Washington State
Department of Social
& Health Services

Report to the Legislature

Traumatic Brain Injury Annual Report

Chapter 356, Laws of 2007 (2SHB 2055, Section 4)

December 2007

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Traumatic Brain Injury Annual Report to the Legislature

Table of Contents

Traumatic Brain Injury Annual Report to the Legislature

Executive Summary

Chapter 356, Laws of 2007 (2SHB 2055), also known as the Tommy Manning Act, was enacted by the Legislature to address issues related to Traumatic Brain Injury (TBI). The law recognizes that current programs and services are not funded or designed to address the diverse needs of individuals with traumatic brain injuries (TBI). The intent of the law is to bring together expertise from the public and private sector to address the needs of this population. This is carried out by creating a Traumatic Brain Injury Strategic Partnership Advisory Council charged with identifying methods and systems necessary to support individuals with TBI throughout Washington State.

This report from the Department of Social and Health Services (DSHS) meets the following requirements specified in 2SHB 2055, Section 4(5):

> (5) By December 1, 2007, and by December 1st each year thereafter, the department shall issue a report to the governor and the legislature containing the following:
> (a) A summary of action taken by the department to meet the needs of individuals with traumatic brain injuries; and
> (b) Recommendations for improvements in services to address the needs of individuals with traumatic brain injuries.

To build this report, DSHS created a workgroup with representatives from various administrations within the department. The report contains the results of a survey completed by each administration and the efforts of the workgroup to identify current work being undertaken to serve individuals with TBI, as well as gaps in current service delivery systems. Recommendations to address the identified gaps are also included.

The legislation also calls for the implementation of a statewide information and referral system, a public awareness campaign, and funding for support groups related to traumatic brain injury. These issues will be addressed in the final report due to the Legislature by December 1, 2008.

Section 1: Background

Traumatic brain injury (TBI) occurs when a sudden trauma causes damage to the brain. According to the Federal Centers for Disease Control (CDC), approximately 1.4 million people sustain a traumatic brain injury each year in the United States from a variety of causes including falls, motor vehicle accidents,

being struck by an object, or as a result of a violent crime. Additionally, an increase in war time activities has produced significant numbers of veterans who sustain traumatic brain injuries from incidents during their service in the military.

Disabilities resulting from TBI depend upon the severity of the injury, the location of the injury, and the age and general health of the individual. Some common disabilities include problems with thinking (e.g. memory, reasoning); sensation (e.g. taste, touch and smell); language (e.g. communication, expression and comprehension); and emotion (e.g. depression, anxiety, personality changes, aggression, etc.). Traumatic brain injuries can also cause seizure disorders and increase the risk for other diseases such as Parkinson's disease and Alzheimer's disease. The impact a traumatic brain injury can have on an individual and his/her family can be lifelong and devastating.

Recognizing the impact that traumatic brain injuries are having on the citizens of Washington State, the Legislature enacted Chapter 356, Laws of 2007, with the intent to:

- Establish the Washington Traumatic Brain Injury Strategic Partnership Advisory Council that must:
    - Collaborate with DSHS to develop a comprehensive statewide plan to address the needs of individuals with TBI and review the plan once developed;
    - Provide recommendations to DSHS for enhancing statewide TBI support groups;
    - Submit a report to the Legislature and the Governor regarding:
        - The development of a statewide comprehensive information and referral network;
        - The development of a statewide registry to collect data related to individuals with TBI;
        - The development of a statewide public awareness campaign; and
        - The efforts of DSHS to provide services for individuals with TBI.
- Charge the Department of Social and Health Services (DSHS) with:
    - Designating staff responsible for coordinating policies, programs, and services for individuals with TBI and providing staff support and coordination to the council;
    - Developing a public awareness campaign to increase awareness of TBI and issues facing individuals with TBI through all forms of media;
    - Providing a preliminary report to the Legislature and the Governor containing recommendations for a comprehensive statewide plan to address the needs of individuals with traumatic brain injuries, including the use of public-private partnerships and a public awareness campaign. The comprehensive plan should be created in collaboration with the council and should consider the following:
        - Building provider capacity and provider training;

        - Improving the coordination of services;
        - The feasibility of establishing agreements with private sector agencies to develop services for individuals with traumatic brain injuries; and
        - Other areas the council deems appropriate.
    - Issuing an annual report to the Governor and the Legislature containing:
        - A summary of action taken by the department; and
        - Recommendations for improvement in services.
    - Providing funding for support groups (Based on the council's recommended criteria); and
    - Providing a final report to the Legislature and the Governor containing recommendations for a comprehensive statewide plan to address the needs of individuals with TBI.

