

Challenges to Providing Services to North Carolina Veterans Who Have Traumatic Brain Injury

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North Carolina is currently at a critical crossroads for meeting the needs of service members and veterans with traumatic brain injuries (TBIs). On one path are the increasing numbers of service members with TBI, often the result of blast-related injuries received during the conflicts in Iraq and Afghanistan. TBIs present complex challenges for identifying, assessing, and meeting needs for treatment and services, because of the wide-ranging injury severity and physical, cognitive, behavioral, and emotional sequelae. The current population of veterans with TBI is larger than ever and involves a unique mix of active duty military, National Guard, and reserve personnel.

On the other path are the approximately 160,000 civilians with TBI in North Carolina, who also face the challenges of living with the effects of TBI. These individuals have learned that access to informed, coordinated medical and other community neurobehavioral services is limited and fragmented. In contrast to veterans, who are eligible for extensive Department of Veterans Affairs (VA) and TRICARE benefits, civilians face limitations associated with private insurance or managed care, and some have no insurance.

Providers of brain-injury care and support are also at the intersection of this crossroads. North Carolina has a severe shortage of providers who specialize in TBI care, and funding continues to be a roadblock. But the crisis is about more than funding. The lack of neurobehavioral services is the major unmet need identified by both civilians and service members

who have experienced TBI, largely because North Carolina lacks an integrated neurobehavioral system of TBI care and services. There is no infrastructure designed to foster the development of programs, the number of qualified providers is insufficient, and reimbursement rates are not commensurate with the specialized costs of neurobehavioral services.

When service members and veterans leave the VA and the Department of Defense systems of care and return to their homes and communities, the next phase of rehabilitation and reintegration begins. This is where their needs intersect with those of civilians, as they search for services and supports in their local communities—whether it be for family counseling, job retraining, cognitive training, day programs, or home modifications.

The Brain Injury Advisory Council of North Carolina and the Brain Injury Association of North Carolina are leading the way to develop an integrated system of community services for all persons with brain injury. These groups are working closely with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, which is the designated lead state agency for TBI. People with neurobehavioral difficulties face significant community-level challenges. As reported in the National Association of State Head Injury Administrators' (NASHIA's) State of the States 2006 Panel on Neurobehavioral Issues, "Individuals with serious behavior disorders after TBI have traditionally been considered difficult to support in community settings and,

CareLine and with the North Carolina National Guard.

The goal of promoting the behavioral and physical health of military families will be addressed with programs and evidence-based practices that support the families' resilience and emotional health. The DMHDDSAS Practice Improvement Collaborative, managed by the Governor's Institute on Alcohol and Drug Abuse, reviews and catalogues evidence-based practices designed to address the health care needs of this special group. The historic collaboration between LMEs and state hospitals has been expanded to include the VA, the University of North Carolina system, Area Health Education Centers and Community Care of North Carolina (CCNC), and the Center of Excellence for Integrated Care (CEIC). The DMHDDSAS will continue to work with SAMHSA's national technical-assistance center to improve the quality of service delivered in North Carolina.

CCNC provides managed primary care for Medicaid-eligible patients, under the guidance of the North Carolina Division of Medical Assistance. According to Michael Lancaster, director of behavioral health at CCNC, care managers help coordinate health care for military members, veterans, or family members who have Medicaid coverage. The CCNC case manager works cooperatively with the LME care coordinator to ensure that appropriate services are secured.

North Carolina has worked to improve care for all of its citizens, including those who served the nation as a member of the military. One avenue of improvement is being investigated by the CEIC, whose work addresses the disconnection between mental health and physical health, a by-product of the US health-care system's payment system. This disconnection has made access to timely mental health services and coordinated care difficult for residents in North Carolina and the United States and has exacerbated the stigma many patients may feel about seeking mental health services. While the VA has led the way in integrating mental health care and physical health care at VA facilities, the public and private health systems have lagged in efforts to help patients who have mental and physical conditions. In 2006, professional organizations, state agencies, consumer groups, and others joined together to create the training program, clinical tools, and practice-based demonstration projects to enable primary care practices to integrate a mental health or substance abuse provider into the practice. This integration could be as minimal as an agreement to share patient care between a primary care practice and a mental health or substance abuse provider in the same region, or it could be as complex as the full integration of the behavioral health or primary care provider into the practice's teams of

therefore, place a disproportionate burden on public health systems. The absence of effective intervention and ongoing support...results in a threat to the safety of self and others" (NASHIA, unpublished data, 2006).

