# GEORGIA STATE HEALTH PLAN
# COMPONENT PLAN

# Traumatic Brain Injury Facilities

**Issue Date: March 2007**

HEALTH STRATEGIES COUNCIL
& GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Division of Health Planning
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***Developed by the Inpatient Physical Rehabilitation Services Technical Advisory Committee of the Health Strategies Council***

Adopted by the HEALTH STRATEGIES COUNCIL on March 9, 2007
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## PREFACE

This State Health Plan is a product of the Health Strategies Council and the Georgia Department of Community Health. The purpose of the Plan is to identify and address issues and recommend goals, objectives and system changes with respect to Traumatic Brain Injury Facilities.

This Plan has been developed through an open, public participatory process developed and monitored by the Health Strategies Council. The Plan is effective upon approval by the Council and the Board of Community Health and supersedes all related sections of previous editions of this component of the State Health Plan.

For purposes of the administration and implementation of the Georgia Certificate of Need (CON) program, this component plan is intended to provide general background and rationales for the criteria and standards set forth in Rule 111-2-2-.34. The Department's rules shall constitute the final authority for all Certificate of Need review decisions.

Any questions or comments on this Component Plan should be directed to:

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# Introduction

The Department of Community Health, through its Division of Health Planning ("Department"), is responsible for managing the state's health planning program and establishing standards and criteria for the granting of Certificates of Need. Two of the Department's primary missions are to contain health care costs by avoiding unnecessary duplication of services and to establish and enforce quality-of-care standards. In addition, the Department is committed to ensuring that providers assume a share of the responsibility for the health care needs of low-income citizens and under-served or at-risk members of their local community. Financial access, clinical proficiency and community outreach are cornerstones of the Department's mission.

In 1989, the General Assembly adopted Senate Bill 360 relating to TBI facilities and led to the formation of a Technical Advisory Council, which adopted the original component plan for TBI facilities and related rules in 1990.

The Health Strategies Council, a 27-member board appointed by the Governor, is responsible for developing Georgia's component State Health Plans and addressing policy issues concerning access to health care services. In 2005, the Health Strategies Council's Long Term Care Standing Committee agreed that the 1994 State Health Plan and Rules that govern the need for new or expanded inpatient physical rehabilitation services in the State of Georgia were outdated. In particular, the Standing Committee recommended that both the State Health Plan and Rules be reviewed to ensure that they adequately address the needs of patients, consumers, regulators, and purchasers and reflect current industry practices.

Membership on the TAC consisted of 19 members, representing a wide range of providers from each of the four planning areas for physical rehabilitation services. Members were affiliated with facilities and organizations from acute care hospitals with rehabilitation units, freestanding rehabilitation hospitals, state-operated rehabilitation hospitals, geriatric and pediatric hospitals, third-party payers, state agencies, consumer/patient advocates, and professional associations. In addition, the TAC members represented both "large" and "small" rehabilitation programs, providers serving unique patient populations such as children's hospital or spinal cord injury programs, a variety of owners (for-profit, not for profit, and hospital authority), and both urban and rural providers.

The TAC held ten meetings from February 2005 until May 2006. Over the course of its deliberations, it was decided that the State Health Plan and Rules would be incorporated into the Plan and Rules for Comprehensive Inpatient Physical Rehabilitation Services.

Throughout the development of the Rules and this component plan, a wide array of data and research, both regional and nationally, was considered by the TAC and the Department. In addition, the public was given the opportunity to comment on the data and the proposals at each meeting. This planning document represents consensus from the TAC and was presented in outline form to the Health Strategies Council at their May 19, 2006 meeting. The Rules were approved by the Health Strategies Council and the Board of Community Health and became effective in December 2006.

# Overview

Traumatic brain injury (TBI) is defined by the Department as “a traumatic insult to the brain and its related parts resulting in organic damage thereto that may cause physical, intellectual, emotional, social, or vocational changes in a person. It shall also be recognized that a person having a traumatic brain injury may have organic damage or physical or social disorders, but shall not be considered mentally ill.” According to the Brain Injury Association of America (1), approximately 1.4 million people sustain traumatic brain injuries each year in the United States. Of those 1.4 million, 50,000 die, 235,000 are hospitalized, and 1.1 million are treated and released in the emergency department. It is estimated that 5.3 million people in the United States live with a disability associated with traumatic brain injury. (2)

Depending upon the type and severity of injury, a traumatically brain injured (TBI) individual might require a range of rehabilitation services, varying in type, intensity and duration, depending upon the needs of the client. The two components of a Residential Treatment and Rehabilitation Program relating to TBI that are regulated pursuant to Certificate of Need rules are “Transitional Living” and “Life Long Living.” “Transitional Living Program” refers to treatment and rehabilitative care delivered to traumatic brain injury clients who require education and training for independent living, with a focus on compensation for skills that cannot be restored. Such care provides clients with maximum independence, teaches necessary skills for community interaction, works with clients on pre-vocational and vocational training and stresses cognitive, speech and behavioral therapies structured to the individual needs of clients.

