

ALASKA LEGISLATURE COMMITTEE FILES 1985-1986 86/2

3232 HESS HB 661 - HB 678 10

AMENDED IN SENATE JUNE 29, 1984

AMENDED IN ASSEMBLY MAY 1, 1984

AMENDED IN ASSEMBLY MARCH 20, 1984

CALIFORNIA LEGISLATURE—1983-84 REGULAR SESSION

ASSEMBLY BILL

No. 2913

Introduced by Assembly Members Agnos, Alatorre, Bates, Bronzan, Willie Brown, Chacon, Farr, Felando, Filante, Hannigan, Hauser, Isenberg, Klehs, Margolin, O'Connell, Papan, Madine Waters, and Norman Waters

(Principal coauthor: Assembly Member Connelly)

(Coauthors: Senators Garamendi, Keene, Lockyer, Marks, McCorquodale, Petris, and Rosenthal; Rosenthal, and Torres)

February 13, 1984

An act to repeal and add Chapter 4 (commencing with Section 4330) of Part 2 of Division 4 of the Welfare and Institutions Code, relating to mental health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 2913, as amended, Agnos. Mental health.

Under existing law, the Director of Mental Health is required to establish a pilot project for brain-damaged persons for one year to be conducted by contract with an appropriate nonprofit community agency.

This bill instead would require the director to contract with a nonprofit community agency meeting certain requirements to act as the Statewide Coordinating Agency Resources Consultant and to also contract with nonprofit community resource agencies to establish not more than 10

~~geographically regionally~~ based ~~regional~~ resource ~~nonprofit~~ ~~community agencies~~ *centers* to provide specified services to brain-impaired adults.

This bill would appropriate \$1,700,000 for the purpose of the bill.

This bill would take effect immediately as an urgency statute.

Vote: $\frac{2}{3}$. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Chapter 4 (commencing with Section
2 4330) of Part 2 of Division 4 of the Welfare and
3 Institutions Code is repealed.

4 SEC. 2. Chapter 4 (commencing with Section 4330) is
5 added to Part 2 of Division 4 of the Welfare and
6 Institutions Code, to read:

7
8 CHAPTER 4. SERVICES FOR PERSONS WITH BRAIN
9 DAMAGE OR DEGENERATIVE BRAIN DISEASE

10
11 4330. The Legislature finds all of the following:

12 (a) That state public policy discriminates against
13 adults with brain damage or degenerative brain disease,
14 *such as Alzheimer's disease*, hereinafter called "brain
15 impairments."

16 (b) That the Legislature has declared state public
17 policy and accepted responsibility to ensure that persons
18 under the age of 18 years who are "developmentally
19 disabled" pursuant to Division 4.5 (commencing with
20 Section 4500), receive services necessary to meet their
21 needs, which are often similar to those of persons who
22 suffer from brain impairments.

23 (c) That persons over the age of 18 who sustain brain
24 impairment have a variety of program and service needs
25 for which there is no clearly defined, ultimate
26 responsibility vested in any single state agency and for
27 which there are currently a number of different
28 programs attempting to meet their needs.

1 (d) That the lack of clearly defined, ultimate
2 responsibility has resulted in severe financial liability and
3 physical and mental strain on brain-impaired persons,
4 their families, and caregivers.

5 (e) That terminology and nomenclature used to
6 describe brain impairments are varied and confusing, in
7 part because of different medical diagnoses and
8 professional opinions, as well as differences in
9 terminology used by the various funding sources for
10 programs and services. Uniformity is required in order to
11 ensure that appropriate programs and services are
12 available throughout the state to serve these persons.

13 (f) *That the term "brain damage" covers a wide*
14 *range of organic and neurological disorders, and that*
15 *these disorders, as identified below, are not necessarily to*
16 *be construed as mental illnesses. These disorders include,*
17 *but are not limited to, all of the following:*

18 (1) *Progressive, degenerative, and dementing*
19 *illnesses including, but not limited to, presenile and*
20 *senile dementias, Alzheimer's disease, multi-infarct*
21 *disease, Pick's disease, and Kreutzfeldt-Jakob's disease.*

22 (2) *Degenerative diseases of the central nervous*
23 *system that can lead to dementia or severe brain*
24 *impairment, including, but not limited to, epilepsy,*
25 *multiple sclerosis, Parkinson's disease, amyotrophic*
26 *lateral sclerosis (ALS), and hereditary diseases such as*
27 *Huntington's disease.*

28 (3) *Permanent damage caused by cerebrovascular*
29 *accidents more commonly referred to as "strokes,"*
30 *including, but not limited to, cerebral hemorrhage,*
31 *aneurysm, and embolism.*

32 (4) *Post-traumatic, post-anoxic, and post-infectious*
33 *damage caused by incidents, including, but not limited*
34 *to, coma, accidental skull and closed head injuries, loss of*
35 *oxygen (anoxia), and infections such as encephalitis,*
36 *herpes simplex, and tuberculosis.*

37 (5) *Permanent brain damage or temporary or*
38 *progressive dementia as a result of tumors (neoplasms),*
39 *hydrocephalus, abscesses, seizures, substance toxicity and*
40 *other disorders.*

1 (g) That brain damage frequently results in functional
2 impairments that adversely affect personality, behavior,
3 and ability to perform daily activities. These impairments
4 cause dependency on others for care and
5 decisionmaking. The manifestations of brain damage
6 include impairments of memory, cognitive ability,
7 orientation, judgment, emotional response, and social
8 inhibition. Brain damage can strike anyone regardless of
9 age, race, sex, occupation, or economic status.

10 (h) That Family Survival Project for Brain-Damaged
11 Adults of San Francisco, a three-year pilot project
12 established pursuant to former Chapter 4 (commencing
13 with Section 4330), has demonstrated that the most
14 successful, cost-effective service model is one which
15 allows a nonprofit community agency to provide a full
16 array of support services to families that have a member
17 who suffers from a brain impairment. This agency
18 provides direct services, coordinates existing resources,
19 and assists in the development of new programs and
20 services on a regional basis.

21 ~~(g)~~

22 (i) That respite care services provide a combination
23 of time-limited, in-home, and out-of-home services which
24 significantly decrease the stress of family members and
25 increase their ability to maintain a brain-impaired person
26 at home at less cost than other alternatives. This ability is
27 further increased when complemented by case planning,
28 care training, and other support services for family
29 members.

30 ~~(h) That providing services to brain-impaired adults,
31 their families, and caregivers requires the coordinated
32 services of many state departments and community
33 agencies to ensure that no gaps occur in communication,
34 in the availability of programs, or in the provision of
35 services.~~

36 ~~(i) That, since 1977, the department~~

37 (j) That, since 1977, the State Department of Mental
38 Health has attempted to identify service gaps and
39 determine a cost-effective, feasible approach to funding
40 and providing services to brain damaged adults, their

1 families, and caregivers. That department has the
2 experience of offering more in the continuum of
3 programs and services than any other state agency and is
4 willing to continue in the lead state agency capacity.

5 (k) That providing services to brain-impaired adults,
6 and to their families and caregivers, requires the
7 coordinated services of many state departments and
8 community agencies to ensure that no gaps occur in
9 communication, in the availability of programs, or in the
10 provision of services. Although the services may include
11 mental health interventions, they cannot be met solely by
12 services of the State Department of Mental Health.

13 4331. As used in this chapter:

14 (a) "Brain damage," "degenerative brain diseases,"
15 and "brain impairment" means significant destruction of
16 brain tissue with resultant loss of brain function.
17 Examples of causes of the impairments are degenerative
18 dementias; cerebrovascular disease and stroke;
19 degenerative diseases of the nervous system; traumatic
20 brain injury; lesions and tumors; anoxia; and infectious
21 disease. Alzheimer's disease, stroke, traumatic brain
22 injury, and other impairments described in subdivision
23 (f) of Section 4330.

24 (b) "Brain-impaired adult" means a person whose
25 brain impairment has occurred after the age of 18.

26 (c) "Respite care" means time-limited substitute care
27 or supervision in support of the caregiver for the
28 purposes of providing relief from the stresses of constant
29 care provision and so as to enable the caregiver to pursue
30 a normal routine and responsibilities. Respite care may
31 be provided in the home or in an out-of-home setting,
32 such as day care centers or short-term placements in
33 inpatient facilities.

34 4332. The director shall administer this chapter and
35 establish standards and procedures, as the director deems
36 necessary in carrying out the provisions of this chapter.
37 The standards and procedures are not required to be
38 adopted as regulations pursuant to the Administrative
39 Procedure Act (Chapter 3.5 (commencing with Section
40 11340) of Part 1 of Division 3 of Title 2 of the Government

1 Code).

2 4333. The director shall do both of the following:

3 (a) Contract with a nonprofit community agency
4 meeting the requirements of this chapter to act as the
5 ~~Statewide Coordinating Agency.~~

6 ~~(b) With the advice of the Statewide Coordinating
7 Agency and within four years from the effective date of
8 this chapter, contract with no more than 10 nonprofit
9 community agencies to establish geographically based
10 regional resource agencies in order to ensure the
11 existence of an array of appropriate programs and
12 services for brain-impaired adults. The regional resource
13 agencies shall place a high priority on utilizing Statewide
14 Resources Consultant, to be selected through a bid
15 procedure.~~

16 ~~(b) With the advice of the Statewide Resources
17 Consultant and within four years from the effective date
18 of this chapter, contract with nonprofit community
19 resource agencies, selected in a manner determined by
20 the director, to establish regionally-based resource
21 centers in order to ensure the existence of an array of
22 appropriate programs and services for brain-impaired
23 adults. The resource center shall place a high priority on
24 utilizing community resources in creating opportunities
25 for families to maintain a brain-impaired adult at home
26 when possible and in other community-based
27 alternatives when necessary.~~

28 4334. The Statewide ~~Coordinating Agency Resources
29 Consultant~~ shall do all of the following:

30 (a) Serve as the centralized information and technical
31 assistance clearinghouse for brain-impaired adults, their
32 families, caregivers, and service professionals service
33 professionals and agencies, and volunteer organizations.

34 (b) *Work closely and coordinate with organizations
35 serving brain-impaired adults, their families, and
36 caregivers in order to ensure, consistent with
37 requirements for quality of services as may be established
38 by the director, that the greatest number of persons are
39 served and that the optimal number of organizations
40 participate.*

1 (c) Develop training packages which are appropriate
2 for a variety of persons, including, but not limited to, all
3 of the following:

4 (1) Families.

5 (2) Caregivers and service professionals involved with
6 brain-impaired adults.

7 (3) Advocacy and self-help family and caregiver
8 support organizations.

9 (4) Educational institutions.

10 ~~(e)~~

11 (d) Provide service and program development
12 consultation to regional resource agencies resource
13 centers and to identify funding sources which are
14 available.

15 ~~(d)~~

16 (e) Assist the appropriate state agencies in identifying
17 and securing increased federal financial participation and
18 third party reimbursement, including, but not limited to,
19 Title XVIII (42 U.S.C. Sec. 1395 et seq.) and Title XIX (42
20 U.S.C. Sec. 1396 et seq.) of the federal Social Security Act.

21 ~~(e)~~

22 (f) Conduct public social policy research based upon
23 the recommendations of the Director of Mental Health.

24 ~~(f) Arrange for and coordinate epidemiological
25 research through subcontracting with appropriate
26 agencies such as educational or medical research
27 institutions as approved by the director.~~

28 ~~(g) Assist the director in establishing criteria for, and
29 in selecting, regional resource agencies.~~

30 ~~(h) Establish an advisory task force which will advise
31 the Statewide Coordinating Agency on matters related to
32 the implementation of this chapter. Membership on this
33 task force shall be determined by the Statewide
34 Coordinating Agency based upon recommendations
35 which may be made by the following: the Directors of
36 Mental Health, Health Services, Social Services,
37 Developmental Services, Rehabilitation, Aging, and
38 Alcohol and Drug Abuse; the Secretary of Health and
39 Welfare; the Insurance Commission; the President pro
40 Tempore of the Senate; the Speaker of the Assembly; the~~

1 Assembly Committee on Aging and Long-Term Care; the
2 Assembly Committee on Health; the Senate Committee
3 on Health and Human Services; and other relevant
4 legislative subcommittees and select committees as
5 determined by the Statewide Coordinating Agency.

6 (g) Assist the director, as the director may require, in
7 conducting directly, or through contract, research in
8 brain damage epidemiology and data collection, and in
9 developing a uniform terminology and nomenclature.

10 (h) Assist the director in establishing criteria for and
11 in selecting resource centers and in designing a
12 methodology for the consistent assessment of resources
13 and needs within the geographic areas to be serviced by
14 the resource centers.

15 (i) Conduct conferences, as required by the director,
16 for families, caregivers, service providers, advocacy
17 organizations, and educational institutions in order to
18 enhance the quality and availability of high-quality,
19 low-cost care and treatment of brain-impaired adults.

