

# beechwords

Deborah Cerra-Tyl, Editor

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## ASK THE LAWYER

### The Patient Protection and Affordable Care Act



**Nationally recognized attorney/advocate Joseph L. Romano, answers questions on the effects of the New Healthcare Reform Law for patients with Traumatic Brain Injuries**

#### ***Why is the New Healthcare Reform Law important legislation for the TBI Community?***

Over 1.3 million people suffer a traumatic brain injury each year and this is one of the leading causes of injury related hospitalizations for children under the age of 14. Meeting the healthcare needs of a patient with a traumatic brain injury requires extensive coordination of both private insurance benefits and governmental benefits. The New Healthcare Reform Law has provided greater access to the benefits and services that patients need.

#### ***What are the most important changes to private insurance benefits under this law?***

I consider **the** most important change the ban on lifetime limits of coverage for private health insurance contracts. Most insurers, prior to this legislation, had a 1 million dollar lifetime cap on benefits. Families, who have a loved one who has suffered a TBI know that a million dollars is often inadequate coverage for this type of injury.

The second most important change is that private health insurers can no longer drop coverage for a person after a serious illness or injury. We purchase health insurance in order to have coverage when it is most needed and to have your insurer drop you when this event occurs is an unfair practice.

Other important changes which have been made through this legislation are:

- Insurance companies cannot deny coverage for children with pre-existing conditions
- Unmarried adult children can remain on their parent's policy until the age of 26
- Establishes an internet site that an insured can view or download their Master Insurance Contract (the key document which identifies the patient's coverage).

#### ***Does the new law prevent insurers from denying benefits?***

No, unfortunately the New Healthcare Reform Law will not prevent an insurer from denying benefits. One of the most common reasons for denial of benefits that TBI patients encounter are Custodial Care denials. When an in-

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## Woods Services Announces New President



Peter S. Bodenheimer, chairman of the Woods Services Board of Trustees, announced that Diana L. Ramsay has been named as the new president and chief executive officer of Woods Services, a private, non-profit provider of services to adults and children with complex behavioral and intellectual disabilities. Ramsay will succeed Dr. Robert Griffith who is retiring after 24 years as Woods' president and CEO.

Ramsay joins Woods Services having most recently led operations integration and clinical redesign for Johns Hopkins Health System. Prior to that, she established herself in the mental health services field with more than 20 years of experience with the Sheppard and Enoch Pratt Health System, one of the nation's top 10 psychiatric health systems, and with Way Station, Inc., a nationally recognized community rehabilitation program and subsidiary of the Sheppard Pratt Foundation.

# The Patient Protection and Affordable Care Act

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insurer decides that a patient is custodial they will no longer cover any additional therapies or treatments. Often times this occurs before the patient is given an ample opportunity to show that they can make rehabilitation gains. Whenever a patient is denied benefits based on a custodial care denial, families should seek the assistance of an advocate or an attorney to challenge the denial.

## **Is there any help for patients who are uninsured and have a pre-existing condition?**

Each state is required to have an interim, affordable health insurance plan for patients who lack health insurance and has a pre-existing condition. In Pennsylvania, this insurance is called PA Fair Care and offers comprehensive coverage for patients for \$283.00 per month. To access more information on PA Fair Care, their website is [www.pafaircare.com](http://www.pafaircare.com) and their toll free number is 888-767-7015.

## **Are there any changes to the health insurance appeal process under this law?**

My experience with the health insurance appeal system is that it is a biased system to protect the fiduciary interest of the health insurer and fails to give due consideration to the opinion of patient's treating physician. Under the new act, an external appeals system will be implemented, and the request for services will be decided on the potential benefit a service or treatment holds for the patient. I have always advocated for this type of decision making process.

