BRAIN INJURY IN MAINE:
A GROWING PUBLIC HEALTH ISSUE

ANNUAL REPORT

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The Acquired Brain Injury Advisory Council of Maine

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OVERVIEW

Brain Injury is a continuing public health issue that can impact each of us and our families; it affects all communities in Maine. Falls, motor vehicle crashes, sports-related concussions, and violence represent real risks to every Maine citizen. In addition, combat related brain injuries and health problems such as strokes, brain tumors and other diseases can cause acquired brain injuries, which result in significant thinking, emotional, behavioral and physical changes that alter lives.

Traumatic Brain Injury
- Falls
- Motor Vehicle Crashes
- Sports Injuries
- Other Injuries Caused by Trauma

Other Acquired Brain Injury
- Strokes
- Loss of Oxygen
- Brain Tumors
- Other Internal Assaults to the Brain

The Center for Disease Control and Prevention (CDC) reports that Traumatic Brain Injury (TBI) is the leading cause of death and disability in children and young adults in the United States. Per the National Center for Health Statistics in 2012: the prevalence rates of acquired brain injury are as follows: TBI (5.3 million), stroke (6.2 million), and epilepsy (2.0 million), adding up to 13.5 million Americans, making acquired brain injury the second most prevalent disability in the United States. Overall, the number of persons currently living with disability due to acquired brain injury represents 4.5 percent of the U.S population (including stroke, TBI, and epilepsy combined). Many will make meaningful recoveries, especially if they access needed rehabilitative care. Unfortunately, public and private health insurance continues to impose limits for rehabilitative care based solely on financial costs rather than based on functional goals or treatment outcomes. Legislation such as the Medicare Post-Acute Care Value Based Purchase Legislation and Medicare Part B caps on outpatient therapy potentially shorten the treatment periods for people with brain injury to obtain needed therapy services. Medicare combines Physical Therapy and Speech Therapy under one annual financial cap of 1,920.00 dollars while Occupational Therapy is capped at 1,920.00 dollars as well. Up to 15% of those who experience a brain injury will live with very difficult, life-altering disabilities. Immediate access to specialized neurorehabilitation information, education, and care coordination is crucial for a positive outcome.

Sometimes, the system of community care ends prematurely for these people, condemning them to costly nursing homes or institutions, cutting off options for the person to return home. History shows that these individuals can live successfully, when treatment and supports are available, outside of institutions. At the other end of the spectrum are those individuals who physically appear uninjured but have significant cognitive and behavioral disabilities, which can improve with expert assistance. This phenomenon is known as the “Silent

Epidemic".

Year after year public hearings in Maine have demonstrated individuals continue to have issues related to brain injuries which are often dismissed or misdiagnosed leading to the provision of ineffective treatment that leaves individuals and clinicians with feelings of failure and frustration. This creates a significant misdirection of valuable resources, poor interactions with family, employers and the community.

The system in Maine is improving access to the right services and supports. When we do the "right thing" we create efficiencies that allow our tax dollars to be used effectively in the utilization of proper resources to include evidence based treatment and recommendations to increase positive outcomes for the individual. By proper use of the tax dollars for treatment of individuals with brain injury we also lower the burden on other support and service systems such as the hospital and criminal justice system.

LEGISLATIVE ACTION

The Acquired Brain Injury Advisory Council commends and thanks the Governor, the Legislature, and DHHS for continuing to support brain injury services and future initiatives.

2018 Recommended Action –

DHHS should continue to support Home and Community Based Services for individuals with Brain Injury in Maine.

DHHS should complete the work of writing and putting new policies into practice that reflect the direction of the Legislature in these statutory revisions (22MRSA §3088 Rights of Recipients with Brain Injuries and 22MRSA§3089 Neurobehavioral Treatment).

DHHS should continue the work to address the needs of individuals who are unable to safely reside in the community without post-injury comprehensive clinical services in the form of a Neurobehavioral Treatment Center.

PRIORITIES & RECOMMENDATIONS

This report reflects the highest priority areas identified for the Council as determined through input by the people of Maine during public listening tours across the State. The needs of Maine citizens with brain injuries are very broad and complex. These recommendations speak to actions that the Council believes could be accomplished in 2018 and have the potential to significantly impact quality of care. Future work of the Council will address the many other areas identified through needs assessments, public hearings, and forums. Public hearing testimony overwhelmingly emphasized the need for improved access to services, education for professionals, workforce shortage challenges, expanded care coordination/neuronavigation, increase public awareness on prevention and education, family and peer supports, employment opportunities, improved children's services and addressing the complex needs of individuals with challenging behaviors.

