

TBI Tuesdays

Return to Learn: Equal Access to Education for Students with Brain Injury

March 23, 2021



TBI TARC is supported by contract number HHSP233201500119I from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201

Welcome to Today's TBI Tuesday Session



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TBI Team Lead

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Webinar Logistics

- Participants will be in listen-only mode during the webinar. Please use the **chat** feature in Zoom to post questions and communicate with the hosts.
- During specific times in the webinar, we will have opportunity to **respond to questions** that have been entered into **chat**.
- The webinar will be live captioned in English.
- The webinar will also have an American Sign Language (ASL) interpreter.
- This live webinar includes polls and evaluation questions. Please be prepared to interact during polling times.



Feedback and Follow-Up

- After the webinar, you can send follow-up questions and feedback to tbitarc@hsri.org
(Please note: This email address will not be monitored during the webinar.)
- A recording, including a pdf version of the slides, will be available on the ACL website (acl.gov)

Who's Here?



“In what role(s) do you self-identify? Select all that apply.”

1. Person with a traumatic brain injury (TBI) or other disability
2. Family member or friend of a person with a TBI or other disability
3. Self-advocate / advocate
4. Peer-specialist / peer-mentor
5. Social worker, counselor, or care manager
6. Researcher / analyst
7. Service provider organization employee
8. Government employee (federal, state, tribal, or municipal)

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○ What we
will
cover

Part 1

Part 1

- Overview of Return to Learn/Return to Play Workgroup
- Policy and best practices in Return to Learn
- Academic supports for students after brain injury participating in online learning
- Lived experience: Pennsylvania's BrainSTEPS Program

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What we will cover

Part 2

Break

Part 2

- To legislate or not to legislate
- Discussion

Meet Our ACL State Speakers



**Julie Myers,
MPH**

*Public Health
Program Administer*

Pennsylvania
Department of
Health



**Karen McAvoy,
PsyD**

*Clinical and School
Psychologist*

REAP and Get
Schooled on
Concussions



**Dr. Brenda
Eagan-Johnson**

Program Director

BrainSTEPS



**Hillary
McClain Tears**

Clinical Instructor

University of
Pittsburgh School
of Dental Medicine



**David Kracke,
JD**

*Brain Injury
Advocate/Coordinator*

Center on Brain
Injury Research
and Training

OVERVIEW: RETURN TO LEARN WORKGROUP



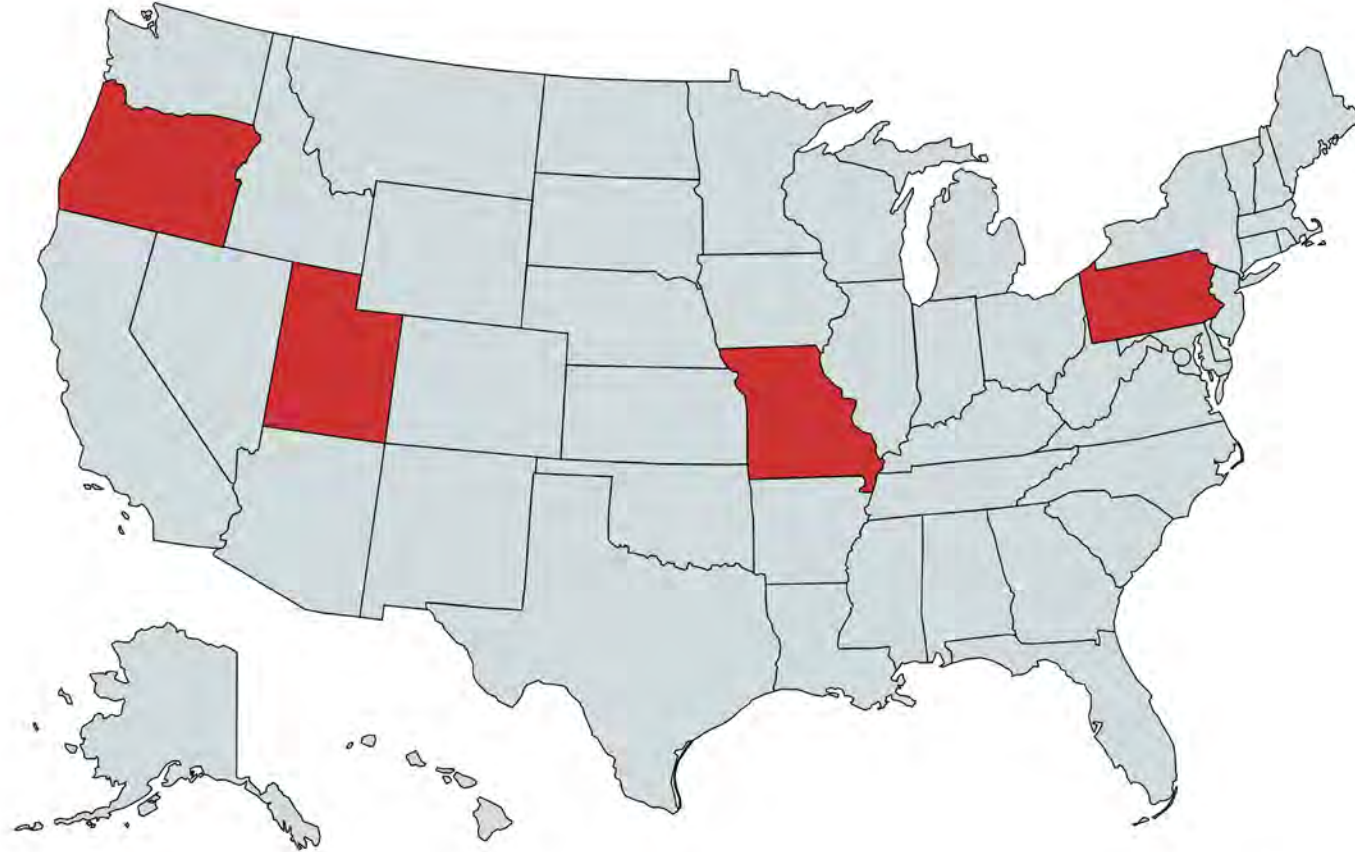
Terminology

- **Return to Play** – covers all activities related to school athletics reentry (should include sports and sports-related clubs and activities, gym class, and recess)
- **Return to Learn** – covers all activities related to academic school reentry
- **Return to School** – umbrella term that encompasses both return to play and return to learn; covers all activities related to school reentry



Overview

- **Participating States:**
Missouri, Oregon, Pennsylvania, Utah
- **Purpose:** To provide mentorship in Return to Learn and to develop Return to Learn products
- **Products:**
 - Return to Learn Workforce Competencies
 - Return to Learn Toolkit





Return to Learn After Concussion: Recommended Protocol



Sample Products

(slide 1 of 4)

BrainSTEPS (Strategies Teaching Educators, Parents, and Students)

Return to Learn After Concussion:
Recommended Protocol

brainsteps.net/_orbs/about/BrainSTEPS.RTL.CMT.Protocol.11.2017.pdf



Get Schooled On Concussions: Points of Vulnerability		
	Yes/No	Comments:
Many states have legislation for RTP and for education (aka identification) of concussion. However, few states have language about Notification (communication) and RTL. This form helps schools/districts figure out if they have the requirements of their law covered and what other "best practices" they might already have, or they might need, to round out a comprehensive concussion management protocol.		
Identification:		Identification: What does your law say about who should be educated about identification of concussion?
Law- What does your law say? Who is required to get "education" about concussion in your state?		
Do other supervisors of sports (not covered by your RTP legislation) also get concussion identification training?		
Do you have Athletic Trainers? For what sports? For what levels? Can ATC's help students with concussion in other sports? Levels?		
Do you have School Nurses and/or Health Techs?		
Do you have a school or district policy on concussion identification/education for your school nurses or health techs?		
Do your PE teachers get training on concussion identification? If yes, how often and how?		
Do your playground supervisors get training on concussion identification? If yes, how often and how?		
Do you have other frontline staff that get training on concussion identification? If yes, how often and how?		
Do your teachers get training on concussion identification? If yes, how often and how?		
Other:		
Notification INTO the school and DOWN to the staff:		What does your law say about who should be notified of the concussion and how communication should flow into a school/district from outside of a school/district?
Law - What does your law say about notification of a concussion?		
Does your school/district have a process for coaches to notify someone IN the school about a concussion? Who?		

Sample Products

(slide 2 of 4)

Sample Products from Toolkit

Get Schooled on Concussion:
Points of Vulnerability

Available for download at
getschooledonconcussions.com



Sample Products

(slide 3 of 4)

Sample Products from Toolkit

Traumatic Brain Injury Classroom Tips for Teachers

[cdc.gov/headsup/pdfs/schools/tbi_classroom_tips_for_teachers-a.pdf](https://www.cdc.gov/headsup/pdfs/schools/tbi_classroom_tips_for_teachers-a.pdf)



Helping Students Recover from a Concussion: CLASSROOM TIPS FOR TEACHERS

Below are some general tips that may help your students slowly get back into their school routine:



- Allow them to spend fewer hours at school until symptoms lessen.
- Excuse them from physical activities, such as recess, physical education (PE) class, and sports, until approved by a healthcare professional who has experience treating concussions.
- Help them avoid noisy and over-stimulating environments if these activities make their symptoms worse.
- Allow them to take more time on tests or assignments, and consider rescheduling testing.
- Plan for times during the day when they can take time to rest.
- For older students, consider having them reschedule, drop, or audit more difficult or elective classes without penalty if they need support for a long period of time.

How can I help students who are recovering from a concussion?

As a teacher, you play an important role in helping students recover from a concussion as they return to school. Making short-term changes to your students' school workload and schedule—and giving them the time to help their brain heal—can help them get back to their regular school routine. As they begin to feel better, you can slowly remove these changes.

Concussion symptoms may return as students get back to physical or mental activities, so be sure to watch out for any worsening symptoms (such as headaches, a hard time concentrating, and/or nausea) and update their parents.

Before choosing what changes you will make:

- Work with students and their parents to identify the type and length of activities your students can handle, and create a plan on how to address any schoolwork they may have missed.
- Tailor the plan to each student. Take into account your student's age, types of symptoms, level of understanding, and emotional status. No two students are alike in the concussion symptoms they have and how they recover from a concussion.
- Coordinate the classroom changes with your students' other teachers and other school professionals so that your students have the same level of support throughout the school day.



Title of Webinar

Presented by

Webinar Sharing Information

Link to recording of the webinar

Webinar Description

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Speaker/Presenter Information

Biography Statement

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Financial Disclosures Statement

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Non-Financial Disclosures Statement

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Suggested/Intended Audience

1. Lorem ipsum dolor sit amet, consectetur adipiscing elit.
2. Sed mollis aliquam nibh.
3. Pellentesque pellentesque dictum urna.

Learning Objectives

1. Vivamus gravida lorem vel neque pulvinar bibendum.
2. Aenean vestibulum odio faucibus sapien.
3. Pellentesque accumsan auctor tortor.

Materials

1. Link to Presentation PDF
2. Other materials

Sample Products

(slide 4 of 4)

Sample Products from Toolkit

Draft: Webinar Sharing Form

POLICY AND BEST PRACTICES IN RETURN TO LEARN



R*E*A*P



Owner of R*E*A*P & Partner with NASHIA on
R*E*A*P: Remove/Reduce*Educate*Adjust/
Accommodate/Pace

Co-Owner of GetSchooledOnConcussions.com

Karen@GetSchooledOnConcussions.com

303-818-8765

Best Practices Return to Learn (RTL)

JOURNAL OF
SCHOOL HEALTH



RESEARCH ARTICLE

Establishing Consensus for Essential Elements in Returning to Learn Following a Concussion

KAREN McAVOY, PsyD^a  BRENDA EAGAN-JOHNSON, EdD, CBIST^b  ROSALIE DYMACEK, PhD^c STEPHEN HOOPER, PhD^d MELISSA McCART, DEd^e
JANET TYLER, PhD, CBIST^f

Citation: McAvoy K, Eagan-Johnson B, Dymacek R, Hooper S, McCart M, Tyler J. Establishing consensus for essential elements in returning to learn following a concussion. J Sch Health. 2020; DOI: 10.1111/josh.12949

National Organizations

National Organizations who endorse the 13 Return to Learn consensus statements

National Organization

American Academy of Pediatric Neuropsychology
American Medical Society for Sports Medicine
Brain Injury Association of America
Defense and Veteran's Brain Injury Center
High School RIO: Reporting Information Online
National Athletic Trainers' Association
National Association of School Nurses
National Association of School Psychologists
National Association of State Head Injury Administrations
National Federation of State High School Associations
North American Brain Injury Society
Unites States Brain Injury Alliance

National Organizations who took part in the Delphi Process: Reached consensus on the 13 statements and gave support

American Academy of Pediatrics
American Physical Therapy Association
American Academy of Neurology

Thirteen Consensus Statements

Table 3. National Collaborative on Children’s Brain Injury Concussion Return to Learn 13 Consensus Statements

- Students recovering from a concussion often need an initial period of relatively greater cognitive and physical rest, the timing and specific nature of which will vary from student to student
- An estimated 70% of students recover from a concussion in 28 days with a gradual reduction of symptoms.¹¹ This supports a gradual return to social and cognitive activity at home and school over the first 4 weeks of recovery. The speed of re-introduction will vary and must be individualized
- Numerous positive social and emotional benefits are gained by being at school, even during recovery from a concussion. Unless contraindicated by a serious medical complication, a student with a concussion should return to school/learn even before symptoms are 100% resolved, provided the student can manage fluctuating symptoms, and the school concussion management team has received education and resources to support the student in the educational setting
- A concussion management team should include representatives from school academic, school physical/health services, medical, and family/student domains who work collaboratively to develop and adjust an individualized Return to Learn plan.
- A family is advised to seek out medical evaluation, specifically, a timely medical evaluation, treatment, and clearance for each concussion (regardless of the age of the student or the mechanism of injury)
- Academic adjustments written into the Return to Learn plan are best overseen and directed by school professionals with dedicated expertise and knowledge of educational law, policy, and curriculum, guiding a collaborative Return to Learn process among the members of the concussion management team
- Progress monitoring should include symptom monitoring, no less than one time per week
- Progress monitoring should include academic monitoring, no less than one time per week
- Schools have existing educational safeguards to support all students who struggle academically, medically, psychologically, and socially at school. Concussion can be included and managed using the existing educational safeguards
- Schools should provide increasing tiers of academic support for the students with concussions that do not resolve in a typical timeframe
- Schools may apply their existing tiers of support for students with concussion and need not delay or postpone academic supports while awaiting community health care input if medical input is not timely or available
- Data from a neuropsychological evaluation, is not required, but can be helpful and should be considered and may be incorporated into a Return to Learn plan if available
- Existing educational safeguards exist for students, although they are little known and underutilized for concussion. They are prompt, flexible, and systematic for all concussed student athletes and non-athletes with academic needs. Return to Learn can be robust, widespread, systematized, and sustainable if embedded into existing educational frameworks

Cognitive Rest

1. Students recovering from a concussion often need an initial period of relatively greater cognitive and physical rest, the timing and specific nature of which will vary from student to student.

2. An estimated 70% of students recover from a concussion in 28 days with a gradual reduction of symptoms. This supports a gradual return to social and cognitive activity at home and school over the first 4 weeks of recovery. *The speed of re-introduction will vary and must be individualized.*

3. Numerous positive social and emotional benefits are gained by being at school, even during recovery from a concussion. Unless contraindicated by a serious medical complication, a student with a concussion should return to school/learn even before symptoms are 100% resolved, provided the student can manage fluctuating symptoms and the school concussion management team has received education and resources to support the student in the educational setting

Concussion Management Team Composition

4. A concussion management team should include representatives from school academic, school physical/health services, medical, and family/student domains who work collaboratively to develop and adjust an individualized Return to Learn plan.

5. A family is advised to seek out medical evaluation, specifically a timely medical evaluation, treatment, and clearance for each concussion (regardless of the age of the student or the mechanism of injury).

6. Academic adjustments written into the Return to Learn plan are best overseen and directed by school professionals with dedicated expertise and knowledge of educational law, policy, and curriculum, guiding a collaborative Return to Learn process among the members of the concussion management team.

Progress Monitoring

7. Progress monitoring should include symptom monitoring, no less than one time per week.
-
8. Progress monitoring should include academic monitoring, no less than one time per week.

Ascending Levels of Academic Support

9. Schools have existing educational safeguards to support all students who struggle academically, medically, psychologically, and socially at school. Concussion can be included and managed using the existing educational safeguards.

10. Schools should provide increasing tiers of academic support for students with concussions that do not resolve in a typical timeframe.

11. Schools may apply their existing tiers of support for students with concussion and need not delay community or postpone academic supports while awaiting community health care input if medical input is not timely or available.

Neuropsychological Testing

12. Data from a neuropsychological evaluation *is not required* *but* can be helpful, should be considered, and may be incorporated into a Return to Learn plan if available.



