2/4/10

BUILDING ALASKA'S SYSTEMIC CAPACITY TO DEAL...

alaska brain injury network

Alaskans with Brain Injury:
10 Year Plan for TBI in Alaska, Core Service Assumptions

Alaska has an opportunity to strengthen families and increase the health and safety of Alaska communities through maintaining a State brain injury program.

Brain injury can happen to anyone in an instant; a fall on the playground, a slip on the ice or in the bathtub, a car or off-road vehicle crash, hockey games, and more. Alaska state government has been successful in identifying the needs of Alaskans with brain injury and developing a plan to meet those needs. Because Alaska does not have brain injury specific funding and programs, the current state service delivery system creates an environment where Alaskans who have disability due to brain injury eventually find themselves in homeless camps, chronic inebriate populations, and mental health court and correction institutions. Brain injury is a unique disability and needs a service delivery system that creates a structure where brain injury survivors, who are at risk for challenging behaviors, substance abuse, emotional impulsivity, and more, can learn to manage these behaviors, moods, and emotions. Brain injury case management, post-acute rehabilitation, community re-entry, community clubhouses, and long-term housing arrangements are just a few solutions to freeing up dollars and waiting lists in behavioral health, public assistance, juvenile justice, corrections, long-term care and other existing state programs, while getting people back into the community, school, and work.

It is important to understand the brain injury survivors described above are proportionally small in number when compared to the number of Alaskans that hit their head each year. Many children and adults are being supported in their homes, many have difficulties and challenges at school, work, with their parents or spouses, but continue to work extra hard to maintain the roles that defined them before their injury; mom, dad, teacher, CEO, professor, student, athlete, fisherman, friend, etc. There are many more individuals in the community that do not recognize they have had a brain injury. Many families and individuals are exhausted by the constant struggle, and would benefit from standard brain injury rehabilitation and long-term formal and natural supports.

The State, the Tribal Health System, the hospitals, non-profit/private/public providers, military and other partners have a role in developing this continuum of care. The assumptions listed at the end are not in priority order. They highlight opportunities to develop a full continuum of care for Alaskans with brain injury. The State's role would be to fund and maintain a TBI Program, which includes developing [a portion of] the sustainable funding so providers and community organizations can create and grow community-based services. The brain injury programs that will develop through the state brain injury program would then be utilized by Alaskans with a variety of pay sources.

Alaska state government, through maintaining a TBI Program, will provide the leadership and incentive to create a service delivery system where children, adults, and service members who sustain a brain injury and their families, will have the opportunities that all Alaskans desire; to learn, love and be loved, and find meaningful work or activities.

The Alaska Brain Injury Network worked collaboratively with the Department of Health and social Services and the Alaska Mental Health Trust Authority to outline a 10 year plan for TBI in Alaska. You can read the full report on the website, www.alaskabraininjury.net.

This document will highlight the following information:

- Why is brain injury a unique disability? (Page 2)
- Current incidence and prevalence of traumatic brain injury in Alaska (Page 2-3)
- Description of populations that are at highest risk for brain injury (Pages 3-5)
- State agency resources currently available for TBI services (Pages 5-6)
- Current Department of Health and Social Services, Alaska TBI Program (Pages 6-7)
- Description of how other States fund TBI services (Pages 7-8)
- 10 Year Plan for TBI in Alaska: Core Service Assumptions (Pages 8-12)

Why is brain injury a unique disability?

It is important to understand that brain injury is a unique disability, and requires the development of brain injury specific programs. A few examples include:

1. Only a few brain injury survivors have a physical sequalae, autonomy often recovers through daily activities.
2. Many brain injury survivors, have a cognitive challenge, and most often have mood and behavior changes
3. Brain injury is an acquired handicap. Most brain injury survivors have a vivid memory of normal life before injury.

Incidence and prevalence of TBI in the State

Every year, the State of Alaska, Department of Health and Social Services (DHSS) reports about 800 traumatic brain injury cases resulting in hospitalization or death. In addition to the 640 seriously injured TBI patients that survive their injuries and are discharged from Alaskan hospitals each year, an estimated three times as many suffer a mild TBI. This is upwards of 3,000 new TBI survivors in Alaska each year, joining the estimated 10,000 to 12,000 Alaskans currently living with brain injury.

The highest rates of TBI in the state of Alaska are among Alaska Natives, residents of rural Alaska, youth aged 15 -19 in motor vehicle crashes, and elderly who suffer injury in some sort of fall. The Alaska Trauma Registry shows that males and females aged 80+ have the highest rates of non-fatal TBI hospitalizations. Falls, motor vehicle crashes, assault, sporting and recreational injuries, and occupational injuries – including war-related injuries – are the primary causes of TBI. Alcohol is often a contributing factor. The crude rate of non-fatal hospitalizations for TBI in Alaska for the five-year period 2001-2005 was 98.6 per 100,000.[1]

TBIs are overrepresented among the Alaska Native population. The Alaska Native population comprises about 16% of the Alaskan population; however, Alaska Natives are 34% of the total population of individuals with a TBI. Similarly, the highest rates of TBIs occur in the rural regions of the state with the highest number of Alaska Native residents: the Northwest (81.1% American

[1] T. Ali. AK DHSS Division of Public Health, Section of Injury Prevention and EMS, Alaska Trauma Registry (personal communication, 2009).

Indian/Alaska Native), North Slope (70.1% American Indian/Alaska Native), Norton Sound (75.4% American Indian/Alaska Native) and Interior region (69% American Indian/Alaska Native).[2]

The Alaska veteran population is 17% of the statewide population, the highest rate among all the states. The Alaska VA Health Systems reports that from September 2001 to October 2008, approximately 146 (11%) veterans receiving primary care screened positive for TBI. Positive screenings are referred for a second screening. Following the second screening, 52 (39%) veterans required further neuropsychological testing to confirm a diagnosis of TBI.[3]

Because of the non-availability of brain injury rehabilitation in Alaska, service members returning with moderate to severe brain injuries must seek services outside of Alaska. Of active duty personnel returning to Alaska in 2007 and 2008, 1,500 have been screened for mild brain injury and 75 are receiving ongoing TBI care. It is anticipated that in the next six months and over the next few years, several thousand troops will return from Iraq and Afghanistan. Estimates are that between 20 and 30 percent of those troops will need TBI services.

