

**Traumatic Brain Injury/Brain Injury Association of America**  
**Effective Partnerships – State TBI Programs and State MCH Programs**

July 21, 2005

JANE MARTIN HEPPEL: Good afternoon. Welcome to our webcast on the Title V program and the Traumatic Brain Injury Program and collaboration. Our purpose today is to introduce state Title V directors to the Traumatic Brain Injury Program and also to introduce Traumatic Brain Injury Program directors to their state Title V programs. Of course, we realize that many of you already know each other and some of you are already working together. And it's good that we have several Traumatic Brain Injury Program directors here with us today who found worthwhile collaborations with Title V. And by being a part of Title V. On our panel we have Cassie Lauver who is from MCHC, from the division Division of State and Community Health. Cassie will be talking about the Title V program. We also have Geoffrey Lauer from the Brain Injury Association of America, where he is head of Affiliate Relations. And we have from the state Toni Wall, director of children's with special health needs program. We have Augusta Cash from the Alabama department of rehabilitation services, where the TWR program is. We also have Tom brown. And also secretary of the board of directors of the national association of state head injury administrators. So we have a few housekeeping details to go over before we begin.

The slides will appear in the central window today. And they should advance automatically. The slide changes are synchronized with the speaker's presentations. You

don't need to do anything to advance the slides. We encourage you to ask questions at any time during the presentation. Simply type in your question in the white message window or on the right of the interface. Select Question for Speaker from the drop down menu and hit send. Please include your state or organization in your message, so that we know where you are calling from. The questions will be relayed to the speakers periodically throughout this broadcast. If we don't have the opportunity to respond to your questions during the broadcast, we will email you following the broadcast with the answer. Again, you can submit questions any time during the broadcast. On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider, which you can access by clicking on the loudspeaker icon.

Those of you who selected accessibility speakers when you registered will see closed captioning underneath the video window. At the end of the broadcast, the interface will close automatically and you will have the opportunity to fill out an online evaluation. Please take a couple of minutes to fill out this evaluation. Your responses will help us to plan future broadcasts in this series, and also provide technical support. We're very pleased with the panel that we have today. There's so much expertise in this room. And so let's get started by hearing first from Geoffrey Lauer.

GEOFFREY LAUER: Thank you. Thank you all the participants and welcome to you. We are here live today. But also a special welcome to who are watching this webcast in the archive version at some point. Good afternoon. For those of you who are live on the east coast, good morning. And for those who of you who are from Hawaii. We're going to run

through the goals today. Our goals today are to provide the TBI Program staff to provide the -- doing that this morning, I'll be presenting some information about the federal TBI Program and Cassie Lauver will be presenting a review of the MCH program. Then we'll be moving into a moderated discussion with Toni Wall, Augusta Cash, and Tom Brown, from Maine, Alabama. About how the programs have been working and discussing the challenges and opportunities they've had. Let's start with some of the slides. Federal TBI Program overview should be a slide now in front of you.

Next slide please. We're going to talk a little bit just for a second about the incidence of TBI in United States. And again for you who are head injury or brain injury administrators, I indulge for a second. This slide is from the Centers for Disease Control. It's reminding there are 1.4 million traumatic brain injuries that occur in the U.S. each year. There are over 1 million emergency room departments and really an unknown and huger number receiving other medical care or no care.

If we move to the scope of the issue – next slide please. The CDC has indicated at least 5.3 million individuals live with a long-term disability as a result of traumatic brain injury. These folks and their families are faced with a range of challenges, starting with improper diagnosis. Many children and adults with brain injury are misdiagnosed into a number of other systems, while the systems are really optimized for other diagnoses, they don't serve well people with brain injury. The inability to access services. We have services, unemployment, the list goes on. One of the biggest troubles for people with brain injuries is trying to navigate what is a complicated, cumbersome and ever changing support

system. That's where I think we have to thank HRSA and the federal TBI Program for providing services and funding to try to optimize the delivery system. That's part of what the next slide will show. We as advocates with the brain injury association in partnership with our stakeholders in 1966 were successful, and for the first time, in garnering federal attention to the brain injury issue.

In 1996, Congress authorized the federal TBI Program in what we call the TBI Act, which is public law 104-166. It was a landmark day for the brain injury community. We've been working in this business for over 25 years. Some have for over 25 years, this was a watershed event. The TBI Act launched an effort to conduct expanded studies and programs for TBI. You will hear about those today and we'll give you information about how to find what those opportunities are in your state. In addition, this law -- the health resources administration the authority to establish a grant program for the state in order that they can address the needs of TBI individuals and their families. There has been progress in the last nine plus years in this area. You have to delegate additional responsibilities for research prevention and surveillance.

Fast forwarding to the year 2000. The TBI Act of '96 was a five-year authorization. It was reauthorized in 2000. At that time was attached to the children's health act. It was reauthorized. We had success. It ran for another five years. That reauthorization also added and recognized the importance of protection and advocacy services in the system at the state level for individuals with traumatic brain injuries and their families. If it was allowed to make grants to the state system. At the federal level, although there is about to

be a name change, we call it the national association for protection and advocacy project.  
Help me out.

JANE MARTIN HEPPEL: NIDR. They're holding it up to me.