PRIORITY ONE – Enhance Maine's brain injury neurorehabilitation system to respond to current needs.

The current system has improved tremendously over the past few years with the implementation of the brain injury waiver. We now have a continuum of care which includes brain injury services within nursing facilities, brain injury waiver group homes, individuals' own homes, outpatient neurorehabilitation settings,

and care management amongst other waiver services.

The Acquired Brain Injury Council recognizes and supports the State's continued participation in Home and Community Based Services for Adults with Brain Injury, commonly referred to as the "Brain Injury Waiver", which provides the opportunity to meet the growing needs of brain injury survivors across the State. The choice of services and supports available offers a variety of services designed to maximize opportunities for individuals to access the community in the most integrated manner possible while maintaining safety, and improving overall health and quality of life.

Although services for individuals with brain injury have improved significantly, there remain several critical shortfalls, including limited transportation that meets the needs of this specialized population, limited access to technology services, supports in one's own home, limited affordable housing options and the lack of a Neurobehavioral Treatment Center.

The addition of a Neurobehavioral Treatment Center to our existing continuum of care would allow access to services for persons with significant neurobehavioral challenges who cannot yet be appropriately served in the community. For instance, some persons with brain injury have shown to be at increased risk for repeated law violations due to impulsivity and behavioral dysregulation. These individuals may find themselves in the correctional system with limited treatment options, such as neurorehabilitation, because there is a lack of understanding of their diagnosed condition. Research and best practice show that prevention and early intervention are likely to mitigate these problems.

2018 Recommended Action –

DHHS should continue its efforts to appropriate additional funding to assure all Maine residents with brain injury have timely access to the services that they need.

DHHS should work with Brain Injury Service Providers to convene a forum to review best practices and develop solutions to enhance Maine's neurorehabilitation and ensure all Maine residents have reliable access to a comprehensive neurorehabilitation service system.

DHHS should engage with stakeholders to determine changes within the MaineCare Benefits Manual Section 18 & Section 102 rules that lead to effective and innovative improvements.

DHHS should improve access to specialized transportation and continue to hold transportation providers accountable for quality of service including reliability and accessibility throughout Maine, including rural areas.

DHHS should enhance contract deliverables to require transportation brokers ensure transportation providers have annual training on persons with acquired brain injuries and related conditions.

DHHS should update the ABIAC and other stakeholder groups of the status of the transportation services.

DHHS should educate transportation providers regarding the unique needs of the brain injury population.

DHHS should continue to explore affordable housing options including rent vouchers specific for individuals with brain injury.

DHHS should support the need for a Neurobehavioral Treatment Center to serve individuals who are unable to safely reside in the community without post-injury comprehensive clinical services.

PRIORITY TWO – Address the workforce shortage of qualified brain injury professionals.

Currently today, we have staffing shortages of qualified professionals across the state of Maine. This has resulted in individuals who have approved funding waiting for services as the provider community recruits, hires, and train members for their workforce. Despite these obstacles, the Maine brain injury support network has made strides in providing individuals with brain injury education utilizing agency resources as well as trainings funded by the Administration for Community Living's Traumatic Brain Injury (TBI) State Partnership Grant Program. The State's TBI grant cycle is in its fourth and final year. The State is expected to generate support for sustainability of funded projects after federal support terminates. One such funding source is the approval by the Maine State legislature to continue funding for key projects such as the Maine Concussion Management Initiative and advocacy, education and resource facilitation provided by the Brain Injury Association of America Maine Chapter.

2018 Recommended Actions

DHHS should continue to adapt existing training programs to include specific modules on brain injury and offer information and technical assistance to other State departments in their training efforts. DHHS and/or Brain Injury Association of America Maine Chapter should provide training to law enforcement entities, correctional facilities, educational systems, first responders, emergency medical services staff (EMS), the Department of Public Safety, transportation providers, vocational rehabilitation providers, and Maine Hospitals to include Riverview Psychiatric Center and Dorothea Dix Psychiatric Center staff in accordance with (MRSA § 3089) (1)(B).

DHHS should explore options for workforce development and convene stakeholders as part of the process, such as rate studies, incentive based systems, supervision and mentorship trainings to ensure current qualification requirements such as the Commission for Accreditation of Rehabilitation Facilities (CARF) are included in the MaineCare Benefits Manual specific to Acquired Brain Injury Services.

