STATE SUPPORT OF INDIVIDUALS WITH TBI

Planning for the Neurobehavioral Needs of Individuals with Brain Injury: The State Perspective

Expanding Options & Creating Capacity: Home and Community Based Medicaid Waivers for TBI/ABI

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"In the past, professionals, family members and individuals with brain injuries came together to further the cause. We worked in unison and fought every inch of the way to make changes. Our commitments never faltered. We need to re-gain that passion if we are ever going to get proper recognition and funding for brain injury services in this country."

Marilyn Spivack, Founder NHIF (BIAA)

When Maria Crowley and I first spoke about the “loss of opportunities” in brain injury services three years ago at a NASHIA conference, we were recognizing that despite valiant efforts by many people, brain injury was still at the bottom of the recognition and funding ladder. While I lamented about the lack of a unified effort and the need for young professionals to “step up” and help, Ms. Crowley stated “let’s do something about it.”

Maria Crowley was right, of course, and this past October, NASHIA and NABIS hosted a first-ever joint conference in Minneapolis that brought together hundreds of medical/clinical specialists and state officials to present best practices in brain injury and to develop strategic partnerships among professionals and state brain injury administrators. The critical issues discussed by all of us can become a road map to creating a better future for brain injury services.

At our conference, Marilyn Spivack, the Godmother of Brain Injury, challenged brain injury organizations to “come together and re-focus” our efforts to strengthen brain injury recognition, funding and services in our country. We have all worked so hard over the years, including NASHIA, BIAA, ACRM, NABIS and the Brain Trauma Foundation and The Sarah Jane Brain Foundation. Most importantly, our work “together” needs to continue.

Over the years, Maria Crowley, Stefani O’Dea, Debra Kamen, William Ditto, Sharyl Helgeson, Susan Vaughn, Lorraine Wargo, Ana King, Jean Bérubé and many, many others have fought hard to meet this challenge with very limited resources to develop services and supports for the millions of people with brain injuries in our country. This issue of Brain Injury Professional presents some of key accomplishments by these dedicated professionals and opens up doors regarding where we all need to go – together.

On behalf of the NABIS Board of Directors, we want to thank Maria Crowley and her NASHIA colleagues for an excellent issue of Brain Injury Professional. This issue is in many ways a “call to action”, as well as an overview of several of our exemplary state programs which serve as models for the future. As many professionals know, we have the expertise to meet the needs of individuals with brain injuries and their families, what we have continually lacked are the proper resources and funding.

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Recovery from brain injury is a lifelong process, changes appearing years after the initial injury. Individuals need a variety of services in order to live fulfilling lives, including rehabilitative therapies, assistive technology, durable medical equipment, case management and in-home and community supports. With few exceptions for those who can afford it, states are generally charged with the task of providing these community services and supports to individuals with brain injury and their families. In current economic times, states are finding that more challenging than ever, and are forced to make difficult choices in order to do more with less. States are asked to provide many, if not all of these services, with increasingly limited funds:

- Information and referral
- Cognitive remediation
- Case management
- Therapy
- Guidance and counseling
- Respite care
- Durable medical Equipment/Supplies
- Vocational guidance, counseling and employment assistance
- Job coaching
- Long-term employment supports
- Housing
- Recreation

Each state tackles this challenge in a variety of effective ways, and this issue is dedicated to taking a closer look at the solutions states have created to meet the unique needs of their citizens.

State Administrators, Stefani O’Dea (Maryland) and Debra Kamen (Massachusetts) have addressed the role of state government in meeting the diverse neurobehavioral needs of individuals with brain injury, and successful components in creating an effective system of care. William Ditto (New Jersey) describes the Home and Community-Based Medicaid Waiver program and its menu of options created to enhance and expand brain injury services effectively for states. Sharyl Helgeson (Minnesota) further explores state challenges and options in identification, assessment and service provision for three of the most difficult barriers in affecting positive, long-term outcomes for those with brain injury: homelessness; addiction disorders; and incarceration. The Expert Interview article with Susan Vaughn (Missouri) provides basic foundations of information on the role of state government in funding, services and access to services. Anna King (North Carolina) reviews a comprehensive history of the Federal TBI State Grant Program, housed within Health Resources and Services Administration’s Maternal and Child Health Bureau, and the components of the State Service and Protection and Advocacy initiatives. NASIIA consultant Jean Bérubé (Maryland) describes effective collaboration between state and federal services for military-service men and women with TBI.

It is far more cost-effective to provide services where individuals live, in home and in communities, than in acute settings. BI can also make it difficult for individuals to learn from one setting and transfer those learned skills and behaviors back home to another setting. Families need individual choice, flexible home and community systems of service and care, continuity and coordination of care. Unfortunately, regardless of the quality of inpatient acute care, individuals often need supports and services at home and in the community that acute care settings are not able or not equipped to provide. State programs are attempting to meet these challenges by maximizing services and supports and make a difference in the lives of individuals with brain injury, while remaining fiscally accountable to state taxpayers and state government, often a provocative and rewarding task for those willing to embrace it.

I am pleased and honored to serve as guest editor for this issue, and I would like to issue a word of thanks to Ron Savage and to NABIS for the opportunity to partner with their organization for Brain Injury Professional, and for the dually sponsored 2010 Partnerships Conference, held in Minneapolis. I would finally like to say thank you to the contributors willing to share their expertise on a variety of challenging issues, their dedication to the field of brain injury and their years of hard work, and to Lorraine Wargo, NASIIA Executive Director, and Susan Vaughn, Director of Public Policy for their efforts toward this project.

Maria Crowley, MA, CRC

ABOUT THE GUEST EDITOR:
Maria Crowley, MA, CRC, currently serves as President of the National Association of State Head Injury Administrators (NASIIA), the first and only forum addressing State government’s significant role in brain injury. NASIIA is the premier source of information and education for State Agency employees who are responsible for public brain injury policies, programs, and services, and the voice of state government in federal TBI policy issues. Mrs. Crowley is the State Head Injury Coordinator with the Alabama Department of Rehabilitation Services, and has over 21 years of experience in disability/rehabilitation issues with State Government. Mrs. Crowley manages the Department’s Head Injury Program, statewide Head Injury Task Force and Impaired Driver’s Trust Fund Advisory Board. She serves as Project Director for Alabama’s current HRSA/MCHB grant project. She also continues to manage the Alabama Head & Spinal Cord Injury Registry, a statewide service linkage system for survivors and their families. Mrs. Crowley holds a BS in Psychology, an MA in Rehabilitation Counseling from the University of Alabama at Birmingham, and is a Certified Rehabilitation Counselor.
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A 43-year-old man who experienced two brain injuries, one in childhood and one in adulthood, was “stuck” in a community hospital with no safe discharge options when he came to the attention of the State TBI Program Director. The reason for admission to the community hospital was neurological damage that resulted from being subdued with a taser gun outside of a police station due to his aggressive behavior. This was his fourth interaction with police resulting in formal legal charges. He was well known to the police and human service professionals in his county and considered a major threat to himself and to the community.

He had no natural supports involved in his life, and had a history of aggressive behavior, and a significant seizure disorder. All of these factors were exacerbated by his frequent alcohol use. Since his second brain injury, he had been involuntarily discharged from two nursing homes, a homeless shelter, and a community mental health program. This gentleman remained “stuck” in the community hospital, where he was heavily sedated to manage his aggressive behavior for six months before finally being admitted to a brain injury rehabilitation unit and accessing the state’s brain injury Medicaid waiver program. The reason that he was not initially able to access these needed programs was that he did not meet the admission and eligibility criteria for either program.

His situation was the impetus for change within this state’s service system, which now has more flexible admission criteria that is sensitive to the neurobehavioral rehabilitation needs, as well as the physical and cognitive rehabilitation needs of individuals with brain injury.

Acquired brain injury is a major public health problem and public awareness of the problem has increased with media coverage of sports related brain injury and blast injuries resulting from Improvised Explosive Devices (IEDs), a common combat tactic being utilized against American soldiers involved in the conflicts in Iraq and Afghanistan. While awareness of the cognitive and physical changes that occur after a brain injury and the subsequent rehabilitative needs are becoming increasingly familiar to the public and to healthcare providers, the behavioral changes and challenges resulting from a brain injury remain an under-recognized and under-treated issue. Yet, behavioral deficits are a major impediment to the brain injury recovery process and impact an individual’s ability to engage in rehabilitation, return home to family, return to work, maintain personal safety, and adapt to societal expectations.

Common behavioral challenges include verbal and physical aggression, agitation, limited self-awareness, altered sexual functioning, impulsivity and social disinhibition (National Association of State Head Injury Administrators, 2006). The literature suggests that agitation and aggression develops in 20-49% of children who sustain a TBI and 25-33% of adults who sustain a TBI, usually within one year of sustaining the injury (Kim, et al., 2007 & Baguley, et al., 2006). Risk factors for developing aggression and agitation include frontal lobe lesions, preinjury history of substance abuse, preinjury aggression, multiple brain injuries, and depression.

It has been estimated that approximately three (3%) to ten percent (10%) of individuals who sustain a brain injury require long term, intensive supports because of neurobehavioral issues (Brain Injury Association of America, 2009; McMorrow). While the prevalence is low, the acuity of the problem is high. People with significant neurobehavioral issues can pose a risk to themselves and to others and require specialized supports and services, which do not currently exist in every State. While most States offer neuro-rehabilitation services that treat physical and cognitive problems
associated with brain injury, many states do not have neurobehavioral programs. The safety risks and level of disruption posed by individuals with significant behavioral problems are barriers to accessing neurorehabilitation services, and without the neurobehavioral expertise that is needed, many deficits and symptoms are left untreated. The components of a neurobehavioral program that are often missing include integrated cognitive, behavioral and pharmacological interventions. One of the challenges faced in the development of programs of this unique nature is the availability of resources such as clinical expertise in neuropsychology, behavioral psychology and neuropsychiatry. Other barriers may include lack of adequate physical space with relevant licenses and reimbursement rates that allow for high and adequate staffing ratios.