Emotional and behavioral challenges after TBI can include (1) impaired control of behaviors and emotions (eg, outbursts, aggression, anxiety, depression, or irritability), (2) verbal and/or physical disinhibition or impulsivity and increased frustration, (3) impaired physical activity (eg, hyperactivity or lethargy), (4) impaired self-management and self-regulation (eg, diminished problem-solving ability), and (5) impaired processing and interpreting of verbal and/or nonverbal communication.

Inadequate and underfunded brain-injury services and programs in North Carolina can result in inappropriate placement and programming, rather than appropriate diagnosis and treatment planning, for people with neurobehavioral challenges. Typical outcomes, placements, and services include the correctional system, psychiatric hospitals, substance abuse services, vocational rehabilitation, community-supported living, institutions (eg, intermediate care facilities for people with mental retardation and skilled-nursing facilities), and homelessness (TBI is estimated to occur in 30% of the homeless population). While some placements (eg, vocational rehabilitation, substance abuse services, and community-supported living) are appropriate, they are often unsuccessful because the underlying neurobehavioral issues have not been addressed. For effective delivery of services, including differential diagnoses and appropriate treatment planning, providers must have a sufficient level of expertise in brain injury.

Acknowledged best practices for treating people with

brain injuries include (1) evaluations by a neuropsychologist, neuropsychiatrist, and physiatrist (specialized rehabilitation physicians), to assess functional abilities and the need for appropriate services; (2) evaluations by other rehabilitation professionals (eg, physical therapists, occupational therapists, speech-language pathologists, vocational rehabilitation counselors, social workers, and nurses), as needed; (3) person-centered, family-centered planning; (4) personal and medical histories from the injured person, as well as personal histories from their family members, friends, or coworkers; and (5) environmental supports for skill development and promotion of independence.

Recommended innovations in community care to meet the needs of returning military service members with TBI include accurate TBI screening; community-based neurobehavioral rehabilitation programs; a hospital-based "booster" approach; crisis stabilization; a mobile-team approach to activities such as assessment, crisis management, intervention, education, and mentoring; a consultation approach, including telerehabilitation; cross-systems training; and family support and training. NCMJ

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providers. Between 2006 and 2010, this partnership, called ICARE (Integrated, Coordinated, Respectful, and Evidence-Based Care), built a formidable base of training, clinical protocols, algorithms, local mental health and patient-support resource listings (grouped by county), and relevant research to assist primary care providers and mental health/substance abuse providers with the integration of care within practices. Funded by The Duke Endowment, the Kate B. Reynolds Charitable Trust, and AstraZeneca, and operated under the North Carolina Foundation for Advanced Health Programs, ICARE was successful in reducing barriers to care for patients who have mental and physical conditions, greatly reducing wait times for mental health outpatient care and increasing patients' self-reported mental health. Providers and patients liked working and receiving treatment in an integrated setting where patients' mental and physical conditions, treatments, and medications could be analyzed and addressed. To integrate mental health care into primary care settings, ICARE trained mental health providers and medical providers in an approach that could fit within busy primary care practices: assessment, brief intervention, and, when a higher level of mental health or substance abuse treatment was indicated, referral to specialty care. Primary care providers can also be integrated into behavioral health spe-

cialty practices, such as the newly emerging Critical Access Behavioral Health Agencies (CABHAs).

In 2010, the North Carolina Department of Health and Human Services asked the foundation to extend ICARE's service integration beyond primary care, to integrate care more broadly across the health care spectrum. In July 2010, with support from Governor Bev Perdue and funding from the North Carolina Health and Wellness Trust Fund and the Division of Medical Assistance, ICARE was reorganized into the CEIC. The CEIC's scope of work includes (1) helping hospital emergency departments incorporate integrated care tools and techniques for patients with mental health and substance abuse conditions, (2) supporting LMEs and the newly certified CABHAs in the performance of physical health screening and placement in medical homes where integrated care for mental health conditions and substance abuse issues is available, (3) training targeted case managers, and (4) supporting the integration of care at primary care practices not enrolled in CCNC. More broadly, the CEIC convenes experts, stakeholders, and patient advocates to examine evidence and secure consensus on effective standards, treatment, and tools for providers to use. The CEIC, while a resource for providers, promises to not only further integrate care in multiple