BSCIP 1st Biannual Advisory Council Meeting-20251112_090216-Meeting Recording

November 12, 2025, 2:02PM

2h 33m 17s

Casavant, Robert started transcription

Casavant, Robert 0:36

So we're going to get started.

Good morning, everybody.

Thank you for joining our first biannual brain and spinal Cord Injury Advisory Council meeting this morning.

Session is going to be regarding our PQI, which is our program quality improvement committee.

We're going to be going over some reports and looking at some things that we can use for benchmarks. So with that.

I will turn it over to Doctor Higdon.

Yes. So first order business is is reviewing the.

Roll, roll call.

So Amanda is going to take roll call and just so everyone knows, Beth is out sick today.

OK, Amanda.

All right.

Do we have Don Chester?

CD

Chester, Don 3:39

I'm on the call.

Casavant, Robert 3:43

Kevin Mullen.

KM

Kevin Mullin 3:45

Kevin Mullen is here.

Casavant, Robert 3:49
Patty Lance.
Jill Ulick present.
Doctor Higdon here.
Doctor faridas.
Gary Rayburn.

Carrie Rayburn 4:19
Brother.

Casavant, Robert 4:22
And Ruthin Tattersall.
All right. You forgot doctor valpoi. Dr. valbuena.

Valbuena Valecillos, Adriana D 4:35
Yeah, you didn't hear my name present.

Casavant, Robert 4:37
OK, I passed by you, sorry.

Valbuena Valecillos, Adriana D 4:41
No problem.

Casavant, Robert 4:44
Good. We have meeting notes from both August 7th and 2025 and October 2nd, 2025.
We'll do each of them, but August 7th.
Those in agreement to for the meeting minutes motion.
Motion to approve.

Carrie Rayburn 5:06
I move to approve.
This is Carrie Rayburn.

Casavant, Robert 5:08
All right.

Kevin Mullin 5:09
Kevin Lowen second.

Valbuena Valecillos, Adriana D 5:10
Second, OK.

Casavant, Robert 5:12
All right.
And then for the October 2nd, 2025 motion to approve.

Kevin Mullin 5:24
Kevin Mullen, I'll approve.

Valbuena Valecillos, Adriana D 5:26
2nd.

Casavant, Robert 5:27
All right.
Thank you.
Thank you.
All right. So we'll be beginning our committee meeting and Florida residency, and US citizenship is our first topic.
Who is giving that award?
So I'm gonna start out and I have Jose Debrock on the phone because he feels primarily with a lot of our applicants that are not U.S. citizens.
Yes. And so he is really our expert in the program on that.
But the Rob, if you can pull up the document.
The document I think Doctor Higgin that you were provided at Brooks there. This is a guideline that our staff use to determine what documents they can use to determine US citizenship and Florida residency.
Yeah, this is not new to the program at all. We've been doing this for years.

We put the document together for clarification for staff.
Because there were some questions that they had.
So we we tried to simplify the document.
That everybody would understand what they can and can't use. Sure.

Valbuena Valecillos, Adriana D 6:41
Yes.

Casavant, Robert 6:46
It's the Florida residency 1.
That's it.
Yep.
So on this document, Beth put it together and and we kind of color-coded it to make it stand out on for US citizenship and legal immigration status. What we can use to determine eligibility and what we cannot accept.
And then it's the same it when you Scroll down on the document. For legal Florida residency.
I know that you expressed that you thought that this might delay enrollment into the program most of the time it really does not.
And Jose, he can.
He can speak to that because, like I said, he is the region that deals with this the most.
If you have specific questions that you want to ask about this I I'm I'm not sure where we're going.
So this came up a patient who.
You know, does not appear to.
Be someone who's from out of state or who's not a citizen.
They're injured in Florida.
They their home is in Florida.
They're discharged into is in Florida.
And their their enrollment in the program is delayed because.
They're just having difficulty this time.
Finding I wish I could remember which side of this, if it's the.
I think is the the US citizenship that they were working to provide information for, but I was more curious kind of what.

What what triggers like you know do. Do we have to get these both sets of documents for each enrollee? And has that always been the case? Or is there other ways besides them producing a document that we can verify that they're that they're both of these things?
Actually.

Dubrocq, Jose A 9:00
No, they they.

Casavant, Robert 9:03
Go ahead. Go ahead, Jose.

Dubrocq, Jose A 9:03
Oh, doctor Higgs.
Yeah, they is. It being established and like Kimberly was saying that our region deals with that most of the time, yes, they need to present the immigration documents.
It's very clear cut if you're a permanent resident, you should show up.
What is a green card which you know that that's everybody knows what it is, but if they're in the progress in the process of an immigration, they need to present the because they might be.
There might be in the parole status and there might be on the way in the path to be arrested and permanent arresting, but they need to present those papers and they should have that because.
They should be working with the lawyer, with an attorney, so they.

Casavant, Robert 9:42
Yeah. So, so this patient was not an immigrant at all. Like this patient was was very clearly not not an immigrant.
Of of, of any kind of variation of that legal status, he to my knowledge, he he was just born and raised in Florida.
I you know, he may move, move from Alabama or something, but.

Dubrocq, Jose A 10:01
Oh.

Casavant, Robert 10:02
But yeah, so so this isn't a question of of immigration. This is someone who.
No one believes that they're an immigrant, but they're having to produce these.

Dubrocq, Jose A 10:10
Oh, OK.

Casavant, Robert 10:11
Documents, yes.

Dubrocq, Jose A 10:13
That's a different, that's a different.

Casavant, Robert 10:13
Yeah, it's it's a delay in the process.
Yeah, so with the.

Dubrocq, Jose A 10:16
Yeah, that's a totally different scenario.
That's that's that.
They're not Florida resident.
They're from another state, yeah.

Casavant, Robert 10:21
No, no. This person is a Florida resident.
No. This person was injured in Florida.

Dubrocq, Jose A 10:24
Oh, he is.

Casavant, Robert 10:27
Their home is in Florida.
But their enrollment is delayed because of paperwork, even though no one really credibly believes that that they're not any of these things.

Dubrocq, Jose A 10:38
But you.

Casavant, Robert 10:39
So with a Florida driver's license, if he if they, if they lose their Florida driver's license, they can go to DMV and get a Florida ID, OK or get their license replaced.
With with BC being a state agency, is there ways to verify that?
Because there in the hospital there that they, they can't just go in the DMV.
It have ways to within the government databases to to verify someone's identity and and and status. I don't believe that we can get into DMV to verify anything like that.
We can't do.

Dubrocq, Jose A 11:14
No.

Casavant, Robert 11:15
We can't verify their voter's registration for them.
We can't look up to see if their homeowner and homesteaded, and so we are limited to what we can look up for the client. OK, but.

Dubrocq, Jose A 11:23
Yep.
You can't, Kimberly.
I'm sorry to jump in. You can't.
You can actually check the driver's license.

Casavant, Robert 11:39
OK.

Dubrocq, Jose A 11:40
You can check if they're valid. If they're, they have a flaw, valid driver's license. You can do that and you can also check the bodies if they're not. If they were born here and they're both, you can check if they will. If they're active, boarded and and.

Then that that should expedite the process there.
That's, you know, the only thing that I could think of.

Casavant, Robert 11:58
Mm-hmm.
Talk about bringing.

Valbuena Valecillos, Adriana D 12:05
Yes, I was wondering how many of these documents they need to present.
It's just one for, like Florida residents.
Just driver license is sufficient and they has to also provide.

Casavant, Robert 12:17
They have to have two.

Valbuena Valecillos, Adriana D 12:18
Prudently.

Casavant, Robert 12:18
They have to have two forms, 2 forms of identification for Florida residency.

Dubrocq, Jose A 12:19
2.
Yes, 2.

Valbuena Valecillos, Adriana D 12:34
OK.

Casavant, Robert 12:35
Is it every every applicant or every every clients has produced these or or or what triggers these?
Yeah, every client. Yep.
But it seems like there is some public public available information that you guys are able to access to. To do that, yes. Yeah. Thank you for, for Jose. For bringing that up. I

didn't think that we could verify driver's license at all.
Mm-hmm.

Dubrocq, Jose A 13:01
But you can just check if they're valid. If they have a valid driver's license, then you can.
You can do anything else.
Just check if they have a valid driver's license.

Casavant, Robert 13:10
So it's.
Sorry. Sounds like they're, I guess maybe the question is, is what other things would cause delay in verification?
Is it just the production of these two or not being able to access the site?
Are there other?
Have you seen other instances of of what causes delays and verification?
For this part of eligibility.
No. The other delays for eligibility come when we're trying to get medical records that that's sometimes a delay.
So an applicant can.
They can stay in applicant status for 90 days before we even would consider closing the case for any reason.
So they have 90 days to produce their documents that we work with them.
So it's not like we get the referral, we give them 10 days or whatever to provide the information they can't and we close it.
So there is a 90 day window.
But in a particular case, it was.
It's not that they weren't that they won't ever be enrolled, but it's that they're getting closer and closer to their hospital discharge and and we're not able to kind of move forward with with some of these resources because of the, you know, working on paperwork, but which we.
All know is gonna is gonna happen.
It's just taking taking too long, but.
Is is. Is there ways since apparently this isn't common knowledge, is there a way to make sure that the regional managers are aware of this process and maybe Jose can

send some of those that information out?
Absolutely. All right. Thank you.
All right.
Any other questions or follow up on that?
Carrie has her hand up.
Oh, go ahead, Carrie.

Carrie Rayburn 14:59
Thank you. I was just curious what you guys do in the instance where someone is in like doesn't have family support or a way to get the documents.
Is there some kind of assistance for them? It sounds like that might be what the position that doctor Huden's patients in and I could see a lot of other patients having trouble.
They don't sometimes always come to the hospital with their ID.
Even so, they have to wait until after discharge to be able to qualify for their the program.

Casavant, Robert 15:28
I'll I'll let the managers speak to that on what they do.

Dubrocq, Jose A 15:32
No, usually usually if they if they're in a situation like that, they have somebody appointed in the hospital to be.
There. Well, they're in the hospital.
They should have like a social worker that's appointed and then we're in contact with that person so we can get and we do the same thing. We try to help and if if they don't have access like with the ID and things like that, we try to log.
On into the DMV or try to see the voter registration that try to expedite it.
But they should have somebody appointed in the hospital if they don't have any family member.

Casavant, Robert 16:04
Mm-hmm.

Carrie Rayburn 16:07
OK.

Casavant, Robert 16:07
Would it be Poss?

Carrie Rayburn 16:08
I just. I'm so sorry.
I just don't think that as like our you know our case manager is at the facility that I work at, couldn't go to someone's home to get those documents for them.

Dubrocq, Jose A 16:22
I don't think we're allowed to do that as a case manager. The case manager are not allowed to go to their home and that that will be.

Casavant, Robert 16:27
Yeah.

Dubrocq, Jose A 16:30
I don't think that will be up, yeah.

Carrie Rayburn 16:30
Right.

Casavant, Robert 16:34
I just recalled some more information about my case, so jump back in here. This particular patient is our client.

Carrie Rayburn 16:34
So.