PRIORITY THREE– Expand care coordination and neuronavigation to meet the needs of all individuals with brain injuries in Maine.

Care Coordinators and neuronavigators are a distinct and essential group of professionals who aide individuals to obtain services. The neuronavigator assists the individual with obtaining services, supports and resources to meet his or her needs in the least restrictive environment. Care coordination, specific to the Brain Injury Waiver, is responsible for ensuring that the health and welfare of the individual can be assured within the community. Without this assistance, the system can feel very complex and insurmountable.

The Brain Injury Association of America -Maine Chapter (BIAA-ME) has continued to provide education, resource facilitation and overall support for family, survivors, care givers and professionals across the State. This past reporting period which runs from September 1, 2017 through November 30, 2017 shows a continued interested in resource facilitation. Four families/survivors received resource facilitation services through BIAA-ME and 37 families, survivors, friends, or professionals received brain injury information and referral services through BIAA-ME's brain injury information center. All information requests were initiated via phone call, email, or in-person, and support was provided via emails, mailings, and phone.

2018 Recommended Actions

DHHS should explore other models, including successful models used by other states, to create a sustainable system of neuronavigation outside of the Brain Injury Waiver to meet the unmet needs of those that may not qualify for Medicaid and Medicare services.

DHHS should support the State's Money Follows the Person transitional planning to ensure an individual has access to

community living and reduce the barriers associated with transitioning into the community.

DHHS should explore collaborations with local Community Action Programs and Area Agencies on Aging to ensure no wrong door entry for those seeking services and supports.

DHHS should open MaineCare Benefits Manual, Section 18, and examine increasing the available care coordination units following the first year of an individual's waiver services. Currently individuals in the first year of the waiver receive 100 hours of care coordination which decreases to only 50 hours in the second year and each subsequent year. This decrease is not found in any of the other Maine Home and Community Based Services. The increase of units may ensure any developing or emergency needs can be addressed and supported to enable individuals to live as independently as possible, attain and maintain employment, avoid homelessness, improve overall health and safety and increase integration into the community to the maximum extent of their abilities and capabilities.

PRIORITY FOUR – Prevent brain injury through education and public awareness.

More education and public awareness is needed to help prevent brain injury in Maine. Prevention requires that we understand the causes of brain injury and how to minimize risk.

2018 Recommended Actions

DHHS should continue to support Maine's CDC initiatives focused on prevention of abusive head trauma and older adult falls.

DHHS should collaborate with Maine Primary Care Physicians Association and Health Homes to increase awareness of acquired brain injury prevention, identification and treatment to include facilitation of rehabilitation and other treatment options.

DHHS should strengthen collaboration with The National Alliance on Mental Illness (NAMI) or other organizations who are offering qualified Crisis Intervention Training (CIT) and awareness of the effects of trauma following brain injury.

DHHS should create a workgroup to formally assess the needs for statutory changes for civil commitment including research on the best practice approaches throughout the country. This should include consideration of an Assertive Community Treatment (ACT) team style approach for brain injury, upfront training for staff, and least restrictive settings, including alternatives to sentencing, detention, and probation.

DHHS should increase collaboration with decision makers from the Departments of Corrections and Public Safety, District Attorney's office, the Judiciary and State Forensic services towards creating solutions to decrease costly incarceration of those with brain injury.

DHHS should continue to collaborate with statewide brain injury and other related advocacy organizations to increase public awareness about brain injury, accurate screening of brain injury, provide training for families, and set best practice standards for service providers working with individuals with brain injuries.

PRIORITY FIVE – Strengthen Family and Peer Supports.

The primary support system for Maine citizens with brain injuries is family members and friends, not the healthcare system. Family and friend support is vital for improving outcomes for persons with brain injuries.

During the acute-care phase of a brain injury, family members are concerned with the survival and immediate needs of their loved one. Once the person with a brain injury returns home, the family may need continued support to understand the complex medical, behavioral and cognitive changes that manifest themselves on the long-term path to recovery. These realities can lead to increased isolation for the family and individual.

Caregiving can often overwhelm the caregiver emotionally, economically and physically. The combination of these pressures can result in loss of jobs, divorce, bankruptcies, or institutionalization of the individual with the brain injury.

Currently, there are 16 active support groups across the State of Maine and two support groups within 15 miles of the Maine border. The New Hampshire support groups welcome any Maine participants in the group. For 2017, there were 2,092 participants across the support groups. The Brain Injury Association of America- Maine Chapter provides outreach and support for any group seeking assistance.