70% of students with a concussion resolve within 28 days

Return to Learn Legislation

13. Existing educational safeguards exist for students. They are prompt, flexible, and systematic for all concussed student athletes and non-athletes with academic needs. Return to Learn can be robust, widespread, systematized, and sustainable if embedded into existing educational frameworks.

Cognitive Rest (Return to School)

1. Students recovering from a concussion often need an initial period of relatively greater cognitive and physical rest, the timing and specific nature of which will vary from student to student.

2. An estimated 70% of students recover from a concussion in 28 days with a gradual reduction of symptoms. This supports a gradual return to social and cognitive activity at home and school over the first 4 weeks of recovery. *The speed of re-introduction will vary and must be individualized.*

3. Numerous positive social and emotional benefits are gained by being at school, even during recovery from a concussion. Unless contraindicated by a serious medical complication, a student with a concussion should return to school/learn even before symptoms are 100% resolved, provided the student can manage fluctuating symptoms and the school concussion management team has received education and resources to support the student in the educational setting

Clinical Report from AAP on RTL

PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

... as symptoms become **tolerable, short-lived, and/or amenable to rest and intervention**, the student may return to school, often with the use of supplemental academic adjustments.

Returning to Learning Following a Concussion

Mark E. Halstead, Karen McAvoy, Cynthia D. Devore, Rebecca Carl, Michael Lee, Kelsey Logan and Council on Sports Medicine and Fitness, and Council on School Health

Pediatrics; originally published online October 27, 2013;
DOI: 10.1542/peds.2013-2867

The online version of this article, along with updated information and services, is located on the World Wide Web at:

<http://pediatrics.aappublications.org/content/early/2013/10/23/peds.2013-2867>

**There is NO RTL
without first a
successful Return to
School**

Source: Halstead ME, McAvoy K, Devore, CD et al. Clinical Report, Returning to Learning Following a Concussion, 2013, <http://www.ksno.org/wp-content/uploads/2014/05/rettolearn.pdf>

Return to School vs. Return to Learn

Return to School (RTS)

Defined as:

- The process of the student physically walking back into a school setting. The decision to send a child to school on any given day is **directed by the parent, often with input from a healthcare provider** and is dependent upon the student's ability to manage symptoms well enough to be physically and cognitively present in the classroom to listen and learn.
- **Audience = parents and healthcare professionals**

Return to Learn (RTL)

Defined as:

- The process by which educators help students with concussion maximize learning while minimizing symptom flare-ups. A successful RTL plan is **directed by educators, especially general education teachers**, who have knowledge and skill in **differentiated instruction** to meet the needs of all students regardless of medical, psychological, learning, behavioral or social conditions.
- **Audience = Educators, primarily general education/classroom teachers**

Return to School & RTL are different audiences that require different messages

R2S audience = Parent & HCP

RTL audience = Teachers and Related Service Providers

Barriers:

- Requires educator-specific language and materials
- If the majority of recovery is within the first 28 days, materials need to be specific to classroom teachers to empower them to direct RTL themselves, immediately, nimbly, flexibly and independently!



Source: © CDC

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Concussion Management Team Composition

4. A concussion management team should include representatives from **school academic**, **school physical/health services**, **medical**, and **family/student domains** who work collaboratively to develop and adjust an individualized Return to Learn plan.

5. A family is advised to seek out medical evaluation, specifically a timely **medical evaluation, treatment, and clearance** for each concussion (regardless of the age of the student or the mechanism of injury).

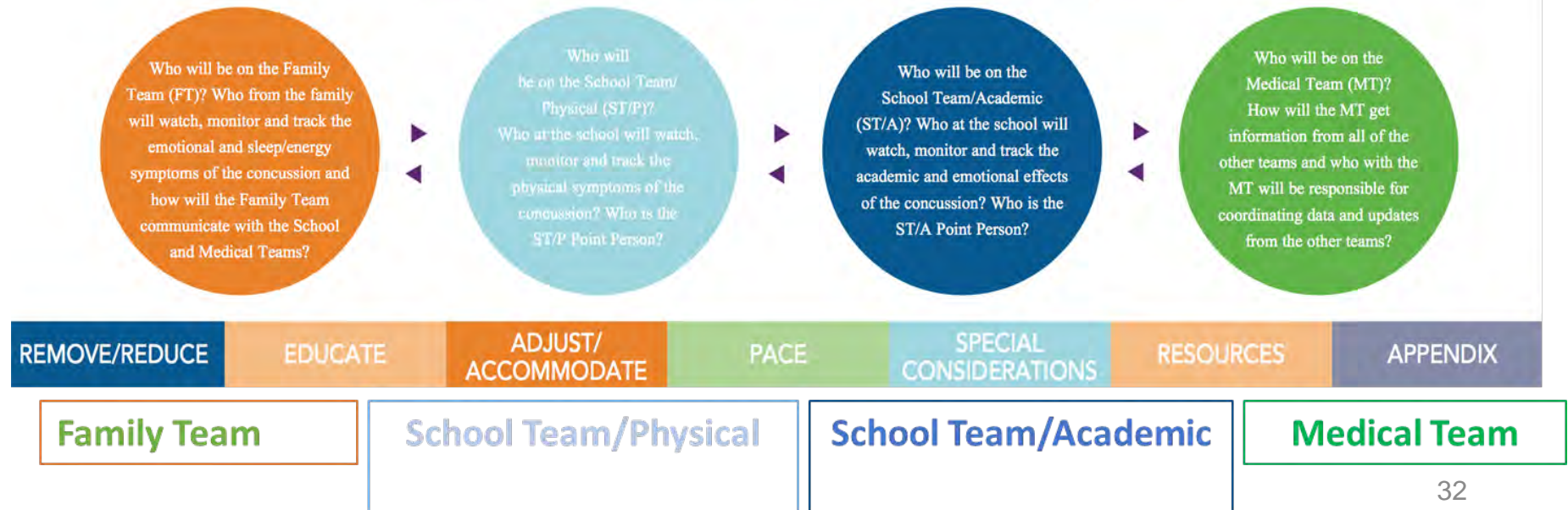
6. Academic adjustments written into the **Return to Learn plan are best overseen and directed by school professionals with dedicated expertise and knowledge of educational law, policy, and curriculum, guiding a collaborative Return to Learn process** among the members of the concussion management team.

REAP: REMOVE/REDUCE EDUCATE ADJUST/ACCOMMODATE PACE

- ✓ An Inter-disciplinary Team approach that sets the stage that every team has an equal & important role
- ✓ A great jumping off point – a way to get all teams to the table
- ✓ All team roles are spelled out and understood by all other teams
- ✓ RTP & RTL
- ✓ Color coded



An "Interdisciplinary Team" = Adults who provide multiple perspectives of the student/athlete AND who provide multiple sources of data to gauge recovery status





The image shows the cover of a brochure for REAP (Remove/Reduce, Educate, Adjust/Accommodate, Pace). The top left features the NASHIA logo (National Association of State Head Injury Administrators) with a tree icon. The top right has a blue background with the text: "How every family, school and medical professional can implement a Community-Based Concussion Management Program" and "REAP® The Benefits of Good Concussion Management" in green. The bottom left is an orange vertical band with "REAP®" in large white letters and the acronym's components: "Remove/Reduce", "Educate", "Adjust/Accommodate", and "Pace". At the bottom of this band, it says "Authored by Karen McAvoy, PsyD" and "© 2018 KAREN McAVOY, PSYD. ALL RIGHTS RESERVED Third Edition 2018". The right side of the brochure features a photograph of a soccer player in a red jersey and black shorts, performing a bicycle kick with a soccer ball in the air against a blue sky with clouds.

States that have customized REAP:

1. NASHIA
2. Colorado
3. Colorado 2013 version translated into Spanish
4. New York
5. Florida
6. New Jersey
7. Washington
8. Nebraska
9. Iowa
10. Alabama
11. North Dakota
12. Wyoming
13. South Carolina
14. West Virginia
15. Hawaii
16. Rhode Island
17. Arkansas


NASHIA REAP (pdf) DOWNLOAD	COLORADO REAP FINAL 2018 (pdf) DOWNLOAD	Montana REAP 2020 FINAL (pdf) DOWNLOAD
ND REAP FINAL 2019 (pdf) DOWNLOAD	South Carolina REAP 2019 FINAL (pdf) DOWNLOAD	Alabama 2018 REAP FINAL (pdf) DOWNLOAD
Hawaii REAP 2018 FINAL (pdf) DOWNLOAD	Iowa 2019 REAP ICCSD Final (pdf) DOWNLOAD	West Virginia 2018 REAP FINAL (pdf) DOWNLOAD
Nebraska 2018 Final REAP (pdf) DOWNLOAD	New Jersey 2013 REAP FINAL (pdf) DOWNLOAD	New York 2012 REAP FINAL (pdf) DOWNLOAD
Spanish 2013 REAP FINAL (pdf) DOWNLOAD	Washington 2013 REAP FINAL (pdf) DOWNLOAD	Florida 2013 REAP FINAL (pdf) DOWNLOAD

Tools For Your Trade:

NASHIA Partners with Karen McAvoy, PsyD,
Brain Injury Educational Consulting, LLC
Ft Collins, CO

Is your state:

- Looking for a comprehensive resource on concussion management?
- Working to establish partnerships with medical providers, schools, youth and families around concussion management?
- Seeking training or consultation on concussion management?



nashia.org

Concussion management is *more* than Return to Play legislation for athletes!

Education/Identification of concussion & Removal from Play (RTP Legislation)

Return to School

Notification and Communication across all teams

Return to Learn

Return to Play for athletes (RTP Legislation)

All students must return to school and return to learn even if they do not return to play

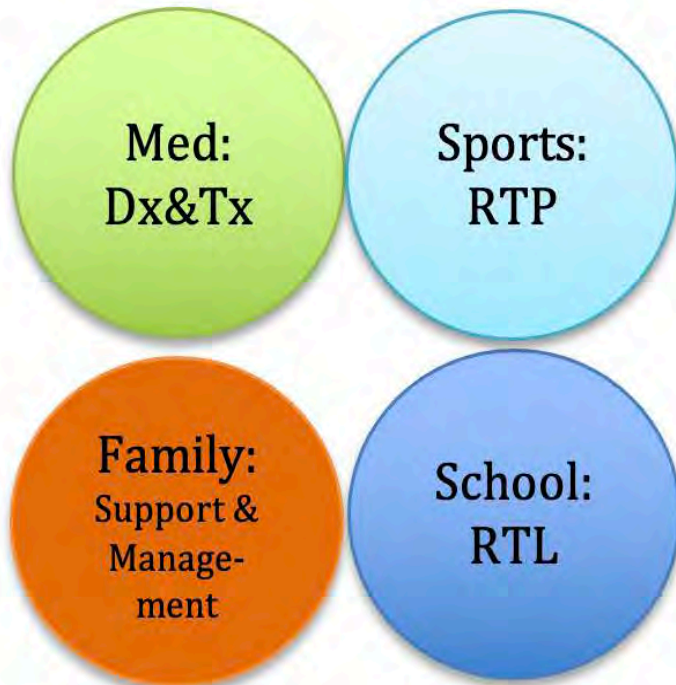
Get Schooled on Concussions Points of Vulnerability



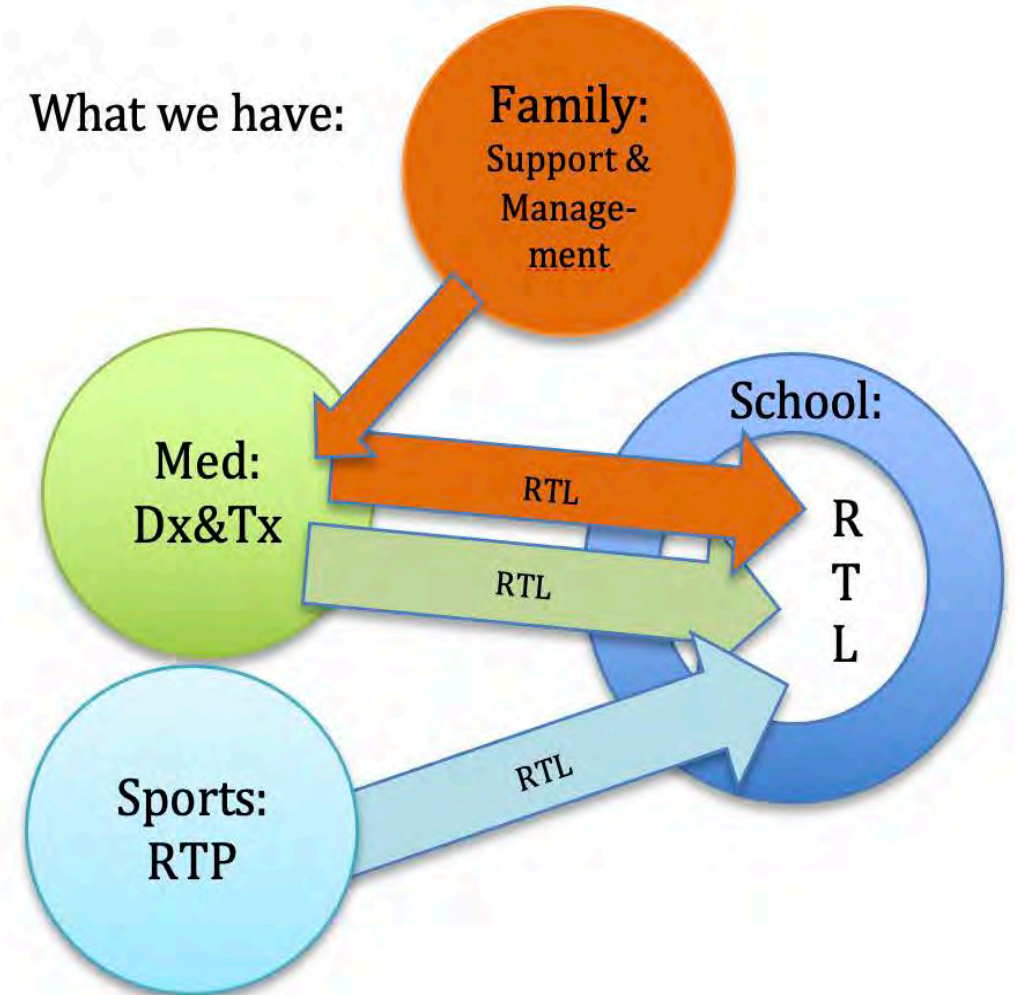
Get Schooled On Concussions Points of Vulnerability	Yes/No	Comments
Many states have legislation for RTP and for education (aka identification) of concussion. However, few states have language about Notification (communication) and RT. This form helps school/district figure out if they have the requirements of their law covered and what other "best practices" they might already have or they might need to round out a comprehensive concussion management protocol.		
Identification: What does your law say about who should be educated about identification of concussion?		
Law - What does your law say? Who is required to get "education" about concussion in your state?		
Do other supervisors of sports (not covered by your RTP legislation) also get concussion identification training?		
Do you have Athletic Trainers? For what sports? For what levels? Can ATE's help students with concussion in other sports? Levels?		
Do you have School Nurses and/or Health Techs?		
Do you have a school or district policy on concussion identification/education for your school nurses or health techs?		
Do your PE teachers get training on concussion identification? If yes, how often and how?		
Do your playground supervisors get training on concussion identification? If yes, how often and how?		
Do you have other frontline staff that get training on concussion identification? If yes, how often and how?		
Do your teachers get training on concussion identification? If yes, how often and how?		
Other:		
Notification: Who should be notified of the concussion and how communication should flow into a school/district from outside of a school/district?		
Law - What does your law say about notification of a concussion?		
Does your school/district have a process for coaches to notify someone IN the school about a concussion? What?		

RTL cannot be ROBUST or SUSTAINABLE if predicated on sports &/or medical direction

What we want: Inter-disciplinary Teams
Each team with equal & distinct roles
Each team determines their own policy & procedures



What we have:



- 7. Progress monitoring should include symptom monitoring, no less than one time per week.
- 8. Progress monitoring should include academic monitoring, no less than one time per week.

1

Symptom Checklist

Name: _____ Assessment Date: _____

Date of injury: _____

Symptom	Mid	Mid	Mid	Mid	Mid	Mid
A I feel like I'm going to faint	0	1	2	3	4	5
V The feeling trouble following	0	1	2	3	4	5
I feel dizzy	0	1	2	3	4	5
I feel like the room is spinning	0	1	2	3	4	5
I have trouble seeing	0	1	2	3	4	5
I have double vision	0	1	2	3	4	5
I have trouble following directions	0	1	2	3	4	5
I don't feel "right"	0	1	2	3	4	5
I feel lightheaded	0	1	2	3	4	5
I have trouble concentrating	0	1	2	3	4	5
I have trouble remembering things	0	1	2	3	4	5
I have trouble following directions	0	1	2	3	4	5
I feel like my thinking is "foggy"	0	1	2	3	4	5
I feel like an incoming at a slower speed	0	1	2	3	4	5
I don't feel "right"	0	1	2	3	4	5
I feel lightheaded	0	1	2	3	4	5
I have trouble learning new things	0	1	2	3	4	5
I feel more emotional	0	1	2	3	4	5
I feel sad	0	1	2	3	4	5
I feel nervous	0	1	2	3	4	5
I feel irritable or grumpy	0	1	2	3	4	5

2

Get Schooled on Concussions

Symptom Progress Monitoring

Name: _____ Assessment Date: _____

Date of injury: _____ Weekly Symptom Monitoring to the Concussion Management Team (CMT) is advised.