There are also significant funding constraints that impact appropriate access to care. Payors (private and public) tend to reimburse only for rehabilitation services that are provided initially after the injury but are less likely to authorize payment for needed long-term services. Brain Injury is a chronic but fluid condition and an individual with brain injury experiences many ups and downs throughout the recovery process (BIAA, 2009). Factors such as secondary injury, substance abuse, co-morbid psychiatric conditions and the aging process impact the recovery process and it is not unusual for an individual with a relatively good recovery to compensate a year or even decades after the injury yet service systems are rarely flexible or responsive enough to these changes in functioning. The gentleman referenced above is a prime example of the fluctuation in level of functioning during his recovery process. Once he accessed the appropriate brain injury services, he began functioning at a much higher level, eventually returning to work.

The Role of State Government

Historically the role of state government has grown as it relates to the safety of its residents and the community at large resulting in a more critical role in serving those in our communities who are most needy. This philosophy and practice has led to the development of state-supported neurobehavioral systems of care and protection that include both secure and community-based programs.

Specifically the sub-population of individuals with brain injury who experience significant neurobehavioral and neuropsychiatric challenges require specialized and integrated treatment programs designed for those with brain injury, who often present with other co-morbid diagnosis, that do not readily exist in most states. These programs are essential to ensuring the safety of these individuals as well as the communities they live in. Those who reach this level of need have almost always depleted any personal resources they or their family may have and often are not successful when participating in those available services that are not equipped to deal with complex neurobehavioral issues, which are also often coupled with co-occurring mental health and substance abuse disorders. The majority of these individuals therefore become dependent on public resources and state funding to access the neurobehavioral treatment that is needed. When such services are not available within a state, many states resort to paying for specialized services out of state ranging in price from $500-$900 per day. Although these programs may ultimately lead to improved outcomes they come at a high cost to taxpayers eating up a large portion of limited state funds.

Resource limitations, funding constraints, and systemic barriers must be solved in order to improve access to appropriate and necessary services while reducing the spending on ineffective and costly treatment. An increasing number of states (AL, GA, FL and MD) have created taskforces, studies, and neurobehavioral state plans to address the missing points on the state’s service continuum. States have begun to identify the economic and social costs associated with the lack of appropriate services such as high rates of incarceration and hospitalization and homelessness among the brain injured population. The CDC reports that as much as 87% of the prison population in the U.S. has sustained at least one TBI. States have experienced class action lawsuits on behalf of individuals with brain injury who are institutionalized in nursing facilities (MA, FL), some of whom are being managed in secure behavioral units, or state psychiatric hospitals (MD) because of the lack of available resources in the community. Individuals get “stuck” in Emergency Departments and community hospitals because appropriate and safe discharge options are not available.

Over the past two decades State TBI programs across the country have taken the lead in the development of a broad array of services that target individuals with neurobehavioral challenges; however, no state has created the entire menu of service options needed, ranging from early intervention services to secure and/or locked neurobehavioral units. The challenges associated with developing this menu of options by states can be daunting and is driven by many factors including the organizational structure of state government, shifting political climates and priorities, and economic downturns.

For example, TBI leadership within state government may be housed in a variety of different state agencies and differs tremendously from state to state. In some cases, the TBI leadership may be separate from the agencies that provide funding for services. The location of the TBI program staff and the state agency they are housed in often impacts the types of strategies states have utilized to address the gaps in the continuum of care for this population such as Advisory Boards, paid studies, task forces and Medicaid waivers to name a few.

TBI program leaders responsible for States’ Brain Injury programs and service development may also have many different titles and levels of authority within their states’ government structure. They may be directors, specialists, coordinators, council members or grant project staff within the lead agency. The level of authority they have influences their ability to impact change within the state system and to garner support from the Governor’s office, which is necessary for funding and program development.

State funding has always been a challenge to accomplishing what needs to be done for the brain injury community, which is often in direct competition with the resource and funding needs of other aging and disability groups. Legislators decide how state resources will be allocated but they are also elected to represent and serve their constituents. The public needs to be educated about brain injury and why appropriate and timely interventions will lessen the burden on society as a whole and are a good investment of state dollars. This often becomes the role of the Brain Injury Association of America State Affiliates who are important collaborators in any efforts to create solutions through state systems.

Reliance on legislators and therefore politics does not end with public support. Accessing state funding is also dependent on the budget process, which varies from state to state. TBI leaders within state government must come prepared to advocate for the
needs of their consumers at multiple levels of government, especially when the cost is so high. There is a need to be well prepared every step of the way which includes written materials that clearly describe the problem, the consequences associated with the lack of program options, the number of individuals that need assistance (ideally by Legislative District), the strategy being proposed based on experiences and successes in other states and, finally, the estimated costs associated with the proposal. Brain injury professionals have played key roles in defining the breadth of these issues and clinically sound interventions that help to minimize the negative impact on the individual, their family and the community.

**Components of Service Delivery Systems**

States that have been successful in the development of neurobehavioral services have worked collaboratively and diligently over time with their State Brain Injury Advisory Boards and Brain Injury Association State affiliates that include individuals with brain injury, family members, and providers who are knowledgeable and committed to serving this population. Together these partnerships have created improved identification and screening tools for TBI, identified gaps in the states’ service delivery system, and led to the creation of programs and supports that improve access to and the timely delivery of appropriate services for those with brain injury including those who present with these significant needs.

Administrators of state brain injury programs have come to rely on their counterparts in other states to share their successes and sometimes failures in attempting to design and implement programs for this population. The experiences of other states and the ability to network and provide critical information have been facilitated through the National Association of State Head Injury Administrators (NASHIA). Even with this resource only a small number of states such as MN and MA have developed secure neurobehavioral programs. No state seems to have all the components of a successful neurobehavioral service delivery system.

The ideal system to address neurobehavioral challenges would consist of early intervention approaches, community-based services and structured inpatient programs. Early Intervention practices are needed to prevent the need for more intensive and costly services in the long term. For instance, effective screening and assessment procedures are important. Alaska screens all individuals who seek public behavioral health services for a history of brain injury. Other states (MN, MD) have implemented TBI Screening on a smaller scale at state psychiatric hospitals, correctional facilities and community mental health programs. Screening also needs to be done in nursing homes and other institutional settings. Assessment of needs and risks and development of risk management plans are also needed as a core component of the system.

Training for professionals working in corrections, mental health, addictions, intellectual disabilities, elderly services and long term care facilities is critical as they are already seeing individuals with brain injury who have multiple diagnoses and needs that change over time. These professionals need to develop the skills to appropriately identify and support individuals with brain injury within their programs. MA has developed such a curriculum, which has been used to train other state agency staff such as case managers and clinicians. MD has established a Co-Occurring Supervisor’s Academy that is training senior staff from mental health, substance abuse treatment and intellectual disabilities services agencies on issues of co-occurring disorders, including brain injury, among these populations.

Access to trained case managers/service coordinators/resource facilitators who can assess changes in an individual’s level of functioning, navigate individuals through the service delivery system as their needs change, and advocate for individuals within the various service settings is critical. These staff must be separate and independent from the service providers to insure adequate monitoring and that service coordination remains in place even if services or funding is lost.

Community-based services and programs are another essential component of an effective neurobehavioral system of care. Services should include: (a) targeted technical assistance to assess and recommend necessary interventions before a situation becomes a crisis (e.g. MA has a formal technical assistance program for school systems that can be utilized when a student with a brain injury begins to exhibit problem behaviors that could result in placement in a less integrated setting); (b) outpatient treatment to prevent hospitalization that includes psychopharmacological and behavioral management, assessment for the need for inpatient hospitalization in times of neurobehavioral crisis, follow-up treatment upon discharge from hospital to the community. Crisis response programs that are mobile and include neuropsychiatric and neurobehavioral expertise are another important resource. These programs may be a component of State’s public mental health system; however, crisis teams typically lack the brain injury expertise needed to benefit this population.

In-home supports and family assistance are also critical to preventing institutionalization secondary to behavioral and psychiatric challenges. Initially after sustaining a brain injury, the majority of individuals are discharged home to their families. Services such as respite care in and out of the home, family support programs (MA), and meaningful daytime opportunities for the person with the brain injury (e.g., NY state clubhouse models) contribute to maintaining safety, stability, community integration, and reducing the risk of institutionalization.

Given the incidence of substance abuse within this population and the fact that use of alcohol and drugs can result in more compromised functioning up to and including significant behavioral and psychiatric issues, there is a need to develop specialized treatment programs that build on traditional approaches yet are flexible enough to accommodate the cognitive and pharmacological needs of those with brain injury (MA).

States need structured residential services that provide 24-hour supervision in a provider operated setting. Staff/participant supervision ratios must be adequate to provide cognitive-behavioral interventions. These providers should be able to access and coordinate other necessary clinical services such as psychopharmacology, neurobehavioral interventions, and medical care. These programs are an essential component of the continuum because they offer intensive services in a community based setting and act as a step down program from inpatient services.

