**BRAIN INJURY ADVISORY COUNCIL (BIAC)**

**Date:** March 13, 2019  |  **Time:** 9:30-3:30 pm  |  **Location:** Governor’s Institute  
1121 Situs Court, Suite 325  
Raleigh, NC  27606

<table>
<thead>
<tr>
<th><strong>TYPE OF MEETING</strong></th>
<th>Quarterly Meeting</th>
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<tbody>
<tr>
<td><strong>FACILITATOR</strong></td>
<td>Jerry Villemain, Chairperson</td>
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### ATTENDees

<table>
<thead>
<tr>
<th>NAME</th>
<th>PRESENT</th>
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<th>GUESTS</th>
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<tbody>
<tr>
<td><strong>Voting Council Members</strong></td>
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<td><strong>Non-Voting Council Members</strong></td>
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<tr>
<td>Jerry Villemain, Chair</td>
<td>✓</td>
<td>Jan White (proxy for Alan Dellapenna.)</td>
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<td>Liz Newlin</td>
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<tr>
<td>Carol Ornitz (proxy for vacant ED position)</td>
<td>✓</td>
<td>Cindy DePorter</td>
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<td>Michelle Merritt</td>
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<td>Jean Andersen</td>
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<td>Amy Douglas</td>
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<td>David Forsythe</td>
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<td>Craig Fitzgerald</td>
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<td>Travis Williams (proxy for Chris Egan)</td>
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<td>Debra Farrington</td>
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<td>Martin Foil</td>
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<td>Michele Elliott</td>
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<td>Jerome Frederick</td>
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<td>Kenneth Bausell</td>
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<td>Sonia Padiel</td>
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<td>Geana Welte</td>
<td>✓</td>
<td>Dreama McCoy</td>
<td>✓</td>
<td>Jeffrey Luber</td>
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<tr>
<td>Virginia Knowlton Marcus</td>
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<td>Robert Johnson</td>
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<td>Cristina Phillips</td>
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<td>Thomas Henson, Jr.</td>
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<td>Jeanne Preisler</td>
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<td>Steve Strom</td>
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<td>Murray Dunlap</td>
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<td>Jim Swain</td>
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<td>Mya Lewis</td>
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<td>Lynn Makor</td>
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<td>Lee Lewis</td>
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<td>Karen McCulloch</td>
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<td>Wes Cole</td>
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<td>Sarah Stroud</td>
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<td>Diane Westbrook</td>
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<td>Pier Protz</td>
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<td>Donna White</td>
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<td>Christine Fernandini</td>
<td>✓</td>
<td>Sandy Pendergraft</td>
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<td>Ryan Lamb</td>
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<td>Michael Brown</td>
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<td>Melinda Munden</td>
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**1. Agenda topic: Welcome, Introductions & Approval of Minutes**  
**Jerry Villemain**

**Discussion**  
Jerry welcomed everyone to meeting. Introductions were made by all in attendance.

**Conclusions**

**Action Items**  
**Person(s) Responsible**  |  **Deadline**
2. Agenda topic: TBI Waiver Update  

Cristina Phillips & Kenneth Bausell

Teamwork
coming together is a beginning
keeping together is progress
working together is success

- Henry Ford

Road to Success
- Continued Collaboration between Alliance, NC Medicaid, DMH/DD/SAS, DSS, BIANC, BIAC & Other Stakeholders
- Direct Feedback from members and their families
- Continued Assessment and Modification of Work Flows
- Continued, thorough and methodical review of barriers
- Continued Interdepartmental Coordination
- Continued Departmental malleability to change infrastructure as needed and adapt accordingly (Ex. RNs, Guide Role, Claims)
- Continued Community Engagement
What Work Has Recently Been Accomplished?

- With assistance from NC DUHCC/SAS, NC Medicaid, Alliance Legal departments-Created TBI WAIVER policy and procedures for MCOs: Care Coordination, UM, Claims, Credentialing, Network Evaluation teams and more.
- Creation of TBI waiver Flyer, TBI waiver Family Guide Book and TBI website
- Credentialed and Approved a strong, dynamic and collaborative TBI WAIVER Provider Network
- Secured funding to provide $600 CBIS training for 10 TBI WAIVER Provider Agencies.
- Collaborated with BANC to provide monthly clinical training to TBI WAIVER Providers and internal staff.
- Alliance Network Evaluations teams ensured HCBS Compliance for all TBI WAIVER Residential, Day Supports, Adult Day Health and SE Providers — TBI Waiver Leading the way for HCBS in NC!
- Ensured Community Engagement- By providing over 15 TBI Waiver Awareness Presentations within Alliance’s Catchment area.

As the Infrastructure was built the Reach Out Began

- Over 70 individuals have been placed on Alliance’s TBI REGISTRY OF INTEREST
- TBI Guide has completed Out Reach to Over 35 Members
- 17 Members have been referred for LOC
- 5 Members actively enrolled
- Active Outreach Continues Daily
- Both TBI GUIDE Role and TBI CC Roles Fully Engaged
- Additional Support Coming to support Waiver Enrollment Process

WHAT DOES OUTREACH ENTAIL?

- Continuous engagement with members and their families
- Seeking documentation from hospitals and clinicians
- Waiver education
- Support with the Medicaid application
- Guidance through eligibility process
- Attending critical appointments
- Meeting with existing team members

LESSONS LEARNED

OUTREACH AND ONBOARDING BARRIERS

- Diagnostic Information may be lost or unattainable
- Member may be in crisis and difficult to reach or engage
- Assets are too high and member is found NOT eligible for Medicaid
  - Life Insurance
  - Settlements
  - Other assets
- Member determines CAP/DA or other state program is more beneficial
- Member is eligible for Medicaid, but not for the right type
- Member determines Co-Pay or Spend Down is too high- Declines Waiver
DISCUSSION

We can’t prevent All Barriers, but how can we help lesson barriers?

- Educational Tools around NC Medicaid Eligibility
- Long Term Planning Resources
- Other?