Symptoms	Mid	Mid	Mid	Mid	Mid	Mid
A I feel like I'm going to faint	0	1	2	3	4	5
V I'm having trouble balancing	0	1	2	3	4	5
I feel dizzy	0	1	2	3	4	5
I feel like the room is spinning	0	1	2	3	4	5
I have trouble seeing	0	1	2	3	4	5
I have double vision	0	1	2	3	4	5
I have trouble following directions	0	1	2	3	4	5
I don't feel "right"	0	1	2	3	4	5
I feel lightheaded	0	1	2	3	4	5
I have trouble concentrating	0	1	2	3	4	5
I have trouble remembering things	0	1	2	3	4	5
I have trouble following directions	0	1	2	3	4	5
I feel like my thinking is "foggy"	0	1	2	3	4	5
I feel like an incoming at a slower speed	0	1	2	3	4	5
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I feel lightheaded	0	1	2	3	4	5
I have trouble learning new things	0	1	2	3	4	5
I feel more emotional	0	1	2	3	4	5
I feel sad	0	1	2	3	4	5
I feel nervous	0	1	2	3	4	5
I feel irritable or grumpy	0	1	2	3	4	5

3

Teacher Feedback Form

Student's Name: _____ Date: _____

1. Your name
2. Class taught

3. How often do you see the student (minimum, no more than once per week)?

4. How often do you see the student (minimum, no more than once per week)?

5. How often do you see the student (minimum, no more than once per week)?

6. How often do you see the student (minimum, no more than once per week)?

7. How often do you see the student (minimum, no more than once per week)?

8. How often do you see the student (minimum, no more than once per week)?

9. How often do you see the student (minimum, no more than once per week)?

10. How often do you see the student (minimum, no more than once per week)?

4

Get Schooled on Concussions

Academic Progress Monitoring

Teacher Feedback Form

Student's Name: _____ Date: _____

1. Your name
2. Class taught

3. How often do you see the student (minimum, no more than once per week)?

4. How often do you see the student (minimum, no more than once per week)?

5. How often do you see the student (minimum, no more than once per week)?

6. How often do you see the student (minimum, no more than once per week)?

7. How often do you see the student (minimum, no more than once per week)?

8. How often do you see the student (minimum, no more than once per week)?

9. How often do you see the student (minimum, no more than once per week)?

10. How often do you see the student (minimum, no more than once per week)?

Ascending Levels of Academic Support

Multi-Tier System of Support (MTSS) or Response to Intervention (RTI)

9. Schools have existing educational safeguards to support all students who struggle academically, medically, psychologically, and socially at school. Concussion can be included and managed using the existing educational safeguards. **MTSS or RTI**

10. Schools should provide increasing tiers of academic support for students with concussions that do not resolve in a typical timeframe. **MTSS or RTI**

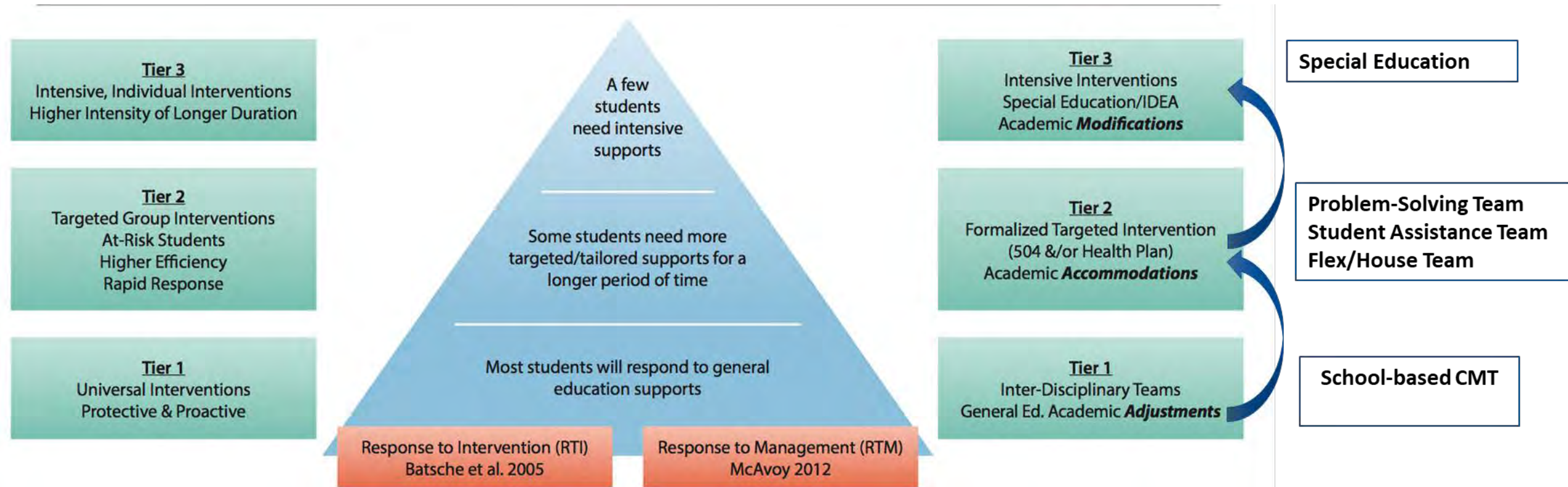
11. Schools may apply their existing tiers of support for students with concussion and need not delay community or postpone academic supports while awaiting community health care input if medical input is not timely or available.

40+% of students receive concussion in non-sports related mechanism; not under RTP Legislation

Source: Myers RK, Eagan-Brown BL, Conway AT, et al. Examining a statewide educational consulting program for pediatric brain injury. Clin Pediatr. 2017;57(6):645-655.

Source: McAvoy K, Eagan-Johnson B, Dymacek R, Hooper S, McCart M, Tyler J. Establishing consensus for essential elements in returning to learn following a concussion. J Sch Health. 2020; DOI: 10.1111/josh.12949

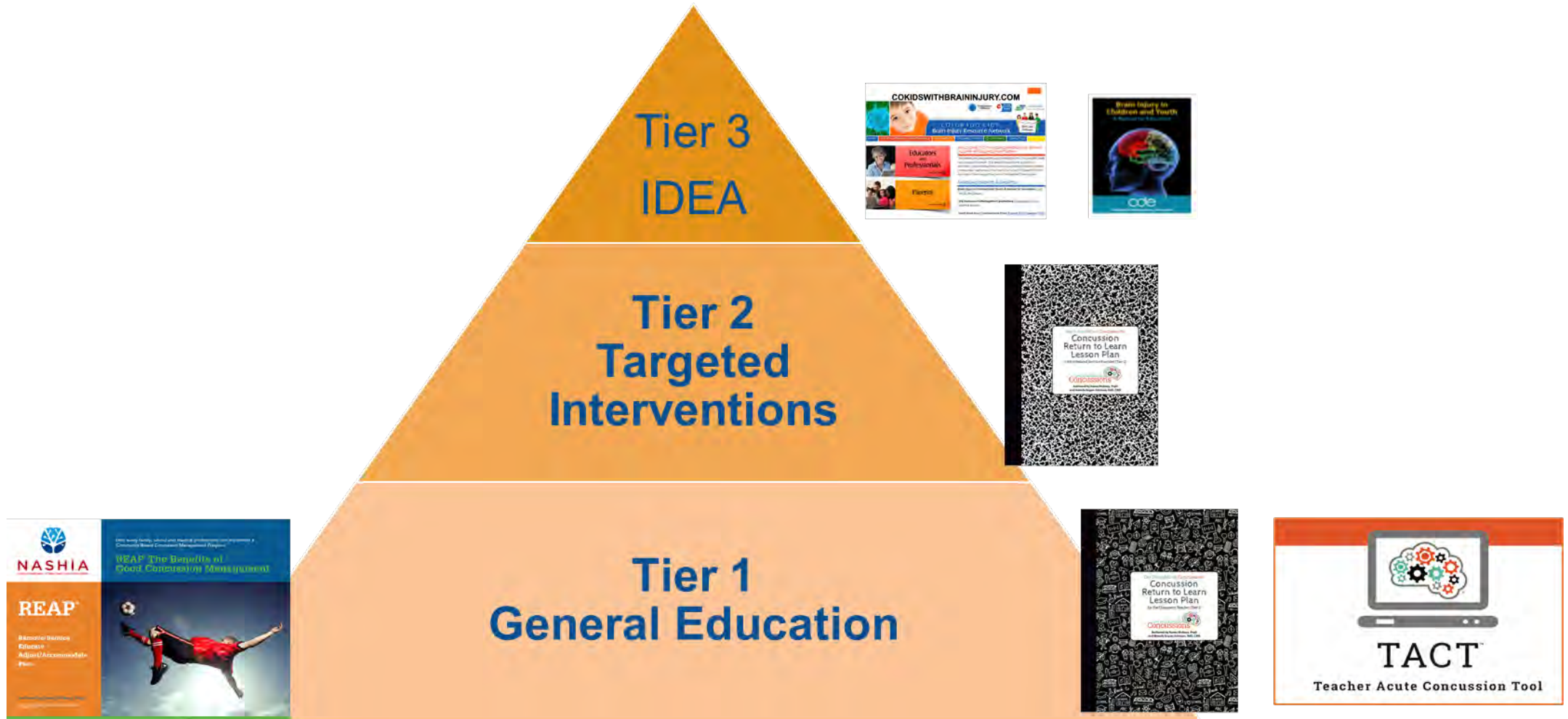
MTSS OR RTI



If research says 70% of students (between the ages of 5 years and 18 years) will recover from a concussion within 28 days, then ...

Return to Learn supports need to be quick, nimble and fall within the purview of general education classroom teachers to apply and lift supports as they see fit

School-Based and School-Directed RTL



Return to Learn

Making concussion manageable
in the classroom

✓ Kid Tested ● Teacher Approved™

GetSchooledOnConcussions.com



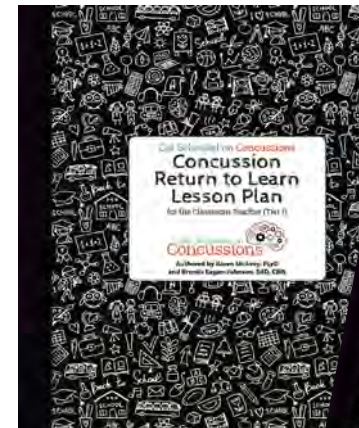
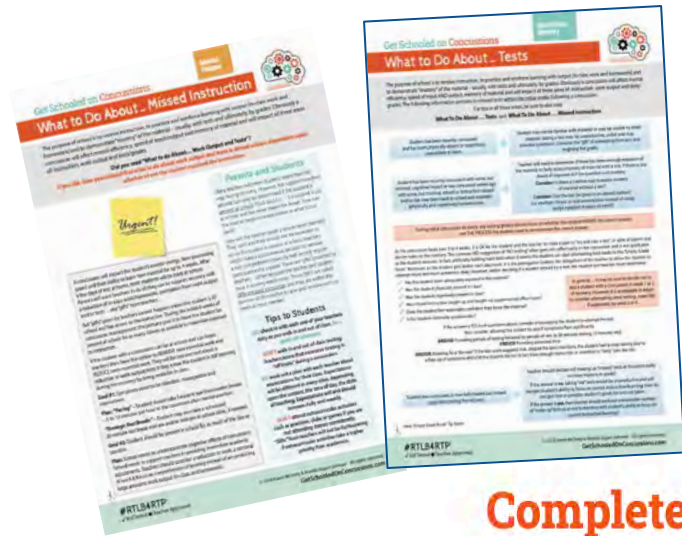
Educators



Parents



Professionals



Complete Return To Learn (RTL) Educational Resources

Being educators ourselves, we know what educational materials are needed for your classroom teachers and related service providers

Return to **LEARN** is the purview of the educator



Videos

- How to use the TACT
- The three common effects of concussion in the classroom
- What to do when the concussion does not resolve within 4 weeks?



Tip Sheets

- ✎ Lessons for the classroom teacher
- ✎ Lessons for the related service provider



Teacher Acute Concussion Tool (TACT)

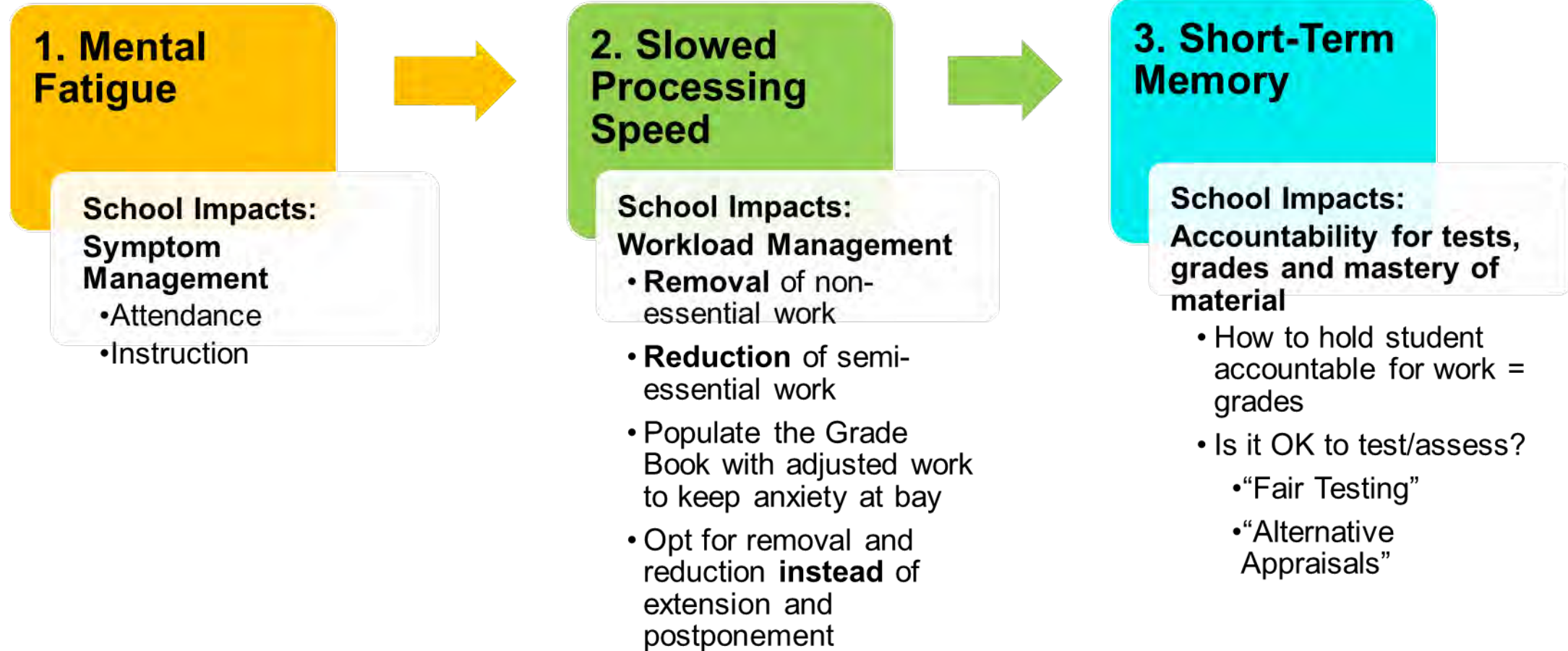
- ✓ Train your classroom teachers how to handle a concussion in the classroom "just in time" – when they get notified of a student in their classroom with a concussion – NO advanced or "face-to-face" training needed



RTL Lesson Plan Booklets

- Tier 1 – for the Classroom Teacher
- Tier 2 – for the Related Service Provider

3 Common Effects of Concussion in the classroom... in this order!



What the teacher hears...

GetSchooledOnConcussions speaks the language of the classroom teacher

Student attends school (with some symptoms but I can make them comfortable in the classroom) to hear instruction

What work is reasonable given they don't feel 100% and what can they learn and produce during this recovery?

How can I assess them, give them a grade and check their mastery in order to advance to next level?

Get Schooled on Concussions

Mental Fatigue Strategies

Mental fatigue is the most common underlying reason for concussion symptoms. Headache is the most common symptom of a concussion and often the first "indicator" of inefficient energy management.