Casavant, Robert 16:41
Prospective client is working on getting their birth certificate and they're they're they don't have quote UN quote papers because because they were born here, but they

don't have their their birth certificate handy. And I guess they don't have a registration.
Would there be a way to to have if if that's the one barrier to?
To some being enrolled if if there's some way to.
Source their their birth certificate information, so we can't. Mm-hmm. Apply for that information.
But you can go online and request copies of your birth certificates right online if they have access to get online.
Yes, you can get and that is public records, OK and how how long does that usually take?
I could not tell you.
No, you have to go to the county of where you were born like to their website.
Yeah. OK. And you can and it's I believe it's a it's a public records request. I had to do it once a long time ago. That's how I.
But you can you can request the records online it I don't know what the fee is to get it.
Usually there's a fee involved in that, and I don't recall what that was for myself, but you can or a client can get that information and I don't know that they will send it electronically.
I believe that they mail it and I do not know what the timeline is for that gotcha.
OK.
I'm just gonna say if you have, you know, a rec therapist. I know Carrie has helped countless patients.
Register or access things you know as part of their treatment and you know, online and sometimes OTS will help. And the social workers, of course.
So it's important IADL collecting government documents. Yeah, exactly.
All right, very good.
Well, I don't see any other hands up, so we'll go on to start looking at our indicator report.
And so you want to talk a little bit about the specific reports 'cause you attached them to the e-mail?
Yes, let me open my folder.
And so the first one is the average service duration report.
And so one of the questions that you all had was how long?
I'm sorry. Let me go to the legend.

The number of days required to complete a service. This report lists each service with an average day to complete and the count of records used to calculate the average.
This tab continued or contains the master.
Master List of services used to produce the averages on the detail page.
So Raj, put these together for us.
So when you look at these B codes, these are the services.
Can you share your screen or Oh well, I'm sorry. I'm ahead of raw. Like, I can't see a thing and I don't have it on my screen.
OK.
So you should have this in your folder as well. So these are the most common services that we provide.
Throughout the life of the case for a client, and So what it's telling you on here is the average number of days it took to provide the service to completion.
So the first one that's lifted here or listed here is other lifts.
So it took an average of 17.
Days to complete this service.
This report goes from January 1st, 2025 to October 30th 2025 and during that duration we provided three of those services is how you read this report. OK, so as you go down through here, you'll see other various services that we're providing what the average?
Length of time is and how many times we've provided that service since January.
I wanted to comment on this report overall, like the the the data service are don't seem like extraordinary for any of them.
There's some that kind of stick out and and we might come in on those either.
I mean, some are just outliers, but.
But thanks a lot for for for providing this.
I'll let other people comment on their support.
Yeah. Yeah. I was gonna say I was.
These are impressive.
Kind of turn around times as I was looking at some of them, I just wondered what? You know, were some of the biggest barriers you all noted for the the kind of the higher volume like assistive devices.
I'm assuming that's like walkers and wheelchairs and I mean walkers and canes and things like that and so.
Is it the vendors specifically that are being utilized to provide those?

Yeah. So we have a variety of vendors within that are enrolled in the program as providers and depending on the geographical area depends on which provider that you're using. We have some new providers that may not be as familiar with our process because we have to get QU.
Before we actually.
Issue the authorization we put out at least three quotes.
We hope to get three quotes.
As payer of last resort, we have to be very mindful of our budget and that's why we get quotes.
So new vendors who are working with us, they might not fully understand our process they're getting on board with that most of the time in the regions, they have vendors that they've worked with for a very long time.
They know the the process and so the turn around time is usually very quickly unless the vendor themselves are having some kind of issue getting the equipment.
So is the average of days took, including the time it took for to get the three quotes.
Yeah, the average time is from the time.
We started the service, issued the authorization to the time the service was completed, which means the vendor provided the service.
We got the billing back and it's done.
And the time for the to get the three quotes.
Yes, OK. But the authorization is preceded by the process of making sure they're the the pair that you're the pair of glasses.
Or yes, OK.
Do you have different metrics on on how long that takes for pair of glass well when?
Yeah. For that when the client is enrolled into the program, one of the first things the case managers do is just to identify if they have insurance. If they don't have insurance, are they applying for Medicaid?
Now when it comes to an insurance company, we aren't obviously issuing an authorization, but we will help the client work with whatever providers are with their insurance companies to obtain the equipment.
Any legs and service there is outside of our control with insurance companies.
So with all the managers on my question to you all is what?
What barriers are you feeling on the ones that take longer or kind of pressure points?
Or things are running perfectly smoothly, you know.

Everything's perfect.
Yeah, I mean, 'cause, obviously the whole reason we're looking at the data is to be able to determine goals later on and see how or where we can support and help.
So online I have Jose and Roslyn I have.
Two regional managers that are out today.
So if Roz and Jose wanna speak to that.

Clark, Rosalind M 24:39
So far I don't see any barriers really.

Casavant, Robert 24:44
Good.

Clark, Rosalind M 24:45
If I'm understanding your question.

Casavant, Robert 24:51
Is there much variability between different regions with with some of these?
Like Jose, do you have the best region?
Like, do you guys deliver these faster than than the Jacksonville region or like I I just don't know.
I don't think there's anyone that's that has more problems or is quicker than the other.

Clark, Rosalind M 25:10
MMM MMM.

Casavant, Robert 25:11
It depends on the vendor, yeah.
And if they're a new vendor learning the the process, their vendor, yeah. Yeah, it's been it.
It depends on the vendor.
Mm-hmm.

DA **Dubrocq, Jose A** 25:21

Yeah, it just depends on the vendor.
Here Region 5 and I'm I haven't seen any barriers to be just like Russell said with the vendor.
Some of them, if we let them know that the client's been discharged, you know, and and there's an urgency, they respond right away.
So I haven't seen any any hiccups.

Casavant, Robert 25:39
OK, great. Are there particular items that are that are the most difficult?
Is it between like on on on this list?
Are there any that are?
I mean, obviously some are longer than others, but do some of these kind of the processes is is more tricky?

DA

Dubrocq, Jose A 25:56
Yes.

Casavant, Robert 25:56
Or what explains the variation between these different different items? Yeah.

Clark, Rosalind M 25:58
Yeah.

DA

Dubrocq, Jose A 25:58
Like.

Clark, Rosalind M 26:00
Specialized shower chip. Yeah, go ahead.

DA

Dubrocq, Jose A 26:01
The shower chairs all right.
Yeah, yeah, go ahead.
That was that was it.
That was it.
That was my go ahead, Russ.

Casavant, Robert 26:08
Oh, go ahead.

Clark, Rosalind M 26:08
Yeah, the specialized shower chairs.

Casavant, Robert 26:10
Hmm.
Tell us more about that.

Dubrocq, Jose A 26:12
Mm-hmm.

Clark, Rosalind M 26:15
Well, with that, the specialized shower chair, they would have to do the measurements and that takes some time for the vendor to make.

Casavant, Robert 26:21
S.

Clark, Rosalind M 26:23
I guess they make the shower chair to fit the the the client, so that takes some time and usually if we know in advance like we know that the client is going to be discharged and if my facility they will, you know let us know that the show.

Dubrocq, Jose A 26:31
Alright.

Clark, Rosalind M 26:41
Chair isn't going to be covered by clients insurance and that way we know in advance.
Send our bids for the shower chair.
Go ahead.
The vendor will go ahead and take the measurements and so forth and start working

on that shower chair prior to discharge. If we know they're going to be discharged within a week, well, we can already start on that shower chair prior to them coming home and maybe by.
The time.
They're home.
Maybe they would have to wait a week, you know, or two time would be.
It would be less time.
I'm waiting on that shower chair as opposed to.
This I'm rambling, but it's the shower chair.

Casavant, Robert 27:15
Starting.
Yeah. So do you all work with?
Do you rely on the facility that the patients currently in for the home like set up and measurements, or are you duly working with the client on getting those measurements for their home?
You know, just from from an education standpoint for me because you know if I'm that way, we can direct our teams even better for you know what they need to be looking for and asking questions.
And things like that.

Dubrocq, Jose A 27:50
Well, yes, it depends on the facility way, way back.

Clark, Rosalind M 27:53
Yeah.

Dubrocq, Jose A 27:55
Jackson Memorial Hospital, the rehab team used to go to the house and and do whatever rehab engineer.

Casavant, Robert 27:58
Yeah.

Clark, Rosalind M 27:59

Assessments.

DA

Dubrocq, Jose A 28:01

Yeah, but right now it's like we have to rely on the rehab engineer going there and just getting the measurements or the family working with the family and also like the the rehab team. Yeah, to provide us that cause, like Rosa. And they need certain measurements.

Of those shower chairs so they can fit in the bathroom.

And and that's about it, because the wheelchair, they usually get a rental while they're getting the one the appropriate one that they need.

Casavant, Robert 28:34

OK.

All right.

Does anybody else have anything specific on this particular report?

You know, we're we're kind of in the process of finding these these smart goals or these one might call them like key performance indicators.

I I I think using because there's such a variety of of different different devices or or other services that are provided.

It's like we could either pick up one or one of these to to focus on, or we could, you know, look at like the average. If we wanted to, to use like this time piece as a as a key performance indicator.

Do do the other committee members have a kind of opinion on that?

It's not everyone speak at once.

And these aren't censored.

I was thinking, you know, you know, over time depending on kind of the the metrics that we see with these these indicators like if one just becomes like, OK, we're satisfied with it.

It's it's it's doing well.

You know, everyone's satisfied then. Then we can go on and look at different indicator over time.

But I think this one is very important for our for our patients and our clients.

To get the the equipment that they need in timely manner.

I was.
I was sort of just thinking just to use average since there's such a variety, just picking out one might kind of overlook some some other nuances or or some other items.
So what do you guys think about using the the average for, for for all of the items?
Yeah. Do you wanna have any exclusions in there like, you know, yeah, true.
The hospital bed and the home modifications piece, for example.
Those are kind of the two.
That I see are the outliers for long periods of time.
Yeah, I was actually surprised by how low the the home.
Me too.
I was really impressed that there might be, you know, there might be some ones and then there might be very complex ones that are that are take much longer than that.
That might explain that.
So you know, as as we dig into this over time, it might be interesting to see like the like, the more the statistics on it, the, the, the mean, the standard deviation, things like that, but.
I'm curious what's what's underneath the hood with the home modification for HUD.
But.
Yeah, but maybe grand total excluded the of all of them, excluding whole modifications, but maybe I'm, I'm still curious about the, the, the underlying metrics for the home modification. Mm-hmm. But I think it'd be kind of those are different beasts.
So I think it'd be reasonable to exclude those.
Yeah, because it's more involved than the piece of equipment itself specifically, right?
So what I'm hearing you say is you want to look further into home modifications on the timelines and what it takes to complete those and exclude the other items.
But what I'm saying is, you know, as a key performance indicator and this is something that you know every every quarter that or this, I imagine it look on other input, but how much is every quarter we get a report saying, OK.
This is our average.
It's going up, it's going down.
This is kind of the breakdown by region, saying, OK, this region's average is is 13 and this region's average is 15.
Or or maybe wider than that. As far as variation.
So just a report to provide the Council, as far as you know, where we're doing well

with this or.
Something's going wrong and and and this number has has increased by 50%.
And home modifications will be excluded from that project 'cause it's a different piece.
That's why I clarify.
Make sure I'm on the right page.
So where it might exclude oh mods?
Multiple modifications is an animal, so yeah, definitely are there.
Are there breakdowns within that?
Like some you know, sometimes it's as simple as, you know, grab bars and things like that.
'Cause then sometimes it's like.
Over so bathroom makeover. Basically, we do bathroom modifications where we're.
Lowering sinks, widening doors, putting in showers for roll in chairs.
Not too often do we just do, you know, leave a tub and they use a transfer board.
Usually we're doing the remodeling the whole bathroom so that they have access to roll in.
And widening doors and ramps.
Yeah, and the any struggles that we have with home modifications is usually the vendor and making sure that they're getting the job done in a timely fashion.
Yeah, I understand that that.
These things are not completely under B Skip's control.
There's other there.
There's other metrics that be even less under PCP's control.
But yeah, and if it you know if we have increasing problems with vendors, it's it's it's worth a conversation.
Agreed.
Yeah, I'm looking forward to the speaker this afternoon. Just kind of there take, yeah, the speaker this afternoon has worked with bskip for a very long time.
Yeah, that's awesome.
Mm-hmm. Yeah. You might have some workflow tips for others in other areas.
OK. Mm-hmm. OK.
Does anybody have anything else on?
This particular report.
And the discussion we just had about the exclusion for the average of home

modifications and monitoring over quarter over quarter to see if we make some improvements or there's particular outliers.

