Members

Rep. Timothy Brown, Chairperson
Rep. Steven Davisson
Rep. Ronald Bacon
Rep. Suzanne Crouch
Rep. Richard Dodge
Rep. David Frizzell
Rep. Donald Lehe
Rep. Eric Turner
Rep. Charlie Brown
Rep. John Day
Rep. Craig Fry
Rep. Scott Reske
Rep. Peggy Welch
Sen. Patricia Miller, Vice-Chairperson
Sen. Ryan Mishler
Sen. Vaneta Becker
Sen. Ed Charbonneau
Sen. Beverly Gard
Sen. Ron Grooms
Sen. Jean Leising
Sen. Jean Breaux
Sen. Earline Rogers
Sen. Vi Simpson

LSA Staff:

Kathy Norris, Fiscal Analyst for the Commission
Casey Kline, Attorney for the Commission

Authority: IC 2-5-23

HEALTH FINANCE COMMISSION

Legislative Services Agency
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Indianapolis, Indiana 46204-2789
Tel: (317) 233-0696 Fax: (317) 232-2554

MEETING MINUTES[1]

Meeting Date:	**October 23, 2012**
Meeting Time:	**1:00 P.M.**
Meeting Place:	**State House, 200 W. Washington St., Senate Chamber**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**3**

Members Present: **Rep. Timothy Brown, Chairperson; Rep. Steven Davisson; Rep. Ronald Bacon; Rep. Suzanne Crouch; Rep. Richard Dodge; Rep. Donald Lehe; Rep. Charlie Brown; Rep. Craig Fry; Rep. Scott Reske; Rep. Peggy Welch; Sen. Patricia Miller, Vice-Chairperson; Sen. Ryan Mishler; Sen. Vaneta Becker; Sen. Ed Charbonneau; Sen. Ron Grooms; Sen. Jean Leising; Sen. Jean Breaux; Sen. Earline Rogers.**

Members Absent: **Rep. David Frizzell; Rep. Eric Turner; Rep. John Day; Sen. Beverly Gard; Sen. Vi Simpson.**

The third meeting of the Health Finance Commission was called to order at 1:05 P.M. by Chairman Tim Brown. Chairman Brown recognized Rep. Dodge on his last meeting before retirement.

Youth First, Inc. Parri O. Black, President and CEO (See Exhibit 1 and Exhibit 2, slide presentation.)
Ms. Black played a video of a successful client of the program and discussed the mission and philosophy of the Youth First Program, which is to strengthen youth and families through

[1] These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at http://www.in.gov/legislative Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for hard copies.

programs that prevent substance abuse, promote healthy behaviors, and maximize student success. She mentioned the program currently serves less than 50% of the students in their four-county service area and wishes it to grow to serve more children and teens.

William Wooten, M.D., the founder of Youth First commented that the program has outcomes that are long term and low cost. He added that Youth First would like to partner with the state to refine and replicate the services elsewhere within the state.
Commission discussion followed regarding the role and cost of the specially trained social workers employed by Youth First and whether the program replaces social workers already in the schools. In response to the Chairman's question regarding funding during the recession, Ms. Black explained that federal grants allowed for increased placements of social workers; private local support has increased to help the program replace federal funding as it is discontinued.

SEA 224 Report from the EMS Commission (See Exhibit 3.)
Lee Turpin, Chairman, EMS Commission (See Exhibit 4, slide presentation.)
Mr. Turpin discussed the purpose and composition of the EMS Commission and then addressed the questions posed in SEA 224. Commission questions and discussion followed with regard to how the 11 counties that do not have advance life support (ALS) capabilities deal with the issue, what constitutes an appropriate facility for transport purposes, and the number and types of complaints made to the Commission.

Rick Archer, State EMS Director (See Exhibit 5, slide presentation.)
Mr. Archer discussed numbers and types of licensed and certified personnel, certified providers, service types, and coverage types in the 92 counties. He added clarifying remarks regarding counties that do not have ALS level of services. Commission discussion and questions followed with regard to ambulance transfers and the definition of intermediate ALS services.

Tony Murray, for the State Fire Marshal and the Indiana Fire Service
Mr. Murray discussed the role of fire services as the first responder to scenes before an ambulance arrives. Commission discussion and questions followed with regard to what could be done to upgrade services in those counties not having ALS and numbers and types of complaints. In response to questions about the cost of providing ALS services, Mr. Archer responded that the decision on the provision of services is made locally and would be dependent on the availability of the funding and the personnel necessary for the operation of the higher certification levels of service.

Gregory Larkin, M.D., State Health Commissioner (See Exhibit 6.)
The Commission had questions regarding the location of the eight hospitals that have indicated their intent to pursue trauma certification and whether trauma centers received state funding. Dr. Larkin explained that currently there is no state funding going to trauma centers; there is no mechanism in place to provide funds. He also indicated that several of the eight hospitals interested in getting a trauma-level certification were located in Northwest Indiana.

Feasibility of Establishing a Teaching Hospital and Trauma Center at IUNW
Rep. Charlie Brown described the concept of building a teaching hospital as a recruiting tool for physician manpower in NW Indiana, including a trauma center at the hospital to serve trauma patients within the state rather than exporting them to Illinois hospitals, and providing economic development opportunities in the Gary area. He mentioned a $3 M appropriation made for architectural and engineering studies in a previous budget period that was never released by the State Budget Agency and asked that the monies be released in order to fund preliminary and feasibility studies. Rep. C. Brown also requested that a letter from Prompt Ambulance Service be distributed to the Commission. (See Exhibit 7.)

Mayor Karen Freeman-Wilson discussed the city of Gary's historical prominence as an economic driver due to the location of the steel mills in the area and current transportation assets the city possesses. She discussed the associated problem of severe blunt force trauma due to automobile accidents and the fact that traffic congestion and distance put many trauma patients at risk since there is no trauma center in the immediate area. Mayor Freeman-Wilson discussed the city's activities with regard to the hospital project; demolition has been started in the University Park area to clear ground using federal funds. She added that she supports the release of the $3 M to provide funding for feasibility studies for a co-located teaching hospital and trauma center in Gary.

Patrick Bankston, Ph.D., Director, IU School of Medicine, NW, described the state as unique since the Indiana University School of Medicine is the only medical school instate and that it is the second largest medical school in the country. He discussed IU's decision to expand the medical class size to address the impending physician shortage as well. The expansion of the Regional Medical Education Centers from two-year programs to provide the full four-year medical education was a decision intended to encourage medical students to stay in the areas to practice after graduation. He supported the concept of conducting a feasibility study and commented that NW Indiana is a good site to train medical students and that there is a clear need for a trauma center.

Michael McGee, M.D., M.P.H, Chief of Emergency Medicine, Methodist Hospitals, commented on the lack of funding for the trauma care system in the state and explained that a trauma center is not a building; it is the guaranteed availability of qualified staff necessary to support critically injured patients within the golden hour. He suggested that the state should examine how other states are supporting their trauma networks, such as with motor vehicle fees. Dr. McGee addressed the lack of ICU pediatrics in NW Indiana and the dollars lost due to patient transfers to Illinois or Indianapolis. Commission discussion followed.

In the interest of maintaining a quorum for conducting official actions, the Chairman called for the consideration of preliminary drafts (PDs).

PD 3365 (Exhibit 8.)
Senator Grooms presented PD 3365 concerning certification of pain control centers. He announced that he would not ask for a Commission recommendation on the PD since the draft requires additional work. Commission discussion followed.

PD 3250 (Exhibit 9.)
Rep. T. Brown introduced PD 3250 concerning an income tax credit for specialty drugs. He explained that the issue is a problem for approximately 1% of the population and that a refundable tax credit of $600 per month might be a way to allow individuals requiring certain specialty drugs to maintain employment and private insurance. Commission discussion followed. A motion was made and seconded to approve PD 3250. The motion was adopted by a 14-0 roll call vote.

Final Report
A motion was made to support the concept of a feasibility study for a teaching hospital and trauma center in Gary and to recommend the State Budget Agency release $3 M appropriated in a previous budget or the amount necessary to perform the feasibility study. The motion was seconded and adopted by a 14-0 roll call vote.

A motion was made to adopt the Final Report with the inclusion of the October 23, 2012, meeting testimony and the Commission's actions taken on preliminary drafts and other motions. The motion was approved by a 14-0 roll call vote.

Report on the Trauma Commission Rule
Lee Turpin, Chairman, EMS Commission, had no report but was available for questions from the Commission, as was Art Logsdon, J.D., Director of the Trauma and Injury Prevention Division, Indiana State Department of Health (ISDH). Commission questions and discussion followed regarding the definition in the rule of "appropriate place" for transport of trauma patients, where paramedics transport cases when trauma centers are located in another state, and what happens when an ambulance is out of the service area on a trauma run for 2 to 3 hours.

Paramedic Licensing
Rick Archer, State EMS Director, reported that as directed by HEA 1186, paramedics are now licensed. Tony Murray reported that the transition from certifications to licensure went smoothly.

EBT Card Update
Adrienne Shields, Deputy Director, Division of Family Resources, FSSA, reported on the use of Hoosier Works cards in restricted locations, restrictions for vendors and recipients, incidence of actual transactions occurring in restricted locations, and education activities for TANF recipients regarding use of the cards in restricted locations. (See Exhibit 10, slide presentation.) Commission discussion followed.

Update on Pain Management Task Force
Derek Spence, Dan Christensen, Shara Haq, and Matt Datillo of the Franklin Commons Neighborhood Assn., described the Clark County Wellness Center that opened in their neighborhood within days of the effective date of a Kentucky law changing the regulation of pain management clinics. They described a cash-based business with armed guards and attack dogs patrolling the facility and people from Eastern Kentucky and from as far away as Florida parking and wandering the neighborhood for hours awaiting their appointments. The neighbors want to see this business shut down, and they also want to see that no other town in Indiana is afflicted with one of these clinics.

Jeffersonville Council members Mike Smith, Dennis Julius, and Nathan Samuel echoed the testimony of the members of the neighborhood association and warned that towns in Indiana should enact moratoriums and try to force the clinics to locate within industrial areas.

Natalie Robinson, Education Program Director, Office of the Attorney General, distributed a list of the members of the Attorney General's Prescription Drug Abuse Task Force. (See Exhibit 11.) Ms. Robinson described the impact of prescription drug abuse on communities and individuals and discussed the organization of the task force into five working committees. She stated that Indiana is one of only two states without any regulations, laws, or medical board rules on the prescribing of opioids. She added that the Attorney General's Office is sponsoring the third annual Prescription Drug Abuse Symposium December 19, 2012, after which the findings and recommendations will be compiled into a report that will be provided to the members of the General Assembly. Commission discussion followed.

Traumatic Brain Injury Study Report (SEA 15-2012)
Brian Carnes, Director, Trauma and Injury Prevention, ISDH, reported that ISDH is working closely with FSSA on the rule promulgation process to ensure that a licensed traumatic brain injury (TBI) facility would qualify for Medicaid funding. In response to Commission questions regarding why TBI patients are being sent to other states for treatment, he referred to the Generations Project work on TBI and Assistant Commissioner Terry Whitson, who was unable to attend the meeting.

June Holt, Assistant Director of the Generations Project, commented that SEA 15 required the Governor to appoint an advisory committee to help address specific questions which were

required to be addressed by the bill. The committee was never appointed. She pointed out that the bill required an array of services to be investigated and that this did not happen - FSSA and ISDH were required to report specific information which has not happened. Commission members requested the Generation's Project report on the Brain Injury Listening Tour in Indiana be distributed. (Exhibit 13)

Kristin LaEace, Indiana Association of Area Agencies on Aging, pointed out that SEA 15 dealt with more than facility issues and asked if the required study was ever going to be done.

Senator Becker commented that the Commission needed to make a point that this study was not performed as required and the Governor never appointed the advisory committee members.

Managed Care for Aged, Blind, and Disabled Pilot Update
Pat Casanova, Director, Office of Medicaid Policy and Planning (OMPP), reported on activities the OMPP has taken to improve care outcomes at lower cost for the Medicare/Medicaid dually eligible population. (Exhibit 14, slide presentation.) Commission questions followed regarding the possibility of web-based and electronic monitoring and patient encounters.

The meeting was adjourned by acting Chairman Dick Dodge at 5:00 P.M.

The Problem

Substance abuse is more common among southwestern Indiana teens than their peers nationwide, according to Youth First's latest survey of over 6,000 local 8th, 10th and 12th graders.

Take the Quiz

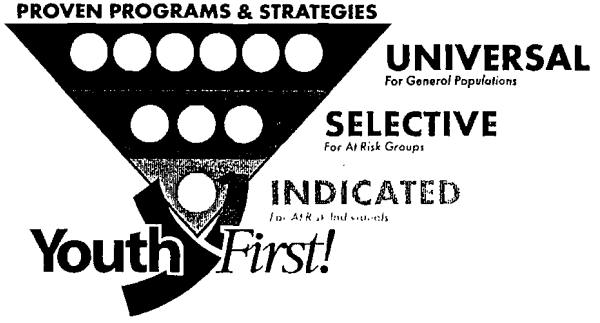
Test your awareness of the problem by taking this True or False quiz:

1. Over 30% of our region's high school seniors were drunk at least once in the last two weeks. T F
2. The rate of daily marijuana use among area 8th graders is twice the national average. T F
3. Though cigarette smoking continues to decline, one in every ten local 10th graders still smokes every day. T F
4. Compared to their counterparts nationwide, our high school sophomores are more than twice as likely to drink alcohol daily. T F
5. Nearly 20% of local college students report they drove drunk at least once in the last year. T F

According to anonymous scientific surveys of area youth, all of these statements are TRUE! That's why Youth First is working so hard to provide proven solutions to this serious problem.

The Solution

Youth First uses comprehensive, collaborative, regional, evidence-based, and sustained strategies to reduce substance abuse.



They include universal programs for broad or general audiences, selective programs for at-risk groups, and indicated programs for individuals with specific needs.

Youth First carefully selects and implements strategies that are designed by experts in the field of prevention and demonstrate positive outcomes through solid research.

A commitment to strong collaborative relationships with schools, churches and other organizations helps Youth First maximize resources and reach as many youth and families as possible.

Learn more about the problem and the solutions at www.youthfirstinc.org.

Youth First!™
The Results Last.
www.youthfirstinc.org

Exhibit 1
Health Finance Commission
Meeting #3, October 23, 2012

812.421.8336
www.youthfirstinc.org

Why put

Youth First!

HE RESULTS LAST.
uilding life-changing foundations
r our children.

outh First's Mission
strengthen youth and families
rough evidence-based programs
at prevent substance abuse,
romote healthy behaviors and
aximize student success.

Why should You Care?

ubstance abuse not only ruins
ves but creates consequences for
e entire community, including
reater health care costs,
dditional accidents, higher crime
tes, crowded jails, more
ropouts, a weaker workforce,
nd increased taxes.

THE RESULTS LAST

Proven Programs to Prevent Substance Abuse

Proven Programs

Youth First works closely with schools, churches, businesses, colleges, communities, and other agencies to provide a menu of proven programs and strategies.

FOR SCHOOLS AND STUDENTS

Youth First School Social Workers

In partnership with schools, Youth First provides specially trained and closely supervised social workers to assess and address student, family, and school needs. They provide prevention and early intervention programs and services for individuals and groups. They also make referrals to community providers for additional services.

Reconnecting Youth

This school-based, semester-long program led by social workers helps youth who are at-risk for dropping out of high school for a variety of reasons.

WhyTry

Social workers use this program to boost the motivation and coping skills of at-risk youth.

Skills for Life

Youth First trains high school students to facilitate the LifeSkills Training program for 4th graders. This provides a double dose of prevention for both the teens and the students they mentor.

FOR YOUTH AND PARENTS

Strengthening Families

These programs help make good families even better families by boosting parenting skills, youth social skills, and family communication skills. Programs are offered for youth ages 3-5, 6-9, or 10-14 and their parents or caregivers. They include fun activities, free meals and door prizes.

Family Connections™

This program assists families with teens, ages 15-18, who are struggling. Parents and youth learn new skills to reduce problem behaviors.

FOR AFTER SCHOOL

In It to Win It - The 7 Habits Way

Based on Sean Covey's book The 7 Habits of Highly Effective Teens, this collaboration with the YMCA helps teens succeed in life by following healthy habits that balance family, friends and school.

Youth Volunteer Group

High school students join together to promote the positive choices that they and most of their peers make and to represent Youth First in the community.

FOR COMMUNITIES

Communities that Care

The CTC initiative brings community members together to promote positive youth development, prevent problem behaviors and encourage healthy decisions.

Most of Us®

Youth First uses this research-proven approach to reduce teen alcohol abuse by correcting misperceptions and promoting positive social norms. For example, most teens think it's common for their peers to use alcohol, but surveys show most youth never or rarely drink. Through this campaign, the positive choices teens make become a positive influence on others.