Around 80 community behavioral health centers screen for TBI using the *Alaska Screening Tool*. The data is gathered by behavioral health service providers statewide and entered into the DBH Alaska Automated Information Management System (AKAIMS) database. In 2006, a total of 6,263 individuals were screened using the AKAIMS system. Of that number, just over 1/3 (2,080 individuals) screened positive for a TBI.[4]

A description of groups at high risk for TBI

Military Personnel

A recent study by the Rand Corporation found that approximately 18.5 percent of US Service Members who have returned from Afghanistan and Iraq currently have post-traumatic stress disorder (PTSD) or depression, and 19.5 percent report experiencing a traumatic brain injury during deployment.[5] Another study provided evidence that screening for depression should be a standard component of TBI assessment protocols. In this study, researchers found that between 30 percent and 38 percent of patients with a TBI were classified as depressed with the NFI Depression Scale and the BDI, respectively.[6]

A study published in the New England Journal of Medicine reported on a survey conducted of 2,714 soldiers from two US Army combat infantry brigades – one Active Component and one Reserve Component (Army National Guard) – deployed in Iraq. The study found that mild TBI was strongly associated with PTSD and physical health problems three to four months after the soldiers returned home and concluded that mild traumatic brain injury (i.e. concussion) occurring among soldiers deployed in Iraq is strongly associated with PTSD and physical health problems.[7]

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[2] US Census Bureau (2006)

[3] Martin, B. (2009, January 9). Update on mental health issue for returning veterans: Demographics, problems, services, access.

[4] Michael Walker (personal communication, May 2008)

[5] Rand Corporation (2008) Invisible wounds: Mental health and cognitive care needs of America's returning veterans.

[6] Seel, RT., & Kreutzer, J.S. (2003). Depression assessment after traumatic brain injury: an empirically based classification method. *Archives of Physical Medicine and Rehabilitation, 84(11),* 1621-8.

[7] Hoge, C.W., et al. (2008). Mild traumatic brain injury in US soldiers returning from Iraq. *New England Journal of Medicine, 358,* 453-63.

In 2007, the Elmendorf Air Force Base in Anchorage, Alaska established a TBI clinic to diagnose and treat returning military personnel impacted by TBI. Screening of those deployed is mandatory through the Post Deployment Health Reassessment. Military base medics and officials anticipated that a portion of the 3,500 paratroopers with the 4th Airborne Brigade Combat Team, deployed to Iraq from Fort Richardson in Fairbanks, Alaska, would return to Alaska with TBI. Since the clinic's opening, 1,500 patients have been screened for TBI and 75 are currently monitored on a regular basis. The military is currently planning to construct a second TBI clinic in Fairbanks to supplement services offered at the clinic in Anchorage and to serve the Fairbanks-based military population.[8]

Because of the increased recognition of the danger of incurring brain injury while engaged in military duty, the Alaska Brain Injury Network (the state's TBI advisory board) has facilitated a TBI Partnership meeting to coordinate TBI awareness, outreach, and treatment among active duty military personnel, National Guard personnel, Veterans Administration personnel, State personnel, and entities serving Alaska Native Tribal beneficiaries since August 2007. The TBI Partnership military members include the 3rd Medical Unit, Alaska Veterans Administration Health System, Alaska National Guard, VA Vet Centers, and the Alaska Federal Health Care Partnership.

Alaska Native/Native Americans

The CDC Traumatic Brain Injury website identifies Alaska Native/American Indian people as one of the two race categories with the highest rates of hospitalization for this type of injury.[9] The Alaska Native population comprises about 16% of the total Alaskan population. However, Alaska Natives are 34% of the total population of individuals with a TBI in the state. Similarly, the highest rates of TBI occur in the rural regions of the state with the highest number of Alaska Native residents: the Northwest (81.1% American Indian/Alaska Native), North Slope (70.1% American Indian/Alaska Native), Norton Sound (75.4% American Indian/Alaska Native) and Interior region (69% American Indian/Alaska Native).[10] Thus, the Alaska Native/American Indian population is statistically overrepresented in the numbers of Alaskans impacted by Traumatic Brain Injury in the state.

Currently, available reports on Traumatic Brain Injury (TBI) statistics in Alaska include general demographic categories such as age, race, or region. Due to the elevated rate identified for Alaska Native people, in addition to the regional variance in the topography, environmental risks, and lifestyles, there is a need to identify differences in TBI incidents and risks among the regions of Alaska. This will better inform prevention efforts and help make region-specific assessments about the risk factors, disparities, trends over time, and hospitalization costs for traumatic brain injuries in Alaska Native populations. Additional information on the costs involved in injury, treatment, recovery, and rehabilitation for this population are needed. The Alaska Native Tribal Health Consortium has been contracted to gather this data by September 2010.

As has already been mentioned, many Alaska Native people live in rural parts of the state where there may be a lack of medical and social services, and a lack of awareness about the impacts of TBI and how to treat the injury in the long term. The combination of high prevalence rates and lack of a full spectrum of long-term services and rehabilitation make Alaska Natives a high priority population for services and prevention measures in the state.

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[8] D'Oro, R. (2009, April 5). Growing Elmendorf clinic treats brain injuries. *Anchorage Daily News*. Retrieved from http://www.adn.com

[9] Traumatic Brain Injury. CDC: NCIPC. Retrieved from http://www.cdc.gov/ncipc/factsheets/tbi.htm.

[10] US Census Bureau (2006)

Elderly
Accidental and usually preventable falls are the number one cause of injury to Alaskans age 65 and older, often causing serious injury such as TBI or hip fracture. Approximately one third of older Alaskans will fall each year and an average of 579 seniors will be hospitalized as a result. Although the Alaska Trauma Registry reported that during a ten-year period, 680 seniors 65 and older were hospitalized and diagnosed with TBI, research shows that brain injury among the elderly is often misdiagnosed and left untreated. Older Alaskans have the highest prevalence rate of brain injury in Alaska.

Per 100,000 Alaska Residents:
Males age 80+.....301.3
Females 80+.....217.2
Males age 15-19.....215.7
Males age 70-79.....200.9

Behavioral Health
Substance abuse is often both a cause of brain injury and a symptom after brain injury. Of the 800 Alaskans hospitalized each year, 32 percent were under the influence of alcohol when the brain injury occurred. From 1999 until 2008, the State of Alaska Department of Health and Social Services, Division of Behavioral Health (DBH), was the lead agency responsible for overseeing TBI services in the state. Through its mission to manage an integrated and comprehensive behavioral health system for Alaska, DBH requires its service provider grantees to screen Alaskans seeking behavioral health services for TBI. Around 80 community behavioral health centers screen for TBI using the *Alaska Screening Tool*. The data is gathered by behavioral health service providers statewide and entered into the DBH Alaska Automated Information Management System (AKAIMS) database. In 2006, a total of 6,263 individuals were screened using the AKAIMS system. Of that number, just over 1/3 (2,080 individuals) screened positive for a TBI.

In order to manage and treat substance abuse in clients with a history of brain injury, substance abuse treatment must be a component of a multidisciplinary treatment approach. In order to increase treatment plan success, it is essential to create a brain injury system of care, connecting behavioral health providers to a multidisciplinary team, ultimately ensuring that people who have access to these services can maintain a functional quality of life.