20 4335. In choosing an appropriate nonprofit
21 community agency to act as the Statewide Coordinating
22 Agency Resources Consultant, the director shall give
23 priority to an agency which meets both of the following:

24 (a) An agency which has a proven record of
25 experience in providing information, technical assistance
26 and direct services to adults with all types of brain
27 impairments, their families, and caregivers.

28 (b) An agency which includes family members and
29 caregivers of brain-impaired adults on its board of
30 directors.

31 4336. (a) The Statewide Coordinating Agency
32 Resources Consultant shall submit progress reports on its
33 activities as required by the director. These reports shall
34 include, but not be limited to, a summary and evaluation
35 of the activities of the regional resource agencies
36 resource centers. Client, caregiver, service, and cost data
37 shall be provided for each operating regional resource
38 agency resource center.

39 (b) The department, in consultation with the
40 Statewide Coordinating Agency, shall conduct an annual

1 evaluation of the effectiveness of the regional resource
2 agencies Resources Consultant, shall report to the
3 Legislature by January 1, 1987, on the effectiveness of the
4 resource centers. The evaluation shall include, but not be
5 limited to, all of the following:

6 (1) A comparative assessment of the costs and
7 effectiveness of each type of service or combinations of
8 services provided.

9 (2) An assessment of the nature and extent of the
10 demand for services which provide respite, and an
11 evaluation of their success in meeting this demand.

12 (3) An analysis of the effectiveness of the program in
13 deterring the institutionalization of brain-impaired
14 adults, allowing caregivers to maintain a normal routine,
15 and promoting the continuance of quality care for
16 brain-impaired adults.

17 (4) Recommendations for ensuring that unmet needs
18 of brain-impaired persons and their families are
19 identified and addressed with appropriate programs and
20 services.

21 4337. The regional resource agencies resource
22 centers shall serve all of the following functions:

23 (a) Provide directly or assist families in securing
24 information, advice, and referral services, legal services
25 and financial consultation, planning and problem-solving
26 consultation, family support services, and respite care
27 services, as specified in Section 4338.

28 (b) Provide single entry point access centralized
29 access to information about and referrals to local, state,
30 and federal services and programs in order to assure a
31 comprehensive approach for brain-impaired adults, their
32 families, and caregivers. Nothing in this chapter shall
33 prohibit access to services through other organizations
34 which provide similar programs and services to
35 brain-impaired adults and their families, nor shall other
36 organizations be prevented from providing these
37 programs and services.

38 (c) Assist in the identification and documentation of
39 service needs and the development of necessary
40 programs and services to meet the needs of

1 brain-impaired adults in the geographic area.
 2 (d) Cooperate with the Statewide ~~Coordinating~~
 3 ~~Agency Resource Consultant~~ and the Director of Mental
 4 Health in any activities which they deem necessary for
 5 the proper implementation of this chapter.

6 (e) *Work closely and coordinate with organizations*
 7 *servng brain-impaired adults, their families and*
 8 *caregivers in order to ensure, consistent with*
 9 *requirements for quality of services as may be established*
 10 *by the director, that the greatest number of persons are*
 11 *served and that the optimal number of organizations*
 12 *participate.*

13 4338. Agencies designated as ~~regional resource~~
 14 ~~agencies resource centers~~ by the director after
 15 consultation with the Statewide ~~Coordinating Agency~~
 16 ~~shall~~ *Resources Consultant shall include in their*
 17 *governing or advisory boards, or both, as required by the*
 18 *director, persons who are representative of the ethnic*
 19 *and socioeconomic character of the area served and the*
 20 *client groups served in the geographic area. Resource*
 21 *centers shall carry out the functions specified in Section*
 22 *4337 through the administration and provision of the*
 23 *following services programs and services that reflect the*
 24 *most progressive care and treatment alternatives*
 25 *available for brain-impaired adults, their families, and*
 26 *caregivers. These programs and services may be*
 27 *provided directly or through the establishment of*
 28 *subcontracts as specified in their contract and within the*
 29 *limitations imposed by budget appropriations. The*
 30 *department shall make efforts to achieve a goal that not*
 31 *less than 90 percent of the funds appropriated through*
 32 *contracts with resource centers shall be utilized for direct*
 33 *services, including, but not limited to, the following:*

34 (a) Information, advice, and referral and family
 35 support services, including, but not limited to, all of the
 36 following:

37 (1) Information and counseling about diagnostic
 38 procedures and resources.

39 (2) Long-term care planning and consultation.

40 (3) Legal and financial resources, consultation, and

1 representation.

2 (4) Mental health interventions.

3 (5) Caregiving techniques.

4 (b) Respite care services through the flexible and
 5 creative use of existing local resources, including, but not
 6 limited to, all of the following:

7 (1) In-home care.

8 (2) Adult day health and social day care services.

9 (3) Foster and group care.

10 (4) Temporary placement in a community or health
 11 facility.

12 (5) Transportation.

13 (c) *Training and education programs for*
 14 *brain-impaired adults, their family members, caregivers,*
 15 *and service providers that will lead to the high-quality,*
 16 *low-cost care and treatment of service clients.*

17 4339. The director shall establish criteria for client
 18 eligibility, including financial liability, pursuant to
 19 Section 4339.5. Income shall not be the sole basis for client
 20 eligibility. The director shall assume responsibility for the
 21 coordination of existing funds and services for
 22 brain-impaired adults, and for the purchase of respite
 23 care services, as defined in subdivision (c) of Section 4331
 24 and described in subdivision (b) of Section 4336, with
 25 other departments that may serve brain-impaired adults,
 26 including the Department of Rehabilitation, the State
 27 Department of Health Services, the State Department of
 28 Social Services, the State Department of Developmental
 29 Services, the Department of Aging, and the State
 30 Department of Alcohol and Drug Abuse.

31 4339.5. Persons receiving services pursuant to this
 32 chapter may be required to contribute to the cost of
 33 services depending upon their ability to pay, but not to
 34 exceed the actual cost thereof. The criteria for
 35 determining client contributions which may be paid to
 36 the ~~regional resource agency resource center~~ under this
 37 chapter and standards for their utilization by the ~~regional~~
 38 ~~resource agency resource center~~ in developing new
 39 programs and services shall be determined by the
 40 director after consultation with the Statewide

1 *Coordinating Agency Resources Consultant.*

2 4339.6. In considering total service funds available for
3 the project, the director shall utilize funding available
4 from appropriate state departments, including, but not
5 limited to: the State Department of Health Services, the
6 State Department of Social Services, the Department of
7 Rehabilitation, the Department of Aging, and the State
8 Department of Alcohol and Drug Abuse. The director in
9 conjunction with the Statewide ~~Coordinating Agency~~
10 ~~shall be involved in the implementation of the Resources~~
11 *Consultant shall coordinate his or her activities with the*
12 *implementation of the Torres-Felando Long-Term Care*
13 *Reform Act (Chapter 1435, Statutes of 1982) in order to*
14 *further the goal of obtaining comprehensive, coordinated*
15 *public policy and to maximize the availability of funding*
16 *for programs and services for persons with brain*
17 *impairment.*

18 SEC. 3. The sum of one million seven hundred
19 thousand dollars (\$1,700,000) is hereby appropriated
20 from the General Fund to the State Department of
21 Mental Health for the purposes of this act.

22 SEC. 4. This act is an urgency statute necessary for
23 the immediate preservation of the public peace, health,
24 or safety within the meaning of Article IV of the
25 Constitution and shall go into immediate effect. The facts
26 constituting the necessity are:

27 In order that certain greatly-needed services to
28 brain-impaired adults may be provided at the earliest
29 possible time, it is essential that this act go into immediate
30 effect.



MISSOURI SENATE

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TO: Senator James Murphy
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Council

Research Analysts: House - Dan Landon
Senate - Toni Messina

Supervisor, Administrative Secretaries - Mary Lou Scott

FROM: Senator Edwin L. Dirck
Chairman, Head Injury Committee
SUBJECT: Senate Concurrent Resolution No. 12
"Joint Committee on Head Injuries."
DATE: July 17, 1984

Pursuant to SCR No. 12, the joint committee on head injury is assigned the task of studying the economic impact and emotional hardships of head injured victims across the state. We are also to prepare a report of findings and to prepare recommendations for submission to the 83rd General Assembly.

In conjunction with the National Head Injury Foundation, Missouri Chapter, Inc., we have scheduled a series of hearings during the months of August and September. (Schedule attached) Also enclosed is a packet of information from the National Head Injury Foundation which I believe will give committee members a good overview of our task.

Each committee member and staff person should arrange for their own lodging and transportation. If you have any questions, please notify my office.

ELD/bf



Colorado Head Injury
Foundation, Inc.

TRAUMATIC BRAIN INJURY PACKETS INCLUDE:

- Connecticut Medicaid Regulations for Traumatic Brain Injury - 1984
- Santa Clara Valley Medical Center Community Low Cost Day Program - 1982
- Florida Head Injury Registry Bill - 1985
- Virginia Head Injury Registry Bill - 1984
- Acute Standards of Care for Brain Injury Programs (C.A.R.F.) - 1985
- Insurance Serious Injury Medical Costs - 1983
- RSA Memorandum on Traumatic Brain Injury - 1984
- California Assembly Bill #2913 Regional Brain Damage Center - 1984
- Impact of Head Trauma on Society, Canadian J. Neurol. Sci. - 1984
- Missouri Legislative Resolution Creating Head Injury Task Force,
Services, Prevention

By Representatives Bass and Gordon

Florida Registry Bill FYE Kennedy

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This publication was produced at an average cost of 1.5 cents per single page in compliance with the Rules and for the information of members of the legislature and the public.

A Bill to be entitled

An act relating to the Department of Health and Rehabilitative Services; creating ss. 413.611 and 413.612, F.S.; providing intent; creating a central registry for reports of head injuries; providing definitions; requiring certain reports of head injuries; creating an advisory council; providing for review and repeal; providing an effective date.

WHEREAS, there is an absence of factual information concerning the scope and the significance of head injury in the state, and

WHEREAS, this absence of information has inhibited the development of proper care and rehabilitative programs and proper funding in both the private sector and in government agencies, and

WHEREAS, this absence of information has also inhibited the development of programs for the prevention of head injury, NOW, THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 413.611, Florida Statutes, is created to read:

413.611 Head-injured persons; legislative intent.—It is the intent of the Legislature to establish a central registry for the collection of such information to facilitate the development of these programs. It is the further legislative intent that the registry ensure the referral of head-injured persons to the Department of Health and

CODING: Words in single through type are deletions from existing law; words underlined are additions.

RECEIVED

MAY 29 1985

NBMC ADMINISTRATION

1 Rehabilitative Services by appropriate individuals or public
2 and private agencies in order that such persons might obtain
3 the appropriate rehabilitative services rendered by the
4 department and other providers.

5 Section 2. Section 413.612, Florida Statutes, is
6 created to read:

7 413.612 Central registry for head-injured persons;
8 advisory council.--

9 (1) As used in this section:

10 (a) "Department" means the Department of Health and
11 Rehabilitative Services.

12 (b) "Head injury" means an insult to the skull, brain,
13 or its covering, resulting from external trauma which produces
14 an altered state of consciousness or anatomic, motor, sensory,
15 or cognitive/behavioral deficits.

16 (2) The department shall establish and maintain a
17 central registry of persons suffering a head injury.

18 (3) Every public or private health and social agency
19 and attending physician shall report to the department within
20 5 days after identification of any head-injured person. The
21 consent of such person shall not be required.

22 (4) The report shall contain the name, age, residence,
23 diagnosis of the person, and such additional information as
24 may be deemed necessary by the department.

25 (5) There is created within the department a 13-member
26 Advisory Council on Head Injury. The council shall be
27 composed of physicians, other allied health professionals,
28 administrators of head-injury programs, representatives from
29 support groups and the Florida Neurosurgical Society. Members
30 of the council shall be appointed by the secretary of the
31 department and shall serve for terms of 4 years, except that 6

1 members shall be initially appointed to terms of 2 years. The
2 council shall meet at least 4 times annually and members shall
3 be entitled to per diem and travel expenses in accordance with
4 the provisions of s. 112.061. The council shall provide
5 advice and expertise to the department in the preparation,
6 implementation, and periodic review of a coordinated
7 rehabilitation program for head-injured individuals in
8 Florida. The council shall assist the department in
9 developing a coordinated multilevel plan of care which will be
10 presented to the secretary for review and approval by July 1,
11 1986.

12 Section 3. Subsection (5) of s. 413.612, Florida
13 Statutes, as created by this act, is repealed on October 1,
14 1995, and The Advisory Council on Head Injury shall be
15 reviewed by the Legislature pursuant to s. 11.611, Florida
16 Statutes.

17 Section 6. This act shall take effect upon becoming a
18 law.

19
20 *****

21 HOUSE SUMMARY

22 Requires the Department of Health and Rehabilitative
23 Services to create a central registry for head-injured
24 persons. Requires health agencies and physicians to
25 report head injuries to the department. Creates an
26 Advisory Council on Head Injury. Provides the membership
27 and duties of the council. Provides legislative findings
28 and intent. Provides for review and repeal.