Despite the goal of reducing reliance on institutional care that is shared by States, the federal government, and many stakeholders, inpatient programs are an important part of the continuum when individuals are not able to reside safely in the community. Every State should have a locked, or at least secure, neurobehavioral treatment program that is “short term” in nature; provides highly structured programming that integrates cognitive, neurobehavioral and psychopharmacological treatment approaches;
has intensive staffing patterns; allows for involuntary admission and leads to improved functioning over time and ultimately community reintegration. Such unit(s) should have the capacity to provide inpatient stabilization in lieu of traditional psychiatric hospitalization for those individuals who require neuropsychiatric and neurobehavioral intervention. States must also have the capacity for chronic and potentially long-term neurobehavioral treatment that keeps the individual safe and eliminates risk to the community for those whose impairments cannot be ameliorated.

Specialty brain injury unit(s) are also needed within nursing facility(s) to support the skilled medical needs of individuals with brain injury who present with significant neurobehavioral and/or neurocognitive impairments. The units must be transitional in nature with discharge planning starting at admission and well-coordinated transitions to community settings.

Summary
In summary, these programs and services mentioned above constitute the most basic components of a state system of care for those with neurobehavioral and neuropsychiatric challenges. Regardless of what a state is able to create, their neurobehavioral service delivery systems must be coordinated and flexible, person centered and cognitively accessible to the extent an individual is able to participate and able to respond to high risk situations that require immediate crisis management responses. Most importantly states need to work closely with the brain injury community and other human service agencies such as mental health and addictions in order to be successful in meeting the needs of this small but significant number of people whose brain injury has resulted in challenges that are difficult and costly to manage.

ABOUT THE AUTHOR
Debra S. Kamen, MS has been the director of the Massachusetts Statewide Head Injury Program (SHIP) since its inception 25 years ago; and has managed the Brain Injury & Statewide Specialized Community Services Department created more than 10 years ago to include SHIP, Nursing Home Transition Services, the TBI HCSB Waiver Program, the Head Injury Treatment Services Trust Fund Program and other disability-related services. She is one of the founding members of the National Association of State Head Injury Administrators (NASHIA).

Stefani O’Dea, MA, has worked as the State TBI Program Director in Maryland for over nine years, where the Brain Injury Lead Agency is housed in the State’s mental health agency and operates the State’s home and community based services waiver for adults with traumatic brain injury. She has also worked for six years as a Director of a community based neurorehabilitation program for individuals with acquired brain injury and currently serves on the Board of Directors for NASHIA.

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Home and Community-Based Services (HCBS) Medicaid Waivers are an option that states can use to enhance the continuum of care for individuals with brain injuries. This summary of the nature and use of home and community-based waivers provides the reader with knowledge of how these waivers may be used to enhance and expand the available brain injury services for individuals in the community. The flexibility of these waivers allows for creativity and draws in federal financial support for states that are struggling with providing adequate and appropriate brain injury services to meet the long-term care needs of this population. The significance of the waiver programs is examined in the context of avoiding inappropriate institutional care for brain injury survivors.

**Introduction**

Since the 1980’s the federal government has provided a way for states to create home and community-based programs to serve individuals with Traumatic Brain Injury (TBI) and/or Acquired Brain Injury (ABI) using federal Medicaid funds (Omnibus Budget Reconciliation Act of 1981, P.L. 97-35). Medicaid is a state/federal partnership that provides medical assistance coverage to individuals with low income and assets. States and the federal government each contribute a percentage towards paying for the cost of covered, approved medical services. Each state has a unique Medicaid program, although the mandated and optional Medicaid services are defined, in part by law, and by the federal Department of Health and Human Services (DHHS), under the direction of the Centers for Medicare and Medicaid Services (CMS) (Social Security Amendments of 1965 (P.L. 89-97, as amended). This means that states vary in terms of the coverage of services and the eligibility criteria used for individuals seeking Medicaid coverage.

In the brain injury world it is well known that very few long-term care services are covered by Medicare (Title XVIII of the Social Security Act), the federal insurance program or private insurance. Many people who sustain a brain injury will find that insurance coverage is limited to acute hospital care and some limited in-patient rehabilitation care. However, we know that individuals with brain injuries will often require a lifetime of coordinated, comprehensive care of a less intense nature if they are to succeed and achieve a good quality of life post injury.

One of the ways in which states may opt to fund on-going services for a specific population group (elderly, disabled, TBI/ABI, etc.) is through the use of “Home and Community-Based (HCBS) Waivers.” These waiver programs are authorized under Section 1915(c) of the Social Security Act, which permits the Secretary of the DHHS to “waive” certain eligibility criteria and other federal Medicaid rules to allow states to develop programs offering community-based services as an alternative to institutional care. Unfortunately, institutional care is a mandatory Medicaid service in every state, whereas home and community services are regarded as optional and not required of states to provide. This fact is often referred to as the “institutional bias” in the federal Medicaid program.

The waiver permits the use of expanded financial eligibility criteria. Thirty-eight states use 300% of the federal monthly Supplemental Security Income (SSI) standard, which is $374 for 2010, resulting in an individual being able to have up to $2,022 in gross monthly income and qualify for a waiver program (Kaiser, 2010). The SSI asset limit is $2,000, but states have flexibility setting a higher income or asset levels if they desire. The HCBS waivers
also require that the eligible individual be afforded full Medicaid coverage as well as receiving specific, unique, waiver services not otherwise available in a state. In fact, the individual must be in need of, and receiving, at least one waiver services in order to maintain waiver eligibility.

In order to qualify for waiver eligibility, the individual must meet a “nursing facility level of care” – in other words the person must be found clinically eligible for a nursing facility (or similar institutional) care to meet the admission criteria to the waiver. Each state has a specific criteria and measurement for level of care. It is not standardized on a national level.

States may limit the number of individuals that are served under the waiver programs. Some states use a slot system, others use an expenditure cap and some use a combination. The bottom line is that the federal DHHS requires that waivers be cost neutral. A state may not receive federal reimbursement when the cost of providing services to waiver participants exceeds the cost of equivalent nursing facility care. Most states use case managers, or service coordinators, to authorize and track expenditures to meet the cost neutrality provisions.

A recent addition to the federal Medicaid waivers is the 1915(i) waiver. This waiver, originally included in the Deficit Reduction Act (DRA), has recently undergone amendments as a result of the Affordable Care Act (ACA) and may be used to create TBI/ABI waivers. Prior to the changes made by the ACA, states were only permitted to have one 1915(i) waiver -- however it is now possible for states to have multiple waivers of this type. The 1915(i) waivers allow states to target specific populations and do not require that waiver applicants meet a specific level of care criteria, as is required in the 1915(c) waivers. There is also no requirement for cost neutrality for this new type of HCBS waiver. However, states may be concerned that the lack of limitations under this waiver authority leaves them in a vulnerable position in terms of state expenditures. Anyone who meets the specific waiver criteria must be enrolled. There are no slot limitations. At present there are only a handful of 1915(i) waivers in operation across the country. It will be interesting to see how many states will opt for the use of this waiver authority over time.

### Brain Injury HCBS Waivers

Serving individuals with TBI and/or ABI via the use of HCBS waivers has been demonstrated to be an effective use of state and federal Medicaid funds. Because waivers allow the creation of unique, population specific, waiver services states have been able to pay a wide array of services that may be needed by individuals with brain injury. These include services such as cognitive rehabilitation, neuropsychological or neuropsychiatry treatment, structured therapeutic day programs and community residential service settings, to name a few. As mentioned earlier, states must offer services under the waiver programs that are not normally covered by the standard Medicaid program.

Thus, the state administered HCBS Brain Injury waiver programs serve as an important component in the continuum of care and offer a step-down between acute rehabilitation and independent community living. Services may be provided at home, or in a day center or in a residential setting. Brain Injury waivers are among the few where there is a potential for residential placement in conjunction with active services. DHSS has a prohibition against paying room and board charges with Medicaid funds, therefore the residential programs are supported by having the individual turn over a portion of their monthly income and then billing the Medicaid programs for supervision and services – not food or lodging.

### Other HCBS Waiver Programs

Many states that do not have a brain injury specific waiver may still accept individuals with brain injuries into other HCBS waivers that can provide the required services. Virtually all of the states have at least one HCBS waiver and a significant number of states administer several. They have become a useful tool in reducing reliance on more costly institutional placements and meeting the mandates of the Supreme Court’s decision in the Olmstead case (Olmstead v L.C., 1999), which requires states to provide community-based services and supports to individuals who do not require ongoing medi-
The absence of waiver programs forces individuals into inappropriate and restrictive living arrangements if families are not prepared and able to provide comprehensive daily care.

Conclusion
Because we are aware that many individuals with TBI are young adult males, who are not living with family at the time of injury or may have pre-morbid and now co-existing substance abuse or mental health issues, the potential of the individual to end up in a state psychiatric institution or correctional facility is significantly greater, if behavior appears out of control. The waiver programs offer an alternative that can assist in a more complete and satisfactory recovery by providing a group of specialized services in a community setting.

REFERENCES

ABOUT THE AUTHOR
William A. B. Ditto, MSW, LSW, is the former director of the New Jersey Division of Disability Services. He was responsible for the administration of the NJ TBI Medicaid Waiver and his agency was designated by the governor as the lead government agency for brain injury services in New Jersey. Mr. Ditto is a past president of NASHIA and chair of its Public Policy Committee. He holds degrees from Monmouth (NJ) College and Rutgers University Graduate School of Social Work.
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Introduction
A young man, in his mid-twenties, hospitalized in a mental health unit, was admitted with the following complaint, “There is something wrong with my head and I can't keep a job.” During a clinical interview, he revealed that his father had not been in his life for almost twenty years. His father had been physically abusive and he was subsequently hospitalized for broken bones. When he was school age, he was hit by a car, resulting in hospitalization for multiple injuries. He was placed in Special Education, as he had trouble learning and controlling his behavior in class. As an adolescent, he began using multiple drugs as well as alcohol. While still a teen, he was involved in another incident, resulting in hospitalization for several days. Thereafter, his ability to concentrate, remember, and control his temper became even worse.