GEOFFREY LAUER: In any event, it's a new name. You will find the link on the web. In any event, on the protection and advocacy systems in your state, if you're not familiar with them, are charged with addressing the rights of people with disabilities. Across the spectrum, not just including brain injury, but now as of 2000 including brain injury. So today, Maternal and Child Health Bureau administers the federal TBI Program. In 2005, funding for the program was in excess of \$9 million. And advocates are currently, as we speak, even today working to reauthorize the TBI Act again. And we're cautiously optimistic that we'll be reauthorizing the TBI Act in 2006 for another five-year run. A special thanks to those of you who have been aware of these efforts and have landed your support for these efforts knowing that policy really does support people with brain injury and their families. The TBI Program vision, the federal TBI Program vision is that all individuals with trauma brain injury and their families will have the four A's. And those, thank you John, those four A's, are they will have accessible, available, acceptable, and appropriate services and support. And now sometimes some of us add another A there.

I'll throw that on your screen. That's also affordable. Affordability is one of those key struggles in health care. In any event, accessible, available, acceptable and appropriate. What does the federal program do? Again, those who are TBI Program administrators,

bear with us because we have in the audience a range of the MCH staff administrators as well. Since 1977, the federal TBI Program and HRSA have provided grants to 51 states, territories and the district of Columbia. The program has been framed out into three types of grants to state agencies. Planning grants, implementation grants and post demonstration grants. I'm going to run through those relative quickly. And again, these slides will be archived in about a week so you can return to them if you would like. The planning grants are available for up to two years and have allowed states to build infrastructure through the programs four core components. And these components are maintained throughout the other two grant frameworks that I'm going to talk about, implementation and post-demonstration grants.

In fact, the goal is to leave these four core components in place after the grants are gone. This is a systems change effort. These components are number one, establishing a TBI statewide advisory board. Now have of you have had statewide advisory boards before these grants came along. Many states have not. This grant process is establishing in many cases. Number two, identifying a lead agency. In some states, the lead agency is the department of rehabilitation services. In some states, the Department of Public Health, in some states, the department of public education. It can be any lead agency that has an interest. Number three, conducts a need assessment. Developing innovative services, we have found and HRSA has found that we need to ask the state to find out where we get the best bang for your buck. Number four, taking that information and putting it into an active living document, which we call the TBI state action plan. HRSA required the states in order to maintain funding to really have that action plan not just be a

book on a shelf, but to be a living, breathing document, and to be a reference point for evaluation.

The second kind of grant which typically comes after a planning grant, but not necessarily, is implementation grants. Implementation grants are for up to three years, have been up to \$200,000 per year, depending on funding availability and have been for the purposes of improving assets to services for individuals with TBI and their families. One of the things that the MCH staff that's out there, what do these grants do? You will hear many things in many states. There is no one size fits all. There is a whole range of implementation grants that are done from Arizona, to Maine, to Alaska to Florida. They focus on the needs of those states. The third type of grant, in order to maintain some continuity in court, have been post-demonstration grants. These grants were authorized by that children's health reauthorization in the year 2000. They're up to one year in length. They're up to \$100,000 and they're to be completed every three years with an implementation grant program.

This next slide is a little complex. It's a big map. Kind of a colored map for you. And you can find a copy again on the archive. This is just to show you where your state might fit. The states that have crosshatching, I'll point out first and foremost, are those states that are currently unfunded. The states that have crosshatching of some kind are currently unfunded. However, they have had in the past a grant of some kind. So you'll find hopefully a lead person at one of the state agencies. There are a handful of states that have never been funded. Five I believe at this point. But most of the states are in some

framework of either having a planning, an implementation or a post demonstration grant. We'll move to that next slide, please. I had mentioned before that the reauthorization of the TBI Act gave grants to the protection and advocacy system.

This talks briefly about that. The protection advocacy grant program is a formula-based program. It allows the 57 states, territories, and a Native American project to assist their advocacy system's responsive to TBI issues and primarily allows the focus of advocacy support to individuals with TBI and their families. For those who are not familiar with them, they're legal eagles if you will at the state level. They are full of lawyers and they are focused on legal advocacy for individuals. Our brain injury association state affiliates, if I may wave my flag here a second, are here to provide information and resources to people in many states. Not all your states. And so we've been working between the three organizations, the first fund grant -- the TBI Program grants have been. They have funded really an enormous amount. In some states they are currently only PNA grants funded. Those are the blue states on your screen. The states that are in orange, they have state and TBI grants from HRSA and state PNA grants from HRSA as well.

One more that's also funded is the Native American protection and advocacy project. So there is a terrific resource for those of you in the MCH community. That is the traumatic brain injury Technical Assistance Center. The path is located at the national association of state injury. It's been established to help [INAUDIBLE] Of the planning and development of programs that improve access to health and other services for people with brain injuries and their family. The traumatic brain injury Technical Assistance Center.

The staff are specialists to provide states with individualized technical assistance. And also, the technical assistance is developed and disseminates a variety of specialized documents and products and initiatives for the federal TBI Program. It's a rich resource.

This next slide is a screen shot of a website which I'm going to give you the address for here in a moment, are so you might want to prepare to write that down. This is TBI TAC. If you go to this website, remember NASHIA, there will be a link to the TBI federal program. If you get to this screen in the bottom left, you will find who to contact for more information. If you are a TBI person, here is how you can find your contact. The website for that screen is as you see on your screen, <http://www.tbifac.nashia.org/tbi cs/>. Just remember NASHIA.org and you can drop into this to that link. That's the best place to identify the contacts for your State TBI efforts. If you have specific questions about what I just presented and you're live with us today, you can type them in on your screen and we'll try to answer them. Otherwise, I'm going to turn the podium over to Cassie. She's going to talk about the MCH program.