<u>State Agency resources available for TBI services</u>

DBH has made great advances in identifying TBI in those Alaskans who access services through a behavioral health facility. However, because TBI is a condition that does not necessarily present behavioral related effects, it is important that efforts to identify and serve individuals with TBI be expanded to the entire state health and social service system. In this way, an individual with TBI will have access to a spectrum of services such as speech therapy, cognitive therapy, physical therapy, and vocational assistance.

Due to Alaska's vast geographic area and large number of remote, often inaccessible communities, coordinating brain injury projects and programs among the military, tribal, state, and community

sectors is challenging. DBH has begun the process of raising awareness, identifying individuals in the behavioral health system with brain injury and identifying the need to expand the TBI service system to include a variety of state and community agencies.

Because DBH has mandated TBI screening, grantees have begun to recognize brain injury and are connecting clients to available brain injury supports and resources. Some providers have also begun work within their own programs to respond to the need for service and prevention. In addition, data collected through AKAIMS has been helpful in advocating for increased funding to meet the needs of individuals with brain injury. This important work has provided the foundation for the state's efforts to plan and develop a comprehensive, coordinated service delivery system.

The Alaska Brain Injury Network (ABIN), incorporated in 2003, has been the TBI advisory Board to the State of Alaska, Department of Health and Social Services, and the Alaska Mental Health Board (the Trust) since 2001. ABIN educates, plans, coordinates, and advocates for a comprehensive service delivery system for the survivors of traumatic brain injury and their families. In 2007, ABIN expanded its role by adding a Resource Navigator to provide statewide information and referral for persons with brain injury, their families, providers, friends, and many others interested in brain injury services within Alaska's communities. ABIN's focus on systems improvement and advocacy, as well as its ability to bring a variety of partners together, positions them to coordinate the development of statewide brain injury services among state, tribal, and military systems. The ABIN Board of Directors consists of 18 members representing all regions of Alaska. At least 50 percent of the board members are TBI survivors or their family members.

The State of Alaska Division of Senior and Disabilities Services (SDS) provides access to a continuum of long term services and supports for low-income seniors and people with disabilities. SDS administers four Medicaid waiver programs that provide home and community based services through a network of service providers as an alternative to nursing home placement. In addition to the four Medicaid Waiver programs, SDS administers programs that assist individuals of any age with disabilities to remain safe and independent in their homes and communities. These programs include Older Americans Act programs, Assisted Living Home Certification, Adult Protective services, Personal Care Assistance services, nursing home transition, Medicare Info, and Aging and Disability Resource Centers. The focus of SDS is multi-faceted in nature – serving seniors, adults with physical disabilities, persons with developmental disabilities, vulnerable adults, and assisted living providers. Because of this broad focus, SDS's service population often includes individuals impacted by TBI.

Other State agencies directly serving Alaskan individuals with TBI include Vocational Rehabilitation (VR), Education and Early Development, and Public Health.

Current Department of Health and Social Services TBI Program

Because of the momentum and leadership provided by the State of Alaska in developing a sustainable TBI system, additional staffing was essential to oversee the activities of the developing system. Even though the state was unsuccessful in their bid for a FFY 09 HRSA TBI Implementation Partnership grant, SDS, DBH, ABIN, the Trust, and the Alaska Native Tribal Health Consortium collaborated to fund a temporary TBI Program Coordinator (Project Director) employed by ABIN. That individual was hired and began work in October 2009. During the next year the Program Coordinator will support the development of the state TBI program and research methods to expand access to TBI services in Alaska, including the development of a TBI Medicaid waiver.

During 2008, SDS designated an interim TBI program coordinator to facilitate the transition of the TBI program from DBH to SDS. That individual has been working collaboratively with ABIN on development of an SDS TBI program, which will include a TBI Program Director and Care Coordinator position.

In 2008, the AMHTA Trustees approved MHTAAR funding to support the development of a Brain Injury Care Coordination project to be administered by Senior and Disabilities Services. In spring 2009, the interim TBI Project Director and ABIN Executive Director worked with a consultant to develop this program. The care coordinator position will be hired in the fall of 2009. The Care Coordinator will assist people with traumatic brain injuries and their families to develop a person-centered, goal-oriented plan to achieve short-term and overall life goals and minimize the severity of disabilities through prevention, interventions and compensatory strategies. This position will be responsible for coordinating services to assure that people have access to a full array of needed community services including appropriate health care, medical, rehabilitative, social, educational, in-home supports or other needed services.

Through this project development, SDS has begun an official State TBI Program which, with appropriate resources, is forecasted to better meet the needs of TBI survivors over the next 10 years. The TBI Program is also forecasted to decrease the number of people with TBI who are in the correctional system, juvenile justice facilities, and behavioral health clinics.

How do other States fund and sustain a TBI Program?

States use a variety and combination of funding streams for planning, policy, prevention and research activities, and to serve individuals with brain injuries and their families who have no other access to needed care or supports. Medicaid, Home and Community-Based Services and Medicaid Waivers, and Federal Block Grant programs are used to serve individuals with disabilities and special health care needs including people with brain injury. At the State level, common non-Federal funding sources for TBI service delivery include trust funds, general revenue and special revenue. Often when two or more sources exist, funds from one are used to leverage funds from the other.

There are 24 States that have a Brain Injury Medicaid Waiver (2006). There are 20 states that have General Revenue or Special Revenue specific to brain injury (NASHIA 2005).

Medicaid waivers targeted to individuals with brain injuries operate in half of the states and are small when compared to waivers targeting other groups. These waivers provide significant cost savings, on average $30,000 annually per person, when compared to institutional facility-based services (Rutgers 2008).

These waivers have been successful both programmatically and financially. In addition to cost savings, these waivers have provided other significant benefits. The existence of these waivers supports the growth of community non-profit brain injury agencies. There is clear evidence of the desirability of home and community-based services among those directly affected by brain injury: there has been growth of these waivers that has resulted in a doubling of the number of persons served over five years; in addition, there is a visible role played by advocates in encouraging states to develop these

waivers. These waivers, over time, have contributed to states' efforts to create and grow an in-state service capacity to provide services to individuals with brain injuries.[11]

10 Year Plan for TBI in Alaska, Core Service Assumptions

(view the full report at www.alaskabraininjury.net)

Information and Referral

Assumptions:

- Department becomes the lead funder; currently Trust funds Information and Referral (I&R)
- GF/MH expands the program to produce and disseminate educational packets
- Department develops methods for following up with individuals hospitalized and reported to the trauma registry
- Department will coordinate brain injury I & R to ADRC
- Training/workshops to disability, health and social service agencies providing I&R to include TBI information
- Workforce will begin to understand service needs for TBI and will be incorporated into existing programs by FY17