## **Home and Community Based Services have proven to be a key benefit for patients with TBI. Will these be expanded under the New Healthcare reform Law?**

I agree that Waiver services have proven to be an essential benefit for patients and their families and under the new law each state will be offered additional funding to expand their Medicaid services to include attendant care as a benefit under their state's Medical Assistance Plan. Under our present system, waivers such as the Commcare waiver are limited benefits and when funding is exhausted, patients are put on a waiting list to receive those services. If attendant care is added to a state's Medical Assistance plan, it would make these services an **entitlement**.

## **How will the Insurance Exchanges work?**

Consumers who cannot obtain affordable health insurance will be able to purchase their health care coverage through an Exchange that will be set up in every state. Depending on income and resources, individuals may qualify for premium assistance with their health insurance through the government. Each policy must cover the following essential services:

- Ambulatory Patient Services
- Emergency Services

- Hospitalization
- Maternity and Newborn Care
- Prescription Drug Coverage
- Rehabilitative and Habilitative Services and Devices
- Prevention and Wellness Services
- Chronic Disease Management
- Pediatric Services Including Vision & Oral Care

## **What advice do you have for TBI patients and their families about healthcare benefits and services?**

My best advice for patients and their families is to become familiar with all aspects of their health insurance contract and to seek assistance from an advocate to help coordinate their private benefits with available governmental benefits and services.

In order to be certain that the long term needs of a patient are met, it is more important than ever to investigate "What Happened?" to cause the injury or illness. The benefits that can potentially be obtained from a third party settlement are essential for providing the long term care for a patient. Patients need certain services and supports such as vans with modifications, home modifications, stem cell treatments, hyperbaric oxygen therapy, and respite care. By using novel long term funding approaches during the litigation process, I have been successful in obtaining these extra-contractual benefits, which are not covered by private insurance, Medical Assistance or Medicare. Having access to these services improves the quality of life for the injured individual.

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Joseph L. Romano, Esquire is an attorney whose practice is limited to the representation of seriously ill and injured children and adults. Mr. Romano assists with health insurance appeals, special education and government benefits, third party litigation, automobile accidents, worker's compensation claims, recreational accidents and defective product claims.

To receive a free copy of Mr. Romano's new book, "Legal Rights of the Seriously Ill and Injured: A Family Guide" contact his office at 1-800-331-4134.

## ARTICLE REVIEW:

# Evidence Based Cognitive Rehabilitation

by Thomas Felicetti, PhD

I want to draw your attention to the recent significant evidence-based review of cognitive interventions published in the April 2011 issue of the *Archives of Physical Medicine and Rehabilitation*. (Vol. 92#4). Dr. Keith Cicerone of JFK Johnson is the lead author and the article represents our work on the Cognitive Issues Task Force of the Brain Injury section (BI-ISIG) of the American Congress of Rehabilitation. The title is "Evidence-Based Cognitive Rehabilitation: Updated Review of the Literature 2003-2008" by Cicerone, Langenbahn, Braden, Malec, Kalmar, Fraas, Felicetti, Latsch, Harley, Berquist, Azulay, Cantor and Ashman.

This is the third and perhaps final meta-analysis of hundreds of the most important articles on cognitive treatment published in peer reviewed journals throughout this decade. For the 6 year period covered in this meta-analysis, we reviewed 141 articles. Each article was assessed for strength of evidence according to a rigorous methodology and each was "graded" by at least two of the authors listed in this review. From there we derived a series of recommendations, suggestions and practice standards, guidelines and options that, with careful reading, may constitute a primer for accepted cognitive treatment in Stroke and Brain Injury Rehabilitation.

As we know, cognitive deficits are a common result of brain trauma and as I stress in training sessions for therapists, families and individuals with brain injury, cognitive deficits are problems in how an individual thinks or organizes his or her thoughts, rather than problems in what the person is thinking. As such, unlike

some Psychoses, cognitive deficits as we see them are "thought processing" disorders rather than "thought content" disorders. The cognitive topics addressed in this meta-analysis are remediation of attention, visual and spatial functioning, language and communication, memory, executive functioning and comprehensive-integrated remediation. In a global sense, most of these deficits are self-explanatory to the layperson (We all have a general understanding of problems in paying attention, the ability to navigate visual space, speech and communication, and memory). Some of the terms are more obscure. For example, "Executive functioning" refers to abilities to organize and sequence thoughts, see the whole picture, plan ahead, make abstract connections etc. "Comprehensive-integrated rehabilitation" refers to treatment environments where numerous interventions are used together to treat cognitive problems rather than single therapies aimed at one particular type of deficit.

