ADVISORY COUNCIL ON BRAIN INJURIES
COGNITIVE REHABILITATION TASK FORCE MEETING
March 2, 2011
On With Life Conference Room
715 SW Ankeny Road
Ankeny, IA 50023

MINUTES

1. Welcome/Introduction — Julie Fidler-Dixon, Cog Rehab Task Force Chair

Members participating:

Julie Fidler-Dixon, On With Life, Cog Rehab Task Force Chair
David Demarest, ACBI &On With Life—Task Force Member
Emily Emonin, ACBI—Task Force Member
Mike Hall, ACBI & V.A.—Task Force Member (via phone)
Lynn Janssen, Janssen Rehab Consulting—Facilitator
Geoff Lauer, BIA-IA—Task Force Member
Ben Woodworth, IACP—Task Force Member

Members who recused themselves:

None

IDPH staff participating:

Megan Hartwig, IDPH, Brain Injury Program

Meeting was called to order at 11:03 a.m. Julie welcomed all participants and provided an update from the BIAA business practice conference.

2. Establish agreement on objectives for meeting

Megan explained to the group why they were meeting. The group looked at the handout with project goals for the HRSA grant. Lynn facilitated discussion to help the group move to consensus regarding what the group wanted to accomplish from the meeting. The group agreed to the following:

- To focus on objective 2.1—"The Services Task force of the TBI council will develop definitions for cognitive rehabilitation in Iowa and recommendations for policy will be presented to lawmakers and key stakeholders in Iowa."
- The work on objectives 2.2 through 2.5 cannot begin until 2.1 is completed.
- There needs to be a definition of Cognitive Rehabilitation that can be shared with Legislators that is understandable to them and should include the following information:
    - The name of the service

- Frequency, duration, cost, intensity and licensure
- Cognitive Rehabilitation needs to be focused "under the supervision of professionals".
- The Advisory Council on Brain Injuries had adopted the following definition: "Cognitive rehabilitation is the systematically applied set of medical and therapeutic services designed to improve cognitive functioning and participation in activities that may be affected by difficulty in one or more of the cognitive domains. When properly applied, it is based upon sound scientific theoretical constructs and strategic approaches drawn from numerous disciplines.
  Theoretical models of cognitive rehabilitation vary along several different dimensions. Treatments may be process specific, focused on improving a particular cognitive domain such as attention, memory, language, or executive functions."
  —From Brain Injury Association of America

The group agreed they would probably only be able to impact public funds, not private insurance or private pay. At present it would be most important for consumers to be able to receive cognitive rehabilitation under the HCBS BI waiver and possibly under straight Medicaid.

The group next discussed how to transition cognitive rehabilitation from a medical model to a disability services model. They discussed changing the name of the service and having a specific training program for direct service providers (Certified Brain Injury Specialist) who would be supervised by a licensed individual (Speech Therapist, Occupational Therapist, etc).

3. Review Action Plan from 2008 Summit

The group looked at and discussed the following items from the 2008 Summit Action Plan: "Develop definitions of the levels of cognitive rehabilitation and how each could be funded. Learn from TBI model systems and the insurance companies."

The group discussed the following points:

- The focus should drive the definition: Medical model vs. community model. The following points were discussed from the Brain Injury Association of America's Publication *Cognitive Rehabilitation: The Evidence, Funding and Case for Advocacy in Brain Injury*, November 2006.
  - Treatments may be skill-based, aimed at improving performance of particular activities.
  - Should restore function or establish compensatory strategies to overcome specific problems.
  - Re-establishing previous skills and behavior patterns
  - Enables adaptation to adjust to problems that are not modifiable.
  - Can be applied to actual functional activities in real-world settings.

- May improve a specific cognitive process or an activity in a clinical setting that is intended to generalize to actual performance in real-life situations.
- Family members and other caregivers play an important role in reinforcing the consistent use of strategies.
- Driven by proper theoretical models and planned, administered and monitored under the supervision of professionals with recognized expertise in cognitive rehabilitation.

- The BIAA definition could be rewritten for the layperson.
- Conversation about specifics vs. generals and what Rehab actually is
  - Improving thinking or processing skills so you can learn other things
  - Enhancing something that has been damaged so you can then work on compensatory techniques.
  - Needs to be a licensed professional, this will show a proficiency to justify medical billing.
  - The definition could depend on which audience it is being presented to.
- Why do we need a professional involved and how often?
  - Professionals need to explain and supervise; they know how the brain works.
  - Oversight could be as often as quarterly or as little as annually—it may depend upon the person receiving services.
  - This should be real life—not everyone can sit down at a computer to learn a skill and then be able to carry it forward.

4. Legislation and Education Implementation

Community Based Cognitive Retraining—this could be a possible term to bridge the world of the lay person and medical professionals that would have the same functionality.