CASSIE LAUVER: Thank you, Geoffrey.

GEOFFREY LAUER: You're welcome.

CASSIE LAUVER: It is my pleasure to be invited here today, to be able to share a little bit about the Title V program. And I know that in some states and in many states these programs work together. And if you don't, this is an opportunity to mutually learn about

each other's programs. And that's something that we're definitely wanting to enhance in support. Thank you for inviting me to be part of this. I know we have both individuals from the TBI programs, as well as state directors on the programs. So for the state directors, I won't tell you to turn off right now, but I know that you've heard some of this information over the years quite a few times and could probably be sitting here at the table right now providing some of this information. But I want to go back and provide some of the information about the mission of the overall Maternal and Child Health Bureau and just a point that the Maternal and Child Health Bureau actually, the Bureau itself administers more than just the Maternal and Child Health grant. I'll list later on in my presentation some of the other programs that the Bureau is involved with and does administer. But the Maternal and Child Health block grant is the biggest piece in terms of dollars that the Bureau does administer.

And on slide 3, I start talking about the Maternal and Child Health Bureau mission. This is the mission of the whole Bureau. In the first bullet, just to read through this is to provide national leadership and to work in partnership with states, communities, and public, private partners and families to strengthen Maternal and Child Health infrastructure and assure the availability and use of medical help, to build the knowledge of Human Resources and in order to assure continued improvement in the health, safety and well-being of maternal health population. There are a couple of key words that are born to the bureau. One is national leadership. The Maternal and Child Health perceives itself as a national leader for the populations that we serve. Another key word is partnership. We work in partnership with the state, with communities, with family organizations. And we're

really very proud of the work that is done over the last number of years, in working with family organizations and other organizations that represent the individuals in the populations that we serve.

And thirdly on the bullet is the word infrastructure. And that is really a key to what Maternal and Child Health does in the state. Where unlike, Medicaid, where you're paying for direct services, Maternal and Child Health has a very strong focus on the development of infrastructure that involves all of our partners and families into what we're doing. On the next slide, and still part of the Maternal and Child Health mission, we talk about that Maternal and Child Health population includes all America's women, infants, are children, adolescents, their families. I mean, there really isn't anyone in that definition that is not covered. But the key to this is that we serve all women. We have a responsibility for all women, all infants, are all children and adolescents. And that's very important, because most federal programs have a specific focus. Either diagnostic-based or oftentimes relative to financial eligibility criteria. And even though Maternal and Child Health does prioritize those that are most disadvantaged in our Nation, our law and our legislation certainly does speak to all women and children and families. So we do have a responsibility for a very broad population. I want to talk, and this is a little history 101.

And so skipping over the slide 5 to slide 6, I just wanted to share, are because I think it's very rich. Maternal and Child Health has a very rich history in the United States. And it is a significantly [INAUDIBLE] , if you look at the last bullet on that page, 1935, Maternal and Child Health came in with the Social Security Act. To go back, Maternal and Child Health

was a critical issue before the turn of the century where there was significantly high infant deaths, children dying, children working, children and women working in sweatshops [INAUDIBLE] . So in 1912, there was the creation of the children's bureau and this is the predecessor to the Title V Maternal and Child Health Program. And the creation of that children's bureau was to investigate and report on the status of children and on their common, as well as special needs. And that was followed in 1921 by the Sheppard-Towner Act. Both of these are very significant legislation and part of our history in the United States. The Sheppard-Towner Act was the First Federal grant and aid program in the United States for those as it related to infancy. As I said, this was a huge focus during the turn of the century. It had a strong social welfare point of view.

In 1935 the Social Security Act. [INAUDIBLE SPEAKER] Title V is a small number. You know it is an older program. And in fact came in 1935. You want to go to the next slide. These are several more pivotal points in our history. One bullet that is not on there is Medicaid title XIX. Those programs, Medicaid, Medicare, supplemental security income, SSI, came in the 1960's. Also critical to our program in the early 1960's, 1963 to 1965, you saw the maternal infant and children. That's when family planning came in. Grants relative to [INAUDIBLE SPEAKER] In 1969, the administration of Maternal and Child Health [INAUDIBLE SPEAKER] . So the 1960's were an active time in our history.

On the next slide, you see in 1981, that was another critical year for Maternal and Child Health. That was the year, the very beginning of the Reagan administration where block grants became very popular, very big. And Maternal and Child Health was one of the first

programs that actually was formulated into a block grant. And at the time, it took seven programs and rolled them into one. And which is now what you know the Maternal and Child Health block grant program. Before it was a grant in aid program to the state. In 1981, it became the block grant program. Basically, the biggest piece of the Maternal and Child Health block grant goes out to states [INAUDIBLE SPEAKER] On a formula grant, are where 85% of those dollars go to your state based on the number of children in poverty in your state, compared to the total number of children in poverty in the United States. In addition to that, 15% of the overall Maternal and Child Health block grants [INAUDIBLE SPEAKER] Discretionary grants that we spoke to and what's referred to in the legislation as [INAUDIBLE SPEAKER] Grants. They are grants that are competitive. There are many of these grants that the bureau administers in a whole variety of areas. And then finally, there's another piece, and it's not on this slide. We'll talk about it later. But we have a community integrated system services grant.

