PROPOSED CHANGES TO ABI WAIVERS

1. Multiple providers have come together to make recommendations for changes to the ABI regulations to improve the quality of services to those we serve, and base regulations on industry standards that allow for performance measurement and comparison to other programs within the state, regionally, and around the country.

2. We recognize that legislatively we must keep both ABI waivers as "Acute" and "Long-Term", however, we need to expand Acute slots for Medically Complex and Neurobehaviorally-Challenged individuals. Their rehabilitation program and rates for services should be adjusted and based on their individual needs.

3. The definition of brain injury should encompass all types of acquired brain injuries including stroke and not exclude individuals because of substance misuse and/or mental health issues. Of course, each case should be decided upon based on need and ability to benefit from rehabilitative services.

4. Clinical expertise is needed within the ABIB Department. This is essential to properly assess a candidate for services; and to provide guidance and expertise to waiver providers to help Kentucky stay current with evidence-based brain injury rehabilitation practices. Additionally, audits conducted by the department should be standardized and consistently applied across providers/programs.

5. Training for personnel working in the ABI Waivers should be consistent and ongoing. The Academy of Certified Brain Injury Specialists (ACBIS) training model, curriculum, and competencies are recommended.

6. Potential ABI providers should be vetted to determine if they have the leadership, financial solvency, strategic planning, stability, and insight to seek input from individuals served and other relevant stakeholders.

7. The Plan of Care is the central plan developed at admission and runs through discharge in rehabilitation programs across the country. It incorporates initial and ongoing assessments completed by team members addressing behavioral, cognitive, communication, cultural, educational, functional, leisure/recreational, medical, physical, psychological, sexual, social, spiritual, and vocational domains, important events and life experiences, routines, decision making capacity, and usability of the living environment. Goals are established from the assessments with input from the person served and family/guardian/circle of support. Team composition is determined for each person served through the assessment and individual planning process. This dynamic group of individuals may change as the person progresses through the program. The team meets at a frequency appropriate to meet the needs of the person served, the program and external stakeholders. Interdisciplinary rehabilitation teams may include the rehabilitation

physician, consulting physicians, nurses, therapists, neuropsychologists, counseling professionals, social workers/case managers, Certified Behavior Analysts, the person served, residential staff, and other staff necessary to ensure the achievement of predicted outcomes. Each person should have a Plan of Care.

8. Covered services and supports in the ABI Waivers should be based on the needs of the individual affected by brain injury and should evolve with progress and aging or other life changes. Services should address impairments, activity limitations, participation restrictions, environmental needs, and the personal preferences of the person served. Services and personnel should facilitate the achievement of outcomes targeted in the Plan of Care.

9. A solid Plan of Care established by the rehabilitation team goals includes goals/strategies to minimize risk relevant to the individual affected by brain injury. In neurobehavioral cases following brain injury these individuals have a Behavioral Plan, established by a Board-Certified Behavior Analyst, as part of the Plan of Care. Behavior specialists are not generally a psychologist, a psychiatrist, a nurse, or a licensed professional counselor. Additionally, risk is assessed routinely by all rehabilitation staff. Examples include the kitchen faucet is marked with a red line to enable a client to not turn the faucet beyond that point to prevent scalding; the therapist stops the client from stepping into oncoming traffic secondary to impulsivity; another clinician prevents a client from touching a client of the opposite sex in the store. In general, rehabilitation team members demonstrate ongoing awareness and vigilance to prevent many risky behaviors associated with brain injury, or address them as they come up throughout the rehabilitation process. There is no need to develop a separate Crisis Prevention and Response Plan.

10. Additionally, rehabilitation teams recognize the importance of balancing cognitive challenges and downtime for the brain to rest and destress when developing the Plan of Care.

11. The industry recognizes SMART goals: Specific, Measurable, Action-Oriented, Realistic, and Time-bound. A cohesive team develops a plan including treatment considerations and client factors that may influence the course of treatment that becomes a practical roadmap for structuring and implementing the steps leading to predicted outcomes. Training on appropriate and functional goal writing that is measurable should be provided across providers and implemented within the ABIB program.

12. The ABIB Department should require providers to report outcomes using the ***Mayo-Portland Adaptability Inventory – 4th edition (MPAI-4),*** a measure of global functioning. The Brain Injury Association of America has endorsed the MPAI-4, and several state-funded rehabilitation agencies and some commercial payers now require the

use of the MPAI-4 as part of their outcomes reporting systems. There are recommended guidelines for administration and scoring to help programs gain insight to this tool's use.

13. Transportation services, such as Uber, Ride sharing, bus lines or Wheels, should be explored for individuals to give greater access to community-based services. Numerous individuals affected by brain injury are able to learn to drive again throughout specialized drivers' training that focuses on adaptations for physical needs and evaluation and support addressing ability to maintain constant position in lane, accurate vision, memory for directions, eye-hand coordination, reaction time and safety awareness and judgment.

14. Adult Day Treatment should be a combination of structured therapy services and community-based programming. Often working with the person served in their typical environments helps anchor skills not learned in group settings. As a result of the COVID-19 pandemic, many individuals with brain injury have received therapy services through telehealth. Research literature shows tele-rehabilitation services may be as effective as in-person rehabilitation for brain survivors who experience attention deficits, and tele-rehabilitation may be even more effective based on fewer distractions at home than at a facility-based clinic. It is recommended that equipment to access telehealth needed be provided and include internet access. (See attached Letter from BIAA re: Delivery of Rehabilitative Therapies via Telehealth during COVID-19 Pandemic)

15. Resource Facilitation should be included as part of a comprehensive brain injury rehabilitation program under the ABI waivers. A solid program provides individualized services to persons to achieve their identified avocational/vocational outcomes. Services may include identification of employment opportunities and resource in the local job market, development of realistic employment goals, establishment of specific goals to achieve employment outcomes, and resources to achieve and maintain employment. Vocational services consider medical, cognitive, behavioral, physical, and functional issues, accessibility and accommodations provided by employers, community resources, vocational goals for the individual being served and economic considerations in the employment sector, and brain injury specific education of the employers and work community.

16. An essential aspect of treatment following brain injury is supportive counseling and psychotherapy for both the individual and the family. This is needed to rebuild relationships, work, intimacy, and self-esteem. Skilled clinicians recognize that brain injury impacts the family dynamic. Therefore, counseling is best when done with the

individual or individual and family, not in group settings. Waiver regulations should reflect demonstrated best practices.

17. Staffing ratios should be based on the needs of individual persons served and perhaps the milieu of the residents within a residential setting. ***No one staff member, especially one who is non-licensed, should be left alone with more than one client in a residential setting intentionally for a significant period of time.***

These recommendations were written after much deliberation with several individuals working in brain injury rehabilitation. The goal of this document is to address key areas that do not follow a person-centered approach to brain injury rehabilitation. I reserve the right to expand, add, delete, and revise areas as discussion surrounding the content of the ABI waivers is open for discussion, collaboration, and positive change.

Respectfully submitted,

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References:

Commission on Accreditation of Rehabilitation Facilities (CARF)
American Congress of Rehabilitation (ACRM)
National Association of State Head Injury Administrators (NASHIA)
American Academy of Physical Medicine and Rehabilitation (AAPM&R)