Life long Living Program refers to treatment and rehabilitative care delivered to traumatic brain injury clients who have been discharged from rehabilitation, but who cannot live at home independently, and require on-going lifetime support. This program may include behavioral management and/or monitored daily living services.

## ***Types of Brain Injury***

According to the National Institute of Neurological Disorders and Stroke (3), Traumatic Brain Injury can be classified as either a closed head injury or a penetrating head injury. TBI symptoms can be mild, moderate, or severe. Mild TBI may include, among other symptoms, headaches, confusion, blurred vision, dizziness, or memory difficulties. Moderate or severe TBI can include the same symptoms as mild TBI, but also vomiting nausea, seizures, increased confusion, slurred speech, or decreased coordination.

## ***Incidence and Prevalence of Traumatic Brain Injury***

The CDC estimates that 100 out of every 100,000 people in the United States experience traumatic brain injury every year. Of this number, 52,000 people die. The CDC also estimates that the number of TBI survivors is between 2.5 million and 6.5 million. It is important to understand that the range is wide because many cases of mild TBI go unreported.

## ***Leading Causes of Traumatic Brain Injury***

Approximately 1.4 million traumatic brain injuries are sustained each year. The most common causes of these injuries are falls, vehicular, motorcycle or bicycle accidents, sports injuries, or violent acts. According to the CDC, children 0-4 years old and individuals 15-19 years old are at the highest risk for traumatic brain injuries, and males are more likely than females to sustain a traumatic brain injury.

**TBI by Sex: Comparing the Numbers**

**Table B. Average Annual Numbers* of Traumatic Brain Injury–Related Emergency Department Visits, Hospitalizations, and Deaths, by Sex, United States, 1995–2001**

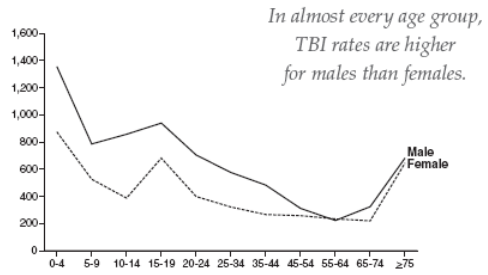
| Sex | ED Visits | Hospitalizations | Deaths | Total |
|---|---|---|---|---|
| Male | 652,000 | 146,000 | 36,922 | 835,000 |
| Female | 459,000 | 89,000 | 12,978 | 561,000 |

* The numbers for ED visits and hospitalizations were rounded to the nearest thousand per National Center for Health Statistics (NCHS) methods; thus sums may not add to rounded totals.

An average of 835,000 TBIs occurred each year among males compared with 561,000 among females. Overall, approximately 1.5 times as many TBIs occurred among males as among females.

**TBI by Sex: Comparing the Rates**

**Figure 3. Average Annual Traumatic Brain Injury-Related Rates for Emergency Department Visits, Hospitalizations, and Deaths, by Age Group and Sex, United States, 1995–2001**




Males from 0 to 4 years of age had the highest rate for TBI-related deaths, hospitalizations, and ED visits combined (1,355.3 per 100,000). Rates were also high for females from 0 to 4 years (874.8 per 100,000), and for both males and females ages 15 to 19 years and 75 years and older (Table 3, page 22; Table 7, page 28; and Table 12, page 35).

Per the CDC, certain segments of the general population are considered at high risk for a traumatic brain injury, including young people, low-income individuals, unmarried individuals, ethnic minority groups, inner city residents, and individuals with previous traumatic brain injury. In addition, alcohol intake prior to brain injury is cited as a common factor among patients, as well as pre-injury personality disturbance, family discord and antisocial behavior. (4)

## ***Client Characteristics***

Traumatic brain injury survivors exhibit a wide range of handicapping conditions that compromise an individual's ability to care for himself/herself and live independently. Cognitive, physical, behavioral and psychological impairments are seen in varying degrees within this population. The recovery process and successful community reintegration necessitates multiple services, care-givers and funding sources. Case management is critical to the timely identification, mobilization and coordination of these services and resources.

