion on a particular subject. Mr. Greif responded that if it is a matter on which foreseeable action is going to be taken by the Council, it would have to be done in the context of a meeting. Dr. Haddix asked if a quorum must be met. Mr. Greif responded no, a meeting is two members and that a meeting doesn't have to result in a vote. A meeting has to be a discussion of topics on which foreseeable action will be taken. Ms. Breen asked for a point of clarification on the use of the word board and if it was synonymous with council. Mr. Greif responded yes. He stated that if you are not a member of the board, you are not subject to the Sunshine Law. He also discussed that although the council is structured to advise only and to not make decisions, it is subject to Sunshine. The matter has already been litigated and is in case law. Dr. Kushner asked about teleconferences and anyone participating. Ms. Kelly responded that if a teleconference will be held that she be provided notice in advance. She will schedule an 800 number for the call and will post a notice to the Department's legal website. The notice will contain a brief paragraph about the intent of the meeting, the time of the meeting, and the phone number so anyone can access the meeting. The notices should be posted as far in advance as possible. The website where meeting notices are posted can be found by visiting MyFlorida.com and searching for the Department of Health. A link within the site lists the legal meeting notices. (Note: This pathway is no longer valid as the MyFlorida.com website has changed following the Advisory Council meeting. To access meeting notices of task forces, the recommended path is [www.doh.state.fl.us/pubmeeting.htm](http://www.doh.state.fl.us/pubmeeting.htm).) Mr. DeLilla asked if the minutes of task force calls were put on this site. Ms. Kelly responded, no, they would be posted to the BSCIP website. Mr. DeLilla asked if they had to include the people who attended. Mr. Greif responded, "the public does not have to identify themselves."

Mr. Collazo asked about the transfer of electronic data to a staffer who would then forward it to another board member for an opinion. Mr. Greif responded that if the communication is relayed back and forth it would be different than if the information was relayed only by the staffer. If there is communication back and forth, it must be disclosed before the board in a meeting. He cautioned "try to stay in the safe harbors. Let's try not to explore the edges of the Sunshine Law because the edges involve attorney's fees and misdemeanors and stuff like that. Not a good place to be." Mr. DeLilla asked what is the obligation or responsibility of other Council members to report violations of the Sunshine Act. Mr. Greif responded that if you discover you are talking about something on which foreseeable action is going to be taken, you can "cure this by saying, "We had an oops and here's what we talked about," and that usually gets you back in everyone's good graces." There is no requirement under the United States common law to report a crime. If we become aware of this ourselves, we would probably have to apprise the person who appointed the council member because this would be a question as to whether they need to be on the Council. A consistent violator would be placing themselves in the hands of anyone who can file a complaint. As long as the council member is open about it, inadvertent mistakes can be corrected. Deliberately violating is another issue. Mr. Greif requested that if any additional questions about the Sunshine Law arise, that they be forwarded to the BSCIP who will forward them to him.

Action Items	Person(s) Responsible	Deadline
None.		

## Agenda topic: Order of Selection Rule

### Discussion

Mr. Greif discussed the Order of Selection Rule that is currently being developed by the BSCIP. This issue was raised two years ago and “looms with importance given that our revenues have been declining at a historic rate.” This applies to the General Program only. It is not about the Medicaid Waiver. Under the eligibility statute for the BSCIP, the second section says if the Department is unable to provide services to all eligible individuals, the Department may establish an order of selection. We have held five workshops statewide “wrestling with this issue” within the last year and a half. We have gone through about three different versions of the order of selection documents. The most recent version ranked everyone according to their progress in being served by the program. After that, everyone else would be ranked based upon the severity of their injury. The program would use the Medicaid Waiver instrument to rank them. During the workshops this was presented at, there were serious objections to this approach because of the nature of the screening instrument. The program decided to draft up another approach. This one focuses on the likelihood that we can maximize our benefit to the individual, not the severity of their injury. Mr. Greif read through the order of selection document that was provided.