My purpose here is not to summarize the numerous recommendations. This would take up too much space in too many issues of *Beechwords*. It is simply to point the reader in the direction of an article which may well help set the standards of cognitive treatment for years to come.

The previous evidence-based reviews in this cognitive series were the most widely cited articles in the history of the *Archives*.

The field certainly owes Dr. Cicerone a great debt of gratitude for his scholarship and leadership.

## ARTICLE REVIEW:

# Vocational Issues in Aging with Brain Injury

by Thomas Felicetti, PhD.

Another recently published article which should be of interest to our readership appeared in the Winter, 2011 issue of *The Challenge*. (Vol 5, #1). This article entitled "Aging with Brain Injury: Vocational Impact Issues and Indicators" by M. Mozzoni PhD and T. Felicetti, PhD, was part of the special "Back to Work Issue" of that journal. *The Challenge* is published by the Brain Injury Association of America.

As with the study by Cicerone et al, this article is, in part, derived from research conducted by a task force of the brain injury section (BI-ISIG) of the American Congress of Rehabilitation Medicine. This particular task force is the Long Term Issues Task Force (LTITF), chaired by Dr. Tina Trudel, who was also lead conductor of the research project. The LTITF study surveyed hundreds of individuals aging with traumatic brain injury. These were individuals who were 10 years or more post injury, had sustained their injury after the age of 16 and were currently at least 30 years of age. The LTITF findings

supported other literature that as individuals age with brain injury, they face great challenges in being able to return to work or if they do return to some level employment, they face great challenges in maintaining that employment. My aim is to point the reader in the direction of this article, not to offer a comprehensive summary, but some salient points are:

1. While there is a very low reported level of post brain injury employment, there are sub-groups of individuals who did maintain a successful work experience. The article explores some factors that may have made this successful transition possible. It is important not to sugarcoat the potential post injury vocational outcomes, but as Dr. Trudel has said many times, *it is even more important to explore the factors that do work at work for individuals with brain injury and to offer practical suggestions*. Just because many people have a

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KEEPING THE TRADITION OF EXCELLENCE VIBRANT:

# Exceeding Stakeholder Satisfaction Expectations

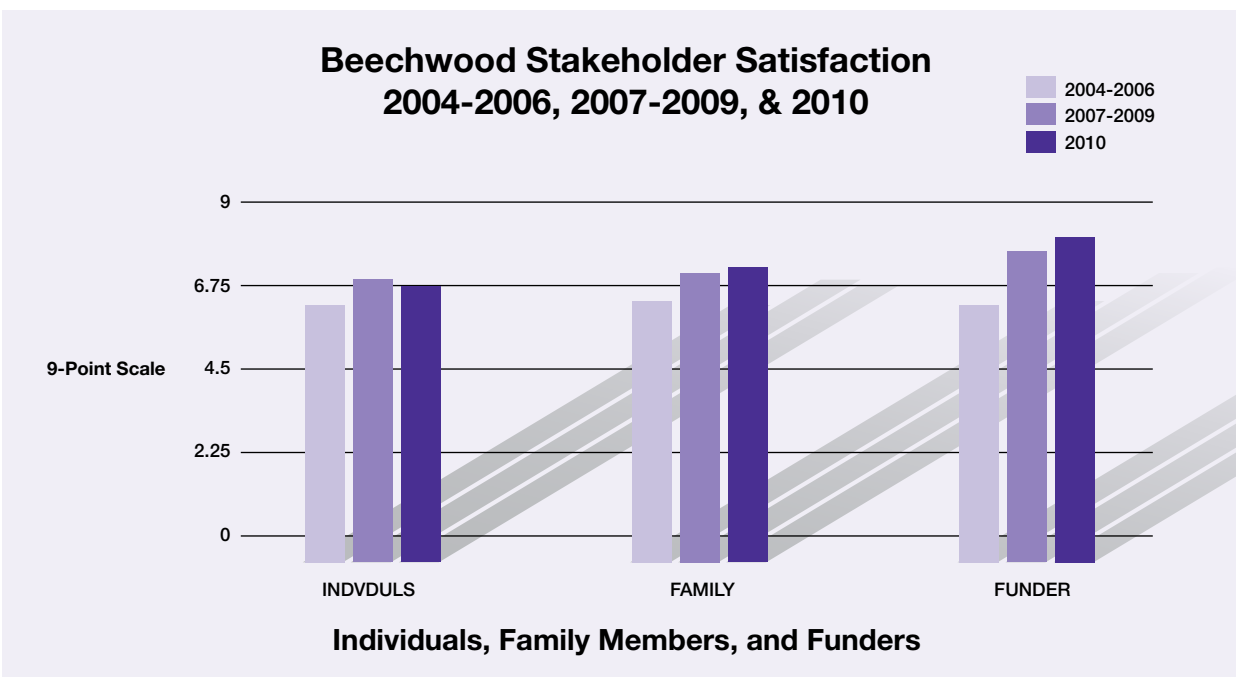
**Dr. Thomas Blash, Clinical Director**

Since our inception the Beechwood community committed to providing our Stakeholders with rehabilitation services of exceptional value. We determined to test our performance through our Program Evaluation System (**PES**). Our **PES** went through a significant modification in 2010 when we joined those providers who use the *Benchmark System*. The *Benchmark System* enables each member- provider to compare its performance against a “benchmark” population constructed from those individuals whose providers participate in this “benchmark” methodology. The *Benchmark System* pivots on the *Mayo Portland Adaptability Scale (MPAS)*. The **MPAS** is a well-researched and published tool with sound validity and reliability.

The *Benchmark System* provides all participants with a way to measure their performance against an external standard (**MAPS**) which becomes historical over time. However, we continue to maintain our passion to compare our performance in Stakeholder Satisfaction against the superb tradition of excellence we have enjoyed for over two decades. This splendid record includes Stakeholder Satisfaction which has consistently exceeded the expectations of those individuals whom we serve, members of their families, and the funders who provide financial support. We accomplish this aim by using the same survey forms we have used since the early 1990’s.

Over the past twenty years we have measured Stakeholder Satisfaction with the same three assessment forms. These forms underwent minor, **CARF**-driven modifications over the years that essentially changed some of the language used but not the domains sampled. Since the 1990’s we have employed the same quantitative scale to assess Stakeholder gratification. On this 9-point scale ratings provided between 1 and 3 represent dissatisfaction. Points given between 4 and 6 indicate satisfaction achieved meeting the rater’s expectations. When Stakeholders pinpoint satisfaction in the range exceeding their expectations they provide scores between 7 and 9.

The graph presented in this article makes comparisons of Stakeholder Satisfaction for our last two **CARF**-accreditation cycles with the year ending on December 31, 2010. These comparisons are made for the Individuals Served, Family Members, and Funders. The comparisons are arranged between the **CARF**-accreditation cycle for 2004 through 2006, the **CARF**-accreditation cycle for 2007 through 2009, and our satisfaction data for 2010. The graph demonstrates that Beechwood’s Stakeholder Satisfaction for 2010 remains consistent with our history of excellence. These data are in the range of “exceeding expectations.”