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The Feedback

THOSE WE SERVE SAY IT BEST:

"For the first time in a long time, I believe that my son actually feels like he can make a positive change in his life."
- *Parent of Program Participant*

"You make my heart feel good."
- *3rd Grader speaking to her Youth First Social Worker*

"I am so glad suicide is not a part of my life anymore, because now I realize that no matter how bad things may get, there are people out there that can help me and that I am not alone."
- *High School Student helped by Youth First Social Worker*

"I sing the praises of Youth First to anyone and everyone who will listen. My experience with Youth First has been nothing short of fabulous."
- *School Principal*

"This program has helped our family enormously, thank you."
- *Strengthening Families Participant*

Youth First!™
The Results Last.
www.youthfirstinc.org

3420 E. Morgan Avenue
Evansville, Indiana 47715

812.421.8336

Why put Youth First!

THE RESULTS LAST.
Building life-changing foundations for our children.

Youth First's Mission
To strengthen youth and families through evidence-based programs that prevent substance abuse, promote healthy behaviors and maximize student success.

Why should You Care?

Substance abuse not only ruins lives but creates consequences for the entire community, including greater health care costs, additional accidents, higher crime rates, crowded jails, more dropouts, a weaker workforce, and increased taxes.

THE RESULTS LAST

Proven Programs to Pr

Proven Prog

Youth First works closely w
businesses, colleges, comm
to provide a menu of prov

FOR SCHOOLS /

Youth First School Soc
In partnership with schools
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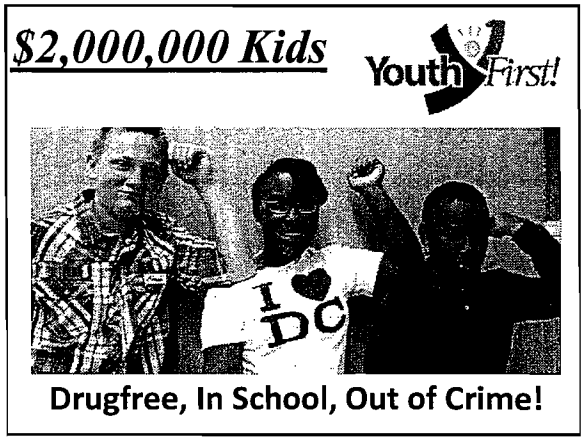


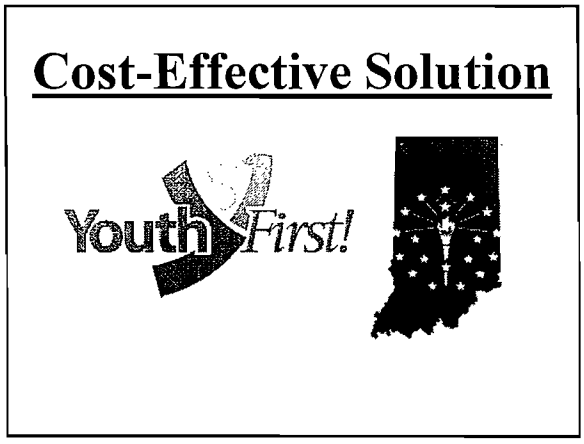
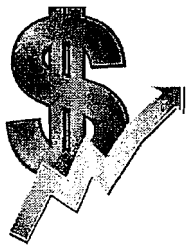


Exhibit 2
Health Finance Commission
Meeting #3, October 23, 2012

Dollars & Sense?

Youth First!



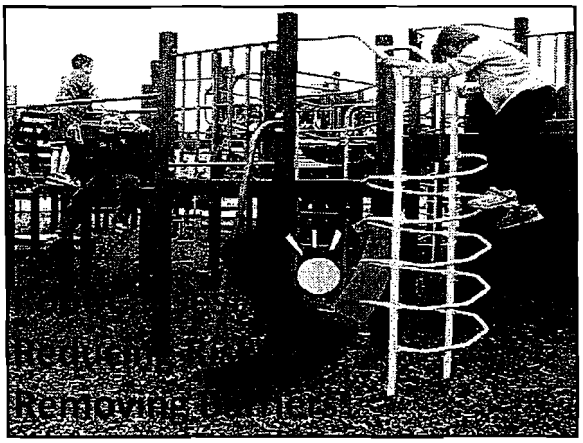
Substance Abuse Consequences = $7.3 Billion

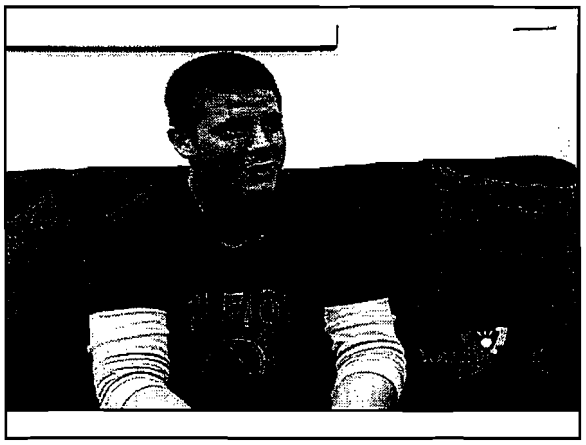
Prevention = $70 Million

Dollars & Sense!

Youth First!

$1 of Effective Prevention Saves $18 in Consequences





Youth First's Prevention Team

Social Work

Youth First!

2011-2012

- 31 MSW/LCSW's in 46 Schools & 11 Systems
- 13,364 Students Served
- 3,423 Parents Served
- 10,204 Faculty/Staff Consultations
- 3,487 Referrals to Other Agencies
- 12 Life-saving Interventions a Week

Top Concerns

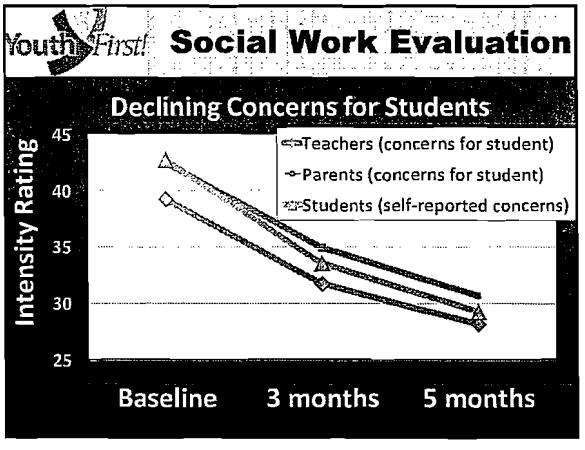
2011-2012

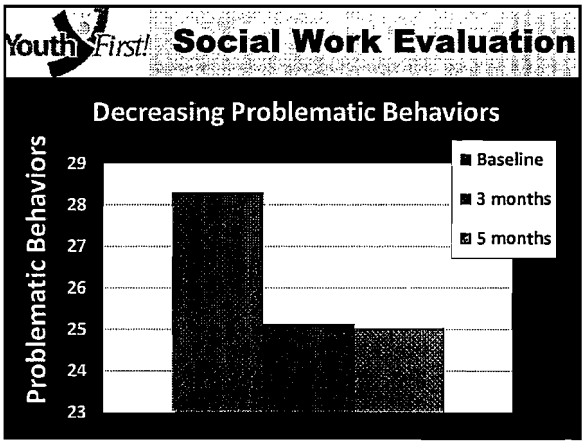
- Depression, Anxiety, Anger Issues
- School Behaviors
- Parent/Child or Home Life Concerns
- Peer Relationships
- Grief or Divorce Adjustment
- Substance Abuse

Top Referrals

2011-2012

- Basic Needs
- Mental Health Care Providers
- Prevention Programs
- Department of Child Services



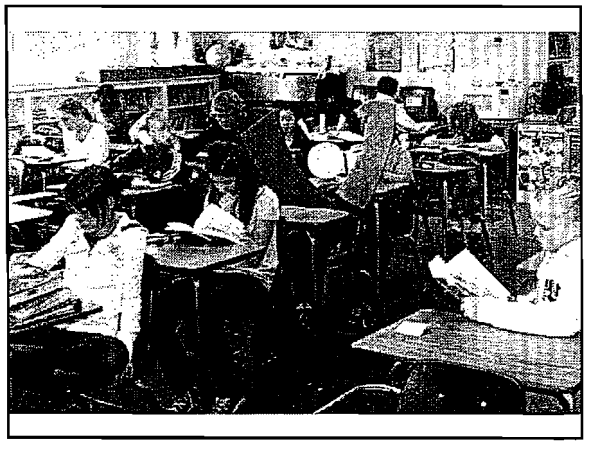


Other Outcomes

Youth First!

Significant Improvements in Risk and Protective Factors

- *Family Conflict*
- *Mood Management*
- *Communication*
- *Resiliency/Coping Skills*
- *Peer Resistance/Assertiveness*
- *Parent/Child Bonding*
- *Children's Hope*
- *Decision-Making*
- *Adult Bonding*



Academic Impact

2011-2012

- 82% of the caseload advanced to the next grade level or graduated.
- 75% of the 103 high school graduates on the caseload had college or career plans.

Annual Cost

$52,000 per Social Worker
or
$123 per individual served

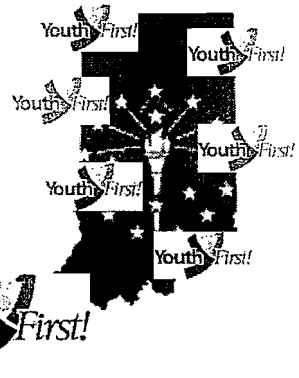
Annual Funding

$2,400,000 Budget

50% Public & 50% Private

Sustainability

- Public-Private Partnerships
- Cost-Sharing with Schools
- Multiple Funding Streams



"You make my heart feel good."

- *3rd Grader speaking to her Youth First Social Worker*

Our Messages to the Future

Youth First! The Results Last.

www.youthfirstinc.org

REPORT TO THE HEALTH FINANCE COMMISSION PURSUANT TO SEA 224

SUBMITTED BY THE DIVISION OF FIRE AND BUILDING SAFTY AND THE EMERGENCY MEDICAL SERVICES COMMISSION

Exhibit 3
Health Finance Commission
Meeting #3, October 23, 2012

THE DIVISION OF FIRE AND BUILDING SAFETY AND THE EMERGENCY MEDICAL SERVICES COMMISSION GRATEFULY ACKNOWLEDGE THE CONTRIBUTIONS OF THE FOLLOWING IN THE PREPARATION OF THIS REPORT:

Archer, Rick	IDHS EMS Certifications and Training Branch Chief
Buckman, John	IDHS Fire Training Branch Chief
Fiato, Elizabeth	IDHS EMS Training Section Chief
Garvey, Michael	IDHS Chief of Staff
Greeson, James	State Fire Marshal, IDHS Fire and Building Safety Division
Lockard, Michael	Indiana Emergency Medical Services Commissioner
Murray, Tony	Indiana Fire Alliance
Peachey, Tony	Indiana Fire Alliance
Robison, Gary	IDHS Fire and Building Safety Division
Seals, Randy	Indiana Emergency Medical Services Association
Sink, Dan	Indiana Fire Alliance
Turpen, Lee	Indiana Emergency Medical Services Commissioner
Ward, Faril	Indiana Emergency Medical Services Association
Woodall, Kenneth	Assistant Director, IDHS Preparedness and Training Division

Introduction

In the 2012 legislative session, Senate Bill 224 required the Indiana Emergency Medical Services Commission (EMS Commission), Division of Fire and Building Safety (Division), and Indiana State Department of Health to report on several facets of Emergency Services including:

1. Policies and procedures for calling and responding to 911 calls for emergency medical services, including the determination of what type of health care emergency service provider should respond to the call
2. Any requirements or guidelines for equipment that should be on an ambulance or other emergency services vehicle that is necessary to respond to the emergency medical needs of an individual.
3. Ambulance response time for emergency calls.
4. Ambulance transportation procedures.
5. Procedures or policies for health facilities to obtain emergency and non emergency medical transportation for health facility residents.
6. How ambulance coverage is affected by ambulances that are subject to geographic or jurisdictional limits within a county, city, town, or township.
7. Procedures or a policy for determining to which hospital a patient is transported.
8. A review of the state trauma care system.

The law required the agencies involved to consult with entities that may be affected by the proposals being considered for the report.

This report is the EMS Commission's and Division's response to the Health Finance Committee as required by SB224 and provides responses to the questions over which the EMS Commission and the Fire Marshal's office have jurisdiction, i.e. questions 1, 2, 3, 4, 6, and 7. The EMS Commission and Fire Marshal's Office find that questions 5 and 8 are best answered by the Indiana State Department of Health as the regulating agency for extended care facilities and the Indiana trauma care system.

Methodology

The Indiana Department of Homeland Security, on behalf of the EMS Commission and the Division convened a committee consisting of members of the EMS Commission, Indiana Fire Alliance, and the Indiana Emergency Medical Services Association to review the requirements of SB224, actively participate in the creation of this report and approve its content. The assistance and contributions of the Indiana Fire Alliance, and Indiana EMS Association is hereby gratefully acknowledged.

Response to SB 224 Questions

Question 1: Policies and procedures for calling and responding to 911 calls for emergency medical services, including the determination of what type of health care emergency service provider should respond to the call.

Response: The EMS Commission does not regulate policies and procedures for calling and responding to requests for an ambulance whether they are deemed emergency calls or non-emergency requests for medical transportation services. There are many factors that must be taken into account before a determination can be made that a certain set of circumstances constitutes an emergency. Some situations may be considered an emergency in one setting and not in another. Therefore, the EMS Commission leaves establishing policies and procedures for determining what medical conditions and circumstances requires an emergency response to local providers, their medical directors and the community to determine.

In order to assist providers in establishing policies to determine what are the appropriate resources and response modes for any particular call, IC 16-31-3.5 requires all entities that dispatch emergency medical services to provide training to EMS dispatchers. Not every call to an ambulance service, whether it is part of a governmental "911" agency or a private provider, requires a "light and siren" response. Many studies have shown that the vast majority of EMS responses, in fact, do not require such a response. Responding with lights and siren to an EMS call where the medical condition of the patient does not warrant such a response places the EMS responders and the motoring public needlessly at increased risk of accidents. However, most of the programs that providers may select to use to train their dispatchers assume the caller is a lay person with no medical training. When calls originate from health care facilities on behalf of a person under their direct care, basic call interrogation techniques that would be used for the general public may not be appropriate. Such medically trained individuals are likely in a good position to accurately provide the medical condition of the patient which leads to a better determination of the response and transportation needs of the patient."

Although regulating how and when the emergency response system shall be used is one way to approach this issue, public education, better training of healthcare workers on the EMS system and implementing best practices, may be equally or more effective.

Question 2: Any requirements or guidelines for equipment that should be on an ambulance or other emergency services vehicles that is necessary to respond to the emergency medical needs of an individual.

Response: The EMS Commission mandates equipment for EMS response vehicles that are appropriate to the certification level of the emergency medical services response vehicle. 836 IAC 1-3-1 establishes ambulance vehicle standards. 836 IAC 1-3-4 provides for rescue equipment to be carried on every certified EMS vehicle, and 836 IAC 1-3-5 establishes minimum emergency care equipment that must be carried on all ambulances. 836 IAC 1-4-2 establishes required communications equipment. Advanced Life Support ambulances are

required to carry additional equipment and supplies needed to provide care according to the organization's medical director's oversight under 836 IAC 2-2-1. The equipment required on all ambulances meet or exceeds national recommendations and Indiana's paramedics carry the emergency care equipment to manage any medical emergency in the same manner as a hospital emergency department would in the first few minutes of the emergency situation. EMS provider organizations are required to maintain daily check sheets that attest that the required equipment is on board the vehicle and is in working order.

The Indiana Department of Homeland Security enforces compliance with these rules through their Preparedness and Training Division, Emergency Medical Services Branch and Field Services Division. Each new provider is inspected and a pre-determined number of providers are randomly selected for audits quarterly. In addition, audits are performed anytime there is a concern that a provider is not in compliance with the EMS Commission's rules. Appendices I, II, III and IV list the equipment and supplies carried on EMS certified vehicles.

Question 3: Ambulance response time for emergency calls.

Response: Ambulance response time traditionally is the most common performance criterion used to evaluate ambulance provider efficacy. Response time is not an effective criterion because it has not been data supported and therefore the EMS Commission does not regulate ambulance response times. With Indiana's diversity of population and geography, with many areas served by volunteer organizations with limited financial and personnel resources, mandating ambulance response times would be impossible without significant financial investment to increase the resources available to respond to ambulance calls and establishing jurisdictional responsibility to do so.

As early as 1979 (Eisenberg), there were recommendations that emergency ambulance response times of around eight minutes were the maximum acceptable response time for producing acceptable patient outcomes, and that reducing response times would have direct correlation to improved outcomes. In 1990, the American Heart Association (AHA) developed the "Chain of Survival" for cardiac arrest victims. The AHA studies indicated that victims of sudden cardiac arrest (SCA) that survive have an excellent prognosis: 83% survive for at least one year and 57% survive five years or longer. The AHA studies indicate victims of sudden cardiac arrest have the best chance for survival if defibrillated within four (4) minutes and advanced life support care is provided within eight (8) minutes.

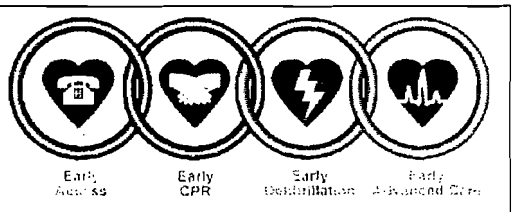


Figure 1-AHA Chain for Survival

The National Fire Protection Association has also suggested that 8 minutes be the standard for ambulance response times.