In an order of selection, everyone would still get analyzed as to whether they are an eligible individual or not. The order of selection would not affect eligibility determination; the program would spend money needed to assess the eligibility of an applicant for services. Every eligible individual would receive case management services in an order of selection. Case management services are those that do not require prior authorization of expenditures.

The program would have to estimate the maximum number of eligible individuals receiving purchased services it could serve each quarter. This would be determined by the estimated revenues the program expects to receive divided by the amount we spend per quarter on a successful case closure. The program is generating a historical review to gather this data. Mr. Greif used the following example: You have \$100,000 for purchased client services and the average cost for successful closure is historically \$500. You could serve 200 people with services other than case management because historically it's an average. Some may receive case management only; some may require thousands of dollars over and above that to achieve reintegration. The program would multiply that number by a number less than one, like .95. This would allow the program to rebuild a balance of the trust fund. The program would recalculate every quarter the maximum number of eligible individuals it could serve.

Eligible individuals would be rank ordered by length of time from shortest to longest from the date of the occurrence of the brain or spinal cord injury to the date of their becoming an applicant. This doesn't weigh severity of injury. Eligible individuals with a rank number less than or equal to the maximum number would have access to purchased client services. If there is more than one eligible individual with identical lengths of time equal to the maximum number, they shall be considered to have a rank order greater than the maximum number. (Example, the maximum to be served is 200, you have four people who could all be number 200, rank order would stop at 199.) Each quarter, everyone who was determined eligible the previous quarter would be reanalyzed again. Services requiring prior authorization would cease immediately for anyone who no longer has access due to a recalculation of the maximum number, except for actual physical modifications to either residences or personal property required to be titled under state law. Such modifications, once begun, shall either be finished or the residence or the personal property shall be returned to its unmodified state, whichever is less expensive to the program.

Dr. Haddix asked if someone who was injured at an earlier time and applied for services might be rank ordered by someone who applied for services at a more recent date. Mr. Greif responded yes and provided an example of an individual who was injured 20 years ago and applies for services while the program is in an order of selection. He stated it was a deliberate decision of the program to try and get to the most recent injuries because they perceive those as being the ones where purchased client services have the greatest impact. Mr. Melia commented that he understands “the two months post versus the 20 years post.” He is worried that if someone is two months post, and there's a reshuffling at the quarter, he's now

somewhere on the list six or more months post. There is then another reshuffling at the next quarter. He asked if they would ever get to the top of the list. Mr. DeLilla stated "probably not. They will keep moving each quarter, further, further back." He stated if you don't make it the first quarter, your chances the second quarter are going to be worse, and so forth. Mr. Melia stated this would be a problem for those newly injured. For those 20, 10 or even 5 years post they should be "in the swing of things" and should probably only need a piece of equipment, but the new injuries are the people we need to care about. Mr. Greif responded that if the program decided to "protect the slot" for someone once they started to receive services, they would no longer be able to serve any newly injured individuals because all of the slots would be full.

Dr. Kerkhoff asked if there is an assumption under the order of selection that in any given quarter the number of people the budget can support would be served within that quarter, and then the next quarter you would pick up the newly injured so that you're not reshuffling the same people. Mr. Greif responded that if a rule like this was "kicked in strategically", he believes the case managers would front load services and have them occur at the beginning of the quarter and not at the end.

Dr. Kornberg asked for clarification about the date of injury, date of application and eligibility. Mr. Greif responded that the rule would apply to the date they apply for services, not eligibility. The timeframe that would be considered is the time between date of injury and date of application to the program. The length of time between application and eligibility may take a long time or a short time. Dr. Kornberg responded that this may subvert the goal of the program to have individuals referred to the program as early as possible after they have been injured. If you have a client with a severe injury in a coma for a month or several months, then the "window is getting longer and longer between the point where they are applied and where they are eligible." That client will be disadvantaged to receive funded services, so it seems that they shouldn't apply until much later and then many of them may be lost. Mr. Greif responded they are not lost, they receive case management services. Dr. Kornberg replied that he meant that if they're not referred right away, they may not get referred at all. He stated that some may be savvy and say "don't apply now because you are not going to qualify for any of the funded services." He believes that using time as the determining factor is not the best way to do it.

