TBI FAQ Document

TBI APPROVED PROVIDER PROCESS QUESTIONS:

Q 1: Is there training for school psychologists to become TBI Approved Providers and provide TBI evaluations? When is the next training?
A: To reach more people more efficiently, the face-to-face curriculum has been changed to an online curriculum. This is the current forum for initial training. Currently, additional trainings can serve as *continued professional development for those already trained and ACTIVE on the TBI Registry* (e.g., additional modules of online curriculum, stand-alone venue, webinar, Exceptional Children's conference, etc.).

Q 2: Who can access the TBI Online Curriculum?
A: The TBI Online Curriculum was created for school psychologists and anyone interested in learning more about TBI, including teachers, administrators, parents, and/or students. School psychologists (licensed by the NC Department of Public Instruction) who successfully complete the online curriculum are eligible to participate in 30 hours of supervision with an approved supervisor.

Upon successful completion of supervision, school psychologists are eligible to be added to the TBI Registry of Approved Providers (TBI Registry).

Q 3: What is required to be added to the TBI Registry?
A: Information about becoming a provider can be found here**.**

Q 4: I'm listed as an approved provider. What steps do I need to take to remain on the TBI Registry?
A: To remain on the Registry, the following steps must be taken:

1. Maintain current contact information
    a. Approved providers are responsible for maintaining current contact information.
    b. Contact information should be reviewed on a regular basis. **Approved providers should notify the Registry of any changes by** updating their profile.
    c. Periodic updates of the Registry will be conducted to ensure it is accurate.
2. Complete professional development
    a. With regard to continuing education, beginning in the 2015-2016 school year, all approved providers will be required to complete a total of 1.5 CEUs on or before June 30th of their five-year anniversary date of addition to the registry. (For example, if a provider was added on October 1st, 2016, they must submit 1.5 CEUs on or before June 30, 2021). Everyone's due date (on or before June 30) is the same for ease of tracking on both the registry's and the provider's part.

TBI FAQ Document

b. This requirement can be met by completing the PD requirements within the established topic areas. This information can be found here. *Please click here to download the suggested topic areas*.
c. Complete the CEU Documentation Form as often as necessary, but at least on or before June 30th of your 5th anniversary year of addition to the registry, and your profile will be updated upon review.

Q 5: What would prompt removal from the TBI Registry?
A: Removal would be initiated if we are unable to reach you due to your changing positions, leaving your place of employment, or leaving the state. Therefore, we must maintain **TWO** email addresses on file (one work, one alternate). as it provides an alternate way to try and reach you should your employment status change.

If an approved provider is unable to be reached at their existing contact information after two weeks and multiple attempts, he or she will be made inactive from the Registry. This is to ensure that accurate information is published to the website at all times.

Removal would also be initiated if continuing education requirements are not met.

Q 6: If I am removed from the Registry, how do I get reinstated?
A: The School-Based Practice Advisory Council for TBI established a policy (10/15/15) regarding the re-entry of TBI approved providers that were removed from "active status" on the registry.

The process and criteria for reinstatement are as follows:

1) The individual must verify they are currently employed by an LEA or charter school in NC as a school psychologist.
2) The individual must provide documentation that they have been an approved provider at one point in time.
3) The individual must request reinstatement in writing to the TBI Registry email address, tbiregistry@cidd.unc.edu.
4) The individual must provide documentation of receiving 1.5 CEUs of professional development that are specific to TBI within 1 year from their written request for reinstatement to the TBI Registry. *Please click here to download the suggested topic areas.*
5) Upon receipt of the CEU documentation form reflecting the TBI-specific professional development received and confirmation of updated contact information by tbiregistry@cidd.unc.edu, the individual will be reinstated to the TBI Approved Provider registry and receive a confirmation letter from the Consultant for School Psychology on behalf of the NC DPI Exceptional Children's Division.
6) Reinstated individuals must continue to accrue the standard 1.5 CEUs within their 5-year CEU cycles to maintain active status.