After high school, he enlisted in the National Guard and served in Iraq for several months. He was injured in an attack, later describing this experience as ‘severe PTSD’. Once he was back in the states, he could not keep a job. His use of drugs and alcohol escalated and he was jailed for various offenses. He had nowhere to sleep except his car. A mental health crisis resulted in hospitalization. The clinician recognized the likelihood of traumatic brain injury (TBI). Neuropsychological testing revealed to the multidisciplinary treatment team problems with his multiple conditions.

This young man was indeed a case of “Unidentified TBI”. Once brain injury was identified as a contributing factor, he was linked to appropriate services and supports and was able to get supported employment and move along with his life.

Why mix a discussion of diagnoses, of clinical conditions, with discussion of life circumstances such as homelessness or incarceration? For those who know individuals with these very complex and multiple conditions, or who work with them as clinicians, the stories are all too familiar. In addition, state systems may be designed for one purpose, such as public safety (e.g., corrections and juvenile justice systems) or treatment for one condition (e.g., alcohol/substance abuse, mental illness, or brain injury) or the lack of appropriate services will result in homelessness for many individuals. In addition, individuals with TBI may have overlaying mental health and substance abuse problems that complicate appropriate diagnosis, treatment and care.

While nearly every state screens for mental health problems within juvenile justice systems according to the National Center for Mental Health and Juvenile Justice, screening for TBI has not been universally adopted. Similarly, most state corrections, mental health and alcohol and substance abuse agencies collaborate with regard to screening and treatment programs for inmates with these problems. An emerging trend across the country is to establish veterans’ treatment courts for nonviolent offenders, recognizing that veterans with mental health and substance use issues end up involved with the criminal justice system (Stateline.org). Although TBI is generally omitted from these initiatives, these collaborative efforts provide opportunities for TBI state programs to educate other systems about TBI in order to better address the needs of individuals with TBI in their systems, as well as to develop appropriate release planning that links individuals to TBI services and supports for those who return to the community.

The purpose of this paper is to highlight examples of state responses to the overlapping sub-populations of persons with alcohol and substance use disorders, persons who are in or have been involved with criminal justice and corrections systems, and those who are homeless.

The Problem: Recognizing TBI
In a publication produced by the New York TBI Model System at Mt. Sinai, it was noted that TBI is often the “hidden” disability that is undiagnosed, yet it can be the cause of cognitive
problems, including poor judgment, poor memory, and lack of
good communication skills; behavioral and personality problems
and disorders; and poor social skills. As such, individuals may
drop out of school, or may be unable to obtain or maintain a
job or are poor risk takers resulting in incarceration in adult and
juvenile correctional systems (New York Model Systems, 2006).

Unless medical documentation is available or a TBI screening
is in place, systems that have primary functions other than
TBI, will not document TBI. In its study of TBI and residents of
Missouri youth services facilities, the researchers noted limi-
tations with regard to the reliance on self-reporting for deter-
mapping TBIs, as TBI information was generally not included in
medical records. Despite these limitations, the findings indi-
cated that nearly one-in-five youths, 18 %, reported a lifetime
TBI. These individuals were significantly more likely to be male,
have received a psychiatric diagnosis, reported an earlier onset of
criminal behavior/substance use and more lifetime substance use
problems and past-year criminal acts, than those who did not
report a TBI (Perron & Howard, 2008).

In a Wisconsin study involving 90 homeless men, 80% were
found to have evidence of cognitive impairment (Solliday-McRoy,
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The Centers for Disease Control and Prevention (CDC)
found that 25-87% of inmates report having experienced a head
injury or TBI as compared to 8.5% in a general population re-
porting a history of TBI. As noted in another study regarding the
prevalence in correctional facilities, TBI can create challenges to
offenders and to their successful community reentry upon re-
lease. This study noted other articles that reported in-prison be-
behavior related to brain injury and associated rates of disciplinary
incidents and inability to adapt to prison life and rules (Solliday-

Crosscutting Issues: Substance Abuse
and Mental Health
The literature reveals that persons with the co-occurrence of sub-
stance use disorders and mental illness may have a high rate of
TBI, which can complicate treatment and can impact a person’s
ability to manage ‘stability’ in community living (Corrigan and
Deutschle, 2008). With regard to inmates the CDC study found:

- Prisoners who have had head injuries may also experi-
tence mental health problems such as severe depression and
anxiety, substance use disorders, difficulty controlling
anger, or suicidal thoughts and/or attempts.
- Studies of prisoners’ self-reported health indicate that
those with one or more head injuries have significantly
higher levels of alcohol and/or drug use during the year
preceding their current incarceration.

Addressing the Problem: Promising Practices
Some states have begun to address the identification of individ-
uals with TBI in juvenile justice, corrections, mental health and
substance abuse systems. A few state legislatures have passed
legislation directing the state agencies to study the needs of
inmates including those with TBI. Another impetus has been the
US Health Resources and Services Administration (HRSA)
TBI Program which awards grants to states to expand service
delivery. These efforts include education and training of sister
state agencies; screening and identification, and initiated
collaborative efforts to improve diagnosis, treatment and care
of those with TBI and co-occurring conditions. Examples are
listed below.

A) Education and Training
Maryland’s HRSA Federal TBI State TBI Implementation Part-
nership Grant funds training for Community Mental Health
Centers and other systems on TBI issues, and funds were used to
provide materials produced by the Ohio Valley Center for Brain
Injury Prevention and Rehabilitation for practical guidance in
assessment, planning, and accommodations for those with TBI
and co-occurring conditions.

The Minnesota TBI program, in collaboration with the De-
partment of Corrections, developed on-line training (three mod-
ules) for correction’s staff, including training on release planning
and TBI resources.

B) Screening and Identification
States are using various screening tools, usually those developed
by the National Institute on Disability and Rehabilitation
Research (NIDRR) TBI Model Systems or Centers for Disease
Control and Prevention (CDC), to screen for TBI. In each of
those states, researcher consultation assists the efforts to imple-
ment the screening processes and to analyze results.

Alcohol and Substance Abuse
Kentucky added a TBI question to their annual alcohol and sub-
stance abuse screening to determine the number of individuals
seeking substance abuse rehabilitation and treatment that also
have a TBI. An analysis of the findings of Kentucky’s TBI screen-
ing question found that almost one-third (31.7%) of substance
abuse treatment clients reported one or more TBI-related loss of
consciousness (LOC). The clients reporting two or more TBI-
LOCs were more likely than clients with none or one TBI-LOC
to have serious mental health problems (i.e., depression, anxiety,
hallucinations, and suicidal thoughts and attempts), trouble
controlling violent behavior, trouble concentrating or remem-
bering, and more months of use of most substances (Walker, et
al., 2007).

Corrections
Minnesota uses the Traumatic Brain Injury Questionnaire
(TBIQ) to survey inmates in correctional facilities and youth in
juvenile detention centers. In a screening of 998 male state in-
mates 82.8% reported having had one or more TBIs during their
lifetime (Walld, et al., Slaughter et al., 2003). South Carolina is
using the Ohio State University Traumatic Brain Injury – Identi-
fication Method (OSU TBI-ID), as modified by South Carolina,
developed by John D. Corrigan PhD, ABPP, and Jennifer Bog-
ner PhD, ABPP, to screen inmates.

Juvenile Justice
Texas is using the Brain Injury Screening Questionnaire (BISQ),
developed by the New York TBI Model System, to screen ap-
proximately 3,000 children and youth in juvenile detention and
203 youth served through the Texas Juvenile Probation Com-
mission for unrecognized TBI. The state is using its HRSA TBI
Systems Change Implementation Partnership Grant to conduct the screening.

**Homeless**

Since 1991, the Minnesota Wilder Research Foundation surveys persons without permanent shelter every three years. Questions to address brain injury were incorporated in 2003. In the most recent survey, in 2009, 35% of adults who were homeless at least a year reported symptoms of a TBI; 38% reported a cognitive disability; 59% have a serious mental illness; 49% reported a chronic health condition, and 27% reporting a drug or alcohol disorder. The reporting of mental health problems and cognitive disabilities and symptoms of TBI has been increasing over time (Wilder Research Foundation).

**C) Collaboration Across Agencies**

In Minnesota, the Governor’s plan to end long-term homelessness has been jointly led by three state agencies: the Minnesota Departments of Corrections, Human Services, and the Housing Finance Agency. The state legislature provided funding for pilots which were later funded as part of a collaborative related to the Long-Term Homelessness Supportive Services fund.

In addition, the Department of Corrections is developing a release planning program specific to the needs of offenders with TBI, including culturally appropriate services for Native Americans returning to their communities. The Minnesota Department of Corrections is a partner in Minnesota’s HRSA TBI State Implementation Partnership Grant administered by Human Services.

The South Carolina Department of Corrections is a key partner with the CDC funded research grant to the Medical University of South Carolina to study the prevalence of TBI and adverse health conditions among incarcerated adults. Additionally, the study is looking at the potential impact of TBI on community reintegration.

