**August 11, 2015**
**Appropriations & Human Services Committees Public Hearing**
**1915(C) HOME AND COMMUNITY-BASED SERVICES WAIVER, CT ACQUIRED BRAIN INJURY WAIVER I and II Proposed Amendments**
**Julie Peters, CBIS, Executive Director**
**Brain Injury Alliance of Connecticut**

Good Day Committee Members. I thank you for the opportunity to present testimony.

My name is Bonnie Meyers, and I am here representing Julie Peters, Executive Director, and the Brain Injury Alliance of Connecticut. For over 30 years, BIAC has served individuals with brain injuries, their families and caregivers, working to assure that services are available to those who sustain a brain injury. BIAC has a long history of advocating for individuals to receive appropriate services in the community. We have come back before you **many times** over the years advocating for the Waivers' expansion and improvement.

I am the Director of Program & Services at the Brain Injury Alliance of CT. I have over 25 years of experience in the field of brain injury services, and I have directed and administered a variety of programs throughout the entire continuum of recovery. I have also overseen community-based vocational rehabilitation programs for brain injury survivors. In addition, I have significant experience with brain injury waiver programs, including oversight/administrative responsibilities for the New York State Department of Health TBI Waiver program throughout the Long Island Region.

The proposed amendment to Cognitive Behavioral Services under both Waiver I and Waiver II modifies both the definition and the rate structure for this service. We support the new definition of Cognitive Behavioral services because rather than focusing on maladaptive behavior, the new service definition more adequately describes the Cognitive Behaviorist's role in promoting and supporting an individual's highest level of functioning within the community.

We also support the new rate structure which will require, at minimum, a quarterly, in person meeting with the waiver participant. We believe it is essential that the Cognitive Behaviorist maintain in person contact in order to effectively evaluate and develop goals and objectives.

A lower rate structure will be used for other types of non-face-to-face interactions, (i.e., planning, phone) We caution DSS to assure that there is no unintentional consequence of losing providers and/or difficulty in recruiting new providers for this waiver service because of the decreased rate of this non-face-to-face service.

In regard to amending Waiver 1 to modify the definition of Prevocational Services, we oppose the amendment as currently written. We understand that CMS guidelines dictate that this service must be time limited. Ideally, there would be no predetermined time limits on any waiver service. Pre-vocational services should continue to be approved for as long as the service is justified. However, if a pre-determined time limit required, then BIAC urges the legislature to remove the word "strong" from both the amendment to Waiver 1 and to the current language of Waiver II. The approval of any waiver service should require justification, and no additional qualifier is warranted.

If and when it is determined by the team that Pre-Vocational Services are not appropriate for the individual, BIAC strongly opposes any plan that would replace these services primarily with a group program such as ABI Group Day. While the socialization which can occur within this setting may be appropriate for some, there needs to be assurance that individual habilitative services, such as ILST, are also included to assure that the participant continues to gain maximum progress.

There is no definitive predictable course of recovery after a brain injury, and this may be particularly true for moderate to severe brain injury. The extent of recovery and the timeline of recovery vary greatly from person to person, and are dependent on a number of factors. Recovery is a long and difficult process, and may continue for many years after injury.

While it is generally agreed upon that the largest scale of recovery may happen within the first 2 years of injury, there is no evidence to suggest that people do not have capacity for ongoing functional improvement, skill development, and advancement beyond 2 years. In fact, I personally have seen individuals 10 years post injury still demonstrate ability to development new skills OR to re-learn skills/behaviors that they had mastery over prior to injury. The pace at which relearning of skills may slow down and/or may be more subtle and in smaller incremental steps, but still individuals are able to develop new skills and relearn previously known skills far beyond that initial 1-2 year period of recovery.

Brain injury survivors have the capacity for ongoing development – given the appropriate level of attention, intervention, identification and implementation of effective treatment modality strategies, and appropriate structuring of the environment. I know this to be true because I have seen it happen. Every individual is different, and to pre-determine an individual's capacity for re-learning is certainly not person centered; neither is a reasonable approach to recovery. One single fit does not fit all brain injury survivors, nor does one single "window of opportunity" for recovery fit all survivors.

I would also like to emphasize the fact that everyone involved has a role in maximizing success for a waiver participant. Oversight, accountability, and responsibility must be a shared effort, to include the waiver participant, treatment staff, agency supervisors, and waiver administrative/management team. Services need to be developed and offered in a manner which facilitates maximal potential for recovery and the relearning of skills. Waiver staff need to be well trained, and there needs to be ongoing supervision from within. Similarly, the waiver management team needs to employ diligent efforts to monitor and oversee services across time.

No amount of progress, whether small or large, can ever be identified, documented, and tracked if treatment goals are not written in appropriate terms. Goals and

objectives need to be realistic, achievable, and measurable. If this is not done, progress, on all levels, will be missed. Targeted information needs to be captured in a manner which will allow for progress (or lack therein) to be easily ascertained. If progress on a specific objective is not met, then questions need to be asked about how service can be rendered differently. Perhaps the objectives need to be changed. Perhaps the strategy, modality, or interventions need to be changed.

In closing, BIAC learned last week that the current wait list for ABI Waiver II is between 2-2 ½ years long. When Waiver II was passed last year, it was projected that its passage would "significantly reduce or eliminate" the Wait list. Clearly this has not happened. Take a moment to consider if this was your loved one. Could you wait years? For families and survivors every day without services is a lifetime. **You** can take action now. **We urge the legislature to consider further amending Waiver II to add more slots, or to, at minimum, release the 30 slots reserved for DMHAS consumers which have not been used for those on the general waitlist.** Everyone deserves the right to be able to live in the community with services and supports they need.