Section 2: Approach to Gathering Baseline TBI Information

To better evaluate current state systems that benefit individuals with TBI, a survey was developed and distributed to administrations and divisions within DSHS. The baseline information gathered in this survey was used to determine the number of clients with TBI currently being identified and served; existing available services; gaps in services; and any potential for new innovation across the department.

Summary of Survey Results

Admin/ Division	General Description of Services	# of Individuals with TBI Served FY 06	TBI Specific Services Provided	Barriers

Economic Services (ESA)	Financial Assistance	205 (Data is incomplete and represents the known portion of General Assistance clients that have brain injuries. Information about brain injuries is unfortunately not available for TANF, Food Benefits, or other ESA programs)	Financial assistance No TBI specific services	▪ No specific services available to clients with TBI. ▪ Lack of training related to identification of TBI and referral to appropriate resources.
Juvenile Rehabilitation (JRA)	Court ordered residential treatment and parole programs for youth	Unknown	No TBI specific services JRA may identify clients w/TBI and try to meet needs through: ▪ Client History Review tool has question about whether a client has had a TBI or lost consciousness. ▪ Integrated Treatment Plan section can address special needs and have treatment adapted to serve needs.	▪ Client History Review tool has not yet been automated, so no tracking of clients can occur. ▪ Lack of training related to identification of TBI.
Children's (CA)	Residential and in-home services for children; Child Protective Services	5 identified (incomplete information)	No TBI specific services	Social Workers and foster parents: ▪ Lack knowledge on identifying TBI. ▪ Are unsure how to locate training.
Health and Recovery Services (HRSA) **Alcohol and Substance Abuse (DASA)**	Treatment and prevention programs	6,752	▪ No TBI specific services ▪ Chemical dependency support groups frequently include TBI survivors ▪ Possible referral opportunities to community TBI support groups, TBI specific case mgt, medical or neuro-psych providers	▪ TBI can be clouded by other substance abuse/MH issues – hard to identify. ▪ Clients sometimes have to complete substance abuse treatment before they can connect to other services.

HRSA Mental Health (MHD)	Residential, in-home and institutional services for children and adults with mental illness; Involuntary treatment services	Unknown in community; About 70 at State Hospitals	▪ No TBI specific services in the community ▪ State hospitals have some specific programming including a designated ward at Western State. Group therapy is offered with a focus on TBI provided by a psychologist. ▪ State hospital nursing staff in monthly new employee training get brief training in specialized treatment for TBI.	▪ Clients may not meet Access to Care Standards to receive services in the MH system. ▪ There is no systematic way to identify TBI in data systems. ▪ More training for staff working with TBI clients is needed.
HRSA Medical Assistance	Acute and Primary care for Medicaid recipients	3,411		
Vocational Rehab (DVR)	Employment Assistance and Supports	872	DVR provides some TBI-specific services for people who qualify for vocational rehab (e.g. assistive technology devices, therapies, training, and other job-related services).	▪ Need for increased coordination with other resources. ▪ No funding specific to TBI has been available.
Aging and Disability (ADSA)	Long term care services for adults and seniors Services, programs and resources for children and adults with developmental disabilities	1669	▪ Assistance with personal care in in-home and community residential settings ▪ Other long term care services and supports including adult day, medical supplies and equipment, skilled nursing, personal emergency response system, home delivered meals ▪ Family Caregiver Support ▪ Nursing Facility care ▪ Private Duty Nursing	▪ Services are not tailored to meet the specific needs of persons with TBI. ▪ Lack of staff training

Survey Trends

As the table above demonstrates, most administrations/divisions within DSHS have no TBI-specific services and no funding earmarked to purchase services for clients with TBI. It appears that people with TBI are receiving services, but tend to be served in the same way as the general populations for each program.