2018 Recommended Actions

DHHS should continue to work with and support the Brain Injury Association of America, Brain Injury Association of America Maine Chapter, the Brain Injury Voices group and other brain injury support groups throughout the state.

DHHS should facilitate improved access to neuronavigation information and referral, resource facilitation, peer-to-peer support, and family support initiatives through collaborative partnerships with these and other organizations.

DHHS should continue to finalize the rules for the Rights of Recipients of Brain Injury Services.

PRIORITY SIX – Improve employment opportunities.

When the Employment First Maine Act was passed into law, Maine became the only state in the country to have both legislation and policy directives designed to embrace and advance Employment First for all state residents with disabilities.

The Employment First Maine Act also established multiple new requirements for the Departments of Education, Health & Human Services, and Labor, to implement as part of carrying out their established duties to provide services and supports to persons with disabilities.

The connection between employment, economic self-sufficiency and better health is clear. Increasingly, the connection between employment and real community integration for people with disabilities is also becoming clear. Recently, research by the Delmarva Foundation (www.delmarvafoundation.org) focused on what disability service provider practices and services most improved quality of life among individuals with disabilities. The researchers found that community integration is strongly tied to increased quality of life, and that receiving employment services was more beneficial than any other service in supporting community integration.[6]

One of the most devastating impacts of disability due to a brain injury is the loss of work. Combinations of intensive, focused rehabilitation coupled with peer support, psycho-social interventions and reliable, accessible transportation can improve outcomes and lead to successful employment. Employers and vocational counselors also need more information and education to better accommodate and support persons with brain injuries on the job. Ensuring access to employment services that support employment reentry, training, education and ongoing support based on an individual's needs is critical. Limited long term work support funds are available from the Department of Labor and the Brain Injury Waiver, but not always accessed by persons with brain injuries.

In 2017 there was a marked decrease in the availability of job development services State wide as providers are no longer able to financially support this service with the current rates. This has meant individuals seeking employment may not have the support needed to obtain and maintain employment.

The ABIAC shall continue to support employment as an outcome for individual with brain injuries by sharing success stories, providing resources and information to people and working in collaboration with others to increase access and success in employment.

Citation for superscript [6]:

http://www.nationalcoreindicators.org/upload/presentation/AAIDD_-_outcomes_that_predict_performance_%282%29.pdf

2018 Recommended Actions

DHHS should continue its partnership with the Department of Labor to better coordinate vocational rehabilitation and long-term job supports and provide additional training on brain injury rehabilitation to all Vocational Rehabilitation staff and their contracted providers.

DHHS should continue to implement a training platform for all Department of Labor staff to attend training on brain injury.

DHHS should evaluate current MaineCare reimbursement rates for job development.

DHHS should continue to support Maine as an Employment First state through implementation of final EFM report.

PRIORITY SEVEN– Addressing the needs of children with brain injury.

Proper screening and identification is essential to working effectively with children who have sustained a brain injury. Without proper identification, the school and medical systems are likely to treat the symptoms without fully understanding the core needs. This often results in misdiagnosis and ineffective treatment which impacts learning and treatment progress throughout the child's life. The State of Maine does not have pediatric brain injury services which has meant that 25-30 children must obtain critical services out of State.

2018 Recommended Action

DHHS should explore systems of Return to Learn to aide students with brain injuries to return successfully to the educational setting.

DHHS should work with the Maine Centers for Disease Control and the Department of Education, through Special Education and the School Nurse Consultant, and Maine Athletic Trainers Association to accurately identify children with brain injury per M.R.S.A (LD 1873).

DHHS should explore evidence based systems to incorporate in relevant Statue, regulation and rules for proper identification, evaluation, treatment and community integration of children with brain injury as opposed to labeling the child as having a behavioral or other mental health need.

DHHS should appoint a representative from the Department of Education to the ABIAC which has been vacant since the Council's inception.

COUNCIL ACTIVITIES AND HISTORY

The Council was originally established in April 2002 to support a federal grant. It was established into law in September 2007 to address the needs of persons with brain injuries and their families, and to raise awareness of those needs in order to promote systemic change.

Over the past eight years the Council has held 43 public hearings (Bangor, Brewer, Portland, Caribou, Presque Isle, Lewiston, Sanford, Houlton, Calais, Farmington, Fort Kent, Dover-Foxcroft, Biddeford, Kennebunk, Rockport, Machias, Rockland, Standish, Waterville, and Effingham, NH) receiving testimony from hundreds of Maine citizens with brain injuries and their families.

