

SB

219

ALASKA STATE LEGISLATURE

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Chair
Senate Special Committee on Energy
Senate Committee on World Trade,
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Co-Chair
Senate Resources Committee

Member
Senate Judiciary Committee

SENATOR LESIL MCGUIRE

Sponsor Statement CS for Senate Bill 219 (26-LS1312\R)

The CS for Senate Bill 219R establishes a traumatic or acquired brain injury program and registry in the Department of Health and Social Services. Currently, Alaska has no specific program specifically to deal with brain injury and yet Alaska has one of the highest rates in the nation. Annually, there are about 800 Alaskans hospitalized with a traumatic brain injury resulting from falls, car crashes, domestic violence, All Terrain Vehicle crashes, and snow-machine crashes, among others. Furthermore, an approximately equal number of Alaskans are suffering from acquired brain injuries resulting from stroke, aneurism, or tumors.

Alaska urban and rural residents, including military are being discharged to their homes with little understanding of brain injury or access to in-state rehabilitation, severely impacting their families. Limited education about the injury, learning to cope with a person who has changed, overwhelming stress from insurance, bureaucracy, and financial burdens and change in family roles may render families dysfunctional.

With appropriate and available care, rehabilitation, community and family support, even the individual who is most severely injured can live at home, return to school or work, or engage in meaningful and productive lives.

Funding a Traumatic or Acquired Brain Injury (T/ABI) Program gives authority to the Department of Health and Social Services to collect data on the injured, positioning the state to access Medicaid funds for T/ABI. Medicaid services for T/ABI will be matched 50% by federal funds. The bill allows for streamlining department services and activities that are unique to T/ABI. This would better assist families and individuals with T/ABI in knowing how to access services and supports.

Early treatment may reduce future medical and social costs. Without appropriate services, some individuals with T/ABI may pose a threat to themselves or others. Without assistance, individuals with TBI often end up homeless, in jail or in nursing homes. Service coordination, rehabilitation, and appropriate supports can help to minimize these risks.

Reston

Centers for Medicare & Medicaid Services, HHS

§ 440.169

(2) On a mandatory basis under section 1932 (a)(1) of the Act or under section 1915(b) or section 1115 waiver authority.

[67 FR 41115, June 14, 2002]

§ 440.169 Case management services.

(a) *Case management services* means services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, in accordance with § 441.18 of this chapter.

(b) *Targeted case management services* means case management services furnished without regard to the requirements of § 431.50(b) of this chapter (related to statewide provision of services) and § 440.240 (related to comparability). Targeted case management services may be offered to individuals in any defined location of the State or to individuals within targeted groups specified in the State plan.

(c) [Reserved]

(d) The assistance that case managers provide in assisting eligible individuals obtain services includes—

(1) Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include the following:

(i) Taking client history.

(ii) Identifying the needs of the individual, and completing related documentation.

(iii) Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual.

(2) Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:

(i) Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.

(ii) Includes activities such as ensuring the active participation of the eligible individual and working with the

individual (or the individual's authorized health care decision maker) and others to develop those goals.

(iii) Identifies a course of action to respond to the assessed needs of the eligible individual.

(3) Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

(4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to help determine whether the following conditions are met:

(i) Services are being furnished in accordance with the individual's care plan.

(ii) Services in the care plan are adequate.

(iii) There are changes in the needs or status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

(e) Case management may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

[72 FR 68091, Dec. 4, 2007, as amended at 74 FR 31196, June 30, 2009]

LEGAL SERVICES

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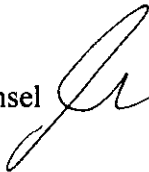
MEMORANDUM

February 9, 2010

SUBJECT: Sectional Summary (SB 219 (Work Order No. 26-LS1312AR))

TO: Senator Lesil McGuire
Attn: Esther Cha

FROM: Jean M. Mischel
Legislative Counsel



You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds longitudinal data on traumatic or acquired brain injury from the registry established under sec. 5 of the bill to the list of databases that the Department of Health and Social Services is authorized to collect, analyze, and maintain.

Section 2. Adds case management services for traumatic or acquired brain injury to the optional services provided to recipients of state medical assistance (Medicaid).

Section 3. Defines "case management services for traumatic or acquired brain injury" and "traumatic or acquired brain injury" for purposes of the optional services added by sec. 2 of the bill.

Section 4. Requires the Department of Health and Social Services to provide medical assistance services under a waiver if approved by the federal government and if the legislature appropriates necessary funding for the services.

Section 5. Establishes a statewide traumatic or acquired brain injury program in the Department of Health and Social Services to evaluate the effectiveness and availability of information and services for the prevention and treatment of traumatic or acquired brain injury in the state. Requires consultation and collaboration with public and private entities to fulfill a list of programmatic requirements including development of a statewide service delivery plan and registry of information and evaluation of current laws and standards pertaining to traumatic or acquired brain injury.

JMM:ljw
10-078.ljw

26-LS1312\R
Mischel
2/5/10

CS FOR SENATE BILL NO. 219()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS MCGUIRE, Ellis

A BILL

FOR AN ACT ENTITLED

1 **"An Act establishing a traumatic or acquired brain injury program and registry within**
2 **the Department of Health and Social Services; and relating to medical assistance**
3 **coverage for traumatic or acquired brain injury services."**

4 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5 *** Section 1. AS 18.15.360(a) is amended to read:**

6 (a) The department is authorized to collect, analyze, and maintain databases of
7 information related to

8 (1) risk factors identified for conditions of public health importance;

9 (2) morbidity and mortality rates for conditions of public health
10 importance;

11 (3) community indicators relevant to conditions of public health
12 importance; [AND]

13 (4) longitudinal data on traumatic or acquired brain injury from
14 the registry established under AS 47.80.500(c)(1); and

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(5) any other data needed to accomplish or further the mission or goals of public health or provide essential public health services and functions.

* Sec. 2. AS 47.07.030(b) is amended to read:

(b) In addition to the mandatory services specified in (a) of this section and the services provided under (d) of this section, the department may offer only the following optional services: case management services for traumatic or acquired brain injury; case management and nutrition services for pregnant women; personal care services in a recipient's home; emergency hospital services; long-term care noninstitutional services; medical supplies and equipment; advanced nurse practitioner services; clinic services; rehabilitative services for children eligible for services under AS 47.07.063, substance abusers, and emotionally disturbed or chronically mentally ill adults; targeted case management services; inpatient psychiatric facility services for individuals age 65 or older and individuals under age 21; psychologists' services; clinical social workers' services; midwife services; prescribed drugs; physical therapy; occupational therapy; chiropractic services; low-dose mammography screening, as defined in AS 21.42.375(e); hospice care; treatment of speech, hearing, and language disorders; adult dental services; prosthetic devices and eyeglasses; optometrists' services; intermediate care facility services, including intermediate care facility services for the mentally retarded; skilled nursing facility services for individuals under age 21; and reasonable transportation to and from the point of medical care.

* Sec. 3. AS 47.07.030 is amended by adding a new subsection to read:

(e) In this section,

(1) "case management services for traumatic or acquired brain injury"

means

(A) care and service coordination to assist individuals and families affected by traumatic or acquired brain injury to minimize the disabling effects of the injury;

(B) collaboration with providers and other organizations to expand and strengthen the local capacity for delivery of needed services, ~~including~~ including housing, for the care and support of a recipient who is diagnosed with traumatic or acquired brain injury;

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(C) participation in planning and accessing services within the community for the care and support of a recipient who is diagnosed with traumatic or acquired brain injury;

(D) the provision of information, referral, and case consultation services to a recipient who is diagnosed with traumatic or acquired brain injury;

(2) "traumatic or acquired brain injury" has the meaning given in AS 47.80.590.

* Sec. 4. AS 47.07 is amended by adding a new section to read:

Sec. 47.07.046. Traumatic or acquired brain injury services. (a) The department shall provide traumatic or acquired brain injury services under a waiver in accordance with 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act), this chapter, and regulations adopted under this chapter, if the department has received approval from the federal government and the department has appropriations allocated for the purpose. In addition to the annual assessment required in (b) of this section, the department shall establish in regulation additional standards for eligibility and payment for the services.

(b) Before the department may terminate payment for services provided under (a) of this section, the recipient must have had an annual assessment to determine whether the recipient continues to meet the standards established by regulation under (a) of this section.

(c) In this section, "traumatic or acquired brain injury" has the meaning given in AS 47.80.590.

* Sec. 5. AS 47.80 is amended by adding new sections to read:

Article 5A. Traumatic or Acquired Brain Injury.

Sec. 47.80.500. Statewide traumatic or acquired brain injury program. (a) A statewide traumatic or acquired brain injury program is established in the department for the purpose of evaluating the effectiveness and availability of information and services for the prevention and treatment of traumatic or acquired brain injury in the state. The department shall consult and collaborate with state agencies, private nonprofit entities, and other organizations in the state that provide

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brain injury services in implementing all aspects of the program.

(b) The program established under this section must include

(1) review and consideration of data collected under (c)(1) of this section;

(2) supervision and coordination of services provided to persons with traumatic or acquired brain injury;

(3) evaluation of standards and laws pertaining to the prevention of traumatic or acquired brain injury and to the treatment, care, and support of persons with traumatic or acquired brain injury;

(4) assessment of the availability of acute and long-term treatment, care, and support options in and outside the state for persons with traumatic or acquired brain injury;

(5) evaluation of the need for and scope of community services for persons with traumatic or acquired brain injury throughout the state;

(6) investigation of the models of service coordination that can be replicated at a local level in the state;

(7) coordination and expansion of publicly and privately funded residential and nonresidential acute and long-term services to persons with traumatic or acquired brain injury, including education, referral, and home and community-based services;

(8) facilitation of admissions to and discharges from acute and long-term care facilities for the treatment of traumatic or acquired brain injury;

(9) identification and description of available treatment and care facilities of all types for persons with traumatic or acquired brain injury based on length of stay, patient capacity, available services, and barriers encountered to community placement after discharge;

(10) a plan that describes recommendations for the development of a statewide service delivery continuum of comprehensive rehabilitative, supportive living, and community programs.

(c) The department shall

(1) establish and implement a traumatic or acquired brain injury

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registry of information from service providers that includes

(A) health status, including age, cause, and severity of injury and region of brain affected;

(B) acute recovery period;

(C) location of the

(i) event that caused the injury;

(ii) hospital treating the injury; and

(iii) residence of the person with traumatic or acquired brain injury;

(D) access to and use of rehabilitation services, including behavioral, vocational, and long-term care services;

(E) access to and use of neuropsychological assessment;

(F) status of long-term recovery at five-year intervals;

(G) financial and social effects on family;

(H) cost associated with services;

(2) establish standards and recommendations for improvement of prevention, assessment, treatment, and care of persons with traumatic or acquired brain injury in the state;

(3) contract with service providers and qualified entities to carry out the purposes of this section;

(4) provide a standardized reporting form for use in gathering data for the registry.

