Virginia Brain Injury Services (BIS)
Program Design Group Workgroup – Meeting #5

Meeting Information	
Meeting Name & Topic	Focused Program Design Sub-Team: Working Meeting with DMAS
Date & Time	May 3, 2023, 2:00 pm EST
Dial-In Information	Click here to join the meeting

Goals & Attachments

Meeting Purpose/Objective: Review input on neurobehavioral unit setting options

Pre-meeting Preparation Required: Review questions in meeting slide deck

Attachments/Handouts: May 3 meeting presentation

Next Meeting: May 16 , 12:30-2:30

Meeting Participants *(attendees marked *)*

Collaboration Team

- Anne McDonnell, OT**
- Ben Pulfer, Neurorestorative*
- Bernice Marcopulos, JMU/UVA
- Cara Meixner, JMU/BI Council**
- Christine Evanko
- Colleen McKay, BCBA
- Dana Larson, Tree of Life Services /Collage Rehabilitation
- David DeBiasi, Brain Injury Assn of VA
- Demetrios Peratsakis, Western Tidewater CSB
- Ivan Velickovic, Neurorestorative VA*
- Jamie Swan, Anthem
- Jason Young, Resilience Health LLC*
- John Lindstrom, Richmond Behavioral Health
- Kara Beatty, Resilience Health LLC
- Kathleen Hardesty, Sentara Healthcare*
- Linsey Mangilit, Optima Health*
- Michelle Witt, ABA Practitioners*
- Monique Wilson, Neuropsychologist*
- Tammy Whitlock, Alliance of Brain Injury Service Providers
- Victoria (Tori) Harding, Neurorestorative VA
- Vik Khot*
- Michael Fotinos*
- Mohamed Ally*
- Lavinia Y Smith*

***Member of workgroup had scheduling conflict and sent written comments on meeting materials.*

State Agency

- Angie Vardell
- Ann Bevan (DMAS HNS)
- Brian Campbell (DMAS BI Program Dev Lead)*
- Christiane (Chris) Miller (Department of Aging and Rehabilitation Services)*
- Courtney Richter
- John Morgan
- Kshitijia (Kay) Karmarkar (DMAS Brain Injury Services Program Advisor)
- Rhonda Thissen
- Sara Benoit (DMAS PRD Rep)*

Rate Setting Consultants

- David Garbarino (Engagement Manager)
- Elizabeth Barabas (Stakeholder Lead)
- Grant Lindman (Project Manager)*
- Lisa McDowell (Program Design Co-Lead)*
- Linda Wegerson (Stakeholder Support)
- Marybeth McCaffrey (Program Design Co-Lead)*
- Poorna Suresh (Rate Setting Co-Lead)*
- Roya Lackey (Clinical SME)*
- Sharon Hicks (Stakeholder Manager)
- Sonja Lee-Austin (Analytics)*
- Tamyra Porter (Engagement Partner)

Slides	Topic	Recommendations
1-4	**Status update**	Information shared on the slides

5-11	**Neurobehavioral Unit Rate Development Assumptions**	***Services 1-3 (1. Neurological assessment, consultation; 2. Neurobehavioral/neurocognitive service plan; 3. Psychopharmacological assessment)***
		• Group agreed with the staff amount of time and frequency for assessments and service planning
		• **Psychopharmacological assessment quarterly too low; would recommend .5 monthly
		• Staffing Service 1 (Neurological assessment)
		  ○ Assessments could be done by either a Licensed Behavioral Psychologist or Licensed Neuropsychologist. Tough to hire a Neuropsychologist. Other professionals could be involved such as a neurologist
		  ○ Could a neurologist provide the assessments? Yes but brain injury experience is critical.
		  ○ ** there are additional options—neuropsychiatry, for instance
		• **Staffing Service 2 (Neurobehavioral service plan)
		  ○ List is okay but not every staff type on every team
		  ○ Nursing and CNS staff okay
		  ○ Additional direct care staff are included such as LST's in residential settings.
		  ○ **It may depend on whether this is a short- or long-term stay, or patient's specific needs
		• Staffing Service 3 (Psychopharmacological assessment)
		  ○ MD for initial and MD extender for follow-up
		  ○ ** Yes, MD initial, MD extenders for follow-up
		  ○ ** Wondering if have a neuropsychiatrist, or even a neuropsychologist w/ pharmacology background, is important (ask Bernice M and Kara Beatty) to consider
		