**D) Expanding TBI Programs**

**Homeless**

Collaborating with shelters and other programs is another important strategy. The Massachusetts Brain Injury and Statewide Specialized Community Services, a component of the Massachusetts Rehabilitation Commission, has been a pioneer in focusing on homelessness for approximately fifteen years. Efforts include the availability of Stateside Head Injury Program (SHIP) staff who provide intensive outreach in shelters to identify individuals with brain injury, including veterans. The program staff also provides TBI training for personnel in various systems. SHIP provides intensive case management through trained brain injury specialists who link individuals to services.

Another example of expanding TBI program services is the New York’s Neurobehavioral Resource Project, which was developed to assist persons with TBI with significant community reintegration challenges served by the state’s TBI Medicaid Waiver. The individuals served have chronic behavioral difficulties along with a co-occurring diagnosis of substance abuse and/or mental health disorder. The highly skilled staff provide on the scene, tailored positive behavioral supports consultative and training services which have been proven to be cost-effective (Ylvisaker, et al. 2007).

**E) Using Federal Resources**

Several federal agencies administer grant programs associated with homelessness which states and other organizations may apply to address the daunting problem of persons who are homeless; often with multiple and confounding health issues. These agencies include the US Housing and Urban Development (HUD), SAMHSA, HRSA, and the Department of Veterans Affairs.

The Project for Assistance in Transition from Homelessness (PATH) is administered by the Center for Mental Health Services within SAMHSA and is a formula grant to states and territories providing funding for persons with serious mental illness, including those with co-occurring substance use disorders who are experiencing homelessness or at risk of the same.

Another approach is to coordinate multiple grants. Minnesota’s current HRSA TBI Implementation Partnership Grant is focusing on two Department of Corrections (DOC) facilities and their substance use treatment programs that were voluntary implementation sites for a Co-occurring Disorders State Incentive Grant (COSIG) from SAMHSA to implement Integrated Dual Disorder Treatment (for persons with mental illness and substance use disorders).

The collaboration supported by these two projects provided an impetus to develop a TBI screening protocol system to track offenders identified with TBI who require complementary services to support an effective chemical dependency treatment experience. This will also lead to the development of community resources to prepare for discharge from prison with linkage to appropriate supports. As the result of a previous Minnesota Department of Education Physical and Neurological Disabilities Assistance (PANDA) grant, funded by US Office of Special Education, the TBI project is able to collaborate with the PANDA Coordinator, who is an Adult Basic Education Teacher and is also a Certified Brain Injury Specialist, to train DOC educators and offender mentor tutors.

**Summary**

State government works in partnerships with other agencies to administer and pay for services and supports to meet the needs of their citizens with TBI who often have complex needs. States rely on the researchers, the advocacy community, practicing clinicians and providers, as well as individuals and family members to inform and assist in promoting the development of effective programs and options in filling gaps in the continuum of services and supports needed by persons with brain injury. States use a variety of approaches to build a safety net, often times incrementally, with a patchwork of seed monies through grant projects, state funding or trust funds, and strategies to serve persons with brain injury in various disability programs. Since many individuals with TBI, including those with dual diagnosis, are also served by juvenile and correctional systems, states are beginning to reach out to those agencies to better address their needs.

**REFERENCES**


**ABOUT THE AUTHOR**

Sharyl R. Helgeson, RN, PHN, Mental Health Program Consultant, has held a variety of public policy positions for over twenty years in the MN Department of Human Services (DHS). She has served as Project Director for Minnesota’s five HRSA Federal TBI State Grants; the current and most recent being conducted in partnership through Minnesota Department of Corrections. She has experience in brain injury and co-occurring conditions in mental health, post-acute rehabilitation, and nursing facility settings. She’s active in the National Association of State Head Injury Administrators and serves on its Board.
In July of 1996, President Bill Clinton signed the Traumatic Brain Injury Act (P.L. 101-166) into law, authorizing federal programs to study, research, and to expand access to service delivery for individuals with TBI and their families. This landmark legislation named three agencies within the U.S. Department of Health and Human Services (HHS) to carry out the purposes of this Act: the Centers for Disease Control and Prevention (CDC) to fund projects aimed at reducing the incidence of TBI, as well as to determine incidence and prevalence; the National Institutes of Health (NIH) to conduct basic and applied research regarding new treatment modalities and continuum of care needs; and the Health Resources and Services Administration (HRSA) to develop a state-based TBI grants program for the purpose of improving access to rehabilitation and other services.

The TBI Act was reauthorized in 2000 as part of the Children’s Health Act (P.L. 106-310), and directed CDC to expand its incidence and prevalence activities to include persons with mild TBIs and individuals with TBIs in institutional settings. The reauthorization also included a grant program for Protection & Advocacy (P&A) systems, which were created initially by the Developmental Disabilities and Bill of Rights Act of 1975 (P.L. 103-230) as independent agencies to protect the rights of individuals with disabilities. In 2008, Congress reauthorized the TBI Act for a third time, which authorized funding through federal Fiscal Year 2012 (P.L. 110-206).

This article provides an overview of these federal programs and their impact on services and supports for individuals with TBI and their families.

**Overview: HRSA Federal TBI State Grant Program**

After passage of the Act, HRSA designated the Maternal and Child Health Bureau (MCHB) to administer the grant program and contracted for a Technical Assistance Center (currently the National Opinion Research Center (NORC) at the University of Chicago) to provide assistance to states in carrying out the goals of the program.

MCHB determined that four core components were essential for a state to operate a coordinated system of services: (1) a designated Lead Agency for TBI to direct policy and coordinate services; (2) a statewide advisory board to make recommendations to improve service delivery; (3) a Comprehensive Needs and Resources Assessment; and (4) a State Action Plan to serve as a blueprint for service delivery.

In 1997, Planning Grants were awarded to 14 states to develop the core components and Implementation Grants were awarded to seven states that had already addressed the core components and had identified other gaps in service delivery. Since 1997, 48 States, the District of Columbia, and two territories have received federal HRSA TBI grants.

Over the years, grant recipients have used funding to develop the four core components; increase public awareness; educate and train providers, educators, and families; develop products; establish policies; build coalitions; and to target outreach to children, the elderly, minorities, veterans, and high risk populations.

**Current State Grant Activities**

Today, the HRSA Federal TBI Program awards four-year Implementation Partnership Grants, however the number of awards is dependent on the level of appropriations. Currently, twenty-one States and the District of Columbia receive these grants. The chart below demonstrates the diversity of the initiatives which the grantees will undertake during this funding cycle.

**Impact of the HRSA State Grant Program**

As states were, and continue to be, in different phases of service development, HRSA has allowed states considerable flexibility in determining its goals and activities. While this was attractive to states, it did prove difficult to measure overall impact of the program. The federal Office of Management and Budget (OMB) Program Assessment Rating Tool (PART), in 2005, called in to question the lack of long-term health outcomes measures for the program, even though the program does not provide direct services.
Subsequently, in 2005, HRSA contracted with the Institute of Medicine (IOM) to evaluate the effectiveness of the TBI Grant Program. The review committee, in its 2006 report concluded: “There has been a demonstrable improvement in two essential preconditions for improving TBI service systems – state-level TBI systems infrastructure and the overall visibility of TBI have grown considerably.” The report went on to say, however, that “Sustainable progress requires reliable, long term data collection and monitoring; interagency collaboration; and effective funding mechanisms” (IOM, 2006).

Several current and previous grant recipients who have been associated with their state programs for many years were asked to identify the most significant changes they have seen in their state which can be attributed to the HRSA grant program. Their comments about the program are summarized as follows:

- Allows opportunities to demonstrate and integrate approaches to improve services without using service dollars (MA).
- Provides opportunities to collaborate with other state partners, resulting in incremental progress in state infrastructure. Grant funds were used to develop and sustain the State Resource Facilitation Program and now partners with the State Corrections Department to improve identification, treatment, and release planning for offenders with brain injury (MN).

Promotes the development of relationships among state agencies, providers, advocates, and other stakeholders, thus improving the visibility of TBI and increasing the knowledge and understanding of TBI and available resources throughout the state (NH).

- Requires a strong advisory council providing a platform for collaboration among partners, has strengthened our brain injury constituency resulting in additional funding for rehabilitation care; builds infrastructure and capacity for services; provides funding for training including the establishment of a TBI Training Institute, public awareness campaigns, and the establishment of Vocational Rehabilitation’s (VR) Comprehensive Evaluation Program for persons with TBI (SC).
- Provides funding for Project BRAIN (created in 2000) to support students with TBI in the school (TN).