FROM WORK FLOWS, POLICY AND PROCEDURES TO OUR MEMBER’S EXPERIENCE
MEET JOHN

- At age 54 was struck by a bus while on vacation with his children and wife in Malaysia.
- John received initial treatment in Malaysia and once stabilized was flown to University of Maryland’s Shock Trauma Center
- Post discharge John and his wife moved to NC to be closer to his brother.
- John lived at home for 1 year. His wife and their local church members were primary care takers.
- However due to John’s need for 24/7 care his wife made the difficult decision of moving John to a SNF.
- However, due to rapid regression in the SNF, John came back home.
- John and his wife were connected to Alliance 3 years post accident
- Prior to his accident, John was a professor and had never accessed public services such as Medicaid.

JOHN’S FIRST CALL INTO ALLIANCE

1. 10/1/2018 - Access Center Completes Screening and Discusses Services Options.
2. 10/2/2018 - John placed on TBI Waiver Registry of Interest
4. 10/9/2018 - John receives initial call from Alliance TBI Guide
5. 10/12/2018 - John, TBI Guide and Natural Supports are able to locate and compile John’s paperwork. John’s wife had kept all of his medical reports and a social security card.
   - Accident Report
   - 3 year old Neuropsychological Report
   - Recent PPI ISP
   - Additional Rehabilitation history

JOHN’S NEXT STEPS

6. 10/22/2018 - TBI Guide Submits John’s Packet to Alliance Medical Team
7. 10/24/2018 - Medical Director refers John for Level of Care Review
8. 10/29/2018 - Level of Care Meet (now in 90 days)
9. 11/1/2018 - Alliance Care Coordinator assigned
10. 11/7/2018 - John’s first TBI CC lead Team meeting - ISP/Goals Developed
11. 11/14/2018 - ISP Complete and Submitted to ALLIANCE UM Team
12. 11/20/2018 - ISP Approved by LIM
13. 11/22/2018 - ISP and John’s complete packet sent to DSS - post thanksgiving
14. 12/5/2018 - DSS Approves and Enrollment Complete
15. 12/14/2018 - Member Enrollment with Day Supports Provider Complete and first Date of Service 12/15/2018 1st day at Day Program

IMPACT OF INITIAL INJURY TIMEFRAME ON SCREENING/ELIGIBILITY PROCESS

- John was connected to Alliance 3 years after his accident.
- Members who were injured 10-15 years ago have found ways to quit together services (NH/OLTS/OLTS state or Medicaid funded) to meet their needs and often don’t have diagnostic information readily available.
- Members who were injured in different states after struggle with finding documentation of injuries.
- Ideally Members will have a smooth transition from Hospital or SNF settings to HCBS TBI Wavier.
DISCUSSION

What can MCO’s do to better support individuals with Co-Occurring Variables as they initiate TBI WAIVER screening process?

- What if John had extremely limited natural supports?
- What if John is actively engaged in Substance Use?
- What if right after John was placed on Registry of Interest John he is admitted to a Facility Based Crisis Center?
- What if John’s Accident had occurred 15 years ago and he has misplaced his records?

DISCUSSION

- How Can MCOs better help explain the screening and eligibility process for TBI Waiver?
- What types of Materials Might be helpful?
- When Should Materials be provided, to whom?

Alliance Currently offers:
- An initial onboarding letter
- TBI web Site
- Coordination with TBI Guide

HOW CAN BIAC HELP?

- Acute Care and SNF Outreach- Assist team in direct engagement with Acute Care hospitals and SNFs.
- Pipeline creation
- Creation of Educational Materials about the NC Medicaid System for individuals with TBI.
- Continue to provide guidance to MCO’s around TBI Continuum of Care for those who exceed waiver level of care and those who do not meet.
- A voice at Quarterly TBI Waiver State Stakeholder Committee
- Attendance at Future Alliance TBI WAIVER stakeholder committee (to begin in April time period)

HOW CAN BIAC HELP?

- Assisting Alliance in ensuring Gaps and Needs assessments are reaching individuals with TBI within our catchment area
- Identification where outreach could be increased and to partner with Alliance for community outreach presentations.
- Encouraging Families to collect necessary documentation to assist with enrollment and eligibility process.
- Input on and Dissemination of Publications NC Division of MH/DD/SAS and ALLIANCE release to general public.
Conclusions

In order for the TBI waiver to be sustainable and replicated in the future – there must be collaboration. A one-page flyer explaining the TBI waiver process – this will be in paper form and electronic form. Carol Ornitz stated that the electronic guidebook may not be accessible to those who do not have computers. Liz Newlin asked will the change in the definition of brain injury affect the TBI waiver – Cristina stated that there are very distinct criteria to follow for waiver – TBI after the age of 22 – poverty level at 100%, spousal income does not count. It was pointed out that families have turned down the waiver because of the spend-down requirement – DSS makes the requirement not Alliance or other LME’s. Cristina stated that Alliance staff is reaching out to DHHS employees to educate about waiver.

Ideas on how BIAC can help with TBI waiver:

- Put TBI waiver information in patient guides in ICU & ICU step-down guides.
- Put TBI waiver information in BIANC skill packs.
- Encourage families to collect necessary documentation to speed up the process.
- Develop brochures specifically for skilled nursing facilities.
- Tailor brochures to target other specific audiences.
- Flyers to local churches.
- Advertise in media/social media.
- Talk with Pier Protz about low number in Johnston/Cumberland counties.
- Reach out to support group in Fayetteville.