SEP 4 1984

UNITED STATES DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES
REHABILITATION SERVICES ADMINISTRATION
WASHINGTON, D. C. 20202

INFORMATION MEMORANDUM
MEDICAL BULLETIN NO. 3
RSA-DM-84-37
August 28, 1984

TO : STATE REHABILITATION AGENCIES (GENERAL)
STATE REHABILITATION AGENCIES (BLIND)
RSA REGIONAL COMMISSIONERS (REGIONS I-X)
RSA SENIOR STAFF

SUBJECT: Traumatic Brain Injury

CONTENT: There is increasing national concern about the problems imposed by traumatic brain injury and the vocational rehabilitation program has an opportunity to become more actively involved in the resolution of these problems.

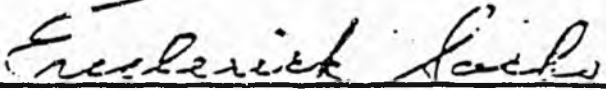
The Committee on Appropriations of the U.S. House of Representatives submitted a report to the whole House on the State of the Union, July 26, 1984, which stated:

"The Committee is encouraged by recent efforts in agencies like the National Institute for Handicapped Research to address the needs of people suffering brain injury due to trauma. With 50,000-90,000 people suffering such injury due to car accidents and other causes, the Committee remains concerned about whether their needs are being adequately addressed. The Committee would like the Rehabilitation Services Administration, in conjunction with all other agencies in the Departments of Education and Health and Human Services involved with issues relating to head injury, as well as outside experts and support groups, to report to the Committee before next year's budget hearings on the following issues: the current research and service delivery activities relative to head injury now being carried out by the various federal agencies; the unmet needs in research, training and service delivery; the most current techniques in acute care and rehabilitation of head injured persons; and a plan for the future direction that head injury research and service delivery should take.

In addition, the report should address the designation of a specific category of disability for the head injured and the utilization of that category by the relevant federal and state agencies."

The concern of this Committee is welcomed by RSA. It is noted that while each year from 50,000 to 90,000 persons who have severe residual impairments caused by traumatic brain damage, relatively few of these persons are served by vocational rehabilitation agencies.

It is therefore suggested that State vocational rehabilitation agencies re-examine their policies and practices in serving this group of individuals "with most severe handicaps" with a view towards making a significant contribution to the resolution of vocational rehabilitation problems imposed by this disorder.


Associate Commissioner of Program Operations

Attachment: Medical Bulletin No. 3

cc: CSAVR Executive Director

"A. Physical

Aphasia	Spasticity
Visual Impairment	Hemiparesis
Hearing	Paraplegia
Physical Disability	Seizures
a) Orthopedic involvement	

"B. Cognitive

Memory Deficit--short and long term	Lack of foresight
Perception	Planning--sequencing
Concentration	Judgement
Attention	Headaches

"C. Psycho-Social-Behavioral-Emotional

Fatigability	Anxiety
Euphoria	Restlessness
Denial	Lack of Motivation - inability to self-monitor
Egocentricity	Emotional Lability
Lack of self-esteem	Inability to Cope
Disinhibition	Agitation
Depression	
Sexual Dysfunction	

"The above impairments, any or all, may occur in varying degrees. The severely impaired may encompass all of the above, but it is important to note that with early and ongoing therapeutic intervention, the degree of these symptoms might decrease.

"Intellectual ability might not improve after a period of time, but social and behavioral aspects and memory could improve over long periods of time.

"Increasing the return to a higher functional level should be a continuing goal."

V. Some viewpoints from RSA

1) Eligibility: Persons who have incurred significant traumatic brain injury in virtually every case have a physical or mental disability which constitutes a significant handicap to employment. At issue is whether or not vocational rehabilitation services will benefit the individual in terms of employability.

2) Evaluation: It is vital that the evaluation of an applicant be provided by qualified professional persons who are skilled in the understanding and management of persons who have sustained traumatic brain

injury. It is recommended that States which have not done so, identify centers where services of a high quality are available for these persons. The National Head Injury Foundation, Inc., 18A Vermont Street, Frammingham, Massachusetts 01701, is compiling a nationwide directory of such resources for evaluation, treatment and management which should be helpful.

The National Institute of Handicapped Research has supported the Traumatic Brain Damage Project at New York University Medical Center, the Severe Head Trauma Project at Santa Clara Valley Medical Center in San Jose, California, and four Research and Training Centers in Brain Injury and Stroke, where more than 75 related projects are currently being supported. These centers are located at New York University, Emory University in Atlanta, Georgia, Washington University in Seattle, Washington, and Northwestern University in Chicago, Illinois. These centers should be looked to for the provision of evaluation and therapeutic services for vocational rehabilitation clients and for recommendations concerning other centers of excellence within States.

University medical centers with strong departments of neurosensory and neuropsychology may provide such services and/or know where such services are provided.

The minimum work-up should include an evaluation by a clinical psychologist or a neuropsychologist. Emphasis should be given to what the individual can do, not just what cannot be done. Included in the evaluation should be consideration of premorbid personality, social, educational, and work experience, the nature of deficits, and the need for continuing therapy.

Because the passage of time in itself may enhance the potential of an individual for work, consideration may be given to the use of the authority for extended evaluation.

3) Coordinated services: Ideally, persons with traumatic brain injury should have available to them a coordinated system of care comparable to the National Spinal Cord Injury Service System. Presently, some elements of such a system are in operation. Acute care is provided at trauma centers; brain injury units of medical centers provide intensive care, with subsequent care provided at brain injury centers in rehabilitation units at the center or at related rehabilitation hospitals. But these elements do not form a "system" because they are not integrated or coordinated. A vocational rehabilitation counselor may carry out such an activity for his or her clients.

It is assumed that vocational rehabilitation services in general would be initiated after the person's condition has become relatively stable, possibly some six months post-injury. A major focus of such services would likely be cognitive services provided with the leadership of a

neuropsychologist, neurological services (for the control of complicating medical conditions such as seizures), physical restoration services as indicated, and vocational counseling, prevocational and vocational training services aimed at job placement.

Because of the devastating nature of this disorder, an individual's family may also need services which may be arranged for by the vocational rehabilitation counselor. Many families are helped by meetings with other similarly affected persons. The National Head Injury Foundation has a list of organized support groups and NHIIF chapters by State.

References:

Handbook of Severe Disability, Stolov and Clowers, editors, 1981. U.S. Department of Education, Rehabilitation Services Administration, Washington, D. C. 20202.

Rehabilitation Brief - Bringing Research into Effective Focus, Volume V, No. 5, U.S. Department of Education, National Institute of Handicapped Research, Washington, D. C. 20202.

Neurology Clinics, Volume IV, Number 3, Baylor College of Medicine/The Methodist Hospital, Houston, Texas 77030.

Programs for the Handicapped, November/December 1981. U.S. Department of Education, Clearinghouse on the Handicapped, Washington, D. C. 20202.

DOCUMENTATION OF HEAD-INJURED VICTIMS IN COLORADO
WITH SEVERE BEHAVIORAL PROBLEMS

<u>SEX</u>	<u>AGE</u>	<u>DATE OF INJURY</u>	<u>CURRENT LIVING SITUATION</u>	<u>BEHAVIORAL PROBLEMS</u>	<u>PHYSICAL STATUS</u>	<u>INSURANCE</u>
F	33	Anoxic 4/82	Psych. Hosp. CU	Organic lability, anger, depression	mobile	John Hancock Group Health & Accident
M	29	2 years ago	Nursing Home Keller Cty	Sexually, socially inappropriate, wanders	mobile	Colo. XIX
M	24	2 years ago	Regency	Impulsive, combative at times, inappro- priate socially and sexually	mobile	Trust Fund & Colo. XIX
M	34	1977	Mounclair Nursing Home in Denver		mobile	Colo. XIX
M	22	8/79	At home (Denver)	Passive, Constant Supervision	mobile	Colo. XIX
M	23	1982	Home (Denver)	Constant Supervision, Suicidal	mobile	Colo. XIX
F	29	1980	Hospital, Pueblo	Suicidal, Constant Supervision	mobile	Colo. XIX
M	19	Nov. 1982	Rehab. Hosp. Denver	Physically aggressive, non-cooperative	mobile	Colo. No-flt Auto, Colo. XIX
M	20	1980	Home in Denver	Abusive, Constant Supervision	mobile	Colo. XIX
F	26	1981	Pueblo Hosp.	Psychosis, Suicidal gestures	mobile	Colo. XIX
M	24	1981	Home Grand Junction	Aggressive physically	mobile	Colo. XIX
M	36	1980	Home Grand Junction	Aggressive physically	wheelchair	Colo. XIX
M	37	1980	Home with parents	Physically abusive	wheelchair	Medicare
M	27	1980	Colorado nursing home	Verbally explosive	wheelchair	Colo. XIX
F	24	1979	Home with parents	Sexual acting out	mobile	private insurance

1983 - CHF Survey Regency, Craig, Hilltop

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5.	F	26	1982	Nursing home	Physically aggressive	wheelchair	Colo. XIX
7.	M	39	1982	Home with sister	Alcohol abuse & Physically aggressive	mobile	Workers Compensation
8.	M	18	1980	Home with parents	Alcohol abuse & Physically aggressive	mobile	Private insurance
9.	F	21	1980	Home with Parents	Impulsive, non-cooperative, suicidal	mobile	No-flt, \$8,000
10.	M	30	1981	deceased	Suicide	mobile	Private Health & accident
21.	M	22	7/81	home	Verbally abusive, Lack of cooperation	mobile	Colo. XIX
22.	N	36	1981	home	Alcohol abuse, Anti-social	mobile	Colo. No-flt., Colo. XIX
23.	M	33	5/80	home	Verbally abusive, Physically abusive	mobile	Colo. XIX
24.	F	18	5/80	home	Verbally abusive, Physically aggressive	mobile	Colo. XIX
25.	M	30	12/81	jail	Alcohol abuse, Physically abusive, Multiple car accidents	mobile	Colo. XIX
26.	M	24	8/82	home	Lack of cooperation, Substance abuse	mobile	Colo. XIX
27.	M	30	12/80	home	Withdrawn	mobile	Colo. XIX
28.	M	31	1975	home	Substance abuse, Uncooperative	mobile	Colo. XIX
29.	M	33	9/81	home	Uncooperative	mobile	Colo. XIX
30.	M	27	1977	Nursing home	Suicidal, Uncooperative	wheelchair	Colo. XIX
31.	M	22	6/79	Denver psychiatric ward	Physically and verbally abusive	wheelchair	Colo. XIX

DOCUMENTATION OF HEAD-INJURED VICTIMS IN COLORADO
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M	36	3/80	Nursing home	Physically abusive, Acting out	wheelchair	Colo. XIX
F	42	3/83	Psychiatric hospital	Wanders, chronic alcoholic, impaired judgement, gravely disabled mentally	mobile	
M	43	4/77	Home	Violent with kids	mobile	XVIII and Insurance
M	25	1983	Hospital		mobile	Colo. XIX
M	29	1983	Home	Verbally abusive, gravely disabled	mobile	Workman's Comp
M	65	1981	Home	Physically abusive, needs constant supervision	mobile	Medicare & Supplement

RESIDENTIAL ADDRESS: XIX Canadian Congress of Neurological Sciences

The Impact of Head Trauma on Society

Leslie P. Ivan, President, Canadian Neurosurgical Society

Can. J. Neurol. Sci. 1984; 11:417-420

In this address I shall discuss head trauma from an angle which may be unusual for neuroscientists. Our preoccupations are diagnostic challenges and management problems, but that which we experience at the bedside is only a narrow segment of a continuum which started with trauma somewhere in a war, on a road, at home, on the football field, in the boxing ring, and in many other distinct locations. When our role is over, there are only three places where head trauma victims can be found: cemeteries, where every year, 5,000 new graves are made to accommodate fatal head injuries in Canada; in chronic hospitals, which are already overloaded with victims of various insults to the brain, and, of course, within society, which accepts the victim as fully recovered or tolerates the subtle and not so subtle consequences of so-called 'minor' head injuries.

To begin, I shall focus on trauma itself and will try to define the magnitude of the problem and match the response of society to it. The magnitude of a health problem, can be judged from the incidence, mortality, and morbidity figures and from the financial costs to society (Waller, 1980). A major epidemic is a disaster in continuity which keeps decimating the population and saps the financial resources of society. But, according to Brian Jennett: "Head injured patients are so common place that they often fail to attract the attention they deserve." (Jennett and Teasdale, 1981)

Let us examine the facts more closely. Reliable data are collected regularly and come from a number of sources. The National Head and Spinal Cord Injury Survey (Anderson and Laurin, 1980), a supplement to the *Journal of Neurosurgery*, and the Central Nervous System Trauma Research Status Report (Dom, 1979) remain excellent documents which can be updated in the World Health Organization Vital Statistics. From these, and other published statistics (Canadian 1982; Causes 77, 1980; Hospital 1978; World Almanac 1970-1983), it can be established that the annual incidence of serious head trauma is very high, and affects as many as 20,000 to 30,000 people in Canada. The variation of 100 to 700 per 100,000 population is site specific, and a tragic peak occurs between 15 and 19 years of age. This should be noted and imprinted on the conscience of parents of the world.