Identification of individuals with TBI, along with ongoing data collection, continues to be a problem facing most department programs, although this is more of an issue for administrations who only assess for financial eligibility, such as the Economic Services Administration. Administrations who assess for functional eligibility and are providing more of a medical or functional based set of services are typically attempting to collect data that identifies individuals with TBI. In this report, data collection is recognized as an area that needs department-wide improvement. However, it should be noted that the TBI council is currently working on recommendations for a statewide registry tool to address this gap; therefore recommendations to address this are not included within this report.

Section 3: Recommendations for improvements to state administered services

Many needs have been identified through the course of work with DSHS staff and the TBI Council. We also have gained important information from several years of participation in federal TBI grant activities. In addition to identifying gaps, these grants have provided resources for educational activities, resource guides and TBI stakeholder development. Although many needs have been addressed through these processes, the highest need is to build a foundation for identifying and appropriately serving individuals with TBI. Public awareness, information and referral, basic educational materials, and statewide planning that include private and public input are key foundations being addressed through Council and grant activities. Other infrastructure needs upon which to build future service delivery options are addressed in the department recommendations.

Overall department recommendations

The department makes the following recommendations, which will improve our ability to identify individuals with TBI, better assess their needs, and enhance coordination of policies and services across the administrations:

1. The establishment of an inter-agency workgroup used to improve collaboration among state agencies that provide services to individuals with TBI and to coordinate research for planning and implementation of new services. Each state agency will identify a representative to participate in the inter-agency workgroup.

2. The department also recommends that the Legislature consider contracting for a comprehensive study to identify evidence-based best practices in TBI assessment and identify common components of clinical characteristics that are important across the department's diverse settings and service delivery systems. The information identified by this study could be incorporated into existing assessment tools already used by the department. Research is necessary to locate the best practices occurring nationally to assess individuals across settings and service delivery systems.

3. The Legislature is also asked to consider contracting for an entity to develop an evidence-based training curriculum that will be used as a tool for department staff most likely to encounter individuals with TBI. The training will be directed at increasing clinical competence, including improvement in the ability to identify potential cognitive and behavioral indicators of TBI.

Administration/Division-specific recommendations

Specific administrations/divisions within DSHS have also made recommendations:

1. The Aging and Disability Services Administration (ADSA), in partnership with the Health and Recovery Services Administration (HRSA), has identified a specific group of clients with TBI who are currently institutionalized in state psychiatric hospitals because there are not sufficient resources in the community to meet their unique needs. The department recommends program development to provide enhanced residential, behavioral and employment supports for this population. ADSA and HRSA recommend the development of a recognized TBI certification or specialty training that could be obtained by community residential providers.

   Certified and trained providers would receive an enhanced residential rate for services to TBI clients in their residences. The program would also provide additional cognitive and behavioral support for the individuals residing in these community settings. While the department does have a small Expanded Community Services (ECS) program for individuals with personal care and behavioral support needs, ECS is not designed to address the specific needs of people with TBI. Also ECS has reached its funded capacity. This recommendation would require additional resources for the department, as well as for providers of TBI residential services.

2. The Division of Vocational Rehabilitation (DVR) Ticket to Work is interested in exploring ways to build partnerships that can result in increased employment outcomes for individuals with traumatic brain injuries. One of the keys for greater successful employment outcomes is for the provision of benefits counseling and an array of longer-term supports for job coaching, peer support and individualized retention strategies.

   For many individuals with significant disabilities, the provision of longer-term supports after job placement can make all the difference in whether or not the individual remains employed. Currently, there is no such mechanism for individuals with traumatic brain injuries.

   The Social Security Administration is currently considering improved payment rates under the Ticket to Work program that could become a significant source of new flexible funding to support such a provision. The proposed payment changes are anticipated to be announced in early 2008.