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<thead>
<tr>
<th>Action Items</th>
<th>Person(s) Responsible</th>
<th>Deadline</th>
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<tbody>
<tr>
<td>Educate and get information about waiver to Johnston, Wake, Durham, and Cumberland counties.</td>
<td>Alliance staff, BIANC staff, BIAC</td>
<td>Ongoing</td>
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3. Agenda topic: Medicaid Transformation  

Debra Farrington
Managed Care Regions and Rollout Dates

**Region 1**: Feb. 2020
**Region 2**: Nov. 2019
**Region 3**: Feb. 2020
**Region 4**: Nov. 2019
**Region 5**: Feb. 2020
**Region 6**: Feb. 2020

**Rollout Phase 1**: Nov. 2019 – Regions 2 and 4
**Rollout Phase 2**: Feb. 2020 – Regions 1, 3, 5 and 6

**Overview of Eligible Population**

**TP Populations:**
- Qualifying IDD diagnosis
- Innovations and TBI Waiver enrollees and those on waitlists
- Qualifying Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) diagnosis who have used an enhanced service
- Those with two or more psychiatric inpatient stays or readmissions within 18 months
- Qualifying Substance Use Disorder (SUD) diagnosis and who have used an enhanced service
- Medicaid enrollees requiring TP-only benefits
- Transition to Community Living Initiative (TCLI) enrollees
- Children with complex needs settlement population
- Children ages 0-3 years with, or at risk for, IDD who meet eligibility criteria
- Children involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs who meet eligibility criteria
- NC Health Choice enrollees who meet eligibility criteria

**Benefit Packages**

Only BH/IDD TPs will cover a subset of high-intensity State Plan BH services; TBI, Innovations and 1915(b)(3) waiver services; and State-funded BH, IDD, and TBI services

<table>
<thead>
<tr>
<th>BH, IDD, and TBI Services Covered by BH, IDD, and TBI Services</th>
<th>BH, IDD, and TBI Services Covered by BH, IDD, and TBI Services</th>
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<tbody>
<tr>
<td>Inpatient behavioral health services</td>
<td>Residential treatment facility services for children and adolescents</td>
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<tr>
<td>Outpatient behavioral health services provided by direct-oriented providers</td>
<td>Child and adolescent day treatment services</td>
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<tr>
<td>Partial hospitalization</td>
<td>Intensive in-home services</td>
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<tr>
<td>Maternal health services</td>
<td>Intensive outpatient therapy services</td>
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<tr>
<td>Psychiatric residential treatment facilities</td>
<td>Psychiatric residential treatment facilities</td>
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<tr>
<td>Acute inpatient services</td>
<td>Acute inpatient services</td>
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<tr>
<td>Professional treatment services in facility-based crisis programs</td>
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<tr>
<td>Peer support (unless from NC state plan)*</td>
<td>Peer support (unless from NC state plan)*</td>
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<tr>
<td>Outpatient opioid treatment</td>
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<tr>
<td>Addictions treatment</td>
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<tr>
<td>Substance abuse comprehensive treatment program (SAPT)</td>
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<tr>
<td>Substance abuse intensive outpatient program (SAIOP)</td>
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<td>Clinically managed residential withdrawal (state inpatient setting)</td>
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<tr>
<td>Medication-assisted inpatient behavioral health treatment</td>
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<td>Diagnostic assessment</td>
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<td>Non-hospital medical detox center</td>
<td>Non-hospital medical detox center</td>
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<tr>
<td>Medically supervised or APAF, detoxification crisis stabilization</td>
<td>Medically supervised or APAF, detoxification crisis stabilization</td>
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</table>

State Plan BH and IDD Services
- Residential treatment facility services for children and adolescents
- Child and adolescent day treatment services
- Intensive in-home services
- Intensive outpatient therapy services
- Psychiatric residential treatment facilities
- Acute inpatient services
- Professional treatment services in facility-based crisis programs
- Peer support (unless from NC state plan)*
- Outpatient opioid treatment
- Addictions treatment
- Substance abuse comprehensive treatment program (SAPT)
- Substance abuse intensive outpatient program (SAIOP)
- Clinically managed residential withdrawal (state inpatient setting)
- Medication-assisted inpatient behavioral health treatment
- Diagnostic assessment
- ECT
- Non-hospital medical detox center
- Medically supervised or APAF, detoxification crisis stabilization

State-funded BH and IDD Services
- Residential treatment facility services for children and adolescents
- Child and adolescent day treatment services
- Intensive in-home services
- Intensive outpatient therapy services
- Psychiatric residential treatment facilities
- Acute inpatient services
- Professional treatment services in facility-based crisis programs
- Peer support (unless from NC state plan)*
- Outpatient opioid treatment
- Addictions treatment
- Substance abuse comprehensive treatment program (SAPT)
- Substance abuse intensive outpatient program (SAIOP)
- Clinically managed residential withdrawal (state inpatient setting)
- Medication-assisted inpatient behavioral health treatment
- Diagnostic assessment
- ECT
- Non-hospital medical detox center
- Medically supervised or APAF, detoxification crisis stabilization
- State-funded TBI Services

Note: NC will submit a State Plan amendment to add this service to the State Plan.
Overview of BH I/DD TP Care Management Approach

NC DHHS
Establishes care management standards for BH I/DD TPs aligning with federal Health Home requirements

The BH I/DD TP will act as the Health Home and will be responsible for meeting federal Health Home requirements.

Care Management Approaches
BH I/DD TPs have flexibility in how they provide care management, as long as the approach meets DHHS standards and care management is provided in the community to the maximum

- Approach 1: Tier 3 AMH with BH and/or IDD Certification
  - DHHS will create specialized BH and IDD certifications for Tier 3 AMHs that serve a substantial number of BH I/DD TP enrollees and have experiences serving these populations

- Approach 2: Care Management Agencies (CMAs)
  - BH I/DD TPs contract with agencies such as those that provide BH or IDD services (e.g., mental health or substance use agencies, home care agencies, etc.) that obtain OMA certification

- Approach 3: BH I/DD TP - Employed Care Managers
  - BH I/DD TPs may provide care management in certain circumstances that will be outlined in more detail by DHHS.

What beneficiaries can expect

Understanding MC Impacts to Beneficiaries

What's New
1. Beneficiaries will be able to choose their own health care plan
2. Most, but not all, people will be in Medicaid Managed Care
3. An enrollment broker will assist with choice

What's Staying the Same
1. Eligibility rules will stay the same
2. Same health services/treatments/supplies will be covered
3. The beneficiary Medicaid Co-Pays, if any, will stay the same
4. Beneficiaries report changes to local DSS

Beneficiary Experience – Auto Assignment
Beneficiaries who don’t choose a health plan will be assigned one automatically, consistent with the following components in this order:
1. Where the beneficiary lives.
2. Whether the beneficiary is a member of a special population (e.g., member of federally recognized tribes or BH I/DD Tailored Plan eligible).
3. If the beneficiary has a historic relationship with a particular PCP/AMH.
4. Plan assignments of other family members.
5. If the beneficiary has a historic relationship with a particular PHP in the previous twelve (12) months (e.g., “churned” off/into Medicaid Managed Care).
Overview of Approved Pilot Services

North Carolina’s 1115 waiver specifies services that can be covered by the Pilot. Pilots will address priority domains for unmet social needs.