Type of Care for SCA Victims after Collapse	Chance of Survival
No care after collapse	0%
No CPR and delayed defibrillation (after 10 minutes)	0-2%
CPR from a non-medical person (such as a bystander or family member) begun within 2 minutes, but delayed defibrillation.	2-8%
CPR and defibrillation within 8 minutes.	20%
CPR and defibrillation within 4 minutes; paramedic help within 8 minutes.	43%

Table 1 - Reproduced from the American Heart Association

Although there are some medical events that require immediate intervention, recent studies indicate it is not a fast response of the ambulance to the patient that determines the patient's outcome. Even in the best of EMS systems, by the time a person initiates a call for help, the run is processed in a dispatch center, responders get to their vehicles, drive to the scene, and get to the side of the patient, the time needed for initiating interventions that will determine the outcome of the patient is passed. An integrated EMS system that includes public education, proliferation of CPR and AED training to non-traditional EMS providers and the public, and a well established "first response" capability" working in concert with ambulance transportation systems utilizing all the local resources available in those "time-sensitive" medical emergencies would be beneficial to those individuals suffering from life-threatening emergencies and would be less costly than developing an ambulance response system to ensure ambulances arrive within a mandated time frame. For more information on ambulance response time studies, please see Appendix V.

To reduce ambulance response times requires an increase in the number of ambulances and certified/licensed personnel in a jurisdiction which is very resource intensive and costly.

NOTE: Ambulance response time does not include patient care provided by first responders and care provided by other persons prior to the arrival of the ambulance, which patient care is a critical component of the EMS system.

Question 4: Ambulance transportation procedures.

Response: The committee respectfully requests clarification of this question. Ambulance transportation procedures are very specific to each provider. Transportation procedures are determined in cooperation with the medical director for each provider and related protocols. Question 7 below addresses the processes EMS crews use to determine where to take patients in medical emergencies.

Question 5: How ambulance coverage is affected by ambulances that are subject to geographic or jurisdictional limits within a county, city, town, or township.

Response: IC 16-31-5 states that the governing body of a city, town, township, or county by the governing body can establish emergency medical services. This law also states, "a

county may not provide, authorize, or contract for emergency medical services within the limits of any city without the consent of the city; and a city or town may not provide, authorize, franchise, or contract for emergency medical services outside the limits of the city or town without the approval of the governing body of the area to be served. In addition, section 2 of this statute states, "A city, town, or county may not adopt an ordinance that restricts a person from providing emergency ambulance services in the city, town, township, or county if:

(1) the person is authorized to provide emergency ambulance services in any part of another county; and

(2) the person has been requested to provide emergency ambulance services:

(A) to the county in which the person is authorized to provide emergency ambulance services, and those services will originate in another county; or

(B) from the county in which the person is authorized to provide emergency ambulance services, and those services will terminate in another county."

Governmental units, private, and volunteer EMS providers commonly have mutual aid service agreements in place that are in the form of policy, formal resolutions or ordinances. These "mutual-aid" agreements address responses by EMS providers outside the normal service jurisdiction in the event that that jurisdiction does not have an available ambulance to respond to a call for EMS. These "plans" are typically predetermined and scripted so when the need arises the authority in charge of dispatching ambulances reverts to that plan or process already agreed upon by decision makers. See also IC 16-31-5.

In addition, Indiana's District Response Task Force system has helped break down jurisdictional issues. There is more coordination and collaboration amongst EMS providers in the Homeland Security Districts than ever before and continues to improve.

Question 7: Procedures or a policy for determining to which hospital a patient is transported.

Response: The Indiana EMS Commission historically has not regulated "transport" procedures leaving these policies up to local jurisdictions, provider organizations and medical directors to make those determinations based on local needs and legal authority. This approach has served Indiana well over the years as local jurisdictions know and understand their healthcare capabilities and can make decisions that are best for their patients. There are, however, some limiting factors to EMS personnel making decisions on transportation on behalf of a patient. The first criterion is that if a patient or guardian is awake, alert, and able to make "informed" decisions regarding their healthcare, including to which hospital they are transported to, EMS crews must either take the patient to their desired destination, or make arrangements to provide for that request. If a patient or guardian is not able to make an "informed" decision regarding his care, then the EMS crew

can use a legal concept known as "implied consent". This concept makes the assumption that a reasonable, prudent person would consent to treatment and transport as needed to stabilize the medical condition. However, once the patient is stable and able to consent to treatment, the patient's directives override all other policies or procedures. In cases where the patient's ability to make informed decisions is impaired, EMS crews generally take the patients to the "closest appropriate facility" based on the patient's condition under protocols established by their medical director.

Conclusion

Emergency Medical Service providers are a passionate, dedicated group of people who work tirelessly for long hours and at personal hardship to be there for their friends, family and fellow Hoosiers in their time of need. Hoosiers want and expect a timely, professional emergency medical response to arrive when they perceive a medical emergency is occurring. Public perception of "timely" response vs. what is really needed is a difficult dichotomy to address. Because of unmeasured and uncontrollable factors, a fast "response time", despite public perception, can be irrelevant to the outcome of seriously ill or injured patients. What occurs before arrival of an ambulance is more predictive of successful patient outcomes. Better public education on signs and symptoms of true medical emergencies and when to call EMS is needed. Better utilization of the many resources in the community to collaborate with ambulance services to create a true "systems approach" to EMS is needed including better collaboration with law enforcement, public health, schools, business and industry, and neighborhood and civic organizations. AED availability in businesses, industrial complexes, schools, and other venues where large crowds gather should be an integral part of the EMS system. A dynamic "first response" capability, using the closest public safety unit, be it fire, law enforcement or EMS provider, to respond in those cases where quick intervention with a simple medical procedure could mean the difference in a positive patient outcome. Such an approach is more cost-effective and reduces the need to have expensive ambulances racing from long distances while nothing is being done to assist the patient.

Respectfully Submitted:

James Greeson, Indiana State Fire Marshal — Date: Sept. 20, 2012

Lee Turpen, Indiana Emergency Medical Services Commission — Date: Sept. 21, 2012

Appendix I – BLS Ambulance Equipment Requirements

Land Ambulance Rescue Equipment

1. One (1) hammer, four (4) pound minimum
2. One (1) wrecking bar, twenty-four (24) inch combination tool minimum.
3. One (1) self-contained portable light source.

Emergency Care Equipment

Each and every land ambulance will have the following minimum emergency care equipment, and this equipment shall be assembled and readily accessible:

1. Respiratory and resuscitation equipment as follows:
    a. Portable suction apparatus, capable of a minimum vacuum of three hundred (300) millimeters mercury, equipped with two (2) each of the following:
        i. wide-bore tubings;
        ii. rigid catheters;
        iii. soft pharyngeal suction tips in child size; and
        iv. soft pharyngeal suction tips in adult size.
    b. Onboard suction, capable of a minimum vacuum of three hundred (300) millimeters mercury, equipped with wide bore tubing and both rigid and soft pharyngeal suction tips.
    c. Bag-mask ventilation units, hand operated, one (1) unit in each of the following sizes, each equipped with clear face masks and oxygen reservoirs with oxygen tubing
        i. Adult
        ii. Child
        iii. Infant
        iv. Neonatal (mask only).
    d. Oropharyngeal airways, two (2) each of adult, child, and infant.
    e. One (1) pocket mask with one-way valve
    f. Portable oxygen equipment of at least three hundred (300) liters capacity (D size cylinder) with:
        i. Yoke
        ii. medical regulator;
        iii. pressure gauge; and
        iv. nondependent flowmeter.
    g. Onboard oxygen equipment of at least three thousand (3,000) liters capacity (M size cylinder) with:
        i. yoke;
        ii. medical regulator;
        iii. pressure gauge; and
        iv. nondependent flowmeter.
    h. Oxygen delivery devices shall include the following:
        i. High concentration devices, two (2) each, adult, child, and infant.

ii. Low concentration devices, two (2) each, adult.
iii. Nasopharyngeal airways, two (2) each of the following with water soluble lubricant:
    1. Small (20-24 french).
    2. Medium (26-30 french).
    3. Large (31 french or greater).
    4. Bulb syringe individually packaged in addition to obstetrics kit.
iv. Nonvisualized airway minimum of two (2) with water soluble lubricant.

i. Semiautomatic or automated external defibrillator and a minimum of two (2) sets of pads.

j. Wound care supplies as follows:
    i. Multiple trauma dressings, two (2) approximately ten (10) inches by thirty-six (36) inches.
    ii. Fifty (50) sterile gauze pads, three (3) inches by three (3) inches or larger.
    iii. Bandages, four (4) soft roller self-adhering type, two (2) inches by four (4) yards minimum.
    iv. Airtight dressings, four (4), for open chest wounds.
    v. Adhesive tape, two (2) rolls.
    vi. Burn sheets, two (2), sterile.
    vii. Triangular bandages, four (4).
    viii. Bandage shears, one (1) pair.

k. Patient stabilization equipment as follows:
    i. Traction splint, lower extremity, limb-supports, padded ankle hitch, and traction strap, or equivalent, one (1) assembly in adult size.
    ii. Upper and lower extremity splinting devices, two (2) each.
    iii. One (1) splint device intended for the unit-immobilization of head-neck and torso. These items shall include the splint itself and all required accessories to provide secure immobilization.
    iv. One (1) long backboard with accessories to provide secure spinal immobilization.
    v. Rigid extrication collar, two (2) each capable of the following sizes:
        1. Pediatric.
        2. Small.
        3. Medium.
        4. Large.
    vi. One (1) ambulance litter with side rails, head-end elevating capacity, mattress pad, and a minimum of three (3) adjustable restraints to secure the chest, hip, and knee areas.

l. Medications if approved by medical director, and solely for use by individuals with a certification as an emergency medical technician or higher, are as follows:
    i. Baby aspirin, eighty-one (81) milligrams each.
    ii. Activated charcoal.
    iii. Instant glucose.

iv. Epinephrine auto-injector or auto-injectors.

m. Personal protection/universal precautions equipment, minimum of two (2) each, including the following:
   i. Gowns.
   ii. Face masks and shields.
   iii. Gloves.
   iv. Biohazard bags.
   v. Antimicrobial hand cleaner.

n. Miscellaneous items as follows:

o. Obstetrical kit, sterile, one (1).

p. Clean linens consisting of the following:
   i. Pillow.
   ii. Pillow case.

q. Sheets and blankets.

r. Blood pressure manometer, one (1) each in the following cuff sizes:
   i. Large adult.
   ii. Adult.
   iii. Pediatric.

s. Stethoscopes, one (1) each in the following sizes:
   i. Adult.
   ii. Pediatric.

t. Sharps collector, one (1) being a minimum of seven (7) inches in height.

u. A current copy of the basic life support protocols.

Appendix II - Communications Equipment

All communication used in emergency medical service vehicles for the purpose of dispatch or tactical communications shall demonstrate and maintain the ability to provide a voice communications linkage with the emergency medical service provider organization's dispatch center within the area that the emergency medical service provider organization normally serves or proposes to serve.
(b) Communication equipment used in emergency medical services vehicles shall be appropriately licensed through
The Federal Communications Commission, when applicable. The maximum power of the transmitter shall be not more than the minimum required for technical operation, commensurate with the:

(1) size of the area to be served; and
(2) local conditions that affect radio transmission and reception.

(c) All emergency medical services vehicles shall be equipped with two (2) channels or talk-groups as follows:

1. One (1) channel or talk-group shall be used primarily for dispatch and tactical communications.
2. One (1) channel or talk-group shall be 155.340 MHz and have the proper tone equipment to operate on the Indiana Hospital Emergency Radio Network (IHERN) unless the provider organization vehicles and all the destination hospitals within the operational area of the provider organization have a system that is interoperable with the Indiana statewide wireless public safety voice and data communications system.

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Appendix III – Emergency Medical Services Nontransport Providers

Every basic life support nontransport provider organization shall have one (1) set of the following assembled and readily accessible emergency care equipment for every vehicle utilized as an emergency medical service nontransport vehicle:

(1) Respiratory and resuscitation equipment as follows:
   i. Portable suction apparatus, capable of a minimum vacuum of three hundred (300) millimeters mercury, equipped with wide-bore tubing and both rigid and soft pharyngeal suction tips.
   ii. Bag-mask ventilation units, hand operated, one (1) unit in each of the following sizes, each equipped with clear face masks and oxygen reservoirs with oxygen tubing:
   iii. Adult.
   iv. Child.
   v. Infant.
   vi. Neonatal (mask only).

(2) Portable oxygen equipment of at least three hundred (300) liters capacity (D size cylinder) with yoke, medical regulator, pressure gauge, and nondependent flowmeter. Oxygen delivery devices shall include high concentration devices, one (1) each of the following:
   i. Adult.
   ii. Child.
   iii. Infant.
   iv. Oropharyngeal airways, two (2) each of adult, child, and infant.

(3) One (1) pocket mask with one-way valve.

(4) Nasopharyngeal airways, two (2) each of the following:
   i. Small (20-24 french).
   ii. Medium (26-30 french).
   iii. Large (31 french or greater).

(5) Semiautomatic or automated external defibrillator and a minimum of two (2) sets of pads.

(6) Wound care supplies as follows:
   i. Ten (10) sterile gauze pads, three (3) inches by three (3) inches or larger.
   ii. Bandages, two (2) soft roller self-adhering type, two (2) inches by four (4) yards minimum.
   iii. Adhesive tape, two (2) rolls.
   iv. Bandage shears, one (1) pair.
   v. Miscellaneous items as follows:
      1. Water soluble lubricant for airway insertion.
      2. Stethoscope, one (1).
      3. Blood pressure manometer, one (1) adult size.
      4. Diagnostic penlight or portable flashlight, one (1).
      5. Disposable gloves, two (2) pairs.

(7) A current copy of the basic life support protocols.
(8) Medications, if approved by medical director, and solely for use by individuals with a certification as an emergency medical technician or higher, are as follows:
    i. Baby aspirin, eighty-one (81) milligrams each.
    ii. Activated charcoal.
    iii. Instant glucose.
    iv. Epinephrine auto-injector or auto-injectors.

Appendix IV – Advanced Life Support Ambulance Equipment

The paramedic provider organization shall ensure that all ambulances used for the provision of advanced life support contain the emergency care equipment required in 836 IAC 1-3-5, the rescue equipment required in 836 IAC 1-3-4, and communication equipment required in 836 IAC 1-4-2. The advanced life support emergency medical services vehicles shall also carry the following equipment:

1. Portable defibrillator with self-contained cardiac monitor and ECG strip writer and equipped with defibrillation pads or paddles appropriate for both adult and pediatric defibrillation. This may be the defibrillator listed in 836 IAC 1-3-5(1)(L).
2. Endotracheal intubation devices, including the following:
    a. Laryngoscope with extra batteries and bulbs.
    b. Laryngoscope blades (adult and pediatric, curved and straight).
3. Disposable endotracheal tubes, a minimum of two (2) each, sterile packaged, in sizes 3, 4, 5, 6, 7, 8, and 9 millimeters inside diameter.
4. Intravenous fluids, medication, and administration supplies approved by the medical director.
5. A current copy of advanced life support protocols shall be maintained on board the emergency medical services vehicle at all times.
6. A copy of the medication list, including quantities and concentrations approved by the medical director.

Appendix V

Interesting facts regarding response times:

- The committee knows of no scientific study that has ever presented a model which can be reproduced using scientific process that lower ambulance response times actually equate to better patient outcomes. In recent years, the applicability of response time correlation to patient outcome has been called into question by the National Association of EMS Physicians and the United States Metropolitan Medical Director's Consortium. Both stated there is a lack of scientific evidence to support fast response times while several studies clearly show no impact.
    - Two such studies are noted below:
        - The District of Columbia Fire and Emergency Medical Services Department conducted a study of the effects of an 8-minute response time in 2004 which essentially showed no impact of ambulance response times in relation to patient outcomes.
        - A study by Peter T. Pons, MD (FACEP) and Vincent J. Markovchick, MD (FACP) in 2001 evaluated the effects of an 8-minute response time standard in response to trauma patients and stated, "Exceeding the ambulance industry response time criterion of 8 min does not affect patient survival after traumatic injury."
- It is generally accepted that reductions to average response times of 60 seconds in a single community can:
    - Cost "millions per minute" of reduction as more static, non-consistently utilized resources (vehicles, equipment and trained people) must be deployed to affect the overall average.
    - Faster response times produce less skill utilization per caregiver as fewer patients are seen by each EMS responder. As individual patient contacts decrease, skills performance degrades.
- Response time measurement varies widely. Some systems may measure from 911 call initiation to arrival on scene, while others measure from the dispatch of the ambulance to arrival on scene. In fact, there are several phases of an emergency response that are generally not measured in response time calculations. Common elements that determine response time are:
    - The time when a medical emergency is identified by a lay person to the time a call is made to initiate the emergency response system. This time can be significant. Often, instead of calling an ambulance, relatives, clergy, or friends of the patient are called prior to activating the emergency response system. Better public education regarding what constitutes a medical emergency and when to call for an ambulance is essential.
    - Call intake – this is the time a call-taker needs to gather information about the incident, determine what resources are needed, and actually notify (dispatch) the crews. In even the most sophisticated of systems, time must be taken to identify the needed resources to ensure an appropriate response.