Mr. DeLilla stated the program has been struggling with not having the funding to be able to provide services to all the people. We recognize that case management is a valuable service. He asked everyone to imagine that we don't have a trust fund, but we have the program. We have a network of facilities and a central registry. People are injured, they're taken to a trauma center, reported to the program, and assigned a case manager. The case manager would coordinate all federal, state and community resources available from Medicaid, Medicare, private insurance, personal resources, independent living center, etc. They would "put this package together to get this person into the community. That's our job." A benefactor has given the program \$2 million a year to help with reintegration and we know it won't be enough to serve all the people. We need your input to determine how best to use it. He stated he doesn't know the answer. It's easy to understand not having any money; the problem is having just a little money and determining how to use it the most effective way. He stated he believes serving the newly injured would be the most effective way and maybe budget the money into certain categories that we can authorize out of.

Mr. Greif discussed that BSCIP does not "care how rich or poor you are, it serves you period." "It doesn't care how much the thing costs that you need. It tries to get it." He asked if the Council would want to include income criteria as part of the order of selection, or would it want to say, "we only spend x amount of dollars and that's it on you." Therefore, the rest of our job getting an individual community reintegrated would have to be through case management services. He stated many are reintegrated without any funded services. However, many need bathroom modifications; they need ramps. He stated ultimately the focus becomes on the newly injured, to less newly injured. "This is a matter of hard choices." It's about looking around at your population and deciding who you can serve with case management only and

who needs money from me the most.

Dr. Haddix stated, "I am deeply, and I can't stress that enough, opposed to this." He stated he believes funds should be distributed by the date of application. "All individuals in the state of Florida are equally allowed to access these services regardless. I think that this should be rewritten to state eligible individuals will be rank ordered by the date of their application."

Mr. Greif asked if he was indifferent to how old the injury is. Dr. Haddix responded, yes he was indifferent to that and thinks the public would feel that way as well. He gave the example of asking how many people would like to be "butted" in line at lunch today. Dr. Kornberg responded, "If I had a really big breakfast, I wouldn't mind as much as somebody who hadn't eaten for a week."

Mr. Melia discussed that he sees new and old injuries on a daily basis. Frequently he is contacted by people moving from other states and countries who say "I need this." He'll ask if they've contacted their insurance and they'll respond they're getting insurance or Medicaid. They'll say the state they were in bought them things and it wasn't a problem. Mr. Melia discussed that he tries to be diplomatic and say they should have done their research before moving, because things are tougher here in Florida.

He would like everyone to have an equal opportunity, but if they move from Ohio after 20 years, they should not be in the same line, or in the same group of weight listed individuals as a new injury that comes through the system or our state. He also doesn't want someone injured in "May 2011 on a Thursday to somehow continually get blackballed or be unfortunate in their number not coming up that they never get the shower chair that will enable them to be more independent or independent enough to get back to school, get back to work because someone that was injured on a Tuesday and the social worker was quick to do the referral, gets them right to the top of the line and they get services the next week."

Mr. Collazo asked if the order of selection can be modified to reflect that if a family has additional resources (family or insurance of the person who is injured) that there must be some kind of match to stretch the dollars similar to what VR is doing. He stated, VR now requires a match if you have income or insurance. Mr. Greif asked if he wanted the program to look at tax forms. Mr. Collazo responded, "it or use a similar system like VR is using."