TBI FAQ Document

Please note: *Any individual who has not completed the necessary steps to remain active on the Registry (by maintaining updated contact information and completing the CEU requirements) and has been "inactive" for one year (or more) beyond their CEU renewal cycle will not be considered for this type of reinstatement. In order to be placed back on the Registry of Approved Providers for TBI, such individuals will be required to successfully complete the entire TBI training process.*

Q 7: Can school psychology graduate students be added to the Registry?
A: Only licensed school psychologists who are employed within NC public schools and who have successfully completed training and supervision are eligible to be added to the TBI Registry. School psychology graduate students in their internship year can access the online curriculum and can engage in supervision. Upon employment with an LEA in the state of North Carolina, these individuals could submit the required materials to be added to the approved provider registry
Please note: Completion of this training would need to be current within the year upon submission of the required documents.

Q 8: Can private practitioners who are not currently employed by a Local Education Agency (LEA) be added to the TBI Registry?
A: The only private practitioners who may be added to the Registry are those who serve as TBI Approved Supervisors. Otherwise, *only* licensed school psychologists who are employed by a Local Education Agency (LEA) and have successfully completed training and supervision are eligible to be added to the TBI Registry. Private practitioners are welcome to access and work through the TBI Online Curriculum to review TBI, if they so desire.

Q 9: Can retired school psychologists remain on the TBI Registry?
A: Yes, retired school psychologists who maintain their licensure and wish to remain on the Registry may do so by (prior to retirement) submitting a letter indicating their interest to do so. In addition to completing the continuing education requirements and maintaining up-to-date contact information, retirees are also required to submit a copy of their active license (SBE or NC Psychology Board) with the TBI Registry.

Q 10: Do I need additional training to be added to the Approved Provider Registry if I have received training in TBI specific assessment in another state?
A: Although many other states offer various forms of training and development to bolster the effective assessment of TBI in the schools, North Carolina is unique in that a policy exists governing the training requirements of those performing the psychological evaluation component when the need for special education services as a result of TBI is being considered and evaluated. For this reason, psychologists who are attempting to join the Registry based on a review of their other training must be vetted according to the North Carolina training criteria.

TBI FAQ Document

The criteria used for inclusion will be as follows:

- The potential provider must show documentation of adequate TBI specific didactic training that covers Neurological Anatomy and Behavior, Advanced Neuropsychological Assessment techniques, and TBI Intervention and Treatment.
- In addition to this, the potential provider must prove that they have undergone at least 30 hours of supervision from a licensed neuropsychologist. This supervision must include supervised assessment of TBI, case study, and other advanced training equivalent to the 30 hours of supervision required for NC Approved Providers.

1) To be considered for inclusion in the TBI Approved Provider registry a request must be submitted in writing to tbiregistry@cidd.unc.edu. Along with this letter, please include any/all documentation of TBI Training as relates to the NC Training Criteria above. This may include documentation of coursework, transcripts, sample TBI Assessment Reports, and any other documentation that would support your inclusion.

2) The submitted documents will be reviewed, and a determination will be made regarding whether any further required training is needed to meet the NC requirement. Your submitted documents will be filed for reference.

3) **If no further training is required**: The potential provider will receive written confirmation of Approved Provider status. You will be required to complete further professional development (CEU) requirements on a 5-year cycle exactly like providers who are added to the Registry through the traditional process.

4) **If further training is required:** Any additional training requirements must be documented, and proof of additional required training must be submitted to tbiregistry@cidd.unc.edu. Your status will be determined based on a review of documentation and, if accepted, you will be issued a confirmation letter from the Consultant for School Psychology on behalf of NC DPI EC Division. To maintain your status, you must complete further professional development (CEU) requirements on a 5-year cycle exactly like providers who are added to the Registry through the traditional process.

TBI FAQ Document

SUPERVISION QUESTIONS:

Q 11: How are Approved Supervisors chosen?

A: Supervisors are practicing neuropsychologists who are approved through a process set out by the NC DPI School-Based Practice Advisory Council for TBI.