- "Out of chute time" – the time it takes for a crew to get to their vehicle, determine how to get to the incident location, and actually have wheels rolling towards the incident. Some hospital-based systems utilize their EMS personnel in their hospitals between runs to improve efficiency; many services utilize a 24-hour shift which means that during part of the shift, crews are sleeping. Responding to an ambulance from deep inside a hospital or from a deep sleep increases the "out of chute" time.
- Drive time- This is the time it takes for the responders to drive (or fly) to the scene. This is typically measured from the time the crew reports "en route" to the time the crew reports "on scene". These times are often imprecise and does not represent when the patient is actually receiving care. In large buildings, the actual time of patient contact can be significantly longer than recorded in dispatch records.

- The primary funding for EMS ambulance transport is provided through Medicare, Medicaid and private insurance reimbursement. In most cases, the reimbursement falls far short of the cost of readiness. Adding units to effect shorter response times without improving funding is a recipe for system failure.
- IC 16-31-3.5, mentioned earlier, requires ambulance providers to provide dispatch training. Many systems utilize Clausen's "Emergency Medical Dispatch" program or other call screening programs to establish criteria for determining the right resources are sent to the right patient at the right time. Many industry professionals are advocating intentionally decreasing the number of "lights and siren" responses to those events that are truly life threatening for the safety of all involved. This reduction results in longer response times to less acute patients identified through the American Society of Training and Materials (ASTM) adopted mechanisms.
- A multi-year project is in place (2009 through the present) where response times have been lengthened in Evansville, Indiana while monitoring the Rapid Acute Physiology Scores of all patients as well as the Return of Spontaneous Circulation (ROSC) rates in cardiac arrest. At this time, there is solid evidence that there has been no patient outcome change based upon a longer response time. This was designed as a combined effort of the City of Evansville, the Evansville Fire Department a private ambulance contractor to save tax payer funds. Savings of over one million dollars a year have been recognized by the community. This project has been presented at several national level conferences and clinical summits and is drawing much attention.

Indiana EMS Certified Personnel
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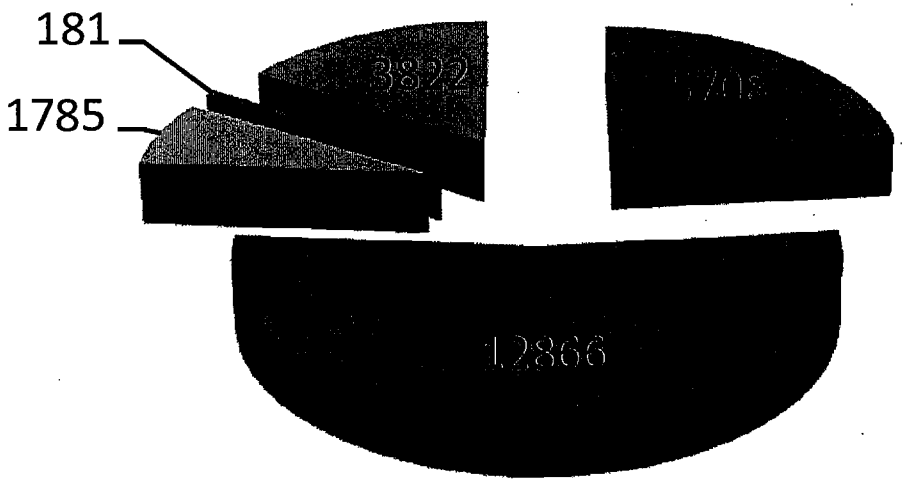
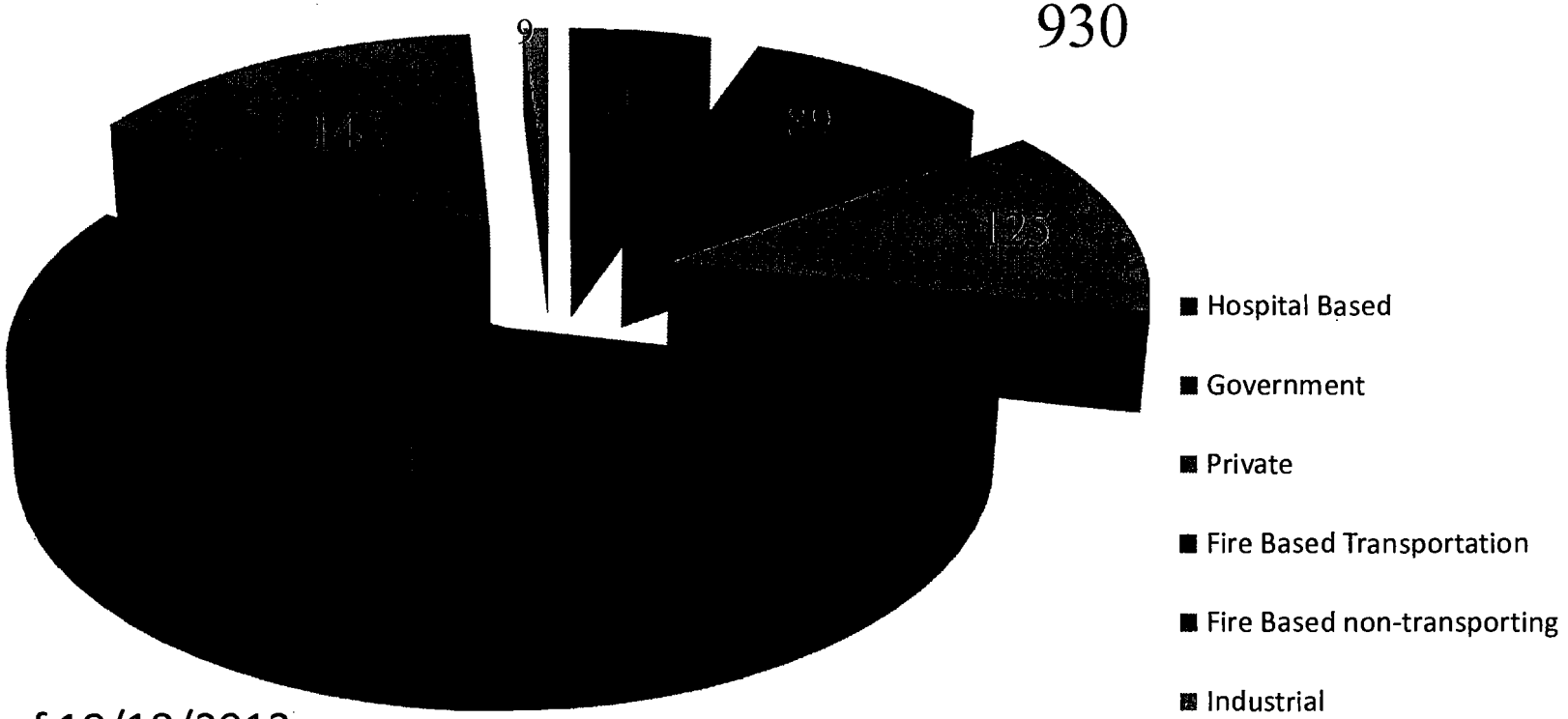


- Emergency Medical Responder
- Emergency Medical Technician
- Emergency Medical Technician -Basic Advanced
- Emergency Medical Technician - Intermediate
- Paramedic

As of October 18, 2012

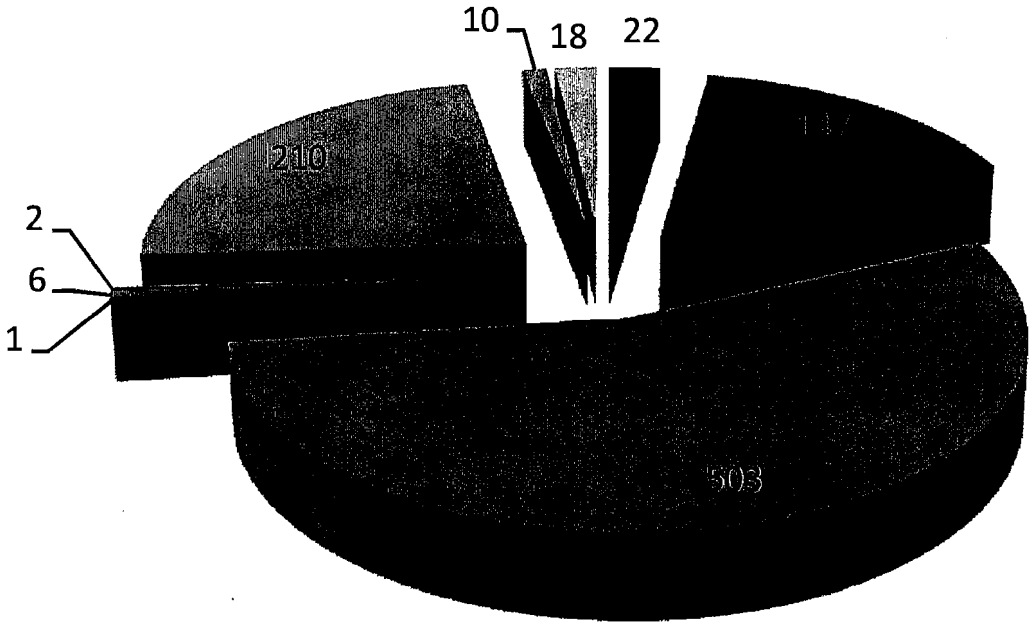
Exhibit 5
Health Finance Commission
Meeting #3, October 23, 2012

Indiana EMS Certified Providers
930



As of 10/18/2012

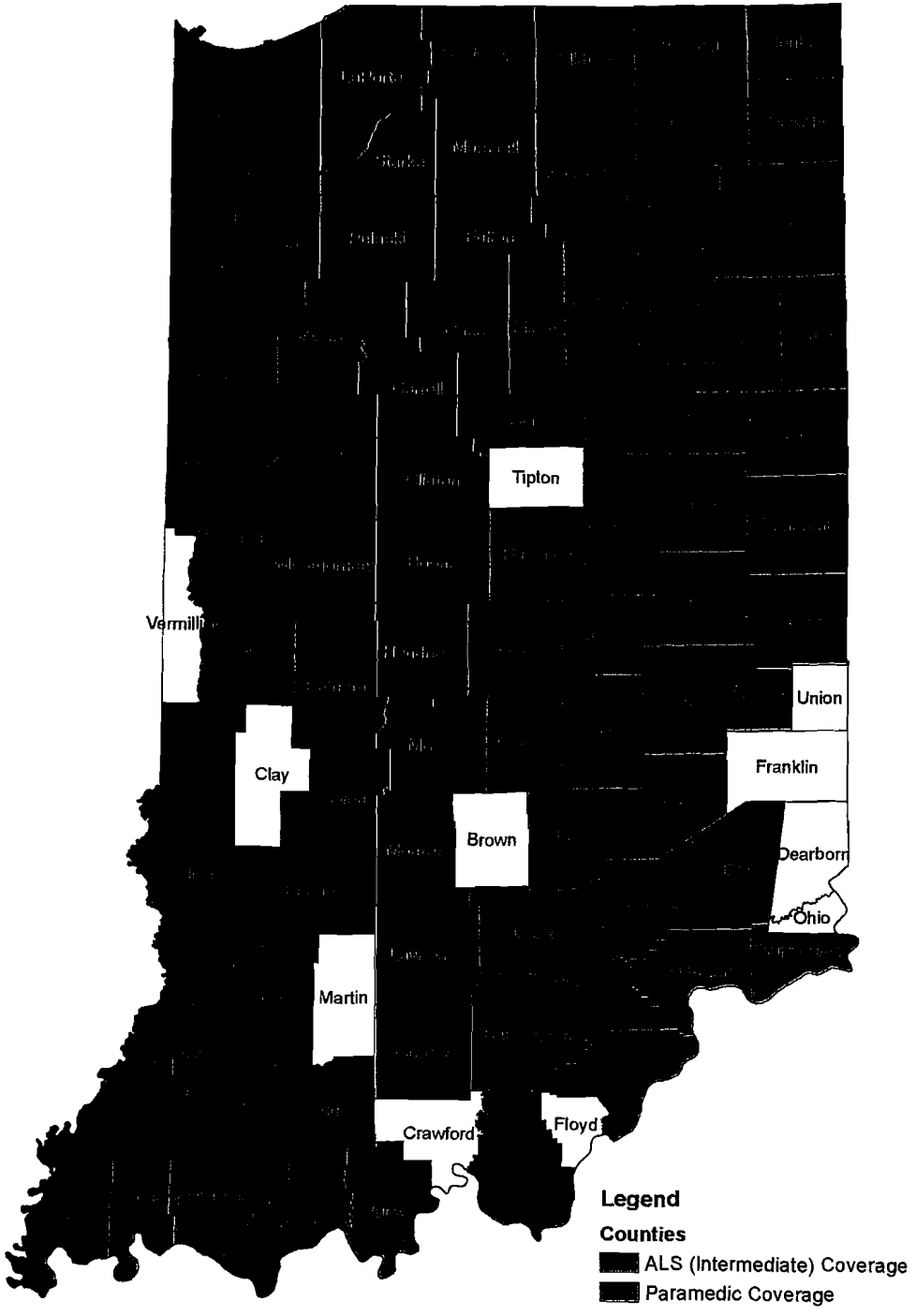
Indiana Service Types



- ALS Non-Transport
- Ambulance Service Provider
- Basic Life Support Non-Transport
- EMT Basic-Advanced Organization
- EMT Intermediate Organization
- Fixed Wing Air Ambulance
- Paramedic Organization
- Rescue Squad Organization
- Rotorcraft Air Ambulance

As Of October 18, 2012

Counties with Paramedic or ALS (Intermediate) Coverage



Counties without Paramedic or ALS (Intermediate) Coverage

SEA 224 Report

- Division of Fire and Building Safety and the Emergency Medical Services Commission

EMS Commission

- IC 16-31-1-1
  - It is the purpose… "to promote the establishment and maintenance or an effective system of emergency medical service…"

Exhibit 4
Health Finance Commission
Meeting #3, October 23, 2012

EMS Commission

- IC 16-31-2-2
  - Governor appointed
  - 13 members
  - Composition

SEA 224 Questions

- Answered by consensus of a sub-committee of 14 persons representing multiple branches of IDHS, the Indiana State Fire Marshal, the Indiana Fire Alliance, EMS Commissioners, and the IEMSA

SEA 224 Answer #1

- Not regulated by the EMS Commission
- Determined by local providers, medical directors and medical community
- Definition of emergency depends on setting

SEA 224 Answer #2

- Minimum equipment is mandated by type of vehicle and is regulated by the EMS Commission
- 836 IAC 1-3-1 Ambulance standards
- 836 IAC 1-3-4 Rescue equipment
- 836 IAC 1-3-5 Ambulance emergency care equipment
- 836 IAC 1-4-2 Communications equipment
- 836 IAC2-2-1 Medical Director authority regarding ambulance AMS equipment
- Indiana required equipment meets or exceed national recommendations

SEA 224 Answer #3

- Traditional belief: 8 minutes optimal for cardiac arrest
- Evidence-based data from US HHS and other studies do not support the 8 minute response time
- Reducing response times requires increases in the number of ambulances, trained individuals and costs
- Most today believe that outcomes are more dependent on first response, pre-arrival instructions and bystander actions than the response time of the transport unit
- See Appendix V

SEA 224 Answer #4

- The committee respectfully requests clarification of this question.
- Provider specific and based local medical community capabilities and needs
- Question #7 answer may provide some of desired information on this particular question

SEA 224 Answer #5

- How health facilities obtain emergency and non-emergency medical transportation would be regulated by the Indiana State Department of Health

SEA 224 Answer #6

- Please refer to the data provided by Director Archer
- IC 16-31-5 gives local governing bodies the ability to establish EMS
- IC 16-31-5 also specifies limitations
- All types of providers in Indiana make all types of ambulance responses

SEA 224 Answer #7

- Based primarily on local capabilities, patient needs and patient choice
- Informed consent
- Otherwise, closest appropriate facility

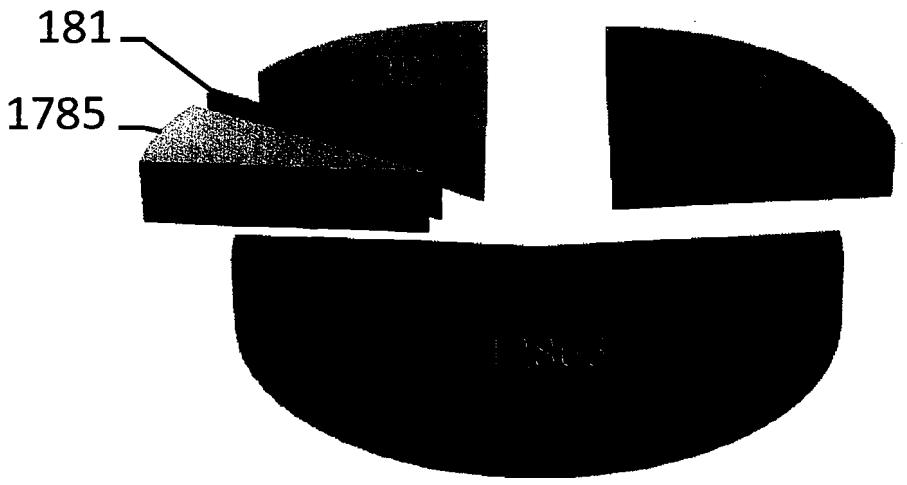
SEA 224 Answer #8

- The State Trauma Care System is under the authority of the Indiana State Department of Health