According to the Brain Injury Association of America, there are numerous “consequences of brain injury,” including cognitive, physical, and emotional impairment. (5) One of the primary differences between the traumatic brain injured individual and victims of other types of trauma is the cognitive impairments produced by the injury. Victims typically experience varying degrees of temporary or permanent effects such as long and short term memory deficits, loss of ability to concentrate, difficulty in sequencing, behavior problems, reduced capacity for new learning, speech and/or visual disorders or seizures. As a result, the ability of many victims of brain injury to function on a day-to-day basis without support services is severely hampered. (6)

The majority of survivors of traumatic brain injury emerge from comas and achieve progress toward regaining their pre-injury functional abilities. However, in most cases the patient is left with a combination of physical, cognitive, and integrative deficits that may persist for many months or years after the injury.

In the physical sphere, a variety of movement disorders may be observed, including abnormal muscle tone, contractures and tremors. Even a traumatically brain injured person with many of these deficits may ambulate functionally within a few months after injury. Although gross movement may appear generally intact, finer movements are usually impaired. Sensory deficits frequently observed included impaired sense of smell and hearing disorders.

Cognitive deficits are almost always present after a severe brain injury. These impairments vary in magnitude but tend to greatly alter the capacity of the patient to acquire, store, and retrieve new information and exercise good judgment. Initially, the patient has a decreased level of alertness and arousal and is observed to fluctuate in the ability to concentrate. Although alertness and arousal levels stabilize, attention deficits are still pronounced. Moreover, brain injuries can produce a variety of impairments in "executive" functions, manifested by impulsive behavior, poor problem solving, and slowness in the rate and complexity of information processing. Speech and language disabilities are commonly found.

The third major sphere of dysfunction can be termed "integrative deficits." This refers to the ability to perform complex tasks that require the operation of numerous perceptual, motor, cognitive, and regulatory processes. Complex activities of daily living and appropriate social functioning may be considered integrative functions. Behavioral problems range from minor irritability and passivity to psychotic behavior. The severely brain-injured client requires a highly structured, consistent, positive-reinforcing environment. Such a person usually cannot return successfully to previous educational or vocational pursuits. (7)

## ***Existing System of Care for Persons Requiring Transitional and Life Long Living Services***

According to most studies, rehabilitation is the main focus of the recovery process for TBI victims. During the acute phase of the illness, patients receive hospital-based care in an intensive care/trauma unit. Once past the acute phase, patients are moved to sub-acute hospital care. The next step is home-based or independent rehabilitation. Other options are community re-entry programs, day treatment programs, residential community programs, neurobehavioral programs. In addition, independent living programs, school rehabilitation programs, supported living programs, and vocational rehabilitation are other options. (7)

Georgia currently has eight designated TBI facilities. The chart below lists the facilities by State Service Delivery Region (SSDR) and by county:

| Traumatic Brain Injury Facilities in Georgia | | | |
|---|---|---|---|
| **SSDR** | **County** | **Facility Name** | **Total Beds** |
| 1 | Walker | Safehaven | 12 |
| 3 | Cobb | Transitions Atlanta | 14 |
| 3 | DeKalb | Shepherd Pathways | 27 |
| 3 | Fulton | Atlanta Rehabilitation Institute | 10 |
| 3 | Fulton | Restore Neurobehavioral Center | 24 |
| 3 | Gwinnett | Learning Services Corporation-Peachtree Campus | 18 |
| 3 | Gwinnett | Palm Creek Farm | 6 |
| 7 | Richmond | Walton Transitional Living Center | 20 |

## ***The Cost of Traumatic Brain Injury Services***

The cost of TBI injuries in the United States is approximately $48.3 billion each year ($31.7 for hospitalization, and $16.6 billion related to fatalities). (8) Estimates from the CDC place the total cost of acute care and rehabilitation of TBI victims is approximately $9-$10 billion per year. This does not include the cost due to lost wages, lost work time, and lost productivity for family members who no longer work due to providing care to the TBI victim. Over a lifetime, care for a severe TBI victim costs between $600,000 and $1,875,000.