CISS. This is also in the legislation. That the overall appropriations of the Maternal and Child Health block grant is over \$600 million, 12 plus percent of that comes off the top for this grant and then the remainder of the money is broken out, 85% to the formula grants to state and 15% for the discretionary grants. We don't take care of calculating those funds, but we work with our grantees with those dollars [INAUDIBLE SPEAKER] On the next slide, I don't want to single out a time relative to these other programs, but you can see how much Maternal and Child Health has developed over the years. In 1984, there was legislation enacted relative to emergency medical services for children. Actually, we saw this as very important legislation. We know that EMS is important, that we have rapid

responders relative to emergency. And there was a real lack at this time or an understanding of the lack of being prepared for children who can't really, when an ambulance shows up and you have equipment that is sized and designed for adults, it doesn't work well for children.

In 1989, OBRA and that is for omnibus reconciliation act. It is a budgetary action by Congress. They introduced a number of changes again to the block grant. And these are also part of the system that you see of Title V, children with special needs program have a significant roll and obligation in. One is [INAUDIBLE SPEAKER] As part of the legislation, states are required to provide assessment every five years, statewide for Maternal and Child Health, and that's [INAUDIBLE SPEAKER] -- it is broader than the children and families program serves. It's a major undertaking. Those block grants are due every year on July 16th. The application and annual report, I see people smiling around the table. I'm sure she's been involved most recently. They were due last Friday. Part of that application process this year is the five-year assessment. We're very excited to see [INAUDIBLE SPEAKER] -- and part of that process, states are looking broadly across the state about what their resources are. They're required in this to prioritize.

Part of the needs assessment process is not only gathering data and analyzing it, it is bringing together the key stakeholders in this state that have a stake in what this program does. Maybe not fund directly, but certainly what would fall under the rubric of the program. I mentioned this and it is very critical for the TBI community to be aware of and be a part of, because you can be a part of shaping what goes on in your state

[INAUDIBLE] -- and make sure that the priorities of your organization are heard by those people who are developing the needs assessment in the state. Also part of that 1989 OBRA legislation, there was a strong focus on having objectives. Budget accountability and also other budgetary acts, such as the state's responsibility to document their -- [INAUDIBLE] . The state programs are required to match every \$4 in this program, they have to match \$3. The state's efforts cannot fall below a certain point, so that has become a certain of the state over the last few years, when there have been cutbacks in the federal government. Law holds them that they cannot fall below a certain point where state financing issues are.

Going on to the next slide, a couple of other important developments over the years. In 1996, are we saw the first abstinence education program. And that's the first bullet. The last bullet on that same slide, in 2004 and 2005, we saw the transfer of those programs out of the Bureau and to the administration for children and families. So we saw the advent of this program and now they move to another administrative entity within the department of health and human services. But again, let me point you to the middle bullet on this page. During 2000 and 2001, we had done a lot of work relative to developing performance majors as they relate to our population. There was a children with special needs survey that has been out in the field that we actually have -- [INAUDIBLE] -- states that have data available. We have technical assistance, resources for the state to be able to use that as a tool in looking at what your state has and what they're doing relative to that population. More recently, are we had a child health survey. I don't believe the data is available yet in the field, but we expect that to be shortly. And on that, you'll see a

website. [WWW.performance.HRSA.GOV](http://WWW.performance.HRSA.GOV). This is an important website. All the state applications and needs assessment are on this website.

You can go into your state or other states and the region or across the United States and look at performance. You can look at the narratives. If you want to use a key word search, you can come up with traumatic brain or TBI or any of the words required to actually look at their narrative and see what they might be doing in the state relative to these issues. If that's too hard to remember, if you go the Maternal and Child Health Bureau website, which is [mchcom.com](http://mchcom.com), you can click on data and it will bring up the Title V information system which is what we call this web-based data resource. It will get you to the same place as the website. Also, as part of the -- that's the complete email address, there is also if you go to the state directors, there is a list of state directors there. You can pull up an individual state and you will have the name and the contact information of all of the state Maternal and Child Health and children with special needs directors in the United States. And I will say we have 59 grants, 59 programs, all 50 states, Washington, D.C., and seven jurisdictions that we serve under this program. Going on to the next slide will give you an idea of not only the Maternal and Child Health health block grant, but also other programs that we administer in the program using traumatic brain injury with the Public Health Service act.

Healthy Start, newborn hearing screening, emergency medical services, all part of the covered health services act. Going on to the next slide and going by it quickly, because actually these are programs that we had at one point that are actually being administered

elsewhere. So I don't really want to spend a lot of time on that. I just want to spend a few minutes on our budget. If you could go to slide 13. You can get a little sense by looking at this what the budget is for the Bureau. With the top line being, and this is 2004-2005, overall and I'll look at 2005, \$724 million that the Bureau administers for the Maternal and Child Health block grant. Of that, approximately \$591 million goes to the state in the form of formula. That's what I mentioned earlier. That's based on the number of children in poverty in the state compared to the total number of children in poverty in the United States. We do recalculate that from time to time. And in fact, two years ago we recalculated it based on that 2000 census. In fact, we saw some significant -- [INAUDIBLE SPEAKER] -- ended up using block grant dollars. And those states, when you look at it visually on a map, around the perimeter of the country gained quite a bit, California, Texas, Florida. These states saw a significant increase of children in poverty.

