8/7 Meeting - Senate Memorial 30 Task Force

Attendance:

In Person -

Lisa McNiven

Dr. Davin Quinn

Jason Kerkmans

Emily Stern

Michael Langford

Michelle Harmon

Andrea Vargas

Remote -

Dr. David Arciniegas

Mariah Apodaca

Cyndi Archuleta

Cass Brulotte

Victoria Herrera

Crystal Cantu

Yvette Pomponi

Crystal Lawrence

Dr. Mark Pedrotty

Mariah Apodaca

Margot Feldvebal

Baindu Akinrotiba

Melanie Buenviaje

Gail Starr

Martha Quintana

Dr. Austin Davis

1. **Requiring Health Insurance Coverage**

Dave A. - DD waiver, there’s a program in Colorado – Brain Injury waiver program, using Medicaid waiver. Link in chat.

Cass B. - Can’t speak to what is or isn’t’ covered by Medicaid, just commercial. NM has no authority over Medicare plans, VA, ARISA, Tri-Care. Can’t mandate more than what is already covered.

Victoria H. - Beneficial to add Telly Tolin, contact info to be shared via email. Melanie Buenviaje is on the call as well and can be POC.

Emily S. - Is there a training component involved? How do we get it recognized.

Michelle H. - New Roads began in NM 8 years ago and started working with HSD to become a residential provider. Saw that NM residents are often most likely sent out of state to different rehab facilities. New Roads specifically started working with the community benefit. Have to be approved as a nursing facility level of care. In NM, they were required to get licensed as an assisted living facility. For residential services, the population of people not ready to go back to their community and live alone, they’ve found, that everything is very fragmented and because of that you have to piece it together. The patients and the providers as well all tend to give up. The licensure for assisted living doesn’t have any specialized care – is more focused toward an elderly population. The TBI population is not that. Texas laws have requirements focused toward rehabilitation. Need something focused toward t Medicaid recipients are eligible for the community benefit, so they get put into that system and then we lose people because it is difficult to navigate.

Michael L. - Used to run a facility from Texas, and brought in New Mexicans. In other states, Brain Injury rehab is a large industry. Need to look at it from a legislative standpoint, to serve this population.

Crystal C. - Identifying the provider network that is currently within our state, and built trainings for families, providers, care staff. Building this database, this should be one of our outcomes. We need to attract more providers into this state.

Emily S. - Is there a quality control entity for these providers?

Jason K. - KS, CO, TX all utilize different funding models/requirements to cover this need. An overview/analysis of each could be helpful in relaying legislative options.

Cass B. - Border communities, our legislature could help with requiring insurance companies include boarder communities in their network, across state lines, e.g. Las Cruces and Gallup (both have more providers in TX and AZ).

David A. - A common dilemna with that is when they get care across a state line, then for them to get Rx after that becomes difficult. If we pursue that, then concurrent discussion for cross state patient relationships would need to be made.

Cass B. - The insurance companies want to change that definition in NM.

Emily S. - Is there anything in regard to workers comp invovled?

David A. - Spent the last 4 years working as a medical director for Paradigm in NM that only does workers comp for brain injury, burns, etc. They have the actuarial models that would be important for this group. They have brain injury care managers in the field. Can help inform the poly-trauma care. It’s a nice way for workers comp and outcomes based care. They are not doing utilization review. They would be useful to talk to. They’ve had their eye on NM because injured workers are often transported to CO, AZ, TX. Because they have not been able to located centers outside of UNM’s acute care.

Michael L. - The workers comp insurance is like regular insurance. They are used to doing what they’ve always done. There are not many brain injured providers in the state. We had to refer a patient to Chicago for services.

David A. - Capacity building needs to be done in state. A necessary part of the conversation.

Michael L. - One of the biggest propblems we’ve had is get a group of professional networking in place so we can provide professional services to our residents. When we talk to them, we get ‘we don’t have any experience with those populations’ a lot of physicians are more experienced working with the DD population.

Gail S. - Representing the vastly underassessed domestic violence victims who never get diagnosed or followed up with. They get told they are just ancious from the trauma of the DV. It’s not being diagnosed or discussed by the doctors. They also face discrimination in that the police will often look at whether the victim is able to take care of her children.