Healthy Opportunities Pilots: Overview

Sample Regional Pilot

North Carolina

Managed Care and DSS Workers

County DSS will CONTINUE:

- Processing Medicaid applications, changes of circumstance, and redeterminations.
- NEMT for FFS Beneficiaries
- Updating PCP for FFS Beneficiaries

County DSS will not be responsible for:

- Choice Counseling
- Enrolling Members in Plans
- NEMT for Managed Care Members (unless contracted with PHP)
- Updating PHP/PCP for Managed Care Beneficiaries

County DSS will START:

- Referring beneficiaries to the enrollment broker for PHP counseling & assignments.
- Referring beneficiaries to their Plan for PCP selection or changes

Managed Care Impacts on DSS

Staff Time

- Increased in-person/walk-in contacts
- Increased telephone calls
- Training time for all staff
- Maintenance of scripts, information, updates
- Participation in outreach events

Operational

- Non-Emergency Medical Transportation (NEMT) changes
- Potential changes in agency layout/traffic flow
- Potential fiscal impacts re: staff, NEMT vehicles, contracts
- Potential additional phones/interview areas to connect beneficiaries to the EB
Conclusions

Be on the lookout for the policy document to be released soon. The vision for NC Medicaid-Managed Care focuses on healthy outcomes. Move from single payer to multiple payers on the healthcare side. Five health plans introduced in NC. NC 1115 waiver can pay for qualifying unmet social needs such as housing, food, transportation, interpersonal violence support programs.

Action Items

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4. Agenda topic: Qmetis

Jack Fitzgibbons
The Brain Injury Advisory Council
March 2019

Pediatric and Adult Traumatic Brain Injury
2018 – 2020 Pilot Program

Today

➢ Provide Update on North Carolina TBI Pilot Program
➢ Next Steps
➢ New Developments

Qmetis Overview, Again

➢ A Health Care Technology Company
➢ Grounded in the Science of Evidence-Based Medicine
➢ Building Real-Time, Interactive, Point-of-Care Decision Support
➢ Better Long-Term Outcomes / Lower Costs
➢ Initial Focus Adult and Pediatric Traumatic Brain Injury

Mission Statement

To Help Doctors, Nurses, and Hospitals, Achieve the Highest Levels of Compliance Possible with the Latest Standards of Care, for Every Patient, for Every Shift, for Many Conditions.
The Critical Issue of Compliance

In 2002, the Journal of Trauma published the results of a national survey of over 500 trauma hospitals that documented an alarming pattern of non-compliance with guidelines, showing that the highly regarded severe head injury guidelines were followed in only 16% of all cases.

![Pie chart](chart.png)

Traumatic Brain Injury

- Incidence Trending Down
- Awareness Trending Up
- Outcomes...

![Graph](graph.png)

The Science - Better Outcomes ~ Lower Cost


Variance in Care – Low Compliance

Initial Levels of Compliance with the Severe Head Injury Guidelines - 2016
Our Solution:

Change Long-Term Outcomes in the Acute Care Phase

Provide Clinical-Decision Support (Early)

Real-Time • Interactive • The Standard of Care • Always

Qmetis

The State of North Carolina
Adult and Pediatric Traumatic Brain Injury
2018 – 2020 Pilot Program

Qmetis

Implementation

1. Assemble List of Potential Hospital Participants

2. Contact Hospitals, Present and Explain Program, Gauge Interest; Continue

3. Multiple Hospital Meetings, Begin to Secure Commitments to Participate

4. Advise State on Commitments, Begin Staff Training for Program

5. Complete Training (Rolling Process), Implement, Patient Monitoring Begins; Additional Staff Training

6. All Hospitals on Board, Ongoing Reporting to State, Regular Interaction With Hospitals

7. Final Measurement Reports Hospital Study of Long-Term Outcomes—Actuarial Analysis of Savings

Pilot Status, March 2019:

➢ Met With, Briefed, 8 North Carolina Trauma Hospitals

➢ Introduced Qmetis, Introduced Program

➢ "This Could Help Our Patients"


➢ Two Hospitals Committed, (Wake Med, Wake Baptist)

➢ Five Pending
Next

The State of North Carolina
Adult and Pediatric Traumatic Brain Injury
2018 – 2020 Pilot Program

New Developments

The State of North Carolina
Adult and Pediatric Traumatic Brain Injury
2018 – 2020 Pilot Program
“...This 4th Edition of the guidelines is transitional. We do not intend to produce a 5th Edition. Rather, we are moving to a model of continuous monitoring of the literature, rapid updates to the evidence review, and revisions to the Recommendations as the evidence warrants. We call this the Living Guidelines model. This is driven by several trends, including advances in technology, the increasing volume of available information, and the corresponding changes in expectations among clinicians and other stakeholders. A static document that is updated after several years no longer responds to the demands of the community we serve.”

Next Meeting

Confirmation of Software in Use

Multiple Hospital Participants

First Data

Updated Pediatric TBI Module

Qmetis.com

Thank You!
Conclusions

Update on NC TBI Pilot Program
- WakeMed and Wake Baptist committed to using the Qmetis software.
- New pediatric guidelines.

