Virginia Brain Injury Services (BIS)
Program Design Group Workgroup – Meeting #3

Meeting Information	
Meeting Name & Topic	Focused Program Design Sub-Team: Working Meeting with DMAS
Date & Time	March 15, 2023, 2:00 pm EST
Dial-In Information	Click here to join the meeting

Goals & Attachments	Meeting Participants *(attendees marked *)*		
Meeting Purpose/Objective: Review input on waiver provider qualifications, neurobehavioral unit service definition and setting options **Pre-meeting Preparation Required:** Submit comments **Attachments/Handouts:** March 15 agenda March 15 meeting presentation Waiver Services synthesis Neurobehavioral Unit Service synthesis **Next Meeting:** March 29	**Collaboration Team** *Anne McDonnell, Brain Injury Assn of VA * 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	**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 BIS Rep) 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
1-9	Workgroup status	Information shared on the slides

10 - 15	Waiver Provider Requirements	***Certified Brain Injury Specialists(CBIS)***
		DMAS would like to broaden the criteria beyond CBIS. Recommendations from workgroup:
		• *Background on BIAV certificate program.* It was developed in response to fundamentals and needs of para-professional staff. When CBIS exam changed, the pass rate was a problem for non-clinicians. BIAV includes basic, critical information missing from CBIS and QBIS: (e.g., waivers).
		• *QBISP professional background*: It is designed to be provided at local level, and specific to state in which it's offered. Perhaps the workbook doesn't make clear, but it's designed to be customized for each state/locale. CBIS is meant for direct care, clinical professionals, targeted to learn more about behavioral issues, and as an extension of what licensed clinical professionals know to help them as they provide services throughout someone's day.
		• *Recommendations for qualifications for direct care staff –*
		  ○ CBIS, a 9-month course - and in this labor market will impede sufficient workforce. QBISP would be a good option to consider. CBIS 500 hours direct care before you can sit for it. It's very difficult test to pass. Could consider having at least one person in the organization with CBIS certification.
		  ○ BIAV is all inclusive and comprehensive. Wholeheartedly support this (several members).
		  ○ 10 hours of continuing ed per year from at least two sources is super important, regardless of whether CBIS is the requirement.
		• *Recommendation for supervisors*
		  ○ Require to be QBIS or CBIS
		  ○ 10 hours of continuing ed per year from at least two sources is super important, regardless of whether CBIS is the requirement.
		• DMAS requested QBIS workbook and BIAV training information.

		Commission on Accreditation of Rehabilitation Facilities (CARF) DMAS is considering various types of CARF standards. Are there specific CARF standards or any other types of standards you recommend? Recommendations from workgroup: • There are 8 major CARF accreditation categories. (e.g., Residential rehab, HCBS rehab, vocational, day program, comprehensive outpatient rehab) with specialty add-ons. • Each state varies greatly with how they categorize licensure types. • Two most appropriate categories for these services are: Employment and Community Supports and Medical.

		• The Virginia state-funded community provider network includes CARF Employment Community Services. There many specialties within that category an agency pursue. The more intensive residential services follow a different type of standard. Brain injury is an "add on" specialty within a broader category. • DMAS is looking for details within those two categories and is open to other appropriate accreditation approaches that would enable other providers to participate • Workgroup member will provide DMAS CARF contact to help DMAS expedite decisions.
		Other Provider Qualification Issues Cognitive Rehabilitation provider recommendations from workgroup: • Hoping BCBAs are included. If there's any information desired to understand how BCBAs support people with BI, we're happy to provide it. • Multiple professions, (OT, etc.) all bump up against cognitive rehabilitation. It would be helpful to have clear guidance about when we bill Cog Rehab vs. OT, SLP etc. • NJ and PA have had success in using alternatives professional licensing approaches. Transitional Living recommendations from workgroup • Concerned about time limitations for start "The services are given only within 18 months of a first brain injury or 3 months of a second brain injury with a hospital stay. ….. The duration of services is generally limited to 6 months."
16- 21	Neurobehavioral Unit Service Definition	***Assessments*** Appropriate type of assessment, recommendations from workgroup • Access to care is difficult and the qualifications should be flexible enough to include multiple disciplines with a focus on experience with brain injury (BI); the model needs to be collaborative o Ensure there is ample consideration of the availability of appropriate professional with the overall objective being the right person with training but most importantly experience with BI. o A variety of disciplines can conduct this assessment including neurologist, psychiatrist, and physiatrist (physical medicine). Important to supplement discipline with BI training. Other disciplines include neuropsychiatrist and behavioral neurologist however limited supply. o Flexibility to accept multiple disciplines is recommended, ensuring that you have a person with the right experience. CARF accreditation enables a unit to have flexibility and be less prescriptive on discipline that can fulfill all the roles o Neuropsychologist with appropriate experience may be appropriate. Or, if PMNR or psychiatry are chosen, then ensure the team has a neuropsychologist o Select an assessment tool that requires the individual(s) completing the form to have the necessary training to conduct the assessment.

		Composition of the Multidisciplinary Team recommendations from workgroup:
		• Core Team should include:
		  ○ An MD: neurologists, psychiatrists, physical medicine and rehabilitation (PM&R) are doctors that all work on the same organ, the brain. All these specialties can get further training in BI. It's going to be hard to find available professionals willing to do this. Looking at the Veterans Administration may yield candidates, like a behavioral neurologist.
		  ○ Direct care staff (licensed and unlicensed)
		  ○ Neuropsychologist (can't prescribe but are important to team)
		  ○ Behavioral BCBA
		  ○ Cognitive therapist
		  ○ Case manager that has a comprehensive knowledge and understanding of the needs of individual with BI, their families, and the community service system, to ensure successful transition to the community, if appropriate. Good models include; Sheltering Arms and Eastern State.
		• In addition to the Core team, require consultation be available from other disciplines to address individual needs, such as registered dietician, endocrinologist With diabetes, or audiology/vestibular challenges or DBT, or coumadin clinics, a core group of people with case management tasked to ensure the person gets access.
		• Consider revising to interdisciplinary to ensure representation from all levels of staff
		Multidisciplinary Team (MDT) recommendations
		• An *inter*disciplinary may work better than *multi*disciplinary. It should not be limited to licensed staff. An interdisciplinary team inclusive of all staffing levels.

22-23	Next steps	• Send meeting materials by for March 29 to discuss settings options for Neurobehavioral Unit

	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	In progress	DMAS - Brian & Consultants