(d) In (c) of this section, "service provider" means a public or private entity that provides health education, group shelter, or criminal justice services to individuals in the state.

Sec. 47.80.590. Definition. In AS 47.80.500 - 47.80.590, "traumatic or acquired brain injury" means an insult from physical force or internal damage to the brain or its coverings, not of a degenerative or congenital nature, that produces an altered mental state and that results in a decrease in cognitive, behavioral, emotional, or physical functioning.

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SENATOR LESIL MCGUIRE

Summary of Changes Between SB 219\A and CS for SB 219\R

This document is an identification of the changes between W.O. 26-LS1312\A and W.O. 26-LS1312\R. Some of the changes between SB 219A and CS for SB 219R are based on recommendations from the Department of Health and Social Services.

Title of SB 219A is amended so that "traumatic brain injury" is replaced with "traumatic or acquired brain injury" in CS for SB 219R because the program, registry, and medical assistance coverage deals with brain injury that is not only a result of sudden trauma but also otherwise acquired through stroke, aneurism, or tumors. All other references in **SB 219A** to "traumatic brain injury" have been replaced by "traumatic or acquired brain injury" in **CS for SB 219R**.

Section 1 of CS for SB 219R amends AS 18.15.360(a)(4) to state "longitudinal data on traumatic or acquired brain injury from the registry established under AS 47.80.500(c)(1); and." This section refers to a registry established under AS 47.80.500(c)(1) in **CS for SB 219R**, which lists specific longitudinal data on traumatic or acquired brain injury that the Department of Health and Social Services is authorized to collect.

4(A) through 4(D) in **Section 1 of SB 219A** is moved to **Section 5(c)(1) in CS for SB 219R** as (A) through (H).

Based on recommendations from the Department of Health and Social Services, the **CS for SB 219R** establishes the registry under AS 47.80, which deals with Persons with Disabilities under the Welfare, Social Services and Institutions. Persons with traumatic or acquired brain injury are currently under the jurisdiction of this sub-department. Originally in **SB 219A**, the registry would have fallen under AS 18.15, which deals with Disease Control and Threats to Public Health under Health, Safety, and Housing.

Section 2 of SB 219A is moved and established in **Section 5 of CS for SB 219R**. As a result, CS for SB 219R establishes the brain injury program in Title 47 of Alaska Statute, removing the program from Title 18 as established in SB 219A. The specifications in (c)(1) and (c)(2) in **SB 219A** are deleted in the **CS SB 219R**.

CS SB 219R therefore also amends the placement of the definition of “traumatic or acquired brain injury” to AS 47.80.590 from AS 18.15.590 in **SB 219A**. The CS for SB 219R changes the definition to “an insult from physical force or internal damage to the brain or its coverings, not of a degenerative or congenital nature, that produces an altered mental state and that results in a decrease in cognitive, behavioral, emotional, or physical functioning.”

Some further clarifications are made in the CS for SB 219R, which are detailed later.

Section 3 of SB 219A is moved and established as **Section 2 of CS for SB 219R**. Section 2 of CS for SB 219R amends the bill to offer case management services for traumatic or acquired brain injury. The wording has not been changed between SB 219A and CS for SB 219 except for the use of “traumatic or acquired brain injury.”

Section 4 of SB 219A is moved and established as **Section 3 of CS for SB 219R**.

Section 3 of CS for SB 219R:

- Adds a new subsection (e)(1) in AS 47.07.030 that defines what “case management services for traumatic or acquired brain injury” means as referred to in AS 47.07.030(b).
- Amends AS 47.07.030(e) by replacing “In this section, case management services for traumatic brain injury means” with “In this section,”
- Adds subsections AS 47.07.030(e)(1)(A), which further defines case management services as “care and service coordination to assist individuals and families affected by traumatic or acquired brain injury to minimize the disabling effects of the injury;”
- Moves what was AS 47.07.030(e)(1), AS 47.07.030(e)(2), and AS 47.07.030(e)(3) in **SB 219A** to AS 47.07.030(e)(1)(B), AS 47.07.030(e)(1)(C), and AS 47.07.030(e)(1)(D) in **CS for SB 219R**.
- Adds 47.07.030(e)(2), which indicates where the definition of “traumatic or acquired brain injury” can be found in Alaska Statute.

Section 5 of SB 219A is moved and established as **Section 4 of CS for SB 219R**.

Section 4 of **CS for SB 219R** adopts the new section AS 47.07.046 as established in **SB 219A**. The CS for SB 219R adds subsection AS 47.07.046(c) which specifies that the definition of “traumatic or acquired brain injury” can be found in AS 47.80.590.

Section 6 of SB 219A is removed in its entirety. However, **CS for SB 219R** does add a subsection (b)(10) in AS 47.80.500 which suggests that the Department of Health and Social Services deliver “a plan that describes recommendations for the development of a statewide delivery continuum of comprehensive rehabilitative, supportive, living, and community programs.”

Section 5 of CS for SB 219R adds new sections to AS 47.80 that define “Article 5A. Traumatic or Acquired Brain Injury” and establish a statewide program under AS 47.80.500. The change was recommended by the Department of Health and Social Services because a traumatic or acquired brain injury registry would be better placed under AS 47.80, which deals with Persons with Disabilities under the Welfare, Social Services and Institutions.

The CS for SB 219R:

- a. Establishes that a statewide traumatic or acquired brain injury program will be covered under AS 47.80 in **CS for SB 219R**. **SB 219A** had the program under AS 18.15.
- b. Clarifies what must be included under the statewide traumatic or acquired brain injury program in AS 47.80.500(b).
 1. AS 47.80.500(b)(1) amends that the data collected under the registry can be found in AS 47.80.500 (c)(1) in **CS for SB 219R** and not AS 18.15.360(a)(4) in **SB 219A**
 2. AS 47.80.500(b)(2) in **CS for SB 219R** is now what was AS 18.15.500(b)(2) in **SB 219A**
 3. AS 47.80.500(b)(3) in **CS for SB 219R** is now what was AS 18.15.500(b)(3) in **SB 219A**
 4. The CS for SB 219R clarifies in AS 47.80.500(b)(4) that there needs to be an “assessment of the availability acute and long-term care treatment, care, and support options in and outside the state for persons with traumatic or acquired brain injury;” rather than an “assessment of the availability of acute and long term care options in and outside the state for persons with traumatic brain injury.”
 5. AS 47.80.500(b)(5) in **CS for SB 219R** is now what was AS 18.15.500(b)(5) in **SB 219A**
 6. AS 47.80.500(b)(6) in **CS for SB 219R** is now what was AS 18.15.500(b)(6) in **SB 219A**
 7. The CS for SB 219R specifies in AS 47.80.500(b)(7) that there needs to be “coordination and expansion of public and privately funded residential and non-residential acute and long-term services, which includes education, referral, and home and community-based services.”
 8. AS 47.80.500(b)(8) in **CS for SB 219R** is now what was AS 18.15.500(b)(8) in **SB 219A**
 9. Adds AS 47.80.500(b)(9), which further defines that there is more than just the traditional treatment and care facilities, which may include long-term acute care hospitals, neurobehavioral programs, neuro-rehabilitation, supportive living, clubhouse model, and home and community based services.
 10. Adds AS 47.80.500(b)(10), which describes recommendations for the development of a statewide service delivery continuum of comprehensive rehabilitative, supportive, living and community programs. This change replaces what was originally Section 6 in **SB 219A**, which developed a pilot project for a statewide traumatic brain injury program under the uncodified law of the State of Alaska.
- c. CS for SB 219R adds a new subsection AS 47.80.500(c), which calls the Department of Health and Social Services to “establish and implement a traumatic or acquired brain injury registry of information from service providers” in AS 47.80.500(c)(1)
 1. Moves what was originally AS 18.15.360(a)(4)(A), AS 18.15.360(a)(4)(B), AS 18.15.360(a)(4)(C), and AS 18.15.360(a)(4)(D) in **SB 219A** under AS 47.80.500(c)(1) in **CS for SB 219R**
 - A. Clarifies what constitutes “health status” in AS 47.80.500(c)(1)(A)

- B. Identifies “acute recovery period” in AS 47.80.500(c)(1)(B)
 - C. Adds “location of the” in AS 47.80.500(c)(1)(C)
 - i. Adds location of the “event that caused the injury” in AS 47.80.500(c)(1)(C)(i)
 - ii. Adds location of the “hospital treating the injury” in AS 47.80.500(c)(1)(C)(ii)
 - iii. Adds location of the “residence of the person with traumatic or acquired brain injury” in AS 47.80.500(c)(1)(C)(iii)
 - D. Clarifies what “access to and use of rehabilitation services” includes in AS 47.80.500(c)(1)(D)
 - E. Adds “access to and use of neuropsychological assessment” under AS 47.80.500(c)(1)(E)
 - F. Adds “status of long-term recovery at five-year intervals” under AS 47.80.500(c)(1)(F)
 - G. Clarifies “family impacts” in **SB 219A** as “financial and social effects on family” in **CS for SB 219R** with AS 47.80.500(c)(1)(G)
 - H. Adds “cost associated with services” in AS 47.80.500(c)(1)(H)
- 2. Moves what was originally AS 18.15.500(c)(3) in **SB 219A** to AS 47.80.500(c)(2) in **CS for SB 219R**
 - 3. Moves AS 18.15.500(c)(4) in **SB 219A** to AS 47.80.500(c)(3) in **CS for SB 219R**
 - 4. Adds AS 47.80.500(c)(4), which calls the Department of Health and Social Services to “provide a standardized reporting form for use in gathering data for the registry”
- d. Adds AS 47.80.500(d) which establishes the definition of “service provider” mentioned in AS 47.80.500(c)

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: CSSB219(HSS)
() Publish Date: _____

Identifier (file name): SB219CS(HSS)-DHSS-SDMS-2-12-10 Dept. Affected: Health & Social Services
Title Traumatic Brain Injury: Program/Medicaid RDU Senior and Disability Services
Component Senior and Disability Medicaid Services
Sponsor McGuire
Requester Senate HSS Component Number 2662

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURE								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims	1,272.0		1,221.0	1,230.0	1,239.0	1,248.0	1,257.0	
Miscellaneous								
TOTAL OPERATING	1,272.0	0.0	1,221.0	1,230.0	1,239.0	1,248.0	1,257.0	

CAPITAL EXPENDITURE							
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CHANGE IN REVENUES							
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	777.4		610.5	615.0	619.5	624.0	628.5
1003 GF Match	494.6		610.5	615.0	619.5	624.0	628.5
1004 GF							
1005 GF/Program Receipt							
1037 GF/Mental Health							
Other Interagency Receipt							
TOTAL	1,272.0	0.0	1,221.0	1,230.0	1,239.0	1,248.0	1,257.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if nece:

SB 219 requires the Department of Health & Social Services (DHSS) to establish a traumatic or acquired brain injury (TABI) program and to provide Medicaid coverage for TBI services.