SEA 224 Conclusion

- Indiana EMS providers are "a passionate, dedicated group of people who work tirelessly for long hours and at personal hardship to be there for their friends, family and fellow Hoosiers in their time of need"
- Response times should not be equated to outcome
- Communities are encouraged to embrace a system approach to emergency care delivery
- First Response collaboration with ambulance transport is key to outcomes

Indiana EMS Certified Personnel
24362

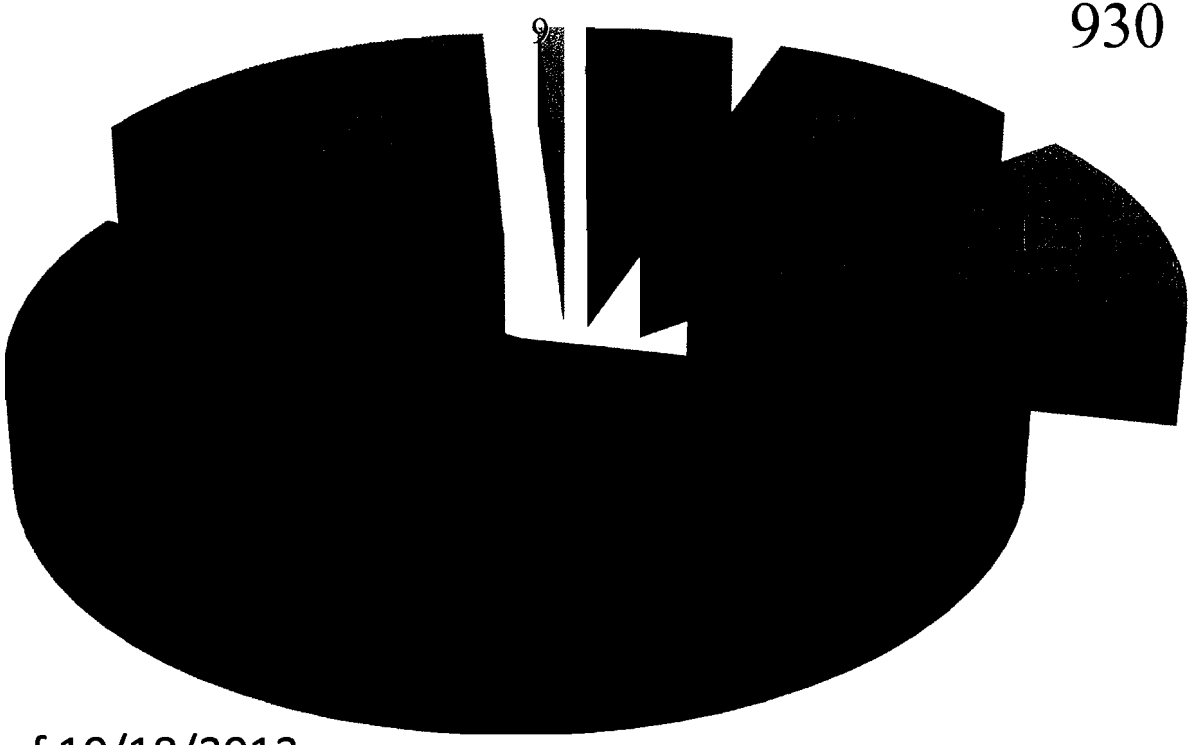


- Emergency Medical Responder
- Emergency Medical Technician
- Emergency Medical Technician -Basic Advanced
- Emergency Medical Technician - Intermediate
- Paramedic

As of October 18, 2012

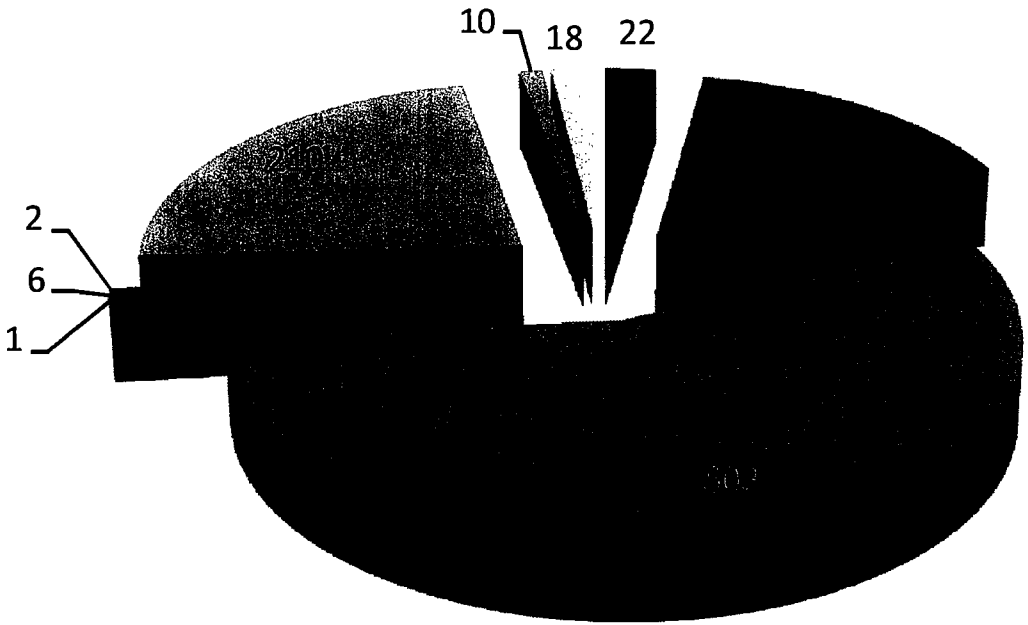
Exhibit 5
Health Finance Commission
Meeting #3, October 23, 2012

Indiana EMS Certified Providers
930



As of 10/18/2012

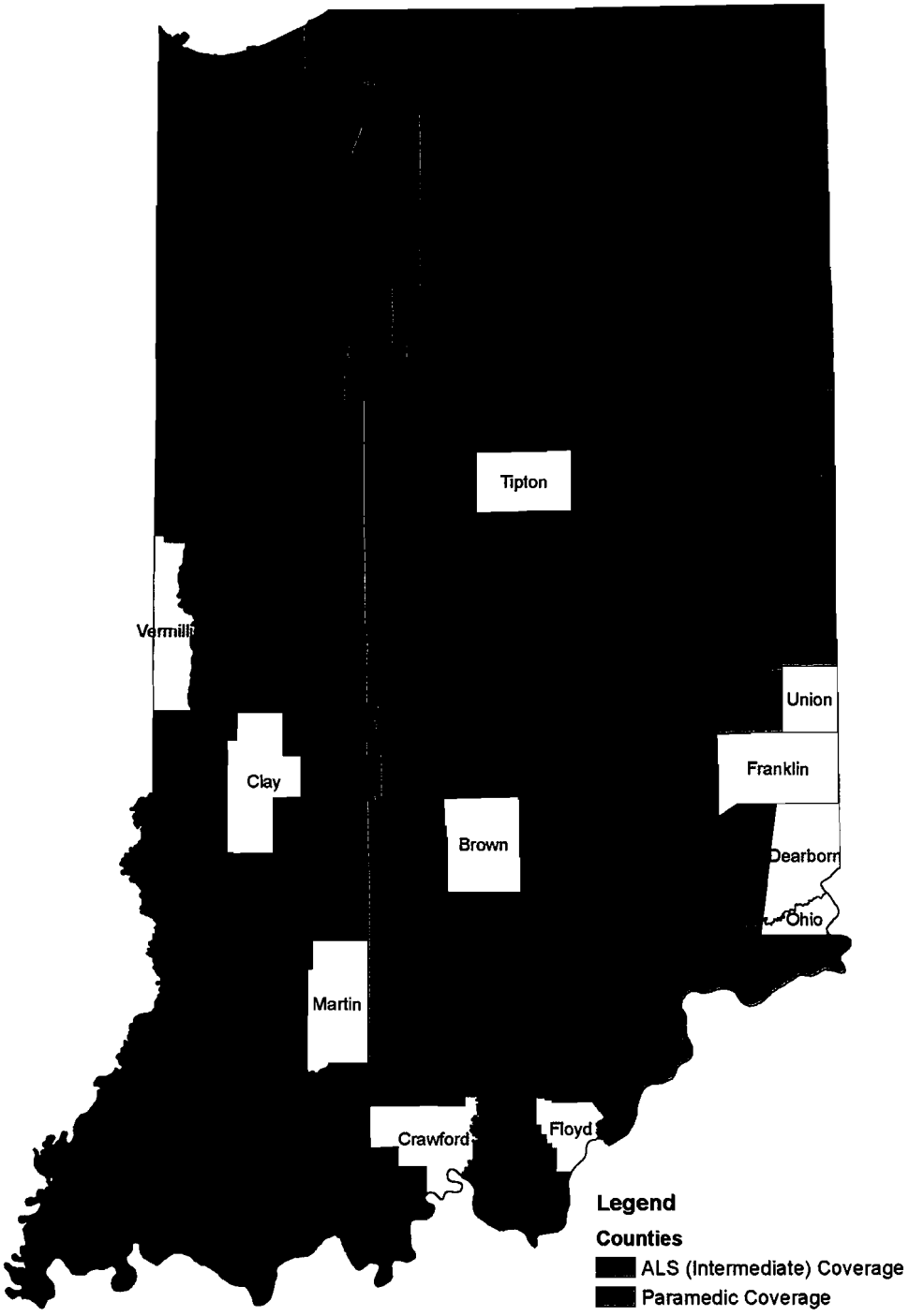
Indiana Service Types



- ALS Non-Transport
- Ambulance Service Provider
- Basic Life Support Non-Transport
- EMT Basic-Advanced Organization
- EMT Intermediate Organization
- Fixed Wing Air Ambulance
- Paramedic Organization
- Rescue Squad Organization
- Rotorcraft Air Ambulance

As Of October 18, 2012

Counties with Paramedic or ALS (Intermediate) Coverage



Counties without Paramedic or ALS (Intermediate) Coverage

In Indiana, the number one killer and disabler of Hoosiers less than 45 years of age is not heart disease, cancer, HIV or other well known diseases. The number one killer of our mid age and young population is Trauma. That is injuries and death caused by major accidents such as MVC, agricultural incidents, falls and penetrating body wounds.

In fact, more than 32,000 citizens are hospitalized and, worse yet, nearly 4,000 Indiana residents die each year from trauma.

Over the past decades, significant trauma care lessons have been learned and applied in the military and most importantly throughout our nation. The most important lessons are:

a) If a severely injured patient obtains highly skilled care within the first hour of the incident, there is a major reduction of permanent injury or death. This is called the "golden hour of care"
b) In states and cities that have implemented a "trauma care system", that is a system that best assures correct identification of the severely injured, rapid transportation to a uniquely qualified care center and high quality rehabilitation care support, the incidence of death or permanent injury is reduced between 15-30%

Indiana is one of only 9 states that has not implemented an integrated statewide trauma care system but significant progress has occurred since legislative action in 2006.

a) 2006, the state legislature charged the ISDH to develop a statewide trauma care system
b) 2008, by state invitation, the American College of Surgeons (ACS), well accepted expert on trauma care systems, audited Indiana's, then, capabilities and published a report of basic and key recommendations:
    a. ISDH establish a division for Trauma Care and Injury Prevention- this was completed in last year.
    b. That the EMS and the Division for Trauma Care be within the same agency so that vital integration of services, common accountability and data analysis can more efficiently be provided. It was noted that 41 other states combine EMS and Trauma into the same agency and most are combined in the Department of Health. To date, in Indiana, this integration has not occurred, however, in the past year, functional operations have improved
    c. Indiana needs one common "triage and transportation" rule so that all EMS service providers have a common roadmap when determining where the severely injured should be transported. In 2012, the EMS promulgated and adopted a statewide triage and transportation rule.
    d. The current distribution of verified Indiana Trauma Care Centers (2 Evansville, 2 Fort Wayne, 1 South Bend and 4 in Indianapolis) is not optimal for statewide patient access. Additional Trauma Care Centers should be considered in poorly covered areas, such as western Indiana, northwestern Indiana, and southern Indiana.

i. Since the passage of Indiana's Triage and Transportation Rule, more than 8 Indiana hospitals have indicated plans to obtain verification as a Trauma Center. All are in areas of present need.

e. Indiana's evolving Trauma Care System needs to be driven and improved with patient care data so that best outcomes and system improvements can be identified.
   i. The ISDH has maintained a "Trauma Care Registry" since 2008. All existing Indiana Trauma Centers plus 20 non trauma hospitals provide patient specific data.
   ii. The IDHS EMS gathers ambulance run data but traditionally, the amount of data gathered and its analysis is only a small fraction of the total number of ambulance runs in Indiana. ISDH Trauma Division and its Health Information component has recently obtained the existing EMS data and will apply intense analytical evaluations on the limited data available, but more importantly will be investigating methods of support so that EMS vendors can be more compliant with national data reporting standards
   iii. In 2013, with the Indiana Hospital Association support and passed legislation, the specific cause of a patient's injuries will be reported via "E-coding". E-coding identifies as an example whether a broken leg was caused by a MVC or a fall off a ladder. Knowing both the "cause" as well as the "nature" of an injury will help Indiana promote more effective injury prevention programs.

f. Reflective of the American College of Surgeons (ACS) report and noting the significant gaps in Indiana's system, in 2009, Governor Daniels, by Executive Order, created a Statewide Trauma Care Advisory Committee consisting of Indiana trauma care experts and chaired by the State Health Commissioner.

g. ISDH and IDHS are actively investigating the development of a "patient tracking system" that is activated the moment a patient enters the health care system, via ambulance or hospital. For mass casualty incidents where the injured are scattered across health care systems and then often transported elsewhere, the ability to know where the patient is receiving care at all times is important for both families as well as needed coordination of provider medical care.

h. This last summer, I, and members of the ISDH Trauma Care and Injury Prevention division launched a "Trauma Care Listening Tour", where we visited each of the 10 State Preparedness Districts. From every visit we heard the importance of improving the communities' response to injured patients. The challenges in rural Indiana differ from the urban, but the desired outcomes- best care as soon as possible, is uniformly desired. We were pleased that at each of the 10 sessions, EMTs, firefighters, hospital leaders, nurses, coroners and patients who have survived major trauma attended and contributed to these important discussions.

i. Indiana is now on the road, albeit long and challenging, in joining the majority of the states in providing our citizens contemporary, life saving care. This has been because of your legislative support and leadership. As our Trauma Care System evolves, we hope your support and advocacy will continue.

PROMPT Ambulance Service

"Serving our Communities 24/7"

October 17, 2012

Representative Timothy Brown, Chairman
Health Finance Commission

RE: TEACHING HOSPITAL AND TRAUMA CENTER IN NORTHWEST INDIANA

Dear Chairman Brown,

I would like to speak in favor of the **Establishment and funding for a Teaching Hospital and Trauma Center for Northwest Indiana.**

PROMPT Ambulance Service, Inc. provides the 9-1-1 EMS service for 30% of Lake County Residents, covering the Towns of Highland, Dyer, Griffith, Munster, Merrillville as well as the City of East Chicago.

We literally and figuratively deal with EMS where the rubber meets the road. From our unique advantage we see first-hand the tremendous amount of Trauma and the resulting need for a well financed Trauma Center. The recent passage of a Statewide Trauma Transport Rule, although well intentioned, has only added to the need for a facility in Lake County. The new rule requires ambulances to transport certain trauma patients up to 45 minutes away. This adds additional burdens to the already resources-stretched EMS system in Lake County, especially for the City of Gary's Ambulances. The main problem is that the amount of time that these ambulances are available is dramatically reduced because a trip which had taken about 40 minutes to complete will now take 4 times as long. This is problematic in that it is common enough to be very disruptive, and yet rare enough that you cannot increase staffing to accommodate the need without increasing "readiness costs" to an unrealistic level.

In addition, to the Emergency Services which we provide, PROMPT also has a very busy non-emergency ambulance transport business. From this side of the business we transport patients daily to Illinois Hospitals for a higher level of care. These patients by definition are more critical and usually require extensive treatment and a longer Hospital Stay. This results in a tremendous amount of Hoosier private insurance dollars leaving the State. For Indiana Medicaid patients the State often directs these patients to facilities within Indiana; from Lake County this is often higher level Hospitals in Indianapolis. This is a fiscally intelligent move but it does create a hardship on the families as they now have to go 150 miles whereas a local teaching hospital may provide some of the same services locally.

Establishing a Teaching Hospital along with a Trauma Center in Lake County would instantly solve much of the problems listed above.