In 2002, a study was conducted at Craig Hospital in Denver, Colorado to examine the service utilization, payor source and costs associated with TBI one year after discharge from initial rehabilitation. The study followed 60 participants who had sustained a TBI and had been hospitalized in an inpatient rehabilitation setting. During the one year after inpatient discharge, the average charges per person were $40,348. The services included in that time frame were therapy, medical services, psychological services, personal assistance, equipment, and other services. Therapy comprised the largest percentage of charges. Personal assistance was the most expensive service on a per person basis; however, only 20% of the study group received this service. At Craig Hospital, the payors of outpatient services include auto insurance, commercial insurance, Medicaid, and Worker's Compensation. Auto and commercial insurance tended to pay more for these services.

## ***Reimbursement for Traumatic Brain Injury Services***

Reimbursement benefits for victims of TBI are available through Medicaid, Medicare, Social Security, worker's compensation, disability insurance, motor vehicle liability insurance, and health insurance.

Inadequate insurance and other third-party reimbursement coverage often become a barrier to obtaining services that may be required for a lifetime. Insurance benefits for services following acute medical care are often limited in duration of coverage and/or by dollar ceilings. Limitations on the scope of coverage of private insurance carriers and programs such as Medicaid, Medicare and Workers' Compensation preclude payment for non-medical care. As a result, educational, social and cognitive rehabilitation services often become unaffordable for traumatically brain injured individuals and their families.

## ***A Review of Insurance Coverage for Traumatic Brain Injury Services***

### Workers' Compensation

This form of insurance is provided by an employer without financial contributions by employees. Its purpose is to provide benefits to employees injured on the job, in exchange for a limitation of the right to sue for compensatory damages, such as pain and suffering. Benefits include disability, provision for loss of income, and medical benefits. State statutes have made provisions for medical and vocational rehabilitation.

Workers' Compensation coverage may provide the greatest opportunity for persons with a traumatic brain injury to reach their maximum rehabilitation potential. Use of the nebulous criterion "reasonable and necessary' as applied to rehabilitation services is usually broadly interpreted. However, experience with Workers' Compensation claims has shown a tendency to rely primarily on medical opinions. This can be detrimental to the brain injured client, especially when higher level cognitive skills are involved. Neuropsychologists and other therapeutic disciplines generally have more expertise in identifying and prescribing appropriate rehabilitation programs than members of the medical profession. When a brain injury client is discharged from a medical model facility and begins to use out-patient services, a significant gap in insurance coverage may occur. This is especially true when terminology such as "custodial" or "'maintenance care" is applied. Most decisions are based on physical restorative concerns rather than cognitive issues. Quality of life and family care-giver burnout may not be given adequate consideration.

### Automobile No-Fault and Liability

No-Fault benefits are paid through an individual's own insurance carrier, regardless of fault or tort liability. Benefits usually include medical expenses, lost wages, and funeral or survivor's benefits in those cases where the accident results in a fatality. The system permits payment of the costs for rehabilitation at the appropriate stage of recovery.

Lost wages in all states currently under No-Fault are capped. As under Workers' Compensation, medical benefit payments are contingent on the "reasonable and necessary" test. Liability coverages, as they pertain to automobile accident victims, provide for compensation resulting from negligent acts or civil wrongs of the insured operator for injuries to innocent third parties. No-Fault generally follows the payment parameters established in the Workers' Compensation system. Unfortunately, auto liability insurance system carriers have been slow to adopt proactive measures incorporating rehabilitation benefits. Instead, many liability insurers negotiate the proportionate liability of their insured, thereby causing delays in the payment of monies for medical care. This results in delays in initiating rehabilitation efforts. In addition,

because of the limited funding available for auto liability coverage, settlement monies may be inadequate to provide for the long term needs of persons with traumatic brain injury.

Health Insurance

Health insurance is usually a type of group insurance purchased primarily by an employer for the benefit of its employees and its employees' dependents. Often, the larger the employer, the more generous the benefit plan. Group policies usually incorporate a basic hospital insurance plan, and a major-medical component, and include inside limits such as a specific number of hospital days, skilled nursing facility days, or limits on the number of therapy sessions. Health insurance policies rarely specify benefits for rehabilitation, other than by reference to speech or physical therapy.

As in most forms of insurance, deductibles exist that require the employee, along with any dependent, to cover expenses up to a prescribed threshold. Aside from deductibles as a risk-sharing device, most health insurance plans use some form of coinsurance. As a part of many health insurance programs, there are certain other cost containment features. Examples include pre-certification prior to hospital admission and mandatory second opinions for selected types of elective services. These programs may at some point in the recovery process have an impact on either the type of rehabilitation setting for persons with a brain injury or the duration, amount, or type of therapeutic services received.