Valbuena Valecillos, Adriana D 34:46
I just got with the home modification. If like the importance to know the average, especially the runs.
As the patient is waiting to be discharged for that, I see that they have they put, they added on the equipment, the portable one, but sometimes when portable is not an option.

Casavant, Robert 35:02
Hmm.

Valbuena Valecillos, Adriana D 35:05
Is that how modification on the ramp component is delaying the the discharge from the rehab center of the hospital?

Casavant, Robert 35:08
Mm-hmm.
Yeah, that's that's a big deal.
So and and the managers can chime in on this one.
The struggles that we sometimes have with getting equipment to the home is the amount of time that's allowed from the time we're told the client's going home.
And you know, sometimes we get a day or two.
Notice that the client's being discharged and that's not sufficient time for us to ensure that for health and safety, the equipment is in the home.
Mm-hmm.
We work very diligently to get it there as quickly as we can.
We have spoke with some of the facilities.
And they actually should be the ones to initiate that equipment.
Not all facilities are doing that.
They just want to tell us when the clients discharged and this is what they're going to need.
So we've been going back to facilities and trying to educate some of the discharge planners, case managers and so forth that.

They put the client at risk when they do that.
When it's when it's everything all at once at the end.

Valbuena Valecillos, Adriana D 36:15
Yeah.

Casavant, Robert 36:16
Yes. Yeah, that's so that's interesting.

Valbuena Valecillos, Adriana D 36:18
I think that's that's.

Casavant, Robert 36:20
Go ahead, Doctor Balboa.

Valbuena Valecillos, Adriana D 36:22
Sorry, no.
Yeah, that's part of the education.
I think that the managers could do with the with the team, especially the vision already in rehab like from the first team meeting. They anticipate in the vision is gonna need this modification to be discharged to be.

Casavant, Robert 36:27
Mm.
Absolutely.

Valbuena Valecillos, Adriana D 36:39
Precipitated and you know, communication with the manager.

Casavant, Robert 36:44
Well, not only that we.
I mean, we have an estimated length of stay.
At the first, after the first four days, technically if you submitting.
But so we should be communicating that.
And so that might be an opportunity for education to your point.

And if we know what those who those outlier facilities are, that are the ones giving it to you with one or two days notice, I mean that's that's.
They need to understand the impact and I'm sure they feel it, especially if the discharge is delayed, right, because the patient doesn't have those things. And so you know, how can we be supportive and proactive and encourage that with the the various.
Facilities that have the patients.

Dubrocq, Jose A 37:31
Yeah, go to Babuana just to let you know that point will be going to Jackson Memor Hospital to meet with the rehab team next week, and that is one of the things that I'm planning to address the timely manner, you know, like Kimberly was saying that we could.

Chester, Don 37:31
Yeah, I this is. I'm sorry.

Dubrocq, Jose A 37:48
Get things you know prior to the discharge and just to give an example, in a case like that for the accessibility, we just had a client that.
Due to her weight, her door to get into the house had to do it whining.
Because of the wheelchair, she didn't have an able.
She was not able to get into the house and we got the vendor actually to do this like in two weeks. So so she can get it done and she could go to her therapist and all that, but we get, you know, it's it's true. We have to.
Talk to the rehab teams so they could be aware of that. See situations like that.


Casavant, Robert 38:24
Rosalind.


Clark, Rosalind M 38:25
What else?
What else gonna say with us?
We can provide the education to the facility, but it's a turnover.
They don't pass that information over, so it's like.

We can have a good relationship and we are getting those reports and the DM ES that are gonna be needed prior to discharge. You know last month, but then the next you know the following month we may not get those again.

Casavant, Robert 38:46
It's.

Clark, Rosalind M 38:50
It's because of the turnover and we provide education, but again.
It's not always passed on to.
The new staffers.
So that's where we are with that.

Casavant, Robert 39:00
Is most of your education to the case management team?

Clark, Rosalind M 39:05
The the therapist, the rehab facility.

Casavant, Robert 39:09
The the therapist specifically.

Clark, Rosalind M 39:11
The therapist? Yes.

Casavant, Robert 39:14
OK.
I mean, I think the typical the program directors.

Chester, Don 39:15
You know, there is always.

Casavant, Robert 39:21
And the the specific leaders are probably the people that can help reinforce that and carry it through versus the there is high turnover with the case managers and social

workers and sometimes you know specific therapists, some some facilities only have travellers in those positions.
So you know that might be an opportunity of who the education and communication goes to.

Clark, Rosalind M 39:39
Thank you.

Casavant, Robert 39:44
Perhaps we could.
Create AI know we're getting into the problem solving part.
But anyway.
They create.
A.
Oh my gosh, I just lost the word, you know.
Document. But that's not the right word.
But anyway, collateral of some sort to be able to provide and you know and also send out to different listservs.
For Florida program directors and things like that of the facilities.

Chester, Don 40:16
You know, keep in mind that one of the challenges, if you need to make modifications is getting permits.
And the permitting process can take quite a few months.

Casavant, Robert 40:28
Is that included in this metric?
Does that fill in that for home mods?
Yeah, I'm not sure if that's including so and that probably means we're excluding them.
Yeah. So typically I'm gonna say yes, it is including permits because from the time that an authorization is issued, you're talking about home mods and so forth to the vendor to the time it's completed.
That's including the time that they've gone out to get their permits.

And there are some counties that are very difficult to get permits with and I believe Palm Beach County is one of them. If I recall correctly from one of our vendors.

Chester, Don 41:05
Oh yeah.
Yeah. No, we you know from my house.
We just, we're in a position where we could just toll tell the the city that we were doing it.
You know the heck with the permits, but most people can't do that.

Casavant, Robert 41:25
Yeah.
Yeah. And I think this, this is all following Doctor Bob Rayne's questions about the ramps for ramps and imagine 'cause, it's an external structure and it's safety related that it's well, it depends, OK.
We do.
A lot of.
Portable ramps and those don't quite, yeah.
So those those don't require permits and so forth, but we do more probably and correct me if I'm wrong managers, we do probably more portable than we do actual attaching to.
A home. Mm-hmm. So when we attach to a home, depending on the type of ramp that it is.
Depends if they have to permit it or not permit there's there's two different kinds of ramps that you can attach to a home.
Yeah. Yep.
Is there a height limitation for like the portable ones like beyond you know, three steps you know beyond like 36 inches?

Valbuena Valecillos, Adriana D 42:20
Yeah.

Casavant, Robert 42:22
It's it's just not gonna work for portable. Or is there certain lengths?

Valbuena Valecillos, Adriana D 42:25

Yeah it does.
The challenge is the it's usually no more than three, as in Max 4, but also the weight.
Of the of the patient, we had some issues with the patient being over the way that the portable ramp.
Will be able to support.

Casavant, Robert 42:49

Yeah.
I just put a ramp on my house for my mom with a brain injury a couple months ago and I just got so lucky. I found one on, you know, on 'cause she's not a resident of Florida, so we couldn't use bscape. But but I found out I.
Found one on on Facebook marketplace that was like the exact length.
The exact height that I needed and it just got so lucky.
But imagine most people are not that lucky.
Nor is be skip. I don't think B Skip can use Facebook marketplace.
No, we can't use that.
All right.
Anything else? Good discussion.
Yeah. So kind of back to metrics.
I think we had a previous conversation about the enrollee, the.
The rate of people saying no thanks to the services being in point metric 'cause right now it's like 2030% that we're struggling with.
Despite these, Kip's best efforts, and then this average time for delivery services.
I have an idea for a third one, but I'm I feel like I drive the conversation too much sometimes so.
You know, I don't know if Jill has any ideas for, for, for metrics or well, I was just gonna go to that client cases closed without service so that we can hit on the second one that we talked about that you had just mentioned.
Yeah. And just kind of review that report and and maybe hit that one and then we can look at the last report that we requested and determine from there, OK.
So Rob, it's the client cases closed without services.
And so this report is a count of records for each closure type category listing each closure alongside its aggregate totals.

So you can quickly see how many cases are distributed by closure reason.
So we have we closed the case for a specific reason and then we also have sub statuses that sometimes tie into.
That specific type of closure.
This report details on the detailed tab, its cases that were closed without any services being provided, showing each case and the specific reason or closure category assigned so you can review why closures occurred without service activity. So when you go to the.
Pivot table.
You have that up. He does.
He has that up.
It's broken down here by closures.
Oops, I'm looking at go to summary, click on the summary tab please.
There you go.
So this is the reasons why these cases are closed. If so closed for client merge.
What that one simply means is the client is a duplicate.
Yeah, that, that's all that that one is.
Then you have community, community, reintegrated and other other can be variable.
I I I always hate using other.
To me, that's an open book.
I'm trying to click on Rob's report and it's.
Not working, so other under Community reintegration.
No, I won't open for me there. 11 is not a huge number.
No. Yeah, device exceptions.
It's not.
So what specific would you like to look at on this one?
Anything that jumps out at you, I think.
Go ahead.
I was gonna say the failure to cooperate will not respond to contact attempts, and then I think it kind of the unable to contact.
Or unable to locate those two or yeah those.
I mean 390 is a is a really big number and 1:33.
I'm curious about why run unable to locate them, but it seems like a high number.
So sometimes the when we're unable to locate them, it's.
Perhaps they were discharged and we got the referral after the fact and we where

you weren't able to make contact within the 1st 10 days.
So when a client is discharged and when the client is referred to be skip and they've been discharged, as soon as the case manager receives that referral.
Has 10 days to to reach out to the client or family.
That may be while they're still in the facility, but if they've left the facility and we haven't, yeah. And we don't have good number or good phone number, good contact information, then it's very hard for us to find that client.
Yeah, they go to another facility that the first facility could give you the name of that facility and then you can reach out to them.
If we know the other facility so it discharges into an unknown facility, that's the.
That's concerning. Yeah. If if they provide that information to us, then yes, we could reach out to the next facility. I would have to ask the managers how often that really happens.
Yeah.
But I think those those two metrics that the the failure cooperate and the unable to locate those things are are important things to change.
So we get better.
Better saturation of of these patient population. So the failure to cooperate where they don't respond to attempts that happens a lot.
And so we use every resource that we have available to make contact attempts.
Will call their contacts that were supplied at the time of referral.
Family contacts will reach out to them.
We'll reach out to whatever phone number was listed for the client.
We send letters to let them know that we've been trying to make contact with them and.
The October meeting you were, you were very detailed with that.
But.
Yeah, so, so, so it's usually not for lack of effort, but I think there's there's other even strategies that might be developed to get that. And I think that's what that's why we want to use this as a metric 'cause. That's the number that we wanna see impro.
Yeah, the what I was gonna say is I think that, you know, if my my curiosity is is when we tag it as failure to cooperate is that you've made zero contact. So you didn't get to meet with them in the hospital and you've made multiple attempts or.
You did meet with them.
Once and then they declined.

They didn't respond to your contacts after that, so they may respond when the case managers are first reaching out and so forth.
But as we go through the eligibility process.
They may decide that they're, you know, they're not answering their emails.
They're not answering their calls, so we may start out with success and it may end up with failures because they're not responding.
OK. And how does it?
I forgot to ask this.
Or maybe I did and I just don't remember.
But how does the numbers show up when it's coming across to their phone?
I'm just wondering if it's, you know, I don't answer calls that I don't recognize and so.
I don't know if it's somebody spamming.
I don't know if that's a concern of theirs. I don't.
I don't for sure if that's something that could very well be to Jose and Roslyn.
Do you have anything that you can further explain on that that maybe case managers have experienced when making calls? Or is it spam that maybe they're not responding to?
Do you have any idea?