About 100,000 people die in the United States every year because of accidents. Half of these deaths are related to road accidents; 70% of fatal injuries occur because of head trauma. In Canada, the situation is not much better, despite the fact that we passed the highest peak in 1973, when road fatalities alone claimed nearly 7,000 lives. In the 1970's sharing the distinction with West Germany, and surpassing the United States, WE

were the world leaders in highway fatalities and WE had the highest percentage of accidental deaths in the world. There is overwhelming proof from excellent studies covering several geographic locations, that road accidents are the single most common cause of head injuries (51%), surpassing the home, which nevertheless, maintains the distinction of being the second most dangerous place for the head.

Looking at morbidity, the picture remains equally distressing. Figures for the United States show that there were 9 million disabling injuries in 1981, resulting in 350,000 cases of permanent disability. We don't have reliable figures in Canada, but as a rough estimate, 10% would probably be realistic.

Translating the morbidity and mortality figures to dollars and cents, the cost of accidents has grown from 18.2 billion dollars in 1970 to 78.4 billion dollars in 1982 in the United States. Motor vehicle accidents account for nearly half of these expenses. Head injuries, therefore, in Canada, cost at least 4 billion dollars per year.

At a recent Trauma Conference in Calgary, Professor John Read stated, "One in twenty Canadian children born today will be killed or severely injured before reaching the age of 15 (Read, 1984). The majority of these injury events will occur in traffic." Just think about it for a minute. The world's population will be about 6 billion in the year 2000, 2.5 billion of which will be children under 14 years of age. If all countries on earth were as advanced as we are technologically, 1.25 million children would die in the year 2001 because of head injuries alone.

In this frightening shadow of an Orwellian forecast, my second concern in this address is to examine society's response to the vastness of the problem and ask:

1. Is it really true that accident is a natural phenomenon?
2. Do head injury patients fail to attract the attention they deserve?
3. Is it really tenable that in 15 years, accidents will continue decimating the children of this country?

Allow me to illustrate the "Vital Signs" of society or the "Coma Scale", if you wish, whereby the response of society can be assessed. Whether a society is alert or in coma may be gauged by testing cultural and organizational phenomena, checking what industry, government and the law do about a noxious reality, and testing how society propagates new knowledge, processes new information, and implements the needed change.

Let us look first at Canadian and American agencies concerned with trauma. These organizations which represent the medical profession, business, industry, government and citi-

Requests to: L.P. Ivan, M.D. Professor and Chairman, Division of Neurosurgery, University of Ottawa, Head, Division of Neurosurgery, Children's Hospital of Western Ontario, 401 Smyth Road, Ottawa, Ontario K1H 8L1

zen groups are listed in Table 1. These are only about 40% of the agencies concerned internationally with trauma and head injuries.

Organized medicine should be proud of the leadership of the American College of Surgeons which has been a powerhouse of resources on how to establish and maintain effective structural and high professional standards in the management of trauma victims. The number of brochures, pamphlets and symposia, reflect the profound concern of the American College about this epidemic of civilized living which can be subdued by improving every phase of trauma management.

In Canada, I must confess, there has been a slow awakening, but within the past few years, from the Royal College to the Canadian Medical Association, the activity has been very impressive.

Time prevents me from checking the "Vital Signs" of society systematically and exhaustively. I shall, however, touch upon a few issues which I consider important because they reflect Canadian concern. These are: 1. Head protection, 2. Injuries to children, 3. Alcohol and youth, 4. Seat-belt and restraint, 5. Trauma research funding.

Head Protection

Great events in history have hinged on head protection. It is no secret that Goliath had a helmet of brass upon his head and that his helmet had a rather substandard construction for David "smote the Philistine, the stone sunk into his forehead and he fell upon his face to the earth." The Romans and Greeks had excellent helmets. Alexander the Great (330 B.C.) had a fluted helmet which successfully deflected blows to his head, and saved his life in many battles. Obviously, a man ahead of his time, he decreed that in all campaigns, horse soldiers should wear helmets. The current trend is in agreement with him, as protective devices in transport, sport, and leisure activity are showing a resurgence today.

The excellent posters of the Ontario Easter Seal Society uses the best psychology to reinforce the use of sports helmets. The improvement of existing helmets is very important, as is shown by a study covering five years of football injuries in the United States (Schneider, 1982) In this study, 69 subdural haematomas with 28 deaths occurred because the helmets did not properly absorb the energy from severe impact. This prompted research to improve helmet design and reduce injury.

In our study, we found bicycle injuries the single most common cause of head injury in children (Ivan et al., 1983; Lapner and Ivan, 1981). We suggest the use of helmets for cyclists and bicycles that are CSA (Canadian Standards Association) approved. We hope that legislation will deal with these issues.

Concerning motorcycle helmets, in the United States, 35 states repealed mandatory motorcycle helmet legislation in May of 1976 (Watson et al., 1980). The result, an increase in head injuries and death, and a 200% increase in medical cost and disability (McSwain and Petrucelli, 1984).

This might be the time to reflect on boxing. The World Federation of Neurosurgeons and the Canadian Neurosurgical Society have been fighting this savage sport for a long time. Last year, our view was presented (by Dr. J. Stratford) to the Canadian Medical Association. In a recent letter, I was informed that the Canadian Medical Association has made a resolution that boxing be banned in Canada, while the Ontario Medical Association, at its annual meeting, indicated that all boxing need not be banned (Rich, 1984). Dr. George Lundberg, in a

recent editorial, stated that blows to the head should be illegal, as have blows to the testes (Newsletters, 1984).

Injuries to Children

Injuries to children is a special issue because of the enormity of the mortality figures compared to other causes of death in childhood (Accidents, 1981). Interestingly, the most recent figures come from the Cancer Journal for Clinicians (Silverstein, 1982), which clearly shows that accidents in the United States killed more children between 1 and 14 years of age, than cancer, congenital anomalies, heart disease, meningitis, cerebral palsy and cystic fibrosis, altogether. For children, the road is dangerous but for toddlers and infants, the home remains the common place of head trauma, and through the Canada Safety Council and the Canadian Institute of Child Health, we have convinced the government to modify safety standards for stairs, walkways and homes.

Alcohol and Youth

Drinking and driving is a serious problem in all age groups (Simpson, 1982; Zuska et al., 1983). The Canadian Automobile Association tells us that in 1981, from the 641 persons killed in traffic accidents, 376 had been drinking. The Bulletin of the American College of Surgeons states, and I quote, "More than 2 million Americans died in wars since 1775" (Connaughton, 1983). Since approximately 50% of motor vehicle deaths are alcohol related, it becomes apparent that drinking and driving has killed more on the streets and highways than we have lost in all wars as a nation. Alcohol abuse and road trauma combine to be the leading causes of death between 17 and 21 years of age. A recent study in the province of Ontario revealed that from fatally injured drivers and pedestrians in one year, only 32 had neither alcohol nor drug in their blood samples (Warren and Simpson, 1980).

The Ontario Medical Association Committee on Accidents and Injuries has made specific recommendations for strategies to decrease drinking and driving (Committee, 1984). This may eventually result in provincial legislation. The Law Reform Commission of Canada has already forwarded a report to Parliament with specific recommendations about alcohol related issues (Report, 1983).

One of the best documents I had in my hands, revealing society's concern is the booklet Task Force of the Government of Ontario on Drinking and Driving (Discussion, 1983). It deals with the problem in depth, both nationally and internationally. At the request of a citizen's group, a Task Force was established by Premier W. Davis in the fall of 1982, in order to spearhead a new assault on the problem. The Task Force made several recommendations in this study which should surface soon in Parliamentary debate.

The Traffic Injury Research Foundation has an equally valuable document in which the emphasis is again on youth-specific reference to changing social behaviour and attitudes towards drinking and driving (Alcohol, 1983). This report emphasizes the development of community based strategies. Examples of these are M.A.D.D. (Mothers Against Drunk Driving), S.A.D.D. (Students Against Drunk Driving). Many of these voices reach the media quite frequently, and some concern appear on such things as shopping bags issued by the Liquor Control Board of Ontario. In magazines, unfortunate

Alcohol is a frequent object of beautiful advertisements. In the distinguished Canadian Geographic (Canadian, 1984), I found five excellent ads. promoting alcohol. The one which caught my eye was Seagrams, which says "When we say don't drink and drive we're not just talking about liquor. Twelve ounces of beer, a 5½ oz. glass of wine and 1½ oz. of spirits — they all contain the same amount of alcohol. So they're all equally wrong to mix with driving, and for that matter, just as wrong to abuse at any time". Moral or immoral, conformist or not, it is good to know that at least one of the merchants of this lethal combination feels some societal pressure.

Seatbelts and Restraining

There has been a remarkable decrease in deaths and injuries since January 1st, 1976, when seatbelts became mandatory in Ontario. In 1975, the year before seatbelt legislation, 1314 drivers and passengers were killed in motor vehicle accidents in Ontario. In 1982, Canadian Road Fatality Statistics show that the number had dropped to 783, a drop of 40%; the lowest number of deaths and injuries since 1965. Unfortunately, seatbelt laws in many countries are not enforced, or if they are, the compliance may be low. A recent blitz in Ottawa showed only 75% adult and 60% child restraint compliance which improved by 10% after a second blitz (Surveys, 1984). Child restraint legislation is now in effect in Ontario, Quebec, Manitoba, Nova Scotia, Newfoundland, Saskatchewan and 41 states of the United States. It remains, however, a matter of education and legislation to protect little citizens who cannot make the decision to protect themselves.

Some researchers believe that a passive restraint system will improve the problem and industrial research remains very active in this field. The U.S. government has recently legislated that air bags and automatic seat belts will be phased into new cars by the manufacturers.

Trauma Research

Finally, I would like to touch upon trauma research. In spite of the improvement of mortality with aggressive treatment of severe head injuries, we seem to have reached a plateau where further improvement remains questionable. Maybe it is true, that a scrambled brain cannot be unscrambled; but, there is plenty of room for research. (Ghent, 1981)

Certain therapeutic vacuums exist which may effect society and man in a rather insidious manner. Probably the two most important areas which deserve more research are from the moment of the 'accident' to the earliest possible management of coma, and the subtle consequences of head injuries. As an example: a 15 year old boy suffered a slight head injury while under the influence of alcohol, when he fell backwards and

struck his head on the floor. He had a Glasgow com. a scale of 12 at admission and left the hospital in less than a week. The CT scan showed, to our astonishment, a dozen small contre-coup haemorrhages in the frontal and temporal areas. He went back to school, but dropped out before graduating, and now works as a painter's helper.

I recently saw him again when he was painting the walls of the hospital where he was treated. He is jolly, uninhibited, calls himself a paintologist and is reintegrated to productive life; but is he really? Can we measure his loss? What else could he have painted? Why did he drop out of school?

Nobody can answer these questions for we don't know the value of lost neurons, and how can we know, when such a small amount of money is spent on head injury research. The figures are embarrassing for only one percent or less of the grant dollars support head injury research. People who suffer from incurable diseases have my deepest sympathy and I am happy for the millions of dollars governments will spend to attempt to solve their problems, but I also have healthy children and three of them are teenage drivers. From the depth of my heart I am crying for all teenagers of Canada and the world, that we may find the wisdom and the money to stop their slaughter on the roads.

Prevention should be the solution, but prevention comes from education and education is the transfer of knowledge. Knowledge can be based only on experience and research, and education and research together are the key issues to the solution of the problem of head trauma.

Neuroscientists should be the champions of this cause, for they know best that the greatest treasure of evolution is the human brain. There should be a new line of evolution in society, not the fittest, but the wisest. An evolution which brings deeper maturity and wisdom to human behaviour, a changed attitude which will protect man from self-destruction. Head injury is not a natural phenomenon. It comes from a hostile environment which is man made and it should be controlled by man.

According to my analysis, the vital signs of our society are quite stable. We are making progress and the scores are quite high on the responsiveness scale. The two weak areas, research and education, are strongly dependent on government support and as we know, it takes a long time before the fixed pupils of some government agencies start responding to light.

ACKNOWLEDGEMENTS

I am indebted to my wife, Maureen, who helped research this problem and put the material into perspective. Dr. W. R. Ghent from Kingston, Mr. Rotenburg from the Ontario Medical Association, Dr. Da Sylva from the Canadian Medical Association and all the organizations listed in Table 1 generously provided valuable information and assistance.

SEP 4 1984

UNITED STATES DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES
REHABILITATION SERVICES ADMINISTRATION
WASHINGTON, D. C. 20202

INFORMATION MEMORANDUM
MEDICAL BULLETIN 7. 3
RSA-IM-84-37
August 28, 1984

TO : STATE REHABILITATION AGENCIES (GENERAL)
STATE REHABILITATION AGENCIES (BLIND)
RSA REGIONAL COMMISSIONERS (REGIONS I-X)
RSA SENIOR STAFF

SUBJECT: Traumatic Brain Injury

CONTENT: There is increasing national concern about the problems imposed by traumatic brain injury and the vocational rehabilitation program has an opportunity to become more actively involved in the resolution of these problems.