Aggregate policy limits for health insurance may be so low that long term rehabilitation efforts are impossible. Often there are no benefits for custodial care, home health care or outpatient group therapies. These policies are designed for acute care rehabilitation and are not oriented toward the chronic care needs of persons with traumatic brain injury.

As brain injury clients progress to the point of requiring community re-entry programs for skills development in cognitive and socialization areas, they may find that some policies do not recognize these programs as eligible for coverage. Such programs are considered educational or psychiatric in nature and therefore are excluded, or severely limited. The development of non-medical environments which provide these kinds of programs usually does not meet the insurer's licensure criteria and therefore, are not reimbursed under current policy provisions.

Other problems often identified upon discharge of a brain injured person from an inpatient program to the home are poor judgment and problem solving skills. Therefore, it becomes difficult to leave the person unattended for long periods of time. In addition, as a result of persistent cognitive disorders, the person may require some prompts or cues to complete more complex activities. Reasoning skill deficits and decision-making difficulties require some form of attendant care, at least for certain periods during the day or evening hours. However, most policies do not make provision for this type of care, and it is often too expensive for the family to provide independently.

# Guidelines for the Review and Development of Traumatic Brain Injury Facilities

## ***Standard: Applicability***

*111-2-2-.34(1)(a) The following Rules apply to Traumatic Brain Injury Facilities defined herein as providing transitional living programs and/or life long living programs.*

*(a) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Transitional Living Program. An application for Certificate of Need for a new or expanded Transitional Living Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.*

*(b) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Life Long Living Program. An application for Certificate of Need for a new or expanded Life Long Living Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.*

## ***Rationale: Applicability***

New or expanded Transitional Living Programs require a CON. New or expanded Life long Living Programs require a CON.

## ***Standard: Transitional Living Need***

*111-2-2-.34(3)(a) The need for a new or expanded transitional living program shall be established through the application of the demand-based need methodology as follows:*

1. *Step 1 – Calculate the Projected Number of Transitional Living Program Clients*

    *(i) Projected Total TBI Discharges - Project the number of TBI discharges in the planning horizon year (the third year) by multiplying the projected resident population in the service area by the statewide hospital discharge rate for acute care hospitals for patients with traumatic brain injury (TBI) diagnoses as determined by using the following ICD-9 diagnosis codes or by using updated codes if applicable: 800.1 to 800.4, 800.6 to 800.9, 801, 803.1 to 803.4, 803.6 to 803.9, 804.1 to 804.41, 804.6 to 804.9, 850.1 to 850.9, 851, 852, 853, 854, 907.0 to 907.11, 907.3 to 907.9.*

    *[Projected Resident Population X TBI Discharge Rate = Projected TBI Discharges]*

*(ii) Projected Transitional Living Clients - Project the number of clients for Transitional Living Programs in the planning horizon year by multiplying the projected total TBI discharges by the estimated percent demand for transitional living which is two percent.*

*[Projected TBI Discharges X .02 = Projected Transitional Living Clients]*

2. *Step 2 – Calculate the Projected Transitional Living Program Client Days of Care. The Projected Transitional Living Clients from Step 1 are multiplied by the expected average length of stay for a Transitional Living Program which is 300 days.*

*[Projected Transitional Living Clients X 300 Days = Projected Transitional Living Program Days of Care]*

3. *Step 3 – Calculate the Projected Number of Beds Needed for Transitional Living Programs*

*(i) Projected Transitional Living Program Clients' Average Daily Census – Divide the Transitional Living Program client days from Step 2 by 365 days per year.*

*[Transitional Living Client Days / 365 = Projected Average Daily Census]*

*(ii) Projected Number of Transitional Living Program Beds Needed – Divide the Average Daily Census by the Optimal Occupancy rate of 85 percent to determine the number of beds. Round fractions up to a whole bed.*

*[Projected Average Daily Census / .85 = Projected Transitional Living Program Beds]*

## ***Rationale: Transitional Living Need***

The projected number of transitional living program clients in the horizon year is determined by multiplying the number of projected TBI discharges by a 2% utilization factor (projected discharges X .02). The TAC agreed that 2% was a rational and acceptable number to reflect the number of TBI discharges that could be expected to need transitional living services.

Determine the number of projected days of care for transitional living programs by multiplying the projected clients by the expected average length of stay for transitional living. Expected ALOS is 300 days under the current rules and the TAC considered this to be reasonable.