Service Coordination (care coordination)

Assumptions:

- SDS will collect appropriate data during pilot years FY10/11 to determine need for expansion
- 30 clients/ care coordinators at any one time
- Train case managers/care coordinators in other programs regarding TBI and available resources
- Develop and continue protocols with hospitals for linking individuals to services following TBI
- Positions hired internally by SDS or granted out depending on evaluation of demonstration positions in FY10/11

[11]Hendrickson, L. & Blume, R. (2008). Issue brief: A survey of Medicaid brain injury programs. *Rutgers Center for State Health Policy*

Acute and Post-Acute Rehabilitation

Assumptions:

- State investment will get match from Medicaid, Tribal Medicaid, Insurance, Workman's Comp, etc.
- Data will be developed through TBI Care Coordinator Program to develop service needs and costs associated with those services to direct the writing of a TBI waiver.
- Department will analyze costs of existing services to determine accuracy of forecast.
- Research a post-acute rehab waiver for TBI needs
- Department will develop funding options through general revenue, federal grant, Medicaid to pay for post-acute rehabilitation and therapies
- Community providers; i.e. hospitals or others will develop TBI post-acute and residential programs
- Pool resources for rehabilitation service system (i.e. Veterans Affairs, Department of Defense, Indian Health Services, and Worker's Compensation)
- Adopt program standards, best practices and outcomes
- Determine rehabilitation options for unserved or underserved populations (i.e. children, elderly, Alaskans living in remote areas)
- Support in-state TBI services for children and youth through BTKH

Education and Related Services

Assumptions:

- Training for STAR care coordinators
- Partner with Statewide Positive Behavior Support Initiative to include TBI-specific behaviors
- Partner with Parent Training agencies (i.e Stone Soup Group) to educate families on TBI
- Partner with SESA and Stone Soup Group to train school districts about TBI
- Hospitals and school districts will communicate when a child is hospitalized with TBI
- Develop Project BRAIN, Brain Injury Resource and Information Network for parents, students, teachers, and medical professionals supporting youth with brain injury.

Vocational Training and Rehabilitation

Assumptions:

- Referral to DVR will increase due to service coordination
- Vocational Specialists will be trained in TBI
- By FY12 there will be at least 1 VR specialist with an emphasis in brain injury

- By FY20 there will be several VR specialists depending on the pilot positions in FY12/13
- Increase long-term supported employment programs (job coaching) for persons with TBI
- Expand Mental Health Customized Employment Grant to include TBI
- Provide training to VR counselors and community VR providers on TBI
- Develop pre-vocational options to prepare people for vocational rehabilitation services
- Recruit and provide training to employers on TBI related disabilities
- Provide supports to maintain employment

Long-term Care and Community Supports

Assumptions:

- Expand existing HCBS waivers to include TBI with cognitive and behavioral problems
- Expand existing HCBS waivers to include TBI services, including therapies, behavioral therapies, counseling
- **Develop TBI HCBS Waiver to cover those who are not eligible for existing waivers**
- **Eligibility is determined by Department and available funding**
- **At least 100 Alaskans hospitalized each year are Medicaid eligible.**
- **The number of people eligible can be capped, as well as the maximum amount for each participant. Medicaid funding can be strategically controlled.**
- **Federal government has a 50% match. There is a 100% match for Alaska Native beneficiaries.**
- **State investment will get match from Medicaid, Tribal Medicaid, Insurance, Workman's Comp, etc.**
- **Develop funding for housing and residential**
- **Obtain dedicated funding or general funds to pay for the array of services needed for individuals who are not Medicaid eligible**
- Include TBI in Senior and Disabilities Services efforts to develop person-centered hospital discharge planning model to help transition to community services
- Develop housing alternatives (i.e. supportive living, structured residential, long-term living homes for people with cognitive disabilities)
- Obtain state or MHTA funds as seed money to start clubhouse/day programs for TBI
- Promote technology in activities of daily living (i.e. assistive technology, PDA, etc)
- Develop technology to support TBI survivors in their homes (i.e. online clubhouse model, support groups)

Public Awareness, Prevention, and Advocacy

Assumptions:

- Trust will continue Coordinated Communications
- DPH will expand TBI prevention awareness to rural Alaska and other populations
- Enact booster seat legislation
- Funding for prevention education programs and collaboration among programs
- TBI self-advocates to assist with injury prevention education programs
- Collaboration among injury prevention agencies to coordinate TBI prevention and support best practices
- Funding for "Second Impact Syndrome" training of health professionals and school coaches
- ASAA adopt Impact program for school sports
- Support local helmet use ordinances
- Fund and implement the Alaska Model Helmet program
- Develop and implement teen focused TBI awareness events
- Develop, fund, and implement an elderly fall prevention program
- Public Awareness funding will lead to lower rates of TBI and higher usage of state and community rehab programs

Outreach and Identification

Assumptions:

- Investment in data collection within state government
- Policy decisions
- Develop MOA to share data
- Work with local school districts, Department of Education and Early Development to expand screening to include TBI
- Incorporate TBI into mental health and substance abuse screenings for inmates in correctional facilities
- Improve Behavioral Health Screening Tool to include questions about service-related causes; i.e. blast injuries, etc.
- Improve AKAIMS information to include TBI-specific referrals, duration, costs,
- Include TBI screening questions in existing screening tools in various sectors, to be identified in further research
- TBI screening in primary care settings, schools, etc.

Training and Workforce Development

Assumptions:

- Develop distance delivered TBI curriculum
- Conduct training through existing educational certificate and endorsement programs
- Conduct training through agency sponsored workshops/conferences for direct care providers, educators and other professionals/paraprofessionals.
- Expand core competencies for the workforce to address TBI
- Expand telehealth for training providers and families, particularly in rural areas
- Integrate TBI into college and vocational curriculums
- Develop program for training long-term care and community-based programs serving older adults to identify and screen older adults for TBI.
- Develop and provide training to educators on identifying TBI symptoms.

Statewide Planning and Policy Coordination

Assumptions:

- State Hires TBI Program Coordinator
- TBI Advisory Board to continue role as a planning board for the Department of Health and Social Services and the Trust, maintaining funding eligibility under HRSA TBI ACT
- Alaska to receive Federal HRSA TBI Implementation/Partnership Grant
- Continue to provide a venue for consumer input on the TBI service delivery system.
- Expand data capacity across pertinent programs to evaluate the TBI service delivery system; i.e. individuals served, services provided, expenditures and outcomes.
- Continue TBI participation among the 4 statutory advisory boards
- MOUs to support coordination of program data; individual service planning, including TBI documentation/evaluations, subject to confidentiality release of information
- Consumer Satisfaction Surveys every 2 years

Brain injury rehabilitation and treatment is standard in many states. The following document explains two federal initiatives focusing on TBI rehabilitation research.