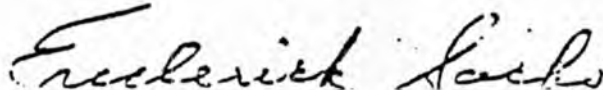
The Committee on Appropriations of the U.S. House of Representatives submitted a report to the whole House on the State of the Union, July 26, 1984, which stated:

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In addition, the report should address the designation of a specific category of disability for the head injured and the utilization of that category by the relevant federal and state agencies."

The concern of this Committee is welcomed by RSA. It is noted that while each year from 50,000 to 90,000 persons who have severe residual impairments caused by traumatic brain damage, relatively few of these persons are served by vocational rehabilitation agencies.

It is therefore suggested that State vocational rehabilitation agencies re-examine their policies and practices in serving this group of individuals "with most severe handicaps" with a view towards making a significant contribution to the resolution of vocational rehabilitation problems imposed by this disorder.


Associate Commissioner of Program Operations

Attachment: Medical Bulletin No. 3

cc: CSAVR Executive Director

"A. Physical

Aphasia
Visual Impairment
Hearing
Physical Disability
a) Orthopedic involvement

Spasticity
Hemiparesis
Paraplegia
Seizures

"B. Cognitive

Memory Deficit--short and long term
Perception
Concentration
Attention

Lack of foresight
Planning--sequencing
Judgement
Headaches

"C. Psycho-Social-Behavioral-Emotional

Fatigueability
Euphoria
Denial
Egocentricity
Lack of self-esteem
Disinhibition
Depression
Sexual Dysfunction

Anxiety
Restlessness
Lack of Motivation - inability
to self-monitor
Emotional Lability
Inability to Cope
Agitation

"The above impairments, any or all, may occur in varying degrees. The severely impaired may encompass all of the above, but it is important to note that with early and ongoing therapeutic intervention, the degree of these symptoms might decrease.

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"Increasing the return to a higher functional level should be a continuing goal."

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2) Evaluation: It is vital that the evaluation of an applicant be provided by qualified professional persons who are skilled in the understanding and management of persons who have sustained traumatic brain

injury. It is recommended that States which have not done so, identify centers where services of a high quality are available for these persons. The National Head Injury Foundation, Inc., 18A Vermont Street, Frammingham, Massachusetts 01701, is compiling a nationwide directory of such resources for evaluation, treatment and management which should be helpful.

The National Institute of Handicapped Research has supported the Traumatic Brain Damage Project at New York University Medical Center, the Severe Head Trauma Project at Santa Clara Valley Medical Center in San Jose, California, and four Research and Training Centers in Brain Injury and Stroke, where more than 75 related projects are currently being supported. These centers are located at New York University, Emory University in Atlanta, Georgia, Washington University in Seattle, Washington, and Northwestern University in Chicago, Illinois. These centers should be looked to for the provision of evaluation and therapeutic services for vocational rehabilitation clients and for recommendations concerning other centers of excellence within States.

University medical centers with strong departments of neurosensory and neuropsychology may provide such services and/or know where such services are provided.

The minimum work-up should include an evaluation by a clinical psychologist or a neuropsychologist. Emphasis should be given to what the individual can do, not just what cannot be done. Included in the evaluation should be consideration of premorbid personality, social, educational, and work experience, the nature of deficits, and the need for continuing therapy.

Because the passage of time in itself may enhance the potential of an individual for work, consideration may be given to the use of the authority for extended evaluation.

3) Coordinated services: Ideally, persons with traumatic brain injury should have available to them a coordinated system of care comparable to the National Spinal Cord Injury Service System. Presently, some elements of such a system are in operation. Acute care is provided at trauma centers; brain injury units of medical centers provide intensive care, with subsequent care provided at brain injury centers in rehabilitation units at the center or at related rehabilitation hospitals. But these elements do not form a "system" because they are not integrated or coordinated. A vocational rehabilitation counselor may carry out such an activity for his or her clients.

It is assumed that vocational rehabilitation services in general would be initiated after the person's condition has become relatively stable, possibly some six months post-injury. A major focus of such services would likely be cognitive services provided with the leadership of a

neuropsychologist, neurological services (for the control of complicating medical conditions such as seizures), physical restoration services as indicated, and vocational counseling, prevocational and vocational training services aimed at job placement.

Because of the devastating nature of this disorder, an individual's family may also need services which may be arranged for by the vocational rehabilitation counselor. Many families are helped by meetings with other similarly affected persons. The National Head Injury Foundation has a list of organized support groups and NHIF chapters by State.

References:

Handbook of Severe Disability, Stolov and Clowers, editors, 1981. U.S. Department of Education, Rehabilitation Services Administration, Washington, D. C. 20202.

Rehabilitation Brief - Bringing Research into Effective Focus, Volume V, No. 5, U.S. Department of Education, National Institute of Handicapped Research, Washington, D. C. 20202.

Neurology Clinics, Volume IV, Number 3, Baylor College of Medicine/The Methodist Hospital, Houston, Texas 77030.

Programs for the Handicapped, November/December 1981. U.S. Department of Education, Clearinghouse on the Handicapped, Washington, D. C. 20202.

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REHABILITATION CLINICS
171.2B.XVI. - 171.2B.XVII.

B. Definitions (con't.)

XVI. Traumatic Brain Injury (TBI) Day Treatment Program

"Traumatic Brain Injury (TBI) Day Treatment Program" means periodic short-term, skilled medical rehabilitation services prescribed by a physician (M.D.) for individuals who have sustained injury which is neurologically-based and has resulted from the interaction of any single or repetitive external forces and the body resulting in any combination of focal and diffuse central nervous system (brain) dysfunctions, both immediate and delayed, occurring at the brain stem level and above. The injury results in a loss of living and working skills, in that, the individual evidences cognitive emotional behavioral, physical, perceptual or language deficits which interfere with restoring the individual to their former living and work situations. Treatment employs a system of cognitive remediation, and other rehabilitative services as required: speech, language, psychological, occupational and physical therapies. These services are uniquely individualized for each participant as a part of a total plan of care. Services are provided on a one-to-one or group treatment basis following an individualized plan of care established by an interdisciplinary team.

XVII. Interdisciplinary Team - TBI Program

"Interdisciplinary Team - TBI Program" means medical rehabilitation professionals such as: speech pathologist; physical therapist; occupational therapist; clinical/neuropsychologist; and social worker under the direction of a physician (M.D.) who is the primary member of the team. The physician provides medical supervision of the team professionals. The team is responsible for assessing the recipient's appropriateness for TBI program services and development of a coordinated individual treatment plan of care. The team is also responsible for the ongoing review of the plan of care, reevaluating the continued need for medical rehabilitation services and adjusting the treatment goal as necessary.

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REHABILITATION CLINICS
171.2B.XIV. - 171.2B.XV.

B. Definitions (con't.)

XIV. Partial Evaluation

"Partial Evaluation" means a re-evaluation or assessment of a patient, in person which will occur within one (1) year from the date a complete evaluation was performed by the same provider clinic. In order to receive payment for this procedure, the following medical developments must exist:

- a. a significant change in the patient's condition which occurs in relation to the current treatment plan;
- b. readmission to a treatment program interrupted by a period of hospitalization;
- c. a new diagnosis requiring a new treatment plan for the same treatment modality.

XV. Medical Check-up

"Medical Check-up" means an evaluation of a patient, in person, who has received maximum benefits and has been discharged from a program of treatment and may require a medical status review for the following medical developments only;

- a. Degenerative conditions
- b. Assessment of a home program recommended and developed by a clinic health professional as part of the patient's discharge plan.

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REHABILITATION CLINICS
171.2B.XVIII. - 171.2B.XVIII.f.

B. Definitions (con't.)

XVIII. Cognitive Remediation

"Cognitive Remediation" means a rehabilitative treatment program designed to improve an individual's verbal and visual-perceptual abilities which are impaired. Specific areas that may require treatment include:

- a. Ability to sustain attention and mental focus on given tasks in order to work effectively in the completion of such tasks.
- b. Ability to retain, retrieve and/or recognize information acquired through hearing.
- c. Ability to organize information in a logical order to facilitate its analysis and comprehension.
- d. Ability to organize visual information within a given physical space, in order to understand, comprehend, and make use of such information.
- e. Ability to use fine motor muscles to perform such tasks as manipulation of small objects and/or writing.
- f. Ability to integrate visual and fine motor stimuli in a coordinated fashion (i.e. copying, writing).

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REHABILITATION CLINICS
171.2B.XVIII.g. - 171.2B.XIX.

B. Definitions (con't.)

XVIII. Cognitive Remediation (con't.)

- g. Ability to discriminate, visually, among different distracting stimuli.
- h. The ability to formulate a problem within context, to analyze its conditions and to develop a strategy and a plan of approach to its solution and verification.
- i. The ability to produce accurate retention and integration of verbal information and analysis of linguistic relationships.
- j. The ability to evaluate and select appropriate alternatives of action to a given situation.

The individual suffering head trauma may evidence deficits in any or all of these areas. A program of cognitive remediation is constructed to address each participant's particular cognitive deficit(s). The goal of such a program is to improve the individual's function level of cognitive abilities, and/or to train the individual in appropriate compensations for permanent deficits.

Services are performed by a speech pathologist or occupational therapist in cognitive areas most applicable to their professional skills and training. Occupational therapy assistants may carry out the implementation of cognitive remediation functioning under the general supervision of the occupational therapist.

XIX. Home

"Home" means the recipient's place of residence which includes a boarding home or home for the aged. Home does not include a hospital skilled nursing facility, or intermediate care facility.

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REHABILITATION CLINICS
171.2B.VII. - 171.2B.IX.

B. Definitions (con't.)

VII. Speech Pathologist

"Speech Pathologist" means a person who is licensed to practice speech pathology under Chapter 399 of the State Statutes.

VIII. Audiological Services

"Audiological Services" means the application of principles, methods and procedures of measurement, testing, appraisal, prediction, consultation, counseling and the determination and use of appropriate amplification related to hearing and disorders of hearing, for the purpose of modifying communicative disorders involving speech, language, auditory function or other aberrant behavior related in hearing loss. Services are performed by an audiologist.

IX. Audiologist

"Audiologist" means a person who is licensed to practice audiology under Chapter 399 of the State Statutes.

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REHABILITATION CLINICS
171.2B.V. - 171.2B.VI.

B. Definitions (con't.)

V. Functional Therapy

"Functional Therapy" means a short term therapeutic rehabilitation program of which the major component is the treatment of a medical and/or psychological condition of disabled or handicapped adolescents or adults who have been determined to have no vocational objective. The program is individually planned and co-ordinated and includes, participation in work activity services concurrent with the medical services and is designed to enhance the individual's daily living skills. The work activity services are provided in a medical sheltered workshop facility which performs such service.

VI. Speech Pathology Services

"Speech Pathology Services" mean the application of principles, methods and procedures for the measurement, testing, diagnosis, prediction, counseling or instruction relating to the development and disorders of speech, voice or language for the purpose of diagnosing, preventing, treating, ameliorating or modifying such disorders and conditions. Services are provided by a speech pathologist.

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REHABILITATION CLINICS

171.2 - 171.2B.II.

171.2 Rehabilitation Clinics

Covered in this Section are: Independent comprehensive rehabilitation facilities; speech, hearing and language clinics affiliated with health centers; and other independent rehabilitation clinics providing diagnostic, therapeutic and restorative services to injured, ill or disabled individuals.

A. Legal Bases

- I. Federal Regulations: 42 CFR 440.130d, 440.110, 440.90
- II. State Statute: 17-134d, 17-313 a,b,c
- III. A.P.A. Regulation: None

B. Definitions

I. Rehabilitation

"Rehabilitation" means the process of restoring an individual to useful life, who has been ill or, who is handicapped and has a potential for improvement.

II. Rehabilitation Services

"Rehabilitation Services" means medical and remedial services provided to an outpatient, the purpose of which, is the maximum reduction of physical or mental disabilities and restoration of eligible recipients to their best possible functional level. The services are performed under the direction of a licensed physician (M.D.) and shall be provided only at the rehabilitation facility except as allowed for Medical Sheltered Workshops.

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REHABILITATION CLINICS
171.2B.III. - 171.2B.IV.

B. Definitions (con't.)

III. "By or under the direction of a physician"

"By or under the direction of a physician" means: a free-standing rehabilitation clinic's services may be provided by allied health professionals, including: audiologists, speech pathologists, occupational therapists, and other medical staff whether or not a physician is physically present in the clinic at the time that medical services are provided. The physician:

- a. must assume professional responsibility for the services provided;
- b. assure that the services are medically appropriate, i.e., the services are intended to meet a medical or medically-related need, as opposed to needs which are clearly only social, recreational or educational;
- c. need not be on the premises, but must be readily available, meaning within fifteen (15) minutes.

IV. Medical and Remedial Services

"Medical and Remedial Services" mean those services ordered by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law and required for the diagnosis and treatment of some physical or psychological problem which affects the health of an individual.