I would encourage your Commission to assist in paving the way for this to become a reality by whatever powers that you have at your disposal. Being a business owner for over 30 years, I understand that funding is a major component of this type of endeavor. Any funding the State can provide would benefit the community greatly.

Sincerely;

Gary T. Miller
Chief Executive Officer

Exhibit 7
Health Finance Commission
Meeting #3, October 23, 2012

9835 Express Drive • Highland, Indiana 46322
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PRELIMINARY DRAFT
No. 3365

PREPARED BY
LEGISLATIVE SERVICES AGENCY
2013 GENERAL ASSEMBLY

DIGEST

Citations Affected: IC 12-7-2-135.8; IC 12-23-19; IC 35-48-7-11.1.

Synopsis: Certification of pain control centers. Requires a pain control center to be certified by the division of mental health and addiction. Sets forth requirements for pain control centers. Allows for the release of information from the Indiana scheduled prescription electronic collection and tracking (INSPECT) program to the division of mental health and addiction.

Effective: July 1, 2013.

Exhibit 8
Health Finance Commission
Meeting #3, October 23, 2012

A BILL FOR AN ACT to amend the Indiana Code concerning human services and to make an appropriation.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-7-2-135.8 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 135.8. "Pain control center", for purposes of IC 12-23-19, has the meaning set forth in IC 12-23-19-1.**

SECTION 2. IC 12-23-19 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]:

Chapter 19. Pain Control Centers

Sec. 1. (a) As used in this chapter, "pain control center" means a facility that:

(1) has a primary practice component of treating patients for pain;

(2) provides treatment for pain that includes the prescribing, dispensing, or administering of controlled substances by any of the following:

(A) A physician who is:

(i) licensed under IC 25-22.5; and

(ii) employed by, or acting on behalf of, the center.

(B) A practitioner who is:

(i) licensed or certified in Indiana to prescribe, dispense, or administer a controlled substance; and

(ii) employed by, or acting on behalf of, the center; and

(3) provides treatment to individuals, the majority of whom:

(A) receive medication or a prescription for a controlled substance for more than a three (3) day supply;

(B) have a history of using a controlled substance for at least a thirty (30) day period; and

(C) have not been referred by the center to another health provider not employed by the center licensed to provide evaluation of the individual's health status or for

alternative therapy.

(b) The term does not include the following:

(1) A hospital:

(A) licensed under IC 16-21-2; or

(B) subject to IC 16-22 or IC 16-23.

(2) An ambulatory surgical center licensed under IC 16-21-2.

(3) A hospice program licensed under IC 16-25-3.

(4) A health facility licensed under IC 16-28-2.

(5) A facility operated by the state or federal government.

Sec. 2. (a) A pain control center shall not operate in Indiana unless:

(1) the pain management treatment program is:

(A) specifically approved by; and

(B) in compliance with;

state and federal law; and

(2) the pain control center is:

(A) owned and operated by a physician licensed under IC 25-22.5; and

(B) certified by the division.

(b) Separate specific approval and certification under this chapter is required for each location of a pain control center in which a pain management treatment program is operated.

Sec. 3. In order to obtain certification and maintain certification under this chapter, the pain control center must meet the following requirements:

(1) Be owned by a physician licensed under IC 25-22.5.

(2) Provide each patient of the center with an individualized medical plan that treats the patient and avoids long term pain medication addiction.

(3) Have a physician licensed under IC 25-22.5 physically present at the center at all times that the pain control center is open.

(4) Before a controlled substance is prescribed for a patient, use the INSPECT program established by IC 25-1-13-4.

Sec. 4. (a) Consistent with standard medical practices in pain management treatment, the division shall adopt rules under IC 4-22-2 to establish and administer a pain control center oversight program. The rules shall address the following:

(1) Standards for operation of a pain control center, including the following:

(A) Minimum requirements for a licensed physician's regular physical evaluation and progress evaluation of each center patient.

(B) Minimum staffing requirements by licensed and unlicensed personnel.

(C) Clinical standards for the appropriate tapering of a

patient off of controlled substance medication.

(2) Fees to be paid by a pain control center for deposit in the pain control center regulation fund established by section 6 of this chapter for annual certification under this chapter. The fees must be sufficient to pay the cost of implementing this chapter.

(b) The division shall conduct an annual onsite visit of each pain control center to assess compliance with this chapter.

Sec. 5. (a) The director of the division may take any of the following actions based on any grounds described in subsection (b):

(1) Issue a letter of correction.

(2) Reinspect a pain control center.

(3) Deny renewal of, or revoke certification of a pain control center.

(4) Impose a civil penalty in an amount not to exceed ten thousand dollars ($10,000).

(b) The director of the division may take action under subsection (a) based on any of the following grounds:

(1) Violation of this chapter or rules adopted under this chapter.

(2) Permitting, aiding, or abetting the commission of any illegal act in a pain control center.

(3) Conduct or practice found by the director to be detrimental to the welfare of a pain control center patient.

(c) IC 4-21.5 applies to an action under this section.

Sec. 6. (a) The pain control center regulation fund is established for the purpose of administering this chapter. The fund shall be administered by the division.

(b) The expenses of administering the fund shall be paid from money in the fund.

(c) The treasurer of state shall invest money in the fund in the same manner as other public money may be invested.

(d) Money in the fund at the end of the state fiscal year does not revert to the state general fund.

(e) Money in the fund is continually appropriated.

SECTION 3. IC 35-48-7-11.1, AS AMENDED BY P.L.84-2010, SECTION 99, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 11.1. (a) Information received by the INSPECT program under section 8.1 of this chapter is confidential.

(b) The board shall carry out a program to protect the confidentiality of the information described in subsection (a). The board may disclose the information to another person only under subsection (c), (d), or (g).

(c) The board may disclose confidential information described in subsection (a) to any person who is authorized to engage in receiving, processing, or storing the information.

(d) Except as provided in subsections (e) and (f), the board may

release confidential information described in subsection (a) to the following persons:

(1) A member of the board or another governing body that licenses practitioners and is engaged in an investigation, an adjudication, or a prosecution of a violation under any state or federal law that involves a controlled substance.

(2) An investigator for the consumer protection division of the office of the attorney general, a prosecuting attorney, the attorney general, a deputy attorney general, or an investigator from the office of the attorney general, who is engaged in:

(A) an investigation;

(B) an adjudication; or

(C) a prosecution;

of a violation under any state or federal law that involves a controlled substance.

(3) A law enforcement officer who is an employee of:

(A) a local, state, or federal law enforcement agency; or

(B) an entity that regulates controlled substances or enforces controlled substances rules or laws in another state;

that is certified to receive information from the INSPECT program.

(4) A practitioner or practitioner's agent certified to receive information from the INSPECT program.

(5) A controlled substance monitoring program in another state with which Indiana has established an interoperability agreement.

(6) The state toxicologist.

(7) A certified representative of the Medicaid retrospective and prospective drug utilization review program.

(8) A substance abuse assistance program for a licensed health care provider who:

(A) has prescriptive authority under IC 25; and

(B) is participating in the assistance program.

(9) The division of mental health and addiction.

(e) Information provided to an individual under:

(1) subsection (d)(3) is limited to information:

(A) concerning an individual or proceeding involving the unlawful diversion or misuse of a schedule II, III, IV, or V controlled substance; and

(B) that will assist in an investigation or proceeding; and

(2) subsection (d)(4) may be released only for the purpose of:

(A) providing medical or pharmaceutical treatment; or

(B) evaluating the need for providing medical or pharmaceutical treatment to a patient.

(f) Before the board releases confidential information under subsection (d), the applicant must be approved by the INSPECT program in a manner prescribed by the board.

(g) The board may release to:

(1) a member of the board or another governing body that licenses practitioners;

(2) an investigator for the consumer protection division of the office of the attorney general, a prosecuting attorney, the attorney general, a deputy attorney general, or an investigator from the office of the attorney general; or

(3) a law enforcement officer who is:

(A) authorized by the state police department to receive the type of information released; and

(B) approved by the board to receive the type of information released;

confidential information generated from computer records that identifies practitioners who are prescribing or dispensing large quantities of a controlled substance.

(h) The information described in subsection (g) may not be released until it has been reviewed by:

(1) a member of the board who is licensed in the same profession as the prescribing or dispensing practitioner identified by the data; or

(2) the board's designee;

and until that member or the designee has certified that further investigation is warranted. However, failure to comply with this subsection does not invalidate the use of any evidence that is otherwise admissible in a proceeding described in subsection (i).

(i) An investigator or a law enforcement officer receiving confidential information under subsection (c), (d), or (g) may disclose the information to a law enforcement officer or an attorney for the office of the attorney general for use as evidence in the following:

(1) A proceeding under IC 16-42-20.

(2) A proceeding under any state or federal law that involves a controlled substance.

(3) A criminal proceeding or a proceeding in juvenile court that involves a controlled substance.

(j) The board may compile statistical reports from the information described in subsection (a). The reports must not include information that identifies any practitioner, ultimate user, or other person administering a controlled substance. Statistical reports compiled under this subsection are public records.

(k) This section may not be construed to require a practitioner to obtain information about a patient from the data base.

(l) A practitioner is immune from civil liability for an injury, death, or loss to a person solely due to a practitioner seeking or not seeking information from the INSPECT program. The civil immunity described in this subsection does not extend to a practitioner if the practitioner receives information directly from the INSPECT program and then

negligently misuses this information. This subsection does not apply to an act or omission that is a result of gross negligence or intentional misconduct.

(m) The board may review the records of the INSPECT program. If the board determines that a violation of the law may have occurred, the board shall notify the appropriate law enforcement agency or the relevant government body responsible for the licensure, regulation, or discipline of practitioners authorized by law to prescribe controlled substances.

(n) A practitioner who in good faith discloses information based on a report from the INSPECT program to a law enforcement agency is immune from criminal or civil liability. A practitioner that discloses information to a law enforcement agency under this subsection is presumed to have acted in good faith.

PRELIMINARY DRAFT
No. 3250

PREPARED BY
LEGISLATIVE SERVICES AGENCY
2013 GENERAL ASSEMBLY

DIGEST

Citations Affected: IC 6-3-3-9.1.

Synopsis: Income tax credit for specialty drugs. Provides a refundable individual income tax credit to the extent that a taxpayer's copayment or coinsurance amount in a particular year for specialty drugs exceeds 8% of the taxpayer's federal adjusted gross income for that year. Defines "specialty drug" as a drug that meets the following conditions: (1) The amount of coinsurance or copayments paid for the drug is more than $600 per month. (2) The drug is included in a specialty pricing group or tier. (3) The drug satisfies other requirements concerning use, handling, and patient management.

Effective: January 1, 2013 (retroactive).

Exhibit 9
Health Finance Commission
Meeting #3, October 23, 2012

A BILL FOR AN ACT to amend the Indiana Code concerning taxation.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 6-3-3-9.1 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2013 (RETROACTIVE)]: **Sec. 9.1. (a) As used in this section, "specialty drug" means a drug that meets all the following conditions:**

(1) The amount of coinsurance or copayments paid by the taxpayer for the drug under the taxpayer's health insurance plan is more than six hundred dollars ($600) per month.

(2) The drug is included in a specialty pricing group or tier of the drug formulary under the taxpayer's health insurance plan.

(3) The drug typically:

(A) is used to treat a chronic condition;

(B) requires special handling and distribution; and

(C) requires a high degree of patient management and counseling.

(b) As used in this section, "taxpayer" means:

(1) an individual filing a single return; or

(2) a married couple filing a joint return.

(c) A taxpayer who pays copayment or coinsurance amounts in a taxable year for one (1) or more specialty drugs is entitled to a refundable tax credit against the taxpayer's adjusted gross income tax liability imposed by IC 6-3-1 through IC 6-3-7 for the taxable year if the amount paid during the taxable year by the taxpayer as copayment or coinsurance for specialty drugs under the taxpayer's health insurance plan exceeds eight percent (8%) of the taxpayer's federal adjusted gross income for the taxable year.

(d) The amount of the tax credit under this section is equal to the result of:

(1) the amount paid during the taxable year by the taxpayer as copayment or coinsurance for specialty drugs under the

taxpayer's health insurance plan; minus

(2) the amount equal to eight percent (8%) of the taxpayer's federal adjusted gross income for the taxable year.

(e) If the amount of the credit under this section exceeds the taxpayer's adjusted gross income tax liability for the taxable year, the excess shall be refunded to the taxpayer.

(f) To receive a credit under this section, a taxpayer must:

(1) claim the credit on the taxpayer's annual state tax return or returns in the manner prescribed by the department; and

(2) submit to the department all information that the department determines is necessary for the calculation of the credit under this section.

SECTION 2. [EFFECTIVE JANUARY 1, 2013 (RETROACTIVE)] **(a) IC 6-3-3-9.1, as added by this act, applies to taxable years beginning after December 31, 2012.**

(b) This SECTION expires July 1, 2017.

SECTION 3. **An emergency is declared for this act.**

Division of Family Resources

EBT Card Update

Adrienne Shields, DFR Deputy Director

Exhibit 1=
Health Finance Commission
Meeting #3, October 23, 2012

What is EBT?

- EBT stands for **Electronic Benefit Transfer**
- EBT is the vehicle for electronic distribution of benefits to Indiana families who qualify for the Temporary Assistance to Needy Families (TANF/cash assistance) and other food and cash assistance programs
- The EBT card is also called the Hoosier Works card

IC 12-13-14-4.5

Restrictions on Cash Withdrawal to Access TANF Benefits

It is a Class C misdemeanor for TANF recipients to use the Hoosier Works EBT card at the following locations:

- Liquor stores
- Bars
- Nightclubs
- Bingo halls
- Casinos
- Horse racing tracks
- Off-track betting parlors
- Gun stores
- Adult entertainment establishments

Restrictions for Vendors

- Indiana law requires prohibited locations to post a sign near their ATM.
- DFR is working with the Alcohol & Tobacco commission.
- Alcohol & Tobacco Commission agreed to educate prohibited vendors on the law and monitor for enforcement of required signage.

Enforcement of Restrictions for Recipients

- DFR will conduct monthly data match for withdrawals at restricted locations
- First offense of making illegal withdrawals, client is notified of offense committed
- Second offense of making illegal withdrawals, client is referred to the local prosecutor (Class C Misdemeanor)

TANF Transactions

- December 2011 (21,012 cases)
  - 101 of the 68,882 TANF EBT transactions (0.15%) took place in a restricted location
  - $9,830 of the $3,679,728 (0.27%) TANF funds were withdrawn from a restricted location
- September 2012 (15,642 cases)
  - 54 of the 50,071 TANF EBT transactions (0.11%) took place in a restricted location
  - $4,190 of the $2,804,458 (0.15%) TANF funds were withdrawn from a restriction location

Educating TANF Recipients

- A notice was sent to all current TANF EBT cardholders on September 10, 2012 informing them of the penalty for using their card at restricted establishments
- Added the same language to the *Approval for Benefits* notice
- Added the same language to the FSSA/DFR website: ***http://www.in.gov/fssa/dfr/2690.htm***
- Updated the insert that accompanies all new and replacement EBT cards

Insert Accompanying All New and Replacement EBT Cards

IMPORTANT INFORMATION ABOUT YOUR INDIANA EBT CARD AND BENEFITS

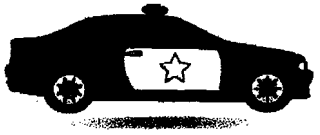
KEEP YOUR CARD

- Your card never expires, even if you are no longer eligible for benefits
- If you order four or more cards in a calendar year, you may be required to complete an interview with FSSA staff to explain why you have had excessive card replacements

ILLEGAL USE OF BENEFITS

Illegal use of your benefits includes:

- Selling, trading or giving away your benefits
- Allowing a retailer to buy your SNAP benefits in exchange for cash or non-food items
- Using or buying someone else's benefits



ILLEGAL TANF WITHDRAWALS

Even if you see the Quest logo, it is a **Class C misdemeanor** to withdraw cash at ATMs in:

- Liquor stores
- Bars, nightclubs
- Private clubs and lodges
- Casinos, horse racing tracks, off-track betting parlors
- Bingo halls
- Gun stores
- Adult entertainment venues

CONSEQUENCES FOR MISUSING YOUR BENEFITS

- Misuse of your benefits can lead to fines and disqualification from the programs
- A person convicted of a Class C misdemeanor for illegal TANF withdrawals can be jailed for up to 60 days and fined up to $500
- The State can forward cardholder information to the county prosecutor for potential prosecution for misuse of SNAP or TANF benefits

INC12166

Questions ?