When a student with a concussion goes back to school within days to weeks, their ability to "manage their symptoms" becomes the crucial skill needed to determine:

- ▢ If they feel symptomatically well enough to physically be at school (Return to School)
- ▢ If they feel symptomatically well enough to be available, cognitively, for learning (Return to Learn)

Symptom Management is the #1 priority, especially in the beginning weeks of concussion management! It is acceptable to be at school with "annoying" symptoms!

Strategies: Rest breaks:

- ▢ "Pacing": Eyes closed/head down/water breaks 5 to 10 minutes, in the classroom, after periods of mental exertion
 - Take eyes off the computer or off the book and look across the room or close eyes for rest
 - Take more water breaks - allow for more generous bathroom breaks if water is increased
 - Take a 5 minute "bean bag" or "head on desk" rest break in the classroom once an hour if needed
- ▢ "Strategic Rest Breaks" - 15 to 20 minute proactive rest breaks in the clinic (perhaps in place of PE class, recess, orchestral 1X in the am and 1X in the pm. The goal is to "schedule" a rest break at a logical time of the morning or afternoon to prevent the build up of symptoms. Be proactive instead of reactive.
- ▢ Only after being physically and cognitively present for **instruction** can a general education teacher fairly assess the REMOVAL of non-essential work and REDUCTION of semi-essential work.

#RTL84RTP
Kit Tested Teacher Approved

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GetSchooledOnConcussions.com

Get Schooled on Concussions

Slowed Processing Speed

What to Do About ... Work Output: In-Class/Homework

The purpose of school is to receive instruction, to practice and reinforce learning with output (in-class work and homework) and to demonstrate "mastery" of the material - usually with tests and ultimately, by grades. Obviously a concussion will affect mental efficiency, speed of input AND output, memory of material and will impact all three areas of instruction, work output and tests/grades. For tips in all these areas, be sure to also read **What To Do About ... Tests and What To Do About ... Missed Instruction**

Student is newly concussed and is physically absent or cognitively unavailable to benefit from instruction.	Student was not exposed to the instruction. Consider giving the "gift" of extra in-class work and homework. Consider re-teaching work and teaching grade.
Student has been recently concussed, has missed some instruction but is now physically present and more cognitively available to learn.	Teacher and student will need to determine what instruction was missed and what now needs to be taught or re-learned. Some in-class work and homework can now be expected but should still be reduced. Consider focusing primarily on what is essential to advance the next learning and not requiring much make-up work unless it is essential for learning.
Student has been recently concussed with some, but minimal, cognitive impact or was concussed weeks ago with some, but minimal, school or instruction missed and/or has now been back to school and available (physically and cognitively) for instruction.	Teacher and student will need to determine what instruction was missed and what now needs to be taught or re-learned. As mental energy increases and symptoms subside, amount of in-class and homework can be increased. Priority needs to be on keeping up with current material. Consider the "gift" of only requiring a quantifiable amount of make-up work; only work that is essential for mastery. Grade only on work done, do not penalize for work missed. Some extracurricular activities may not have been added back yet, there should still be time after school available for teachers and students to meet to learn material missed during recovery. This process is outlined by written plan for each class so everyone knows what is expected.

As the concussion heals over 1 to 4 weeks, it is OK for the teacher to expect more in-class work and more homework. In spite of parent and doctor notes to the contrary, the common MD suggestion of "NO in-class work or NO homework" often goes into effect early in the concussion and is not applicable as the student recovers. In fact, artificially holding back in-class work and homework when it seems the student can start attempting more work leads to the "Empty Grade Book" scenario, as the student gets better each day/week, it is the progressive removal of the obligation of the teacher to allow the student to attempt more and more academics daily. However, before deciding if a student should increase in-class and homework expectations, the student and teacher should determine:

- ▢ Has the student been adequately exposed to the material? If the student has not been exposed to the material, the purpose of reinforcement of learning via in-class work and homework is a moot point. No in-class homework practice is helpful if the concept has not been taught. So teachers ask yourself first:
 - ▢ Was the student physically present in class? Was the student cognitively present in class?
 - ▢ Was missed instruction caught up and taught via supplemental office hours?
 - ▢ Does the student feel reasonably confident they know the material?
 - ▢ Is the student minimally symptomatic?

Parents and Students: If you want your teacher to provide these "gifts," what "What To Do About Missed Instruction"!

If the answer is YES to all questions above, consider encouraging the student to increase in-class work and homework. **But, keep in mind, with mental fatigue and slowed processing speed (even though improving) - it is NOT possible to make up all missed work! Making student responsible for ALL missed work causes significant anxiety!**

Consider allowing the student to back down on some in-class or homework if symptoms significantly flare again. **AND/OR** providing periods of work followed by periods of rest (e.g. 20 minutes work, 10 minutes rest). **AND/OR** allowing for a "do over" if the grade on in-class work and homework suggests that, despite the best intentions, the student did not in fact have enough instruction on the material.

Student was concussed, is now fully healed, but missed some tests during the recovery. Take back to full academics - Focus on keeping up on current learning. **Do NOT** require a lot of work. **Do not** require a lot of work. **Do not** require a lot of work.

Get Schooled on Concussions

Class/Team Memory

What to Do About ... Tests

The purpose of school is to receive instruction, to practice and reinforce learning with output (in-class work and homework) and to demonstrate "mastery" of the material - usually with tests and ultimately, by grades. Obviously a concussion will affect mental efficiency, speed of input AND output, memory of material and will impact all three areas of instruction, work output and tests/grades. The following information pertains to missed tests within the initial weeks following a concussion. For tips in all these areas, be sure to also read **What To Do About ... Tests and What To Do About ... Missed Instruction**

Student has been recently concussed and has been physically absent or cognitively unavailable to learn.	Student may not be familiar with material or may be unable to recall material. Taking a test may be unproductive, unfair and may provoke symptoms. Consider the "gift" of assessing from text/dictating the grade.
Student has been recently concussed with some, but minimal, cognitive impact or was concussed weeks ago with some, but minimal, school or instruction missed and/or has now been back to school and available (physically and cognitively) for instruction.	Teacher will need to determine if there has been enough exposure to the material to fairly assess mastery of material with a test. If there is any doubt of exposure, all the questions in of mastery. Consider: Is there a creative way to assess mastery of material without a test? Consider: Can the test be given in an alternate fashion? (i.e. multiple choice, or oral presentation instead of essay, posters project or video of a test?)

During initial concussion recovery, any testing/grades should focus on whether the student KNOWS the correct answer, not THE PROCESS the student used to communicate the correct answer.

As the concussion heals over 1 to 4 weeks, it is OK for the student and the teacher to make a plan to "try and take a test". In spite of parent and doctor notes to the contrary, the common MD suggestion of "NO testing" often goes into effect early in the concussion and is not applicable as the student recovers. In fact, artificially holding back tests when it seems the student can start attempting tests leads to the "Empty Grade Book" scenario, as the student gets better each day/week, it is the progressive removal of the obligation of the teacher to allow the student to attempt more and more academics daily. However, before deciding if a student should try a test, the student and teacher must determine:

- ▢ Has the student been adequately exposed to the material?
- ▢ Was the student physically present in class?
- ▢ Was the student cognitively present in class?
- ▢ Was missed instruction caught up and taught via supplemental office hours?
- ▢ Does the student feel reasonably confident they know the material?
- ▢ Is the student minimally symptomatic?

In general, it may be wise to decline not to test a student with a concussion in week 1 or 2 of recovery. However, it is acceptable to begin to consider re-testing some testing, especially if supported by week 1 or 4.

If the answer is YES to all questions above, consider encouraging the student to attempt the test. Also consider allowing the student to stop anytime/leave significantly. **AND/OR** providing periods of testing followed by periods of rest (e.g. 20 minutes testing, 10 minutes rest). **AND/OR** providing extended time. **AND/OR** allowing for a "do over" if the test score suggests that, despite the best intentions, the student had to stop testing due to a flare-up of symptoms. **AND/OR** the student did not in fact have enough instruction or retention to "fairly" take the test.

Teacher should decide what making up "missed" tests of that point really increase anxiety or grade? If the answer is no, "take old" tests would be unproductive and a "do over" student's ability to focus on current instruction/learning, then do not give test or penalize student's grade for test not taken. If the answer is yes, then teacher should work out a reasonable number of "do over" tests and not penalize the student's ability to focus on current instruction/learning.

I have students with ADHD that have slow processing speed; I have students with LD that have memory issues ... I can handle concussions!

Teacher Acute Concussion Tool (slide 1 of 4)

[Colorado Educators Home](#) [TACT](#) [Tip Sheets](#) [Videos](#)

Welcome Colorado Educators

We know that COVID-19 has created unique challenges for districts throughout the state leading to in-person vs. hybrid vs. remote learning. While the TACT was developed to provide guidance to teachers in the classroom, the contents of the TACT is equally helpful for students learning in a myriad of settings. We strongly suggest that teachers/schools coordinate a way to share the TACT information with parents/guardians supporting students with concussion who are learning (partially or fully) from home.

BROUGHT TO YOU BY:



ACCESS TACT

4-week specific classroom strategies delivered directly to your inbox tailored to your teaching style, content area, environmental and student factors.

ACCESS TIP SHEETS

Access to over 30 individually crafted lessons on how to support students in the classroom and with protracted recovery.

ACCESS VIDEOS

Video tutorials on the academic support of concussion management in elementary, middle and high schools.

- TACT for Teacher Training and/or “just-in-time” training
- 30+ Tip Sheets available for download
- Videos available for download



Teacher Acute Concussion Tool (slide 2 of 4)

- The TACT questions take less than 5 minutes to complete
- Elementary school teachers – answer 7 questions with student in mind
- Middle/high school teachers – answer 8 questions with student in mind
- Teachers are asked to answer “how,” “what” and “when” you teach & “how much reading or computer” you use in their lessons

Get Schooled on Concussions

Home About Trainings TACT Tip Sheets Resources

I teach *

at the Elementary level

at the Middle or High School level

Middle or High School level

You have been informed of a student with a concussion in your class. Please mark if you have that student in your morning class(es), afternoon classes(es) or both morning and afternoon classes. *

In the morning

In the afternoon

I have this student in both morning and afternoon classes

Please rate the time of the grading period this concussion is coming to your attention (1 = very beginning of the grading period; 3 = middle of the grading period; 5 = end of the grading period): *


1	2	3	4	5
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please mark which style of teaching (simultaneous versus sequential) best describes the way you deliver instruction: *

In general, I teach in a way where new general concepts layer over past concepts. Learning builds over weeks to months. Or I teach a topic where concepts don't necessarily layer over past concepts at all. Examples: Social Studies, Language Arts, Health.

My content area is primarily sequential: I teach concepts where each new lesson builds on the last 1 to 2 lessons. Yesterday's learning is important for today's learning (i.e. Math, Science).

Some of my content builds on past learning from yesterday; some of my content builds on general concepts from weeks to months ago.



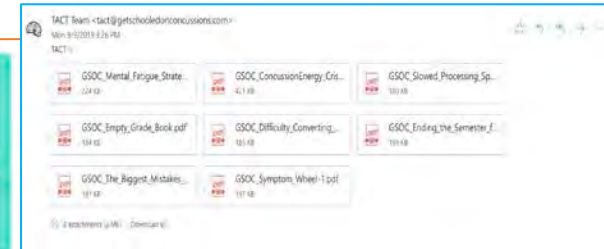
Teacher Acute Concussion Tool (slide 3 of 4)

- Within minutes, an email will appear in each teacher's inbox. The TACT delivers RTL guidance via email ... face-to-face training not required; advanced training not required
- Email is customized based upon teacher's answers on the TACT that will give ideas and attached Tip Sheets on how to adapt in each classroom when a student with a concussion returns to the classroom...

Mental Fatigue	Slowed Processing Speed	Short-Term Memory
Symptom (aka) Energy Management <ul style="list-style-type: none">• Impacts attendance• Impacts instruction	Impacts work output <ul style="list-style-type: none">• REMOVE non-essential work• REDUCE semi-essential work	Impacts demonstration of mastery, tests & grades <ul style="list-style-type: none">• "Fair Testing"• "Alternative Appraisals"

You selected: I have this student in both morning and afternoon classes

- A concussion is an **energy crisis** (brain running on empty) that leads to **mental fatigue** which leads to symptoms of headaches, dizziness, tiredness, difficulty concentrating, irritability, etc. Flaring of symptoms is the biggest contributor to truancy, missed instruction from the classroom (due to being in the school clinic) and/or inability to learn due to pain. Your **1st goal** in supporting a student with a concussion back into your classroom is to help your student manage symptoms so they can be physically and cognitively present in class, all day, every day, so they can hear instruction.
 - **Mental Fatigue Strategies:**
 - "Pace" their energy - allow frequent 5 to 10 minute eye/brain/water/bathroom breaks **IN** the classroom after periods of mental exertion and/or
 - "Strategic Rest Breaks" - a proactive 20 minute rest break in the school clinic 1X mid-morning and/or 1X mid-afternoon
- If you teach this student in both morning and afternoon classes, encourage your student to pace energy so they can stay at school all day, if possible. **Being able to attend school and hear instruction is a necessary 1st step before adjustment of workload can happen.**
- **Attachment(s):**
 - [Mental Fatigue Strategies](#)



Teacher Acute Concussion Tool (slide 4 of 4)

- Classroom RTL guidance continues automatically, via follow-up emails, for 3 additional week...including additional Tip Sheets

TACT Week 2 - Follow up #1



TACT Team <tact@getschooledonconcussions.com>

Wed 7/8/2020 6:43 PM

To: Karen McAvoy

Karen,

You identified your student had a concussion on July 2nd. Last week you filled out the TACT to help you get started supporting a student with a concussion in your classroom. Usually concussions get better with time so hopefully your student is beginning to feel better each day, each week. As you enter week 2, remember that symptoms tend to subside (as energy is better managed by the student) and it is permissible to add in more activities and academics. The primary goal in week 2 is to continue to help your student manage symptoms (aka energy) well enough to be physically and cognitively comfortable enough to be at school, ideally, everyday, full days, to hear classroom instruction (**Mental Fatigue** Strategies). Once available to hear instruction, you can strike a nice balance between:

- REMOVING non-essential work
- REDUCING semi-essential work
- Focus precious limited energy on a reasonable amount of essential work throughout recovery

Opt for REMOVING and REDUCING work rather than EXTENDING and POSTPONING work (due to **Slowed Processing Speed** Strategies). If you are already doing so, it may be wise to continue exempting this student from tests and quizzes for a week or 2 more (due to **Short-Term Memory** Strategies) but do begin to creatively grade "adjusted" work. As you approach week 3, review the Tip Sheet on "Fading Academic Adjustments" and start trying to "dip their toes in water". If your student is not showing steady improvement (as evidenced by fewer symptoms with increased social, academic and technology activities), be sure to share your concerns with the RTL Facilitator and/or the Student Assistance Team at your school.

- [Fading Academic Adjustments](#)
- [What to do about Missed Instruction](#)
- [What To Do About Work Output](#)

Thank you, the TACT Team



RTL Teacher Empowerment in 2 ways...

Whole Staff Teacher Training

GetSchooledOnConcussions video
(15 minutes)

+

TACT (5 minutes)

Train your whole staff on RTL
in 20 minutes

And/
Or

“Just-in-Time” Training

When a student with a concussion
comes to the attention of the school –
Send link to all teachers of that student
to complete TACT “just-in-time”

Get 4 weeks of email guidance again
around particular student – AT THE
TIME of the concussion



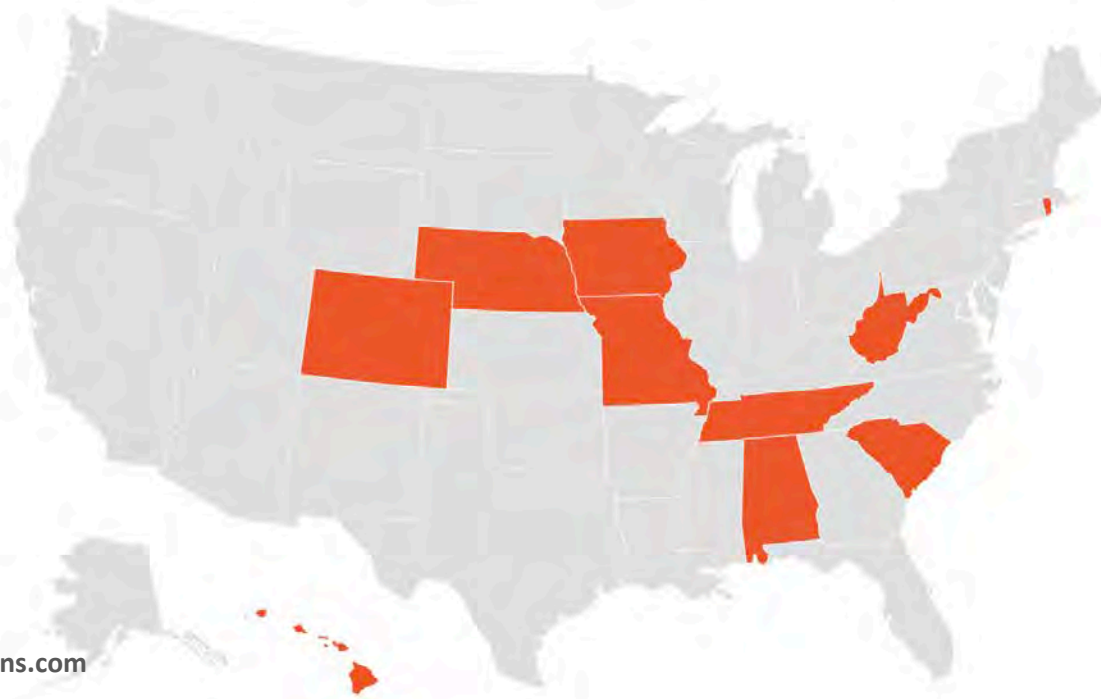
Participating States

Is Your State Schooled on Concussions?