The next column or the next line are the -- that's the amount of dollars that represents -- minus the grant that go out. And a whole variety of discretionary grants. You see the amounts of the CISS grant, which is approximately 12 plus percent of the overall block grant. And the last line or grant earmarked. And earmarked are specifically mentioned in legislation by Congress of different programs. And you will see the asterisks below in those years that are being funded out of the administration. Going on to the next slide, I think Geoffrey mentioned that TBI was a little above 9 million. There you can see on the fourth line down, FY-2004, traumatic brain injury 9.4 million. Slightly down, 2005. Some of the other programs that we administer in the bureau, what their funding amount is. So at any rate. Finally, I just want to go to the organization and I was actually surprised.

If we can go to slide 16. To look -- I know that there's been an effort to flatten organizations in the federal government. This is a flat organizational chart. It's a new one that I haven't seen. Just to look at it, the office of the associate administrator and I know that you all know -- [INAUDIBLE] -- from the Maternal and Child Health Bureau. The [INAUDIBLE SPEAKER] is part of the bureau, although they have a broader responsibility than the bureau. Going across the bottom, the middle size, -- [INAUDIBLE] Who represents that are in the room today. Division of child adolescent and family health. Division of research and training. Healthy Start and prenatal services and the division of community health, those are the five main divisions of the Bureau. And the Bureau that I direct is -- [INAUDIBLE SPEAKER] It's our job and our responsibility, and this is an excellent opportunity to be able to work across these areas and share our information and hope that we can promote collaboration and coordination of our services and get synergy going. I think I'll stop with that. Thank you, Geoffrey.

GEOFFREY LAUER: You're welcome. All right. We have some questions coming in, but I do want to encourage you to submit questions for either Cassie, myself, or any of the rest of the speakers as we go. I'll try to catch as many as we can at the end of this. At this point, I'm going to open it up to a few questions which I prepared. I'll moderate it as we go. I'm going to start with Jeanne, if I might, just to pick things up a little bit. In terms of the TBI Program and for our audience who are Maternal and Child Health staff, are the TBI programs different across the state and how are they different and how do people find out what's going on?

JANE MARTIN HEPPEL: Well, it's almost easier to say the ways in which they are alike. There are a few of those, I think we mentioned earlier, that in all the states, TBI must be located within a lead state agency. They must have a comprehensive plan for traumatic brain injury services. And that is developed out of the needs assessment that they have done. And the other thing that they all must have is a state advisory board that is representative of individuals with TBI and their families, as well as the range of services that we know are required by the condition. That the social services, legal services, rehabilitation services, education, a very long list. And so they all must have that. But then as I think we noted earlier, the programs can be located in a variety of state agencies, rehabilitation, education, health and human services to name a few. So that being different, and I think that the programs are as different as the states are in terms of what the states come in to the program with in terms of resources and what their needs are, what their population is because we know that certain groups have a higher incidence of traumatic brain injury.

We also know that the states, when they receive their grant from HRSA, were in different stages of development. So we've developed a set of benchmarks that can help states determine whether they're in the very beginning of their process, if they've reached the intermediate stage, or if they are what we call comprehensive services. So they're very different. And I suspect that they will continue to be very different as they try to relate to specific needs.

GEOFFREY LAUER: Cassie, kind of the same question to you, if you will. The MCH program, I for one was under the impression for many years that the state that I lived was the model for MCH programs. Can you tell me how the MCH programs differ across the states?

CASSIE LAUVER: Well, just as Jane talked about the similarities between the TBI, I think I can say about the state Maternal and Child Health with special needs programs, you see one program, you see one program. These are all very different across the United States. I was talking with a guest before we started, and she said she worked in the program in Alabama and she assumes that the programs are all alike. When you think about the Maternal and Child Health block grant program, this is a big state Title V program. This is a block grant. States have wide latitude in the delivering or developing their programs or designing of programs. As I said earlier, they all conduct a needs assessment and they establish their priorities. They also establish a performance major that address those priorities -- [INAUDIBLE] We require in the block grant don't address those priorities. And as you can imagine, going around the country, priorities of states of very individualized and they're very different. And so that's one difference that the states are allowed to establish their own priorities and their plans to serve them under the block grant application should be directed to their own priorities. So that is one difference.

And the other is, there is a lot of state legislation that affects this program. Particularly, in the area of children with special needs. Most of those programs, in many states, those programs are even older than Title V, or 1935. These programs go back to the teens

and 20's in the states and have a long history and long state legislature history of setting out -- [INAUDIBLE] Programs that are diagnostic phase, financial eligibility criteria, some states have moved away from that, looking at assurity services. They don't provide services at all any more, either authorized services, since they -- [INAUDIBLE] To functional eligibility. So you see great variation in these programs. So that's why it's important for you all to get together, meet each other, and understand how both of these programs work. And particularly, I guess since there's more differences in the block grant program, to find out how they work or what kind of role that you all can play in working together in this.

GEOFFREY LAUER: Thank you. I'm going to start with our southern belle, if I can. Augusta, you talk about the primarily focus and the accomplishment of the TBI Program in your state and the specific focus on how it's -- [INAUDIBLE]

AUGUSTA CASH: Okay. First of all, Alabama was in somewhat of a unique condition. I think about 11 other states, when the HRSA grant became available, we already a task force in place. We had services for adults with traumatic brain injury. We had -- [INAUDIBLE] -- and had resource coordination available through the -- [INAUDIBLE] So when this grant opportunity came available, we, and I say we, I mean the task force -- [INAUDIBLE SPEAKER] And the task force was to look at this grant as an opportunity to expand services to other specialized populations within the traumatic brain injury population. And our first grant focused on children with traumatic brain injury. And the second grant focused on children with -- [INAUDIBLE] , and then the most recent grant

focused on domestic violence and traumatic brain injury. So we were looking to expand services to special populations within the traumatic brain injury population.