   The proposed outcome-milestone payments could result in a maximum of approximately $20,000 in flexible funding resources for the provision of services that allow individuals receiving SSI and/or SSDI to retain employment. The Ticket to Work program could provide a new mechanism

for monthly ongoing supported employment support payments for beneficiaries who previously lacked ongoing support funding.

Additional recommendations to be addressed after priority recommendations above

Other recommendations were identified in the individual survey responses in the attached appendix. However, the department recommends a focus on the three overall, as well as the division-specific recommendations summarized above. This focus would develop necessary infrastructure prior to tackling some of the more detailed elements required for an available, user-friendly TBI toolbox that promotes education, acceptance, and accessibility of services for the citizens of Washington.

APPENDIX: DSHS STRATEGIC PARTNERSHIP SURVEY RESULTS

1. Does your agency have a way to count or estimate the number of people served who have traumatic brain injury (TBI)?

IF YES:

1) **What is that method?**
2) **Approximately how many people with TBI did your system serve in FY 2006?**

IF NO:

1. **Based on statistical, anecdotal, or historical information do you believe that people with TBI make up a significant portion of your client population?**
2. **What evidence is your answer based upon?**

Aging and Disability Services Administration (YES)

1. We are able to determine the number of individuals to whom we provide personal care services based upon self-reported diagnosis of Traumatic Brain Injury.

2. *Home and Community Services* - 1,145 Current CARE clients with TBI as one of their diagnoses
   Division of Developmental Disabilities -185
   Nursing Homes - 339

Division of Vocational Rehabilitation (YES)

1. A DVR counselor enters the disability type for each eligible individual into the DVR case management system (STARS).

2. During the 2006 state fiscal year (July 1, 2006-June 30, 2007), DVR served 872 individuals with a traumatic brain injury. This number includes customers who were in the process of developing a plan for employment, those who completed a plan and those who received post-employment services during the reporting period.

Juvenile Rehabilitation Administration (YES)

1. The Client History Review (CHR) has a question about whether clients have had a head injury or loss of consciousness. These responses could be counted in our Automated Client Tracking, once the CHR is fully implemented. The accuracy of this information may not be perfect, but there is a place to document this information, and each youth/family would be asked. At the time of the survey the Automated Client Tracking was not fully implemented. It has since been implemented.

2. Won't be able to track until it's automated.

Economic Management Administration (YES)

1. To qualify for General Assistance, a person must have a medical or mental health issue that prevents them from working. Social Workers determine if a person is able to participate in gainful employment by reviewing medical records. Information about medical or mental health conditions that is directly related to employment is stored in our Inclusive Case Management System (ICMS) as the Social Worker goes through the process of determining capacity to work. However, sometimes (e.g., multiple body system issues), medical or mental health issues are grouped under a broader category. Additionally, we do not have a specific code in our system for "traumatic" brain injury and all injuries are coded as "brain injury." Also, other types of injury (such as a brain aneurysm) are sometimes coded as "brain injury" in ICMS. It is important to consider these constraints when reviewing data for the General Assistance program on persons who have experienced brain injury.

2. During the time period between August 2006 and July 2007, our system served approximately 205 persons with a brain injury

Children's Administration (NO)

1. Not significant but certainly some portion of children in foster care have TBI.

2. Children in foster care have a higher rate of disability than any other Medicaid population. Physical abuse often includes injuries to the head, neck and shoulders.

Health & Recovery Services Administration

A. *Mental Health*

ANSWER: No. The Mental Health Division collects ICD-9-CM diagnostic codes for the primary and secondary diagnoses of individuals receiving outpatient service(s) through the public mental health system.

Unfortunately, the ICD-9-CM diagnostic codes collected by the Mental Health Division do not include a specifying code indicating traumatic brain injury as the underlying etiological basis for the medical disorder.