- Potential supervisors should submit a letter of interest to the Consultant for School Psychology.
- The potential supervisor will be asked to submit a CV and other supporting documents to the TBI Council.
- The supervisor will then be assessed by council members using a rubric which was developed to ensure that knowledge and understanding of school eligibility criteria exists, as well as practice specific to pediatric neuropsychology.
- An adequate score on the assessment rubric and review of supporting documents will lead to addition to the list of approved supervisors for TBI training purposes. The newly added supervisor will receive a welcome letter and information on guidelines for TBI Supervision from the Consultant for School Psychology on behalf of NC DPI EC Division.

**The TBI Council will only be required to vote on a potential supervisor if there is some relevant question or the assessment rubric is borderline for a candidate.*

Supervisors are also sought out based on their geographic location to try and provide adequate opportunities for supervision in all 8 of the DPI established regions within North Carolina.

Q 12: I don't live close to any of the approved supervisors. Can I complete supervision through a virtual platform?

A: Electronic supervision should generally be reserved for supervision groups consisting of no more than 3 supervisees. With these smaller group sizes, when possible, at least 15 hours should be provided in-person. Individuals interested in utilizing electronic communication for a portion of supervision should discuss the option with their potential supervisor. It is ultimately up to the supervisor and trainee to decide if electronic supervision is appropriate.

TBI ASSESSMENT QUESTIONS:

Q 13: Is a TBI provider required to administer the psychological evaluation of all students being considered for TBI, including reevaluations of those students with existing TBI classifications?

A: Any student case brought forward for consideration as TBI (whether in the context of an initial referral or reevaluation) should involve a school psychologist or private psychologist who has met the guidelines of the Exceptional Children Division for training in the assessment of Traumatic Brain Injury and listed on the Exceptional Children Division's Registry of Approved Providers.

TBI FAQ Document

Involvement in the individual evaluation:
This involvement may include collaboration with other members of the student's evaluation team to assist with reviewing student records, conducting observations, and administering formal and informal assessments of the student's functioning. This involvement may be within the context of collaborative consultation, and limited to providing guidance to the IEP team on the evaluation process and specific assessments that may be needed. Ultimately, the TBI Approved Provider should determine the extent of their direct involvement in the individual assessment process on a case-by-case basis.

Involvement in the analysis & synthesis of evaluation data, and instructional recommendations:
The TBI Approved Provider should be directly involved and collaborate with other evaluators and IEP team members to analyze and synthesize all evaluation data, and make instructional recommendations for the student.

Q 14: Do we call our evaluations neuropsychological vs. psychoeducational evaluations?
A: Unless the evaluation is conducted by a trained neuropsychologist, the reports should not be called neuropsychological evaluations. Due to the multiple sources of data collected in any evaluation, the title of 'evaluation report' is sufficient. The signature section should indicate the school psychologist's/private psychologist's status as a TBI Approved Provider to demonstrate that the evaluation was conducted in alignment with the policy requirement.

Q 15: Are school psychologists able to conduct TBI evaluations during the supervision process?
A: Yes, it is actually recommended that school psychologists engage in their first TBI assessment case while they are under the direct supervision of a TBI Approved Supervisor. For school psychologists conducting the psychological evaluation of TBI referrals during supervision:

1. The report should reflect that the evaluation was conducted during supervision
2. Supervisor and credentials should be referenced; however, the supervisor does not need to sign the report
3. Sample wording for the report: *"This evaluation was conducted while under the supervision of NAME/CREDENTIALS OF APPROVED SUPERVISOR, an approved supervisor for traumatic brain injury (TBI) in accordance with the North Carolina Department of Public Instruction."*

Q 16: When determining eligibility for services, what are the recommended assessments for communication skills? Are there specific assessments that are preferred or specific areas that a speech/language or communication evaluation should focus on when assessing students with a TBI?
A: The SLP is a core component to the TBI team. It is recommended that the expertise of the SLP be used to determine which assessment tools may be appropriate. In general, the assessment of communicative intent, receptive language, expressive language, and

TBI FAQ Document

pragmatic skills should be considered. Remember to consider the capability of the child (e.g., do they have speech at all) when selecting which assessment tools to measure these skills.

Q 17: What battery of tests is recommended for a TBI assessment?