Moderator: Thank you. Toni from Maine, could you talk a little bit about the primary focus and accomplishments of your TBI Program?

TONI WALL: Sure, we're finishing up one of our planning grants that was started in 2002. We have now established a very solid brain injury council, which is working strongly to capture the -- [INAUDIBLE] -- and finish up the state planning grant that we're working on right now. One of the major accomplishments that I feel was the establishment of a lead state agency within our health and human services -- [INAUDIBLE] Brain injury program. We look forward to working with the new deputy commissioner on that and having a role in forming the lead state agency. And we actually just got our implementation grant. It started in April and we're looking forward to doing some of those things.

GEOFFREY LAUER: Thank you. Tom, Tom Brown from Iowa.

TOM BROWN: Like Augusta's experience, Iowa had a very established system in place with our advisory council on brain injuries which had been established in 1989. Our brain injury association of Iowa, which was the second charter chapter of the Brain Injury Association of America, which had been established back in I believe 1980. We had established our Medicaid waiver for persons with brain injury in the state in 1996. So this granting opportunity allowed Iowa to really step forward relatively quickly. We completed

our planning grant, identified that the majority of persons that we surveyed, that being family members, persons with brain injuries and service providers, really had a lack of access to information about brain injury and about available services and supports. And also training, training are for how to work with people with brain injuries and their family members. So Iowa established what was then called a pre discharge planning model where we distributed resources out of five trauma centers and one rehab center. We did that. During our implementation phase, established the program. That program has grown from the five pilot sites. We just added I believe six sites. The brain injury manager and the brain injury director added six sites this last week. I think we're around 75 sites across the state now. And we've distributed, it's hard to keep track sometimes, I think somewhere around 4,000 tote bags since the program started, which really got off the ground and going in the year 2000.

GEOFFREY LAUER: [INAUDIBLE] First of all, we would like to thank the MCH staff who are listening. There is a wide variety of initiatives that the brain injury community has supported. It behooves you to go to the website and find the contact that you have locally and if you haven't already done that and find out what is going on. Tom, in Iowa what has been the program effort and relationship between the TBI grant programs and the MCH program?

TOM BROWN: I started with the program in January of 2001. So the program had been established by the efforts of the University of Iowa and the brain injury association of Iowa, who are two primary contractors under the initial grant. When I came on, I worked with

the council and the leadership of the council. And what we looked at, we were just ready to kick off a state planning process, actually. We were ready for doing our second state plan, because we had done the first one back in '96, '97. And what we did was we already had representation from the Department of Public Health on the advisory council in an ex officio capacity, but we added ad hoc membership to the council, that both from the family services bureau, which is the Maternal and Child Health Program in Iowa and for the child health specialty clinics, which is the Title V program for children with special health care needs, added them both to the TBI council, as well as membership on our state planning task force. So really the first step in collaboration was bringing the MCH programs to the table of brain injury.

GEOFFREY LAUER: We have a question that ties into this. It's for Cassie. It's a question from someone from Idaho. He says he understands the developmental disabilities assistance and bill of rights act that funds -- now requires that the council has a representative from MCH. Should the TBI statewide advisory committee go out of their way to bring an MCH representative on to those? Does that make sense to you?

CASSIE LAUVER: Actually, I think it would be a wonderful idea. I'm not familiar with what the TBI legislation is requiring now, although I can say that before I came to the federal level, I was in a state for over 20 years running a state program. I know that we had -- on the council. But it would just seem to be logical to think about the involvement of having a representative from Title V, particularly since we're both being administered federally from

the state program. And even if not, their services would need that. So I would recommend it. There is no requirement for it, but it seems like a positive act.

GEOFFREY LAUER: Toni, I know you and I have talked about this. But the relationship in Maine between the brain injury program and the MCH program.

TONI WALL: Well, actually the TBI Program -- [INAUDIBLE] Program in Maine. So the relationship isn't through me. So it's actually the same thing. But I just want to go in -- I know we're short for time. But some of the benefits of having it in the MCH or having a connection with MCH is something that Cassie said about the leadership, our mission and our leadership. I think that we incorporated TBI in the five-year needs assessment this year. All the work that was done on the needs assessment in the block grant this year. It's a wealth of knowledge to use those tools, to spread the information and need around traumatic brain injury. And, you know, for me, it broadens my horizon, because typically -- [INAUDIBLE] Only serves populations of 21. As we know traumatic brain injury, is across the life span. I've had to learn new words, although what Geoffrey said in the beginning around accessible, affordable, those are some of the words that we use at MCH typically, successful, comprehensive, coordinated. I know folks at TBI -- it's a different concept or different words. But for me it's broadened my horizons and broadened the players I work with. I've enjoyed my collaboration with TBI in my state and nationally.

GEOFFREY LAUER: Thank you. Augusta, the relationship in Alabama sounds like it's somewhat similar?

AUGUSTA CASH: That's correct. Actually, our children's limitation service which is a Title V program is about -- [INAUDIBLE] Needs within the Alabama department of rehabilitation services. [INAUDIBLE SPEAKER] DRS has been on the task force since the task force was created and their division was in our department. As I had mentioned to Geoffrey a little bit earlier, we across the state, many of our offices are located in the same building with our DRS offices. So our staff know each other and we lunch together and have coffee together. This was really a very natural and for the most part easy relationship. And it certainly may develop into programs for children, are which in Alabama we call Passages, I have a copy of that right here. It is available for anybody that would like to have a copy. It made it easier, because we are in the same department and we have relationships with each other that we didn't have to establish. And that's so important, I think, when you are working on a project like this.