- The main focus should be keeping people out of facilitates. Remediation is how to cope so they can stay out of facilities.
- Should move away from the term Cognitive Rehabilitation—need to come up with own term for Iowa and services.
- Want to get funding for this service
- Could start with an evaluation from a Speech Therapist.
  - Do we need to define documentation?
  - Should the group set minimum standards?
  - Professional supervision will need to be built into the billing rate.
  - What level of functioning would a person gain? Pre-injury status?
  - What would the billing schedule look like?
  - Would licensed staff be required to become a Certified Brain Injury Specialist?
    - There are strong arguments for both.

    - Is it a "slap in the face" for a licensed professional to become a CBIS?
  - Practitioners will be Certified Brain Injury Specialists.
    - What are the potential levels of service delivery?
    - How many levels are there and who could do what at each level?
    - How many professionals/paraprofessionals are needed to cover the continuum?
    - What are the major levels of training for each type of service?
    - How will the community, payers, providers and others be educated about the need for various levels of service and the lifelong need?
    - How do you get funders and providers to collaborate to meet the lifelong needs of brain injury survivors?
    - Could Telemed be used for this service?

The group decided to name the service Neuro-Cognitive Remediation.

5. Group Exercise

What is Cog Rehab?

- Could be called the following:
  - Neuro-Cognitive retraining
  - cognitive retraining community based (this could be a dimension of cog rehab)

Completed
- Had a definition from BIAA-
Cognitive rehabilitation is the systematically applied set of medical and therapeutic services designed to improve cognitive functioning and participation in activities that may be affected by difficulty in one or more of the cognitive domains. When properly applied, it is based upon sound scientific theoretical constructs and strategic approaches drawn from numerous disciplines.

We need to translate this for funders
-Medical Model
-Non-medical Model

Is Still a Priority
-Treatment is focused on two key areas of focus
1. Improving thinking
2. Compensating

Requires Action
How it is defined will determine where the focus is
-Supervision by a professional (Speech Therapist, Occupational Therapist, NeuroPsychologist, etc.)

-supervision could be as often as quarterly or could be annually (should be no less than annually as needs and functioning can change)
-Laypersons may not understand it the same as a medical professional

Urgency
-There is currently a waiting list for the BI Waiver in Iowa
-Currently sports injuries are in the mind of Iowans and Americans--"strike while the iron is hot"
-There are many unserved and underserved including servicemen and women (including National Guard in Iowa)
-of the 16,000 in Iowa:
-47% have sought services
-53% have not sought any services
-34 to 48% of military have experienced a loss of consciousness or military sexual assault.
-there is a need to remove the stigma that accepting help is not "macho" or "tough"
-Iowa has a very high geriatric population--falls are the biggest cause of TBI in the elderly.

Can Be Better
-A person could live in their own community--this is a benefit to society because of better social networks and life in their home community.
-There is a need for real life stories.
-Need to avoid costly inappropriate services
-Judicial
-Mental Illness
-Substance Abuse
-Batterers Education-domestic violence

Here is How
-Families will have techniques to better support individuals with Brain Injury to live, work, learn and play as independently as possible in their chosen home.
-Meaningful community integration and rehabilitation together
-Delivery will be by a professional with specialty experience and training in brain injury who is supervised by a licensed health care professional.
-Provide people the natural supports they have in their home communities.

Minimum Standards for Neuro-Cognitive Remediation

Evaluation
- To be completed by a licensed medical provider prior to service
  - Cost: $150-$200
- The evaluator should be a Certified Brain Injury Specialist or have equivalent training/experience with brain injury
- Goals would be defined in the initial evaluation and updated annually
-Follow up would need to built into the rate (quarterly up to annually (minimal)

Intervention
-Direct services for the individual with brain injury

-Delivered by a paraprofessional (practitioner) who is a Certified Brain Injury Specialist
- Services could include:

 - Assisting individuals in identifying their needs and developing appropriate compensation techniques to accommodate the effects of their brain injuries
 - Collaborating with individuals to develop techniques to enhance problem solving, organization, and processing skills.
 - Developing memory compensation strategies.
 - Integrating employment, educational, and independent living goals.
 - Increasing the individual's awareness of their brain injuries.
 - Educating individuals, families, and staff about the consequences of brain injury.

Where

- The most natural environment possible.
-Community based.
- The first step could be with Medicaid.
- Should be included in the Iowa State Plan for Brain Injury

6. Questions or Comments

There were no public questions or comments.

7. Next Steps

- Approach Medicaid with plan and include them prior to talking with legislators.
- Megan & Julie to develop definition
- Ben to take definition to community based provider group for feedback
- Geoff to work with Julie on the framework Ben provided from the Kansas model

Meeting adjourned at 1:56 p.m.

Next meeting scheduled for Wednesday, March 23, 2011 from 11:00 a.m. to 2:00 p.m.

Minutes submitted by Megan Hartwig

DRAFT