A: If you have gone through the training to be an approved provider, you'll know that the focus is more construct-driven, rather than battery-driven. Within a problem-solving model, the idea is to figure out what it is you are trying to accomplish with an assessment. For example, if you are trying to assess memory, there are many tools you could use, such as the WRAML2, CMS, or the TOMAL-2. It is important to remember, however, that there are some students who cannot withstand a complete battery, so you may need to critically pick and choose subtests based on where the child is with their cognitive stamina, physical stamina, and attention. So, in general, focus on construct, rather than battery. You are encouraged to review the tests and measures listed for each construct in the TBI Online Curriculum. Additionally, it is important to note that it is critical for schools to utilize multidisciplinary teams to address TBI issues, including speech & language pathologists, occupational therapists, physical therapists, school nurses, and others.

Q 18: How much medical documentation is needed to consider TBI?

A: Documentation is required that shows that some event happened, and the brain was affected. Documentation that lists residuals is especially useful. This does not automatically mean the child qualifies for special education services. Neurologists and neuropsychologists may also differ in their opinions about an individual. NC Policy [NC 1503-2.5 (13)(ii)] requires that a written verification by a physician or a licensed psychologist, appropriately practicing in the specialty of neuropsychology, must be obtained. No time limits exist for written verification.

Q 19: Could a sample report or template for a TBI assessment be provided?

A: It is preferred that school psychologists work within their own district because there are different requirements for report formatting, etc. among districts. However, it is generally recommended that reports be construct-driven. For example, when assessing memory, you may discuss verbal vs. visual memory, short-term vs. long-term memory, incidental memory, retrieval cues, etc. For attention, you may want to discuss selective attention, sustained attention, and divided attention, and then discuss any breakdowns. Go through each construct this way. Your SLP may help you break apart language functions. OTs and PTs will be an asset in this process, too. Scores may be provided, but this is not the focus of a TBI report.

Q 20: What are the challenges of locating or recognizing cases of mild TBI?

A: In NC and around the country, mild cases are often the ones missed. In general, about 75 to 80 percent of brain injuries are mild on the continuum. Although they are called mild, some of the symptoms are still significant and challenging (e.g., double vision, recurring

TBI FAQ Document

headaches, attention difficulty). The Gfeller-Waller Concussion Awareness Act helps to identify students who are injured during school sports; however, this still misses elementary-aged children and those who suffer injuries outside of the school sport arena. In October 2016, NC State Board of Education approved a concussion monitoring policy (SHLT-001) that extends beyond the scope of Gfeller-Waller. Section (d) of this policy requires the following: *each LEA and charter school will include in its annual student health history and emergency medical information update a question related to any head injury/concussion the student may have incurred during the past year.*

DEFINITION QUESTIONS:

Q 21: How does the revised definition of TBI impact evaluations of students who appear to have characteristics of both Autism and TBI?

A: This issue would present the most challenges in very young children, where there is a clear indication of a brain injury. In these cases, distinguishing factors of ASD may be difficult to ascertain due to the TBI occurring early in the child's developmental history. Children with ASD can incur a TBI; however, it likely will never be the case that a child who sustains a TBI will manifest a developmental disorder, although many of the same symptoms might surface (e.g., blunted affect, social problems, communication difficulties, pragmatic language issues, etc.). A thorough developmental history is critical in these cases.

Q 22: Can seizure disorder be considered within the TBI classification?

A: Two questions should be considered: 1) what is the nature of the injury and 2) does it affect educational performance and require specially designed instruction? To answer the first question, not all seizure disorders cause traumatic brain injury. It is the extreme causes, like status epilepticus, that cause injury. Those with seizures lasting multiple minutes (status epilepticus) may have sustained significant injury from the seizure. Therefore, TBI would likely be a consideration for these cases. To answer the second question, not all individuals with seizure disorders require special education. To be eligible, the injury must interfere with educational performance and require specially designed instruction.

Q 23: Can meningitis be considered within the TBI classification?