If you are an educator working in a public or private school within any of the 10 states highlighted on the map below, you have unlimited, FREE access to all of the Get Schooled on Concussions tip sheets, videos, and use of the Teacher Acute Concussion Tool (TACT).

Click on your state to locate the organization providing this resource subscription to all schools within your state. Your state's organization will then send you the required link and password access. **You must use your school email address when registering.**

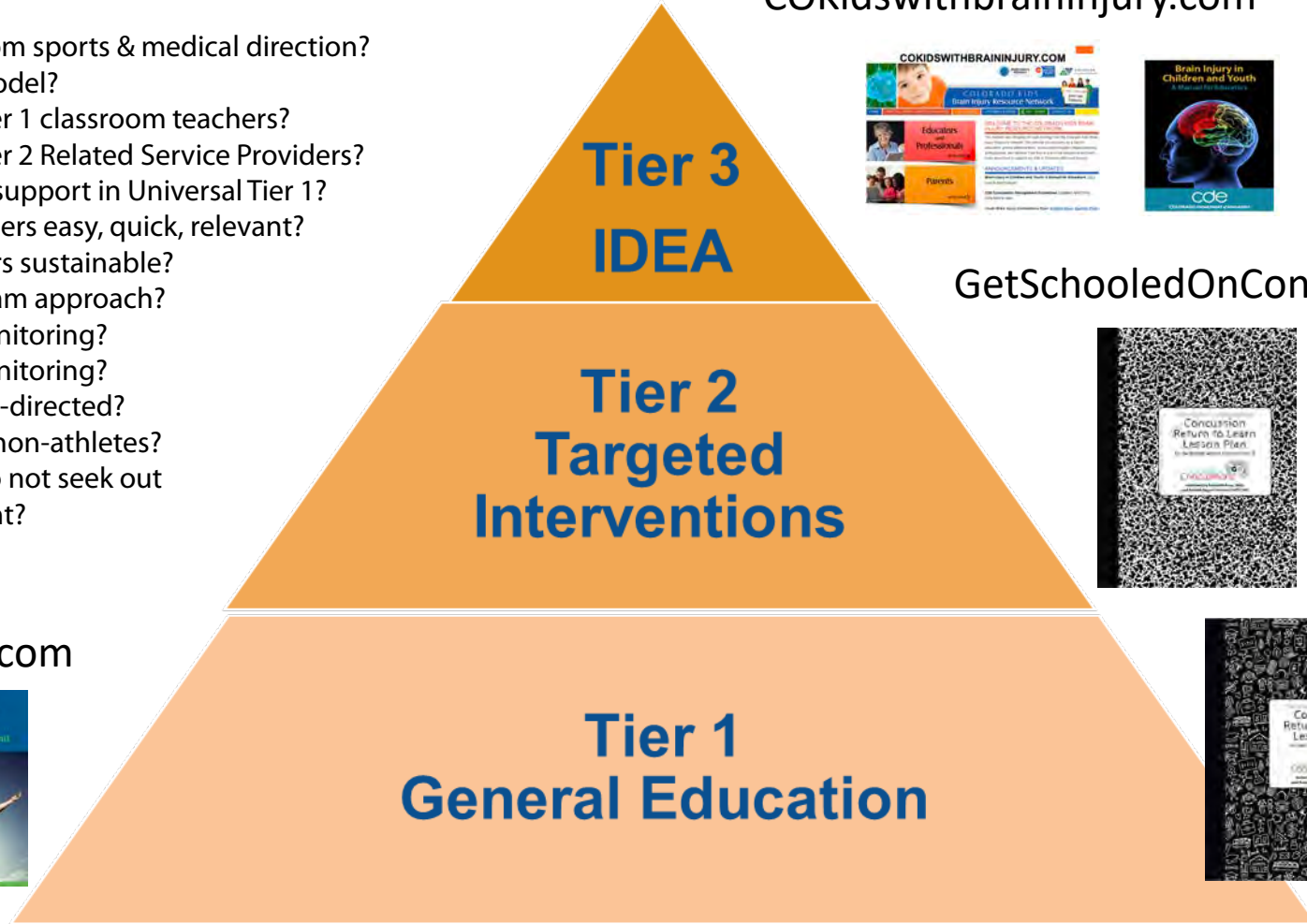
If you are an educator in a state without a subscription plan, [contact us](#) now to find out how easy it is to obtain these resources for your school.



School-Based and School-Directed RTL

Does your RTL resource check the boxes?:

- Is it geared toward educators (RTL), not parents or HCP's (return to school)
- Does it allow independence from sports & medical direction?
- Does it fit into a MTSS or RTI model?
- Is there specific language to Tier 1 classroom teachers?
- Is there specific language to Tier 2 Related Service Providers?
- Is the emphasis on immediate support in Universal Tier 1?
- Is delivery of guidance to teachers easy, quick, relevant?
- Is training to classroom teachers sustainable?
- Is there an inter-disciplinary team approach?
- Is there symptom progress-monitoring?
- Is there academic progress-monitoring?
- Is RTL school-based and school-directed?
- Is it applicable to athletes and non-athletes?
- Is it applicable to those who do not seek out medical evaluation or treatment?
- Is it applicable to all grades?



COKidswithbraininjury.com

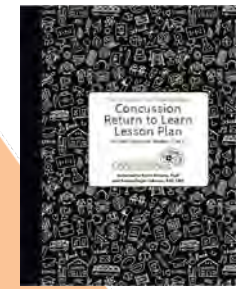


GetSchooledOnConcussions.com



- Protracted Recovery
- 504 Plans

REAPconcussion.com



Return to Learn Legislation

13. Existing educational safeguards exist for students. They are prompt, flexible, and systematic for all concussed student athletes and non-athletes with academic needs. **Return to Learn can be robust, widespread, systematized, and sustainable if embedded into existing educational frameworks.**

Questions?

Karen McAvoy, PsyD

Karen@GetSchooledOnConcussions.com

ACADEMIC SUPPORTS FOR STUDENTS AFTER BRAIN INJURY PARTICIPATING IN ONLINE LEARNING



Presented by...

Dr. Brenda Eagan-Johnson

BrainSTEPS Project Director

eagan-johnson@biapa.org

724.944.6542

www.brainsteps.net



BrainSTEPS

Strategies Teaching Educators, Parents, & Students

A BRAIN INJURY SCHOOL RE-ENTRY CONSULTING PROGRAM



Objectives

- We will discuss the BrainSTEPS Program
- How students can be academically supported during online learning based on their individual signs & symptoms of brain injury.

Overview of BrainSTEPS (slide 1 of 2)

Created in PA by:

PA Department of Health – 2007



Unique funding partnership:

PA Department of Health;

PA Department of Education, Bureau of Special Education



Implemented by:

Regional educational Intermediate Units

Under direction from:

Brain Injury Association of Pennsylvania



Adopted the BrainSTEPS Model in 2016:

Colorado Dept of Ed



Overview of BrainSTEPS (slide 2 of 2)

- Support for students with **ALL Types & Severities** of Acquired Brain Injury
 - 10% nonTBI
 - 10% TBI moderate/severe
 - 80% concussions
- **30** BrainSTEPS Brain Injury Consulting Teams cover the state of Pennsylvania
- **300+** Brain Injury Consultants
 - Educational professionals
 - Medical & Rehab professionals
 - Family members



BrainSTEPS Premise

If brain injury related educational supports:

- ✓ Are **immediately frontloaded** upon return to school,
- ✓ Include **validated** instructional practices,
- ✓ Are monitored (*phased out, continued, or increased*) over time.

Students with Brain Injury:

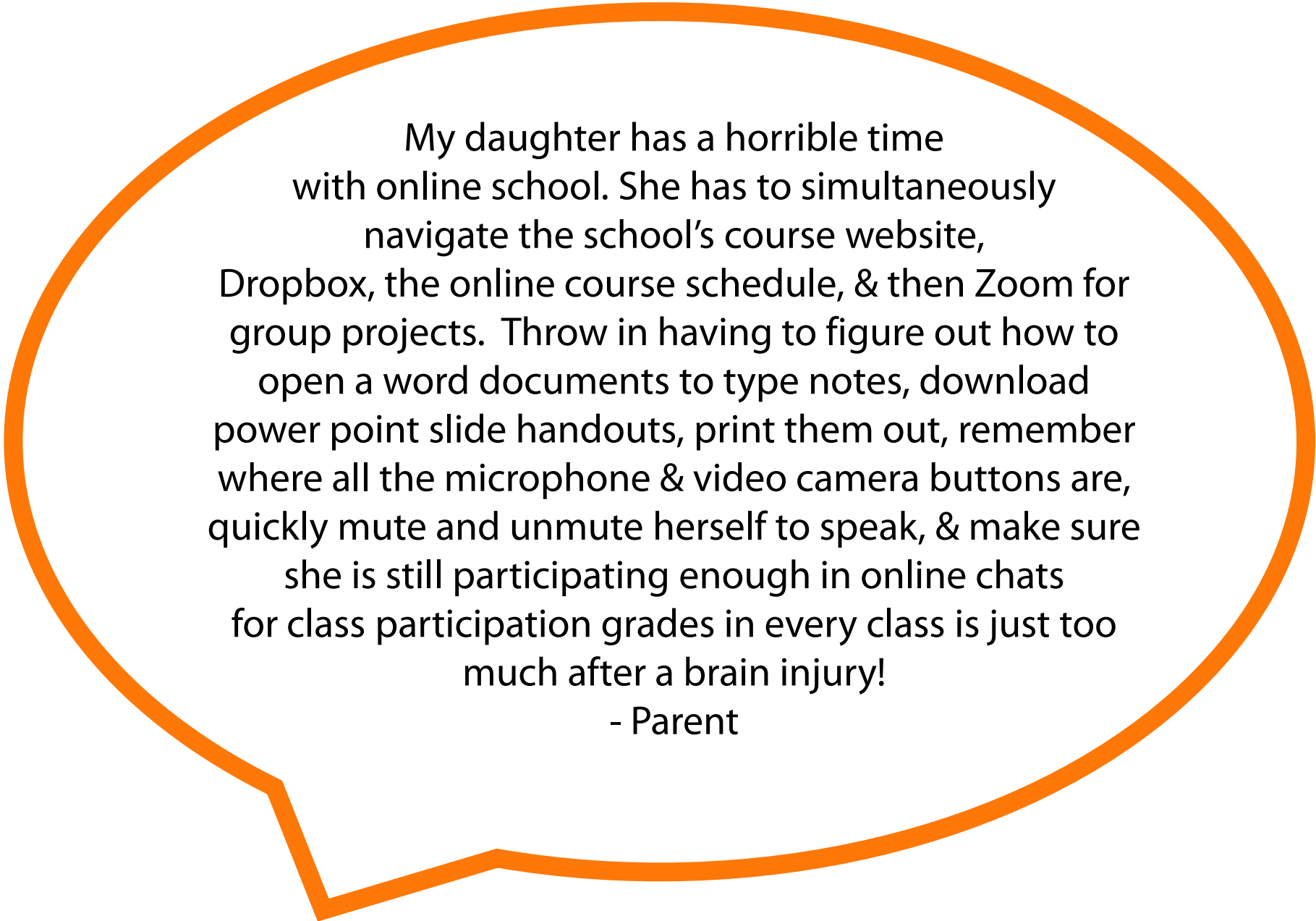
- ✓ Will receive appropriate levels of support based on need/changing needs over time,
- ✓ Not experience academic failure,
- ✓ Remain in school & graduate.

COVID-19, Online Learning, & ABI

Common student difficulties after brain injury during online learning (but not all!):

- **Visual scanning**
 - Searching/scanning for visual information
- **Visual attention**
 - Mentally focusing on what is on the screen
- **Visual memory**
 - Difficulty recognizing, encoding, recalling visual information
- **Cognitive fatigue**
 - A decrease in cognitive energy that occurs from focusing on sustained cognitive demands (e.g., schoolwork, learning), independent of sleepiness.



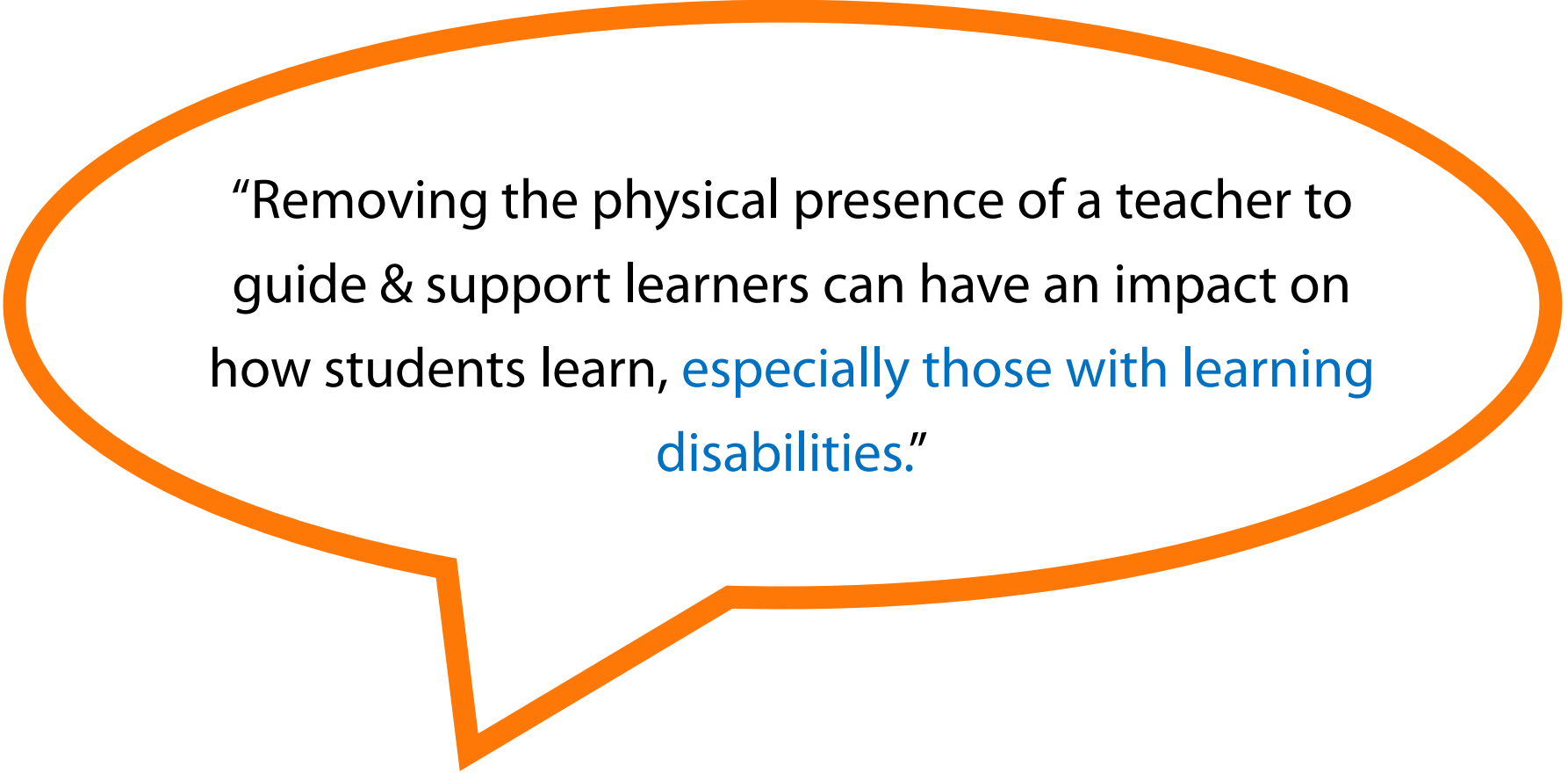


My daughter has a horrible time with online school. She has to simultaneously navigate the school's course website, Dropbox, the online course schedule, & then Zoom for group projects. Throw in having to figure out how to open a word documents to type notes, download power point slide handouts, print them out, remember where all the microphone & video camera buttons are, quickly mute and unmute herself to speak, & make sure she is still participating enough in online chats for class participation grades in every class is just too much after a brain injury!