NIDRR funds both Rehabilitation Research and Training (RR&T) Centers and TBI Model Systems of Care.

Rehabilitation Research and Training (RR&T) Centers

The National Institute of Disability Rehabilitation Research funds two RR&T Centers on brain injury. Both are housed at The Institute for Rehabilitation and Research (TIRR), Houston, Texas. The two RR&T Centers are: (1) Rehabilitation and Training Center on Community Integration in Persons with TBI and (2) Rehabilitation Research and Training Center on Rehabilitation Interventions Following Traumatic Brain Injury.

The Rehabilitation and Training Center on Rehabilitation Interventions following Traumatic Brain Injury promotes the scientific advancement of rehabilitation research by focusing on several areas identified as needing further research. These include areas of weakness in the current knowledge and future research regarding TBI recovery and rehabilitation effectiveness: improvement of the diagnosis and treatment of persons with mild TBI; development of interventions to assist school-age children with TBI; the needs of minority groups members with TBI; evaluation of the effectiveness of rehabilitation interventions; and treatment for the family members of people with TBI. Activities include publishing an informational and technical assistance resource for consumers and professionals; training for medical and neuropsychological fellows in rehabilitation research; coordinating a state-of-the-science conference on mild TBI; and producing an educational videotape to train family members in effective coping skills. Through representation on the advisory committees, consumers are involved in all aspects of planning and evaluating research and training activities

TIRR's National Database of Educational Resources on Traumatic Brain Injury

This National Database of Educational Resources on TBI is a part of TIRR's Rehabilitation Research and Training Center in Rehabilitation Interventions in TBI grant from the National Institute on Disability and Rehabilitation Research (NIDRR). The database contains information on more than 350 educational videotapes, audiotapes, and written materials that people with TBI, their family members and health care professionals can use. Information can be retrieved directly from the web site or by calling the TIRR Department of Education. To retrieve information from the database or for more information, visit www.braininjuryresearch.org/birc/database.htm.

TBI Model Systems of Care

In 1987 the National Institute on Disability and Rehabilitation Research (NIDRR) in the U.S. Department of Education established the Traumatic Brain Injury Model Systems of Care (TBI Model Systems). NIDRR's multi-center model systems program is designed to study the course of recovery and outcomes following the delivery of a coordinated system of care including emergency care, acute neurotrauma management, comprehensive in-patient rehabilitation and long-term interdisciplinary follow-up services. Each Center systematically collects important data about each individual who meets criteria for inclusion in the TBI National Database and sends this information to the TBI National Data Center. The Centers are currently located at 16 sites throughout the United States that provide comprehensive systems of brain injury care to individuals who sustain a traumatic brain injury, from acute care through community re-entry. The mission of the TBIMS is to improve the lives of persons who experience traumatic brain injury, their families, and communities by creating and disseminating new knowledge about the course, treatment, and outcomes relating to their condition.

The TBI Model Systems serve a substantial number of individuals, allowing the projects to conduct clinical research and program evaluation, which maximize the potential for project replication. In addition, the TBI Model Systems have the advantage of a complex data collection and retrieval program with the capability to analyze the different system components and provide information on project cost effectiveness and benefits. Information is collected throughout the rehabilitation process, permitting long-term follow-up on the course of injury, outcomes, and changes in employment status, community integration, substance abuse, and family needs. The TBI Model Systems serve as regional and national models for program development and as information centers for customers, families, and professionals.

Initially, approximately $1.5 million funded five centers: Wayne State University in Michigan, Mt. Sinai Hospital in New York, Santa Clara Valley Medical Center in California, The Institute for Rehabilitation Research in Texas, and the Medical College of Virginia in Richmond. For a few years, there were only four (Mt. Sinai left the program), and by 1997, Virginia's center no longer participated, but the Moss Rehabilitation Center in Pennsylvania won a grant for a center as did Ohio State University in Ohio.

In the fall of 1997, the Brain Injury Association of America and others successfully advocated for an additional $5 million for the program so that more centers could be established. Twelve new sites were awarded funds to establish model systems of care for traumatic brain injury.

Alaska is Combating Traumatic Brain Injury

Jill Hodges
Executive Director
Alaska Brain Injury Network

Jeff Jessee
Chief Executive Officer
Alaska Mental Health Trust Authority

Pat Hefley
Deputy Commissioner
Department of Health and Social Services

Past legislative hearings

2007- What is traumatic brain injury?
What does treatment look like?
Guest presenters: Dr. Tina Trudel (national expert) and partner boards

2008- Impact of TBI on the state.
Military issues related to TBI
Guest presenters: Capt. Richard Barker, Elmendorf; Dr. Russell Cherry, Providence; Stephanie Tanner, military wife of TBI survivor

2009- Importance of Medicaid Waiver to develop coordinated, comprehensive brain injury services in-state
Guest Presenters: Dr. Christie Artuso, Providence Neuroscience Director

Today's presentation- State System Development and Operationalizing

- Jill Hodges, Past 20 years of AK efforts
- Jeff Jessee , Trust Role
- Pat Hefley , DHSS Role
- Public testimony:
  - Martha Moore, ABIN Chair
  - Providers, partnerships essential
  - Consumer, treatment works, family support
- Jill Hodges-Questions and Solutions
  - State and Legislature

TBI Systems Development in AK-1990-2000

Phase 1: 1990-1995

Advocacy

- Brain injury survivors mobilize
- Early 1990's
  - Testimony to GDCSE, Legislature, AMHTA
- Brain Injury Association of Alaska organizes

Phase 2: 1995-2000

Advocacy Continues

State of Alaska

- State of Alaska-Public Health recognizes TBI
- Public Health awarded CDC grant
  - TBI Registry
- MHDD awarded Federal Grant-systems

TBI Systems Development in AK 2000-2007

Phase 3: 2000-2003

Advocacy

State of Alaska

Federal TBI HRSA Grant

- Needs Assessment
- 1st State Action Plan
- TBI Program Coordinator (FTE)
- Advisory Board

AMHTA-beneficiary group

Alaska Brain Injury Network

- TBI Advisory Board (ABIN) organizes and becomes 501 c3

Phase 4: 2003-2005

Advocacy/TBI Advisory Board

State of Alaska

- Behavioral Health (lead agency)

Data/Surveillance

- DBH mandates screening and data collection
- Consumer Satisfaction Surveys
- AK Trauma Registry Data

Phase 5: 2005-2007

State of Alaska: TBI Dir. turnover

Data- AKAIMS(32% in BH screen TBI)

Workforce: 1st AK Brain Injury Conf

Momentum builds- 2007-2009

Phase 6: 2007-2009

ABIN

- "Service" recommendation
  - Info and Referral
  - Case Management

AMHTA-Funds ABIN recomm.