Mr. Melia stated he has concerns about someone who "lives right down the street from Tiger Woods." He is not as concerned for that individual (although he wants to make sure their health stays good, they get the best rehab possible, and they maximize their independence) as he is for someone who was hurt, doesn't have insurance, is now getting \$500 a month from social security and is on a Medicaid HMO. He knows from experience he needs to watch them more closely than the other. Dr. Kornberg stated this issue has come up for many organizations. He stated Shriners' Hospital in Tampa has provided services without charge for whatever the kids needed from wherever they came from. As time has gone on and their revenue and resources have become more limited, they now have to utilize the resources of the patients and their families. They now bill insurance instead of just getting them equipment that might have been paid for through another resource. He believes to use time as a factor without looking at external resources sounds nice, but in today's reality we have to. "If somebody has resources, if somebody has a third party funding source, then from an ethical standpoint or a sensible standpoint it doesn't make sense to use our limited resources for those individuals that can get that piece of equipment or that modification in another way when there's somebody else." Dr. Kerkhoff stated, the program has always been the payer of last resort.

Dr. Kushner asked if there is a limit on the amount of money that's spent on each individual. Mr. Greif responded there are no upper limits and the program works hard to ensure that it is not just a "piggy bank." Dr. Kushner stated perhaps that should be looked into so that the system is more fair and equitable and there is more money to go around for others who may need it. Mr. Greif responded that the mission of the program is not to be an insurance company, but to reintegrate individuals back into the community. He asked if you place strong

caps on the amount of money you spend on an individual and you run out of money just short of integrating them into the community, what do you do then.

Mr. Starke commented that in previous discussions on the topic, it was noted that you can't rely on a person's tax return because what they made prior to their injury and what they are going to be making post-injury could very well be different.

Ms. Breen discussed that Brain Injury Association of Florida hired an administrative law attorney to fight the first order of selection that was proposed to go into rule. She stated she has discussed with Mr. DeLilla and others about alternatives and the issue came up of "do we serve many with a little tiny, tiny bit, or do we serve the few with some money." She stated the issue always in traumatic brain injury is that a large percentage doesn't even become eligible for services. One of the issues to consider, is if you consider this as a pot of money that sits there and about nine/ten million goes to Medicaid for whatever reason even though we get reimbursed over time. She asked is it better to structure a way that essential services are provided. For example, people with brain injuries get a neuropsychological evaluation and their prescription drugs are paid for and that for spinal cord injury it might be a wheelchair or something else is provided. She stated that this program was statutorily established for brand new injuries and it remains in statute. She stated that people with brain injuries don't qualify for Medicaid right away, so BSCIP is payer of last resort unless there are other insurance resources. She believes defining what that essential service is for people with brain injury and for people with spinal cord injury is key to what the program does with the money.

Mr. DeLilla stated that Ms. Breen was speaking about something he said earlier. He said the program could look at the possibility of obligating all of the money. For example, the program could decide it would pay for 200 neuropsychological assessments each year at a cost of \$500 each. You would set that amount aside. Then you would find another service not covered by Medicaid or Medicare or your private insurance (a home modification/ramp) and say you're going to do 300 of them at an average cost of \$5000. You budget it and make it available first come/first served. You could keep expanding the list until it has all been allocated into "little pots of critical and important services."

Mr. Santella asked "how do you break that up into spinal cord and TBI. Then how do you say, traditionally we know that spinal cord tends to use more money than TBI. It's shown that. Wheelchairs, ramps." He asked how are you going to be equal that way.

Dr. Kushner asked if a task force should be created to look into this further as it is a very complicated issue. Dr. Kerkhoff responded that the Advisory Council hasn't been tasked with proposing a system, but maybe it's time to think about creating a task force.