		Service 4 (4. Interdisciplinary intensive neurobehavioral/neurocognitive treatment)
		• Need for counseling therapy, cognitive services, BCBA, behavioral services essential, rather than traditional therapy
		• Need for 1 to 5 sessions per week of therapy by a behavior analyst
		• A member might need 40 hours a week of services that could be provided by a Registered Behavior Technician (RBT) or QMHP.
		• **For "expectation of reasonable improvement" would, need to be at least two 30 min session daily
		• Staffing -
		  ○ Services would be a mix of individual one-on-one to group based on the person.
		  ○ Might have a one-to-five ratio; BCBA with RBTs, recreational therapists with OTs.
		  ○ May have groups that simulate community integration.
		  ○ ** Should be part of the 2 hr treatment plan being established, so no additional time should be required.
		  ○ ** BCBA's might be used as an add on therapy or to substitute for PT as needed, for example to meet a minimum daily treatment requirement

Services 5-7 (Clinical Director, Therapy services, Community-based Activities)

- If the goal is to move to a lower level of care/community the approach needs to be more aggressive with higher amounts and frequency of delivery

Service 5 (Therapy services – Baseline (Usual NF level of service at max of 1.7 hours per day)

- Services will vary by person
- Therapy needs would be primarily for OT, then SLP as the next most common, with PT the least common need.
- For those whose goals include return to community, allow for therapies:
  - OT for ADL & IADL, SLP for cognition. It's an intense level of care not as intense as post-acute.
  - May need more than 1.7 hours a day but less than 3 hours 6 days/wk.
  - Duration is individualized.
- For those with longer term stays,
  - 1-5 sessions per week
  - Emphasis on OT followed by SLP with PT only if needed
- **At least 2 hrs. OT/SLP/PT
- **More than 1.7 hours of OT/SLP/PT is needed.
- Staffing
  - What is the role of a nurse?

Service 5a (Clinical Director)

- Staffing
  - ** Yes any of the disciplines listed are acceptable for clinical director
  - ** May also have a DNP or similar

Service 6 (Therapy Services – daily active or passive ROM)

- ** Passive range of motion is rarely used/needed for patients who do not have an acute injury or who are not in a minimally responsive state; The individuals that would be eligible do not need this service. Recommend removing.
- Staffing:
  - Best practice would be to have an individual receive about 6 hours a day at 5 to 7 days a week – plus or minus 2 hours based on the individual.
  - Getting staff on weekends is challenging. Might need to be paraprofessionals
  - ** CNA/LST's are always an important part of the team, so invest in and use them.
  - ** LPC/LCSW can be used as adjunct if the patient can benefit from the counseling. But many patients at this level lack the cognitive ability to engage in a psychotherapeutic relationship.
  - **May depend on severity of brain injury and how it manifests, especially as we consider therapy/counseling.

Service 7 (Community-based Activities)

		• For those with shorter term stays - Community-based activities could be provided by a recreational therapist or community health worker. • For those with longer-term stays, a member might leave the NF for a community event at least two times a month; also, events could bring the community into them at the facility more often. • ** 2 to 3 hours minimum. The more complex the community service the more time and effort needed for planning. For example, the difference between planning for a weekly trip to the grocery store vs a novel outing like a picnic • **Based on what I've observed at facilities, it may depend on planning and transition. Please build in time for both. **Care Model:** • Ideally, roughly half-time (50%) Individualized (1:1) and half-time Group, depending on what the person can tolerate • **All three can be used depending on the goal and the ability of the patient to benefit from the therapeutic environment. The patient should be able to progress from 1:1 to less intensive treatment and maintain an upward trajectory of improvement before that model is discontinued. • ** I appreciate the balance of group/team/1:1. Curious to see what other NB facilities offer. Some treatment modalities are more amenable to group/team than others.
12-14	**TCM Rate Assumptions**	No comments or recommendations provided
18-19	**Next steps**	Welcome further input this week; send notes to this group.

	Action Items			
#	**Action Item**	**Due Date**	**Status**	**Responsible**
1	Send revised eligibility decisions to workgroup	Monday, March 6	Complete	Consultants
2	Send draft service definitions to workgroup	Thursday, Feb 16 5 pm	Complete	Consultants
3	Workgroup send responses to Grant Lindman	Wednesday, Feb 22 5pm	Complete	Workgroup
4	Share March 1 meeting prep materials	Tuesday, Feb 28, a.m.	Complete	DMAS
5	Send revised waiver service definitions to workgroup	TBD	In progress	Consultants
6	Send draft Neurobehavioral unit definition to workgroup	Monday, March 6 5 pm	Complete	Consultants
7	Workgroup send responses to Grant Lindman	Thursday, March 9 noon	Complete	Workgroup
8	Share March 15 meeting prep materials	Tuesday, March 14, a.m.	Complete	DMAS- Brian
9	Share March 29 meeting prep materials	Monday, March 27	Complete	DMAS - Brian & Consultants
10	Send revised neurobehavioral unit definition to workgroup	TBD	In progress	Consultants
11	Send meeting notes to this group for review and further input	Thursday, May 4	In progress	DMAS – Brian and Consultants