State of Alaska

- Lead agency transfers to SDS
- TBI Case Management Program developed

Workforce:

Intro to TBI Course

Advance Brain Injury Workshop

Vocational Rehabilitation Counselors

Legislation

- SB 118 introduced-medical assistance for TBI

Medicaid Funding: Waivers

- Preliminary research on Medicaid Waivers
- Targeted Case Management

Treatment

- After Hospital/Post-Acute
  - Site Visits
  - AK Providers Coalition
  - Military/Tribal partnerships sought

Key Points

- System Planning– created framework and foundation for action
- Next step: operationalize
- General Funds or GF/MH essential

- Phases 1-4 (1990-2005)
  - advocacy, planning, increasing awareness.
- Phases 5-6 (2005-2009):
  - Direct 'services':
    - info and referral;
    - case management
  - Workforce development
- Phase 7 – 10 (2010-2020)
  - Case Management
  - Treatment: Funding for Residential and Day Program
  - Workforce

2010 Session: SB 219 and House Companion

SB 219 and House Companion

- Traumatic/Acquired Brain Injury Program
  - Gives statutory authority to develop/improve program.
  - Establishes standards for treatment and services.
  - Defines brain injury.
  - Develops cost/ longitudinal data
  - Planning for Medicaid Waiver/Targeted Case Management

Opportunities

- Positions the state to access federal funding for TBI services.
- The existence of brain injury waivers supports the growth of community-based rehabilitation programs.
- DoD/VA/Tribal/State coordinate planning and implementation of rehabilitation and community re-entry programs.
- Early treatment may reduce future medical and social costs.
- Potential cost savings in acute care, existing state programs; behavioral health, juvenile justice, corrections, homeless activities, and long-term care in institutional facilities.

2010 Session: FY11 Governor's Operating Budget

$350.0 for TBI Service Coordination Program

- $200.0 GF/MH
- $150.0 MHTAAR

Focus: Case Management

- Year 2 of the project
  - (FY10 funded by MHTAAR)
- 2 case managers (serving 60)

Focus: Grant program

- grants funds for specialty services.

Opportunities:

- Reduce emergency dept visits;
- Deter more costly care by keeping people within their own homes;
- increase readiness for vocational rehabilitation/ employment.
- Increase independence
- Serve as benchmark for Medicaid Waiver application and funding requests

The Trust's Role- Jeff Jessee

- TBI as a beneficiary group (late 1990's)
- Trust role: planning, demonstration
- Maximize collaboration
- Alaska too small of a state to have separate TBI treatment systems of care (VA, DoD, Tribal, State)
- Treatment: General Fund commitment

Past 10 years, Trust has invested $2.8 million in <u>brain injury systems development</u>

- Trust FY09 Funding specifically for brain injury program: $628,000
  - Core Services Development
    - Information and Referral
    - Case Management
    - Technical Assistance for planning treatment
  - Systems Development
    - Public Awareness-anti stigma
    - Workforce development
    - Statewide planning- TBI Advisory Board

Department of Health and Social Services Role- Pat Hefley

- Development, now operationalizing.
- 44 States use General Revenue and Medicaid Waivers for brain injury treatment/ services.
- TBI folks are already in the system - need to move them into specialty programs in order to see results.
- Appropriately staged incremental GF/MH budget requests.

Upcoming 2010 Activities

- Federal Grant- $250.0/year 4 years
  - lead agency: Senior and Disabilities Services
- State of Alaska T/ABI program
  - Case Management
  - Research federal funding opportunities: Medicaid Waiver/Targeted Case Management
- Data/Prevention: regional study, Alaska Native and Non-Native

Public Testimony

- Martha Moore: ABIN Chair
  - Composition of ABIN
  - Recommendation Philosophy
  - Perspective: State role (data collection) and ABIN chair.

- Alaska providers: readiness to partner- TBI post-acute programs
  - Dr. Lester, St. Elias (LTACH)
  - Margaret Carloni, Trauma Nurse, ANMC

- Shannon- Juneau resident, experienced TBI
  - TBI treatment works
  - Family support

Many of Alaska's challenging questions have been asked and answered by other States

- Alaska can learn from 30 years of state system experience; and
- treatment research by the Federal Government, State experiences, military advances

Questions and Solutions

Is brain injury impacting State government?

1980 findings...

- Uninsured or underinsured
- Unemployment
- Trauma/EMS
- Long-term care and support needs
- Family Support

1990 findings...

- Educational System
- Vocational Rehabilitation

2000 findings...

- Criminal Justice
- Behavioral Health

Question and Solutions

How will State Gov't know how to develop TBI systems?

TBI Act of 1996

- Federal Statute
  - Defined TBI in Federal Statute
  - Authorized funding to HHS
  - Established TBI program in CDC
  - Created State grant program (HRSA)
- State experience has broadened program definition to ABI- same service needs.
- National Association of State Head Injury Administrators (1990)
- TBI Technical Assistance Center-specifically for state administrators (since 1996)

Question and Solutions

Is recovery possible after a TBI?

Does treatment work?

- Feds fund TBI model systems since 1987, over 20 years of longitudinal data- yes with specialized support, recovery/ independence is possible
- Research at acute/medical level led to need for community reentry programs
- Military funding is supporting research of community reentry programs and Mild TBI assessment and treatment

Question and Solutions

How will States pay for brain injury treatment?

- 1990's, Centers for Medicare/Medicaid Services (CMS) developed TBI HCBS Waiver prototype
- IDEA 1990 added TBI as disability to report
- State General Funds
- TBI Trust Funds

Question and Answer

How will states develop <u>treatment</u> and prepare a <u>specialty workforce</u>?

- Many providers have 30 years of experience.
  - Utilize existing models: medical, community reentry, clubhouse, and long-term living..
- TBI specific workforce will build as TBI programs are operationalized.
  - Professional/para-professional specialists have on the job training, does not take special educational training.

Question and Answer

How will rural residents have access to these treatment and services?

- Military and a few states utilize telemedicine for treatment.
- Opportunity for Alaska to become the national leader in providing care to rural areas?

Question and Answer

What type of legislation is/has been successful?

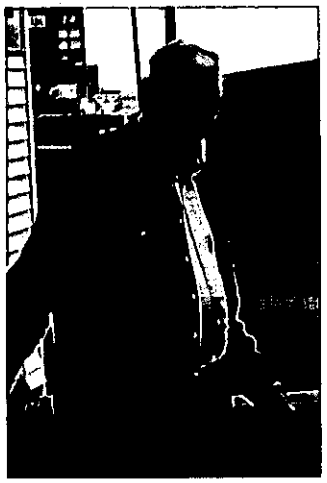
- Resolutions- awareness
  - Last five years
- Prevention
  - AK primary seatbelt law and child safety/ booster seat)
- T/ABI Program into Statute
  - SB 219 and HB Companion
- Interagency Taskforce
- Prevention-concussion management
- Military-screening

Alaska has an opportunity!