Clark, Rosalind M 50:35
No idea but.

DA

Dubrocq, Jose A 50:35
Well, that might be.

Casavant, Robert 50:39
I'm sorry, Roslyn.

DA

Dubrocq, Jose A 50:39
There might be a situation that them them go ahead.

Casavant, Robert 50:42
OK.

Clark, Rosalind M 50:44

No, I was going to say they they, you know, they would.
Case managers here will send a contact letter and then no response. A 10 day contact letter.
So there is initiative to to get them to respond to previous calls, so.

Casavant, Robert 51:02
Yeah. So letters going to the home often if they're in the in the hospital or in the rehab, they don't even.
See that mail that goes to their home.
And sometimes they don't even. Ever.
They don't necessarily go back to that home.
They might go to a family member's home, so I'm just wondering if that's.
You know, they're just overwhelmed at the time, obviously, of every of all the life changes.
And so that's like the last piece of mail. I think that they're gonna open.
From a male standpoint.

Dubrocq, Jose A 51:35
Well, what we're doing also is if we get a situation like that, we call, it might be a spam and it might not take it where I try to do is have you know the case manager contact the case manager at the hospital and try to find out.
Where they are in the hospital, so the case manager can give us more information because they might be other numbers there that we we didn't get at the time of the referral. So that's.

Casavant, Robert 51:53
Yeah.
Yeah, I think that goes back to, you know.

Dubrocq, Jose A 52:01
Or we try to see in Phillips and the Medicaid.
Website If they do have Medicaid, then we might be able to get information there as well.
That's all the strategies that we use.

Casavant, Robert 52:13

Yeah, and. And and there's all these tragedies and that's part of making it have a a performance indicator is that you know that there's all these nuances that go into this, and it's almost like your your your salesman in some ways.

There's different strategies that within a region, you know, OK, this person has a reputation for for being ace and this person, you know, is new in their learning and within a region. And then between regions, share best practices among bskit staff to improve this metric because.

Right now, 390 a year that you know that that very well may be eligible for these services and then aren't benefiting from these services.

Is is a very large number.

Yeah, I think it goes back to that partnership with the facilities that you you know, you're supposed to be getting accurate information from and follow up and I'm not sure that they appreciate the full impact that they're having on those clients lives and on your lives as you.

Really follow up and help the individual.

So I think that just kinda adds another piece to that, maybe collateral and education and the target group for that.

Anybody online have anything?

Oh, Carrie, go ahead.

Carrie Rayburn 53:37

I was just curious as as we follow this moving forward, could we also have it to where it shows us if there a spinal cord injury or a brain injury as well?

I think that that would be interesting to see.

Casavant, Robert 53:48

Yeah, that'd be great.

That'd be great.

Yeah, for sure.

For the people that decline services, do we retain their data as far as their their their their injury and things like that. As far as our our statewide statistics we do OK.

Good, yes.

Yeah. So if they reach out later, yes.

So a client can at any time request their case to be reopened.
So if they decide they don't want vskip services today.
Six months down the road, they decide that they want to see what we have to offer.
They can call central registry and request their case to be reopened.
A what we call TDD things to do is assigned to the case manager and the regional manager that had that was assigned to that the client was assigned to originally and they are notified that this client has reached out and wants their case to be reopened.
Yeah. Also from a just a statistical perspective to track you know the the frequency of spinal cord injury and brain injury in Florida is a is a is the data collector on that and and make sure we retain that data. So to that point, if they reach out.
Do we have a mechanism in place of maybe annually for any cases that were or every six months or whatever any cases that were closed and we never made contact with the client just?
I mean sending a letter or sending some sort of communication to say, you know, please let us know if you are interested.
And yeah, so that's part of what Becky Robinson does with our surveys at certain stages of a client's case, even after closure, she sends out a survey. She reaches out to send out a survey and has a series of questions that they ask.
So that kind of might spur the client to say, Oh well, you know, maybe I need to go back and revisit and see if there are services that maybe this program can help us with.
I think I didn't realize.
Or maybe I don't remember that she's sending it to those who never even.
Yeah, applicants.
Yeah, that's good.
OK. And I believe those surveys are the ones that the, the Council, I don't know if you two were on the Council at that time when we created those surveys and those questions.
Yep. So the unable to locate my my question on that is there's a hundred listed under other what what is what is that?
Under it, under I have to pull it up to see what it says here.
And that's where.
Ah.
I pivot tables not working the way I wanted to, so let me.

And I think Kerry has her hand up too.
Kerry. Yeah, so the description doesn't doesn't really say what other is. So I would have to ask the the managers.

Carrie Rayburn 56:39
Thank.

Casavant, Robert 56:48
Part of it is does not meet statutory definition of a brain or spinal cord injury.
Oh, long term institutional.
Or institutionalization.
Or they've been incarcerated.
Those are two very different things.
Well, yeah.
And that's that's long term.
I'm just looking at the details. I think we're the the other under unable to locate was the 99 there was.
Yeah, that's the one I was looking at. Yeah. But as we get as as as we're probably getting.
Beskip and, you know, selling bskip generally.
Then we're gonna get more, and we're gonna catch more program. Ineligible people.
You know, but that's fine.
We can deal with that. Yeah, but it's more the these unlocated ones.

Carrie Rayburn 57:43
In the instance where you said that the cases can be reopened at a later date, is there instances where if they wait till a later date, they then become ineligible because their status has changed like their medical status and others pretty strict, especially with brain injury.
Requirements. So would they then if they waited, would they then be ineligible, or do we use like you know the data from when they were hospitalized?

Casavant, Robert 58:01
So.
We would use the the initial medical records to show that it was a traumatic injury

and then they may also have to produce current medical records so that we know the current status, because now you're getting into.
Especially for brain injuries, you have to look at Rancho scores.
So when they apply for the program, their Rancho may have been, let's say A5, which would have qualified them.

Carrie Rayburn 58:34
Mm-hmm.

Casavant, Robert 58:36
But if it's been six months, nine months.
Whatever.
And they want their case reopened and they now are a Rancho, that is.
A nine or ten, nine or ten would not qualify for the program.

Carrie Rayburn 58:54
So they would then be ineligible to receive any services.

Casavant, Robert 58:57
Yes, they would.
Yes, they would not.
They would not meet the meet the medical eligibility requirements according to statute.
Yeah, 9 or 10 is pretty good, yeah.
So Jose and I'm sorry, what's?
Jose and Roslyn on the unable to locate.
There's 100 listed in the other category.
What are those instances?
Or some examples.

Dubrocq, Jose A 59:32
Hi.

Clark, Rosalind M 59:34
No foreign address if the case manager is unable to reach client by all information

provided by the hospital.
That would be one.
Jose another if they move away.

Casavant, Robert 59:52
And that would fall fall under the the second listed one, yeah.
Yeah.
Yeah, there's a line 41, just the referral source, yeah.

Clark, Rosalind M 1:00:04
The other unable to locate.

Casavant, Robert 1:00:08
So I'm looking at the details specifically for unable to locate and the reasons on the detail tab on the report. I'm sorting it, and so the comments that I see in here are all contact information changed without bskip, without notification to be skip contact information Referral Source, Inc.
Or unavailable.
And then they just have other for some of these.
But when they use other, they're supposed to put a description.
And so I'm looking to see.
What else is listed here?
Contact information from referral referral source incorrect or unavailable.
Yeah, I think this is not going to be really tractable to to to to further B skip efforts like the other one maybe.
All that I can do, which is part of what?
I commonly request in the program is if there's a comment field, put a comment in there.
Don't just say other and leave comment blank, because then other is just useless information.
To make exactly I need to know the the reason for and some of these fields we have actually made to be required to where they have to put comments in. Yeah, yeah.
You know, I think to some degree the una able to locate is tractable. You know, being more proactive with the with the referral sources that the referral sources provide the correct, the correct contact information and family contact information,

things like that. And then you know, keep track of.
Where their clients are discharged to.
If it's other institutions, but you know of all these things, I'd I'd much rather focus on the on the decline services or the OR this kind of unable locate category.
Anybody have anything else that's online?
Do we have any other reports?
Just one more, one more, right?
That's what I thought. Sorry.
So the last one is.
Drink this.
Let's see.
Is the client case closure report days old?
And number of attempts of success. If you could share those pivot table ROM.
Please.
So this report provides A1 line summary per case showing case, the age of the case, how many days it was open and the contact activity with client family or hospital with two metrics. Each attempt in successful contacts allowing quick assessment of outreach efforts and effectiveness at a.
And the total number of clients that were closed was 2187 and this report is for the time span of July 1st, 2024 to June 30th, 2025.
So last state fiscal year, OK.
So that the total success family and the total success hospital columns just.
That is.
What specifically?
The contact attempts.
So that's the the how many they've successfully made contact with. Yes, with family, with hospital.
With clients.
So you have success and then you have the attempts.
How many times did they make an an attempt?
So each time that a case manager reaches out to a client, a family facility, provider, whatever it is, tracked, it's a it's a case note.
So we have to document how many times we've attempted to make these contacts and how many times we were successful.
So they're two different case note types.

In the average of number of attempts, hospital is like when they're going in person to the to no.
Not necessarily in person. That's probably. And managers can correct me if I'm wrong. It's calling the facilities OK to get more information.
But what this doesn't caption is my larger point is, you know, we obviously need to be making these steps, but it's like the strategy and the and the salesmanship with when these attempts happen, you know, make sure that we're we're clearly identifying ourselves, what services we offer.
And just all all, all the details that go into.
How successful these attempts are?
Not just the obviously the number. Like if you're not doing it, you need to do it, but obviously the all the nuances that go into succeeding with these with these contact attempts.
So what ties into this report?
And it's not an, it's an indicator that report that I've provided to you all is.
When there is a client who is either an applicant status or in service status and there's been no.
Context. So bskip has.
Policies in place for our case managers and timelines in which they have to make these calls, these attempts, and if they are outside of that requirement, then they hit this other indicator report that says you haven't made contact with this client in over 45 days or over.
60 days it counts. It tells us how old. So we utilize that to go back, to tie it back to this one.
So that we stay in compliance, yeah.
Yeah, I I wouldn't say the person.
I'm a very good salesman.
I think that with with my treatments is like that. I you know, I I give informed consent so like that but I don't try to sell my patients on different treatments. But I think you know part of part of the this role for for your case managers is.
Being a salesman, you know you're you're there's no cost for this program.
That's the point that it's free.
But there is some some involvement there to be more open.
Some people are aren't a fan with interaction with the government.
That so, so, so so.

It's so it's not 0 cost, you know, you know, zero effort on on the clients part, but you know you're you're selling a free service and you know to people who are really needing it at the time of their lives and for for for that to be 3.
190 is is is a number that we need to improve on.
So that's why we do have applicants that can stay open for 90 days, because we wanna make sure that we're doing our due diligence.
To present the program properly, yeah.
And to give them every opportunity to understand what it is.
As we do. Yeah. But Despite that being over for 9 days, the number's still 390.
Yeah, I'm curious for the managers.
How many patients do you actually get to visit in person at that facility?
I will leave that to the managers to answer.
I can speak for Fallon.
I know for sure Fallon has, which is region one, I'm sorry.

Dubrocq, Jose A 1:07:47
Wait.