Action Items

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5. Agenda topic: TBI Data

Abha Varma – DMH/DD/SAS

Discussion

DMH/DD/SAS
TBI Data Updates

Abha Varma, Quality Management Analyst

March 13th, 2019

Traumatic Brain Injury (TBI) - Evaluation Agenda

- New grant - data driven, emphasis on developing an evaluation agenda that defines program planning and implementation
- Purpose - to use data for better policies, goal setting, program planning, and implementation
- Primary question - how many individuals with a documented TBI are accessing service systems such as Mental Health (MH) and Substance Use Disorder (SUD):
  - Screenings at entry into the system
  - Diagnosis data from NC Tracks
  - Access to care
  - Available services (Medicaid and DMH funded)
  - Gaps in service infrastructure
  - Need for additional services
  - Tailored plans to address the gaps
Evaluation Questions

- Who gets screened — under-reporting or over-reporting?
- Is data consistent with expectation?
- Is it consistent with other data sources?
- What can be done to improve screening information?
- Is the self identification substantiated with DX – need for diagnosis data?
- Are individuals with TBI accessing and receiving needed services (Medicaid and DMH funded)?
  - Number of services accessed and received by individuals with TBI
  - Relevance of services accessed
  - Comprehensiveness of services accessed

Exploring Data Sources

- TBI Screenings – LME/MCO Reports (Self Reported on Screening Questions)
- BIANC Reports
- Network Adequacy and Accessibility Reports – TBI question added, starting July more information will be available from all LME/MCOs
- Diagnosis and Service Utilization Profile of NC Tracks clients diagnosed with TBI
- NC TOPPS – Consumer Survey (Self Reported)
- NC DETECT – Real time access to North Carolina Acute Care Emergency Departments, Pre Hospital Medical Information System
- Behavioral Risk Factor Surveillance System (BRFSS) – conducted by the CDC and includes NC questions on TBI

LME/MCO TBI Screenings – SFY 2018

5 LME/MCOs submitted data on 1,385 screenings for TBI during State Fiscal Year 2018 using the Ohio Screening Tool (not a formal DX tool but can be used to indicate that the individual may have likely sustained a TBI).

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<tr>
<th>LME/MCO</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance</td>
<td>10</td>
<td>7.41</td>
</tr>
<tr>
<td>Cardinal</td>
<td>53</td>
<td>37.76</td>
</tr>
<tr>
<td>Catawba</td>
<td>41</td>
<td>30.93</td>
</tr>
<tr>
<td>Sandhills</td>
<td>40</td>
<td>3.16</td>
</tr>
<tr>
<td>Trillium</td>
<td>17</td>
<td>12.86</td>
</tr>
<tr>
<td>Total</td>
<td>1,185</td>
<td>100</td>
</tr>
</tbody>
</table>

LME/MCO Conducted TBI Screenings By Quarter – SFY 2018

<table>
<thead>
<tr>
<th>LME/MCO</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance</td>
<td>20</td>
<td>38</td>
<td>22</td>
<td>10</td>
<td>60</td>
</tr>
<tr>
<td>Cardinal</td>
<td>173</td>
<td>341</td>
<td>136</td>
<td>92</td>
<td>546</td>
</tr>
<tr>
<td>Catawba</td>
<td>61</td>
<td>56</td>
<td>163</td>
<td>116</td>
<td>432</td>
</tr>
<tr>
<td>Sandhills</td>
<td>13</td>
<td>6</td>
<td>13</td>
<td>3</td>
<td>40</td>
</tr>
<tr>
<td>Trillium</td>
<td>0</td>
<td>51</td>
<td>104</td>
<td>92</td>
<td>217</td>
</tr>
<tr>
<td>Total</td>
<td>330</td>
<td>336</td>
<td>412</td>
<td>308</td>
<td>1,385</td>
</tr>
</tbody>
</table>
LME/MCO TBI Screenings – Cause of Injury

- Of the 1,385 individuals who received screening, 300 (22%) indicated motor vehicle accident as the cause of injury.
- Cause of injury was not recorded for 350 out of 1,385 screenings administered statewide. This is 26% of all screenings reported during the fiscal year.

<table>
<thead>
<tr>
<th>Cause of Injury</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident</td>
<td>81</td>
<td>5.85</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>46</td>
<td>3.32</td>
</tr>
<tr>
<td>Infants and Child Abuse</td>
<td>8</td>
<td>0.56</td>
</tr>
<tr>
<td>Military</td>
<td>3</td>
<td>0.22</td>
</tr>
<tr>
<td>Motor Vehicle Accident</td>
<td>300</td>
<td>21.66</td>
</tr>
<tr>
<td>Non-Motorized Vehicle</td>
<td>5</td>
<td>0.36</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>131</td>
<td>9.50</td>
</tr>
<tr>
<td>Self Harm</td>
<td>3</td>
<td>0.22</td>
</tr>
<tr>
<td>Slips and Falls</td>
<td>540</td>
<td>39.91</td>
</tr>
<tr>
<td>Sports Related</td>
<td>40</td>
<td>3.32</td>
</tr>
<tr>
<td>Struck by Against Events</td>
<td>294</td>
<td>14.01</td>
</tr>
<tr>
<td>Unknown</td>
<td>389</td>
<td>28.02</td>
</tr>
<tr>
<td>Other</td>
<td>48</td>
<td>3.47</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,385</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Implications – Cause of Injury

- Targeted interventions based on community need
- Strategic partnerships based on stakeholder engagement with the cause
- Better data collection to resolve the “unknowns”

LME/MCO TBI Screenings – Insurance

- 478 of 1,385 individuals screened for TBI indicated that they did not have any insurance. This is 35% of all screenings for the fiscal year. 45% indicated that they were on Medicaid whereas 12% indicated they had private insurance.