GEOFFREY LAUER: Augusta, t -- if you could wave the magic wand, what things would you do to change or increase TBI and MCH collaboration?

AUGUSTA CASH: Again, Geoffrey, we started this project, we already had collaborative relationships with our children's program. In terms of traumatic brain injury. This is not going to be a big deal. I wish our staff that works with adults of TBI -- [INAUDIBLE] Had more time to meet together and continue to have joint training and collaboration together. But everybody is so busy with their case loads and work, work, work. That's not a real big deal, but it's an important deal, I think, because we do work so closely together --

[INAUDIBLE SPEAKER] Children in youth get transition today rehab -- [INAUDIBLE] We work together. So those relationships are very important. We do have our annual meeting and bring all of the staff together with other players who work with traumatic brain injury in the state. So we think that's really important.

GEOFFREY LAUER: Thank you. Tom in Iowa, unlike Maine or Alabama, the MCH program wasn't woven into the TBI Program. Do you recall any opportunities or obstacles during that process? What was the breakthrough in terms of linking them together?

TOM BROWN: Yeah. What is now called the Iowa brain injury resource network, our 75 locations that distribute our information and resources. The child health specialty clinics. Again, the special needs program, we went out and did face-to-face orientations and brought them into the brain injury resource network as distribution centers, as linkage centers, and as referral centers to get families to both the brain injury association of Iowa and the Department of Public Health lead agency. So I think the regional structure in Iowa, that we had the regional clinic set up, that set the groundwork for doing the outreach. I would say that the fiscal cuts over the recent years have cut back the regional clinics in Iowa somewhat, so that is slightly limited just because of reduction in programs and staff. We've had to go out and do additional trainings in certain locations and there's new people. That always causes a little confusion.

GEOFFREY LAUER: Cassie or Toni, in terms of -- [INAUDIBLE] -- what do you see or do you see any specific obstacles to working with the traumatic brain injury community? Are

there differences in the models that people are dealing with? Either of you can jump in on that one.

CASSIE LAUVER: Toni, I would defer to you because you are probably closer to the field and knowing what those might be. I don't think there are particularly inherently any obstacles between the two programs working together. But again, you probably have a better reality than I might.

TONI WALL: I think for us in Maine it comes down to terminology. I think for us in Title V, the term medical home, we've been working with that for many years. But what does that exactly mean to folks who are in the TBI community? Medical home is really pediatrics from the A.A.P., so across that life span, we have that whole other realm of adult health care providers, what does that mean to them? I think that some of the transition issues, are again, we need to sit down and think this is what you mean, this is what we mean. A lot of these individuals, you know, families after the injury, families go who have traumatic brain injuries. So we need to sit down and understand the terminology. I think we're not too far off to come to an agreement of what we mean.

GEOFFREY LAUER: What are some of those terms that you see -- [INAUDIBLE SPEAKER].

TONI WALL: I think medical home is a big obstacle. Not so much around family-centered care, I think that's transferable. I think medical home will be a big issue, not a big issue, just an obstacle.

GEOFFREY LAUER: One of the things we talked about Toni, is MCH historically having a 21-year-old, not limit, but focus with the brain injury community, we struggle to have this life long sense of care. Where do you see that fitting in terms of these relationships between the two programs?

TONI WALL: Well, I should say that the 21 is around the health needs, it's not around the whole MCH population. I need to broaden it and say as it crosses the life span and it doesn't end at 21. MCH is typically across the life span for women, children, infants, fathers which I saw included up there which is nice to see. So it's not much of a step to go beyond and say, okay, across a life span.

GEOFFREY LAUER: Okay. Tom, I'm going to come back to you with -- Augusta, go ahead, please.

AUGUSTA CASH: I want today add one thing related to obstacles. This is not a big deal, but in Alabama, MCH -- [INAUDIBLE] Traditional medical model. Doctors, nurses, very, very medical. I think one of the early issues when we got the grant was we need to do a lot of training, particularly about traumatic brain injury and about the life [INAUDIBLE] TBI there is certainly the medical issue up front. But at times you have this life span issue. It

was a small but important issue for both sides to understand, the TBI folks to understand where the MCH folks were coming from and them to understand TBI. We got through that, but it's something that needs to be considered, because you're coming from different worlds.

GEOFFREY LAUER: Thank you. The magic wand question, Tom, in terms of if you could wave a magic wand in Iowa, what things would you change to increase collaboration or what obstacles would you zap?

TOM BROWN: Can I say funding? No. [LAUGHTER]

GEOFFREY LAUER: Yes, you can.

TOM BROWN: That's an obvious one over the last several years of budget cuts that we've gone through in Iowa, as well as across the United States. I think it's across the board, government budget cuts. But I know the MCH program, the child health specialty clinics have been particularly hit hard in Iowa. So the wand that I would wave would bring in or at least bring back the money that had those programs. And I'm not saying it from a money standpoint as much as I am looking at it from a rural perspective. A lot of the families that are out in the rural areas of Iowa, which is pretty much 95% of the state, you know, the child health specialty clinics are off. And the only specialty services they can get beyond the general practitioner. And to have those programs be further away from traumatic brain injury survivors is very problematic. Transportation is a big problem in

Iowa, as well as across the nation. So I'm a big advocate for ADA and Olmsted-related issues. Community-based services. And I really would like to see things moving in that direction, because it's very important from a brain injury perspective to get people back to home to their families, to their support networks, just from a rehabilitation and long-term living standpoint.