Casavant, Robert 1:07:49
Jacksonville, but she has a case manager that's in Alachua County that makes rounds once a week at the hospital to go follow up on the clients. If she can meet with a client, sometimes you can't always meet with the clients when you go to the facilities busy with.
Therapy.
They're always at therapy, yeah.
Well, sometimes the the hospitals, you know, if they're in.
I see you or whatever, you're not going to get back there to see them at all.
Yeah. So. But Paige, I know goes and meets and does rounds and meets with people and gets the update on where the client is currently.
Yeah, but they might develop a relationship with the staff and say, hey, can you have the family step out to the family meet room and and have a conversation?
So I would let Roslyn and Jose speak about their staff.

Clark, Rosalind M 1:08:37

Well, Peggy does the same thing.
Sorry, Peggy does the same thing.

Casavant, Robert 1:08:40
That's right, Peggy's another good one.

Clark, Rosalind M 1:08:41
Yeah. So she's, you know, attend the round staffing team conference. She meets with the family.
Conducts her initial interview.
So yeah, she does the same thing. So.

Dubrocq, Jose A 1:08:56
Yeah. In our region is the same.
We luckily we have. Jackson is very close by. I'll say it's like 10 minutes away.
So we the the case managers go there to the the intake.
Mostly the refers come from there, but if if they have to go to Kendall Regional Hospital, which is further from here, they go to or Aventura.
So it's yeah, we try to, we try to do the conductor first.
Intake has to be in person.
That's how I like.

Casavant, Robert 1:09:27
So what percent do you actually get to have an in person?
Connection with do we know that?
I cannot tell you that.
No, I would have to ask the managers that.

Dubrocq, Jose A 1:09:39
Yeah.

Casavant, Robert 1:09:40
That's nothing that we really report on.
It may be documented as a successful contact, but I don't know that it's that they went to the home or to the facility.

Would there be a way to recategorize that in the future?
Because you know, I I think you know personally, you know, face to face conversations.
It'll go much better than just a phone number popping up.
I can have even if they pick up the phone.
Yeah, I can have Amanda.
I can have the RIMS team create a new case note type that says in person, yeah.
Yeah, I think that would be very telling. 'cause I I would be curious then how many you've actually met with in person that then don't.
Yeah, that, that the fallout of the program versus you know, a voice on the other line.
You know.

Carrie Rayburn 1:10:26
I was thinking I was thinking the same thing. Joe, I think you might see more people staying involved with the program if they have a person that they've met.

Casavant, Robert 1:10:27
With every.

Carrie Rayburn 1:10:35
You know, face to face.

Casavant, Robert 1:10:36
Mm-hmm.
Yeah. And I I can appreciate that.
You know you can't get into the ICU's and things like that, and so.
You know, and sometimes they transition from the ICU to the floor, then onto the post acute level of care very quickly. And so it's not reasonable for you to be able to get back to that facility.
But then the communication from the the trauma facility to where the the client went is really important for the success because that's the things that you're talking about in the post acute settings.
Is how you're gonna get reintegrated back into the community and what all resources are needed, and that's where the major identification comes of, you know, if there's modifications needed, what equipment's needed, all of those things, that is

the resource that's being provided by bskip. And so and.
I think it it's really important that when we're able to go out to the client's home when they're first discharged to make an assessment of their home to see.
What is it that they're going to need?
What do they have?
What is it that they're going to need with doors winding the ramps?
You you get a full picture when you go to the client's home to really see the environment that they're in to get better knowledge on what it is because they might not realize what it is that they're going to need.
We're the ones that are the experts telling them this is what you're going to need in order to be successful with your new life.
So I think it's very important that case managers go out.
Some are not always able to go to the patient.
Home. But we do make the best attempts to get out there and maybe that's another 'cause it's not specifically a metric that's specifically being tracked at this moment, right? If it gets the patient's own, but maybe we can add that as well.
I have it here for a new case.
Note height.
That's why I have Amanda here. Yeah. Amanda.
Outstanding. So I think within this particular.
Goal. There's actually a couple pieces to it.
And so I personally don't know that we need to identify a third goal, but we can have a couple subsets of a second goal.
What are your thoughts on that?
I.
You know, I'm I'm curious about kind of all the all the things on the hood, but I think you know the purpose of picking indicators 'cause then one indicator 'cause then it captures everything under it.
I have two ideas for other goals, so I'll I'll mention them and kind of see see, but I don't.
Again, I don't wanna force my goal on on on this Council, but one both are near and dear to my heart, from from previous conversations one would be tracking the number, the the number of clients that transition from bskip.
To vogue rehab, it might be good to capture this as people who are working age.
You know, I don't if we want to draw a line at 65 or 60 but but but capturing you

know how many we successfully transition to vogue rehab and then then the other metric is the ratio in a given region of.
Or statewide as well of referrals received from the acute care.
Referrals received out out of acute care when they get to rehab or or or even out in the community is is, you know they're, you know, ideally there there's more and more that are coming from the. I mean the goal is 100% because we still want.
To capture those people who are who kind of, you know, are injured in Alabama, but they're sort of, you know, residents of Florida, things like that, but.
But we're kind of watching that ratio of of acute care to to community referrals.
To Earth, or I mean, you could even find that, you know, acute care or and then all other ones, yeah.
So so those are my other ideas.
So when you talk about tracking those referrals?
Right now.
We can provide and I think I provided this to the Council before.
The referrals by facility.
Mm-hmm. Yeah.
So that would and then categorize those facilities by you know are the facilities are the rehab facilities umm and obviously patients uh especially coming to Jacksonville.
Maybe from out from other regions, but but you know the the, the, the and sometimes their trauma happens outside the region as well.
So it's a little bit of all depend not not clear cut but but but we should be tracking OK how many regain?
From acute care versus after they get there.
So I know that's an ongoing effort with staff turnover. It's like trying to trying to build a sandcastle while it's raining, but you're trying to short short of the short of the castle and try to get try to keep on getting cute care referrals but.
But but, but making sure that that we're maintaining a a a high number or high percentage of of referrals from acute cares.
So let me ask a question then and.
That goal? How would you?
Where would you wanna see self referrals? Where maybe the person was injured in another state?
Maybe they were in Shepherd Center and Shepherd Center does send us referrals, but they discharge from Shepherd and they come back to Florida and now they're

self referring.
Yeah, but I mean for the patients who are injured in Florida, I wish that their acute care hospital had just OK. So in made a referral so.
So.
Yeah, you might really, if you wanna be really precise, you could look into the data of like, OK, for people who are injured in Florida.
How many of them are being?
Being referred by their trauma center versus versus going down the road. Yeah. And I you know, one to discourage.
I'm trying to think several wider and I wanna make sure I'm capturing what it is.
That's why I bring up self referrals. Yeah. Yeah. OK.
Yeah. I think with the the point of the trauma facility tracking.
This is really, we've said it needs to.
It's part of the requirements, right?
They should be reporting yes, so it would be feedback to them.
And the the state trauma.
Council that, you know. Look, we're this is not being successful or this is what your percentage is. It really needs to improve and and perhaps even some of that collateral and that facility partnership information gets filtered out through the trauma.
You know, we partner with the trauma counsel, which you already do.
And they are able to communicate some of these specifics and requirements and the impact that it's having on the patients down the line.
OK.
I'm sorry. What was the the first one?
I had a thought on that.
The the VOC rehab.
In fact, we had that some you have something with vocal rehab that transitioned, so it would be, yeah, it might be in the on the closure report it it wasn't so even even if we don't make it a AAPI quote UN quote, you know, it might be good to.
To categorize that appropriately. Yeah, I see an eligible for VR under program ineligible. Oh.
Oh, maybe I missed.
Yeah. So I I always have an issue with that in our program as as a closure status, right as program ineligible.

But in statute it it will tell you that the client is program ineligible if they are referred to VR.
So when we close the case, we have to mark them as program ineligible in the substatuses referred to VR.
But should they have benefited up to that?
Well, they were in the program up to that, up to the point that we referred them to VR.
So they're only 12, they just transition to the next level. That's correct.
OK.
They're not ineligible for the program, but, and This is why I don't like that status. Yeah, they were enrolled in the program. They got services from us, but now we're closing them as programming eligible because we're referring them to VR. But there are only 12 over this time period.
That one.
Just remembers stands well with me.
I'm sorry. There are only 12 during this time period.
I'm gonna say yes. If that's OK. Yeah.
That's not very many in a year, no.
Yeah. So some people, they we can offer VR services to them, but we can't make them take them.
So.
But there's different ways to offer and I maybe I'm a salesman after all, but like. Sometimes it's like, well, now the time we're gonna refer you VR, of course it's their option.
It's it's, it's their program to have back and forth conversation with VR. But you know, there's a way to be like, alright, now we're, you know, we're we're we're trying to wind things down now. We're gonna refer you VR.
So the issue that we've had in the past with referring clients to VR is.
We would close their case and we would refer them to VR.
It takes VR 90 days to do their enrollment process.
So then what Beeskip changed was we started a transition period.
So we start.
Earlier, with the clients that are wanting to go to VR, we we try to fill that gap because once we close them and VR has their case, that client may not answer that case manager. They may not follow up with their appointments, they may not

provide whatever doc.
So we've tried to close the gap on that to make it more successful from the time that we refer them to, we close them to their now enrolled with VR.
So is the resistance to that. Maybe just? Is it fear of change?
Is it I?
I don't if the managers have any idea like what feedback they're getting from those patients who don't want to go onto VR or who don't end up participating in VR, even if they become eligible.
Because really, I mean, that's the whole one of the the main goals.

Dubrocq, Jose A 1:20:48
Yeah.

Casavant, Robert 1:20:50
You know, especially brain injury patients just are not going to be not not not going to be really candidates for VR.
Yeah. So I guess this is partly with my spinal cord injury had on but, but yeah, 12's still in context of that. And so in context that probably half these clients are are over 65.
You know, still very low number.
Yeah, go ahead, Jose.

Dubrocq, Jose A 1:21:12
All the resistance that they have is that they think if they go to VR, they're gonna lose their benefits and.
In what Doctor Higgins is talking about being a salesman to that VR because we keep a very good contact with VR here in this region. They have sent me a a video which actually introduces a program.
So what we try to do is when we talk to the family members, we send them that video so they could see it and they could know what VR is all about.
But the resistance mainly comes from the part that they think that they're gonna lose the benefits that they got to VR, and that's that's not true.
They in some cases that they they might, they might be able to work and still you know.

Casavant, Robert 1:21:50
Well.

Dubrocq, Jose A 1:21:56
And still keep the benefits.
There is that work program. Yeah, that they have. And that's explained to them by VR.

Casavant, Robert 1:22:00
Yeah.

Dubrocq, Jose A 1:22:05
They have counselors who specialize that they do that.

Casavant, Robert 1:22:09
Kevin.

Kevin Mullin 1:22:11
Just Speaking of someone that's been through this program myself years ago, the first thing is when you get hurt in the hospital, a lot of people say, OK, you got to apply for Medicare.
And of course, it's usually about a two week two year process to get on the Medicare benefits.
But you find out that you have a state funded program like the brain and spinal Cord Injury program that's going to assist and you find out it's going to help with home modifications or anything else that possible insurance doesn't cover.
And it's value added when you hear the words VR.
Or vocational rehabilitation.
Understand that it's a work related environment, just like that gentleman just stated.
What scares everybody is OK.
I'm gonna lose my Medicare benefits that I'm applying for currently.
I'm going to lose all these other aspects that I'm just applying for and getting on to.
It's basically learning that you're getting onto a system that's gonna help with monthly funding, and then the first thing is and it's just. I'll education, in my opinion,

that they don't.
Understand that.
Yes, you can still work part time and able to gain an income and still hold on to benefits.
So I think it's a little bit of a salesmanship, but it's more about education that we need to provide to these individuals when they sustain a catastrophic injury or disorder because being through myself and having to work with hundreds and hundreds of clients in the state of NE.
Disabilities and disorders.
The same thing first comes up.
Oh, I don't wanna even look at VR.
Why? Oh, I don't wanna lose my benefits.
So I think that's one of the things that needs to be addressed when there's discussions about VR and where you can still hold onto the benefits and there's ways and and different aspects and programs that are available. And I think that's what really needs to be taken into.
Consideration.