Determine the projected number of beds needed for transitional living programs by dividing the projected client days by 365 and then divide by .85 to reflect an 85% occupancy standard. The TAC reviewed this standard and determined that 85% remains a reasonable occupancy standard.

## ***Standard: Life Long Living Need***

*111-2-2-.34(3)(b) The need for a new or expanded Life Long Living Program shall be determined through the application of the demand-based need methodology as follows:*

1. *Step 1 – Estimate the number of Current Life Long Living Program Client Candidates*

    *(iii) Estimated Prevalence Rate for TBI Clients Currently - Multiply the TBI discharge rate by 4. The TBI discharge rate should be determined by using the following ICD-9 diagnosis codes or by using updated codes if applicable: 800.1 to 800.4, 800.6 to 800.9, 801, 803.1 to 803.4, 803.6 to 803.9, 804.1 to 804.41, 804.6 to 804.9, 850.1 to 850.9, 851, 852, 853, 854, 907.0 to 907.11, 907.3 to 907.9.*

    *(iv) Estimated Current Life Long Living Candidates - Multiply the current estimated population in the service area by the estimated prevalence rate for TBI clients and then apply the demand factor for Life Long Living by multiplying by 0.5.*

2. *Step 2 – Project the number of New Clients for Life Long Living Programs. For each service area, project new clients for life long living for year one of the three year planning period by multiplying the projected service area population by the hospital discharge rate for Georgia acute care hospitals for patients with traumatic brain injury (TBI) diagnoses as determined using the following ICD-9 diagnosis codes or by using updated codes if applicable: 800.1 to 800.4, 800.6 to 800.9, 801, 803.1 to 803.4, 803.6 to 803.9, 804.1 to 804.41, 804.6 to 804.9, 850.1 to 850.9, 851, 852, 853, 854, 907.0 to 907.11, 907.3 to 907.9*

3. *Step 3 – Make an Annual Attrition Adjustment. Adjust for annual attrition due to death or discharge to another setting. The estimated existing clients (Step 1) are added to the projected new clients (Step 2) for life long living to determine clients for year one. This number is multiplied by a ten percent attrition rate to account for death of clients or discharge to another setting.*

4. *Steps 4 and 5 – Estimating Clients for Life Long Living in Following Years. Estimate client numbers for year two of the planning period by repeating Steps 1 through 3 using projected population figures provided by the Office of Planning and Budget. Estimate client numbers for year three of the planning period by repeating Steps 1 through 3 using the appropriate population estimates.*

## ***Rationale: Life Long Living Need***

Potential Life Long Living Clients Currently

Determine the TBI prevalence rate per 1,000 by multiplying the TBI discharge rate for the most recent year available by 4 (because prevalence rate is assumed to be 4 times the incidence rate). The TAC considered this prevalence rate to be acceptable.

To determine the number of potential life long living program clients, the prevalence rate is adjusted by a demand factor of .5% (TBI prevalence rate X .005). This demand factor was considered reasonable by the TAC.

Potential Clients in Year One, Two, and Three

Determine the Life Long Living clients expected in the 1st, 2nd, and 3rd years of the horizon period by multiplying the projected resident population by the TBI incidence rate (actual discharge rate per 1,000), and then adjusting for the .5% Life Long Living demand factor. Finally, apply a 10% adjustment for losses due to attrition. ((Year 1 Population X TBI Incidence Rate) X .005) X .10)

Sum of Clients in Each Year

Add the number of clients currently to the number of clients in Year 1, Year 2, and Year 3 to determine the projected number of clients in the horizon year.

## ***Standard: Adverse Impact***

*111-2-2-.34(3)(c) An applicant for a new or expanded Traumatic Brain Injury Facility or program shall document that the establishment or expansion of its Facility or program will not have an adverse impact on existing and approved programs of the same type in its Planning Region. An applicant for a new or expanded Traumatic Brain Injury Facility or program shall have an adverse impact on existing and approved facilities or programs of the same type if it will:*

1. *decrease annual utilization of an existing facility or program, whose current utilization is at or above 85%, to a projected annual utilization of less than 75% within the first twelve months following the acceptance of the applicant's first patient; or*
2. *decrease annual utilization of an existing facility or program, whose current utilization is below 85%, by ten percent over the twelve months following the acceptance of the applicant's first patient.*

*The applicant shall provide evidence of projected impact by taking into account existing planning region market share of facilities or programs of the same type and future population growth or by providing sufficient evidence that the current population is underserved by the existing Traumatic Brain Injury facility or program of the same type within the planning region.*

## ***Rationale: Adverse Impact***

Specifications were added of how an applicant for a new/expanded TBIF will not adversely impact existing and approved facilities or programs. A decreased annual utilization of an existing and approved facility that was at or above 85% to less than 75%, and a decreased annual utilization of 10% to existing facilities/programs whose current utilization is below 85%, is considered an adverse impact. Sufficient evidence includes existing planning region market shares and current population.