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REHABILITATION CLINICS
171.2B.XI. - 171.2B.XIII.

B. Definitions (con't.)

XI. Occupational Therapist or Occupational Therapy Assistant

COTA
"Occupational Therapist or Occupational Therapy Assistant" means a person who is licensed to practice occupational therapy under Chapter 376a of the State Statutes.

XII. Physical Therapy Services

Physical Therapy Services means: (1) diagnostic services to determine an individual's level of functioning, employing such performance tests as measurements of strength, balance, endurance, and range of motion; (2) treatment services which utilize therapeutic exercises and modalities of heat, cold, water, and electricity, for the purpose of preventing, restoring, or alleviating a lost or impaired physical function. Services are performed by a licensed physical therapist who develops a written individual program of treatment. The term "physical therapy" does not include the use of cauterization or the use of Roentgen rays or radium for diagnostic or therapeutic purposes.

XIII. Physical Therapist

"Physical Therapist: means a person who is licensed to practice physical therapy under Chapter 376 of the State Statutes.

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171.2B.X. - 171.2B.X.

B. Definitions (con't.)

X. Occupational Therapy Services

"Occupational Therapy Services" means services prescribed by a physician for the evaluation, planning, and implementation of a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximal physical and mental functioning of the individual in his daily pursuits. The practice of "occupational therapy" includes, but is not limited to, evaluation and treatment of individuals whose abilities to cope with the tasks of living are threatened or impaired by physical illness or injury, emotional disorder, congenital or development disability, using (1) such treatment techniques as task-oriented activities to prevent or correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the individual, (2) such evaluation techniques as assessment of sensory motor abilities, assessment of the development of self-care activities and capacity for independence, assessment of the physical capacity for prevocational and work tasks, assessment of play and leisure performance, and appraisal of living areas for the handicapped, (3) specific occupational therapy techniques such as activities of daily living skills, the fabrication and application of splinting devices, sensory motor activities, the use of specifically designed manual and creative activities, guidance in the selection and use of adaptive equipment, specific exercises to enhance functional performance, and treatment techniques for physical capabilities for work activities.

Services are performed by an occupational therapist to evaluate the patient's level of functioning and develop a plan of treatment. The implementation of the plan may be carried out by an occupational therapy assistant functioning under the general supervision of the occupational therapist.

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REHABILITATION CLINICS
171.2E.I.j. - 171.2E.II.a.

E. Services Covered and Limitations (con't.)

I. Services covered: (con't.)

j. Functional therapy, must include at least one of the following:

1. Physical therapy
2. Speech therapy
3. Occupational therapy
4. Audiological services
5. Psychiatric and/or psychological services
6. Other medical services

Social Services may also be covered with any of the above medical rehabilitation services. The Social Services must be included in the plan of treatment and contribute to the improvement of the individual's condition.

k. Early Childhood Intervention Programs

l. Traumatic Brain Injury Day Treatment Program

II. Limitations

- a. All services, treatments, and therapy which are contained in the individual's plan of care must be provided at the facility except for medical services for participants in sheltered workshop facilities providing functional therapy which do not furnish the required medical services at the facility. These facilities must contract with licensed and Department of Health Services recognized professionals in private practice or in clinics to treat the participant's medical need.

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REHABILITATION CLINICS
171.2E.II.b. - 171.2E.II.e.

E. Services Covered and Limitations (con't.)

II. Limitations (con't.)

b. Evaluations and Diagnostic Testing

1. Only one (1) complete evaluation per recipient will be paid for per year involving the same treatment modality by the same provider.
2. Only one (1) tympanometry test, full impedance battery, or electronystagmography per recipient will be paid for per year by the same provider. (Refer to Section H.).

c. Sheltered workshop services for individuals who are primarily diagnosed as developmentally disabled are covered only if their need for this type of program stems from an etiology readily identifiable as medical or psychological in origin.

d. Treatment services are limited to one (1) unit of service per day for the same procedure and the same patient, regardless of the length of time it takes to complete the procedure, except those clinics providing speech therapy reimbursed in half ($\frac{1}{2}$) hour increments, as approved by the Department. These clinics will not be reimbursed for more than three (3) half-hour units of service per day for the same patient.

e. T.B.I. treatment programs are limited to individuals who have sustained injury from interaction of any external forces resulting in the central nervous system (brain) dysfunctions. Developmental impairment primarily contributing to brain dysfunction is not included. The impairment must be readily identifiable as having been sustained through injury.

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REHABILITATION CLINICS
171.2E.III.b. - 171.2E.III.e.

E. Services Covered and Limitations (con't.)

III. Services Not Covered (con't.)

- * b. Concurrent services for the same client involving similar services or procedures
- c. Periodic follow-up visits upon completion of treatment services except as limited to services involving "medical check-up" (See Section B)
- d. Speech services involving non-diagnostic, non-therapeutic, routine, repetitive, and reinforced procedures or services for the patient's general good and welfare; e.g., the practicing of word drills. Such services do not constitute speech pathology services for Medicaid purposes and would not be covered since they do not require performance by or the supervision of a qualified speech pathologist.
- e. Services as described in section E.I. and E.II. are not covered if an individual's expected restoration potential would be insignificant in relation to the extent and duration of rehabilitation services required to achieve such potential.

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REHABILITATION CLINICS
171.2E.II.f. - 171.2E.III.a.

E. Services Covered and Limitations (con't.)

II. Limitations (con't.)

- f. The TBI program is primarily as medical rehabilitation program, however, vocational, social and educational services may be covered only when these services are (1) related to the individual's injury, (2) are reasonable and necessary for the diagnosis or treatment of the injury, (3) a part of the recipient's written individual plan of care.
- g. Services covered are limited to those listed in the Department's Fee Schedule.
- h. Programs relating to the learning of basic living or social skills, or other activities of daily living are limited to individuals who have lost or have had impaired functions of daily living and require retraining to maximize restoration of these skills.

III. Services Not Covered

- a. Services provided by the facility's professional staff which are related solely to specific employment opportunities, workskills, work settings, and/or academic skills (reading, writing, mathematics) and are not reasonable or necessary for the diagnosis or treatment of an illness or injury are not covered.

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SUPERSEDES PT82-47

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REHABILITATION CLINICS
171.2F.I.b.1. - 171.2F.I.b.2.(a)

F. Need for Service and Authorization Process (con't.)

I. Need for Service (con't.)

b. Functional Therapy Program

1. A recipient may participate in a functional therapy program at a medical sheltered workshop, if
 - (a) The recipient has a condition which is appropriate for the workshop, and
 - (b) The workshop is able to provide the services which the recipient's physician (M.D.) orders and which are deemed appropriate by the Department's Medical Consultant.
 - (c) The recipient has a substantial, documented, medical or psychological condition which can be expected to improve or provide functional improvement through services provided by the medical sheltered workshop.
2. For functional therapy participants, a written plan of care and a written agreement of participation must be executed by the recipient and/or the recipient's guardian or conservator, prior to the recipient's admission into the program.
 - (a) Plan of Care

The plan of care is based upon recommendations from the individual's physician, the individual's progress as determined by workshop staff, and other supportive services approved by the Department's medical consultant. The plan of care shall be coordinated with a total plan of care.

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SUPERSEDES PT82-31

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REHABILITATION CLINICS
171.2E.III.f. - 171.2F.I.a.

E. Services Covered and Limitations (con't.)

III. Services Not Covered (con't.)

- f. When maximum benefits from any treatment program are reached, the service will no longer be covered, in other words, there is no payment for services providing maintenance at maximum functional levels.
- g. Cancelled clinic visits or appointments not kept or other lack of attendance for services.
- h. Services provided to a hospital inpatient.
- i. Payment for hearing aid orientation services by facilities licensed to dispense hearing aids. The dispensing fee includes this service.

F. Need for Service and Authorization Process

I. Need for Service

- a. Any Medicaid eligible person requiring medical or medically related treatment necessary to improve daily functioning due to a disabling mental or physical condition may receive rehabilitation services as prescribed by a physician.

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REHABILITATION CLINICS
171.2E.I. - 171.2E.I.i.

E. Services Covered and Limitations (con't.)

I. Services covered:

- a. Physical Therapy
- b. Speech and Language
- c. Audiological
- d. Hearing Aid
- e. Occupational Therapy
- f. Electronystagmography
- g. Inhalation Therapy
- h. Psychological
- i. Physician

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REHABILITATION CLINICS
171.2C, - 171.2E.

C. Provider Participation

- I. The provider must meet all applicable licensing and certification requirements.
- II. The provider must meet all departmental enrollment requirements.

D. Eligibility

Payment for clinics providing rehabilitation services is available for all persons eligible for Medicaid subject to the conditions and limitations which apply to these services.

E. Services Covered and Limitations

Except for the limitations and exclusions listed below, the Department will pay for rehabilitation services which conform to accepted methods of diagnosis and treatment, but will not pay for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the Department to treat the recipient's condition or for services not directly related to the recipient's diagnosis, symptoms or medical history.

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REHABILITATION CLINICS
171.2F.I.b.2.(b) - 171.2F.I.c.1.(a)

F. Need for Service and Authorization Process (con't.)

- I. Need for Service (con't.)
- b. Functional Therapy Program
2. (con't.)

(b) The admission agreement shall include:

- (1) Any nonfinancial obligations of the individual to the workshop. (e.g. a commitment from the individual to attend the workshop a specified number of days per week).
- (2) The days and hours the program operates
- (3) A schedule of holidays when the workshop is closed, and
- (4) The announcement procedures for unexpected closing due to disaster or inclement weather.

c. Traumatic Brain Injury Day Treatment Program

1. A recipient may participate in a TBI Day Treatment Program, if

- (a) the recipient's impairment results in an identifiable medical, physical and psycho-social need for medical rehabilitation services to the extent that the recipient may be expected to be restored to a level of daily functioning that they may enter a traditional vocational program, and/or educational program, and/or have attained an optimal level of independent living as possible.)

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REHABILITATION CLINICS
171.2F.I.c.1.(b) - 171.2F.I.c.1.(d)

F. Need for Service and Authorization Process (con't.)

I. Need for Service (con't.)

c. Traumatic Brain Injury Day Treatment Program

1. (con't.)

(b) The services are a part of an individual's plan of care which primarily includes any of the following skilled medical rehabilitation modalities: (1) physical therapy; (2) occupational therapy; (3) speech and language therapy; (4) cognitive retraining; (5) psychological/psychiatric services. Concurrent to the medical rehabilitative services, subordinate vocational, social and educational services may be provided as a part of the written plan of care. (see subsection E.II. and E.III. for program limitations)

(c) The plan of care must contain the diagnosis, the type, amount, frequency and duration of services to be given and the anticipated program goals.

(d) The plan of care must be reviewed by the interdisciplinary team under the direction of the team physician at least every sixty (60) days. Following the review, the team physician should certify that the plan of care is being followed and that the patient is making progress in attaining the established rehabilitation goals.

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REHABILITATION CLINICS
171.2E.III.f. - 171.2F.I.a.

E. Services Covered and Limitations (con't.)

III. Services Not Covered (con't.)

- f. When maximum benefits from any treatment program are reached, the service will no longer be covered, in other words, there is no payment for services providing maintenance at maximum functional levels.
- g. Cancelled clinic visits or appointments not kept or other lack of attendance for services.
- h. Services provided to a hospital inpatient.
- i. Payment for hearing aid orientation services by facilities licensed to dispense hearing aids. The dispensing fee includes this service.

F. Need for Service and Authorization Process

I. Need for Service

- a. Any Medicaid eligible person requiring medical or medically related treatment necessary to improve daily functioning due to a disabling mental or physical condition may receive rehabilitation services as prescribed by a physician.

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REHABILITATION CLINICS
171.2F.I.b.1. - 171.2F.I.b.2.(a)

F. Need for Service and Authorization Process (con't.)

I. Need for Service (con't.)

b. Functional Therapy Program

1. A recipient may participate in a functional therapy program at a medical sheltered workshop, if

(a) The recipient has a condition which is appropriate for the workshop, and

(b) The workshop is able to provide the services which the recipient's physician (M.D.) orders and which are deemed appropriate by the Department's Medical Consultant.

(c) The recipient has a substantial, documented, medical or psychological condition which can be expected to improve or provide functional improvement through services provided by the medical sheltered workshop.

2. For functional therapy participants, a written plan of care and a written agreement of participation must be executed by the recipient and/or the recipient's guardian or conservator, prior to the recipient's admission into the program.

(a) Plan of Care

The plan of care is based upon recommendations from the individual's physician, the individual's progress as determined by workshop staff, and other supportive services approved by the Department's medical consultant. The plan of care shall be coordinated with a total plan of care.

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REHABILITATION CLINICS
171.2F.III.b. - 171.2F.III.b.2.

F. Need for Service and Authorization Process (con't.)

III. Prior Authorization (con't.)

- b. The initial authorization period for ongoing rehabilitation services will be up to three (3) months except functional therapy and TBI treatment programs which shall be authorized up to six (6) months.