- Alaska can operationalize at a faster rate.
- Alaska can become the leader in rural TBI treatment and supports

Alaskans Thank the Legislature...

For recognizing the 10,000+ Alaskans with TBI and working to bring more services close to home



Outline for TBI Presentation to House HSS, Feb. 4th 2010. 3:00-5:00 committee hearing
1 hour presentation, 20 minutes questions/comments

CO-CHAIR: Representative Herron CO-CHAIR: Representative Keller
VICE-CHAIR: Representative T.Wilson
MEMBER: Representative Lynn
MEMBER: Representative Seaton
MEMBER: Representative Cissna
MEMBER: Representative Holmes

Presenters:
Pat Hefley
Jeff Jessee
Jill Hodges

Invited testimony:
Martha Moore
Shannon-consumer
St. Elias person
Dr. Groves

Jill Hodges	Do an overview of the 1 hour presentation Review previous presentations Walk through past phases Roles of State, Trust, ABIN, Providers, legislators Highlight 10 Year plan, treatment gap analysis Talk about current bill, FY11 budget recommendation,	15 min.
Jeff Jessee	Alaska too small of a state to have separate TBI treatment systems of care (VA, DoD, Tribal, State) Purpose: max collaboration, so everyone comes out a winner History of establishing TBI as a beneficiary group Trust funding has supported planning, pilot projects, technical assistance, workforce Trust role- development, efficacy of programs. Next steps will take General Fund committment	10
Pat Hefley	State of Alaska needs to catch up- 24 States have been utilizing TBI Medicaid Waivers, and 20 states have General Funds/General Revenue for brain injury specific programming. BTKH metaphor TBI folks are in some level of care now, but need specialized type	10

	of care. TBI folks are already in the system-need to move them into specialty programs in order to see results. For several years, been in development mode, now moving into operationalizing. Timeline *As we progress, there will be appropriately staged incremental budget requests. The waiver will have a GF component. Military efforts: ongoing	
Martha Moore	ABIN Chair- different phases met different needs Composition of ABIN Our recommendation philosophy for building system: partnership-adapting successful models-pilot projects perspective State role (data collection) and ABIN chair. ***The amount of work that has been accomplished despite the limited funding due to volunteers/ABIN Board/persistent advocates/Federal Funds/Trust funds	5 min.
Shannon	Share her story- wants everyone to know that improved functioning after brain injury is possible. She wouldn't be here without her mother's support.	5 min.
Dr. Lester or Patti	Post-acute setting to send folks to. Improved outcomes if stay in state. Workforce moral lifted. Families can stay in AK.	5 min.
Dr. Groves	TBI as a chronic condition, need for TBI to be identified and treated. Importance of case management, multidisciplinary treatment team meetings, improved functioning is possible	5 min
Jill Hodges	Take away messages: Though SOA is 30 years behind, we are in a position to move faster with better information due to initiatives in other states, Federally (TBI Model systems-know treatment improved functioning), and in the Military (identification, screening, Mild TBI). future budget recommendations, legislation possibilities Thank you to HSS members Support HB ?? /SB 219, $350 in Governor's budget	5 min.
HSS members	Questions, Comments	20 min.

Phases/Timeline To Develop Alaska (In-State) Brain Injury Treatment And Services

Advocates	State of Alaska/DHSS	Data/ Surveillance/ Identification	Treatment	Alaska Brain Injury Network	Workforce Development	TBI Resource Navigation (info and referral)	Case Management	Providers to develop direct services	Military efforts
[illegible]	Vocational Rehabilitation	Educational System	Criminal Justice	Prevention	Legislation				
Phase 1: 1990-1995		Advocates speak out, organize, increase awareness among state government and anybody else willing to listen							
Phase 2: 1995-2000		Advocates come together. Brain Injury Association of Alaska formalizes		State of Alaska hired TBI Program Director **Federal HRSA funds,** Lead Agency: DHSS, Division of Mental Health/Developmental Disabilities		Data and Surveillance- CDC federal grant. Public Health reports ATR data to lead agency (projected findings: Alaska has a high rate of hospitalizations, higher than national average) **Federal Funds**		Treatment: Trauma/EMS- mostly available in urban settings	
Phase 3: 2000-2003		ABIN: Alaska Traumatic Brain Injury Advisory Board organized (now ABIN), funded by MHTAAR Trust funds		State of Alaska: Federal requirement Alaska multidisciplinary committee develops needs assessment and 1st state action plan (findings: ***TBI is public health issue, access to after hospital/long-term rehab is limited, TBI Waiver recommendation***)					
Phase 4: 2003-2005		ABIN: Alaska Traumatic Brain Injury Advisory Board (ATBIAB) gains non-profit status (501 c3) Trust Funds		State of Alaska: Lead Agency: DHSS, now DBH designs and implements TBI Screening tool (TBI Project Director turnover) Federal Funds		Data/Surveillance-Alaska Trauma Registry analysis continues			

Phase 5: 2005-2007	ABIN: ATBIAB changes name and receives grant from Trust to develop TBI information and referral service *(projected findings: there are hundreds of Alaskans living in the community (statewide) being discharged to inappropriate facilities or home, case management will be a key service, post acute services needed, TBI Waiver)*	State of Alaska: TBI Program Director (staff turnover) **Federal HRSA funds.**	Workforce- 1st Alaska Brain Injury Conference, training for BH clinicians **Federal HRSA funds.**	Data/Surveillance-in addition to ATR data (, now have AKAIMS (BH screening tool shows 32-34 % clients screening positive for TBI)
Phase 6: 2007-2009	ABIN and partners develop 10 year plan for TBI in Alaska (Plan has been recognized nationally) TBI lead stage agency transitions to Senior and Disabilities Services- utilize strengths in that division which focuses on Aging and Disability Resource Centers. Hospital Discharge, care coordination, Medicaid Waivers **State Capital Funds**	State of Alaska: DHSS does not receive Federal funds for the TBI Systems project. No TBI Project director Workforce capacity building- Intro to TBI (distance delivered 40 students) **Trust Funds** Legislation: SB 118 introduced for Medicaid Brain Injury Waiver. Waivers: Preliminary research on 24 TBI Waivers in other states. Information gathering.	ABIN TBI Resource Navigation program develops TBI Resource Directory, provides information/referral to nearly 600 Alaskans, 'callers' or 'cases studies' ***show need for case management, instate after hospital/community re-entry/long-term rehab/supportive living/clubhouse)*** **Trust Funds**	Data/Surveillance: Additional data collection includes: Vocational Rehabilitation. Special Education, Nursing Homes, and Hospital Discharge Data. Opportunity for Longitudinal data: Case management to identify: types of referral to the program, service needs, duration of services, costs associated, societal costs and indirect social costs (family, financial, etc)
	Case Management Demonstration Project: MHTAAR funds approved for TBI Service Coordination (1state employee, serving 30-50 clients)Purpose : provide framework to gather longitudinal data on persons with brain injury (money available	Treatment/Direct Service: Preparation/Research on post-hospital treatment (post-acute, community reentry, continuum included neurobehavioral, neuroresidential, supportive living, clubhouses, home supports,)	Providers: Identify providers to deliver post-hospital services (identified agencies include Providence, St. Elias, Mat Su Health Services, supportive living home in valley, "outside" brain injury programs.	Military brain injuries recognized; DHSS highlights need to partner with military to identify needs, coordinate planning. DHSS Commissioner, Trust, and ABIN meets monthly with Elmendorf, VA, Vet Centers, etc.