Mr. Edwards stated that "we are talking about two things that relate to each other, but they are different. One is developing a priority for services to be provided. So do we put our money toward ramps and accessibility, or for neuropsych testing? Another is some sort of selection criteria to determine which people get those services." He stated the consensus is that you can't go with one simple thing, the date of injury or just the cost of the services. A sort of matrix or weighted selection criteria would need to be developed "so you can equally put a number to people so the person ends up getting a 100 score might be your priority over someone that gets a 50 score." He stated if the Council and the program can identify where it wants to expend its resources, "to have an arbitrate number of that, we spend 50 percent of the resources, whatever those resources happen to be, towards accessibility. And perhaps 40 percent or whatever number toward services such as neuropsych testing and maybe some guidelines that these are for non-ongoing services for one-time services. The two things together, this is what we can do with our revenue; if the revenue goes up we are still putting x percent toward one goal and x percent toward another. Then you still have a selection criteria for people that apply so that they are weighted against each other is the recommendation."

Ms. Porter commented that everyone knows "the severity of the injury the less the money, there's no money there or not enough." She discussed her son's brain injury and that over the

	<p>past six years, services and needs have changed over time. She discussed that she didn't know what services he would need over time and that "taking dollars or making a person eligible for a certain service isn't going to do them any good when that service by the time they get it isn't going to be needed any more. It's going to change to be something else." She stated case management services were the most needed service for her and thousands of families that she speaks to because they are the education point that tells families that things may change. She wanted to make the point that being "eligible for services that are going to be paid for through the trust fund are going to change" over the course of time.</p> <p>Dr. Kerkhoff proposed creating a task force to come back with a set of recommendations for the Council to consider at the next meeting. He asked Mr. Greif if it was proper for the Advisory Council to come up with a set of proposals. Mr. Greif responded that the Advisory Council's job is to advise BSCIP and that there is no limitation on that advice except maybe relevance.</p> <p>Dr. Kushner made a motion to create a task force to look into "this complicated matter." Dr. Byers seconded the motion. The motion was passed unanimously.</p>	
Action Items	Person(s) Responsible	Deadline
Provide recommendations to the Advisory Council on an Order of Selection.	Order of Selection Task Force	May 2011 Advisory Council Meeting

**Agenda topic: Update on Advisory Council Composition**

Discussion	Ms. Kelly reported that the Council is fully staffed at this time. Five members were recently appointed and are taking the seats of Mimi Sutherland, James Edwards, James Carrell, Ken Weas, and Dr. Jacob. Mr. Weas was recently appointed as the national vice president of the PVA and had to step down from the Council due to a conflict of interest. In February, three seats will be vacated. Two individuals have been selected, Evan Piper to fill Dale Santella's seat, and Cynthia Kovacs will be filling Bob Melia's. The remaining seat belongs to Grace Peay and we are requesting that those interested in serving, please complete an application and submit it to the program. Ms. Peay's seat requires that the individual be a TBI survivor or the family member of a TBI survivor. The program has one application on file, but would like to have a pool of applicants for consideration.	
Action Items	Person(s) Responsible	Deadline
Submit applications to serve in Council seat to be vacated by Grace Peay.	Interested individuals who meet the statutory requirement.	None given.

**Agenda topic: Standards Revisions Task Force**

Discussion	Dr. Kerkhoff reported that BSCIP is revising its standards for designated facilities. The areas of focus are psychology, nursing, medicine and administration. Psychology has completed its revisions except for a vote by the Council. The revision was not included in the handouts, so could not be voted on. He indicated the Council would vote on these standards during the next meeting in May. He stated Nursing is putting the finishing touches on their revisions. Medicine is consulting with each other. The date of completion is unknown. The administrative standards task force is just getting started and planning a conference call in December.	
Action Items	Person(s) Responsible	Deadline
Vote on Psychology standards during the May 2011 Council Meeting.	Advisory Council	May 2011 Advisory Council Meeting