With the release of the IOM report, HRSA was prompted to focus greater attention on the ability of lead agencies to build partnerships with other state agencies and community organizations to assure a bigger resource pool, a more coordinated approach to service delivery, and a greater chance for program sustainability. In the HHS, HRSA FY 2011 budget and performance measures document, the HRSA Federal TBI Program cites the FY 2011 objectives as to (1) promote effectiveness of healthcare services and (2) increase collaborative efforts to improve the capacity and efficiency of the public health and health care system (HHS FY 2011 Online Performance Appendix). These objectives are to be measured by:

- Proportion of children with brain injury who are able to participate in community activities.
- Increase the number of states and territories that have achieved minimum TBI core capacity, although, HRSA acknowledges the number of states and territories that have

<table>
<thead>
<tr>
<th>State</th>
<th>Initiatives</th>
</tr>
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<tbody>
<tr>
<td>AL</td>
<td>Expand statewide system of care to unidentified/underserved children you particularly in rural areas; improve access to neurobehavioral health services</td>
</tr>
<tr>
<td>AZ</td>
<td>Enhance services for youth 15-19 transitioning from children to adult services – emphasis on African-American youth; improve services and resources to wounded warriors/families</td>
</tr>
<tr>
<td>DC</td>
<td>New needs assessment, Action Plan, Re-establish Advisory Board</td>
</tr>
<tr>
<td>ID</td>
<td>Establish trust fund, monitor Medicaid Waiver, solidify Advisory Council, support system for veterans</td>
</tr>
<tr>
<td>IN</td>
<td>Improve vocational outcomes through Resource Facilitation, coordinated infrastructure, single point of access; establish leadership board</td>
</tr>
<tr>
<td>IA</td>
<td>Update needs assessment, Action Plan, Expand BI Resource Network, cognitive rehab services; Services to inmates and victims of domestic violence</td>
</tr>
<tr>
<td>ME</td>
<td>Improve access to information, integration of services, strengthen support networks, Improve professional/para-professional; skills; coordinate surveillance data</td>
</tr>
<tr>
<td>MA</td>
<td>Improve identification, outreach, service delivery to Latino community; establish New England consortium for veterans</td>
</tr>
<tr>
<td>MI</td>
<td>Establish partnerships with organizations serving high risk populations, assimilate/disseminate data, establish a waiver, rebuild Advisory Council</td>
</tr>
<tr>
<td>MN</td>
<td>Refine/demonstrate a TBI screening, followup and assessment process for use in correctional facilities; model release planning; prepare corrections department staff; develop implementation team of clinicians, etc.; develop materials for offenders; develop plan for sustainability; maintain 4 core components</td>
</tr>
<tr>
<td>MO</td>
<td>Create a leadership infrastructure for projects serving persons at high risk for TBI; implement a state plan within areas of public awareness and access to services that targets persons at high risk; assure culturally competent services; develop partnerships; evaluate outcomes and processes</td>
</tr>
<tr>
<td>NE</td>
<td>Increase knowledge/skills, build systems capacity to serve children 0-4, juvenile detainees; veterans, and elderly</td>
</tr>
<tr>
<td>NY</td>
<td>Establish locus of authority within Department of Health promoting access to services; increase public and waiver participant knowledge of Medicaid waiver &amp; expand provider training; expand access to services in two high risk populations</td>
</tr>
<tr>
<td>NC</td>
<td>Increase access to community based services through social support, cognitive retraining, vocational services; prepare families with knowledge/strategies for accessing support and services; increase competence of substance abuse providers for improved identification, assessment and treatment</td>
</tr>
<tr>
<td>OH</td>
<td>Web-based training; respond to needs of Ohio’s Family &amp; Children First Councils and National Guard; Strengthen Caregiver Alliance; expand and improve Resource Coordination System; improve data collection/reporting</td>
</tr>
<tr>
<td>OR</td>
<td>Educate 90 legislators about issues/needs related to TBI; increase collaboration among state agencies; apply for foundation funding; outreach to service members, Native Americans, youth ages 15-19</td>
</tr>
<tr>
<td>PA</td>
<td>Activities that assure that the medical community addresses TBI, that children and adults are consistently identified; that children can successfully transition into adult services; that Pennsylvanians are aware and knowledgeable about TBI</td>
</tr>
<tr>
<td>TN</td>
<td>Increase knowledge of school personnel; expand Project BRAIN capacity to improve linkage between hospitals and schools</td>
</tr>
<tr>
<td>TX</td>
<td>TBI screening and pre-neuropsych testing for members of juvenile justice system diagnosed with mental health and substance abuse issues; collaboration on new TBI registry; train Juvenile Justice (JJ) Department personnel, other initiatives related to JJ system; implement activities identified in Needs Assessment; connect clients with appropriate services/supports; assure appointment/attendance of consumer/family members to Advisory Council</td>
</tr>
<tr>
<td>UT</td>
<td>Collaboration between lead agency, ombudsman, and Advisory Council to promote implementation of Action Plan; educate policy makers, other stakeholders; lay groundwork for new Needs Assessment; focus on needs of children 0-4, veterans</td>
</tr>
<tr>
<td>VA</td>
<td>Screening for TBI of juveniles committed to Department of Juvenile Justice; development of materials, improvement in system of care</td>
</tr>
<tr>
<td>WVA</td>
<td>Improve access to services, services promoting return to work for military and veterans; development of waiver and/or trust fund</td>
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BRAND INJURY PROFESSIONAL 23
achieved minimum core capacity. A replacement measure has been proposed.
• Increase the number of states and territories that have begun to implement their TBI plan of action.
• Increase the number of states/territories that have completed at least 50% of the objectives in their TBI plan of action.

HRSA PATBI Program
The state Protection & Advocacy (P&A) systems were first established in 1975 to protect the rights of individuals with developmental disabilities, and over the years have expanded to cover other populations in accordance with various pieces of legislation. The first HRSA PATBI grants were awarded in 2002, and since 2004, every state P&A, four territories, and one tribal agency have received formula grant funding. This expansion has been made possible with increases in legislative appropriations. The services provided are broad in scope, and address barriers that prevent individuals with TBI from fully participating in their communities and leading productive and independent lives.

The 2008 Annual Report of the National Disability Rights Network regarding PATBI activities across the country provided these statistics: PATBI agencies responded to over 15,000 information and referral requests, provided training on issues and rights to 66,849 people, and provided case services to 2,127 people (includes cases that may have been opened in the previous fiscal year). The issues addressed/number of cases break down as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
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<tbody>
<tr>
<td>Abuse</td>
<td>100</td>
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<tr>
<td>Access to Records</td>
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The Disability Rights Center (DRC) in Maine was among the first Protection and Advocacy agencies to receive HRSA funding. Executive Director, Kim Moody, described her agency’s experience with the grant program as follows:

In 2002, DRC hired an advocate who has a brain injury and is also an expert in the field, and hired an attorney when the advocate left. As a result of the HRSA grant, and working closely with the State of Maine, DRC has:
• authored and pushed for legislation relevant to brain injury including legislation creating a designated state agency, an Office of Brain Injury Services and an advisory council
• provided training for individuals, families, clinicians and service providers
• advocated for services and rights on behalf of individuals with TBI
• educated legislators, and other coalitions
• provided outreach to facilities that provide brain injury supports and services
• focused proactively on brain injury issues, research and services
• Provided legal and advocacy services throughout the P&A

All P&A attorneys and advocates now assess every case for brain injury implications. In September, 2009, DRC joined other agencies and formed the Brain Injury Information Network to share information, coordinate resources, and ensure that all citizens with brain injury have appropriate access to both.

CDC TBI Programs
Since 1996, the Centers for Disease Control and Prevention (CDC) has supported data collection and follow-up studies in a number of states in order to track the incidence of TBI, link people with TBI to information about services, and prevent related disabilities. When the TBI Act was amended in 2000, the CDC was mandated to report to Congress on how best to determine the incidence and prevalence of new cases of mild TBI. The findings and recommendations of the Mild TBI Work Group were released in 2002. During the same time period, the CDC launched a national initiative to prevent mild TBI and improve clinical management for individuals who have sustained a mild TBI. The initiative is known as Heads Up, and includes tool kits for primary care physicians. More recently, the initiative has been expanded to include tool kits and on-line training for coaches of youth and high school sports to better acquaint them with the prevention and management of concussions. The CDC has also set up a forum for dialogue about brain injury on Facebook known as CDC Heads Up – Brain Injury Awareness. CDC has also funded projects on a number of issues such topics as older adults and TBI and TBI in correctional facilities.

CDC has also funded linkages projects in Colorado and South Carolina to study the needs of individuals discharged from hospital care and to study the feasibility of using the state’s surveillance system to link individuals with TBI who are hospitalized with information on the availability of services in their communities (Sample, 2005). A few states have also used their HRSA State Grant for purposes of improving linkages to community services and service coordination.

A report to Congress is being prepared on procedures that can be implemented by the CDC, NIH, the Department of
Defense, and the Department of Veterans Affairs to improve collection and dissemination of data related to the incidence/prevalence of TBI in the military and veterans populations, in accordance with the TBI Act reauthorization in 2008 (Public Law 110 – 206).

**TBI Act Appropriations**
The TBI Act is authorizing legislation, which means that Congress must appropriate funding in order for money to be available for the programs. Initially, Congress appropriated $2.857 million for the HRSA State Demonstration Grant program, although Congress authorized $5 million each year through FY 1999; and Congress appropriated $2.6 million for the CDC TBI program, although the legislation authorized $3 million. Currently, nearly $10 million has been appropriated for both the State Grant and the Protection & Advocacy (PATBI) Grant Program combined and over $6 million for the CDC TBI Program.

**In Summary**
The TBI Act is the only federal law that authorizes funding specifically to address TBI education, prevention, incidence and prevalence, research and access to rehabilitation and services for individuals with TBI and their families. Each of these programs provides state and national resources that are integral to service delivery. The current law expires at the end of FY 2012. TBI stakeholders* are already beginning to assess the need for any statutory changes and have been working to increase the level of funding so that more states may participate in the program and sustain their efforts. In addition, the TBI stakeholders are also collaborating with HRSA to initiate a process for developing a national TBI plan that would provide a mechanism for public input into the federal program plan and priorities.

*Brain Injury Association of America (BIAA), National Association of State Head Injury Administrators (NASHIA) and National Disability Rights Network (NDRN).