Casavant, Robert 1:23:52
Thanks for that, Kevin. Absolutely.
I think we were supposed to have a break about 14 minutes ago.
I was just gonna say time for break.
Great discussion and we'll come back.
And that clock is an hour off. Oh yeah.
So it's 10/10/26, so we'll just call it 10:45, if that's OK, sure.
And finish up talking about the goals and kind of follow up with more discussion and break in.
Breaking down our target outcomes.
OK.
Thank you.

Valbuena Valecillos, Adriana D 1:24:30
Thank you.

Casavant, Robert 1:43:46

You want to welcome everybody back.
All right.
Welcome everybody.
Back to the last part of our quality meeting this morning and our goal for this, this part of the meeting is really to discuss and determine our actions for our target outcomes.
We had lots of great discussion on what potential goals we want and even started kind of some of the the problem solving.
And what we might want to do, but I think we need to 1st determine specifically which goals we want to do.
You know, probably three goals is reasonable amount.
I think that's what we kind of targeted in the past.
So the first thing that we spoke about specifically was.
Sorry, I'm back here.
You changed my computer, so it wasn't. You weren't having my head to you.
Was specifically on the average service duration.
And we talked about that being one of our goals is kind of seeing if we can reduce.
Track and trend quarterly the average service.
Days, excluding the home modification piece.
And so I just wanna go ahead and ask the group if that's the goal. We wanna go ahead and decide on and then we can discuss how we wanna word the goals specifically.
We need both.

Valbuena Valecillos, Adriana D 1:45:28
I agree with that goal.

Casavant, Robert 1:45:32
OK.
Thank you, Doctor Balboa.
Now anybody else have any other opposition or?
Thoughts on that specific goal?
I'm the one who brought it up, and now I'm like, maybe we want to focus on the other ones.
I don't know.

But yeah, I I can be convinced either way.
Goals were that we talked about.
Yeah, we can talk about the other list them all out. OK first.
Just. Mm-hmm.
Yep, that's fine.
So we talked about the tracking, the average service duration, that's one.
The second one was specific around the client cases closed without service.
Not responding to contacts by staff or providers.
And we talked about that kind of having a couple of components to it.
That was specific to and you wrote them down.
Good morning.
I probably didn't let me look.
Yeah, so the attempts.
Oh no.
Failure to cooperate.
Find services, case managers visits prior to discharge, education to facilities for client contact, adding injury types to that report.
Yes. And I think we wanted to delineate. We wanted to add 2 categories so that we could track and separate them out.
The case note type yes.
So the case, well, we talked about that under client case closure report and that had that report was regarding the Kempson success.
And so the question was how often do case managers meet with clients in the home's ability?
And we wanna add a new case note type, maybe in person interview contact.
We'll have to come up with what that should be to better track.
Some of the closures cases where client where cases where case managers have actually gone in done site visits.
OK.
So that was the kind of 2nd.
3rd.
Goal combination and then the next were the two that Doctor Higgin discussed and that was specific.
How many transition the tracking officially of the transition to BER, which we already know is a very low number?

And if there's the potential to improve that and then the second one was specific.
To.
Umm.
If you care referral rates.
The ratio between the ratio between acute care referrals and other types of referrals.
Yep. So that's really in essence the five, I guess really specific things that we were looking at.
Port or 'cause?
The other one was two-part gotcha, yeah, yeah.
All right, so.
Part of the reason I'm less interested in the service ration is just, honestly, that that number is pretty reasonable.
You know the average of of to pull up that excel sheet, but I think it's like 12 or 14 was the average ratio and and that's that's actually including the the 28 days for the for the average for the home mods which would balance that even lower.
So so it's part of my interest in, in, in kind of getting rid of that.
It's just, you know, it's it's prerecalable and sometimes.
That matter?
That number matters a lot when it's, you know, it's the last day of the rehab and maybe it's rehab hospital's fault that it didn't get dinged.
But sometimes that speed matters, and sometimes that speed doesn't matter 'cause they're in the hospital anyways.
So this is kind of two reasons why I'm less interested in the in that number one, because it's good. And two, it's kind of variable.
How much it matters to the actual client and artificially lowing that doesn't help.
You know, the majority of patients you know if.
They're if they're not discharging in two weeks.
It doesn't really matter what week, they're what week they're, you know, they're their Peach equipment shows up as long as it's there when they get home.
So that's that's my devil's advocacy against my own.
My, my, my own metric. I guess my my other question is.
When is the equipment getting delivered? Like the days is low, but as the patient, the client already at home. I mean obviously a lot of times for wheelchairs they are because they're getting a loner chair and they're going home.
But what about the other equipment?

Valbuena Valecillos, Adriana D 1:50:18
Yeah, that's exactly my my point too.

Casavant, Robert 1:50:19
Mm-hmm.
Yeah.

Valbuena Valecillos, Adriana D 1:50:21
It's just depending of. Yeah, it may show like two days, 3 days participation already at home or, you know, struggling at home with the need of the equipment.
But I think also tight with the if we had the case manager meeting the patient in person, we may be addressing to other goals. One is to.
Trying to avoid the the clients not getting.
In the service because of not knowing exactly what it can be offered to them, and at that same time maybe getting that information of what we anticipated, the patient is gonna need.
You know, if we have this one to one service, you know evaluation in person, I think that that could be you know definitely that's an area that should be encouraged like case manager having at least one to one face to face meeting.

Casavant, Robert 1:51:17
Mm-hmm.

Valbuena Valecillos, Adriana D 1:51:19
To to not only educate the client, other benefits of the service, but also maybe communicating with other disciplines database and and trying to anticipate needs on this patient discharge the tenant discharge.

Casavant, Robert 1:51:31
Yeah.
And I think the face to face is two different two different things the face to face when they're in the facility is different than the face to face once they're already home and have to go look at the home.
And so I have a question about face to face.

So some of our case managers are not necessarily able to travel.
So would an acceptable platform.
Be teams.
Based FaceTime on phone on your phone. What would you consider an acceptable face to face platform if they're not able to actually do a physical visit to the home?

Valbuena Valecillos, Adriana D 1:52:18
I think the susceptible, I mean those are resources we we have able to to contact.

Casavant, Robert 1:52:21
With the whole, I would say that's.

Valbuena Valecillos, Adriana D 1:52:24
I think it's that will open.
You know the the possibility of this. Now, once you establish that contact face to face, either saying face to face through soon or through teens or through FaceTime, it's very likely now families will be more.
Agreable to either take your calls or you know, getting information.
Once you establish that one to one, you have chaired the information they they will be answering your calls.
Very. I mean I will.
I will be surprised if those numbers doesn't get improved.
With a face to face first assessment.

Casavant, Robert 1:53:00
Yeah.
And I think a virtual home visit is totally fine. I think the hospital or the facility that the client is in a virtual visit can be fine, but.
How is that going to get facilitated directly?
Like you still have another question on this one.
So I'm just an average caseload for a case manager. I'm gonna say is 40 people that's applicable.
Can't and in service?
So if an average caseload is 40 people, what is your expectation for?
Actual face to face visits for that 40 people.

Is it 100% that you want for every client?
Is that you want them to do?
50% face to face. What is your expectation?
Well, I don't think we have a baseline to know specifically even where we're at, for how many get to meet. But to start with what?
What would you want to as your starting point so that you can grow from that base?
What do you want as a starting point? Excuse me?

Carrie Rayburn 1:54:13
I think that if we're doing it like opening it up to virtual, you know, to having even a FaceTime call, it might be like good to set that pretty high with at least one one time you're meeting with them. And what we're calling face to face.

Casavant, Robert 1:54:29
Yeah.

Carrie Rayburn 1:54:29
Right. Or were you meeting?
Were you meeting weekly, Kim?

Casavant, Robert 1:54:33
OK.
OK.

Valbuena Valecillos, Adriana D 1:54:38
At 100% of the 40 clients or or with setting at 80 and looking.

Casavant, Robert 1:54:45
What? OK.

Valbuena Valecillos, Adriana D 1:54:45
Because I don't think we have a number right now.

Casavant, Robert 1:54:48
No, but let me ask in a week, for example, how many new referrals do you get?

Does that one case worker get?
It depends on.
Depends on the region, so I would have to go out and ask Jose and Roslyn on an average how many new referrals do your case managers get.
And now there's a variance between region 3 and region 5 as well.
You know, as far as sure the amount of referrals.
So just so to the managers as an average, what do you?
What would you say is the average amount of referrals, new referrals that your case managers are receiving in a week?
We can't hear, you can say I know you're.
I know you're unmuted OK. Now we can.

DA **Dubrocq, Jose A** 1:55:45
Yeah. Yeah, I will say we we've been getting a lot.
Per case managers, do you want to know or just overall in a week?

Casavant, Robert 1:55:58
Just that the average amount a case manager will get in a in a week, a case manager.

DA **Dubrocq, Jose A** 1:56:02
Uh.
I will say at least four or five each. We'll be getting a lot of referrals lately especially.
This last couple month.
Well, I'll say at least four or five each case manager.

CR **Carrie Rayburn** 1:56:22
Are all of those?

Casavant, Robert 1:56:22
But I really like.

CR **Carrie Rayburn** 1:56:24
Are all of those like eligible people though?
So if you get four or five a week, what if only half of them are eligible?
Then we would only require a meeting face to face with those that are eligible.

Dubrocq, Jose A 1:56:35
I would say half of them will be eligible, not all of.

Carrie Rayburn 1:56:37
OK.

Casavant, Robert 1:56:40
And another thing that I've experienced as far as that is, you know, if I get a patient from Orlando or something that you know, they're gonna have regional manager from that that station in that metro region and they're not gonna be traveling to, I don't expect them to.
Travel to Jacksonville to see them.
My hope would be that they would be seeing Orlando before they come to Jacksonville, but.
But I I think Jose or brought the example of, you know, one of the case managers visiting the the the trauma hospital once a week and and seeing the seeing those patients.
I think you know, with that practice, you know that that doesn't wanna apply to all clients and all regions.
Some regions are larger and more spread out but but I think with that practice with with because going to patient's home, that's gonna take a lot of, you know, gas, money time etcetera etcetera to go. But if they have the practice of of going to the hosp.
On a regular basis.
Or, you know, if they don't catch them in the in the trauma hospital, catch them in the rehab hospital.
And having a face to face visit that way.
I think that way you'd probably capture, you know, 80 plus percent of the patients.
But with the exception of, you know, the if if they're out, if they're physically located out of the region, if there can be a method to work between regions and say, hey, you know, this is going to be my, my client going forward, but you're going to be.
In the hospital anyways, you're going to be stopped by Brooks.
Let me see all the.
All the clients or prospective clients who are Brooks and have you just stop by and

introduce yourself and give you my teammates, teammates, contact information.
And a relationship that way.
So one of the challenges that we will have with actual face to face visits and that's why I'm asking about different platforms to be able to facilitate those is budget for travel.
Yeah, because, yeah, I, you know so much spread out.
Yeah, I have to spread out my travel budget in each case manager is given a budget every year, and so we have to be cognitive of that.
When word.
Setting this goal? Yeah, specifically, yeah.
Yeah. So we wanna set this reasonable and it's hard to set a reasonable without no kind of the the range of options, but yeah, but you have a starting point. So if we had a starting point and then from there we can see if you maybe.
It's it's successful and we can keep moving.
Or maybe it needs to be tweaked a little bit by the next meeting.
Or whatever.
Yeah, that's why I'm asking these specific questions.
Well, I get it.
Yeah, but with like the weekly, you know visit to the trauma and rehab hospital be be outside of that budget.
Yeah. OK.
So they get, they get vicinity mileage when they go to site visit or to facility visits.
Yeah. Any visit really, they get, they get reimbursed mileage.
Mm-hmm. So I guess the question is, there's a couple that are pretty spread out like up in the Panhandle. They've got, they cover a large area.
So what is the frequency that they go to the facility?
Is not on and I can't ask her about clay.
That would be clay, but.
What I did, I just had, you know, with example of, you know, someone's outside the region when they're getting rehab or even in trauma is, you know, when you have that when you have that visit be like, hey, let me FaceTime or or or let me do.
A team's meeting with with your actual case manager while working in the room and and and do a quick quick communication and that could be a matter of just just 5 minutes.
Here's my information.