Section 2 amends the Medicaid statutes to include case management services for individuals with TABI to the list of optional Medicaid services. The provision adding TABI case management services to Alaska's optional Medicaid services has the potential to increase Medicaid utilization. This would necessitate an amendment to the state Medicaid Plan.

(continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Division Health Care Services

Phone 269-7827
Date/Time 2/3/10 1:00 PM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Date 2/12/2010

ANALYSIS CONTINUATION

Assumptions:

The Alaska Brain Injury network estimates approximately 1,300 new hospital discharges per year due to TABI. The department estimates approximately 20% of new TABI discharges would be on Medicaid, which is the same prevalence of Medicaid enrollees in the general population. Also the number of new TABI cases is expected to grow with the population at 1% per year.

$1,300 * 0.20 = 260$ new cases in FY11

$260 * 1.01 = 262.6$, rounded to 263 new cases in FY12, and so on

Case management services, based on an examination of similar services covered by Medicaid, is estimated to cost \$250/month for new TABI cases.

New Case Cost for FY12: $263 * (12 * 250) = 789,000$

In addition, there were approximately 9,200 hospital discharges due to TABI from 2001-2007 and it is estimated that 30% of these discharged individuals are still living with TABI related effects. It is estimated that 30% of people living with disabilities or effects from past TABI (existing cases) are currently on Medicaid. This estimate is somewhat higher than the general population due to a higher prevalence of disability, unemployment and lower income in this group.

$9,200$ past discharges * 0.30 living with effects from TABI = $2,760$

$2,760 * 0.30$ on Medicaid = 828 existing TABI cases

It is expected that approximately half of those cases would continue services. For existing cases - Medicaid currently has about 100 persons on waiver due to TABI (see below).

$828 - 100$ on waiver = 728

This would mean approximately 360 existing cases using case management services in FY11. Although it is anticipated that in the first year there would be a higher demand for services that in following years meaning an additional 50 cases in FY11. Future years the demand would level at about 360 continuing cases each year.

It is estimated that these existing cases would use services, but at a lower level than new cases, so \$100/month for 12 months.

Continuing Case Cost for FY12: $360 * (12 * 100) = 432,000$

Total FY12 Case Management Costs Estimate: $432,000 + 789,000 = 1,221,000$

For 2011, Title XIX services are expected be reimbursed at 61.12%, in further years, the federal reimbursement rate is estimated at 50%.

The department will also be required to either develop a new TBI Medicaid waiver or modify an existing waiver to accommodate the needs of TABI survivors. Federal regulations require that in order for individuals to be eligible for home- and community-based waivers, they must meet the state's criteria as needing an institutional level of care. Currently, those individuals with TABI who meet this level of care are already being served under the current waiver program. As of February 1, 2010 that number is 102 individuals. An increase in the cost of waiver service is not expected with this bill.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: CSSB219(HSS)
 () Publish Date: _____

Identifier (file name): SB219CS(HSS)-DHSS-SDSA-2-12-10 Dept. Affected: Health & Social Services
 Title Traumatic Brain Injury: Program/Medicaid RDU Senior and Disabilities Services
 Component Senior and Disabilities Services-
 Sponsor McGuire Administration
 Requester Senate HSS Component Number 2663

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING								

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES (
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

This bill will establish a Traumatic or Acquired Brain Injury (TABI) Registry, establish a TABI case management program within the Division of Senior and Disabilities Services, and add case management services for people with TABI to the list of optional Medicaid services available in Alaska.

Two positions are required: a TABI Program Manager who will supervise data collection and analysis, coordinate services to people with TABI, evaluate standards and laws related to TABI, assess the availability of and evaluate acute and long-term care community services, investigate model community services, and coordinate funding of TABI care; and a Research Analyst to develop procedures for the collection of TABI information statewide, design and present statistical data, construct and modify research procedures and instruct others in their proper use.

Current resources within the Division of Senior and Disabilities Services are sufficient to meet program needs.

Prepared by: Rebecca Hilgendorf, Director Phone 907-269-2083
 Division Division of Senior and Disabilities Services Date/Time 2/10/10 1:00 PM
 Approved by: Alison Elgee, Assistant Commissioner Date 2/12/2010
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: CSSB219(HSS)
() Publish Date: _____

Identifier (file name): SB219CS(HSS)-DHSS-SDSA-2-12-10 Dept. Affected: Health & Social Services
Title: Traumatic Brain Injury: Program/Medicaid RDU: Senior and Disabilities Services
Component: Senior and Disabilities Services-
Sponsor: McGuire Administration
Requester: Senate HSS Component Number: 2663

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services	172.0		172.0	172.0	172.0	172.0	172.0	172.0
Travel	6.0		6.0	6.0	6.0	6.0	6.0	6.0
Contractual								
Supplies								
Equipment	12.0		0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	190.0		178.0	178.0	178.0	178.0	178.0	178.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES (
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	95.0		89.0	89.0	89.0	89.0	89.0
1003 GF Match	95.0		89.0	89.0	89.0	89.0	89.0
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	190.0		178.0	178.0	178.0	178.0	178.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time	2.0		2	2	2	2	2
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

This bill will establish a Traumatic or Acquired Brain Injury (TABI) Registry; establish a TBI case management program within the Division of Senior and Disabilities Services; and expand Medicaid waivers to include TABI program participants.

Two additional positions will be required along with one-time setup costs for those positions, which include office furniture, telephone, and computer equipment. The first position, a TABI Program Manager (Range 19), will supervise the review and consideration of data collection; coordination of services to people with TABI; evaluation of standards and laws related to TABI; assessment and availability of acute and long-term care evaluation of available community services; investigation of model community services; coordination of funding of TABI care; facilitation of admissions and discharges; and identification and description of treatment and facilities for clients with TABI. The second position, a Research Analyst (Range 18), will develop forms, procedures and draft regulations regarding the collection of TABI information statewide; design and present statistical data; construct and modify research procedures and instruct others in their proper use. There are also annual travel costs associated with the work of this program. Federal funding for this position is 50% of total expenses. The salary and benefits for the two additional position totals \$172.0.

Prepared by: Rebecca Hilgendorf, Director Phone 907-269-2083
Division: Division of Senior and Disabilities Services Date/Time 2/10/10 1:00 PM

Approved by: Alison Elgee, Assistant Commissioner Date 2/12/2010
DHSS Finance & Management Services

FISCAL NOTE

**STATE OF ALASKA
2010 LEGISLATIVE SESSION**

Fiscal Note Number: _____
 Bill Version: SB 258
 () Publish Date: _____

Identifier (file name): SB258-CED-INS-2-11-10
 Title: Dental Care Insurance
 Sponsor: Senator Huggins
 Requester: Senate Health and Social Services Committee
 Dept. Affected: DCCED
 RDU: Insurance
 Component: Insurance
 Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES ()								
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: None

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

This bill would prohibit health care insurers that provide dental care coverage from setting a minimum age for receiving dental care coverage, allow those insurers to set a maximum age for receiving dental care coverage as a dependent, and prohibit those insurers from setting fees that a dentist may charge for dental services not covered under the insurer's policy.

The department does not expect additional operating expenses as a result of this legislation.

Prepared by: Linda Hall, Director
 Division: Insurance
 Approved by: Emil Notti, Commissioner
Department of Commerce, Community and Economic Development

Phone 907-269-7900
 Date/Time 2/11/10 9:30 AM
 Date 2/11/2010

SUPPORTING DOCUMENTS RECEIVED FROM:

1. St. Elias Specialty Hospital
2. Alaska Statewide Independent Living Council, Inc.
3. Sean Murphy

~~1. St. Elias Specialty Hosp.~~

4. The AK MENTAL Health
Trust



January 29, 2010

1

The Honorable Lesil McGuire
Alaska State Capitol
Room 125
Juneau, Alaska 99801

Dear Senator McGuire,

Thank you for introducing Senate Bill 219, which establishes a traumatic or acquired brain injury program registry within the Department of Health and Human Services, and also relates to the medical assistance coverage for traumatic or acquired brain injury services.

At St. Elias Specialty Hospital, we treat and assist many patients who are affected by brain injury. Our patients' stories are personal to them and to us; but the outcomes of their injuries effect us all. Frequently, many patients who have suffered from a brain injury come to St. Elias on a ventilator and are unable to speak, eat, or walk. We have been fortunate to be able to watch many patients walk out of the hospital. Others have suffered injuries too significant and are not that lucky. We are very concerned about the resources available to our patients after they leave St. Elias.

We, at St. Elias, support SB219 because it would provide a mechanism for better tracking of the traumatic brain injury (TBI) patients in Alaska. We also feel that it would identify what services are lacking for patients post hospital discharge. This bill would create a more public awareness of the increasing numbers of Alaskans living with TBI, who may not be receiving the necessary help for their condition. Sadly, due to lack of rehabilitative services, many of our patients and families have been forced to leave the state for much needed long term rehabilitative services. We think Senate Bill 219 would combine all entities including profit, not for profit, military, and native to better serve all Alaskans. Possibly, the outcome would be an inpatient rehabilitation unit that would serve all Alaskans.

St. Elias Specialty Hospital is expanding its programs to better serve patients with traumatic and acquired brain injuries; however, we believe Senate Bill 219 could help us provide a better discharge plan for our patients with brain injury so they can continue their recovery and lead productive lives.

Senate Bill 219 would also help identify TBI patients who need early treatment. This in turn may reduce future medical and social costs and would help TBI patients integrate into the community positively as active and participating Alaskans.

Senator McGuire, thank you for your consideration and introduction of this bill. It is vital to the hospitals, our state, and most importantly, our patients.

Sincerely,

Sharon Kurz, PhD
Chief Executive Officer
St. Elias Specialty Hospital

**ALASKA STATEWIDE INDEPENDENT LIVING
COUNCIL, INC.**

2

February 1, 2010

The Honorable Lesil McGuire
Alaska State Capitol, Room 125
Juneau, Alaska 99801



1057 W. Fireweed Lane, Ste. 206
Anchorage, AK 99503

Toll Free 1 888 294 7452
Phone 907 263-2092, 2011
Fax 907 263-2012

Dear Senator McGuire,

Thank you for introducing SB 219, the act which relates to medical assistance coverage for traumatic or acquired brain injury services and which will establish a traumatic or acquired brain injury program and registry within the Department of Health and Social Services.