**REFERENCES**
Traumatic Brain Injury Collaboration Space at thtac.norc.org. Information provided by personal contact with HRSA state grantees.
National Disability Rights Network Website: www.ndrn.org
Center for Disease Control Website: www.cdc.gov/ncipc/factsheets/tbiactivities.htm
Information provided by Susan Vaughn, Director of Public Policy, NASHIA (www.nashia.org)

**ABOUT THE AUTHOR**
Ana King retired in 2001 from the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services where she served as TBI Program Specialist for eight years. Following retirement from State government, she worked for five years on a part-time basis for the NASHIA TBI Technical Assistance Center.
Introduction

Traumatic Brain Injury (TBI) has become known as the “signature wound” of the wars in Iraq and Afghanistan. A 2008 Rand Report estimated that perhaps as many as 320,000 service members may have TBI as a result of combat (Tanelian, et al., 2008). As of May, 2010, the Defense and Veterans Brain Injury Center at the Department of Defense (DoD) reported only 178,876 cases of TBI of all levels of severity including mild. This disparity in reporting is most likely caused by the uniqueness of TBI, particularly mild TBI (or concussion) that may go unnoticed until after one has returned home and has difficulty with daily life. Many mild TBIs are caused by blasts from improvised explosive devices and complications from concussion are often not recognized.

The military culture and training often make warriors want to shrug off what might seem at the time to be minor ailments such as dizziness, headaches, fatigue, and agitation. While most mild TBIs heal, tens of thousands of returning service members continue to experience longer term problems such as persistent memory loss, mood swings, headaches and hearing and vision problems. In addition, screening for TBI among returning service members and veterans has been inconsistent. The result has been that many service members return to their communities without proper diagnosis or treatment. The 2008 Rand Report noted that despite the many services that are available, families and patients remain unaware of either the range of available services or how to access the necessary assistance. In addition, a gap exists between DoD and the Department of Veterans Affairs (VA) efforts and coordination with community-based services.

Press reports on cases of veterans with undiagnosed TBIs going untreated, and efforts by non-profit national organizations interested in improving brain injury care for wounded warriors, have put pressure on Congress to take action. Congress has held hearings and enacted laws directing DoD and VA to be more aggressive in detecting service members with TBI and providing them with appropriate care. For example, in the Defense Authorization Act for Fiscal Year 2008, Congress directed DoD and VA to collaborate with local, State, and private entities to improve services for military personnel and veterans with TBI.

In March 2010, the Institute of Medicine (IOM) issued a report recommending DoD and VA to partner with the private and public sector to provide services and supports in the community. The IOM found a critical shortage of health care specialists and noted that the length of time that veterans have to wait for appropriate care remains a problem. In addition, the IOM noted that there is a paucity of information on the lifetime needs of persons with TBI in the military and civilian sectors and recommends additional research into protocols to manage the lifetime effects of TBI.

Addressing Unmet Needs

In the meantime, families and veterans with TBI call state TBI programs for assistance. In some cases, when military discharge status is unsettled, veterans turn to state resources first. State TBI programs are often the point of contact for information and referral for families and returning soldiers and veterans seeking local services, especially with regard to the National Guard and Reserves.

States have reached out to VA staff to participate in educational forums and national TBI conferences. Some states have reached out to work with the VA to promote collaboration in order to better understand VA benefits for veterans that may be seeking state services, and for VA to understand what is available in the communities. In addition, some states have added representatives from VA, National Guard and Reserves, state veterans affairs, and/or veteran’s organizations to serve on their state advisory board in order to improve communications and policies across these programs. Some states have used grant funding from
the Health Resources and Services Administration as authorized by the Traumatic Brain Injury Act as amended, to address the needs of returning service members and veterans with TBI.

With the knowledge that veterans could fall through the cracks between discharge from the military or veteran care and community reentry, states have responded in a variety of ways.

Here are a few examples:

• Alaska convened an informal group of representatives from the State TBI Program, 3rd Medical Group (Elmendorf Air Force base), Alaska VA, Vet Centers, Alaska Federal Health Care Partnership, Alaska Native Tribal Health Consortium, hospital providers, behavioral health providers, workforce development agencies, and disability advocacy organizations. The purpose of this group is to assess the services and resources available in Alaska and partner in the planning of a comprehensive system of care, emergency medical services, acute/trauma care, post-acute rehabilitation, community reentry, and long-term supports.

• The Nebraska Veterans Brain Injury Task Force, which includes representatives from the civilian and military sectors, and key state and federal government agencies, addresses the increasing needs for brain injury awareness and education among returning service members from Iraq and Afghanistan.

• The Vermont TBI program and the Division of Vocational Rehabilitation share the cost of a neuro-resource facilitation (NRF) Job Developer to educate and coordinate training for the Vermont business community to increase awareness of the issue facing returning veterans with TBI. Similarly, the state TBI program shares the cost of a NR Facilitator with the Department of Mental Health as a liaison to the mental health court, specifically serving veterans involved with the Department of Corrections.

• Using funds from the American Recovery and Reinvestment Act, the California Department of Rehabilitation, the lead agency for TBI, awarded a grant ($486,923) to the Central Coast Center for Independent Living to increase independent living service capacity and coordinate existing services and programs for veterans with TBI and other TBI survivors.

• The New York TBI Program and the BIA of New York partner to promote awareness, training, outreach and support to Iraq and Afghanistan military with TBI and their families.

• Similarly, the Massachusetts Brain Injury & Statewide Specialized Community Services Department, is partnering with the VA, veteran service organizations, TBI providers and the BIA of Massachusetts to conducting outreach, information and referral services.

In August 2010, the National Association of State Head Injury Administrators (NASHIA) circulated a survey on State TBI programs. Eighteen states responded. Preliminary findings from the survey indicated that all but one state are involved to some degree in assisting returning service members and veterans. Although this survey is not complete, those who responded indicated that the activities in which they were engaged include: outreach and screening (75%); information and referral to community services (75%); public education (62%), service coordination (65%); and provision of services and supports (50%). Other activities include in-service training and state planning and needs assessment. To fund these activities states are using state general revenue, trust funds, Medicaid, and federal grants and earmarks.

Most states have reported that they have to some degree a collaborative working relationship with the VA (66.6%) and with the state veterans’ affairs office (66.6%). These states report that they have less of a working relationship with the DoD, including the National Guard/Reserves (44.4%).

In some states the states veterans’ affairs office is the lead agency involved in outreach and screening returning service members for TBI. In 2007, Illinois established the Warriors Assistance Programs’ screening tool, developed at The Rehabilitation Institute of Chicago, for purposes of screening every returning Illinois National Guard member for TBI, becoming the first state to implement screening. The following year, Governor Arnold Schwarzenegger signed legislation requiring the California Department of Veterans Affairs and the California Military Department to develop outreach plans to National Guard members or veterans returning from combat and assist them in obtaining a screening for TBI and post traumatic stress disorder (PTSD).

Also in 2008, Michigan enacted legislation requiring the state veterans’ affairs office to administer a PTSD and a TBI questionnaire to those who are serving in the National Guard who have returned from Operation Iraqi Freedom or Operation Enduring Freedom, unless he or she has completed similar questionnaires approved by the VA and DoD.

While information has been gathered by NASHIA anecdotally regarding state initiatives to address the needs of wounded warriors carried out by public TBI programs, state veterans’ agencies and other state agencies, overall results of these efforts remain unknown.

Summary
Although DoD and VA are responsible for providing medical and rehabilitative care to wounded warriors, often returning service members seek assistance from public agencies for resources in their home communities. Despite directives from Congress for DoD and VA to collaborate with state, local and private agencies, it appears that states are initiating these efforts in response to the needs of their own citizens returning from Iraq and Afghanistan.

REFERENCES
Institute of Medicine, Preliminary Assessment on the Readjustment Needs of Veterans, Service Members and their families, National Academy Press, Washington, DC, 2010.

ABOUT THE AUTHOR
Jean E. Bérubé, JD is a Washington attorney and lobbyist representing clients interested in improving access to services, research, treatment and education for persons with brain injury and their families. Ms. Bérubé has authored many articles and reports to Congress and drafted legislation regarding brain injury programs in the Departments of Defense, Health and Human Services and Veterans Affairs. She has represented NASHIA since 2005.
AN INTERVIEW WITH SUSAN L. VAUGHN, M.ED., NATIONAL ASSOCIATION OF STATE HEAD INJURY ADMINISTRATORS, DIRECTOR OF PUBLIC POLICY

ABOUT SUSAN L. VAUGHN
Susan L. Vaughn, M.Ed., is the Director of Public Policy for the National Association of State Head Injury Administrators and monitors state and federal legislation and initiatives for the Association. She previously was the Director of the Missouri Head Injury Advisory Council, a position she held for 17 years. She was recently honored by NABIS for her public policy accomplishments.

What is the role of state government in providing TBI services?
State government provides a safety net for its citizens, including individuals with disabilities.

Following the formation of the National Head Injury Foundation, now known as the Brain Injury Association of America, in 1980, families and individuals with brain injury began to advocate state policy makers for services and supports to address their needs, often citing the inability to access state service systems due to diagnosis, or lack of appropriate services or lack of expertise. Yet, individuals with TBI and their families had similar needs of individuals with other disabilities in order to return to home, school and work following their injury. Thus, states began to develop services and methods for paying for these services that are not otherwise paid for by third party payers, such as private insurance.

Are TBI services mandated in the states?
No, there is no federal mandate for states to provide TBI services. Some states have enacted legislation establishing services, but the amount and scope are subject to the amount of appropriations or revenue available for the program and services. However, individuals who are Medicaid eligible are covered with the federally mandated benefits (e.g. in-patient hospital care, physician services, laboratory and x-ray services, and nursing facilities for age 21 and older).

How do states pay for services?
In general, states use state funds or general revenue; dedicated funds, such as funds derived from traffic fines that are placed into a separate account generally referred to as a trust fund; federal funds, such as Medicaid and Vocational Rehabilitation; or a combination of these funds to pay for TBI services. There are federal and other state funded programs that individuals with TBI may be eligible for, such as centers for independent living, substance abuse, children with special health care needs, and developmental disabilities.