I'm gonna be calling you in a week.
G give me G giving you update and just establish that relationship, sure.
I mean I I think the face to face in whatever form it is, is critical to their being success. Ful.
My my team huddles are every day at about 10:00.
They'll be awesome if, if if Bscap case manager could stop in and and and run the list OK.
But I I mean, all of those hospitals have have weekly team conferences, so yeah.
Even dropping in for team conference time for some.
Just a few minutes face to face with the with the Dream team. So.
That brings up a really good point.
So it's some of these facilities.
And again, I'd have to go back to the managers. I know some of our case managers have really good rapport with the social workers and case managers and so forth. But in some of these facilities where it's constantly changing and I'll use Brooks as an example, how would?
They get.
Access to attend your team huddle.
So it'd be around that time, but you know, talk to the case manager.
Yeah.
But to the point that sometimes the case managers turn over, I think the program directors or the administrator of the the program, however they're classified.
Are important to relaying the information and the the therapy leader.
OK.
And that's 10:00 AM every day, right?
So the weekly team conferences is is a certain day of the week, so probably it's Wednesdays, but you usually gonna be well now the regulation changed. So now we have to do it multiple times a week, but.
But usually that there's gonna be a set time every week for any hospital that they're gonna do their team conferences.
And yeah, and there's different variations, but you sometimes it's in the patient room, sometimes it's outside the patient room.
But.
Then, of course, we're talking about other patients at the same time.
So be like, OK.

You're in the room, so we're gonna talk about your client 1st and then and then you can leave the room and we can talk about the rest of the clients, OK?
And you said for the other facilities, the best contact is to reach out to the so whoever the the program director is.
And that's for trauma. The program directors for trauma. Those are in the like, inpatient rehab facilities, OK.
Specifically, the trauma facilities, the trauma coordinator to me, is the person that I would specifically connect with because they're the ones who are supposed to be tracking the metrics, making sure facilitating.
You know they've they've got the relationship with EMS.
They've got the the communication with the whole team on on what needs to be done so.
So, Amanda, that might be like another type of case note type that we would add not just not just the one I mentioned previously, but maybe a contact for face to face facility.
We'll have to talk about those.
Case notes that we could track, yeah.

Carrie Rayburn 2:03:26
I think it might be fair to like when you talk with the like, if you're talking to the leadership of facilities like expressing to them that like bskip needs someone that is designated to be the one that reports to them and communicates with them. And so that way.

Casavant, Robert 2:03:26
Yes.

Carrie Rayburn 2:03:42
Could pick someone within their facility, and so if that person is leaving, they know that they need to hand that that duty off.
And that might be a way that you could have that connection.

Casavant, Robert 2:03:55
Yeah. I mean, I think as you know, enhancing the facility partnership overall is is critical and the things that we talked about you know getting putting together some

collateral about that, the key contact, making sure that the contact numbers and correct for the patient or the client and.
That there's a couple of contact numbers so that.
You know, just the client doesn't get lost after they leave.
Additionally.
Where the client is transferring out to. That's another piece of information that would be helpful.
This wouldn't be a quality metric for you guys, but I would love to see the ratio of like a like Earth versus LTAC versus snip discharges for for this patient population.
I'm not sure if we're currently tracking that.
Amanda.
Do we track like if these referrals like end up going to LTAC or sniff?
Does B Skip track that?
Well, that would be in the closure.
So if if they were being discharged to a sniff, that would be institutionalized, I mean, they may get a sniff and then they may go home 3334 weeks later. We might not know that they've gone home unless they call us back the black hole of.
Sniffs. Yeah, and L tags.
So to that point, though, if they're being institutionalized, that's long term care.
Not. Yeah, exactly.
Not the short term. Yeah, because be that that could be sub acute rehab. Yeah.
Correct. OK.

Carrie Rayburn 2:05:31
Is that like a statue that that is determined that way?
Like if they go to skilled nursing that is automatically like it's in the pilot's or whatever.

Casavant, Robert 2:05:39
If they go to long term, if they go to long term side that that that that won't be program eligible that's correct.
The the long term care side Carey case.
You didn't hear that?

Carrie Rayburn 2:05:49
OK, OK.

Casavant, Robert 2:05:49
Mm-hmm. Yeah, not the not the short term rehab side, correct.

Carrie Rayburn 2:05:51
Thank you.
OK.

Casavant, Robert 2:05:54
Yeah, sometimes they just if they're in long term care or they're in a sniff and they're gonna be discharged home. Mm-hmm. They can contact the program and ask their case to be reopened.
Yeah, to see if there's any services that be skip could help provide.
Yeah, when they get home. But you know, for the have the wherewithal, uh to initiate that if we can be honest and we we're having trouble with acute care hospitals and Earth's. I can't imagine trying to chase down every sniff to sort of trauma patient on that.
Just not going to happen.
So even more important that they get enrolled in tracked in acute care hospital.
I think we have about 20 minutes left, so I did want to try to bring it back to exactly now and down these metrics.
'Cause, I think we've got a lot of lot of useful kind of content for for for bscape to work on. But so we have 4 metrics, the service duration for these items the decline services.
Services about average of like 14 and 12 to 14 right now declines herses and that's like the 390 patients that that decline services the vocation we have. That's the one where there's only 12 or the last months and acute care referral rate which I don't think we.
Have a metric now.
But of those four, I guess it's easier to talk about the the one that we're not gonna follow. Mm-hmm.
I wanna hear other.

I mean, of course, other people that offer their opinions on on, on this, since I've spoken enough.

Carrie Rayburn 2:07:26
The first one that we discussed, like the days that services or equipment is rendered, cannot just be like an ongoing thing that we track and then we can review it. If it, you know, right now it looks good. If it doesn't in the future, then we can ***.
It in a different way, but I think just making sure that it's something that's being reported to the Council would be great.

Casavant, Robert 2:07:45
So do you want that like in the Excel report that Raj did and track it monthly or quarterly? Maybe just an annual report you can?
I was gonna say quarterly simply just because.
We could review it at our two different meetings quarter over quarter.
It just be curious to see if there's a particular time of year that there's more issue or. You know, you get a few more data points and then it might be able to go year to year after that. OK, that's my opinion.
Anybody else on the phone?

Carrie Rayburn 2:08:21
I agree.
Quarterly would be better.

Valbuena Valecillos, Adriana D 2:08:25
I agree quarterly.

Casavant, Robert 2:08:27
But that's the one where they were putting less focus on.
Yeah. Yeah, you're excluding home mods.
Yes, but that whole category of service ration.
I'm pretty satisfied that number, so I don't think I think the other thing the other three, I'm less satisfied with. So I'm so I wanna bring the microscope on those more, OK.
OK.

So it sounds like we're in agreement to proceed with the other three.
For quality goals for the next year.
Yeah, I think it's still worth like nailing down the exact definition of some of these metrics so that we can give.
Bscript kind of.
More ways to define it.
So like how?
How exactly are we gonna find the acute care referral rate?
How how exactly are we gonna find the VOC rehab? As far as like the age cut off and things like that.
So. So let's have conversation about each of those over the next 19 minutes.
Yeah, I think we already identified the things that we want to break down further to understand for the client cases closed what relative to failure to cooperate, not able locate so.
We we can keep those, add those to defining areas for tracking and then go from there.
As far as the VOC rehab wanna start with that one?
Yeah, I'm curious what data we already have. 'cause. I don't wanna add too much data bird into this. It's just more tracking.
But do do we have data on whether or not they're currently employed at the time of the injury?
Hmm.
Maybe I'd have to now.
I don't.
I don't think we have if they're currently employed, we have, if it was what type of injury it was, which would tell us if it was workman's comp or something like that. But I don't believe that we track employment at all.
So we can't use that unless we start collecting that we can't really use that.
Now keep in mind on some of your.
Metrics that you want to put on these goals.
If rims doesn't already do it, then.
Amanda's team is gonna have to.
Develop. Yeah, exactly.
So we're trying to avoid that whole process.
Yeah, but I mean, but if we said it just simply as age, then we have to have that copy

on our mind saying, OK, not every.
Not every six year old is gonna still be, you know, working.
There's gonna be some people who retired, some people that are previously disabled, things like that.
So we're not gonna expect 100%.
Answer or so it judges all of the so we can we can track their injury type, we can track their age. Mm-hmm.
Those are the demographic changes, yeah.
Yeah.
Yeah, for sure, that's.
The central the referral form. No. Yeah. So we have.
We have the data that's on the referral form that comes in. Yeah, yeah.
Yeah, and it's more work on everyone, right from top to bottom.
So. So what other my top rows are?
Just use age.
You know, 62 is the youngest that people can apply for for age-related Social Security.
So we could set new, you know, 61 and below or 16 below.
'Cause, if you get injured when you're 60, then by the time you get done with your rehab, you're probably not gonna wanna go back to work. If you're six years old.
So maybe six years, 60 years old and and younger.
For our percentage.
OK.
What other people think about that?
Yeah, 1618.
Well, I mean, teenagers, teenagers who are injured, I would expect to be referred to VOC rehab, their school services, but even bother in high school, they can still be referred to go rehab.
So I'd say like 14 to 14 to 60, I don't think a 10 year old should be referred to VOC rehab by their high school age.
So like 14 to to 60.
Those would all be reasonable ages.
Uh to to refer client you want 14 to 60 is the age range. Mm-hmm. 14. OK.
I had 18 and then subdivided by brain injury and spinal cord injury.
Mm-hmm. And then we'll have the Rancho data as well.

So if they start as a do do we collect are are we able to collect the Rancho as it improves or do we just get initial?
We just get an when when the intake.
Yeah, we intake the initial and you know if they're if the Rancho.
Six when they get enrolled, it's gonna mean something different than if they're rancher, you know.
Three, forget what the the lowest cut off is, but obviously that improves over time.
But for the program it's 404.
Yeah, that's right.
Yeah, they're not yet. It's too severe. Yeah.
But you know, we can track by brain injury and then track by by their enrollment Rancho, which is not necessarily gonna be their initial Rancho, but but they're, but we can track by that and then spinal cord injury, whatever metrics we have for spinal cord injury we can.
Track that by that as well.
I don't think we're even collecting like pair versus quadrup.
Yes, the age range would be whether or not they'd be included in the metric, and then of those people then break it down by their enrollment. Rancho.
Yeah.
So for the spinal cords.
For the data you gather, is it?
Does it include level of spinal cord injury on the referral form? Yeah, yeah. So.
No brain is the Rancho level.
So that's, yeah, that's OK.
So we want it divided.
Out by brain and spinal cord, and then brain will be Rancho level.
Spinal cord will be level of injury.
Just whatever current metrics we have, yeah. OK.
I think that's all very doable.
Anybody on the line have anything else specific?
That they want to understand as we start looking at the VR referral, do we have any other demographics, education, marital status?
Do we have that in our mail?
E-mail. I mean, the number's so low.
12 yeah, 12 during this period.