More specifically, the appropriate ICD-9-CM diagnostic code is:

294.10 Dementia in conditions classified elsewhere, with behavioral disturbance
294.11 Dementia in conditions classified elsewhere, without behavioral disturbance

It is possible to determine how many individuals are served with the ICD-9-CM diagnostic code; however the total would be reflective of *all* individuals served with *any* dementia due to a condition classified elsewhere, not specific to a TBI.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Test Revision (DSM-IV-TR) is the guide most commonly used in the mental health field to record diagnoses. Even so, the DSM-IV-TR does not have a diagnostic

code specific to Dementia due to head injury but rather relies on an additional code recorded on Axis III (medical conditions), which does denote head injury (854.00). The Mental Health Division does not capture DSM-IV-TR codes.

Based on anecdotal information, a significant portion of the population provided with publicly funded outpatient mental health services are **not** likely individuals with the primary diagnosis related to traumatic brain injury. While the total population is likely not significant, it is also anecdotally believed that individuals with traumatic brain injury who do qualify for publicly funded outpatient mental health services likely have specialized needs that may be intensive and may not be well met within the community mental health system.

B. *Division of Alcohol and Substance Abuse*

Year	#Total Admissions	TBI Yes	% increase over previous year TBIs
2007	44,904	7,625	12.9%
2006	44,351	6,752	7.4%
2005	41,502	6,285	6.4%
2004	37,623	5,905	9.0%
2003	35,472	5,420	

- Answer. However, we anticipate that this is a low number, since many clients coming in to our system who are using alcohol and other drugs heavily don't always recall a TBI, or even see a possible TBI event as pertinent to their substance use issue.

- In addition, TBI is just one of the many issues that may complicate early recovery along with fetal alcohol syndrome, post traumatic stress disorder, domestic violence, sexual addictions, pathological gambling, physical and other mental illnesses and conditions.

- Frequently the first six months of recovery is characterized by sorting out what ailment or combination of conditions is primary and which are simply part of the constellation of post acute withdrawal symptoms. Sometimes this is not clear for months or years.

C. *Medical Assistance*

Some diagnoses that are associated with/equal to TBI:

- Closed head injury
- Sub-dural hematoma
- Epidural hematoma
- Traumatic CVA
- Penetrating head wound
- LaForte fractures

- LOC
- COMA
- Dog bite/head
- Blunt injury/head
- Penetrating injury/head
- Trauma/head
- Assault/head
- Contra coup injury

Medical assistance was able to identify the following ICD-9 codes related to TBI:

- The 800-804 series should include ICD-9 codes in the range 800.00-804.99
- 850.5 Concussion with Coma, NOS
- 851.14 Open cortical contusion, prolonged coma
- 851.16 Open cortical contusion, coma, NOS
- 851.80 Brain laceration, NEC
- 852.00 Traumatic subarachnoid hemorrhage
- 852.10-852.39 open subarachnoid hemorrhage
- 852.40 Traumatic extradural hemorrhage
- 852.41-852.59 extradural hemorrhage
- 853.00 Traumatic brain hemorrhage, NEC
- 853.01-853.19 Brain hemorrhage due to injury
- 854.00-854.19 Brain injury, open or otherwise

2. Does your system provide TBI-specific services to people with TBI?

If YES:

1) **What are those services?**

2) **What fund sources are used? Select all that apply:**

1) **state only**
2) **Medicaid match**
3) **Grant funding**
4) **Public/Private partnership**
5) **Other (please specify):**

3) **What is the FY 08-09 appropriation?**
4) **What types of providers offer services to individuals with TBI?**
5) **What steps could be taken to build provider capacity and provider training?**
6) **Are there additional services you would like to provide if funding were available? If yes, what are those services?**

If NO:

1) **What additional services would benefit clients with TBI in your system?**
2) **What are the barriers to providing those services?**
3) **What specific changes would your system need to undertake in order to overcome those barriers (e.g. additional or shifted**

funds, development of collaborative projects, training for staff or clients, improvements in access to information about TBI, etc.)?