<table>
<thead>
<tr>
<th>Insurance</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare/Medicaid</td>
<td>1</td>
<td>0.07</td>
</tr>
<tr>
<td>Medicaid</td>
<td>616</td>
<td>44.48</td>
</tr>
<tr>
<td>Medicare</td>
<td>58</td>
<td>4.19</td>
</tr>
<tr>
<td>Private</td>
<td>171</td>
<td>12.35</td>
</tr>
<tr>
<td>Veterans</td>
<td>4</td>
<td>0.29</td>
</tr>
<tr>
<td>Uninsured</td>
<td>478</td>
<td>34.51</td>
</tr>
<tr>
<td>Unknown</td>
<td>57</td>
<td>4.12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,385</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Implications – Insurance

• Large number of uninsured or with insurance unknown
• What implications does it have for access to services
• How do we use allocated resources to maximize benefits
• Have tailored plans factored in access to services issues

LME/MCO TBI Screenings – Self Identified TBI

- 468 (34%) of 1,385 individuals screened for TBI self identified themselves as with TBI. 47% indicated that they did not have TBI
- Question – accurate identification or over or under reporting based on Diagnosis data
- Next Data Step – check against Dx data (NC Tracks) and plan for resource allocation and access to services accordingly

<table>
<thead>
<tr>
<th>Self Identified TBI</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>468</td>
<td>33.79</td>
</tr>
<tr>
<td>No</td>
<td>657</td>
<td>47.44</td>
</tr>
<tr>
<td>Unk</td>
<td>178</td>
<td>12.85</td>
</tr>
<tr>
<td>N/A</td>
<td>82</td>
<td>5.92</td>
</tr>
<tr>
<td>Total</td>
<td>1,385</td>
<td>100</td>
</tr>
</tbody>
</table>

LME/MCO Screenings – Referral to Treatment

- 1,026of 1,385 (74%) individuals screened for TBI received referral for mental health services.

<table>
<thead>
<tr>
<th>Mental Health Referral</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1,026</td>
<td>74.08</td>
</tr>
<tr>
<td>No</td>
<td>255</td>
<td>19.13</td>
</tr>
<tr>
<td>Unk</td>
<td>61</td>
<td>4.44</td>
</tr>
<tr>
<td>N/A</td>
<td>3</td>
<td>0.22</td>
</tr>
<tr>
<td>Total</td>
<td>1,385</td>
<td>100</td>
</tr>
</tbody>
</table>

- 532 (38%) individuals received referral for substance abuse treatment services

<table>
<thead>
<tr>
<th>Referral - Substance Use Treatment</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>532</td>
<td>38.41</td>
</tr>
<tr>
<td>No</td>
<td>718</td>
<td>51.84</td>
</tr>
<tr>
<td>Unk</td>
<td>105</td>
<td>7.58</td>
</tr>
<tr>
<td>N/A</td>
<td>30</td>
<td>2.17</td>
</tr>
<tr>
<td>Total</td>
<td>1,385</td>
<td>100</td>
</tr>
</tbody>
</table>
LME/MC0 Screenings – Referral to Treatment

- Of the 1,385 screenings, 41 (2%) individuals received referral to IDD services. This number includes the very small percentage who declined the referral.
- Data collection issue with the number of unknowns

<table>
<thead>
<tr>
<th>IDD Referral</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>41</td>
<td>2.96</td>
</tr>
<tr>
<td>No</td>
<td>485</td>
<td>35.02</td>
</tr>
<tr>
<td>Unknown</td>
<td>613</td>
<td>44.26</td>
</tr>
<tr>
<td>N/A</td>
<td>246</td>
<td>17.76</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,385</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

BIANC – Training Events

- A total of 4,295 individuals participated in 104 training events scheduled during the first two quarters of the Grant Year 2018-19. 1,297 participants received training during the first quarter and 2,998 participants received training during the second.
- In addition, 74 survivors/family members/caregivers/professionals were advised by the Neuro-Resource Facilitator during the first six months of the grant year.
- 288 participants of the 422 individuals enrolled in online training completed the online training during the first two quarters of the 2018-19 Grant Year.

<table>
<thead>
<tr>
<th>Online Training</th>
<th>First Quarter</th>
<th>Second Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online Training</td>
<td>Number Enrolled</td>
<td>Number Completed</td>
</tr>
<tr>
<td>Cognitive &amp; Behavioral Consequences of TBI to Adults</td>
<td>100</td>
<td>50</td>
</tr>
<tr>
<td>Peers: TBI</td>
<td>75</td>
<td>15</td>
</tr>
<tr>
<td>Primary Care &amp; TBI</td>
<td>50</td>
<td>15</td>
</tr>
<tr>
<td>Public Service &amp; TBI in NC</td>
<td>25</td>
<td>10</td>
</tr>
<tr>
<td>Substance Use &amp; TBI</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Crisis Management &amp; De-Escalation for First Responders</td>
<td>50</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>288</strong></td>
<td><strong>150</strong></td>
</tr>
</tbody>
</table>

*Online Training includes Group, 1:1, and Self-paced training.
*Online Training includes Group, 1:1, and Self-paced training.
*Online Training includes Group, 1:1, and Self-paced training.

BIANC – Individual Contacts

- Overall 1,268 individual contacts were established during the first two quarters of Grant Year 2018-19, these included in-person, email and phone contacts.

<table>
<thead>
<tr>
<th>Number of Individual Contacts</th>
<th>First Quarter</th>
<th>Second Quarter</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td>510</td>
<td>281</td>
<td>791</td>
<td>55.9%</td>
</tr>
<tr>
<td>Face-to-Face</td>
<td>150</td>
<td>36</td>
<td>186</td>
<td>12.3%</td>
</tr>
<tr>
<td>Phone Calls</td>
<td>80</td>
<td>120</td>
<td>200</td>
<td>13.3%</td>
</tr>
<tr>
<td>Combined*</td>
<td>840</td>
<td>281</td>
<td>1121</td>
<td>72.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,268</strong></td>
<td><strong>600</strong></td>
<td><strong>1,868</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

*Emails, Phone Calls, Face-to-Face not disclosed due to HIPPA Guidelines - 2018-19

Number of Individual Contacts - First and Second Quarters, Grant Year 2018-19

- Emails: 510, Face-to-Face: 186, Phone Calls: 200, Combined: 1121

*Emails, Phone Calls, Face-to-Face not disclosed due to HIPPA Guidelines - 2018-19
Conclusions

There was discussion regarding who is being screened for TBI and if the LME/MCO's are screening the same way. It was noted by Cristina that the LME’s have different ways of collecting information. There was also

Bianc – Individual Contacts Summary

- Overall email contact increased by 14% during second quarter (contact with survivors and families went up by 21% and with professionals it went up by 10%)
- Overall face to face contact indicated a downward trend – went down by 17% when compared with first quarter. Face to face contact with survivors decreased by 10% whereas with professionals decreased by almost 23%
- Overall phone contact increased by almost 33%. The interesting thing is it increased by almost 30% with survivors and families whereas it decreased by 14% with professionals