## ***Standard: Exception to Need***

*111-2-2-.34(3)(d) The Department may grant an exception to the need methodologies of 111-2-2-.34(3)(a) and (3)(b) to remedy an atypical barrier to the services of a Traumatic Brain Injury Facility or program based on cost, quality, financial access or geographic accessibility.*

## ***Rationale: Exception to Need***

Added allowance of exceptions to need methodologies of standards (a) and (b) to remedy an atypical barrier to TBIF services based on cost, quality, financial access, or geographic accessibility.

## ***Standard: Minimum Bed Size***

*111-2-2-.34(3)(e) Minimum bed size for a Traumatic Brain Injury Facility or program is six beds; A Life Long Living Program may not exceed thirty beds, except that an applicant for a new or expanded Life Long Living Program may be approved for total beds to exceed 30 beds only if the applicant provides documentation satisfactory to the Department that the program design, including staffing patterns and the physical plant, are such as to promote services which are of high quality, are cost-effective and are consistent with client needs.*

## ***Rationale: Minimum Bed Size***

This criterion sets the minimum bed size for the TBIF or program to be 6 beds. The TAC considered this to be the minimum bedside that would be cost effective considering economies of scale. Furthermore, the criterion specifies that just Life Long Living Programs may not exceed 30 beds, except if the applicant provides satisfactory documentation that program designs, including staffing patterns and the physical design, promote high quality services that are cost-effective and consistent with client needs. The TAC felt that limiting the size of life long living programs would insure that quality services and treatment is provided patients/residents.

## ***Standard: Accreditation***

*111-2-2-.34(3)(f) An applicant for a new or expanded Traumatic Brain Injury Facility shall demonstrate the intent to meet the standards of the Commission on Accreditation of Rehabilitation Facilities (CARF) which apply to post acute brain injury programs and residential services within twenty-four (24) months of accepting its first patient. An applicant for an expanded Traumatic Brain Injury Facility or program shall be CARF-certified as of the date of its application and shall furnish proof of the certification as a part of the Certificate of Need application process.*

## ***Rationale: Accreditation***

Under this criterion, applicants must demonstrate intent to meet CARF standards which apply to post acute brain injury programs and residential services. An applicant for a new TBIF or program shall meet standards within 24 months of accept the first patient, and an applicant for an expanded TBIF or program shall be currently certified and shall furnish proof as part of the CON process. The TAC felt that such requirements were necessary to guarantee quality care.

## ***Standard: Licensure***

*111-2-2-.34(3)(g) An applicant for a new or expanded Traumatic Brain Injury Facility shall demonstrate the intent to meet the licensure rules of the Georgia Department of Human Resources for such facilities. An applicant for an expanded Traumatic Brain Injury Facility or program shall demonstrate a lack of uncorrected deficiencies as documented by letter from the Georgia Department of Human Resources.*

## ***Rationale: Licensure***

Adds specifications for licensure Rules of the Georgia Department of Human Resources. An applicant for a new TBIF or program shall demonstrate intent to meet the Rules. An applicant for an expanded TBIF or program shall demonstrate an absence of uncorrected deficiencies. The TAC maintained the importance of this criterion in ensuring quality of care.

## ***Standard: Utilization Review***

*111-2-2-.34(3)(h) An applicant for a new or expanded Traumatic Brain Injury Facility shall have written policies and procedures for utilization review. Such review shall consider the rehabilitation necessity for the service, quality of client care, rates of utilization and other considerations generally accepted as appropriate for review.*

## ***Rationale: Utilization Review***

The TAC maintained that quality control is essential for the consistent high quality required of a Traumatic Brain Injury Facility. Quality control includes an evaluation of the necessity,

appropriateness and efficiency of the use of health and health related services, procedures and facilities. Generally, this includes the review of the appropriateness of admissions, services ordered and provided, length of stay, progress toward discharge and discharge practices, both on a concurrent and retrospective basis. Utilization review can be done by a utilization review committee, a Professional Review Organization (PRO), a peer review group and/or a public agency.