Aging and Disability Services Administration (YES)

- We provide personal care services to eligible individuals. We also provide Medicaid nursing facility care for eligible individuals. Caregivers are served through the Family Caregiver support program. Information and Assistance (I&A) is available for individuals who need assistance with understanding and accessing the long-term care service delivery system. Although the Information and Assistance program is funded to provide services to individuals aged 60 and over, many of our I&A programs do respond to questions from younger populations. The Aging and Disability Resources Center being piloted under grant funding in Pierce County provides information and assistance to individuals with disabilities regardless of age.

- ADSA has had a federal HRSA grant specific to infrastructure building since 2002. The types of activities undertaken by the grant include: A statewide needs assessment; Development of training materials and opportunities for survivors, families, caregivers, and professionals: a series of video casts providing on-site training opportunities for people in urban and remote areas of WA, ID, and OR on a number of TBI special topics, development of a curriculum for paid and unpaid caregivers on TBI specific topics, funding numerous opportunities for TBI survivors and their families to attend regional and national TBI Conferences, funding a TBI track at the annual Co-occurring Disorders Conference; Development and distribution of information and resources on TBI in WA state with a TBI tool kit for both survivors/families and professionals; Building collaborations across state agencies in order to improve options for individuals with TBI within current resources.

- ADSA, in partnership with the Mental Health Division, provides expanded community services to 152 individuals at any one time; 13 current program clients have TBI as a primary diagnosis, and several others have a known or suspected TBI along with a primary psychiatric diagnosis who require both personal care and behavioral supports who are relocated or diverted from State Psychiatric hospitals.
- The program provides enhanced care for specific individuals who have moved from or are at risk for long stays at state hospitals. Individuals who qualify include individuals with TBI who have both personal care needs and high behavioral challenges. The program currently costs an average of $150/day including enhanced behavioral support (including intensive case management, behavioral support in a client's residence, and individualized training to clients' residential providers) and an enhanced rate for contracted residential providers.
- Providers include: Individual Providers, licensed home care agencies, adult family homes, boarding homes, nursing facilities, and non-profit entities provide family caregiver support through area agencies on aging.

  Capacity could be increased by:
  - Funding models that recognize needs of the population and provide enhanced rates to meet those needs.
  - Training of providers on how to successfully meet the needs of individuals with TBI.

- Creation of state-only funding to provide behavioral interventions necessary to keep stable placements.

Division of Vocational Rehabilitation (YES)

1. Providing TBI-specific services is not the purpose of DVR; however, if an eligible individual needs a specific service to be able to participate in VR services or achieve employment, DVR can provide TBI-specific services.

2. Grant funding: DVR receives a state-federal grant through the U.S. Department of Education, Rehabilitation Services Administration. Other (please specify): DVR receives funds in the form of reimbursements from the Social Security Administration when an eligible individual who achieves employment as a result of DVR services is also a Social Security recipient.

3. There is no appropriation set aside for TBI services (or any other services). An individualized plan is developed for each eligible individual.

4. DVR VR counselors provide professional counseling and guidance for customers. DVR Assistive Technology Practitioners conduct technology evaluations and consulting to VR counselors and eligible individuals. DVR also purchases services from a wide variety of providers to meet the individualized needs of eligible individuals. DVR purchases a variety of job-related services from Community Rehabilitation Programs and Independent Living (IL) providers. DVR also purchases assessments and other diagnostic services, assistive technology devices and services, physical/mental therapies and services, training, and a number of other services.

5. First there is a need to identify the unmet needs and the level of capacity needed. DVR could work within its network of providers to communicate the specific services and capacity needed to the disability community. A number of existing resources (Community Rehabilitation Programs, Independent Living Centers, Assistive Technology providers) could add capacity.

6. Peer support and mentoring. Individuals with a TBI would benefit from learning about the experiences of others with a TBI and their family members.

Juvenile Rehabilitation Administration

- There is a section on the Integrated Treatment Plan that addresses how individuals with special needs will have their treatment adapted to serve their needs. Included in this section are specific check-offs for cognitive deficits, psychiatric diagnoses, or other. I would expect that individuals with TBI would have their treatment adapted to address cognitive impairments, emotional or behavioral issues (e.g., impulsivity, poor ability to regulate emotions, poor planning, low comprehension while learning, etc.). As such, these are accounting for TBIs but not necessarily TBI-specific services.