<table>
<thead>
<tr>
<th>Information &amp; Referrals</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Total</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email: Survivors/Families</td>
<td>210</td>
<td>263</td>
<td>473</td>
<td>53%</td>
</tr>
<tr>
<td>Email: Professionals</td>
<td>154</td>
<td>209</td>
<td>363</td>
<td>51%</td>
</tr>
<tr>
<td>Face to Face: Survivors/Families</td>
<td>58</td>
<td>26</td>
<td>84</td>
<td>-53%</td>
</tr>
<tr>
<td>Face to Face: Professionals</td>
<td>44</td>
<td>24</td>
<td>68</td>
<td>-41%</td>
</tr>
<tr>
<td>Face to Face: Total:</td>
<td>102</td>
<td>70</td>
<td>172</td>
<td>-36%</td>
</tr>
<tr>
<td>Phone Call - Survivors/Families</td>
<td>43</td>
<td>41</td>
<td>84</td>
<td>-1%</td>
</tr>
<tr>
<td>Phone Call - Professionals</td>
<td>42</td>
<td>62</td>
<td>104</td>
<td>+50%</td>
</tr>
<tr>
<td>Phone Call: Total:</td>
<td>85</td>
<td>103</td>
<td>188</td>
<td>+18%</td>
</tr>
<tr>
<td>Email, Phone Calls, Face to Face contact in3rd quarter vs 4th quarter (Change in Contacts)</td>
<td>586</td>
<td>492</td>
<td>1,078</td>
<td>+13%</td>
</tr>
</tbody>
</table>

| Email, Phone Calls, Face to Face contact in3rd quarter vs 4th quarter (Change in Contacts) | 586 | 492 | 1,078 | +13% |

Bianc – Website Access and Social Media Summary

- Overall, 7,968 individuals accessed BIANC website during the first six months of the grant year for a total of 26,878 hits in the first half of the grant year. 2,099 individuals accessed the TBI resource guide within the same period.
- Of the 7,968 unique users who accessed BIANC website in the first two quarters, the number of new users per quarter was 2,944 for the first quarter and 2,606 for the second. The number of new users accessing the TBI Resource Guide was 97 for the first quarter and 54 for the second.

<table>
<thead>
<tr>
<th>BIANC Website</th>
<th>1st Quarter</th>
<th>2nd Quarter</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Hits</td>
<td>15,457</td>
<td>11,391</td>
<td>26,848</td>
</tr>
<tr>
<td>Total Number of Users</td>
<td>4,915</td>
<td>3,033</td>
<td>7,948</td>
</tr>
<tr>
<td>Total Number of New Users Per Quarter</td>
<td>2,944</td>
<td>2,606</td>
<td>5,550</td>
</tr>
<tr>
<td>Total Number of Returning Users</td>
<td>1,904</td>
<td>777</td>
<td>2,681</td>
</tr>
<tr>
<td>Total Hits</td>
<td>23,362</td>
<td>14,127</td>
<td>37,489</td>
</tr>
<tr>
<td>Resource Guide on BIANC Website</td>
<td>1,082</td>
<td>1,047</td>
<td>2,129</td>
</tr>
<tr>
<td>Total New Users Per Quarter</td>
<td>97</td>
<td>54</td>
<td>151</td>
</tr>
<tr>
<td>Social Media</td>
<td>4,567</td>
<td>4,627</td>
<td>9,194</td>
</tr>
</tbody>
</table>

Building the Evaluation Agenda – Why Data

- Integrating information from multiple sources for the purpose of
- Informed decision making
- Data driven policy decisions
- Targeted interventions
- Strategic partnerships
- Community Capacity building
- Leveraged resources

Questions?
discussion whether the trauma center data should be used. There was consensus that there needs to be a standardized way to screen for TBI as well as collect data and clarification of the categories of cause of TBI.

<table>
<thead>
<tr>
<th>Action Items</th>
<th>Person(s) Responsible</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBI Screening procedures to be looked at and discussed with the LME’s with monthly feedback from the LME’s. Investigate ways to collect additional data</td>
<td>State TBI Program Staff Quality Management</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

**6. Agenda topic: Children & Youth**

**Discussion**

Concussion (mTBI) Management and Monitoring
Supporting Students in NC Public Schools

NC Brain Injury Advisory Council
Children & Youth Committee Updates
March 13, 2019

**Presenter Information:**

Liz Newlin, RN, BSN, NCSN
Co-Chair Children and Youth Committee
NC Brain Injury Advisory Council
Daisy8091@gmail.com

NC’s Important “Who”
Over 1.5 Million Students
Care Approach

Most symptoms will resolve within a few weeks. However, may get worse before they get better.

Cognitive rest
> Difficult to ‘rest’ your brain – more intentional awareness needed

Individualized approach

Presence of pre-existing mental/behavioral health conditions is more likely to extend symptoms

Centers for Disease Control and Prevention (CDC) recently released Pediatric mTBI Guideline.

This information provides essential recommendations for healthcare providers.

NC’s Why: Protections Existed for Student-Athletes Only

The Gfeller-Waller Concussion Awareness Act was drafted and implemented to protect the safety of student-athletes in North Carolina and was signed into law on June 16, 2011.