**Agenda topic: Task Force Report - Diaphragm Pacing - Ventilator Dependent**

Discussion	Dr. Byers reported that there is now a filter to track the number of patients with a high C-spinal
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cord injury that need pacers and go through the trauma centers. This was a major accomplishment. She reported that nine people have gotten the pacer, and that in the last month or so two more for a total of 11. Eight are 100% off the ventilator and the rest are partially off. It has been very successful. Unfortunately, we haven't gotten funding for the cost of the pacer itself. Mr. Melia reported that Orlando Health just completed two of the pacers and both patients are doing well. One is in rehab and the other is going shortly. Dr. Kornberg asked if there was any information about where funding is, what things are looking like for the future. Dr. Byers responded that based on the economic climate, she would say it's unlikely. It was hoped that funding would come through Medicaid and AHCA. She stated we would have to see what happens with the new government after the election. Dr. Kerkhoff asked if there is an outcome study going on with this procedure, so that we could demonstrate efficacy and good outcomes. Dr. Byers responded the state is tracking it. Mr. DeLilla stated that as more procedures are done successfully this will lead to credibility and justification for funding the diaphragm pacer.

Action Items	Person(s) Responsible	Deadline

**Agenda topic: Task Force Report - Utilization of Assistive Technology for TBI/SCI**

**Discussion**  
 Dr. Kornberg reported that Andrea Slapion has done a lot of work communicating with several companies and looking at and testing specific devices. The task force has been held up trying to find some cost advantage to using these devices and getting funding for them. He will follow up with Andrea about that. He stated he has not had time to take the lead on this task force, but is trying to find somebody else who might be able to assist.

Action Items	Person(s) Responsible	Deadline
Follow-up with Andrea Slapion about device research. Recruit an individual to serve as lead for the task force.	Dr. Kornberg	Non given

**Agenda topic: Task Force Report – BSCIP/VA Community Partnership**

**Discussion**  
 Mr. Edwards reported that the brochure that was presented to the Council is in the process of being printed. Once printed, it will be distributed through the VA facilities in the state and will help educate veterans on the services available from BSCIP and its community partners. Mr. DeLilla reported that Ms. Slapion has also taken the brochure and turned it into an electronic version that allows you to click on links to access the websites for each of the resources listed. Dr. Kerkhoff discussed the possibility of a collaborative conference to showcase the VA's Polytrauma program. A phone conference has been held and the VA was very open and excited about the project. They would do the "heavy lifting for this conference in terms of logistics." It is tentatively scheduled for next summer. We will have more information as it becomes available. Mr. DeLilla recognized Mr. Edwards for the work he had initiated with the task force and re-stated that funding has been put in the Brain Injury contract to develop relationships with the county veteran service officers and to provide cross training.

Action Items	Person(s) Responsible	Deadline

**Agenda topic: Task Force Report – Comprehensive Benefits for Catastrophic Injuries**

**Discussion**  
 Mr. Collazo reported that as of the last meeting, he, John Prosser and Neal Flannery have reached out to various groups to inform them of the task force's efforts to pass a similar law like Michigan's model to have comprehensive benefits. They are starting to get support from the Neurotrauma Association, which is newly formed in South Florida. He has attended several of their meetings. They have also attended the Workman's Comp conference in Orlando and met with various stakeholders, suppliers, vendors, and doctors to get their support in their effort to communicate with the legislature about the need in Florida. Now that the elections are over, they are going to ask these associations to begin contacting the local offices of legislators and meet with them to inform them of the need here in Florida and provide information packages on the Michigan model.

Action Items	Person(s) Responsible	Deadline

**Agenda topic: Task Force Report - School Reintegration**

<b>Discussion</b>	Dr. Kerkhoff stated that the School Reintegration Task Force had provided a handout and that Ms. Schweitzer was available to answer any questions regarding the progress of this group. If not, the report would speak for itself. There were no questions.		
<b>Action Items</b>	<b>Person(s) Responsible</b>	<b>Deadline</b>	