The State Independent Living Council (SILC) is comprised of Alaskans, a majority of whom have disabilities, and who are appointed by the Governor to promote the philosophy of independent living, including a philosophy of consumer control, peer-support, self-help, self-determination, equal access, and individual and system advocacy in order to maximize opportunities for individuals with disabilities, and the integration and full inclusion of individuals with disabilities into the mainstream of society.

The program supports four Centers for Independent Living (CILs). These Centers provided a wide array of services in 2009 to 3,828 Alaskans with disabilities and seniors who seek to live independently in their communities. Many of those Alaskans have sustained traumatic or acquired brain injuries and are in desperate need for services to become available in Alaska that can be tailored to their individual circumstances.

The SILC is very supportive of SB 219, which will streamline services delivered by the State of Alaska by helping families with TBI better access services and supports. The bill directs the Department of Health and Social Services to assess both the needs of individuals with TBI and the state capacity for services based on data collected. This will ensure any planned services and supports are targeted to meet needs effectively and economically.

SB 219 facilitates and links services from hospital to home and community in order to ensure that individuals have resources necessary to live independently in their homes. It will allow for them to return to work, thus diverting them from more expensive alternatives.

SHB 219 will help people in the community access case management services, which will, in turn, promote better access to TBI services. Case managements helps to support families and individuals with TBI by bringing resources together and avoiding potential duplication of efforts across agencies.

SB 219 provides many benefits to the State of Alaska. It positions the state to potentially access a federal funding stream for TBI services. The bill would give the Department of Health and Social Services the authority to access Medicaid funds for TBI, thus maximizing resources.

The Statewide Independent Living Council appreciates your ongoing support of this important legislation. Please let us know if there is anything we can do to promote swift passage of this bill.

Sincerely,

Andra Nations
Executive Director

Esther Cha

From: Murphy, Sean [Sean.Murphy@asrcenergy.com]
Sent: Wednesday, February 03, 2010 2:04 PM
To: Esther Cha
Cc: jill@alaskabraininjury.net
Subject: SB 219
Attachments: TBI Accident.pdf

Sean & Dee Murphy
5745 Greece Dr.
Anchorage, AK 99516
Feb 3rd, 2010

3

The Honorable Lesil McGuire
Alaska State Capitol, RM 125
Juneau, Alaska, 99801

Dear Senator Lesil McGuire:

First, I would like to thank you for introducing SB 219: An Act establishing a traumatic or acquired brain injury program and registry within the Department of Health and Social Services; and relating to medical assistance coverage for traumatic or acquired brain injury services.

My name is Sean Murphy and I am recovering from a traumatic brain injury from a skiing accident two years ago at Whistler/Blackcomb B.C. I hit a tree at nearly 30 MPH head first, thankfully I was wearing a helmet and the recovery process could have been much worse. I was air lifted down the mountain to the clinic at W/B where they kept me on life support until the second air medivac was available to transport me to Vancouver General Hospital. Three days later I awoke from my coma and my wife realized she would have to raise another child (husband) since I could not talk, walk or even feed myself.

SB 219 gives the Department of Health and Social Services many specifics to help address issues related to TBI which are all necessary here in Alaska. However, the main reason for writing you today is not for me or the treatment and support from my injury; but the needed support for family members dealing with TBI patients. TBI patients often have emotional issues that impact the entire family. It was extremely difficult to obtain any information, a single agency to assist in identifying resources, support groups, etc. would have been most beneficial for families in this situation.

As I found out weeks or understood months later, was the amount of stress that my wife had to endure. From first, being out of the country, then in Seattle and then again in Anchorage my wife had to continually start the processes over again to get me needed treatment. Again, having case management services to assist would have been extremely helpful in finding a neurologist, physical therapist, and the resources needed to aide in the recovery process. While researching these types of injuries, my wife and I noticed that the majority of states have facilities to assist people in obtaining the information and contacts needed. We could not find this in the state of Alaska. With the many outdoor activities and amount of highway accidents in Alaska we were surprised to find that this was the case.

Sincerely,

Sean Murphy



My husband Sean and I spent a week in Whistler/Blackcomb, BC. Sean was skiing expert terrain all week. On the last day of the trip, he and his buddies stopped for a bowl of soup before heading home. After lunch, he got into his skis and picked a casual groomed ski trail to head down the mountain. He was the first one back in his skis as they started down the mountain. When his friends started down the trail, they saw him veer across the trail over an embankment into the tree line. To this day, having lunch is the last thing that he remembers. They both called down to see if he was ok, when he doesn't respond, one friend came down to check on him and found that he was not conscious. The second friend began stopping others for assistance. A doctor and nurse happened to ski near the accident and began CPR and a ski instructor stopped and contacted ski patrol. Ski patrol arrived within minutes and provided an open airway and artificial respiration while packaging Sean for transport to a helicopter arriving. We believe that due to preparation for the Olympics, the response time of the ski patrol and helicopter was extremely quick, within minutes, Sean was transported to the clinic at the base of the mountain, examined and prepped for another helicopter ride to Vancouver General Hospital.

Our friends and I packed and drove from Whistler to Vancouver only to discover that he had still not awoken and they might have to drill into his brain to release some of the pressure due to swelling caused from severe bruising and 8 sub dermal hematomas. The good news was that after a full body CAT scan to determine the extent of his injuries, other than the head injury, he had a broken finger. After three unconscious days in the ER Sean finally came out of a coma. The doctors asked if he knew what happened, he shook his head no, he asked if he knew who was next to him. All he could do was say wife, but that was more than enough considering we were told that his long term memory would probably be affected by the injury.

On the evening of the third day, Sean was transferred to the Neurological Intensive Care Unit. He was unable to speak coherently, sit up, walk, and other basic motor functions. The doctors informed me that the recovery process would more than likely take months and that we would need to stay in Vancouver until the pressure on his brain decreased considerably and he was able to walk with assistance. The Neurologist stated that if he hadn't been wearing a helmet he would not be here today. In fact, his helmet was used during several meetings to encourage the use of helmets with the staff at VGH.

Sean began the process of recovery, and I began the process of notifying employers and family of our situation. Luckily for me, two of the friends that were on vacation with us offered to stay in Vancouver for support. I was surprised to find out that Canada does not accept health insurance, so having to figure out how to pay for this care, and my stay in Vancouver and trying to keep our daughter from knowing how serious the injury was since she was alone in Anchorage was almost more than I could tolerate. To this day, I cannot thank our friends enough who stayed with us in Vancouver.

The days following consisted of me massaging his legs and arms, little stretches to keep him from stiffening up and numerous trips to the nurse's station trying to reach the Doctor for an update. I was told that he did not see patients during visiting hours because time was allotted for surgeries. The only care provide for the first two days in NICU were hourly vitals check by the nursing staff and my attempts to do stretches with him lying in bed. After 3 days in the NICU, and dozens of requests to see the doctor, he finally stopped in to provide an update. He stated that the bruising was improving, but had not decreased enough for air travel and that air travel could cause further damage to his brain. I asked about road travel so that we could get back to the US, he indicated that since he was barely able to feed himself, had not walked yet, and could not speak more than a word or two when responding to questions, that we needed to realize that long term hospital care and physical therapy was required. I asked when physical therapy would begin, and he indicated that the physical therapist would be by to see us that day.

I increased our efforts to get him to do more on his own. I asked that he feed himself; even though he wore more of the food then he ate. I got him to stand next to the bed with me and our friend on either side to see if he was able. He was not able to take a step or stand on his own, but it strengthened my resolve to get him walking again. Later that date, the PT examined Sean and gave us stretches that we could do to help him improve and that we could attempt to get him to stand periodically throughout the day. We followed the regiment for two days, than were given approval to see if he could walk. We began walking him to the restroom, which was only about 8-10 steps from the bed. The following day the Physical Therapist was surprised to see how much he had improved. Much less food on his clothes, able to speak short sentences and could walk with assistance to the restroom. She then gave us permission to walk the halls as long as our friend and I were with him at all times. We began this trek immediately after she left and continued every hour if he was awake. Day 8, he can walk two times around the NICU floor and we attempt the stairs without the PT's knowledge. He was able to take two steps. We continued to walk as often as possible so that he could build up his strength and improve his balance. The following day, I asked that he be examined again to see if the bleeding and swelling had gone down. It had, I then ask the PT if we can attempt the 5 steps so that we could travel to Washington by car. Sean climbed 5 stairs with Danny and me on either side. The PT consulted with the doctor and they gave us authorization to travel to Washington after resting at the hotel for 1-2 days to ensure that he is able to travel. I asked that they provide a CD of his cat scan and all medical records; they indicated that they would fax the reports to the doctor in Seattle and would provide the CD prior to checkout. So with a stop by accounting, I paid the bill by check and credit card. (I had contacted our credit card company earlier in the week and told them of the situation. They agreed to increase our limit enough to cover the hotel and hospital bill). Sean rested in the hotel and our friends from Seattle came to pick us up. I felt we were one step closer to getting home.

In Seattle, I made numerous calls to Neurologists, but none would take a new patient without a referral. After several calls to Vancouver General and little success in

getting help, our friend Jane said she had an appointment and we could go with her, so we did. We explained to her doctor why we were crashing Jane's appointment, and to our surprise, she examined Jane in 10 minutes and the remainder of the appointment was Sean's. She was astounded that this accident was less than two weeks prior and immediately contacted a Neurologist that she knew and had an appointment for Sean the following day. Again, we were told that it would be several weeks before we could travel and were surprised that we were given approval to leave Vancouver as there were still several areas still swollen and bleeding on the brain. Three times a week, Sean and I went to see the Neurologist. They worked motor skills and did brain teasers and each visit seemed to be better than the last. At the end of the third week, we were given the green light to travel home to Anchorage.

I thought the process would be much easier in Anchorage, only to find out we had to start the process all over again. Neurologists and Physical Therapists require a referral. We went to our family physician and were referred. My Dad agreed to come to Alaska to help care for Sean since he could not be left alone and I needed to get back to work since we had used all of our vacation time and all that could be done now FMLA, which is family medical leave without pay. Without both our incomes, this was not an option.

Sean could not be left alone, could not cook, could not take stairs on his own, etc. So I was so thankful that my Dad was with me to care for him because I needed to get back to work at least part time. As I finish this letter, I have a tough time keeping my composure, I reflect on the stress that I had to endure due to Sean's accident and the fact there wasn't someone I could talk to that understood what we were going through. The angry outburst from Sean which are typical of head injuries, the fact that he was basically having to develop mentally and physically, newborn through adult hood all over again.