Economic Management Administration (NO)

- The General Assistance program provides cash and medical assistance to persons who are unable to work due to a medical or mental health issue. There are no associated TBI-specific services.

Children's Administration (NO)

1. Social worker and foster parent education.
2. Lack of knowledge on where to access training; availability of social workers and foster parents to attend specialized training.
3. Blend TBI training in with other health related issues – especially accessing the services needed by children with complex health issues such as TBI.

Health and Recovery Services Administration

A. *Mental Health*

- **Answer:** No. The public mental health system does not currently provide TBI-specific services to individuals with traumatic brain injury. Public mental health services encompass a variety of outpatient treatment modalities which may be tailored, at the local level or by a clinician with specialized training, to meet the needs of individuals with TBI. However, there is not currently a statewide approach to providing outpatient mental health services specific to this population.

- Additional services that might be of benefit to individuals receiving publicly funded mental health services might include the development of specialized residential services or other intensive/specialized services targeting the unique needs of individuals discharging from one of the state mental health hospitals into the community or leaving a skilled nursing facility to return to the community. Because there are likely not significant numbers of individuals in each area of the state, it might be practical to develop models of care at a regional level. More data is needed to determine the most efficient and effective way to develop and implement specialized programs targeting this population. The Regional Support Networks and licensed community mental health agencies will undoubtedly have current and pertinent information concerning the level of need and desired services for their local communities.

- The public mental health system primarily serves individuals eligible for Medicaid and also serves a limited number of low-income individuals with an acute or chronic mental illness. All individuals must meet medical necessity criteria to qualify for care.

- Individuals may experience difficulty accessing public mental health services if they are not eligible for Medicaid.

- The medical necessity criteria are defined in the Access to Care Standards (ACS). The ACS includes the following criteria:
  Individual is determined to have a mental illness. Diagnosis is covered in the list of "Covered Adult and Older Adult Disorders" or the "Covered Child and Youth Disorders" list.
    - Impairment and corresponding need are the result of a mental illness.
    - Intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of mental illness.

- Individual is expected to benefit from the intervention.
- Individual's unmet need cannot be more appropriately met by any other formal or informal system or support.
- Moderate or serious functional impairment must be present in at least one life domain requiring assistance in order to meet the identified need which must be evidenced by a Global Assessment of Functioning Score (GAF) for adults and older adults OR the Children's Global Assessment Scale (C-GAS) for children and youth, of 60 or below.

- Dementia due to a head injury is considered a "B" diagnosis which requires that an individual meet one additional criterion to demonstrate the presence of medical necessity. The additional criterion is related to severity and/or acuity of the impairment. Examples of severity and/or acuity include but are not limited to: high risk behavior demonstrated during the previous 90 days including potential for self-harm, harm to others or at risk of grave disability, risk of loss of housing or residential placement, recent discharge from a psychiatric inpatient setting, 2 or more hospital admissions due to a mental health diagnosis during the previous 2 years or currently being discharged from a residential treatment setting.

  Specific funding may be required to support targeted services to this population, especially for those not eligible for Medicaid funding.

  In addition, training and education for clinicians delivering service through the licensed community mental health agencies will be required, especially if there are evidence-based practices that can be developed and implemented regionally and/or locally. Collaboration with allied system providers and other stakeholders is desirable and will require additional targeted funds.
  - More training of staff who primarily work with TBI clients is needed. For instance, more staff could become certified as Brain Injury Specialists.
  - Additional specialized training for staff who primarily work on a TBI ward.
  - Hiring of a behaviorist, physiatrist, medical, occupational, or physical therapy staff whose primary specialty is TBI.
  - Additional resources for housing of TBI clients once they leave institutions.
  - Provide assistive devices (such as PDAs and other memory aids) to clients with TBI and additional training for staff on how to help clients benefit from these items.