So like breakdowns can really be that useful, but we get more.
But having those, if we're able to run statics on it, you know, then if it's all mailed, if it's twelve mails and no females, it's like OK.
But I don't think that's the gonna be the case.
I don't think we're operating like that, but yeah.
So you want me to add gender?
Did you want me to add education?
Do do we have that?
We have that as.
An indicator of but we may or may not have what their level of education is.
So you may get a lot of unknown.
Yeah, yeah, but just it'd be interesting to dive on this. OK. OK.
Maybe only 20 year olds, 20 year olds years old are are sign up for it and like OK, maybe we should think about 30 and four years old.
But yeah.
And I don't know.
I'm not sure if this is possible.
I would have to ask Raj, but would would you want to know from the the time that we referred them to VR versus?
Closure. We don't necessarily know when they're accepted to VR. Once we close the case, but we might be able to give you a timeline from the time we started the referral to VR to the time of closure.
I don't know. Did you?
Did you really want that?

Carrie Rayburn 2:16:53
It would be in.

Casavant, Robert 2:16:54
I can't tell you.

Carrie Rayburn 2:16:55
Yeah, it would be interesting to see like what?
I don't know if you can do this or if you already know when they refer to VOC rehab versus when they're contacted by VOC rehab.

I know just in my local place like I've referred people and they've never heard from VOC rehab. And so I would hate for you guys to refer them and then check them off of your list. And they never.

Casavant, Robert 2:17:14
Yeah.

Carrie Rayburn 2:17:19
They're just kind of left out in the wind at that point.

Casavant, Robert 2:17:22
Well, that's why we tried to close the gap.

Carrie Rayburn 2:17:26
Mm-hmm.

Casavant, Robert 2:17:26
So yeah, so we start that initial referral a little bit earlier. So that by the time they're ready to discharge from the skip, hopefully they're already through or close to the end of the process for VR.
Yeah, yeah, that would be good to track.

Carrie Rayburn 2:17:41
OK.

Casavant, Robert 2:17:54
I think once we have that data then we'll be able to kind of set the target.
Yeah, we can look at it.
And then if it's not what you wanted, yeah, I think the meeting or two before like the JB pass program, I'm going back to that like really kind going back to Don's comments, but really kind of using that as a carrot.
Like hey, yes, we can get you in VR and we can get on the JP Pass and your family members can can can get commentated for can you open the morning getting your work that.
Yeah.

Moving on to acute care referral rate, Yep.
How would you categorize or how are we currently categorizing where is it just self, referral, institution, referral? Or is it?
Are we currently categorizing by acute or they have facility names in them in the list, right?
Yeah, but yeah, so on the referral report, it actually lists the facility that the referral came from when the referral comes in, it's identified as either a beatscript referral, a facility referral or a self referral.
Mm-hmm. Yeah. Those are just the three cap. And then the rest breakdown.
Yeah, the report that I run for you guys for report actually breaks it down to each facility per county per injury. If a facility has an in in in hospital rehab unit.
Does that is it subdivided like that?
Like if that if that rehab facility sends us the referral, then it's identified by that.
Specific rehab if it's just coming from a trauma hospital, even though they're in their rehab and it comes over as the facility is the trauma hospital, that's how it's identified.
It's not identified that it came from the referral or from the rehab section. OK yeah, 'cause.
Sometimes it's just like, well, our our third floor is our rehab unit.
And and our 4th floor is our trauma floor.
But you guys can pull that out from the current day that we have if they come from the the rehab floor versus the the trauma floor.
Not necessarily, no.
Yeah, but we can give him credit. I mean, yeah, we can count that under even if there are on on the on the rehab floor of the hospital. If they've transitioned that, we'll still, we'll still include that as a as a positive outcome for this number, I'd rather.
It happen when they're on the on the acute care side, but sure.
I bet you to say some of them are separates on the list already because they might have be termed a rehabilitation center versus the Mm-hmm.
Straight hospital facility and they have different Medicare numbers and things like that so.
All right, so I have referring facility.
I don't know if it's going to be acute or non acute and injury type.
Mm-hmm. OK.
And we want that.

Kind of. The ratio within within the state and within the region, umm, between between rehab facilities and and.
And thank you, Kerr.
Do we currently know what that number is?
I I have this injured point in front of me, but I have to go by hand and and categorize these as rehab versus not.
Ah.
We're excluding self referrals, correct?
Well, I think self referrals as far as I understand where we're going with the ratio because obviously we want to get it the information to them. But the self referrals might tell us where the fallout of the gap was and why.
Why are they self referring versus?
So a lot of our self referrals that we get are people who have heard about the program long after their injury is over or they've relocated to Florida.
And they've heard about us.
So their injuries, they could be 20 years old, you know.
The oldest injury we had was 30 years old that.
Yeah. So if my mom relocated to Florida, she could be become be skip eligible. Not I don't she, she she. She's gonna snowbird here not. She's not gonna move down here but but but for example. Yeah.
So so I think it makes sense like you were suggesting to just exclude those since it's not really getting at what we're, what we're what we're targeting.
Umm.
Anybody on the line have anything specific?
Are we able to see where they were injured if they're injured in Florida or outside Florida, do we have that OK, so it excludes anyone that was out injured outside of Florida from this metric as well?
Yeah, but we're not counting on so. So they get injured when they're traveling up to Atlanta, and then they, oh, yeah, let's go to Brooks instead of Shepherd.
They they they're not gonna hold it. Hold it against bskip that they weren't referred by Emory.
Trauma hospital or or Grady or whatever. So so so that if they're injured up in Georgia and then came down to came down and then we made the referral, I wouldn't want that counting.
Counting against the acute against this metric.

Does that make sense?
Yeah, but I I'm still curious to know how many.
Of those are happening, how many are having entries outside and then either getting referred by the they're coming back for their rehabilitation, or it's after the fact when they come back to the state and still be interested in knowing, knowing that it may not be something that we.
Work from from the goal standpoint, yeah. I mean, you'd be curious to know, but I don't think we should include the metrics.
So I I had a patient who's injured up in Maine, but he lives in Florida and he came.
We we kind of repatriated him back to.
Back to Florida.
But for the metric itself, as far as what we wanna track, what we're how, how well we're kinda collaborating with acute care hospitals. I don't think that's that's gonna be a target.
So we're excluding clients that were injured outside of Florida, but they may they might reside in Florida.
They're a Florida resident, of course, but they were not.
They were not injured in Florida, OK?
So screw those from the from this ratio of acute versus.
Referrals. But if you wanna know how many there are, we could tell you that.
Yeah, I'd still like to know sidebar.
Yeah, simply because you know, there's there's a good portion.
Then and upcoming, you know back whether it's for the rehab or they've had their rehab, they go to shepherd and then they come back and you know, there's there's a gap that.
OK, I'm putting it as a sidebar.
Yeah, yeah, that's perfect.
I mean, you know, it's down the road, but it might be something that we're.
But we wouldn't exclude those that were injured in Florida went out of state correct to shepherd, right or UAB, right?
And then came so. So wouldn't exclude those from the metric, right?
President points the trauma facility that they were initially.
So some of those clients could be self referrals.
Right. That's why I was saying I don't necessarily.
Yeah, but it's gonna be hard to really track those down and defeat those up data

wise.
So I'm not.
But I want I I want the acute care hospitals to get credit for referring them.
Yeah, we can run that one as a side or just just to look at, but it won't be included in your acute care referral, OK.

Carrie Rayburn 2:26:18
1.
When someone saw when someone saw.

Casavant, Robert 2:26:23
Go ahead, Kerry.
Oh, you're, you're back on mute, Kerry.

Carrie Rayburn 2:26:31
Thank you. When?
When someone self referrals, do you ask them how they learned about the BASK program?

Casavant, Robert 2:26:44
They might be asking, but not from a data perspective.
A lot of our self referrals we're getting through the portal.
Is where we're getting a lot of the self referrals.

Carrie Rayburn 2:26:52
And the portal doesn't prompt that question.
Like, how did you hear about our services?

Casavant, Robert 2:26:56
So in order for them to enter their their self referral through the portal, they have to have gone to the Resource Center.

Carrie Rayburn 2:27:05
OK.

Casavant, Robert 2:27:05
The Resource Center drives them and so when they go to the Resource Center and they click on the Central registry portal.
A self you have a self referral or a facility referral. If you pick self referral you have to go through a series of qualifying questions pre qualifying questions and if you answer you know yes you you know you meet all of these pre qualifying questions and it gives.

Carrie Rayburn 2:27:24
Yeah.

Casavant, Robert 2:27:31
Sends them to the actual referral form if they do not meet all of the requirements and then.
And they submit.
Then they get a notice at the end that tells them why they didn't qualify.
For services from the program and it drives them back to the referral source or to the referral center.
I'm sorry, the Resource Center.

Carrie Rayburn 2:27:51
OK.

Casavant, Robert 2:27:54
I guess the question is how they find the Resource Center to begin with, but.

Carrie Rayburn 2:27:54
It's.
Yeah. Is it?
Is it easy to add?

Casavant, Robert 2:27:58
I'm not sure.

Carrie Rayburn 2:28:00
Is it added?

Casavant, Robert 2:28:01
Yeah.

Carrie Rayburn 2:28:01
Is it easy to ask the question or add the question in the forms like simply to ask them where they learned about it?
How did they hear about it?

Casavant, Robert 2:28:11
We would have to modify it.
So I would have to go back to Amanda's team and see if we can modify.
The preliminary questions.
Yeah, for self referrals.
How did you hear about? Yeah.
Yeah, yeah, it's a it's a non required question.
Non qualifying is what I meant non qualifying question.
Good idea, Kerry.
Yep, and it's if if you know my rehab hospital told me to get on the website and.
Yeah.

Carrie Rayburn 2:28:48
Right. I think it might be another way that we can track like where.
Information is coming from.

Casavant, Robert 2:28:56
Mm-hmm.
So some of our self referrals carry just as a point of interest for you is coming from BIF.

Carrie Rayburn 2:29:06
Good. That's great to hear.

Casavant, Robert 2:29:07

Nice way to go BIF.
Yeah, that's awesome.
And the Resource Center is also listed.
Actually have it on my computer, so do a little bit.
So promotion.
But Brooks has a collaboration with the UF called Sharp, and it's a community group and we have a website endless bskip on that website as a as a resource for folks. So.
Nice. Thank you. Thank you.
Justin, all right, it is 1131, so.
Just wanted to ask if there's any additional comments relative to our goals and the data that we want to look at.
I'm excited that we've got it narrowed.
And we can solidify.
The Burbage, once we have the data and take a look at the data for our next meeting.
So I have two indicator reports for the next meeting I have VR and then I have acute care referrals and then the decline services. OK and that has a subcategory of the the in person visits. Yeah. OK.
So vogue rehab, acute care referral rate and the decline services.
OK.
So we have 3.
OK, OK.
All right.
I don't see any hands raised so.
With that, we can break for lunch.
Yes, yes, I will.
I was just gonna keep the timing and then we'll make a motion. 11:30 to 1:00. We'll return at one for the.
Meat and potatoes meeting.
That's what you referenced it earlier. Yeah. Afternoon session.
Yeah, the afternoon session.
Anyway, do I have a motion to adjourn?
Motion 2nd.

Carrie Rayburn 2:31:15
A second.

Valbuena Valecillos, Adriana D 2:31:15
2nd.

Casavant, Robert 2:31:17
Great, alright.
Thank you.
See you all at 1:00.

Valbuena Valecillos, Adriana D 2:31:20
See you guys.

Casavant, Robert 2:31:21
See you guys at 11.

Casavant, Robert stopped transcription