Rx Drug Abuse Task Force
Committee List

Salutation	First	Last	Title	Office/Agency	Role
	Greg	**Zoeller**	**Indiana Attorney General**	**IN Office of the Attorney General**	***Task Force Chairman**
Dr.	**Joan M.**	**Duwve**	**Chief Medical Officer**	**IN State Department of Health**	***Task Force Vice Chairman**
	Natalie	**Robinson**	**Education Program Director**	**IN Office of the Attorney General**	***Task Force Coordinator**
	Michelle	**Sybesma**	**Consultant**	**Professional Skills Consulting, Inc.**	***Task Force Coordinator**
	Josh	Anderson	Pharmacist	Crowders Pharmacy	Take-Back Member
	Derek	Green	IPA Board Member/Pharmacist	Indiana Phamacy Alliance	Take-Back Member
	Greg	Pachmayr	Director of the Pharmacy Board	IN Professional Licensing Agency	Take-Back Member
	Lisa	Paine Perez	Recycling & Household Hazardous Waste Programs	Office of Pollution Prevention, Department of Environmental Management	Take-Back Member
Special Agent	Dennis A.	Wichern	Assistant Special Agent in Charge	Drug Enforcement Administration, Indianapolis District Office	Take-Back Member
	Lora	Williams	Pharmacy Board Member	IN Pharmacy Board	Take-Back Member
Dr.	**Deb**	**McMahan**		**Allen County Health Dept. Officer**	**Education Committee Chair**
	Abby	**Kuzma**	**Chief Counsel, Director, Consumer**	**IN Office of the Attorney General Consumer Protection**	**Education Committee Vice-Chair**
	Tamara	**Weaver**	**Deputy Attorney General**	**IN Office of the Attorney General Consumer Protection**	**Education Committee Liaison**
	Sharon	Blair	Advocate	Social Justice Advocate	Educational Member
	Lori	Croasdell	PT Coordinator	CEASe of Scott County	Educational Member
Dr.	Mark	Gentry		American Congress of Obstetricians & Gynecologists	Educational Member
Dr.	Amy	LaHood		IN Academy of Family Physicians/ St. Vincent Residency Program	Educational Member
Senator	Pat	Miller	Legislator	IN General Assembly	Educational Member
	Jim	Mowry	Director of Indiana Poison Center	IN Poison Control Center	Educational Member
	Pam	Pontones	State Epidemiologist	IN State Department of Health	Educational Member
	Cynthia	Stone	Director - Indianapolis	IN Nurses' Association	Educational Member
	Shelly	Symmes	CME Recognition Admin	Indiana State Medical Association	Educational Member
	Cindy	Vaught	Dental Board Director	IN Professional Licensing Agency Dental Board	Educational Member
Rep.	Peggy	Welch	Legislator	IN General Assembly	Educational Member
Dr.	Michael	Whitworth	Chairman of IN Pain Society	IN Pain Society	Educational Member
	Julie	Wirthwein	State Epidemiologist	IN State Department of Health	Educational Member
	Craig	Andler	Executive Director	ICAADA	Treatment Member
	Dave	Bozell	Assistant Deputy Director	FSSA Division of Mental Health & Addiction	Treatment Member
Dr.	Bob	Burgbacher	Executive Director	EmberWood Center	Treatment Member
	Sonya	Carrico	Director	Substance Abuse Services	Treatment Member
Dr.	Andy	Chambers	Former Asst. Medical Director, DMHA	IU Associate Professor of Psychiatry	Treatment Member
	Zoe	Frantz	Business Development & Contracting	Valle Vista	Treatment Member
Dr.	Tim	Kelly	Medical Director	Fairbanks	Treatment Member
	Jill	Matheny	Director	Indiana Addictions Issues Coalition	Treatment Member
Rep.	Cindy	Noe	Legislator	IN General Assembly	Requested
	Charlotte	Pontius	Director of Program Dev. & Outreach	Fairbanks	Treatment Member
	Karl	Stout	Chairman	Indiana Addictions Issues Coalition	Treatment Member

Exhibit 11
Health Finance Commission
Meeting #3, October 23, 2012

Presented: 10/23/2012

Rx Drug Abuse Task Force
Committee List

	Mary	Allen	Executive Director	IN Criminal Justice Institute	Enforcement Member
Special Agent	JoAnn	Burkhart	Special Agent	Federal Bureau of Investigation, Indianapolis	Enforcement Member
	Jay	Federick	Detective & NADDI Officer	NADDI	Enforcement Member
	Tom	Ferguson		IN State Police	Enforcement Member
Senator	Ron	Grooms	Legislator	IN General Assembly	Enforcement Member
	Jennifer	Haley	Staff Attorney/Narcotics	IN Prosecuting Attorneys Council Narcotics Div	Enforcement Member
U.S. Attorney	Tim	Horty	Law Enforcement Coordinator	U.S. Attorney's Office (Northern District)	Enforcement Member
	Mary Kay	Hudson	Court Services Director	IN Judicial Center	Enforcement Member
	Chris	Johnson	Medicaid Pharmacy Director	Family & Social Services Administration , Office of Medicaid Policy & Plan.	Enforcement Member
	Kristen	Kelley	Medical Licensing Board Director	IN Professional Licensing Agency, Medical Licensening Board	Enforcement Member
	Tom	McKay	President	IN Drug Enforcement Officers Association	Enforcement Member
	Allen	Pope	Director/Chief Counsel	Medicare Fraud Control Unit	Enforcement Member
	Michael	Rinebold		IN State Medical Association	Enforcement Member
	Jane	Seigel	Executive Director	IN Judicial Center	Enforcement Member
Lt. Col.	Todd	Smith		IN State Police	Enforcement Member
Special Agent	Dennis A.	Wichern	Assistant Special Agent in Charge	Drug Enforcement Administration, Indianapolis District Office	Enforcement Member
	Marty	**Allain**	**Chief Legal Counsel/INSPECT Director**	**IN Professional Licensing Agency**	**INSPECT Committee Chair**
	Lou	Belch		IN American College of ER Physicians	INSPECT Member
Rep.	Tim	Brown	Legislator	IN General Assembly	INSPECT Member
Senator	Mike	Delph	Legislator	IN General Assembly	INSPECT Member
	Meredith	Edwards	Director of Legislative & Region Affairs	IN Academy of Family Physicians, Director of Legislative & Region Affairs	INSPECT Member
	Andy	VanZee		Indiana Health Information Technology	INSPECT Member
	Tami	Watson	Senior Detective	IN State Police	INSPECT Member
	Brian	Wikle	Chief Executive Officer	Intercept Rx	INSPECT Member
Dr.	Eric	Wright	Director	IUPUI Center for Health Policy	INSPECT Member

Presented: 10/23/2012

Indiana's Prescription Drug Abuse Task Force

Established: September, 2012

Office of the Indiana Attorney General
Prescription Drug Abuse Task Force

Background:

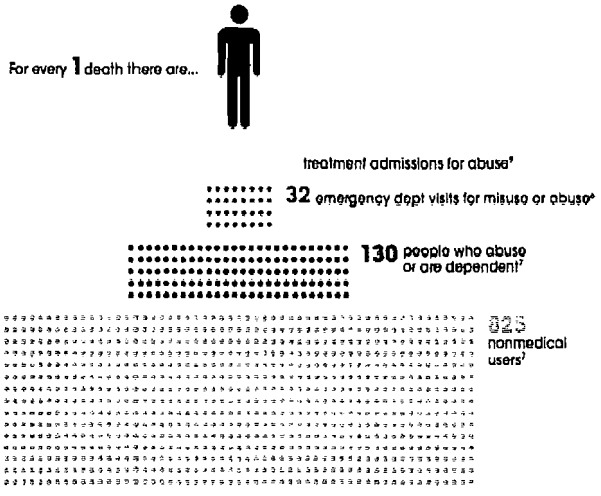
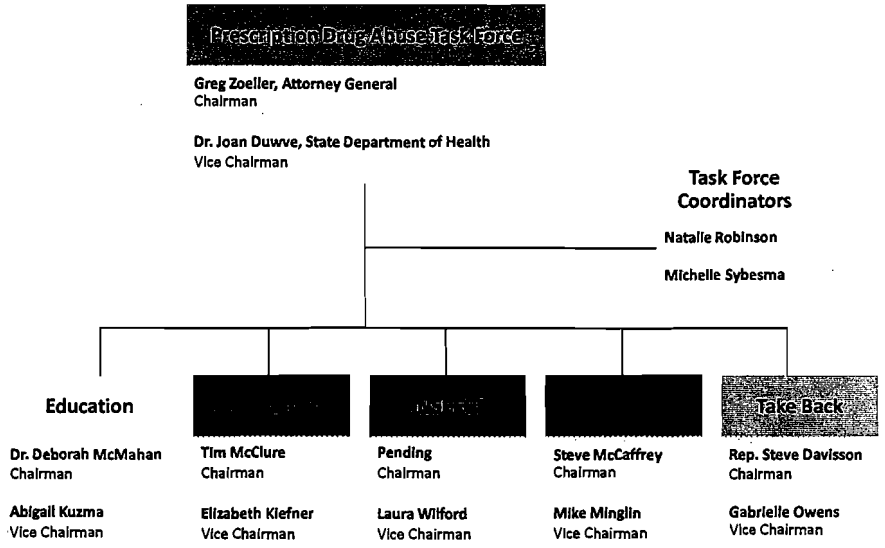


Exhibit 12
Health Finance Commission
Meeting #3, October 23, 2012

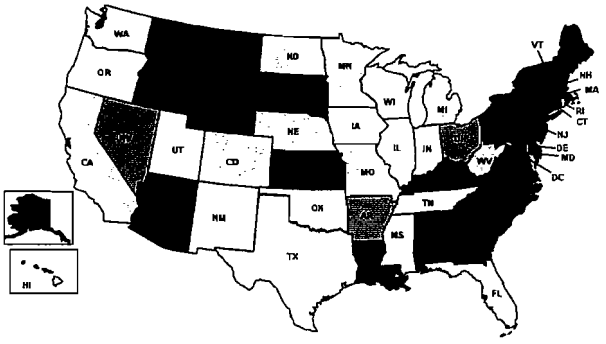


Rx Task Force Mission:

To reduce significantly the misuse and abuse of controlled prescription drugs; decreasing the number of people addicted to and deaths associated with these drugs in the State of Indiana

State Statutes, Regulations, or Guidelines Regarding Opiate Use:

Indiana remains as one of only two states without any regulations, laws, or medical board rules on prescribing of opioids. (Wisconsin Pain Policies Group)



Education Committee

Goal: Raise awareness of the dangers of Rx drug abuse and misuse through the education of parents, youth, patients, and healthcare providers. Ensure adequate training to prescribers on appropriate prescribing and dispensing of controlled substances.

INSPECT Committee

Goal: Secure funding and increase usage of state-based prescription drug monitoring program.

Office of the Indiana Attorney General
Prescription Drug Abuse Task Force

Rx Disposal/Take-Back Committee

Goal: Develop long-term controlled substance disposal solutions through the adoption of the take-back bill and other means.

Enforcement Committee

Goal: Build support for law enforcement efforts that reduces the prevalence of "pill mills" and doctor shopping through the investigation and prosecution of law violators.

Office of the Indiana Attorney General
Prescription Drug Abuse Task Force

Treatment and Recovery Committee

Goal: Identify ways to strengthen access to treatment and recovery solutions for those suffering from addiction.

III Annual Prescription Drug Abuse Symposium

Developing Strategies to Curb the Epidemic in Indiana

December 19, 2012

IUPUI Campus Center, Indianapolis

(Online registration opens November 5, 2012)

Audience: State lawmakers, law enforcement, pharmacists, healthcare providers, officials from state and local agencies, and education providers.

Reports and Legislative Recommendations

- Findings and recommendations that result from the Rx Drug Abuse Symposium will be compiled into a report
- The Rx Task Force will provide the Health Finance Commission and other members of the General Assembly with a copy of the report which will likely include legislative recommendations – some of which will be proposed for this session
- The report will be finalized shortly after the Symposium
- Periodic reports detailing its progress in implementing the initiatives set forth in their operational plan

What's Working, What's Not?

Brain Injury Listening Tour in Indiana

THE GENERATIONS PROJECT

October 2012

Exhibit 13
Health Finance Commission
Meeting #3, October 23, 2012

What's Working, What's Not? Brain Injury Listening Tour

Acknowledgements

The Generations Project is grateful to the following organizations for their financial support of this project:

Paralyzed Hoosier Veterans

Service Employees International Union

We would also like to thank Jeff Terp and the chancellors of the following *Ivy Tech Community College* campuses for allowing us to meet in their beautiful facilities: Columbus, Evansville, Fort Wayne, Indianapolis, Kokomo, Lafayette, Muncie, Richmond, Sellersburg, and South Bend.

The WILL Center of Terre Haute, Vincennes University (Area 13 AAA) and Indiana University Hospital in Bloomington were gracious hosts for the listening sessions in their areas.

Our gratitude also goes to Nancy Griffin who was co-facilitator at many of the listening sessions and added insight from her experience as an advocate for people with disabilities. Nancy is a board member of The Generations Project and Local Support Network Leader for the Brain Injury Association of Indiana's HRSA grant project.

Thank you to Carol Davis for her skilled note taking at the Indianapolis meeting and final review of this document.

A thank-you goes to John Cardwell, Director of The Generations Project, and Nancy Griffin for their patient and thorough editing of this report.

Finally we thank all the participants across the state who freely shared their challenges, heartbreaks, joys and determination at the listening sessions.

June Holt
Assistant Director
The Generations Project

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Executive Summary

What's Working, What's Not? Brain Injury Listening Tour in Indiana

In July and August 2012, representatives from The Generations Project traveled the state listening to brain injury survivors, their family members and advocates. Experiences shared in person were combined with answers on questionnaires to form the basis of this report. Questionnaires were also collected from survivors, family caregivers, and professionals who could not attend the listening sessions. Therefore, this report is not a quantitative assessment of needs throughout the state, but an account of what was heard from brain injury survivors and those who care about them. Participants spoke of their experiences during recovery, their current needs, and what they would like to see in a good system of care for all brain injury survivors.

Although many topics were covered, the following unranked issues were identified as major concerns throughout the state:

- A lack of early information and consistent referral systems for survivors and family members.
- Inadequate awareness and understanding regarding brain injury among professionals, families and the general public.
- Delays in the provision of time sensitive services and therapies that slow or harm the recovery of brain injury survivors.
- Undertrained medical and other professionals using outdated information.
- No organized system or continuum of services exists beyond the acute phases of recovery and rehabilitation. The services that do exist are fragmented, short in duration and/or hard to find.
- A pervasive need for services to help survivors reconnect to their communities through pre-vocational, vocational, educational, recreational and social opportunities.
- The need for transportation systems that provide viable access to the community.
- Few, if any, safe housing options that support independence and community engagement.

The overriding message delivered by brain injury survivors and their families is that once the initial medical treatment and short-term rehabilitation is finished they feel like they "drop off a cliff" into nothing. Left in isolation, they struggle to find treatments, services, and supports to continue their recovery or maintain any abilities they have reacquired. Family members must become care managers, brain injury experts, and providers of services. They are challenged to find information and appropriate treatment for the survivor. Clashes with untrained or undertrained professionals who misdiagnose or brush off the persistent symptoms experienced by the survivor are frequent occurrences. Families battle with insurance providers to cover essential services and supports. If they persist, families are fortunate to find one competent professional. But an isolated professional can only give a brain injury survivor fragmented care. Coordination is needed with other providers and community supports. Services and supports are more available in the major metropolitan areas, but nowhere in the state is there a network of connected professionals that allows for a comprehensive continuum of care throughout the recovery process or, if needed, for the life span of the survivor.

The tour demonstrated that professionals and policy makers in Indiana must actively listen to people with brain injury, their family caregivers, and their advocates. ALL stakeholders must be at the table and working together to meet identified needs and to develop a well-organized, consumer-focused plan of action to establish a lifelong continuum of care for brain injury survivors.

The Current Dilemma

Brain injury is a significant problem that affects countless people in all walks of life. Yet it remains a lightly explored issue in the state.

For several years, advocates, professionals, survivors of brain injury and their families have invested thousands of volunteer hours asking the state of Indiana to examine the need for brain injury services here. Little has come from that investment — two years of legislative summer study committees culminated in the passage of Senate Enrolled Act 15 (SEA15) in the spring of 2012. SEA15 directed the Indiana State Department of Health and the Indiana Family and Social Services Administration to

> "study the current brain injury services offered in Indiana; and determine any deficiencies in the provision of brain injury services in Indiana; and determine how to implement additional brain injury services and neurobehavioral rehabilitation programs in Indiana."

The law called for establishment of a treatment advisory committee to assist in these efforts. The sixteen member committee was to consist of state administrators and professionals and included one consumer of brain injury services and one individual who is a caregiver of a consumer of brain injury services. The committee had until October 1, 2012 to complete its work. Despite repeated requests from citizens and members of the General Assembly, Governor Mitch Daniels did not appoint the advisory committee. As a Kokomo professional duly noted, "Brain injury survivors need a champion.." As of October 1, 2012 that champion has not emerged.

Listening to Consumers

The *2012 What's Working, What's Not? Brain Injury Listening Tour* brought consumers and their families into the conversation regarding the need for comprehensive brain injury services in Indiana. The listening tour was designed to hear from survivors and their families in an open discussion of what has worked for them and what has been difficult in their efforts to regain function, purpose and quality in their lives.

Representatives of The Generations Project held sessions in Bloomington, Columbus, Evansville, Fort Wayne, Indianapolis, Kokomo, Lafayette, Muncie, Richmond, Sellersburg, South Bend, Terre Haute and Vincennes, d to listen to local citizens. In addition to their comments in the open-format meetings, attendees were asked to fill out questionnaires about their concerns. The questionnaires were also distributed to individuals who could not attend a listening session. Providers of brain injury services

No one spoke to them about how long the brain might take to heal, what potential difficulties might arise and what the final outcome might be. If they received information, most families received words of discouragement, not hope.