**Agenda topic: Other Council Business/Next Council Meeting**

<b>Discussion</b>	<p>Dr. Byers discussed the trauma report. Trauma mortality has decreased from 6.8% in 2004 down to 4.8% in 2009. They are closing in on the national average of 4.4%. The number of trauma patients continues to rise; 72% were discharged to their homes. Of the rest, half went to rehab facilities and half went to long-term facilities. Fifty-two percent are in the hospital three or more days, meaning they are "fairly severely injured." There are currently 22 verified trauma centers with Tallahassee Memorial and Longwood coming on board. The strategic plan last cycle was successful with 90% of the objectives being achieved. There has been 98% compliance with the integrated site surveys between trauma and BSCIP in this last cycle and has resulted in a cost savings. They have the telemedicine project, so if there is anything you want to do with spinal cord, let the Office of Trauma know. They have five or six trauma centers reaching out to rural hospitals providing teaching and patient triage. The rural trauma course gives small outlying clinics or these hospitals that barely have an emergency room the wherewithal to stabilize patients for transfer. This is being funded by a grant. Julia Paul has been organizing the mass casualty course throughout the state and it has been well received. There is another grant cycle for it.</p> <p>Dr. Kornberg asked what they consider long-term care discharge dispositions for trauma patients. Dr. Byers responded, nursing homes. Dr. Kornberg discussed that there has been a shift in rehabilitation and patients that may be too high level for acute rehab are now going to skilled nursing facilities for short-term rehab. He stated it might be useful to do an analysis of this information. Ms. Paul discussed that a lot of insurance companies do not have long-term rehab services built into their coverage. As a result, patients with injuries that require greater than 90 days of recovery are placed into long-term care facilities. There really is no choice. Dr. Kerkhoff stated, "I'd like to raise the larger issue of not having a financial choice versus a moral choice and that may be something the health care system has to deal with more broadly." Dr. Byers stated we have a trauma criterion to go to a trauma center. By statute, the patient must be brought there because they need it. We don't have criteria by statute that disabled people need to go to rehab. She suggests that we build that into the trauma system and have a network of hospitals that trauma centers can discharge to regardless of the patient's names or funding. She stated, "that for the continuity of care for the trauma system I would implore this group to look at that possibility."</p> <p>Dr. Kerkhoff announced that the Order of Selection Task Force has an assigned chair. It will be Dr. Haddix, with help from Mr. Collazo and Michael Greif.</p> <p>Ms. Hearn asked about the criteria for the trauma centers to send patients to rehab centers. She stated this is a problem right now. Ms. Paul responded that they look at rehab centers first and that it begins at the day of admission. They involve their rehab services on an inpatient basis very early, but the question is where do they go when they no longer need acute care. She stated Brooks Rehab is one of their partners that take a lot of patients, but there must be a balance between funded and non-funded patients they can accept. She stated a "good 30 to 40 percent of our patients, especially our motorcycle riders, are not insured." When patients are unfunded, there are very little resources. They remain at Shands because there is nowhere for them to go.</p> <p>Dr. Kornberg stated the issue has become more complicated because of the regulations that have been placed on acute rehab centers over the last few years. It is becoming progressively more difficult to get patients into acute rehab. Rehab centers are having to follow national guidelines and Medicare regulations in order to maintain licensure. He stated, "there are two criteria in terms of the intensity of care, the diagnosis of brain injury and spinal cord injury</p>		
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usually will be good. But it has become very difficult. Those patients that are cognitively impaired but are pretty independent with their mobility, an acute rehab center is very limited in their ability to take those patients because they may jeopardize their ability to keep their doors open. There have been centers that have had to close up because the government has come back and said these were inappropriate patients. We want our money back." He stated the term rehab has changed quite a bit. Now skilled nursing accepts more patients for rehab these days than acute rehab centers.

Ms. Paul stated that to get in rehab, the patient has to participate. Depending on the degree of brain injury (a certain rancho level or a certain skill level), some can't go to rehab even though it may benefit them. Others can't go because "we have done such a wonderful job with them and they are too high."

Ms. Hearn asked how we are approaching that with the new standards from the government. They are noticing it themselves in their inpatient rehab. They have tried to refer people who were not accepted because of the new standards. She stated "it needs to get back to the government that you have really made it too limited. There are a lot of people that could be helped, but they just don't fit the mold."