David Q. - This also relates to the incarcerated populations as well.

1. **Establishing a Brain Injury Registry**

David A. - A surveillance system or a registry system – anonymous versus opt-in with identifiable info?

Melanie B. - In regard to surveillance, there is a CDC survey that goes out and we could add brain injury to that survey. Going through the Dept of Health’s epidemiology department.

Emily S. - Is it possible to ask questions about whether the person is a survivor of DV or sexual assault.

Melanie B. - Yes, you have to work with the DOH and there is a fee for that data collection piece, buy you can add any questions. It’s been collected for 40 years so there may already be questions asked that we can access data on.

Jason K. - Does it work to look at these as to which of these survey versus registry would serve the purpose of what we are trying to achive with providing better care for brain injured populations?

Davin Q. - The Memorial asks for establishing a brain injury registry that tracks statistics. We should be addressing the feasibility of a registry. To provide both information and access to care. Surveillance, which has been done at different points, looking at rates of incidents of brain injury in NM. The information will help us advocate and obtain the services needed. How many patients does the statewide system of care need to provide care to? Would advocate a registry first and then a survey to add to.

David A. - I would flip it. The survey doesn’t require consent. Reliable data from the survey, and the opt-in registry will give us data that tk. Could build a registry that has both. Policymakers get concerned about mandates to opt-in. Realistically need both.

Cass B. - Could see a lot of our elected officials balking at creating a database with individuals’ names. We have a strong libertarian streak here.

David A. - Would not get a good registry of people who want to sign up for this, giving us wonky data.

Lisa M. - Aging and long term services has a special needs registry app. It could be something we could look at if we want to invite them.

Davin Q. - Appreciate Dr. Arcinegas’s point, in order to have an effective surveillance program, what does that look like?

David A. - Typically, there’s a reporting requirement with injury types, ex. Gunshot wounds. So with brain injury, there becomes a requirement. The CO program has had this for years. Barbara Tk, the senior epidemiologist there, could be someone who we talk with about the best set up.

Margot F. - My concern is that I hear from people over and over again that even after having gone to multiple EDs they aren’t getting diagnosed with a brain injury. So how does that data get collected?

David A. - I agree. Any structure would have to have an appropriate capacity building component to it.

Lisa M. - Regarding the registry, looking for statistics, I reached out to Gwendolyn G(sp?) in aging and long term services. The DOH collects data through the emergency rooms, and it’s very time consuming to put together the data. They do spinal cord injury data collection and may collect brain injury as well but need to reach out to confirm. Also, in regard to youth data collection relating to disabilities, we had a question that was competitive with other entities for what questions could get added by the CDC, so it was competitive to get the question added to the questionnaire. Having a brain injury question is important. I’d like to create a disability statistics portal, and it could help the brain injury community, with a component of survey and registry together.

Melanie B. - Medicaid has a comprehensive needs assessment that has a question that talks about brain injury. So HSD can run data based on those codes. That can tell us how many people within Medicaid have been diagnosed with a brain injury.

David A. - To learn about the injury surveillance programs the states and CDC have been using, it would be worth reaching out to the CDC. Victor Coronado ran it. Juliette Harbat-Cruge(Sp?) now. Have a conversation with how much of a burden it is to run this and what costs there may be.

Mark P. - Important if you take Rick Campbell’s research on sports funding, that law needs to apply to all students not just athletes.

David A. - The TBI specific program could help provide cost estimates for standing up this

Davin Q. - There are demonstration grants available that could help pay for this. If we find the right state partner we could apply.

**NEXT STEPS**

We have until Nov to meet and work online.

Emily will help us get it started for a draft.

Need authors to volunteer to help with sections.

Volunteers -

Austin Davis

Jason Kerkmans

Mark Pedrotty

David Arciniegas

Margot F – Can this report encompass all acquired brain injuries, not just TBI focused? I’d like this to not exclude all of those people who don’t

David A. - Adding acquired brain injury causes a lot more complexity. Starting with TBI, and getting a solid basis, then expanding to include, vascular injury, hypox injury, etc.

Next meeting – September 11 (same time frame – 10 a.m. to 11:30 a.m.)