	July 1, 2009, Department is interviewing first week in February) ***(expected findings, need additional case managers, utilize federal funds to support expansion)*** **Trust Funds**	3 separate site visits to TBI rehabilitation programs (20 programs in New Hampshire, Wisconsin, Virginia, Texas, Kentucky, Illinois) (Funded by Trust) **Trust Funds**	Coalition grows to include all Alaska providers interested in seeing post-acute options available in state: Providence, St. Elias, Mat Su Health Services, Regional, community providers, supported living programs.	ABIN hosts Defense and Veterans Brain Injury Center and National Intrepid Centers for Excellence for Psychological Health and TBI directors. Col Michael Jaffee and Dr. James Kelly. Sen. McGuire and Rep. Craig Johnson co-host roundtable discussion.
Phase 7: 2010	TBI Case management will be hired (care coordination): 1 FTE hired 30-40 people served **Trust Funds** Case Management: FY11 Governor's budget includes $350.0 ($200.0 GF and $150.0 MHTAAR) for TBI Service Coordination to include additional care coordinator with small grant program. Grants to support funding services needed. Positions the state to bring in federal funds (through Targeted Case Management in Medicaid State Plan) **General Funds/Mental Health** **Trust Funds** Research and recommend utilizing targeted case management to expand the program using federal dollars (instead of growing general funds). **Federal Funds**	ABIN: Full Time TBI Program/Project Director hired-**ABIN/SDS/Trust/ANTHC funds** Workforce capacity building continues-funded by Trust and ABIN- advanced course, course for vocational rehabilitation counselors **Trust and ABIN funds**	TBI Resource Navigation partners with Aging and Disability Resource Centers (250 new callers/year) Prevention: TBI Study-regional information (Alaska Native and non-native) to identify priority communities for prevention efforts ABIN Funds	Waivers: More in depth research on Waivers (see additional document for timeline of activities) Legislation: T/ABI Program introduced by Senator McGuire

Phase 8: 2010-1012	Case Management: Amend state plan to include brain injury as a target population to expand number of case managers. ***Projected findings: case management is key for coordinating services (efficiency and cost savings)***	Waiver: TBI Program Director to draft first waiver based on information from Alaska Trauma Registry, ABIN TBI Resource Navigation program, SDS TBI Care Coordination project, department/agency data, research on other State waivers **Federal or GF** (projected purpose of 1st waiver and projected findings- purpose- residential rehabilitation program for those who have opportunity for recovery; findings-need a clubhouse for those in the community (not a good fit for behavioral health and/or not available to work); Apply for waiver that focuses on residential neurorehabilitation. Start with 8-16 Medicaid eligible persons.***(Projected findings-will learn there is a need for a transitional program (supported living) from the neurorehabilitation to home)***	Data/Surveillance-systematically improves identification through screening; criminal justice systems, corrections, juvenile justice, primary care, schools. ***(projected findings, need to increase awareness in systems that TBI exists; message is recovery is possible, appropriate supports make a difference, identification is key to appropriate referrals and services)*** State of Alaska: DHSS/SDS applies for Federal HRSA funds to support TBI program/project director, ANTHC TBI director, workforce ($250/year 4 years)	Workforce capacity building- increase awareness and prepare workforce through a Brain Injury Conference. **(ABIN/DHSS/Trust/Partner funds)** Additional awareness building/training to VR counselors Educational System: Increase awareness in educational system Prevention: Funds requested to implement prevention programs in pilot communities
Phase 9: 2012-2015	TBI Info and Referral –additional grant dollars needed to support volume of callers (400 callers) **GF and Trust**	Treatment: Increase direct services: Apply for additional waiver with focus on supportive living services. General funds (aggregate funds) to pay for Medicaid brain injury services (30-40 people served) **General funds** to support brain injury clubhouses.	Case management- grows depending on first 3 years of the project. GF and Federal	Data Surveillance-implement screening tools in criminal justice systems ***(expected findings higher percentage of offenders will screen positive)***

Phase 10: 2015-2020	TBI Info and Referral- going strong	Case management, est. to serve 60-100 people	Treatment: Providers improve post-acute services: residential neurorehabilitation, supportive living, clubhouses Decide how to deal with neurobehavioral.	Criminal Justice System-early identification leads to appropriate trials and treatment
	Vocational Rehabilitation counselors specialize in TBI	Educational System- early linkage from hospital to 504 or special education accommodations		
Projected Outcomes of a coordinated, comprehensive, interdisciplinary State TBI Program	Individual outcomes: increase in recovery, intact family structures, increases in return to work and school Family outcomes: strengthens families, supports family to support their loved one (decreases burnout), decreases divorce rate	State of Alaska outcomes: less strain on behavioral health system, lower recidivism in corrections/juvenile justice, decrease in discharges to nursing homes.	Provider outcomes: increase in jobs, improved work moral, economic gains.	Community outcomes: decrease in homeless population, chronic inebriation, domestic violence/sexual assault.
Key Points	All activities stated above relate to unofficial State of Alaska TBI Program (systems change). Community, Tribal, Military, Individual and other activities are not included. All activities in the state have been funded by Federal grants administered by Behavioral Health and Senior and Disabilities Services, Alaska Mental Health Trust Authority Funds, Federal Earmark, Alaska Native Tribal Health Consortium, State Capital funds No General Funds or GF/MH Phases 1-4: Funding has been directed towards advocacy, planning, increasing awareness, workforce development. Phases 5-6: Funding (Trust funds and FY11 GF/MH Gov. budget) for Information and Referral and Case Management, the first 'direct service' projects. They are both demonstration projects with a research focus. Phases 7-10 Will need General Funds to support activities, move into treatment/direct services			