Ms. Paul discussed that Medicaid gives them 30 days and wants to make sure that those 30 days are used for rehab and not as continuing recovery from their injury. They take a "two-prong" approach and send the patient to a skilled nursing facility. Once the patient gets to the point where they can participate in rehab, they move to rehab. They sometimes have to "make a pit stop between." The case managers are trying to ensure that they are truly able to participate in rehab, are able to progress and are not actually recovering from the injury.

Ms. Hearn asked, "What is the carryover then from the Medicaid in the nursing home to get them back into the inpatient rehab when they have recovered?" Ms. Paul responded that BSCIP case managers track clients who are sent to skilled nursing and follow-up with them. Once they get to that point, they will send them to rehab. She stated you "absolutely have to make sure that you do not use those Medicare days for the rehabilitation center when they are not and the skilled facility and the long-term care has a different coding aspect."

Dr. Kushner clarified that he doesn't believe Medicaid gives 30 days for rehab. He believes they give 30 days for treatment, so whatever days are left after the acute treatment, that's what may go to rehab. If there are no days left, it becomes a big problem. He stated another problem is that insurance companies including Medicaid and Medicare are limiting the amount of rehabilitative services which are available to anyone. The situation continues to worsen, the amount of days available are being more limited. They are increasing the ways they are restricting the ability to have rehab. He stated, "there's this thing now called CMS-13, which has been in effect for the past 10 years. That was one way to try to limit access for rehabilitation, and these insurance companies continue to come up to limit accessibility to rehab services."

Dr. Kerkhoff stated, "There really is no effective way to regulate the private sector as we have seen." He discussed that Medicare and Medicaid do have periodic reviews of their criteria and that professional groups have chosen to campaign for their vested interest as they revise their rules and regulations. He stated it may be a useful strategy to go through your professional groups to offer testimony and advice to CMMS as they reregulate themselves or modify their rules.

Dr. Kushner stated there is a huge difference in the rehabilitation services that are provided in a comprehensive rehab facility versus what is administered in a nursing home.

Ms. Breen stated it "boils down to the diagnostic and procedural codes." She stated the first person you become best friends with is the billing department who communicates with the physician. The physician provides the services, the billing department is supposed to bill. She stated, "You have these regulations, but there are ways to do them in a certain way that can

	<p>help with some of that care, but nobody knows that.”</p> <p>Mr. DeLilla stated that we've talked in the past about each trauma center identifying skilled nursing facilities throughout the state that have some level of expertise working with our population. They could refer these individuals to them for a period of time to recover from their injuries until they are ready to actively participate in a rehab program.</p> <p>Dr. Kerkhoff stated that its “done in at least a casual way now, if not a formal way, per rehab center.” “The case managers within the rehab centers visit all the nursing homes in their area and they create their own priority list of places they can recommend.”</p> <p>Mr. DeLilla discussed that we have approached AHCA about an enhanced rate for skilled nursing facilities to provide for higher level of care for people with catastrophic injuries. The program ran into obstacles because nursing homes are signing agreements that say they provide this level of service even though they don't. There's no room for any supplemental type of service because they are already supposedly being provided.</p> <p>Dr. Kushner stated most nursing homes are not going to have the financial means to have the adequate equipment and specially trained personnel to care for this complicated population.</p> <p>Dr. Kerkhoff stated, “Back in the early '90s, it was more possible when funding for nursing homes, when sub-acute was invented they actually had quite sophisticated staffs. But that didn't last very long. Now, it's bare bones.”</p> <p>Dr. Kerkhoff asked for a motion to adjourn. Ms. Schweitzer made the motion to adjourn. The motion was seconded by Dr. Kushner. The motion passed unanimously.</p> <p>The meeting adjourned at 2:37 p.m.</p>	
<b>Action Items</b>	<b>Person(s) Responsible</b>	<b>Deadline</b>

Respectfully submitted by Suzanne Kelly, Advisory Council Liaison