Generally, the duties of peer review organizations include the establishment of criteria, norms, and standards for diagnosis and treatment of diseases and a review of services to determine any inconsistencies with established norms. The norms may be input, process or outcome measures.

## ***Standard: Referral Arrangements***

*111-2-2-.34(3)(i) An applicant for a new or expanded Traumatic Brain Injury Facility shall document the existence of referral arrangements, including transfer agreements, with an acute care hospital within the planning region to provide emergency medical treatment to any patient who requires such care. If the nearest acute-care hospital is in an adjacent planning region, the applicant may document the existence of transfer agreements with that hospital in lieu of such agreements with a hospital located within the planning region.*

## ***Rationale: Referral Arrangements***

Specifications were added for documentation of referral arrangements of TBIFs. TBIF referral arrangements, including transfer agreements, are to be with acute-care general hospitals in the same planning area, or with the nearest acute-care hospital in an adjacent planning area, to provide emergency medical treatment.

## ***Standard: Financial Accessibility***

*111-2-2-.34(3)(j) An applicant for a new or expanded Traumatic Brain Injury Facility shall document that the Facility will be financially accessible by:*

1. *providing sufficient documentation that un-reimbursed services for indigent and charity patients in a new or expanded Facility shall be offered at a standard which meets or exceeds three percent of annual gross revenues for the Facility after provisions have been made for bad debt and Medicaid/Medicare contractual adjustments have been deducted. If an applicant, or any facility owned or operated by the applicant's parent organization, received a Certificate of Need (CON) for a Traumatic Brain Injury Facility and the CON included an expectation that a certain level of un-reimbursed indigent and/or charity care would be provided in the Facility(ies), the applicant shall provide sufficient documentation of the Facility's provision of such care. An applicant's history, or the history of any facility owned or operated by the applicant's parent organization, of not following through with a CON expectation of providing indigent and/or charity care at or above the level agreed to will constitute sufficient justification to deny an application; and*

*2. agreeing to participate in the Medicare and Medicaid programs, whenever these programs are available to the Facility.*

*111-2-2-.34(3)(k)* ***Reserved.***

## ***Rationale: Financial Accessibility***

Specifications were added that an applicant shall foster an environment that assures access to services to individuals unable to pay and regardless of payment source/circumstances, based on the following standards:

1. evidence of policies related to nondiscrimination
2. a written commitment that 3% of service adjusted gross revenue be offered for indigent/charity care services (Providers offering both Life long and Transitional Living Programs may make one commitment.)
3. documentation of demonstrated performance foe Medicare, Medicaid, and indigent care
4. documentation of current/proposed policies regarding expected pay from charity, self-pay, and uninsured patients
5. agreement to participate in Medicare and Medicaid programs, if applicable.

The TAC maintained that the inclusion of these criteria would standardize financial accessibility criteria throughout the Department's rules.

## ***Standard: Provision of Data***

*(l) An applicant for a new or expanded Traumatic Brain Injury Facility shall document an agreement to provide the Department requested information and statistical data related to the operation of such a Facility and to report that information and statistical data to the Department on a yearly basis, and as needed, in a format requested by the Department and in a timely manner.*

## ***Rationale: Provision of Data***

Uniform data related to the provision and utilization of Traumatic Brain Injury Facilities is important to the assessment of service needs and other planning requirements. Information reported to the Division continues to improve as annual and special surveys are refined. The submission of timely and accurate data allows for a more precise assessment of the current level of programs and services being provided, need for additional services; costs, charges, patient origin and other factors important in planning for Traumatic Brain Injury Facilities. The Division plans to continue conducting annual and special surveys in order to collect information for planning, Certificate of Need, and other appropriate purposes. Failure to provide adequate data could jeopardize the awarding of a future Certificates of Need. Non-reporting also could lead to erroneous Certificate of Need decisions if adequate data are unavailable

# References

1. Brain injury Association of America; www.biausa.org
2. North American Brain Injury Society; www.nabis.org
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4. National Center for Injury Prevention and Control, CDC; www.cdc.gov/ncipc
5. Brain injury Association of America; www.biausa.org
6. Head Injury in New York State, A Report to the Governor and the Legislature, New York Department of Health, May, 1986

7 Whyte, John and Mitchell Rosenthal, PhD., “Rehabilitation of the Patient with Head Injury”, Rehabilitation Medicine: Principle and Practice, Lippincott, Philadelphia, PA., 1988

8. Lewin – ICF, The Cost of Disorders of the Brain, Washington, D.C.: The National Foundation for the Brain