- Parent

In-School In-Person Learning Environment

Teachers implemented academic supports



“Removing the physical presence of a teacher to guide & support learners can have an impact on how students learn, especially those with learning disabilities.”

Carnahan, C., & Fulton, L. (2013). Virtually forgotten: Special education students in cyber schools. *TechTrends*, 57(4), 46-52.

Virtual Learning Environment

Parents/Family are now responsible for monitoring/cueing/reinforcing *(if needed)*

1. What are the supports schools typically provide to students after brain injury?
2. How can those supports be adjusted to fit online learning needs of students?
3. How can parents learn about these supports?

Brain Injury & Virtual Learning

(slide 1 of 2)

The physical activity & cognitive demands of attending in-person school can trigger symptoms (lights, sounds, movements).

However:

At home, students have more control over environmental symptom triggers.





Brain Injury & Virtual Learning

(slide 2 of 2)

Online learning may result in increased cognitive fatigue due to screen time.

- Quick brain breaks can be beneficial.
- Schedule breaks automatically into the day.
- Student can use a timer.
- Discourage daytime napping.

In Person vs. Online Learning: Flexibility

Flexible Scheduling at Home:

- Half day versus full day
- Rearranging courses to a time when student is more alert can be difficult if a class is only offered in-person 1 time per day
- Online provides much more flexibility for all coursework, repeating classes, credit recovery courses, etc.

Brain Injury & Virtual Learning

(slide 1 of 5)

Online learning may **decrease** student mental health issues.

Positives: For some students when home & online, more focused effort can go toward learning rather than exerting cognitive effort *worrying about school bullies or other school-related anxieties.*

Brain Injury & Virtual Learning

(slide 2 of 5)

- Ensure parents, school counselor, school psychologist are aware of **red flag signs** to look for regarding depression, anxiety, suicidal ideation...
- School staff can use screening tools virtually
- School staff can schedule private online sessions or phone calls to frequently check in with the student post-brain injury
- Keep in regular communication with parents

Brain Injury & Virtual Learning

(slide 3 of 5)

- Online learning may be difficult due to active brain injury signs & symptoms during synchronous real-time discussions & question/answer periods via chat feature due to (for example) the **physical process of typing** or **slowed mental processing**.
- **Asynchronous** activities may be best during the initial days of recovery.

Brain Injury & Virtual Learning

(slide 4 of 5)

- Teachers can provide questions prior to being asked so the student can prepare an answer & have it typed out or written out before virtual class begins.
- The student can use their computer microphone to speak the answer instead of typing, or the student can use text-to-speech software.
- Teachers should provide checks for understanding & regular reinforcement of new concepts. Don't rely on the student to tell you they don't understand.

Brain Injury & Virtual Learning

(slide 5 of 5)

- For new key learning content, teachers may be willing to **pre-record a parent lesson or meet directly with the parent to pre-teach them the skill**, so the parent who assists their child at home can be better prepared for that day's online lesson.
- Teachers may also be able to record their online class sessions so the student can review repeatedly, as needed.

Online Learning Supports After Brain Injury (slide 1 of 2)

Use Worked Examples

- ***Step by Step Cueing System***
- Extremely beneficial to all students, regardless if they have experienced effects from a brain injury
 - *Scaffolding process*
 - *Reduces cognitive load for working memory*
 - *Efficient for students learning a new task or how to solve a problem*

Online Learning Supports After Brain Injury (slide 2 of 2)

Virtual self-advocacy skills –

Encourage students to ask themselves the following questions each day when participating in online learning:

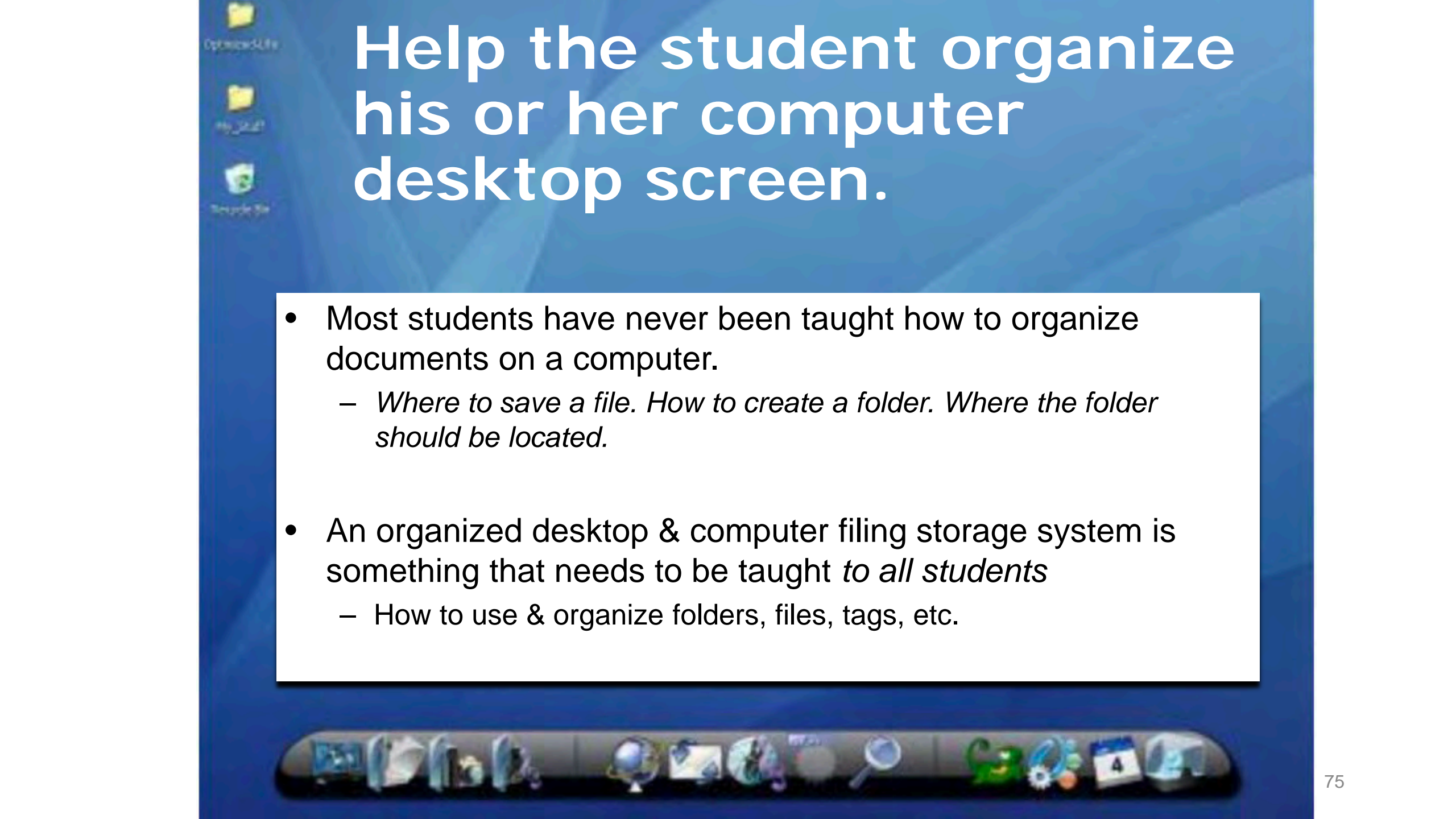
1. Do I understand what I just learned? If not...

+

2. How can I contact the teacher for help?

Role play the question/answers with them.





Help the student organize his or her computer desktop screen.

- Most students have never been taught how to organize documents on a computer.
 - *Where to save a file. How to create a folder. Where the folder should be located.*
- An organized desktop & computer filing storage system is something that needs to be taught *to all students*
 - How to use & organize folders, files, tags, etc.

BrainSTEPS Online Learning Supports

1. 37-minute BrainSTEPS Brain Injury, Online Learning Supports for School Staff:
[youtube.com/watch?v=kVioDG2nW0E](https://www.youtube.com/watch?v=kVioDG2nW0E)
2. BrainSTEPS Guidance Document with suggestions for online brain injury academic supports: tinyurl.com/covidmtbi
3. Accompanying video that supports the document:
youtu.be/uNeLVNypQEO



www.brainsteps.net



BrainSTEPS

Strategies Teaching Educators, Parents, & Students

A BRAIN INJURY SCHOOL RE-ENTRY CONSULTING PROGRAM

Pennsylvania

Brenda Eagan-Johnson, Ed.D., CBIST

BrainSTEPS Project Director

Phone: 724-944-6542

Email: eagan-johnson@biapa.org

HILLARY
MCCLAIN
&
DECLAN



DECLAN'S STORY



WE CAME TO SWIM BEFORE EAR TUBE SURGERY





AUGUST 11, 2016
A DAY WE WILL NEVER FORGET



**NEXT SEVERAL WEEKS AT
CHILDREN'S HOSPITAL**



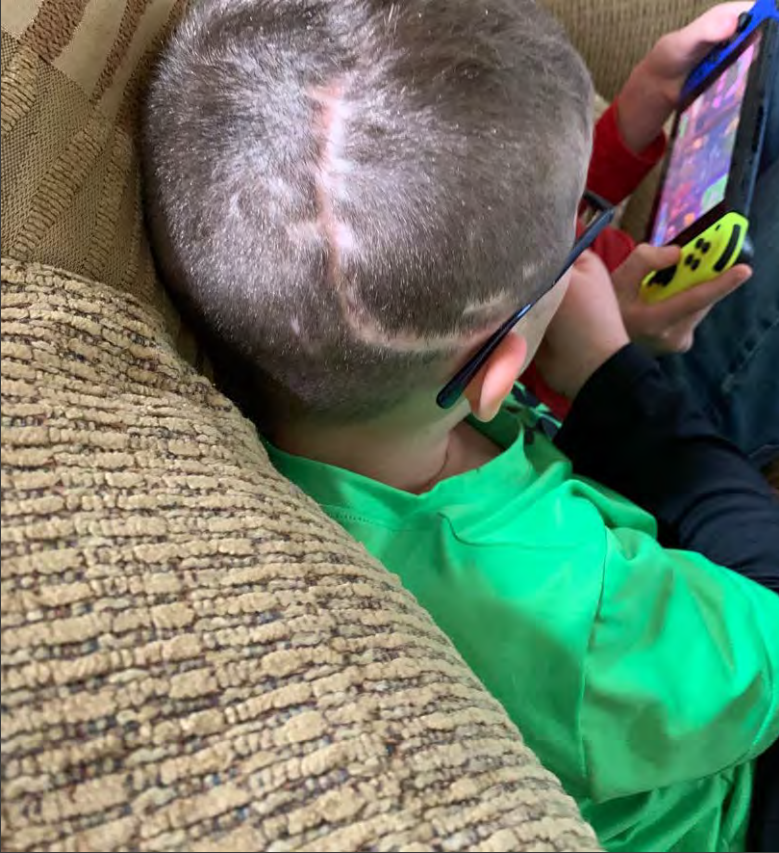
**REHAB AT CHILDREN'S HOME –
APPROX. 6 WEEKS**

| DECLAN

Then:

- Age 3 (8/11/2016)
- *Craniectomy*
- *Cranioplasty*
- *Severe TBI*





He is well aware of these scars



- We grow our hair out to cover these up



Declan's School Experience Post-TBI



DECLAN'S RETURN TO SCHOOL POST-TBI

- Age 5
- Kindergarten
- Public School in Southwestern PA
- Issues for Declan at school
 - Impulsiveness
 - Teacher's inability to teach him
 - Seizures at school
 - Frequent dizziness due to meds



POST-TBI ONGOING ISSUES

- Frequent EEGs
- Headaches
- Seizures
- Emotional
- Blurry vision
- Noise sensitivity
- Side effects of medicine



LIMITED ACTIVITIES



FREQUENT OCCURRENCES

- Unpredictable
 - Hospital stays
 - Ambulance calls
 - Occurs often at school
 - Causes him to miss school
 - Causes parent to miss work
-



DECLAN

**Another day of
not feeling well...**

This is his life...





-FALLING AT SCHOOL FROM BEING DIZZY
-SEIZURES IN THE MIDDLE OF KARATE



BrainSTEPS
Strategies Teaching Educators, Parents, & Students
A BRAIN INJURY SCHOOL RE-ENTRY CONSULTING PROGRAM

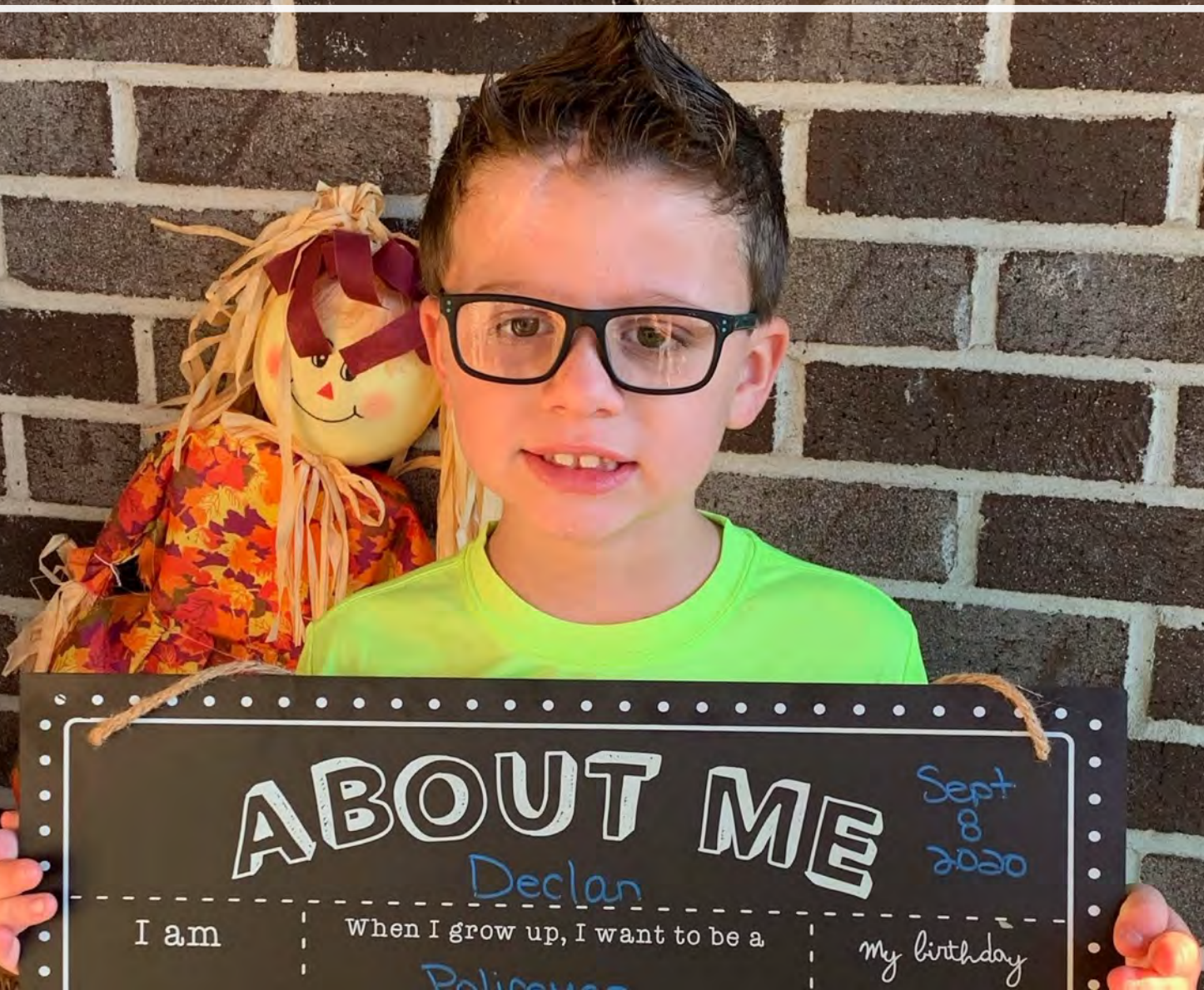
- Declan and I got connected to BrainSTEPS through a referral from the school
- BrainSTEPS helped:
 - Organize all of our facts;
 - Teach the teachers how to help Declan learn;
 - Stay on top of the teachers;
 - Advocate for services for him:
 - Talk to text features
 - Push for more services
 - Stay on top of IEP
- Natalie and Brenda attend every school meeting;
 - She has no problem telling the team they are wrong,
 - Advocated for services that would be beneficial for him not hold him back (as the school was suggesting)



BrainSTEPS
Strategies Teaching Educators, Parents, & Students
A BRAIN INJURY SCHOOL RE-ENTRY CONSULTING PROGRAM

Declan would not have made it as far as he has without the guidance and expertise of Brenda and Natalie. There has been many times where I am so overwhelmed, I can't hold myself together. I have been blessed to have a team that never gave up on him like everyone else has. I can't thank my BrainSTEPS team enough.