Family caregivers and advocates said it is vital that information about brain injury and available services be provided to them soon after the time of injury. Timely information would let them know that they are not alone, would begin their education about brain injury, what to expect, who to contact, and what may be needed to help themselves and their loved one. Learning about where to get services, filling out forms, researching rehabilitation programs, applying for services and connecting with medical insurance all need to be addressed while families are still reacting to the shock and grief they are dealing with after a loved one's brain injury.

Listening session discussions often centered on the reality that Indiana has no standard pathway to access brain injury services, no structured network of services, nor a "team approach" to brain injury management. Participants said family members are the primary resource for locating brain injury services. As such, family members expressed intense frustration in finding appropriate providers. Caregivers reported their main avenues for finding services were through word of mouth, internet research, phone calls, books, physicians, nurses, and therapists.

> ***"How do we get services that will take my family member to the next plateau?"***
> ***...a worried mom in Lafayette***

Participants stated that Indiana nursing homes are not appropriate placements for people with brain injuries. Nursing home staff members don't have appropriate brain injury rehabilitation or caregiving skills. Consequently, survivors experience little or no improvement and that results in transfers to lower custodial levels of care that provide little chance for improvement. Home and community care options are not available without long wait times to be approved for services. If a care plan exits at any level, it is not comprehensive, and does not include rehabilitation, community connections, housing options, transportation, education goals and returning to work. Families indicated that having a brain injury specialist/care manager to work with them throughout the recovery process would be extremely helpful. In Bloomington , Indianapolis, Fort Wayne, and South Bend participants reported they found the beginnings of local service networks, but getting referrals to appropriate services could still be difficult.

The listening tour moderators learned that many services are utilized by people with brain injury. These services include home care, Medicaid waiver services, transportation services (when available), physical, occupational, and speech therapies, nursing home care, group homes, adult day services and vocational rehabilitation services. People with TBI on the Developmental Disability (DD) waivers can receive enhanced services that include behavior and music therapy, and community habilitation.

Although there are some service successes, many Hoosiers with long term brain injury needs receive no services to help them improve or maintain physical and cognitive function. Under current practice, Medicare, Medicaid and private insurance providers limit the number of therapy visits available to the survivor. These limits are based on improvement expectations of people who have physical disabilities and not brain injuries. Often brain injury survivors will improve more slowly or will plateau in their recovery, and are then denied additional therapies that could lead to better recovery. In many parts of the state competently trained providers are not available.

Support Groups

> ***"Support groups are great, but I don't consider them a part of a network of services." ...a family member in Bloomington***

The listening sessions produced mixed comments regarding brain injury support groups. A little more than half of the participants who were aware of brain injury support groups in their area attended them. Some attendees saw brain injury support groups – where available – as a compassionate place to share problems and a great networking and educational resource. Some support groups offered social opportunities which were welcomed. Family members and survivors who attended support groups no longer felt alone in their struggle and felt other members understood what they were going through. The greatest barriers that prevented support group attendance included not knowing who to contact about the meetings, lack of transportation, distance to travel to the meeting, feeling they were too late in recovery to be helped, or a feeling of not fitting in. Participants thought support groups could better serve their community by concurrently raising public of awareness of their existence and of brain injury. Support groups could also offer a variety of activities that would accommodate both the wheelchair user and the ambulatory survivor. Support group activities that provide information, opportunities and programs for single people appropriate to their time in life would

> ***"We need a regular location and time for support group meetings with timely communication with people who inquire about this support service." ...a mom in South Bend***

be welcomed. Caregivers suggested that support groups could also be the local advocate for all people with brain injury. Through modeling and training, and by standing up for a brain injury survivor, a community-based support group could fill a much needed role. Many communities thought they would benefit from a Clubhouse[3] or community center for BI survivors.

Awareness, Professionals and Services Needed

Participants thought medical professionals lacked training in brain injury treatment and needed specialized brain injury certification. Doctors – neurosurgeons, neurologists, pediatricians and family practitioners – should have the skills to recognize and treat brain injury. Many families and survivors, especially those with mild brain injuries, felt misdiagnosed or pushed aside because their doctor did not have appropriate training. Appropriately trained care managers that remain with the survivor and family during all phases of recovery are needed. Therapists and direct care workers also need to understand the unique issues that may arise when working with someone with brain injury.

> ***" Doctors of all specialties should recognize and understand brain injury and be part of a network of professionals that provide services or can refer survivors to appropriate providers." ... a survivor from Kokomo***

Families and survivors stated they often had to travel to Indianapolis to find professionals who were trained and experienced in the treatment of brain injury. They repeatedly stressed that limits on the number of therapy sessions are a barrier for people with brain injury who improve slowly and often need ongoing therapy to maintain function, improve cognition, manage difficult behaviors, or deal with emotional issues.

Participants were also discouraged that the general public is unaware of issues that people with brain injury face or how they can help survivors and their families. Ignorance and prejudice often result in fear and stigmatization of brain injury survivors and hinder their recovery and their ability to return to full community participation.

People with mild to moderate brain injury reported there are few services to help them return to maximum functioning in the community. They are not considered "ill" enough to be covered by insurance, and professionals and family members don't "see" or understand their reduced capacity to function. Services are denied or delayed for years while the survivor searches for validation and support. With no help to retrain or relearn skills, no training in compensatory techniques, and no assistance in returning to work, these survivors feel useless and lost. They stated that help with finding suitable employment and employer education about brain injury is needed for them to secure and

remain in suitable jobs and keep them from dependence on entitlement programs. Transportation barriers are also a major issue.. It was often stated that many of these survivors are frustrated and have given up on their efforts to recover and to make more progress towards independence.

Many families of survivors who received out-of-state post acute rehabilitation reported that their loved one returned to Indiana with high hopes of moving forward only to realize there was no ongoing rehabilitation plan to help them maintain their new skills and functions. They return to an environment void of therapy, vocational, social and recreational opportunities. Their hope of "getting a life back," quickly turned into a life of inactivity, isolation, and depression. Family caregivers find themselves providing all the services required by their loved one including case management, housing, shopping, help with activities of daily living, medication management, money management, therapy, transportation, recreation and social activities. They also may pay out-of-pocket for rehabilitation, bail money, substance abuse treatment, and housing for their loved one. After out-of-state rehabilitation, families need follow-up services to connect their loved ones to new teams and a care manager who will work with them to focus on continued improvement, setting life goals and planning for the future.

Family caregivers want ongoing or intermittent services for brain injury survivors as needed throughout a survivor's lifetime to help them maintain the skills acquired during acute and post-acute rehabilitation.

Physical and Social Isolation

This issue was very emotional for some survivors to discuss. Many report they feel they have lost their friends because of the brain injury and how this has changed them. Friends don't know what to do or how to react to them after the injury and simply leave. Feelings of being different, rejected and isolated prohibit them from reconnecting to their community. Brain injury support groups address some of this void, but monthly meetings are not enough to satisfy the need to be connected. People want recreational and social opportunities with other survivors who understand what they have experienced as a first step in rebuilding confidence and connecting with the greater community. Participants thought Clubhouse programs[3], specialized community centers, and centers for independent living might help meet this need.

Return to School or Work

For the most part, people with brain injury state that they want to return to work. Many find out they are no longer able to return to their former career and must retrain or go back to school. Participants in the listening sessions were generally aware of vocational rehabilitation services in their area, but not aware that they could ask for a brain injury specialist. Many expressed the concern that people with brain injury struggle with issues that make it difficult to remain in a job or be a successful student.

Brain injury survivors and family members noted that returning to school is often difficult. Cognitive skills and processing speeds have changed. Physical stamina, function, and sensory perception have changed. Their ability to focus and concentrate is diminished. Family members suggested that more informal learning opportunities and on-the-job training could meet some educational needs. Others agreed that more educational options with special accommodations for students with brain injury would help a great deal. Professional educators who attended the sessions requested information on how to better assist survivors to be successful in post-secondary school.

Ivy Tech could provide educational opportunities to many people with brain injury. Professionals from the community college disability services offices gave attendees support and encouragement. The Indianapolis and South Bend campuses have been very successful in assisting brain injury survivors through these services.

Without a doubt, survivors of brain injury who are or want to be students must overcome many issues. One concern expressed in Kokomo was the requirement that a new, updated neuropsychological evaluation was required before a survivor could be accepted as a student. This is an expense few can afford. Other survivors found that they need help with tuition expenses, but qualify for assistance only if they are full-time students. However, carrying a full class schedule is impossible for many. Participants thought these issues could be solved with appropriate coordination and training of educators and opening up scholarship opportunities for part-time students with brain injuries. Formal vocational rehabilitation services might also be able to help with some of these issues. Classes that focused on improving cognitive skills would be a good prerequisite for entering mainstream course work. Campuses that are having success working with student survivors should be encouraged to share their expertise with other educational professionals.

Housing Options

> ***"How will I live independently after my mom is gone?"***
> ***...an Indianapolis survivor who lives with her aging parent***

Brain injury survivors who currently live independently worry about the future – keeping a home, paying bills, staying organized and focused. Most participants maintained that housing choices appropriate to the survivor's level of need and function are not available in Indiana. Most young adults said they live with their parents, but want and need to live as independently as possible. There is considerable need for residential options including rehabilitative community care, shared housing with services, and independent living in a safe and accessible environment. Few people with brain injury said they have the resources to pay for non-subsidized housing. Many families indicated that sharing rent with people with similar needs might be a good option for their family member. Group homes or (Medicaid) waiver houses designed for people with developmental disabilities or mental illness are not appropriate living situations for brain injury survivors. Parents and professionals know that with reduced cognition and processing speed, and obvious physical disabilities, persons with brain injury are prime targets of criminals and need a safe living environment. Family caregivers noted that balancing safety and independence for this adult population is essential, but very difficult. Baseline training to recognize and work with people with brain injury is largely missing among law enforcement officials. A professional attendee stated too many survivors who did not receive proper services and supports currently live in jails and mental health facilities.

Family caregivers and brain injury survivors agreed that they should never be placed in programs, housing or employment designed for people with mental illness or developmental disabilities. These programs are not appropriate for them. They do not take into account the survivor's potential and chances for improvement given the right supports. These programs may provide inappropriate therapy and interactive environments for persons with brain injuries.

Funding Issues

Family members and survivors are concerned that Indiana currently focuses on funding research on TBI to the exclusion of research on other acquired brain injuries and to the exclusion of funding services. The state recently adopted a more restrictive definition of traumatic brain injury that eliminates many acquired brain injury survivors from receiving services through the Traumatic Brain Injury (TBI) waiver. Family members were also disappointed to know that Indiana has a Traumatic Brain Injury/Spinal Cord

Injury (TBI/SCI) Research Fund which does not fund services. Of the twenty one other states that have brain injury trust funds, all focus on services for people with brain injury. Some of these states have a second trust fund for research projects. No other state has a trust fund for research and no fund for services. In fact, the lack of recognition and discussion between citizens and their policy makers regarding the scope and depth of funding needed to establish viable brain injury services remains a foreboding barrier to progress in Indiana.

Monthly spend down to receive Medicaid medical services is a concern for some who are living on their own and trying to make enough money to survive. Keeping track of medical expenses every month is difficult. Participants were in favor of an annual spend down assessment.

Funding brain injury services represents a major barrier to appropriate and sustainable brain injury services in Indiana. Fears regarding costs for medical care and ongoing therapies were consistently expressed by participants in the listening sessions. Poverty is a huge problem for persons with brain injury. Nonetheless, persons participating in the listening tour consistently identified common problems faced by most, if not all, persons with brain injury and their families. They also identified practical solutions. The ability to identify the most salient problems and their solutions strongly suggests we have the means to quantify and pay for them. An honest, open dialogue needs to begin between the consumers of brain injury services and public policy makers regarding practical funding solutions.

Conclusions

Brain injury survivors and their family members have identified many barriers to recovery and a return to a "new normal" with a good quality of life. These difficulties begin with the lack of early education for family members and the survivor of the brain injury. Consequently, accurate brain injury assessments, practical knowledge about probable consequences, and realistic strategies for recovery and growth are needed by all parties. We know barriers to services and supports will continue throughout the recovery and lifetime of the survivor. That is why the practical solutions identified by the participants in the listening tour are so important. They represent the pathways to hope for persons with brain injury and their families. They are the building blocks that policy makers should use to construct workable and affordable solutions.

Families and survivors require timely and sufficient knowledge about potential care needs and early referral to services in order to begin the process of recovery. Often the

very professionals who should be helping are untrained or undertrained in the issues and nuances of brain injury detection and treatment. The lack of awareness and appropriate knowledge by professionals, policy makers, and the community-at-large have led to a fragmented and uncoordinated system of care. That fractured system is especially evident beyond the acute phases of recovery and rehabilitation. Within that so-called system, services are hard to find or simply unavailable.

Brain injury survivors and families have identified a pervasive need for the development of a continuum of lifelong services and supports. These services and supports must be provided in a ***timely*** manner and continued long enough to achieve maximum progress towards recovery. Caregivers frequently noted the need for ongoing or intermittent services throughout the lifetime of survivors to help them maintain the skills they acquired in acute and post-acute rehabilitation. These services serve as tune-ups or refresher courses to help survivors who have difficulty with physical disability, behavior control, short term memory and cognition. Participants in every community spoke about the need for reliable and suitable transportation systems that can provide safe access to the community at reasonable times of day and night. Survivors of brain injury want social and recreational opportunities that will allow them to make new friends and to connect and contribute to the community. Services that provide support to family caregivers are often as important as services provided to brain injury survivors.

Survivors often spoke of their need to be independent and to be able to live on their own. However, families, professionals and advocates agreed that there are few safe housing options which provide support and encourage independence and community connection. Housing options – especially housing with supports and services to live as independently as possible – are needed across the state. Advocates, families, professionals, and providers of all services, including housing agencies and transportation services, are the stakeholders that need to work together to solve this problem.

The *What's Working What's Not? Brain Injury Tour* offered people with brain injury and their families an opportunity to talk about what they need. Tour participants were thankful to have this opportunity and want to continue such discussions in the future. Everyone who cares about people who have survived brain injury and are concerned about their recovery can learn from these listening sessions. Together we can continue the process of learning and building a system of care, supports and services that will help survivors of brain injury attain their best lives possible.

References

1. Brain Injury Statistics from The Brain Injury Association of America, 2012 www.biausa.org/LiteratureRetrieve.aspx?ID=104992

2. *CDC Cancer rates by state:* http://www.cdc.gov/cancer/dcpc/data/state.htm

3. The following definition of a clubhouse appears on the International Brain Injury Clubhouse Alliance web site at http://www.braininjuryclubhouses.net/clubhouse.aspx

   "An ABI Clubhouse is a community center for people living with the effects of an acquired brain injury (ABI). The Clubhouse is based on a model that has been recognized for over 70 years. It offers a safe environment where people are treated with dignity and respect.

   A Clubhouse focuses on abilities rather than disabilities, and capitalizes on these abilities for the combined good of all Members. Members of the Clubhouse are recognized for their contribution, no matter how big or small that contribution is. There are no 'patients' in the Clubhouse. Members work together to support each other in the pursuit of personal goals. In the process, people develop the skills and self-esteem needed to regain control of meaningful and productive lives. The Clubhouse encourages community re-entry, the rebuilding of social relationships and the training of skills required to return to productive activity.

   The Clubhouse is divided into four main areas: Work Ordered Day, (which consists of Units such as Kitchen and Business), Employment, Education and Evening/Weekend activities. Members choose who they want to work with and how they want to utilize the Clubhouse. Staff is sufficient to engage the membership, yet few enough to make carrying out their responsibilities impossible without member involvement."

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The Indiana Family and Social Services Administration

Office of Medicaid Policy and Planning

Health Finance Commission

October 23, 2012

Exhibit 14
Health Finance Commission
Meeting #3, October 23, 2012

Aged Blind and Disabled/Duals Population

- Indiana Medicaid spends more than $4 billion (state and federal) to care for the ABD population.
- Many of these beneficiaries are dually eligible for Medicare and Medicaid, but are not receiving coordinated care, which leads to poor health outcomes.
- State is reviewing options for creating better care at reduced cost.
- Looking at other states for best practices in managing target population.

Aged, Blind and Disabled/Duals Population

- FSSA established a Duals Advisory Council with membership representing aging, DD and mental health provider associations, State Department of Health, AARP and advocate organizations.
- Stakeholder meetings held on Dec. 13, 2011; April 20, 2012; July 13, 2012
- All meeting agendas, minutes, notes can be found on the FSSA website at: http://www.in.gov/fssa/ompp/4347.htm

Aged Blind and Disabled Population

- The current timeline to find a solution that works for Indiana tax payers, consumers, and providers continues to be fluid as we seek input from all parties.

Other Related Initiatives

- Program of All Inclusive Care for the Elderly (PACE)
  - PACE provides on site comprehensive services including nursing supervision, ancillary services (lab, PT, OT) to dually eligible individuals.
- Balanced Incentive program to reduce institutionalization
  - Federal approval received September 4, 2012
- Health Homes for certain populations are under consideration and policy development

Questions?