The Council has sponsored seven, one-day forums for in-depth exploration of critical public health challenges:

- Military service members and Veterans with brain injuries - June 2007
- Children and adolescents with brain injuries - October 2008
- Domestic violence and brain injury - March 2009
- Public policy challenges in brain injury - October 2009
- Homelessness and brain injury - March 2010
- Complex Needs of persons with brain injuries - March 2011
- Employment and brain injury - December 2011
- Assessment and Care Coordination - June 2012

In the three years since the ACL/TBI partnership grant award, the Council has co-sponsored two training forums each year, one held in spring and one held in the fall, to further increase education around brain injury and best practices in supporting and treating individuals with brain injury.

The Council gathered information through these public hearings and forums to formulate its recommendations. The Council met seven times in 2017 including a day-long review of DHHS' brain injury initiatives and action plans developed at the forums.

The Council acknowledges and thanks the DHHS Liaison to the Council: Derek Fales, Neurobehavioral Services, from the Office of Aging & Disability Services.

ABIAC AND COLLABORATIVE PARTNERS ACCOMPLISHMENTS:

- The Brain Injury Waiver received CMS approval to begin on November 1, 2014; the first person began receiving service in January 2015. Currently the Waiver is serving approximately 174 members, with 36 individuals holding a funded offer with an additional 45 individuals deemed medically eligible for services but do not have a funded offer.
- All MaineCare Services for brain injury require accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) and staff who are Certified Brain Injury Specialist (CBIS) or other equivalent qualified brain injury training. This past year 7 agencies have either received or renewed their CARF accreditation.
- The Council supported a family training completed by the University of Southern Maine, Muskie Institute with funding through the Traumatic Brain Injury State Partnership grant (TBI grant) managed by the Office of Aging and Disability Services.
- The TBI grant funded forums, webinars, and conferences to train professionals and staff throughout Maine.
- The ABIAC acknowledges the creation of the Brain Injury Association of America of Maine Chapter (BIAA-ME) in 2014. The Brain Injury Association of America Maine Chapter continued delivering resource facilitation (served 55 individuals and families to date) and information and referral services (served 847 individuals to date), which are currently funded by the TBI State Partnership Grant.
- The BIAA – ME Chapter representative has visited over 85% of the brain injury support groups in Maine. There are 16 brain injury support groups serving the people of Maine and in 2017 these groups were utilized 2,092 times by brain injury survivors, family members, and caregivers. To date, BIAA-ME has visited 82% of Maine hospitals. At these visits, BIAA-ME provided hospital staff with presentations and materials on Maine brain injury resources and supports for survivors, family members, and professionals.
- Maine Concussion Management Initiative (MCMI) has offered 35 educational opportunities in 2017. Among these, 6

were tailored to providers of brain injury and related services, 3 focused on coaches and other key personnel at Maine schools, and 26 programs reached the general public and interested stakeholders on the topic of understanding and screening for concussion. MCMI's proprietary Head Injury Tracker (HIT) has over 160 concussions entered by over 25 Maine schools in the last year. Moving forward, MCMI will continue to collaborate around education, outreach and science with key stakeholders in youth concussion prevention and management throughout the state. As the primary provider of such resources in the state, it remains vital that these offerings continue to support Maine's youth in staying active, safe and prosperous. Continuing to collaborate with the state's health professionals and schools will only improve our understanding and the consistent management of this injury.

- The ABIAC supports the Maine CDC Injury Prevention Program as it advocates at the local, state, and national levels and conducts prevention education regarding brain injury. A newly appointed representative from the CDC will be attending the council.
- A representative from Vocational Rehabilitation is actively attending the ABIAC meetings and reporting data on how many individuals with brain injury are accessing Vocational Rehabilitation services.
- The council supports the efforts of the Tri Commissioners in regards to the recommendations of the Employment First Committee.
- The BIAA-ME annual Conference on Defining Moments in Brain Injury has offered a certified concussion training track by MCMI. Participants acquire the skills to employ best practice concussion management principles as well as strategies for interpreting neurocognitive baseline and post-injury assessments.

STATUTORY REQUIREMENTS

Title 34-B: Behavioral and Developmental Services

§19001. Acquired Brain Injury Advisory Council

1. Council established. The Acquired Brain Injury Advisory Council, referred to in this section as "the council," is established to provide independent oversight and advice and to make recommendations to the commissioner, the Director of the Office of Adults with Cognitive and Physical Disability Services within the department, the Director of the Maine Center for Disease Control and Prevention within the department and the Director of the Office of MaineCare Services within the department. [2007, c. 239, §2 (NEW) .]