After two years, there are still outburst, but they are less frequent, and his short term memory has been affected where he must keep more detailed notes. But on a positive note, the recovery was much quicker than anyone thought it would be and physically he is in the best shape of his life. He is running under 6 minute miles now and he continues to improve emotionally, mentally and physically.

The TRUST

The Alaska Mental Health Trust Authority

February 10, 2010

The Honorable Lesil McGuire
Alaska State Senate
Alaska State Capitol, Room 125
Juneau, Alaska 99801

Re: **Letter of Support for SB 219**

Dear Senator McGuire,

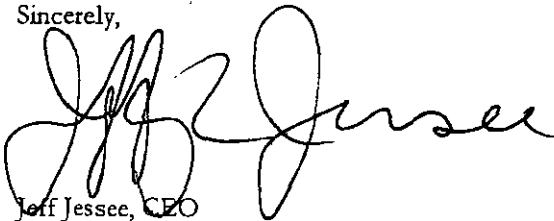
The Alaska Mental Health Trust Authority (The Trust) is pleased to support SB 219, an act establishing a traumatic or acquired brain injury program and registry within the Department of Health and Social Services (DHSS); and relating to medical assistance coverage for traumatic or acquired brain injury services. This bill is a significant step forward and will bolster the existing statewide efforts of a diverse and active committee which has been focused on brain injury services for several years.

The Trust is a state corporation that administers the Alaska Mental Health Trust, a perpetual trust managed on behalf of Trust beneficiaries who include individuals with mental illness, developmental disabilities, chronic alcoholism and those with dementia or other related disorders; many also have a co-occurring traumatic brain injury. Our goal is to partner with the Department of Health and Social Services as well as other state departments and branches of government, as a catalyst for change towards the improvement in Alaska's mental health continuum of care. The Trust has and will continue to partner with DHSS and the aforementioned statewide committee to ensure a system of care for Alaskans with brain injuries is developed.

It is an unfortunate reality that Alaska has one of the highest rates of TBI in the country. Upwards of 800 Alaskans are seriously injured or die from a TBI annually. It is estimated that at least 10,000 Alaskans are currently living with TBI in our communities, some with support services, most undoubtedly without. This bill will assure the development and implementation of services for Alaskans with brain injuries; specifically, it provides direction to the Department of Health and Social Services to assess prevalence, service gaps, and the development services in a targeted, effective, and fiscally responsible manner. Thereby, increasing and improving access to much needed services and supports for these Alaskans. Furthermore, this bill places the State of Alaska in position to access federal dollars for payment of these services through grants and Medicaid.

The Trust appreciates your leadership on this very important issue. Please let us know if there is anything we can do to further support your efforts and the successful passage of this bill.

Sincerely,



Jeff Jessee, CEO





3745 Community Park Loop, Ste. 140
Anchorage, Alaska 99508
office: (907) 274-2824 fax: (907) 274-2826
www.alaskabraininjury.net

The Honorable Lesil McGuire
Alaska Senate
Alaska State Capitol, Rm 125
Juneau, Alaska 99801

Dear Senator McGuire,

Thank you for introducing SB219, the act which relates to medical assistance coverage for traumatic or acquired brain injury services and which will establish a traumatic or acquired brain injury program and registry within the Department of Health and Social Services.

The Alaska Brain Injury Network, Inc (ABIN) is a non-profit organization dedicated to Alaskans whose lives have been changed by brain injury. ABIN's eighteen member board represents all regions of Alaska and at least 50 percent are TBI survivors or family members.

The primary ABIN mission is to educate, plan, coordinate, and advocate for a comprehensive service delivery system for the survivors of traumatic brain injury and their families. ABIN also serves as a statewide resource navigation agency specializing in information and referral for brain injury services and supports available in Alaska. ABIN has heard from 600 Alaskans requesting brain injury services since 2007. In addition, ABIN has heard public testimony from hundreds of Alaskans from Anchorage, Juneau, Fairbanks, Kenai, Barrow, Nome, Kodiak, Dillingham, Bethel, Copper River Basin, Tok, Ketchikan, Sitka, and more.

In the past several years, ABIN has worked collaboratively with the State of Alaska, Alaska Mental Health Trust Authority, the Alaska Native Tribal Health Consortium, Alaska Federal Health Care Partnership, major hospital providers, community providers, and many more agencies to coordinate the development of brain injury services in Alaska. We have coordinated meetings with these agencies to identify:

1. the services we have available in the State,
2. the services we do not have available,
3. which providers have the capacity to develop different segments in the continuum of care,
4. barriers; and
5. solutions for the development of this care.

The agencies participating and the findings are depicted in a document titled "Demonstrating the Need for Community-Based Rehabilitation."

Barriers to treating brain injury include:

- Brain injury as a medical condition versus a long-term condition: Patient often enters an injury-based medical model to treat what may become a manageable, chronic condition.
- Post-acute/Treatment/Rehabilitation funding for those who are Medicaid eligible: Currently, Medicaid funding is available for acute care, but does not cover brain injury specialty residential and day programs, often resulting in a higher level of care (more expensive) than what is needed.
- Workforce capacity- Alaska is too small of a state, with a strong yet limited workforce, to support separate brain injury systems of care in each service sector: military, tribal, and civilian.

- Screening/assessment in all state programs and primary care clinics- appropriate identification begins with screening and then assessment. Behavioral Health is the only state program that includes brain injury screening questions.

SB219 provides many direct and indirect opportunities to resolve these barriers:

- Creates longitudinal data on persons with brain injury to identify demographics, cause of injury, severity, diagnosis, treatments, medical and social costs which will help determine future policy and budget recommendations.
- Increases access to case management for those who are Medicaid eligible.
- Evaluates the need for and scope of acute, post-acute, long-term, and community treatment, care, and supports.
- Positions the state to identify the best 'menu' of brain injury services to include under a Medicaid Waiver.
- Positions the state to access federal funding for TBI services and for targeted case management.
- Encourages a seamless transition from acute settings to transitional and community settings.
- Establishes standards and recommendations for improvement of prevention, assessment, treatment, and care.

Indirect Opportunities

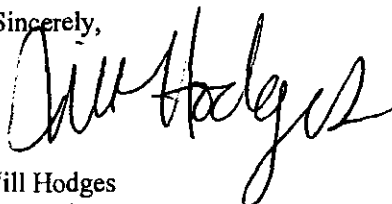
- Many Alaskans with undiagnosed or unrecognized brain injury currently access State of Alaska services and supports. The T/ABI program encourages screening and identification, as well as development of and access to appropriate treatment.
- A T/ABI program may create cost savings in acute care costs and existing state programs budgets, including behavioral health, juvenile justice, corrections, homeless initiatives, and long-term care in institutional facilities.
- Research shows, Medicaid funding specifically for brain injury services supports the growth of community-based rehabilitation programs (residential and day programs).
- Provides framework for the Department of Defense (DoD), Alaska Veterans Affairs Health System, Alaska Tribal Health System, State of Alaska, and private/non-profit entities to coordinate planning and implementation of rehabilitation and community re-entry programs.
- Development of these programs increases access for all Alaskans with a variety of pay sources, including insurance, private pay, and federal health care.
- Research shows early treatment and access to appropriate brain injury services may reduce future medical and social costs.

The Alaska Brain Injury Network has worked diligently to create a 'framework' for successful development of a seamless system of care for Alaskans with brain injury, including the development of a comprehensive plan and the coordination of the many key providers that will build the system. The State of Alaska T/ABI program will be the 'foundation' that will allow the 'entire state system' to develop and grow. The State T/ABI Program, the 'foundation', is the first step to resolving the barriers, so providers can act, and Alaskans will have an opportunity for a more successful and positive life.

The Alaska Brain Injury Network appreciates your ongoing support of this important legislation.

Our organization is made up of many professionals, providers, and specialists. If you have any questions I would be happy to answer them or connect you to someone with that knowledge.

Sincerely,



Jill Hodges
Executive Director

Rutgers Centers for State Health Policy, Issue Brief: A Survey of Medicaid Brain Injury Programs, March 2008

State	Waiver year ending	Number Serviced	Expenditures (GF and Federal match)	Annual Per Capita Costs	Average Length of Stay	Per Diem Costs
New York	2006	1953	\$79,029,120	\$40,465	310	\$131
Illinois	2006	3,601	\$42,541,226	\$11,814	264	\$45
Connecticut	2006	344	\$25,691,011	\$74,683	305	\$245
Wisconsin	2006	334	\$20,095,110	\$60,165	351	\$171
New Jersey	2006	276	\$18,374,797	\$66,575	329	\$202
South Carolina	2006	497	\$12,247,128	\$24,642	338	\$73
New Hampshire	2006	140	\$11,487,626	\$82,054	332	\$247
Iowa	2006	825	\$10,883,459	\$13,192	296	\$45
Colorado	2006	293	\$9,027,736	\$30,811	247	\$125
Pennsylvania	2005	152-324	\$6,897,762	\$45,380	285	\$159
	2005	98	\$6,532,587	\$66,659	285	\$234
Kansas	2006	269	\$6,289,071	\$23,379	242	\$97
Florida	2006	283	\$5,903,410	\$20,860	316	\$66
Massachusetts	2006	90	\$4,883,813	\$54,265	315	\$172
Wyoming	2006	137	\$3,940,878	\$28,766	297	\$97
Indiana	2006	131	\$3,390,758	\$25,884	355	\$73
Utah	2006	91	\$2,079,141	\$22,848	333	\$69
Maryland	2006	23	\$1,489,321	\$64,753	255	\$254
Idaho	2006	19	\$1,133,542	\$59,660	354	\$169
North Dakota	2006	29	\$797,371	\$27,496	315	\$29
Nebraska	2006	26	\$733,247	\$28,202	335	\$84
Vermont	2006	68		\$5,500/month	no data	
Alaska	2008	15	\$0.00			

\$150,000 FY10 MHTAAR for brain injury case management-DHSS SDS Administration

Blue states have been identified has Waiver programs that may meet Alaska's needs (more up to date funding levels needed)

Yellow areas are Waiver programs that have a rehabilitation focus and long-term care option



Attachment: ABIN Letter of Support for SB 219/HB 328

Why brain injury begins as an emergency medical condition and often becomes a social catastrophe?