FIRST DAY OF 2ND GRADE



ABOUT ME

Sept
8
2020

Declan

I am

When I grow up, I want to be a

my birthday



**WE DO HAVE SOME
SPECIAL MOMENTS...**

QUESTIONS



BREAK

Up Next:

- Facilitated Discussion –
To Legislate or Not to
Legislate
- Open Discussion /
Questions and Answers



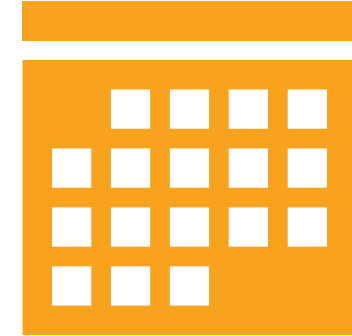
Future TBI Sessions

March 30, 2021, 1:00 – 4:00pm (ET)

"Justice for All: Serving Individuals with Brain Injury Across the Justice System." [Register for the session.](#)

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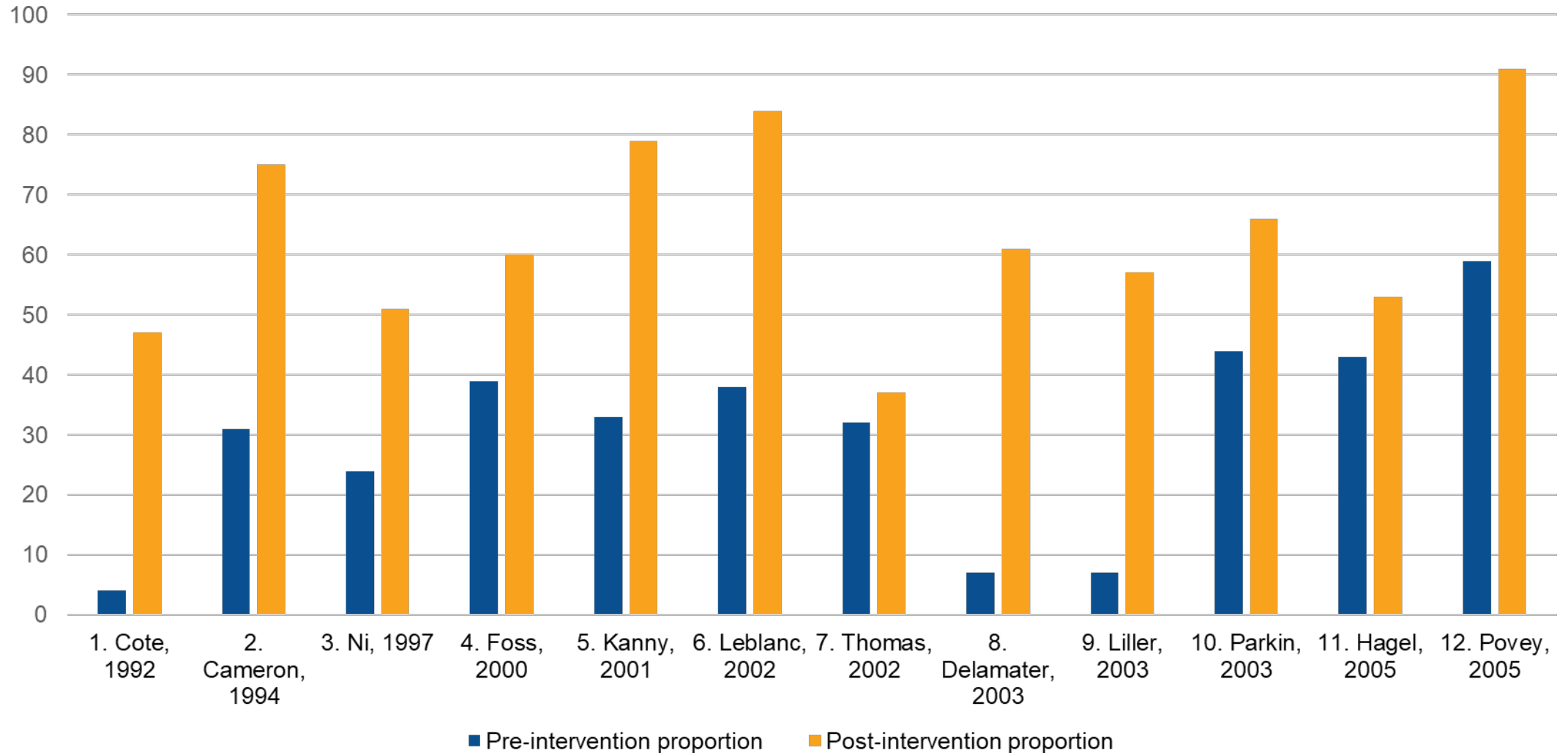
"Maximizing the Effectiveness of Advisory Boards Through Full Participation." [Register for the session.](#)



TO LEGISLATE OR NOT TO LEGISLATE?



Table 3 Change from baseline helmet use in studies evaluating the effectiveness of legislation on helmet use in cyclists





Legislation increased helmet use among cyclists, particularly younger age groups and those with low pre-intervention helmet wearing proportions. These results support legislative interventions in populations without helmet legislation.¹

1. Karkhaneh, M., Kalenga, J. C., Hagel, B. E., & Rowe, B. H. (2006). Effectiveness of bicycle helmet legislation to increase helmet use: a systematic review. *Injury prevention : journal of the International Society for Child and Adolescent Injury Prevention*, 12(2), 76–82. <https://doi.org/10.1136/ip.2005.010942>

»» Implementation of Max's Law in Oregon High Schools

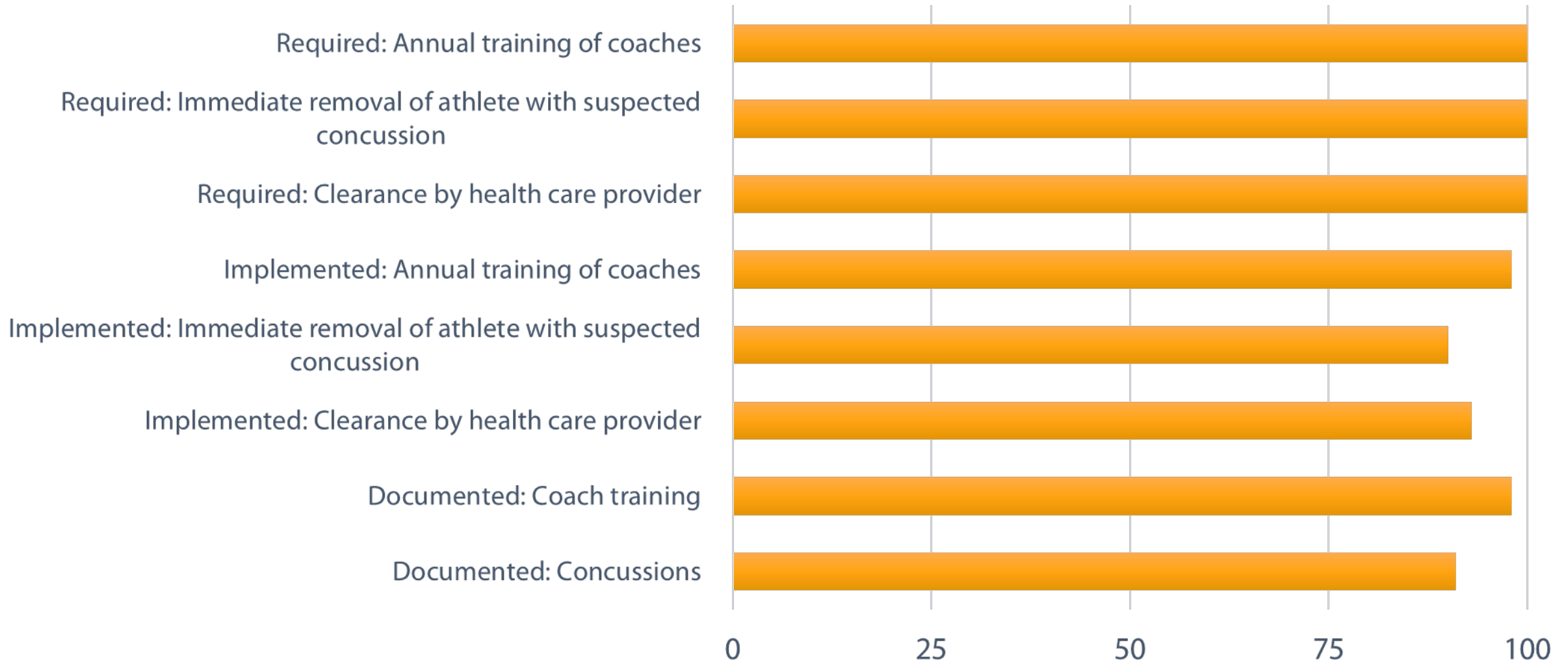
Results from a Survey of High School Athletic Directors



Max's Law Mandates

Training	Annual training for coaches in recognizing the symptoms of concussion
Removal	Removal of student athletes suspected of having a concussion from competition or practice
Clearance	Evaluation and clearance by an eligible medical provider before returning to competition or practice

Percentage of Sample High Schools that Require and Implement Max's Law Protocols



Why do we need legislation?



Max's Law's return to play mandates have been nearly universally implemented in Oregon high schools.



Without a return to school mandate, only 21% of schools surveyed had an active concussion management team.

Oregon HB 4140 (2020)



- Broad support from variety of stakeholders
- Effective date January 1, 2021
- Requires the Oregon Department of Education to develop a form for public education programs to use when students have been diagnosed with concussion or other brain injury
- This form facilitates schools in providing immediate, appropriate accommodations for students with brain injury



Return to Learn: To Legislate or Not to Legislate? Pennsylvania's Experience

Dr. Brenda Eagan-Johnson
BrainSTEPS Project Director
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724.944.6542
www.brainsteps.net

Published in Network for Public Health Law, 2015 (slide 1 of 2)



“RETURN-TO-LEARN”: ACADEMIC REENTRY FOR STUDENT ATHLETES RECOVERING FROM SPORTS-RELATED TBI
Issue Brief

“Return-to-Learn”: Academic Reentry for Student Athletes Recovering from Sports-Related TBI

Return-to-Learn as a Public Health Problem

Sports-related concussion, a type of traumatic brain injury (TBI), has received much attention over the past few years. The potential impact on child and adolescent health is significant and nationwide, because so many young people participate in youth and school sports in the United States. For example, the National Federation of State High School Associations reported that participation in high school sports exceeded 7.7 million in 2012-2013, increasing for the 24th consecutive year.¹ Participation in recreational sports is more difficult to ascertain, but estimates hover around 25 million Americans aged 6 to 17.²

For people ages 15 to 24, sports are the second leading cause of traumatic brain injuries, behind motor vehicle crashes.³ Even a single concussion can result in confusion and a decline in memory processes and cause persistent physical symptoms such as dizziness, headaches, and nausea for the days following the injury.⁴ Neuropsychological testing to assess post-concussion recovery has mainly focused on college and professional athletes, and not younger ones, but early research has found pronounced memory decline lasting at least seven days in high school athletes who suffered one concussion without losing consciousness.⁵

These effects seem to be more pronounced in younger athletes; concussed high school athletes have been shown to experience longer memory dysfunction and protracted recovery times as compared with college athletes.⁶ Recently concussed young athletes have also been found to perform more poorly on tests measuring attention, concentration, processing speed, and mental flexibility compared with young athletes with no history of concussion or a history of one concussion.⁷ The same study found that young athletes with two or more previous concussions that reported no physical or mental symptoms were indistinguishable from those who had experienced a concussion within the past week, supporting the proposition that the cognitive effects of concussion in otherwise healthy young athletes linger.⁸

The effects of concussion not only impact the injured child's ability to compete in athletics, but also their ability to perform

Published in Network For Public Health Law, 2015

(slide 2 of 2)

Informal Return-to-Learn Approaches

Some states have addressed academic reentry outside the legislative or regulatory realm. One such example is Pennsylvania, which has established the BrainSTEPS program.²³ The BrainSTEPS program is jointly funded by the Department of Health, the Department of Education and the Bureau of Special Education, and establishes a return-to-learn protocol utilizing school based academic Concussion Management Teams (CMTs). CMTs consist of one academic monitor and one symptom monitor who may increase or fade school adjustments depending on how the student is doing. While such programs do not carry the force of law, their implementation and cooperation among collaborative parties may be enhanced by the parties' shared understanding of purpose and organizational capabilities and infrastructure. That is, because the joint partners themselves developed the program and protocol and understand their organizations' capabilities and structure, they are unlikely to encounter difficulties with implementation.

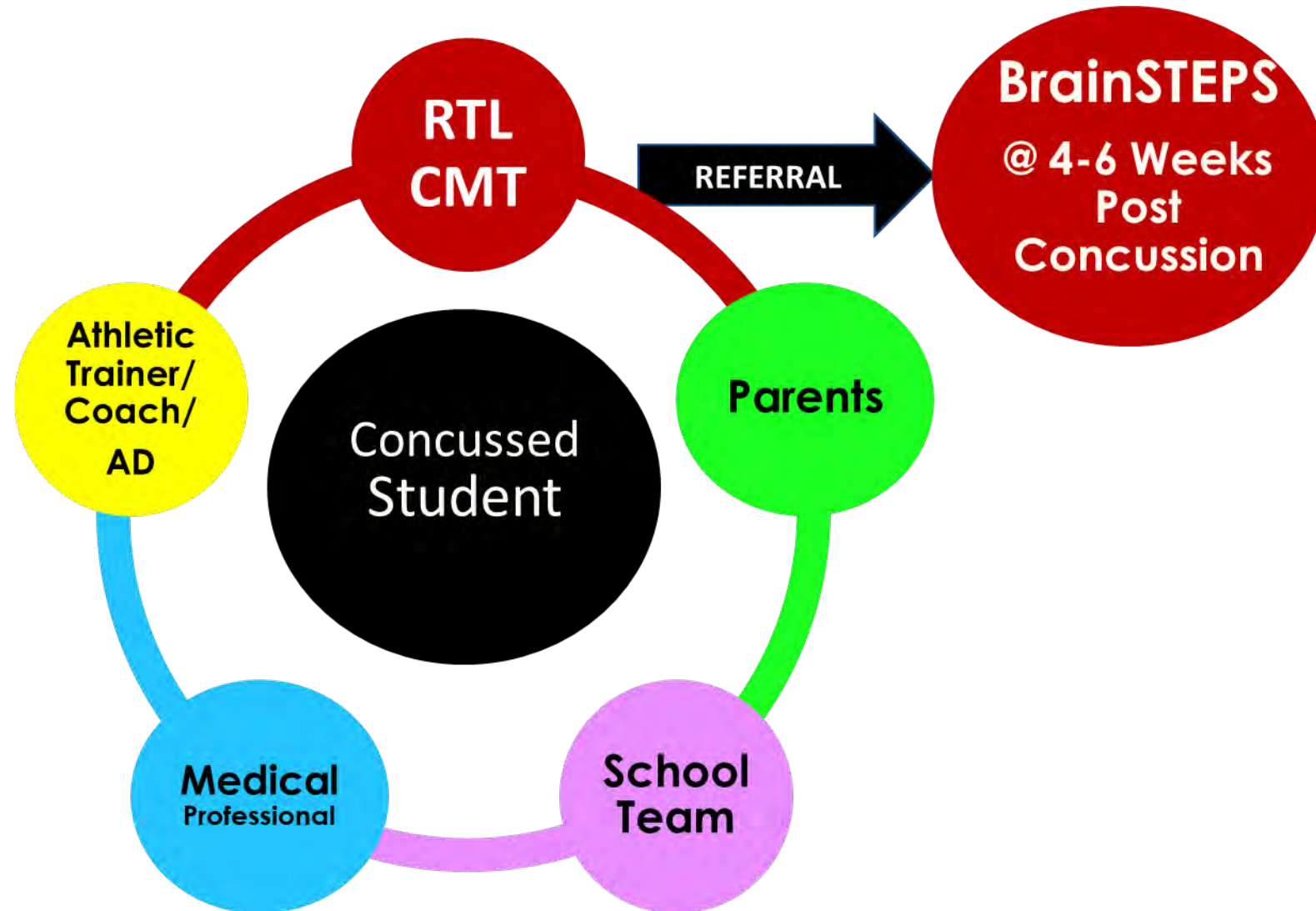
Return to Learn Concussion Management Team (RTL CMT)

- Ancillary BrainSTEPS Model to build school internal capacity to manage concussions for initial 4-6 weeks