B. ***Division of Alcohol and Substance Abuse***

- Sometimes

1. What are those services?

Answer. Our long-term residential treatment providers frequently include TBI survivors in "double trouble" support groups that explore how multiple disabilities can complicate recovery. This is also true for many outpatient programs, but many clients with a TBI history do not have access to assessment services such as a neuro-psychological evaluation that can measure impairment. In addition, many do not have enough clean time for the neuro-psych to be accurate. Frequently the client has completed treatment before they are able to connect to further assessment.

2. **What fund sources are used? Select all that apply:**

   The TBI is usually not specifically treated in a CD program under these funding sources but the CD treatment program
   (a) Medicaid match
   (b) Grant funding
   (c) Public/Private partnership
   (d) Other (please specify):

3. **What is the FY 08-09 appropriation?**

4. **What types of providers offer services to individuals with TBI?**

   The predominant provider is a chemical dependency professional (DOH Certification). In addition, many programs have medical personnel and mental health professionals associated with their programs.

5. **What steps could be taken to build provider capacity and provider training?**

6. **Are there additional services you would like to provide if funding were available? If yes, what are those services?**

   We support our programs providing referrals to community TBI support groups and medical or neuro-psychological evaluations. It's great when TBI specific case management services are available.

3. What steps could be taken to improve coordination of services for individuals with TBI?

Aging and Disability Services Administration (YES)

- Establish an intra-agency workgroup for coordination of TBI-related policies across divisions. Each agency within DSHS would identify/appoint a representative to participate in the workgroup.
- Development of assessment criteria that can be used across the department's services and settings to identify individuals with TBI and better understand the strengths, limitations, and needs of individuals impacted.

Division of Vocational Rehabilitation

- Training to ensure proper identification of individuals who have experienced a TBI.
- Assess capacity of current providers to effectively serve individuals with TBI.
- Collaborate with others to support the development of peer support and mentoring programs for individuals with TBI.
- Provide DVR staff with training opportunities on TBI issues, providers and partnerships.

- Encourage DVR staff and customers to attend TBI conferences, including the Northwest TBI Annual Conference.
- Identify a DVR program employee with responsibility for coordinating and collaborating on TBI issues.

Juvenile Rehabilitation Administration

Getting providers in the community who understand TBI and can continue the work begun in institutions. Our low-functioning clients are the ones who suffer the most, and seem to most regularly end up back in the JRA/DOC system. Often because their community providers (especially residential) simply are not trained to work effectively with them.

Economic Services Administration

(Division of Employment and Assistance Programs)

It is always helpful to provide staff with information about available community services. Feel free to contact Logan MacGregor at (3690) 725-4605 or macgrld@dshs.wa.gov if you have additional questions.

Children's Administration

- Centralized referral service to help parents and medical providers identify services available to caregivers (parents, foster parents, relatives) within their community.
- Telemedicine opportunities for people who live outside of King, Snohomish, Pierce and Thurston counties.

Health and Recovery Services Administration

A. *Mental Health*

ANSWER: Facilitate development of relationships between systems at the local level. Provide accessible, affordable training statewide. Identify and communicate goals specific to improvements with regard to this unique population (public service campaign, increased penetration rate, method to track services). Research the best, emerging and promising practices. Identify program(s) for implementation based on a needs assessment that is inclusive of stakeholders, cross-system partners and most importantly individuals/families impacted by traumatic brain injury.

- Train community care providers on how to work with TBI clients, so they are more willing to accept these clients into the community.
- Provide additional resources/FTEs to institutions so that we can have staff who are assigned specifically to facilitate the discharge process and work with the community provider to prepare the facility for the TBI client's needs.
- Provide possible monetary incentives for community providers to take TBI patients.

- With additional resources, we could provide a more comprehensive assessment of the client's psychological, behavioral, and vocational needs, then provide this information to the community treatment providers.

C. ***Division of Alcohol and Substance Abuse***

Answer. Publicly funded TBI services available to survivors during and after CD treatment would be wonderful, especially neuro-psychological assessment services, case management support for obtaining TBI services and mental health treatment for the accompanying depression, anxiety, and adjustment issues. Unfortunately the MH system is often not able to see our clients unless they meet sometimes stiff eligibility and severity criteria.