Gfeller-Waller Concussion Awareness Act

<table>
<thead>
<tr>
<th>Major area covered:</th>
<th>What is not addressed under GWCA Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>All student athletes who sustain a concussion within the realm of school related sports</td>
<td>ALL students who sustain a concussion... anywhere (in or outside of school)</td>
</tr>
<tr>
<td>Education of coaches, school nurses, volunteers, student athletes, parents</td>
<td>Educational information/materials for ALL educators working in NC public schools</td>
</tr>
<tr>
<td>Emergency Action Plan to include a post-concussion protocol (specific to removal from play for student athletes)</td>
<td>Removal from play/physical activity for ALL students who sustain a concussion</td>
</tr>
<tr>
<td>Return-to-play procedures for student athletes</td>
<td>Protocol specific to the return to the educational environment (for ALL students who sustain a concussion)</td>
</tr>
</tbody>
</table>
NC’s “What”: Education Policy to Support ALL Students

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Title</td>
<td>Return-to-Learn After Concussion</td>
</tr>
<tr>
<td>Policy Category</td>
<td>Student Health Issues (SHLT)</td>
</tr>
<tr>
<td>Policy ID</td>
<td>SHLT-001</td>
</tr>
<tr>
<td>Policy Date</td>
<td>2015-09-01</td>
</tr>
<tr>
<td>Statutory Reference</td>
<td>GS 115C-12(12)</td>
</tr>
</tbody>
</table>

**SHLT-001 – Key Components:**

**NC Public Schools must:**
A. Develop a plan, to include four main requirements
B. Identify a team responsible for identifying and monitoring students who sustain concussion
C. Provide relevant staff development on concussion and district/school procedures (annually)
D. Include a system of surveillance (question about head injury) collected annually

**OUTCOME DATA:**

**Return-to-Learn Policy SHLT-001**

SHLT-001 Implementation
2016-2017: 96/115 LEAs
2017-2018: 111/115 LEAs

[Graph showing NC Public Schools Concussion Data]

https://www.screencast.com/a/49368052/Return-to-Learn-Services-Resources
Suggestions for Concussion Diagnosis Discharge Instructions

- Determine who the “Concussion Contact” is at your child’s school
- Provide the paperwork from your health care provider in order to facilitate their safe return to the classroom/school environment and any suggested accommodations for school
- Talk with your child’s teacher, school nurse, coach, school psychologist, and/or counselor about your child’s concussion and symptoms they are experiencing.
- Provide ALL follow-up documentation from the health care provider to the Concussion Contact
- Communicate with school staff members about any concerns you have regarding your child’s recovery and/or functioning

Information/Resources

NC DPI Concussion Webpage
Developed to support effective concussion management and monitoring for ALL NC public school students who sustain a concussion, in accordance with State Board of Education Policy SHLT-001.

Return-to-Learn Implementation Guide – This resource was developed to support teams of professionals in establishing and delivering their response, support and monitoring protocol to ensure a student’s healthy and safe return to the school environment after sustaining a concussion.

Concussion Information Brochures (English and Spanish versions available)
These educational resources were developed in partnership with the NC Brain Injury Advisory Council, Children and Youth Committee.
Conclusions

There has been an increase in the identification of concussion due to parent/staff/teacher education. Gaps have been identified between hospitals and medical providers and the school system. The Children and Youth Committee is currently going to every Regional Trauma Group in NC suggesting emergency departments and medical providers follow the concussion diagnosis discharge instructions as presented in the presentation. The Children and Youth Committee is also reach out to county-led sports associations in NC to address the gap.

Sandy Pendergraft asked is committee has reached out to parent-teach associations and was told yes. Michael Brown stated that the soccer league that he is affiliated with has agreed for someone from BIANC to come out and set up booths to educate about concussions. There was a question if REAP was still being considered. Currently, REAP is not being implemented in NC due to duplicate efforts.

Action Items

<table>
<thead>
<tr>
<th>Person(s) Responsible</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &amp; Youth Committee</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

7. Agenda topic: TBI Action Plan and Council By-laws Update

Discussion
Volunteers are needed to assist with updating the TBI State Action Plan.

Conclusions

Action Items

<table>
<thead>
<tr>
<th>Person(s) Responsible</th>
<th>Deadline</th>
</tr>
</thead>
</table>

8. Agenda topic: Public Comment

Discussion
BIANC Update – Sandy Pendergraft gave an update on BIANC’s upcoming training, webinars, family conference, events, etc. BIANC still in search of executive director. Go to [www.bianc.net](http://www.bianc.net) for updated information.

TBI Waiver – there were some concerns from BIAC regarding
the rollout of the Medicaid TBI waiver. It was pointed out that the waiver has been slow to get started – due to procedures that have to be followed in order for approval for waiver. The momentum has picked up. Michelle Merritt updated group on provider training for the TBI waiver. Jerry Villemain reminded group that this is a pilot program and there are a lot of lessons to be learned.

Jeffrey Lube announced that the will be a Brain Injury Awareness Night event at the NC Museum of Natural Sciences on March 15, 2019 from 5:30 – 9:00 p.m. The event is free.

Carol Ornitz – Legislative Update
- HB 50 Hyperbaric O2 – Veterans TBI
- HB 77 Electric Stand up Scooters – Letter from council about safety without helmets.
- HB 257 Motorcycle/facemask bill – motocyclists will be permitted to wear facemasks while operating motorcycles.
- HB 267 Requires safety helmets under age 21
- HB 269 NC Caregivers Act - designate a caregiver

Liz Newlin – mentioned HB 76 – Arming teachers bill

Jerry Villemain asked for a motion for a consensus of council that legislative committee could respond on behalf of council on legislation related to TBI. Due to a lack of a quorum – Mr. Villemain decided that the legislative committee would respond on behalf of the council on legislation related to TBI.

There was also discussion about HB250
- Definition of TBI
- DHHS wrote this bill
- Debate about whether to include the definition of ABI or stick with TBI.
- Opportunity to get a definition of TBI into state law
- Statement of how TBI fits in the different systems
- TBI must be included whenever policy changes made including Medicaid Transformation.

Jean Andersen stated that CFAC is adding six seats to State CFAC.

Jerry Villemain announced that he will be stepping down as Chairperson of BIAC. Elections will be held at the June meeting.

<table>
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<tr>
<th>Conclusions</th>
<th>Continue legislative efforts on legislation related to TBI.</th>
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<td>Action Items</td>
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<th>9. Agenda topic: Adjourn</th>
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<td>Discussion</td>
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<th>Next BIAC meeting scheduled for June 12, 2019 at the Governor’s Institute.</th>
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<td>Action Items</td>
<td>Send out reminders to council members regarding next BIAC meeting</td>
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Respectfully submitted: Sandy Pendergraft.