How do families and individuals with TBI access services?
Obviously, each state is organized differently, yet each state administers similar programs. In most states that offer TBI specific services, the services are organized around a case management or service coordination system, sometimes referred to as care coordination, to assist individuals in assessing their needs, developing goals and objectives, and obtaining services and supports, including natural supports in the community. In a few states, service coordination or care coordination (case management) is a service unto itself. States may use a 1-800 number, distribute brochures and materials and/or post information on the state TBI website. These programs may be located in the state health, Vocational Rehabilitation, social or human services, mental health, developmental disabilities, Medicaid, or education department. Most states have identified a “lead” state agency for TBI and work with other state and local programs to coordinate resources and services.

How are services provided?
States may contract with provider agencies, professionals (i.e. therapists, neuropsychologists, psychologists, social workers) and organizations to provide services or they may provide the services with state staff or a combination of these methods. For example, a state may employ service or care coordinators (case managers) and purchase other services that may be needed. Or, a state may contract with non-state agencies to provide all of the services and supports, including service/care coordination or resource facilitation. The state agency that administers the TBI program is generally responsible for ensuring that providers under contract meet certain qualifications and follow the rules and regulations of the state program with regard to eligibility, individual service plans and other assurances.

How can I become more knowledgeable about services in my state or become involved in improving service delivery in my state?
In addition to a “lead” state agency that may deliver TBI services, most states have created an advisory board or council to help plan and make recommendations for improving services. Usually, these advisory boards are connected to the lead agency, but not always. These boards are generally comprised of an array of people representing state and local programs, professionals, family members and individuals with TBI who collectively work to improve and expand services. The members may be appointed by the state agency or the Governor. Persons who are interested in serving on the board or becoming involved in its activities should contact the board or the lead agency or state TBI program.

How can I find the key contacts in my state with regard to the lead agency, advisory board and services?
The National Association of State Head Injury Administrators (NASHIA), which was formed by state government program administrators, maintains a Directory of State Contacts for its members. If you are interested in learning more about your state’s programs, you may contact Lorraine Wargo, RN, Executive Director at execdirector@nashia.org.
BRAIN INJURY PROFESSIONAL 29

conferences

2011

FEBRUARY
18-20 – 21st Annual Meeting - Innovations and Excellence in Skull Base Surgery: The Future is Here, Scottsdale, AZ. For more information, visit nasbs.org/meetings.

24-26 – The Santa Clara Valley Brain Injury Conference, Historic Dolce Hayes Mansion in San Jose, CA. For more information, visit www.tbi-sci.org .

MARCH
4 – The 4th Translational Neuroscience Conference, State of the Science Across The Lifespan, Denver, CO. For more information, please visit www.du.edu/braininjury

7 – The Traumatic Brain Injury Conference, Washington, D.C. For more information, visit www.tbiconference.com/home


APRIL
7-10 – 20th Annual Multi-Disciplinary Conference, Atlanta, GA. For more information, visit www.nora.cc

MAY

JUNE

JULY
10-13 – The 29th Annual National Neurotrauma Symposium, including the AANS/CNS Section on Neurotrauma & Critical Care, Fort Lauderdale, FL. For more information, visit www.neurotraumasymposium.com.

SEPTEMBER
14-17 – 23rd Annual Conference on Legal Issues in Brain Injury, New Orleans, LA.

14-17 – 9th Annual Conference on Brain Injury, New Orleans, LA.

2012

MARCH
21-25 – Ninth World Congress on Brain Injury, Edinburgh, Scotland. For more information, visit internationalbrain.org. This is the official World Congress of IBIA.

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• Physical, occupational, speech, language and cognitive therapies and psychological counseling
• Case management
• Medical services including on-site nursing, neurological, physiatric and psychiatric treatment
• Vocational services from sheltered employment through to community placement
• Residential services on a main campus, in community group homes and supported community apartments
• Outpatient services

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NORTH AMERICAN BRAIN INJURY SOCIETY

The 2010 NABIS/NASHIA Joint Conference entitled Brain Injury Partnerships: NASHIA and NABIS in the Twin Cities was an overwhelming success. The meeting, held in Minneapolis, Minnesota, October 5-8, 2010, was attended by over 400 brain injury professionals from the United States, Canada and beyond. The meeting opened with a full-day pre-conference symposium, entitled “Reaching Persons who are Under-Identified and Under-Served”, where experts in the field addressed the challenges in treating and providing services to the homeless, prison populations, and those with substance abuse and co-morbid neurological/psychiatric challenges.

The three days of the main conference were filled with many poignant presentations and discussion involving a wide range of clinical and medical areas in brain injury. Presentations were given by an internationally recognized invited faculty as well as over 65 oral and poster presentations from submitted abstracts. As in years past, the accepted abstracts were published in the Journal of Head Trauma Rehabilitation. A highlight of the meeting was a keynote presentation from Senator David Durenberger, entitled “Healthcare Reform and Brain Injury Care”.

The meeting was held concurrently with the well-attended 23rd Annual Legal Issues in Brain Injury Conference which provided attendees with a comprehensive range of practical information focused on meeting the challenges presented by brain injury litigation.

The 2011 Medical and Legal NABIS meetings will take place in New Orleans, September 14-17, 2011. Visit www.nabis.org for more details as they become available!

BRAIN INJURY ASSOCIATION OF AMERICA

The Brain Injury Association of America released its new, interactive Website on Nov. 1, 2010. The site delivers up-to-date information, lets visitors share opinions and experiences and is branded with 14 of BIAA’s 42 chartered state affiliates. A new, fully automated online certification process, including application, test and notification, also debuted in November. BIAA kicked off its 30th Anniversary celebrations with a special edition of THE Challenge!, featuring retrospective articles on science, medicine, advocacy/public policy, state affiliate development and BIAA’s many accomplishments over the years. The 15th Annual State Affiliate Leadership Conference was held in Detroit in early December, where Daniel Chamberlain, Esq. and Tony Zink, MD, PhD, were elected to BIAA’s Board of Directors along with returning members James Humphreys, Esq. and Christopher Slover. Planning is underway for the 6th Annual Brain Injury Business Practices College, taking place Feb. 22-24, 2011, at The Menger Hotel in San Antonio. BIAA and its Business & Professional Council continue to lobby aggressively for favorable regulations under the Affordable Care Act. For more information, please see www.biausa.org.

INTERNATIONAL BRAIN INJURY ASSOCIATION

As of December, 2010, seventeen internationally recognized associations and professional societies have provided their official endorsement of the International Brain Injury Association’s Ninth World Congress on Brain Injury. This biennial event will be held March 22-25, 2012, in the historic city of Edinburgh, Scotland. Progress continues to be made in the plan the Congress; international and local planning committees have been established, comprised of some of the leading experts in brain injury research and rehabilitation. The oral and poster abstract submission categories are being revised and expanded for the Congress to accommodate the significant increase in scientific submissions enjoyed at the previous two events in Lisbon, Portugal, and Washington, DC. The Congress will be relevant to professionals who work with people with acquired brain injury and will provide a forum for education, formal and informal discussion and debate. Up to date research will be presented on a variety of topics ranging from neurobiology to neurorehabilitation from the theoretical to the very applied. The IBIA awards will be presented, including the Jennett & Plum Award for Clinical Achievement in the Field of Brain Injury Medicine, the Henry Stennington Award for best review article in Brain Injury, the IBIA Young Investigator Award and the Car of the Year Award. IBIA will have a host of exhibitors to complement more formal aspects of the conference and to encourage collegial networking. Edinburgh, the capital of Scotland, is a picturesque historic city, dominated by its famous castle with many fine hotels, restaurants, museums and traditional pubs! There is easy access to Glasgow, the Highlands and to tourist and sporting opportunities. A number of social events will be organized that will give opportunities to explore the depth and breadth of Scottish culture and the beautiful scenery of Scotland. The abstract submission system will open in the Spring of 2011. Please visit www.internationalbrain.org for more details as they become available.

NATIONAL ASSOCIATION OF STATE HEAD INJURY ADMINISTRATORS

NASHIA and the North American Brain Injury Society (NABIS) joint conference held in October, with over 400 attendees, was a tremendous success! Not only did we hear from outstanding leaders in the field of brain injury but also had the opportunity to connect with our members and colleagues from across the country and territories. NASHIA annual membership meeting, held at the joint conference, included election of officers and Board of Directors. Officers are: Janice White, President; Carolyn Cass, President Elect; Erin Weaver, Treasurer; Amy Flaherty, Secretary. Susan Vaughn, Director of Public Policy, presented and the membership approved NASHIA legislative priorities for the upcoming 2011 Congressional session.

NASHIA annual membership drive was launched this month! With a changing political climate and discouraging financial challenges experienced across our country it is even more critical that NASHIA voice be heard! Become a member and you can influence: State and National Public Policies, Best Practices, and Professional Development! Remember to visit our website at www.nashia.org for details and updated information!
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Stephen M. Smith
Founder, Brain Injury Law Center

Brain Injury Law Center - Advocates for Brain Injury Survivors and their Families Throughout the United States and the World.

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Belli Society national board member
Multi-Million Dollar Advocates Forum member
Listed in Who's Who in American Law
Washington Post "DC's Best Lawyers" 2009
Leaders in the Law – 2008
Graduate of Marquette University, College of Health Sciences, in Neuro Anatomical Dissection of the Human Brain and Spinal Cord