Several decades ago brain injury was viewed solely as a medical condition, more specifically a life or death injury. Because of the advances in emergency medical services and intensive/acute care, more people are surviving very severe brain injuries. These advances have created an entire new system of care, a brain injury continuum of care. This system of care is essential because of the long-term cognitive effects caused by the injury. After 30 years of state and federal government recognition, research, and longitudinal studies, it is now understood that 'brain injury begins as an emergency medical condition, and often becomes a social catastrophe.' Because of the potential for many different social challenges, it is essential that those who survive brain injuries receive timely, appropriate services and ongoing supports.

How did other states develop brain injury programs?

In addition to the local networking, ABIN is well connected to many state brain injury programs (public and private) outside of Alaska. Through conferences and ongoing dialogue, ABIN has learned the role legislation (in other states) has played in developing a seamless, comprehensive service system for after hospital care for brain injury. In 1980 the first appropriation for brain injury funding for case management was accomplished in Missouri. Legislation for a T/ABI program soon followed. 2005 data shows at least 44 states had a formal T/ABI program in their state government or funded brain injury specific programs.

The following is an example of the order in which legislation and funding has progressed in other states.

- Step 1: Establish a T/ABI program in statute
- Step 2: Approve general funds for case management, position state to access federal funds to expand this service to more people (targeted case management).
- Step 3: Approve a Medicaid brain injury waiver (50% Federal match)
- Step 4: Prevention and concussion management legislation.
- Step 5: Screening and case management for military

HB 328/SB 219 gives Alaska the opportunity to not only 'catch up' developmentally with other States, but it also positions Alaska to become a national leader in providing brain injury case management and treatment to rural and remote citizens across service sectors (military, tribal, civilian).

How do other states fund and sustain a T/ABI 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.¹

¹Hendrickson, L. & Blume, R. (2008). Issue brief: A survey of Medicaid brain injury programs. *Rutgers Center for State Health Policy*

Dave Eubank
9527 Victor Rd.
Anchorage, AK 99515

Good afternoon:

My name is Dave Eubank and I approve this message. A few long years ago I sustained an acquired brain injury, not to be confused with traumatic; it was pretty traumatic to me but acquired? I didn't ask for any of this but it seems as though it was required because I see life through a different set of eyes and have been blessed with a different set of values. I, as well as a host of many others, have had to work twice as hard to get back half of what I lost but I appreciate life more than twice as much so in a sense, ... doesn't that make me twice the person I once was?



Just for starters I have an awful lot of admiration for the people who are in the health care industry for the support, care, and understanding they provide to others who are less fortunate than you. The T.B.I. Resource Navigator allows access to monitor a wealth of information for this silent minority. The DHSS provides additional funding for thankful services to a thankful people. I am not thankless; I am thankful, I am thankful I do not require such needful things but I know. I know exactly what it's like to be on the inside looking out and I know exactly what it's like to have the ability to absorb the incoming information but not having the capability to process it and I know exactly how frustrating that can be and for some people there is no way out and I know that too.

You see, once upon a time, in a land far, far, away, I collapsed as the result of a life threatening, death defying, brain aneurysm; grade 5. You name it and I did not have it but in comparison to what I had lost, I have gained a whole lot more and what it was that I really lost, really was not even worth having and I am thankful for the things I have gained rather than being resentful over the things I have lost but it literally turned my life upside down yet here I am ... 10 years post, standing right side up and sitting right side down, still there are an awful lot of questions and *not* many answers; however:

Would a T.B.I. Care Coordinator have been helpful in my own recovery? Absolutely! We all have to crawl before we can walk and we seem to forget all about that but not me because in the bitter end of this past century I tried to walk before I could crawl and I fell flat on my face. But when I went down, I got up and when I got up, I woke up, and when I woke up, I got a grip and I can see much more clear this second time around but instead of taking my life, it gave me a life *however*; I may have gotten it a whole lot quicker with a T.B.I. Care Coordinator.

Would the funding for T.B.I. Care Coordination and Case Management have been helpful in my situation? Absolutely! I as well as a host of many others often felt like beating my head up against a brick wall but soon discovered that there was nobody home but suddenly on one bright, sunny, and cheerful summer day, a light bulb went off, BING!!! And as I wondered my way through this maze of uncertainty, I realized that I could not change people. I could not change anything about them. The only thing I could change was *myself* and when I changed myself? Poof!!! It was magic because I would change the perception of how others perceived me. A T.B.I. survivor is scarred for life and even though it may not be the kiss of death, there is a distinction and it is *not* a real good one but, ... *By choosing the path of least resistance and combining the elements of good with that of the bad, you rise above the distinguished height of an unjust society and you still embrace it* (Martin Luther King).....and yet it works.

Do I have any regrets on how I've approached and sidestepped the obstacles that have obstructed my most difficult challenges? Absolutely not! Very few of us get out of here alive without being rudely slammed down by some sort of adversity but there's an old saying that adversity has a peculiar way of introducing you to yourself. Welcome to my world; we all make choices in life but I really don't know anyone who chose to walk a path which has no end and for some people there is no end but for others who wish to boldly go where many have gone before, with careful consideration of care coordination and case management there is. You probably think it's pretty easy for me to discuss this stuff; it's not easy, ... it's not easy at all. That's it, my work is done here.

Thank you

Title 47. Welfare, Social Services and Institutions.

Chapter

05. Administration of Welfare, Social Services and Institutions (§§ 47.05.010 — 47.05.390)
07. Medical Assistance for Needy Persons (§§ 47.07.010 — 47.07.900)
08. Assistance for Catastrophic Illness and Chronic or Acute Medical Conditions (§§ 47.08.010 — 47.08.150)
10. Children in Need of Aid (§§ 47.10.005 — 47.10.990)
12. Delinquent Minors (§§ 47.12.010 — 47.12.990)
14. Juvenile Programs and Institutions (§§ 47.14.010 — 47.14.990)
15. Uniform Interstate Compact on Juveniles (§§ 47.15.010 — 47.15.080)
17. Child Protection (§§ 47.17.010 — 47.17.290)
18. Programs and Services Related to Adolescents (§§ 47.18.010 — 47.18.900)
20. Special Services for Certain Children (§§ 47.20.060 — 47.20.390)
21. Adventure-Based Education (§§ 47.21.010, 47.21.020)
24. Protection of Vulnerable Adults (§§ 47.24.010 — 47.24.900)
25. Public Assistance (§§ 47.25.001 — 47.25.990)
27. Alaska Temporary Assistance Program (§§ 47.27.005 — 47.27.990)
30. Mental Health (§§ 47.30.011 — 47.30.915)
31. Mental Health Treatment Assistance Program (§§ 47.31.005 — 47.31.100)
32. Centralized Licensing and Related Administrative Procedures (§§ 47.32.010 — 47.32.900)
33. Assisted Living Homes (§§ 47.33.005 — 47.33.990)
37. Uniform Alcoholism and Intoxication Treatment Act (§§ 47.37.010 — 47.37.270)
40. Purchase of Services (§§ 47.40.011 — 47.40.120)
45. Older Alaskans (§§ 47.45.010 — 47.45.309)
55. Alaska Pioneers' Home and Alaska Veterans' Home (§§ 47.55.010 — 47.55.900)
60. Multipurpose Senior Centers (§§ 47.60.010 — 47.60.090)
62. Office of the Long Term Care Ombudsman (§§ 47.62.010 — 47.62.090)
65. Service Programs for Older Alaskans and Other Adults (§§ 47.65.010 — 47.65.290)
70. Interstate Compact on the Placement of Children (§§ 47.70.010 — 47.70.080)
75. Social Services Planning (§§ 47.75.010 — 47.75.060)
80. Persons with Disabilities (§§ 47.80.010 — 47.80.900)
90. Displaced Homemakers (§§ 47.90.010 — 47.90.070)

Revisor's notes. — The provisions of this title were redrafted in 1984 to remove personal pronouns pursuant to § 4, ch. 58, SLA 1982, and in 1984, 1990, 1995, and 2008 to make other minor word changes.

Administrative Code. — For health and social services, see 7 AAC.
For hearings, see 7 AAC 49.

Chapter 05. Administration of Welfare, Social Services and Institutions.

Article

1. General Administrative Provisions (§§ 47.05.010 — 47.05.100)
2. Oversight of Medical Care Programs (§§ 47.05.200 — 47.05.290)
3. Criminal History; Registry (§§ 47.05.300 — 47.05.390)

Title 18. Health, Safety, and Housing.

Chapter

05. Administration of Public Health and Related Laws (§§ 18.05.010 — 18.05.070)
07. Certificate of Need Program (§§ 18.07.021 — 18.07.111)
08. Emergency Medical Services (§§ 18.08.010 — 18.08.200)
10. Health Units and Districts (§§ 18.10.010 — 18.10.260)
13. Genetic Privacy (§§ 18.13.010 — 18.13.100)
15. Disease Control and Threats to Public Health (§§ 18.15.150 — 18.15.900)
16. Regulation of Abortions (§§ 18.16.010 — 18.16.090)
20. Hospitals and Nursing Facilities (§§ 18.20.075 — 18.20.390)
23. Health Care Services Information and Review Organizations (§§ 18.23.005 — 18.23.100)
25. Assistance to Hospitals and Health Facilities (§§ 18.25.010 — 18.25.120)
26. Alaska Medical Facility Authority (§§ 18.26.010 — 18.26.900)
28. State Assistance for Community Health Aide Programs (§§ 18.28.010 — 18.28.100)
31. Asbestos (§§ 18.31.010 — 18.31.500)
35. Public Accommodations and Facilities (§§ 18.35.010 — 18.35.365)
40. Shelter Cabins and Comfort Stations (§§ 18.40.010 — 18.40.070)
45. Atomic Energy (§§ 18.45.020 — 18.45.900)
50. Vital Statistics Act (§§ 18.50.010 — 18.50.990)
55. Housing, Public Buildings, Urban Renewal, and Regional Housing Authorities (§§ 18.55.010 — 18.55.998)
56. Alaska Housing Finance Corporation (§§ 18.56.010 — 18.56.900)
57. Regional Electrical Authorities (§§ 18.57.010 — 18.57.110)
60. Safety (§§ 18.60.010 — 18.60.890)
62. Certificates of Fitness (§§ 18.62.010 — 18.62.080)
63. Hazardous Painting Certification (§§ 18.63.010 — 18.63.100)
65. Police Protection (§§ 18.65.010 — 18.65.870)
66. Domestic Violence and Sexual Assault (§§ 18.66.010 — 18.66.990)
67. Violent Crimes Compensation Board (§§ 18.67.010 — 18.67.180)
68. Sexual Assault Investigations (§§ 18.68.010 — 18.68.040)
70. Fire Protection (§§ 18.70.010 — 18.70.900)
72. State Regulation of Fireworks (§§ 18.72.010 — 18.72.100)
74. Cigarette Fire Safety (§§ 18.74.010 — 18.74.290)
76. Alaska Avalanche Warning System (§ 18.76.010)
80. State Commission for Human Rights (§§ 18.80.010 — 18.80.300)
85. Public Defender Agency (§§ 18.85.010 — 18.85.180)

Revisor's notes. — The provisions of this title were redrafted in 1986 to remove personal pronouns pursuant to § 4, ch. 58, SLA 1982, and in 1986, 1991, 1994, and 2002 to make other minor word changes under AS 01.05.031.