All evaluation reports shall include the individual treatment goals, short and long term, and evidence of the medical need from rehabilitation services.

1. The authorization request shall include a copy of the written clinical evaluation report for each treatment modality for which prior authorization is requested.
2. The authorization request for a TBI day treatment program shall include the interdisciplinary team's written clinical assessment of the recipient's condition which evidences the need for medical rehabilitation services and any other clinical reports the team may deem to be important supportive evidence of need. Such reports must result from an evaluation by other rehabilitation professionals, clinics, or physicians, occurring within the immediate three (3) months prior to the date the recipient is to enter the TBI Day Treatment Program.

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REHABILITATION CLINICS
171.2F.III.c. - 171.2F.III.c.

F. Need for Service and Authorization Process (con't.)

III. Authorization Procedure (con't.)

- c. A reassessment by the rehabilitation professional or interdisciplinary team (for TBI program participants) evidencing continued need for treatment is required at least once during each period of departmental authorization.

If the findings of the reassessment disclose the need for further services, the reassessment, in written summary form, signed by a physician (M.D.) together with any other written clinical evidence relating to the recipient's need for further services, is attached to Form W-626, "Request for Prior Authorization for Private Clinics". The new authorization request shall be submitted to the Department not less than fourteen (14) days prior to the expiration of the current authorization period. The reassessment shall describe the further treatment required, progress of the participant to date with goals achieved, and further treatment program goals and is submitted to:

State Department of Income Maintenance
Medical Consultant
110 Bartholomew Avenue
Hartford, Connecticut 06106

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REHABILITATION CLINICS
171.2F.III.b. - 171.2F.III.b.2.

F. Need for Service and Authorization Process (con't.)

III. Prior Authorization (con't.)

- b. The initial authorization period for ongoing rehabilitation services will be up to three (3) months except functional therapy and TBI treatment programs which shall be authorized up to six (6) months.

All evaluation reports shall include the individual treatment goals, short and long term, and evidence of the medical need from rehabilitation services.

1. The authorization request shall include a copy of the written clinical evaluation report for each treatment modality for which prior authorization is requested.
2. The authorization request for a TBI day treatment program shall include the interdisciplinary team's written clinical assessment of the recipient's condition which evidences the need for medical rehabilitation services and any other clinical reports the team may deem to be important supportive evidence of need. Such reports must result from an evaluation by other rehabilitation professionals, clinics, or physicians, occurring within the immediate three (3) months prior to the date the recipient is to enter the TBI Day Treatment Program.

ISSUED BY PT83-32
SUPERSEDES PT82-47

State of Connecticut
Department of Income Maintenance
Medical Care Administration

MEDICAL SERVICES POLICY

REHABILITATION CLINICS
171.2F.II. - 171.2F.III.a.

F. Need for Service and Authorization Process (con't.)

II. Prior Authorization

The following services require prior authorization from the Department:

- a. All individual therapy or treatment services and day treatment program services;
- b. Partial Evaluations in excess of one (1) in ninety (90) days from the date of a complete evaluation, medical check-up, or another partial evaluation, involving the same treatment modality and provider;
- c. Medical Check-up in excess of one (1) in ninety (90) days from the date of a complete evaluation, partial evaluation, or another medical check-up, involving the same treatment modality and provider,
- d. Complete evaluations which occur within ninety (90) days from the date a partial evaluation or medical check-up involving the same treatment modality and provider.

III. Authorization Procedure

For services prior authorized, the procedure or course of treatment must be initiated within six (6) months from the date of authorization.

- a. Form W-626 "Authorization Request for Private Clinics" is used to obtain prior authorization and is submitted to:

Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106

ISSUED BY PT83-32
SUPERSEDES PT82-47

State of Connecticut
Department of Income Maintenance
Medical Care Administration

MEDICAL SERVICES POLICY

REHABILITATION CLINICS
171.2F.III.d. - 171.2F.III.f.

F. Need for Service and Authorization Process (con't.)
III. Authorization Procedure (con't.)

- d. All requests requiring authorization must also include:
 - 1. The name of the physician, and/or clinic making the referral
 - 2. The specific number of visits required
 - 3. The period of time by dates covered by the request
 - 4. The specific type of service required and a description of the service to be rendered.
 - 5. The complete diagnosis and other conditions for which the recipient needs services.
- e. A request for a partial evaluation or medical check-up in excess of one (1) in a ninety (90) day period as described in Section F.II. shall document the specific medical need for such additional services.
- f. To request additional services or other changes in the treatment plan within a period already authorized, a copy of the authorized form W-626 for that time period must be submitted with justification for the additional request and the statement "Additional Services" should be written on the form.

ISSUED BY PT83-32
SUPERSEDES PT82-47

State of Connecticut
Department of Income Maintenance
Medical Care Administration

MEDICAL SERVICES POLICY

REHABILITATION CLINICS
171.2G. - 171.2G.II.

* G. Other

I. Payment to a Salaried Physician

Physicians who are fully or partially salaried by a clinic may not receive payment from the Department unless the physician maintains an office for private practice at a separate location from the clinic.

Physicians who are solely clinic-based either on full time or part time salary are not entitled to individual payment from the Department for services rendered to Title XIX recipients. Services are to be billed by the provider clinic.

Physicians who maintain an office for private practice separate from the clinic may bill for services provided at the private practice location or for services provided to the physician's private practice patients at the clinic only if the patient is not a clinic patient.

- II. Rehabilitation services must relate directly and specifically to a written individualized treatment plan established by or under the direction of a licensed physician. The written plan of treatment shall be part of the individual's record on file in the clinic, and shall be reviewed periodically by the appropriate facility health professional(s) to reassess goals and objectives of treatment making changes in the treatment plan as necessary.

ISSUED BY PT83-32
SUPERSEDES PT82-47

State of Connecticut
Department of Income Maintenance
Medical Care Administration

MEDICAL SERVICES POLICY

REHABILITATION CLINICS
171.2G.IV. - 171.2G.V.d.

G. Other (con't.)

- IV. The functional therapy program and TBI Day Treatment shall be subject to periodic monitoring by the Department of Income Maintenance staff. The purpose of monitoring shall be to:
- a. Assess the quality and appropriateness of participant's plan of care
 - b. Determine the effectiveness of the program
 - c. Determine adherence to provider eligibility requirements and other program requirements contained in the medical services policy.

- V. Procedure for discharge from the functional therapy and TBI treatment programs.

The facility is required to document in writing the following information which shall be placed in the participant's record:

- a. A discharge summary (final reassessment)
- b. Recommendations for continuing sources of treatment, if appropriate
- c. Referrals to other agencies or facilities for continuing treatment or service, if appropriate
- d. Written notification to the participant and, if appropriate, to the participant's guardian or conservator if the facility's intent is to discharge the participant from the program.

ISSUED BY PT83-32
SUPERSEDES PT82-47

State of Connecticut
Department of Income Maintenance
Medical Care Administration

MEDICAL SERVICES POLICY

REHABILITATION CLINICS
171.2G.III. - 171.2G.III.f.

G. Other (con't.)

III. The functional therapy participant's record must contain at least the following:

- a. Basic identifying information e.g. name, address, date of birth, sex, source of referral, date(s) of admission into the workshop and Medicaid case number
- b. Emergency contact (name and telephone number)
- c. The name and telephone number of the participant's physician or medical provider
- d. A signed order by the physician specifying the need for medical sheltered workshop, with findings and recommendations
- e. The prior authorizations (W-626) for the initial and extended periods of attendance at the workshop beyond the initial authorization

f. A copy of the written agreement between the participant and the workshop.

ISSUED BY PT82-47
SUPERSEDES PT82-31

State of Connecticut
Department of Income Maintenance
Medical Care Administration

MEDICAL SERVICES POLICY

REHABILITATION CLINICS
171.2H.IV. - 171.2I.I.d.

H. Billing Procedure (con't.)

- IV. Except for services which are all-inclusive, an evaluation performed outside the rehabilitation clinic must be billed by the licensed professional actually providing the service. (Refer to section E.II.)
- V. For an evaluation or test which is not completed on the same day, the provider should bill for services as of the date the evaluation or test has been completed.

I. Payment

- I. Payment will be made at the lower of:
- a. the usual and customary charge to the public, or,
 - b. the Medicare rate, or
 - c. the fee as contained in the individual clinic's fee schedule published by the Department, or
 - d. the amount billed

ISSUED BY PT82-47
SUPERSEDES PT82-31

State of Connecticut
Department of Income Maintenance
Medical Care Administration

MEDICAL SERVICES POLICY

REHABILITATION CLINICS
171.2H. - 171.2H.V.

H. Billing Procedure

- I. Form HCFA 1500 "Health Insurance Claim Form" is used for billing all clinic services. The bill is mailed to the Department's fiscal agent:

Electronic Data Systems Federal
P.O. Box 2941
Hartford, Connecticut 06104

- II. All claims submitted for payment which include prior authorized procedures must include the authorization number from the current authorization.
- III. Claims submitted for services not requiring prior authorization must include the name of the physician, or clinic making the referral.
- IV. Except for services which are all-inclusive, an evaluation performed outside the rehabilitation clinic must be billed by the licensed professional actually providing the service. (Refer to section E.II.)
- V. For an evaluation or test which is not completed on the same day, the provider should bill for services as of the date the evaluation or test has been completed.

ISSUED BY PT83-32
SUPERSEDES PT82-47

State of Connecticut
Department of Income Maintenance
Medical Care Administration

MEDICAL SERVICES POLICY

REHABILITATION CLINICS
171.2I. - 171.2I.II.b.

I. Payment

I. Payment will be made at the lower of:

- a. the usual and customary charge to the public, or,
- b. the Medicare rate, or
- c. the fee as contained in the individual clinic's fee schedule published by the Department, or
- d. the amount billed

II. Payment Rate

a. In-State Clinics

The Commissioner of the Department of Income Maintenance establishes the fees as contained in the in-state rehabilitation facility's individual fee schedule. The fees are based on reasonable costs in the respective facility where the service is rendered.

b. Out-of-State Clinics

The fees as contained in the out-of-state rehabilitation facility's individual fee schedule are based on the Medicaid rate established by the appropriate rate setting agency in the respective state where the clinic is located.

ISSUED BY PT83-32
SUPERSEDES PT82-47
SUPERSEDES PT82-31

State of Connecticut
Department of Income Maintenance
Medical Care Administration

MEDICAL SERVICES POLICY

REHABILITATION CLINICS
171.2I.III. - 171.2I.III.a.4.

I. Payment (con't.)

III. Payment Limitations

- a. The rate is determined annually by the Commissioner of Income Maintenance for the following facilities in accordance with Section 17-313 of the General Statutes:
1. Rehabilitation centers affiliated with Easter Seal Society for Crippled Children and Adults of Conn., Inc.
 2. The association affiliated with United Cerebral Palsy of Conn., Inc.
 3. The facilities affiliated with the Association for Retarded Citizens.
 4. Any private non-profit agency providing such programs for autistic or neurologically impaired persons for services to clients referred by any State agency.

ISSUED BY PT83-32
SUPERSEDES PT82-31

State of Connecticut
Department of Income Maintenance
Medical Care Administration

MEDICAL SERVICES POLICY

REHABILITATION CLINICS
171.2I.III.c. - 171.2I.III.g.

Payment (con't.)

III. Payment Limitations (con't.)

- c. The fee for an evaluation of any individual treatment modality includes a written report.
- d. The cost of electroneurostagnography includes interpretation unless otherwise approved by the Department.
- e. No payment is made for periodic reassessment of an individual's treatment goals and objectives, except for partial evaluations and medical check-ups as defined in Section B.
- f. If the facility provides transportation as a part of its fee, no separate payment for transportation will be made.
- g. Payment for TBI day treatment services will discontinue when the TBI program interdisciplinary team determines the recipient to be eligible for vocational training. A referral shall be made to an appropriate vocational training program by the team.

ISSUED BY PT83-32
SUPERSEDES PT82-47

State of Connecticut
Department of Income Maintenance
Medical Care Administration

MEDICAL SERVICES POLICY

REHABILITATION CLINICS
171.2I.III.b. - 171.2I.III.b.4.

I. Payment (con't.)

III. Payment Limitations (con't.)

b. The rates for the following medical rehabilitation programs are all-inclusive and represent the maximum amount payable for any recipient from all sources of necessary rehabilitation services. The all-inclusive rate is comprised of services which are: (1) certified by a physician (M.D.) that the recipient requires skilled rehabilitation services, (2) furnished under a written plan of care developed by the facility's professional staff, and, (3) a service directly relating to the recipient's impairment and treatment goals as established by the staff. These services include, but are not limited to: therapy, evaluations, psychological/psychiatric services, other medical rehabilitation services, and transportation services:

1. Functional Therapy
2. Ripple Program
3. Early Childhood Intervention Programs
4. Traumatic Brain Injury Day Treatment Program

ISSUED BY PT83-32
SUPERSEDES PT82-47

State of Connecticut
Department of Income Maintenance
Medical Care Administration

MEDICAL SERVICES POLICY

REHABILITATION CLINICS
171.2J.I. - 171.2J.I.