# Information Management and Performance Improvement Expanded

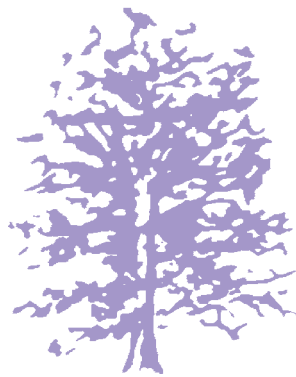
In December 2009 Beechwood received a three-year accreditation from the Commission on the Accreditation of Rehabilitation Services (CARF). This represented the sixth consecutive three-year accreditation achieved by Beechwood. In their formal report, the CARF survey team summarized their review by stating that Beechwood demonstrates a culture of performance improvement, has a well-tenured and experienced interdisciplinary team and enjoys strong relationships with the community. Improvements noted included an expansion of the existing IM and PI program to more fully incorporate the full extent of the Beechwood services and programs.

As we embarked on this expansion the following plan was completed and implemented in the fall of 2010. This IM and PI will be issued semi-annually and will consist of nine sections, with the final section as a summarizing management report. Most of the sections are either measures of program effectiveness or program efficiency. There are also demographics, accessibility information, satisfaction data and a business report. For each category of program efficiency and program effectiveness, there are general and specific measurable performance indicators.

The following is a list of the first eight of the sections of the report:

- Characteristics of persons served
- Benchmarking of client outcomes through the Mayo-Portland inventory and vocational rating scales
- Major behavioral incidents
- Major injuries, falls and reportable incidents
- Client, funder and family satisfaction
- Client, funder and family complaints
- Accessibility
- Business practices

The ninth and final section is the management summary. This report summarized reports 1 through 8 as well as other data relevant to the Woods Services corporate authorities. This establishes the communications feedback loop regarding Beechwood needs and performance to the Vice President/COO, President, The Director of Quality Assurance and The Board of the Parent Corporation of Beechwood, Woods Services. Corporate objectives relative to Beechwood are established and tracked and corrective actions for continuous quality improvement are assessed on an ongoing basis.



*Beechwood*  
**REHABILITATION SERVICES**

A Community-Integrated Brain Injury Program • An Affiliated Service of Woods Services, Inc.  
Program Locations in PA • 1-800-782-3299 • [www.BeechwoodRehab.org](http://www.BeechwoodRehab.org)

Beechwood does not discriminate in services or employment on the basis of race, color, religion, sex, national origin, age, marital status, or presence of a non-job related medical condition or handicap

## Aging with Brain Injury

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poor track record on employment, does not relegate any single individual with brain injury to an outcome of vocational breakdown.

2. Many of the issues that are challenging in the work environment for people with brain injury are social issues. These include negative attitudinal barriers on the part of employers and co-workers as well as social skill problems on the part of the person with brain injury. For example, we all may want to tell our bosses what we really think of them, but individuals without brain injury tend to hold back their thoughts in the interests of job security, while some folks with brain injury, who may be verbally disinhibited, do not practice this discretion as the better part of valor. Other potential roadblocks for some people with brain injury may be the tendency to over-socialize with customers and co-workers or to fail to pick up subtle non-verbal cues from the boss or fellow employees.

This may well point to the need for co-workers without brain injury to reach out at times to their colleagues with brain injury. Such relationships could evolve in a job culture which fosters mutual support and where co-workers are given some education about the effects of brain trauma.

## Congratulations to Dr. Felicetti



Dr. Thomas Felicetti, executive director of Beechwood was honored as a 2010 Fellow of the American Congress of Rehabilitation Medicine (ACRM). This honor was presented in recognition of his significant contributions to the field of medical rehabilitation and to the

ACRM. Dr. Felicetti has a long, prolific history working in the field of brain injury rehabilitation and providing human services. He has published numerous academic articles in scientific journals, book chapters, and non-academic articles as well. Dr. Felicetti also engaged in important research with ACRM colleagues, such as the recently published meta-analysis of evidence-based cognitive rehabilitation. Dr. Felicetti joined the ACRM 20 years ago, and served as chair of the Brain Injury-Interdisciplinary Special Interest Group from 2004-2006, chair of the BI-ISIG Nominating Committee from 2006-2008, led the BI-ISIG Long-Term Issues Task Force from 2000-2003 and served on the BI-ISIG Cognitive Rehabilitation Task Force.

# Beechwood

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