Administrative Code. — For health and social services, see 7 AAC.

Alaska Brain Injury Network			
Alaska Scorecard and TBI Dashboard – (DRAFT)			
DRAFT #1 – May 22, 2008			
○ Getting worse		↔ Not changing	● Improving
	5-year Trend	Current Data	Source
SCORECARD: A “scorecard” provides a snapshot of the status of TBI issues in the State of Alaska			
Traumatic Brain Injury Non-fatal Incidence Rates			
TBI rate per 100,000	●	98.6	1
Causes			
Falls	○	28.7	1
Motor Vehicle Transportation Occupant	●	24.7	1
Assault	●	12.2	1
ATV	○	6.5	1
Bicycle	●	4.5	1
Snowmachine	●	4.4	1
Pedestrian	●	3.6	1
Sports	●	1.8	1
Water Transport	↔	1.3	1
Suicide Attempt	●	.8	1
Gender			
TBI percentage among males		65.4 %	1
TBI percentage among females	↔	33.2 %	1
Ethnicity			
Percentage of TBI population that is Alaska Native		34%	1.a
Percentage of TBI population that is White		53%	1.a
Percentage of TBI population that is Other; unknown, Pacific Islander, Hispanic, Black, American Indian, Asian		22%	1.a
Those at highest risk for hospitalization due to TBI (rate per 100,000)			
Males age 80+		301.3	1
Females age 80+		217.2	1
Males age 70-79		215.7	1
Males age 15-19		200.9	1
Traumatic Brain Injury Numbers			
TBI hospitalizations/year		640	1.b
TBI deaths/year		150	1.b
Est. TBI-related Emergency Department Visits		2953	2

- 1 Alaska Trauma Registry 2001-2005 – Non-fatal TBI hospitalizations
- 1.a Alaska Trauma Registry 1996-2005 – Non-fatal TBI hospitalizations
- 1.b Alaska Trauma Registry 2006 – Non-fatal TBI hospitalizations
- 2 HRSA TBI Implementation Grant

Alaska Trauma Registry records those who are hospitalized for more than 24 hours. This does not include the number of people who visit the emergency department and are sent home in the same day. This does not include the number of returning service members with traumatic brain injury.

DASHBOARD: A "dashboard" provides a way to see how well an activity is working to affect the TBI population

○ Getting worse ⇔ Not changing ○ Improving

Dashboard: Behavioral Health

TBI and Mental Health	Spot look trend	Current Data	Source
Percentage BH clients screening positive for TBI	⇔	32%	3
TBI and Substance Use			
Alcohol-related TBI 100,000		33%	1
TBI and Suicide			
Percentage of suicide victims with history of TBI		32%	4

Dashboard: Education

Special Education	Spot look trend	Current Data	Source
Number of children in Special Education statewide with TBI diagnosis (2007)	⇔	66	5

Dashboard: Justice

Corrections	Spot look trend	Current Data	Source
Percent of incarcerated Alaskans (adults) who are Trust beneficiaries, including those with cognitive disabilities		42%	6

Dashboard: Employment

Vocational Rehabilitation	Spot look trend	Current Data	Source
Number of TBI cases		167	7
Number of TBI cases closed employed		17	7
Number of TBI cases closed with plan for employment		11	7
Average wage at closure		\$12.54	7

Dashboard: Providence

ImPACT Program	Spot look trend	Current Data	Source
Number of baselines (ImPACT)		57	8
Number of student/athletes seen in program (ImPACT)		25	8
Emergency Department			
Patients given the diagnosis of "head injury" or "concussion in Emergency Department in 2006		547	8
% of TBI-related ED visits that led to hospitalizations		1%	8
% of ED visits that are Pediatric		15%	8

Dashboard: Alaska Brain Injury Network

TBI Advisory Board	Spot look trend	Current Data	Source
Est. Board Member Volunteer hours/year	⊕	1054	9
Board Member Participation in Quarterly Board Meetings		83%	9
Ex-officio participation in quarterly board meetings		65-80%	9
% of survivors/family members on TBI board		55%	9
% Board Members who give a financial contribution		100%	9
TBI Resource Navigation			
Average new consumer contacts per month	⊕	30	9
Average unique visitors/month to ABIN website	⊕	750	9
Number of people on Alaska Brain Matters Listserve	⊕	100+	9

- | | |
|---|--|
| 3 AKAIMS | 7 Division of Vocational Rehabilitation (FY07) |
| 4 Suicide Follow-back Study | 8 Providence Neuroservices |
| 5 http://www.eed.state.ak.us/stats/ | 9 Alaska Brain Injury Network |
| 6 Trust/DOC Study 07 | |

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, ready to operationalize

- 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 HB 328

SB 219 and HB 328

- 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.

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 brain injury systems development

- 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 treatment
and prepare a
specialty
workforce?

- 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



Brain injury rehabilitation and treatment is standard in many states. The following document explains two federal initiatives focusing on TBI rehabilitation research. Excerpted from: www.nashia.org/programs/federal/docs/nidrr.doc

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

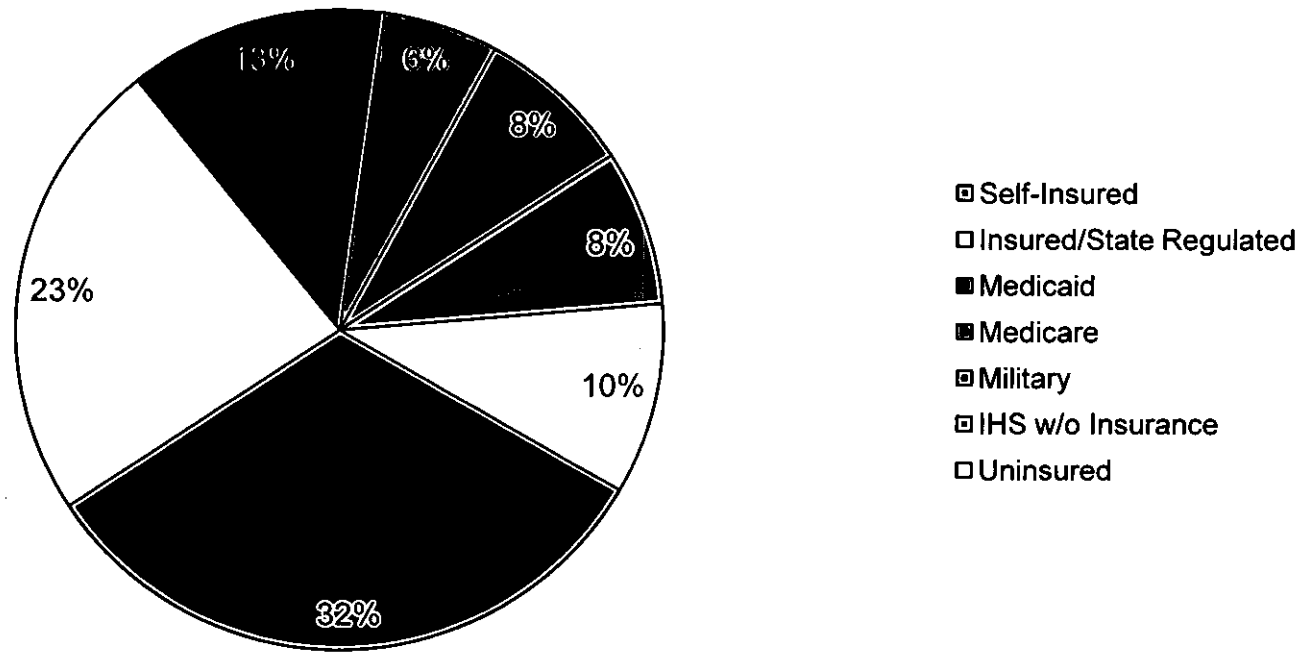
In 1987 the National Institute on Disability and Rehabilitation Research (NIDRR) in the U.S. Department of Education established the Traumatic Brain Injury Model Systems of Care (TBI Model Systems). NIDRR's multi-center model systems program is designed to study the course of recovery and outcomes following 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.

Health Coverage of Alaska Population



*Navigant 2003 Report, 2008 Population

Celeste Hodge

From: Jill Hodges [jill@alaskabraininjury.net]
Sent: Wednesday, February 03, 2010 4:20 PM
To: Celeste Hodge
Subject: RE: Alaska Brain Injury Network
Attachments: Senate_Outline for TBI Presentation to HSS.doc;
Skeleton_BrainInjurySystemsChange2010.ppt

Cancelled request will provide Public testimony on the 15th when will be scheduled for hearing

Hi Celeste, thank you for your ongoing work on this. Attached is an outline. I have also attached the power point for the presentation we are giving to House HSS this week. The Senate presentation will be a shorter version of this power point.

Jeff Jessee, CEO, Alaska Mental Health Trust
Pat Hefley, Deputy Commissioner, Department of Health and Social Services
Myself

Are all available on the 24th at 1:30. We will be prepared for a 30 min. presentation.

Past presentation focused on: What is TBI, What does treatment look like?, Military impact? (focus was to show the need to recognize TBI as an AK public health issue).

This year's presentation will focus on coordinated state efforts (Trust, DHSS, ABIN, AK providers) to improve the state system to better meet the needs of Alaskans with brain injury. It will highlight the importance of SB 219, as well as funding in the Gov. budget. The presentation focuses on solutions, roles, timeline/phases, implementation.

Equipment: computer, projector

I do have additional materials that I will send you a week before the presentation.

Jill Hodges
Executive Director

Alaska Brain Injury Network
3745 Community Park Loop #140
Anchorage, Alaska 99508

office: 907 274-2824
fax: 907 274-2826

www.alaskabraininjury.net

"Educate, plan, coordinate, and advocate for a comprehensive service delivery system for the survivors of traumatic brain injury and their families."

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Wednesday, February 03, 2010 3:20 PM

To: 'Jill Hodges'
Subject: RE: Alaska Brain Injury Network

Okay. Just checking. Thanks.