A: Meningitis is an infection of the brain that could be considered under the TBI classification. However, just because a student had meningitis does not mean they have brain impairment, because the brain can heal. Studies show that if you have meningitis and concomitant neurologic impairment at that time, you are at greater risk for having neurocognitive and neurologic impairment post recovery. Consider what is going on with the child while they have meningitis. Conduct assessments and determine if they have educational needs that warrant special education services.

Q 24: What about districts where there is a small number of school psychologists

TBI FAQ Document

trained to conduct TBI assessments? Does the current definition mean that all school psychologists need to be appropriately trained?
A: As of December 2016, approximately 22% of the NC school psychology workforce is trained and on the Registry of Approved Providers. Although school psychologists should have some level of training, it is not expected that all school psychologists within the state of NC be certified as approved providers.

Q 25: Are we to differentiate between TBI and SLD?
A: Yes, you must differentiate between TBI and SLD. TBI, in general, tends to be an acute process. In other words, the child functions one way, then an event occurs, which causes injury. In comparison, a child with a learning disability was born with a brain that is different. This does not automatically mean a brain injury; it is more of a neurodevelopmental issue.

Q 26: I have a student who had a grade 4 brain hemorrhage at birth, was 13 weeks premature, and stayed in the NICU for three months. He suffers from severe seizures and right-side hemiplegia. He has a diagnosis of Cerebral Palsy and is currently six years old. The cause of his problems seems to be an internal occurrence. Is there any reason why this student's disorder would not be considered a TBI or that he would be considered for a different area of eligibility? He has visual, auditory, and language consequences.
A: Ultimately, it comes down to how the team and family decide on services – remember, it is a team decision. The definition opens the possibility of considering students like this within the educational classification of TBI. This may also help to decrease the number of students being classified under the category of Developmental Delay, when TBI or Multiple Disabilities may be more appropriate.

Q 27: We often see children who had the umbilical cord around their neck at birth or children who were born prematurely and have learning difficulties later. These children often do not fit a specific category. What are some specific birth trauma that would fall under the TBI definition?
A: For example, the grade 4 hemorrhage is a neurologic event that could occur and cause problems later. Cords wrapped around the neck are not always a problem (i.e., it depends on the amount of pressure: sometimes there is enough slack that it does not cause injury, while other times it could cause anoxic brain injury). *Anoxic brain injury falls under TBI*. Prematurity by itself does not fall under the TBI classification. For prematurity to fall under TBI there should be a specific event that occurred causing the prematurity. For example, when you hear that a child was premature, in general, you should watch the child to see if they are struggling and possibly consider other areas of eligibility. *Stroke, anoxic events, etc. fall under the TBI category.*

Q 28: What about injuries that occur in utero?

TBI FAQ Document

A: An example could be fetal alcohol syndrome, but this does not currently fall under the NCDPI definition of TBI. Birth injuries can be considered, but not those that occur in utero or prenatally (e.g., strokes, seizures, etc.).

Q 29: Where would drug use or substance abuse fall, such as the use of inhalants, specifically, if they cause neurological impairment?
A: If brain impairment exists as a result of substances and it can be documented, then it could be argued that TBI may be an area for *consideration* for that student. Research shows that children that have used and stopped do not look different neurocognitively. It is the chronic users that look different neurocognitively.

Q 30: In a case where a child underwent surgery to drain subdural hematomas, is the surgical report signed electronically by the surgeon with a discharge diagnosis of bilateral subdural hematomas sufficient to meet the requirements of Section1503, 13 ii (written verification by a physician or a licensed psychologist, appropriately practicing in the specialty of neuropsychology… must be obtained)?
A: Yes, it is. That is a clear brain injury and you can find out how the injury occurred from their history.

MISCELLANEOUS:

Q 31: What are some directives on how we can better serve those students who are currently placed in Youth Development and Detention Centers?
A: Unfortunately, there is much improvement to be had in our work to support children in this setting. It is important to screen and thoroughly assess individuals at these facilities because many probably have either neurodevelopmental problems (severe learning disability or neuropsychiatric condition) or TBI. This will allow us to better understand what they can and cannot do, as well as their history, which will drive their treatment.