*Trained over 3,000 RTL CMTs since 2013

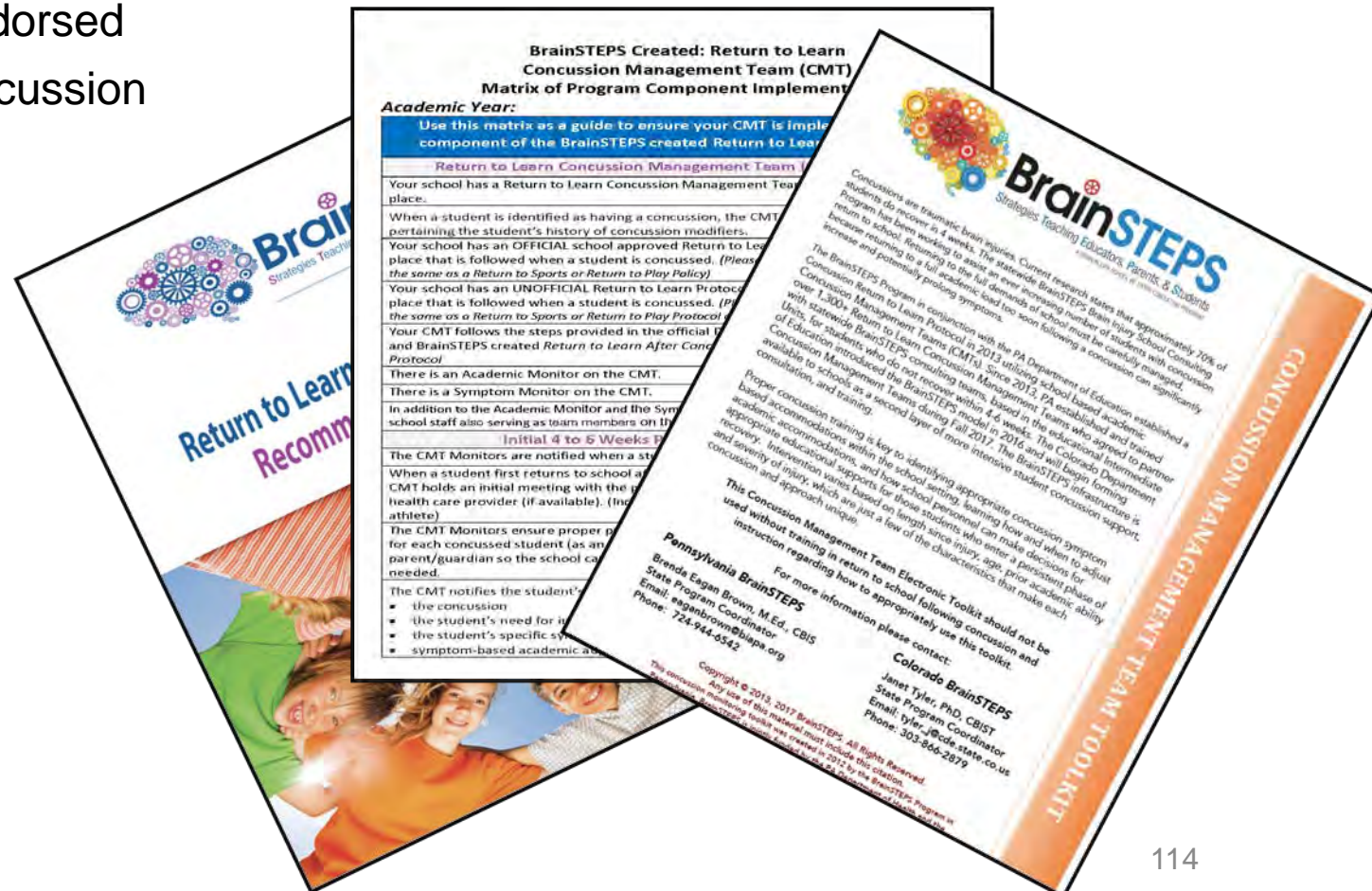


Return to Learn Process of Support for Concussion



BrainSTEPS: RTL CMT Training

- 5.5 hour, asynchronous, online, interactive 7-module course
- 3 resource tools are provided to CMTs to implement the protocol:
 1. State Department of Education endorsed BrainSTEPS: Return to Learn Concussion Protocol
 2. Protocol Implementation Checklist
 3. Concussion RTL Monitoring Toolkit



RTL CMT Training Site



[Home](#) [About](#) [Course](#) [Presenters](#) [Admin](#) - [Inbox](#) [My Account](#) [Logout](#)

Take the Official BrainSTEPS Interactive Video Course: Return to Learn Concussion Management Team Training

A nationally recognized model for brain injury school-based educational consulting, delivering training to thousands of educational professionals for over a decade. Earn up to 6.5 professional development credit hours in Colorado and Pennsylvania.

[Go to Course](#)






About the Course

This course is designed to train members of the school building's Return to Learn Concussion Management Team (CMT) how to manage student concussions for the initial 4-6 weeks post concussion. CMT members will learn how to monitor a student's academics and post-concussion symptoms while gathering appropriate data to justify educational decisions. Second, CMT members will learn how to ensure concussed students receive appropriate educational supports during the initial 4-6 weeks post concussion to promote faster recovery. School staff serving on the CMT will learn how concussion affects learning and strategies they can employ to help students remain in school throughout the recovery process.

[Learn More](#)

Course Outline

 Introduction to the Return to Learn CMT Training Presented by Janet Tyler, Ph.D., CBIST	15 M
 Concussions: What You Need to Know From a Medical Perspective Presented by Mark Halstead, MD	45 M
 Concussions: What You Need to Know From an Educational Perspective Presented by Brenda Eagan Brown, MEd, CBIS	20 M
Academic Planning for the Return to Learn Concussion Management Team - Part 1 Presented by Brenda Eagan Brown, MEd, CBIS	50 M
Academic Planning for the Return to Learn Concussion Management Team - Part 2 Presented by Brenda Eagan Brown, MEd, CBIS	67 M

Expanding Concussion Laws Not Necessary for Return to Learning After Concussion

Mark E. Halstead, MD,^a Karen McAvoy, PsyD,^b Brenda Eagan Brown, MEd, CBIS^c

The concept of returning to learning (RTL) after a concussion is relatively new in the history of concussion management. McGrath, in 2010, was 1 of the first to publish the idea of providing for academic support to student athletes recovering from a concussion.¹ The American Academy

disorder, learning disabilities, autism, and diabetes, as well as concussions. With attention deficit disorder, for example, a physician may conduct an evaluation and receive input from teachers before prescribing medication and other treatment, but the day-to-day adjustments and accommodations

Halstead ME, McAvoy K, Eagan-Brown B. (2016) Expanding concussion laws not necessary for return to learning after concussion. Pediatrics, 138(6):e20163194

Published in Pediatrics, 2016

(slide 2 of 2)

Why?

- Educational support frameworks currently exist to aid students with medical disabilities who rise to the level of more intensive intervention.


Instead:

- Educate general education teachers about concussions, specifically on how to make short-term academic adjustments in the general education classroom to impact the majority of students with concussions that resolve within several weeks.
- Although it is true that legislation comes with an increase in public awareness, for RTL it may be more appropriate to use time and funding to enhance existing educational resources.

Published in Journal of School Health, 2020



1st National Concussion Return to Learn Consensus (slide 1 of 4)

JOURNAL OF
SCHOOL HEALTH

 American
SCHOOL
HEALTH
ASSOCIATION
www.ashaah.org

RESEARCH ARTICLE

Establishing Consensus for Essential Elements in Returning to Learn Following a Concussion

KAREN McAVOY, PsyD^a  BRENDA EAGAN-JOHNSON, EdD, CBIST^b  ROSALIE DYMACEK, PhD^c STEPHEN HOOPER, PhD^d MELISSA McCART, DEd^e
JANET TYLER, PhD, CBIST^f

ABSTRACT

BACKGROUND: Returning to learn following a concussion is the process of managing a student's recovery during the school day by implementation of academic supports with varying intensity. Due to a lack of consensus or even guidance on Return to Learn, this paper set out to establish cross discipline consensus on some essential elements of Return to Learn using a Delphi method.

METHODS: Sixteen national organizations participated in a Delphi process to reach consensus on overarching themes of Return to Learn focused on: returning a student to school, composition of the school-based concussion management team, progress-monitoring, educational safeguards, neuropsychological testing, and legislation. Two rounds of questionnaires were disseminated via email using a Delphi process. Consensus was established during round 2.

RESULTS: Twelve national organizations were able to reach consensus and endorse 13 essential elements of Return to Learn following a concussion.

CONCLUSIONS: There continues to be limited research on concussion Return to Learn leading to confusion in the field. In this paper, we demonstrate consensus on a number of essential elements, from a wide variety of professional disciplines who participate in the care of students following a concussion, as a starting place for some guidance on Return to Learn.

Keywords: concussion; traumatic brain injury; return to learn; return to play; interdisciplinary team; section 504; individual health care plan.

Citation: McAvoy K, Eagan-Johnson B, Dymacek R, Hooper S, McCart M, Tyler J. Establishing consensus for essential elements in returning to learn following a concussion. *J Sch Health.* 2020; DOI: 10.1111/josh.12949

Received on July 18, 2019
Accepted on March 30, 2020

The PROS of enacting Return to Learn legislation include:

1. Increased awareness of concussion & resulting learning impacts among among educators
2. Potentially improved and more consistent communication among school, family, and health care providers who serve on the concussion management team
3. Higher school accountability for RTL academic supports at school

The drawbacks of enacting RTL legislation:

1. May be interpreted to apply only to sports-related concussions if Return to Learn language is written into current or existing Return to Play legislation;
2. Does not provide the ability to direct specific Return to Learn guidelines toward school districts which exert local control;
3. Does not account for the varying needs and resources of districts;

The DRAWBACKS of enacting RTL legislation:

4. May not be necessary in light of already existing federal educational laws requiring districts to support all students regardless of medical diagnosis (even temporary);
5. Does not include funding for school personnel training; and
6. Could increase the potential for litigation.

In Conclusion

- ✓ **Schools are required by federal law to support struggling students.**
- ✓ Although RTL legislation may help align all schools within a state into doing something to create a plan for RTL concussion management, the biggest missing piece continues to be (typically) a lack of funding for training to meet the requirements of the legislation.
- ✓ To change the culture and function of a school infrastructure, it requires more than just legislation. It requires a commitment to training.

OPEN DISCUSSION





Real-Time Evaluation Questions

- Please take a moment to respond to these seven evaluation questions to help us deliver high-quality TBI TARC webinars
- If you have suggestions on how we might improve TBI TARC webinars, or if you have ideas or requests for future webinar topics, please send us a note at TBITARC@hsri.org

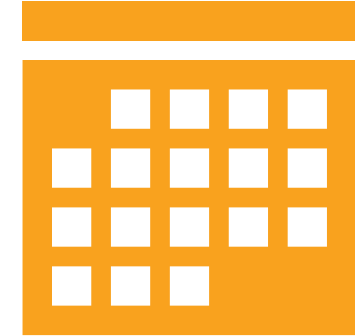
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Thank You.

The Traumatic Brain Injury Technical Assistance and Resources Center (TBI TARC) is an initiative from the Administration for Community Living that helps TBI State Partnership Program grantees promote access to integrated, coordinated services and supports for people who have sustained a TBI, their families, and their caregivers. The Center also provides a variety of resources to non-grantee states, people affected by brain injury, policymakers, and providers.



MEET THE PRESENTERS



Julie Myers, MPH

Public Health Program Administer

Pennsylvania Department of Health

julimyers@pa.gov



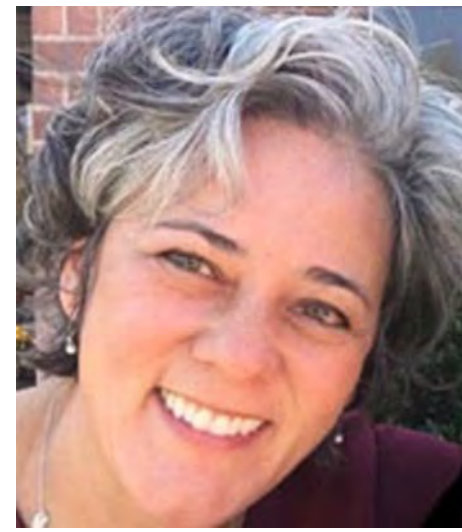
Julie Myers, MPH is the Program Administrator for the Bureau of Family Health's Traumatic Brain Injury programs. She is involved in several grant projects involving education and training for TBI, school reentry, and neuroresource facilitation. She serves on the Board Logistics and Support Team for Pennsylvania's Traumatic Brain Injury Advisory Board. She is a graduate of Penn State College of Medicine with a master of public health in Health Systems Organization and Policy.

Karen McAvoy, PsyD

Clinical and School Psychologist

REAP and Get Schooled on Concussions

karen@getschooledonconcussions.com



Karen McAvoy, PsyD, is dually credentialed as a clinical and school psychologist. Her career has spanned positions in Pediatric Psychology (with the Children’s Hospital Colorado and Rocky Mountain Hospital for Children) to positions in School Mental Health (with Cherry Creek School District and the Colorado Department of Education). Dr. McAvoy is the author of REAP (Remove/Reduce* Educate* Adjust/Accommodate and Pace) – a community-based interdisciplinary team approach to concussion management. She is also the co-founder and owner of GetSchooledOnConcussions.com, a website and training curriculum empowering educators to direct Return to Learn efforts for students with concussion at school. Currently, Dr. McAvoy continues to serve as a consultant to the Colorado Department of Education where she provides trainings to educators on the impact of neurologically-based disorders on learning and behavior. She also directs the Concussion and Neurological Health Center with Berkana Rehabilitation Institute in Ft Collins, Colorado.

Dr. Brenda Eagan-Johnson

Program Director

BrainSTEPS

eagan-johnson@biapa.org



Dr. Brenda Eagan-Johnson, Ed.D., CBIST, has over two decades of experience in the field of pediatric brain injury, education, and neuro-developmental issues in children. Dr. Eagan-Johnson is instrumental in the creation, ongoing development, and daily oversight of the nationally recognized Pennsylvania statewide child and adolescent brain injury school consulting program, BrainSTEPS – Brain Injury School Re-Entry Consulting Program. She also serves as a consultant for a Centers for Disease Control and Prevention–funded study related to BrainSTEPS outcomes. Through her work, Dr. Eagan-Johnson regularly trains medical, rehabilitation, and school staff on the identification, symptoms, and educational treatment methods to improve cognitive, executive function, behavioral, social, and communication skills, as well as transition strategies, for students who sustain acquired brain injuries.

Dr. Eagan-Johnson received her master’s degree in transition special education specializing in pediatric traumatic brain injury from George Washington University, where she has served as an adjunct instructor since 2015. She holds a doctor of education degree in Mind, Brain, and Teaching (educational neuroscience) from Johns Hopkins University. Dr. Eagan-Johnson has three teaching certifications and serves on three national advisory boards. Additionally, she has held a Certified Brain Injury Specialist certification since 2008. Dr. Eagan-Johnson is published in pediatric brain injury, regularly presents at the national and international levels, and has received multiple awards for her work. She was the co-lead for the first Concussion Return to Learn Consensus for the National Collaborative on Children’s Brain Injury, which is endorsed by 12 national organizations. Spearheading development and creation of Pennsylvania’s Return to Learn Concussion Management Team Model, now endorsed by two State Departments of Education, Dr. Eagan-Johnson has trained over 2,800 school-based concussion teams since 2013. Her brother sustained a severe TBI when they were teenagers, which is where her passion in the field began.

Hillary McClain Teears

Clinical Instructor

University of Pittsburgh School of Dental Medicine

lhim28@pitt.edu



Hillary McClain Teears is a clinical instructor in the Department of Periodontics and Preventive Dentistry at the University of Pittsburgh School of Dental Medicine. Ms. McClain Teears is a mother to 4 young boys, 2 biological and 2 stepsons, all of whom live with her and her husband full time. Her biological 8-year-old son is a survivor of a severe traumatic brain injury. She discusses her experiences with her son's school following his TBI and the valuable support she received from the BrainSTEPS Program.

David Kracke, JD

Brain Injury Advocate/Coordinator

Center on Brain Injury Research and Training

dkracke@cbirt.org



Dave Kracke, JD, is the Oregon Brain Injury Advocate/Coordinator. David has been a member of the Oregon State Bar for 28 years. He has an extensive background working with private and public stakeholder groups in the realm of legislative and policy initiatives. He is a recognized legislative and policy expert in TBI. David served as a lead author and legislative advocate for the stakeholder-informed efforts to pass concussion-response education laws, including Oregon Revised Statute (ORS) 336.485, (“Max’s Law”), one of the nation’s first enacted laws establishing concussion protocols for concussed high school athletes and ORS 417.875, (“Jenna’s Law), a companion law to Max’s Law which provided statewide concussion protocols for all youth athletes in the state of Oregon regardless of league affiliation. In 2020, David and Melissa McCart from CBIRT led the successful effort to require immediate temporary academic accommodations for concussed students returning to school.

David’s position at CBIRT is the first step toward establishing a permanent Brain Injury Advocate-Coordinator Director for the state of Oregon.