Celeste Graham-Hodge, Legislative Administrator
Office of Senator Bettye Davis - AK State Legislature
State Capitol, Rm 30, Juneau, AK 99801
T (907) 465-4906, F (907) 465-3756
716 W. 4th Ave., #400, Anchorage, AK 99501
T(907) 269-0144, F(907) 269-0148
Celeste_Hodge@legis.state.ak.us

From: Jill Hodges [mailto:jill@alaskabraininjury.net]
Sent: Wednesday, February 03, 2010 1:34 PM
To: Celeste Hodge
Subject: RE: Alaska Brain Injury Network

This was before our phone conversation, sorry for the confusion. I have sent a note to state folks to see if 24th works.

Jill Hodges
Executive Director

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Anchorage, Alaska 99508

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"Educate, plan, coordinate, and advocate for a comprehensive service delivery system for the survivors of traumatic brain injury and their families."

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Wednesday, February 03, 2010 11:13 AM
To: 'Jill Hodges'
Subject: RE: Alaska Brain Injury Network

Was this before our conversation or did you want the 15th? Let me know. Thanks.

Celeste Graham-Hodge, Legislative Administrator
Office of Senator Bettye Davis - AK State Legislature
State Capitol, Rm 30, Juneau, AK 99801
T (907) 465-4906, F (907) 465-3756
716 W. 4th Ave., #400, Anchorage, AK 99501
T(907) 269-0144, F(907) 269-0148
Celeste_Hodge@legis.state.ak.us

From: Jill Hodges [mailto:jill@alaskabraininjury.net]
Sent: Wednesday, February 03, 2010 9:37 AM

To: Celeste Hodge
Subject: RE: Alaska Brain Injury Network

Hi Celeste, we will take the 15th. Thank you.

Jill Hodges
Executive Director

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Anchorage, Alaska 99508

office: 907 274-2824
fax: 907 274-2826

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From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Wednesday, February 03, 2010 8:25 AM
To: 'Jill Hodges'
Subject: RE: Alaska Brain Injury Network

Jill,
Hello. As soon as I hear from you regarding the two dates (Feb. 8 and 15th), I'll be in a position to confirm your participation. Please let me know this morning. Thanks.

Celeste Graham-Hodge, Legislative Administrator
Office of Senator Bettye Davis - AK State Legislature
State Capitol, Rm 30, Juneau, AK 99801
T (907) 465-4906, F (907) 465-3756
716 W. 4th Ave., #400, Anchorage, AK 99501
T(907) 269-0144, F(907) 269-0148
Celeste_Hodge@legis.state.ak.us

From: Jill Hodges [mailto:jill@alaskabraininjury.net]
Sent: Tuesday, February 02, 2010 10:55 AM
To: Celeste Hodge
Subject: RE: Alaska Brain Injury Network

Hello Celeste. I know we are presenting on the 4th to the house hSS committee. I can check with Jeff and Pat Hefley to see if they are available for the Senate HSS on Monday at 1:30. I just arrived in Juneau this morning and will come by your office to catch up.

Jill Hodges
Executive Director

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"Educate, plan, coordinate, and advocate for a comprehensive service delivery system for the survivors of traumatic brain injury and their families."

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Tuesday, February 02, 2010 8:42 AM
To: 'jill@alaskabraininjury.net'
Subject: Alaska Brain Injury Network

Jill,

Hello. I'm waiting on a response from Matt regarding a joint House and Senate H&SS meeting. If we're not successful at scheduling a joint meeting. The Senate H&SS has some time on Monday, February 8th at 1:30 PM and can schedule your presentation at that time. Because there's a process for scheduling notices, I'll need to know ASAP whether this date and time works. Please let me know.

Celeste Graham-Hodge, Legislative Administrator
Office of Senator Bettye Davis - AK State Legislature
State Capitol, Rm 30, Juneau, AK 99801
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T(907) 269-0144, F(907) 269-0148
Celeste_Hodge@legis.state.ak.us

Outline for TBI Presentation to Senate HSS, Feb. 24th 1:30 committee hearing
30 min.

Presenters:

Pat Hefley, Deputy Commissioner, Department of Health and Social Services

Jeff Jessee, CEO, Alaska Mental Health Trust Authority

Jill Hodges, Executive Director, Alaska Brain Injury Network

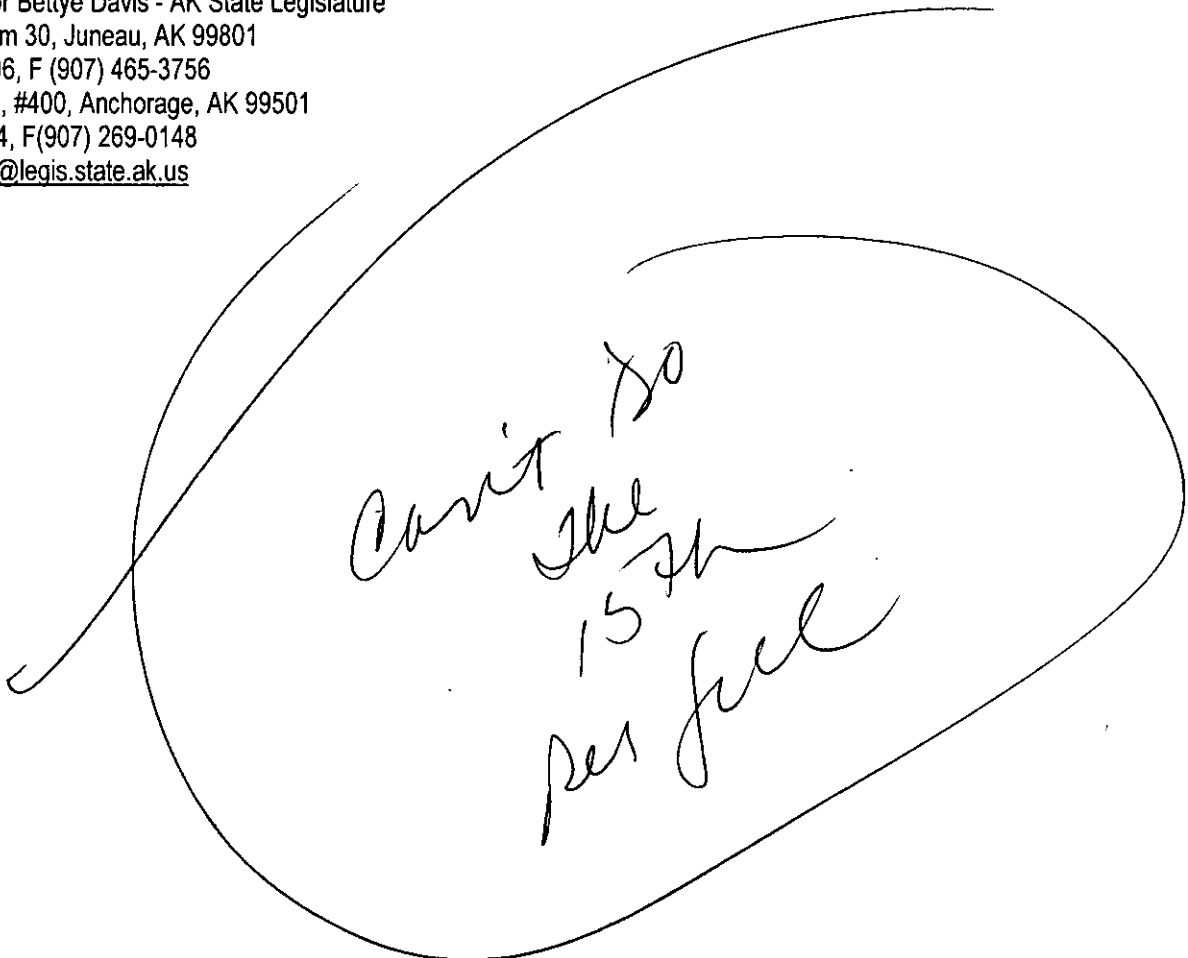
Jill Hodges	<ul style="list-style-type: none"> • Do an overview of the 30 min. presentation • Review previous presentations • Walk through phases-system capacity building last 20 years • Roles of State, Trust, ABIN, Providers, legislators • Highlight 10 Year plan, treatment gap analysis • Talk about SB 219, FY11 budget recommendation, (\$350.0 Gov. Budget) 	10 min.
Jeff Jessee	<ul style="list-style-type: none"> • 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. 	10
Pat Hefley	<ul style="list-style-type: none"> • 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. • TBI folks are in some level of care now, but need specialized type 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 	10
HSS members	Questions, Comments	

Celeste Hodge

From: Celeste Hodge
Sent: Tuesday, February 02, 2010 8:42 AM
To: 'jill@alaskabraininjury.net'
Subject: Alaska Brain Injury Network

Jill,
Hello. I'm waiting on a response from Matt regarding a joint House and Senate H&SS meeting. If we're not successful at scheduling a joint meeting. The Senate H&SS has some time on Monday, February 8th at 1:30 PM and can schedule your presentation at that time. Because there's a process for scheduling notices, I'll need to know ASAP whether this date and time works. Please let me know.

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Celeste_Hodge@legis.state.ak.us



Commit to
the
15th
per full

Celeste Hodge

*Feb 4
Joint
Request*

From: Jill Hodges [jill@alaskabraininjury.net]
Sent: Monday, January 25, 2010 11:27 AM
To: Celeste Hodge
Cc: Matthew Johnson
Subject: Request for a Brain Injury Presentation to Senate/House HSS, first week in February

Good morning Celeste, as requested, here is an email with a request for a presentation for Senator Davis's HSS committee. I have been in contact with Matt Johnson in Rep. Keller's office as well. Should a joint presentation be possible, we would welcome that as an option.

The past few years, ABIN has organized a presentation on brain injury. Topics have included: what is brain injury, how brain injury affects Alaskans, military issues, and service/program recommendations. Senator Davis had shared in previous presentations that she understands the need and would like to learn more about the solutions and strategies.

This year, we would like to do a joint presentation with Commissioner Hogan (DHSS), Jeff Jessee (Alaska Mental Health Trust Authority), and myself (Alaska Brain Injury Network, Exec. Director) so we can speak to the coordinated efforts focusing on improving the current gaps and building state systems capacity to better meet the needs of Alaskans with brain injury. We would describe the joint efforts, current strategies, barriers, and outcomes of planning and developing a state system of care for Alaskans with brain injury.

We would be interested in presenting next week. I spoke with Matt this morning and he still needs to check with his boss. (preliminary discussions have highlighted February 4th date (3pm) as an option). I have checked with Jeff Jessee and he thinks that would be a good time. Commissioner Hogan has asked that I connect with Wilda when a day/time has been decided.

I appreciate everyone's efforts and flexibility as we try to organize lots of very busy people ☺.

Email or call if you have any questions 907 250-9597.

Jill Hodges
Executive Director

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