2. Duties. The council shall:

A. Identify issues related to brain injury, including prevention and the needs of individuals with disabilities due to brain injuries and the needs of their families; [2007, c. 239, §2 (NEW).]

B. Recommend methods that will enhance health and well-being, promote independence and self-sufficiency, protect and care for those at risk and provide effective and efficient methods of prevention, service and support; [2007, c. 239, §2 (NEW).]

C. Seek information from the broadest range of stakeholders, including persons with brain injuries, their families, rehabilitation experts, providers of services and the public, and hold at least 2 public hearings annually, in different regions of the State, to generate input on unmet needs; [2007, c. 239, §2 (NEW).]

D. Review the status and effectiveness of the array of brain injury programs, services and prevention efforts provided in this State and recommend to the commissioner priorities and criteria for disbursement of available appropriations; and [2007, c. 239, §2 (NEW).]

E. Meet at least 4 times per year and by January 15th of each year submit a report of its activities and recommendations to the commissioner and to the Legislature. [2007, c. 239, §2 (NEW).] [2007, c. 239, §2 (NEW).]

Title 22: Health and Welfare, Ch. 715-A: Assistance for Survivors of Acquired Brain Injury

§3086. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1987, c. 494, (NEW).]

1. Acquired brain injury. "Acquired brain injury" means an insult to the brain resulting directly or indirectly from trauma, anoxia, vascular lesions or infection, which:

A. Is not of a degenerative or congenital nature; [1989, c. 501, Pt. P, §26 (NEW).]

B. Can produce a diminished or altered state of consciousness resulting in impairment of cognitive abilities or physical functioning; [1989, c. 501, Pt. P, §26 (NEW).]

C. Can result in the disturbance of behavioral or emotional functioning; [1989, c. 501, Pt. P, §26 (NEW).]

D. Can be either temporary or permanent; and [1989, c. 501, Pt. P, §26 (NEW).]

E. Can cause partial or total functional disability or psychosocial maladjustment. [1989, c. 501, Pt. P, §26 (NEW).] [2011, c. 293, §1 (AMD).]

§3088. Comprehensive neurorehabilitation service system

The department shall, within the limits of its available resources, develop a comprehensive neurorehabilitation service system designed to assist, educate and rehabilitate the person with an acquired brain injury to attain and sustain the highest function and self-sufficiency possible using home-based and community-based treatments, services and resources to the greatest possible degree. The comprehensive neurorehabilitation service system must include, but is not limited to, care management and coordination, crisis stabilization services, physical therapy, occupational therapy, speech therapy, neuropsychology, neurocognitive retraining, positive neurobehavioral supports and teaching, social skills retraining, counseling, vocational rehabilitation and independent living skills and supports. The comprehensive neurorehabilitation service system may include a posthospital system of nursing, community residential facilities and community residential support programs designed to meet the needs of persons who have sustained an acquired brain injury and assist in the reintegration of those persons into their communities. [2011, c. 293, §3 (RPR).] SECTION HISTORY 1987, c. 494, (NEW). 2011, c. 293, §3 (RPR).

§ 3089.Acquired brain injury assessments and interventions; protection of rights

The department is designated as the official state agency responsible for acquired brain injury services and programs.

1. Assessments and interventions.

In addition to developing the comprehensive neurorehabilitation service system under section 3088, the department may undertake, within the limits of available resources, appropriate identification and medical and rehabilitative interventions for persons who sustain acquired brain injuries, including, but not limited to, establishing services:

A. To assess the needs of persons who sustain acquired brain injuries and to facilitate effective and efficient medical care, neurorehabilitation planning and reintegration; and

B. To improve the knowledge and skills of the medical community, including, but not limited to, emergency room physicians, psychiatrists, neurologists, neurosurgeons, neuropsychologists and other professionals who diagnose, evaluate and treat acquired brain injuries.

2. Rights of patients and responsibility of department to protect those rights. To the extent possible within the limits of available resources and except to the extent that a patient with an acquired brain injury's rights have been suspended as the result of court-ordered guardianship, the department shall:

A. Protect the health and safety of that patient;

B. Ensure that the patient has access to treatment, individualized planning and services and positive behavioral interventions and protections; and

C. Protect the patient's rights to appeal decisions regarding the person's treatment, access to advocacy services and service quality control standards, monitoring and reporting.

3. Rules. The department shall establish rules under this section. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.