J. Fee Schedule (con't.)

I. Procedure Code and Description of Service Summary (con't.)

02630	Speech, Language & Hearing Therapy
02700	Speech & Language Evaluation - Complete
02701	Speech and Language Evaluation - Partial
02710	Speech & Hearing Evaluation - Complete
02711	Speech and Hearing Evaluation - Partial
02730	Aural Rehabilitation
02890	Psychological/Psychiatric Evaluation Related to Rehab. Therapy
03110	Transportation - One Way
03120	Transportation - Round Trip
92541	Electronystagmography (includes interpretation)
92566	Impedance Testing
92567	Tympanometry
94664	Inhalation Therapy

State of Connecticut
Department of Income Maintenance
Medical Care Administration

MEDICAL SERVICES POLICY

REHABILITATION CLINICS
171.2J.I. - 171.2J.I.

J. Fee Schedule (con't.)

I. Procedure Code and Description of Service Summary (con't.)

02161	Medical Evaluation - Partial
02190	Individual Psychotherapy Related To Rehab. Therapy
02200	Group Psychotherapy Related to Rehab. Therapy
02250	Functional Therapy
02255	Transitional Rehabilitation Services
02300	Early Childhood Intervention Program
02320	Ripple Diagnostic Evaluation
02330	Ripple Program Transdisciplinary Team
02340	CDEC Diagnostic Evaluation
02350	CDEC Diagnostic Evaluation (mini)
02500	Speech Evaluation
02510	Speech Therapy
02511	Speech and Language Medical Check-up
02530	Hearing Therapy
02531	Hearing Therapy Medical Check-up
02570	Hearing Training

State of Connecticut
Department of Income Maintenance
Medical Care Administration

MEDICAL SERVICES POLICY

REHABILITATION CLINICS
171.2J. - 171.2J.I.

J. Fee Schedule

I. Procedure Code and Description of Service Summary

The following are procedure codes that can be used by free-standing Rehabilitation Clinics. Not all providers can bill for all of these services.

02010	Occupational Therapy Evaluation - Complete
02011	Occupational Therapy Evaluation - Partial
02020	Occupational Therapy
02021	Occupational Therapy Medical Check-up
02030	Traumatic Brain Injury Day Treatment Program
02060	Physical Therapy Evaluation - Complete
02061	Physical Therapy Evaluation - Partial
02070	Physical Therapy
02071	Physical Therapy Medical Check-up
02080	Hearing Evaluation - Complete
02081	Hearing Evaluation - Partial
02100	Hearing Aid Evaluation
02150	Speech & Hearing Therapy
02151	Speech and Hearing Medical Check-up
02160	Medical Evaluation - Complete

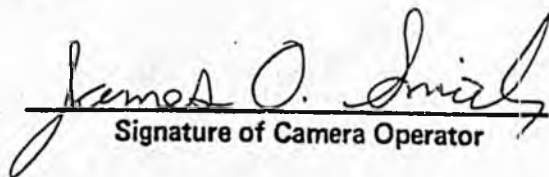
ISSUED BY PT83-32
SUPERSEDES PT82-47

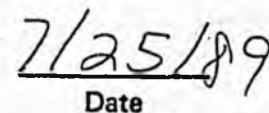


RECORDS CERTIFICATION



I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.


Signature of Camera Operator


Date

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ANCHORAGE
SCHOOL DISTRICT

4600 DeBarr Avenue
P.O. Box 196614
Anchorage, Alaska 99519-6614
AREA CODE [907] 333-9561



SCHOOL BOARD

Betty Davis
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Martha Roderick
Vice President

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Clerk

Jean Buchanan
Clerk Pro Tem
Past President

Jim Robinson
Treasurer
Immediate Past President

Carol Stolpe
Assistant Treasurer

Betty Bruckman
Parliamentarian

SUPERINTENDENT

E.E. (Gene) Davis, Ed.D.

March 17, 1986

The Honorable Max Gruenberg, Jr.
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Mr. Gruenberg:

This is response to House Bill No. 674 entitled: "An Act relating to certification requirements for teachers."

The District finds this Bill to have major impact. It is not in the best interest of the District to allow teachers with twenty (20) years to automatically retain a teaching certificate for the purpose of substitute teaching. It is extremely important to have highly qualified teachers, including substitutes. Therefore, substitutes need to earn recency credit to keep current with new teaching practices and instructional strategies.

Sincerely,

E. E. (Gene) Davis, Ed.D.
SUPERINTENDENT

nct
LEGIS 1.08

cc L. T. Freeman, Assistant Superintendent for Business Management
Bill Miles, School District Lobbyist

Introduced: 2/17/86
Referred: Health, Education &
Social Services

1 IN THE HOUSE

BY NAVARRE

2

HOUSE BILL NO. 674

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

4

FOURTEENTH LEGISLATURE - SECOND SESSION

5

A BILL

6 For an Act entitled: "An Act relating to certification requirements for
7 teachers."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. AS 14.20.020(d) is amended to read:

10 (d) The board may by regulation establish various classes of
11 certificates. The board shall provide that a teacher who has held an
12 Alaska teacher's certificate for 20 years may retain the certificate
13 for purposes of substitute teaching appointments without meeting
14 continuing education requirements.



RECORDS CERTIFICATION



I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.

James O. Smith
Signature of Camera Operator

7/25/89
Date

H

B

6

78

POSITION PAPER

HOUSE BILL 678

I. PURPOSE OF HB678

HB678 seeks greater Departmental discretion in defining the General Relief Medical services to be offered if adequate funds are not available to continue a comprehensive range of medical services. HB678 also gives the Department authority to establish recipient cost sharing for services received, limits the amount of assistance to a maximum of \$25,000 a year per person, and permits the Department to effect a pro rata reduction of facility payment rates in order to operate within the funds appropriated.

This legislation is necessitated by the proposed reduction in the General Relief Medical program budget from \$11 million to \$5 million in fiscal year 1987. Passage of HB678 is essential to insure that the Department of Health and Social Services has adequate legal authority to effect significant program reductions in FY87.

The Division of Medical Assistance has published a briefing paper dated February 12, 1986, describing the scope of the present General Relief Medical program and the changes proposed for FY87.

II. SECTIONAL ANALYSIS

This sectional analysis is repeated verbatim from Governor Sheffield's transmittal letter for HB678 which appears in the 1986 House Journal on pages 2157 and 2158.

Section 1

Section 1 of the bill proposes that in making general relief assistance eligibility determinations, the Department of Health and Social Services take into account the income and resources of persons who reside with the needy person and who either are related to the needy person or who would benefit directly from assistance given to the needy person. In addition, the maximum amount of assistance that can be received for medical care would be \$25,000 per year per person. The amendments in Section 1 of the bill also require the department to establish, by regulation, categories of medical care services and any applicable conditions, and establish priorities for reducing services if the department anticipates that requests for assistance under the assistance program will exceed the program's appropriations.

Section 2

Section 2 of the bill proposes that the needy person pay for the first \$50 of expenses incurred for each day of a hospital stay, to a maximum of \$200 per hospital admission. The needy person will also be liable for \$20 for each outpatient visit. The needy person's liability will

be deducted from any assistance for medical care that is paid to a medical provider on behalf of a needy person.

Section 3

Section 3 of the bill adds a new subsection to provide that when there is insufficient money for medical assistance, the department may by regulation establish a prospective pro rata reduction of a health facilities' payment rates.

Section 4

Section 4 of the bill amends AS 47.25.250 to provide that temporary general relief assistance for transportation may not exceed \$120 per month. Under the amendment, only medical care temporary assistance may exceed the \$120 limit. Medical care is defined to include medically necessary transportation therefore the \$120 temporary assistance limit would not apply.

Section 5

Section 5 of the bill requires repayment of medical assistance under certain conditions.

Section 6

Section 6 of the bill repeals the department's authority to give discretionary assistance to a needy person not entitled to such assistance under the general relief program.

III. DEPARTMENT POSITION

The Department strongly supports HB678 as its passage provides essential legislative direction supporting the program reductions proposed in FY87. These program reductions are so significant that the Department anticipates a legal challenge will be filed. Passage of HB678 will place the Department in a much stronger position to defend the proposed reductions.

Recommended By:

Rod Betit
Rod Betit, Director
Division of Medical Assistance

Date:

2.25.86

Approved By:

John R. Pugh
John R. Pugh, Commissioner
Department of Health and
Social Services

Date:

2/25/86

STATE OF ALASKA 1986 LEGISLATIVE SESSION FISCAL NOTE

Revision Date: _____

REQUEST

Bill/Resolution No. : HB678
 Title: An Act relating to General Relief Medical

Sponsor: Governor/Rules
 Requestor: _____
 Date of Request: _____

FISCAL DETAIL

Agency Affected: Health & Social Services
 BRU: Medical Assistance

Components: General Relief Medical

EXPENDITURES/REVENUES : (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS		-0-	-0-	-0-	-0-	-0-
MISCELLANEOUS						
TOTAL OPERATING		-0-	-0-	-0-	-0-	-0-

CAPITAL						
---------	--	--	--	--	--	--

REVENUE						
---------	--	--	--	--	--	--

FUNDING : (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL		-0-	-0-	-0-	-0-	-0-

POSITIONS :

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : Attach a separate page if necessary

Please note that the Governor's FY87 General Relief Medical budget of \$5,000.0 presumes passage of this bill.

Prepared by: Rod Betit, Director *[Signature]*
 Division: Medical Assistance

Phone: 465-3355 *[initials]*
 Date: 2/20/86

Approved by Commissioner: Joe R. [Signature]
 Agency: Department of Health & Social Services

Date: 2/25/86

- Distribution (by Agency preparing fiscal note):
- Legislative Finance
 - Legislative Sponsor
 - Requestor
 - Office of Management and Budget
 - Impacted Agency(ies)

BILL SHEFFIELD
GOVERNOR

Bill Sheffield



HB678

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

February 19, 1986

The Honorable Ben Grussendorf
Speaker of the House
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear Representative Grussendorf:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to persons in need of financial assistance. This bill proposes the amendment of current statutes governing the general relief assistance program administered by the Department of Health and Social Services.

Section 1 of the bill proposes that in making general relief assistance eligibility determinations the Department of Health and Social Services take into account the income and resources of persons who reside with the needy person and who either are related to the needy person or who would benefit directly from assistance given to the needy person. In addition, the maximum amount of assistance that can be received for medical care would be \$25,000 per year per person. The amendments in sec. 1 of the bill also require the department to establish, by regulation, categories of medical care services and any applicable conditions, and establish priorities for reducing services if the department anticipates that requests for assistance under the assistance program will not exceed the program's appropriations.

Section 2 of the bill proposes that the needy person pay for the first \$50 of expenses incurred for each day of a hospital stay, to a maximum of \$200 per hospital admission. The needy person will also be liable for \$20 for each outpatient visit. The needy person's liability will be deducted from any assistance for medical care that is paid to a medical provider on behalf of a needy person.

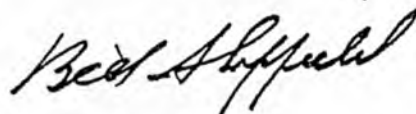
Section 3 of the bill adds a new subsection to provide that when there is insufficient money for medical assistance, the department may by regulation establish a prospective program reduction of health facilities' payment rates.

Section 4 of the bill amends AS 47.25.250 to provide that temporary general relief assistance for transportation may not exceed \$120 per month. Under the amendment, only medical care temporary assistance may exceed the \$120 limit.

Section 5 of the bill requires repayment of medical assistance under certain conditions.

Section 6 of the bill repeals the department's authority to give discretionary assistance to a needy person not entitled to such assistance under the general relief program.

Sincerely,

A handwritten signature in cursive script, appearing to read "Bill Sheffield".

Bill Sheffield
Governor

ae
2/17

STATE OF ALASKA 1986 LEGISLATIVE SESSION FISCAL NOTE

Revision Date : _____

REQUEST

Bill/Resolution No. : HB 678
 Title : An act relating to General Relief Medical

 Sponsor : _____
 Requestor : _____
 Date of Request : _____

FISCAL DETAIL

Agency Affected: Health & Social Services
 BRU: Medical Assistance

 Components : General Relief Medical

EXPENDITURES/REVENUES : (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS		-0-	-0-	-0-	-0-	-0-
MISCELLANEOUS						
TOTAL OPERATING		-0-	-0-	-0-	-0-	-0-

CAPITAL						
---------	--	--	--	--	--	--

REVENUE						
---------	--	--	--	--	--	--

FUNDING : (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL		-0-	-0-	-0-	-0-	-0-

POSITIONS :

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : Attach a separate page if necessary

Please note that the Governor's FY87 General Relief Medical budget of \$5,500.0 presumes passage of this bill.

Prepared by: Rod Betit, Director
 Division: Medical Assistance

Phone: 465-3355
 Date: February 14, 1986

Approved by Commissioner: [Signature]
 Agency: Health & Social Services

Date: 2/17/86

Distribution (by Agency preparing fiscal note):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)