GEOFFREY LAUER: Thank you. I'm going to turn this over to all three of you. What resources do the TBI Program -- [INAUDIBLE] What resources do you have to bring to the table to MCH staff? How can you make MCH staff, how can you make life easier for the MCH level, for brain injury? Where does it make it easier?

TOM BROWN: Well, I think in a couple of areas. From the information resources standpoint, what we found when we did our needs assessment was that there was no coordinated set of information that families receive after experiencing a brain injury. So it was family members and service providers together that created the tote bags of information. It was not people sitting around a table saying this is what families with brain injuries need. So we were able to offer the programs they need to meet the needs of the families. We also have skilled staff with three people within the program that have worked in rehabilitation. I think we did the math. We're somewhere around 45 years combined experience in brain injury rehabilitation. So we have the opportunity to offer training to service provider locations, not only the MCH programs, but also the programs that they work with, that their consumers work with. If they would be a mental health provider or

mental retardation provider. We can go out and do brain injury trainings, offer technical assistance.

GEOFFREY LAUER: Are you charging for that?

TOM BROWN: Not at this time. [LAUGHTER] But, you know, I think all of that, the success has completely hinged on the traumatic brain injury act. So the council in Iowa and the staff at the Department of Public Health won't go away. If the grant program works, it will go away I hope. But it's the grant program that allows the opportunity to shine and to really begin meeting the needs.

GEOFFREY LAUER: Augusta in Alabama or even if you are thinking about your colleagues in other states, because I know you have contacts across the country. Where do you see the value added for these grant monies coming? How do you see yourself and the other administrators adding value to the MCH program?

AUGUSTA CASH: I think, Geoffrey, since we have made the commitment in Alabama to particularly work with children in youth with traumatic brain injury, I certainly agree with Tom that we bring expertise to the TBI community in Alabama, bring expertise in terms of training, working with adults with traumatic brain injury, having been out in the trenches, you know, actually doing things with folks with traumatic brain injury. So I think we are so glad that CRS has gone to this population, specifically traumatic brain injury, and that will make things easier for us in the adult population by the things they do. But I think we also,

because we work so closely, we offer support. We work again as -- [INAUDIBLE] -- we start rehabbing with trained counselors. We have our adult care coordinators. They can bring expertise actually to the teen, as well as to -- [INAUDIBLE] -- they work together as a team. For example, the head injury foundation can provide rest services. By having the foundation at the table with their resources, head injury foundation provides recreational resources. They can come along with that resource. Our folks can come along and say, hey, we can do these things. So it's that kind of coordination and cooperation between programs that we bring services together that benefit individuals with brain injuries and families.

GEOFFREY LAUER: Toni, you could be considered the new kid on the block, -- [INAUDIBLE] -- wearing both hats, how do you see the brain injury program bringing value to the MCH program?

TONI WALL: Well, for me it's looking more broadly at the MCH program and how those programs within our bureau can help the brain injury association and the planning grant expand their role. They work very closely with our injury prevention program. That program can provide the prevention education, and do a lot of the legwork around that area, around helmet use and other areas. [INAUDIBLE SPEAKER] Other school-based programs because in multiple ways that we can access other programs that Maternal and Child Health offers, but not necessarily have to spend a lot of resources and funding in order to get the message out. And that's -- most of those programs sit on our advisory

council. They do a lot of the work for us. We can concentrate on the information and resources that -- [INAUDIBLE] -- in Iowa to try and get that kick started.

GEOFFREY LAUER: Thank you. On that same note, Toni, from an MCH program's perspective, what do you see as the key benefit of the MCH staff who may be listening to this webcast reaching out and trying to infiltrate or show up at the table to the brain injury initiative? You can answer it in a couple different ways?

TONI WALL: In what MCH can bring?

GEOFFREY LAUER: In what MCH can bring?

TONI WALL: MCH has brought a lot to the table. They know a lot of players in their own individual states and nationally. For example, we have a lot of national centers, in the medical home. We have an insurance center. We have a lot resources at the national level on best practices, just like -- [INAUDIBLE] But most MCH programs have connections with their pediatric associations within the state. They have connections with emergency centers. They should have connections with early intervention and Department of Education and VR. There are many connections that the brain injury association and the implementation planning grant -- [INAUDIBLE]

GEOFFREY LAUER: That's great. I'm going to pause for a second and just ask if there are any additional comments on any of these questions from the folks in the room?

TOM BROWN: I guess I was thinking about that one as you were saying some of the benefits. I know in Iowa, one of the things that we experienced, like I said, I started with the brain injury program in 2001. And at that point in time Iowa's Medicare waiver had roughly 175 individuals that were being served through the waiver. And the waiver program has directly said that it's because of the brain injury resource network and child health specialty clinics and their referral network that that program has grown since 2001 from 175 people to, we just had our cap raised as of July 1st, to 875 slots, but we have a waiting list of I think it was around 500 people on July 1st. So we're going to see 300 new people coming onto the system. We'll have another 100 or 150 slots coming October 1st of this year. So the linkage service, the information linkage service that lets people know where they need to go to get the information and support they need, are and to tie with the child health specialty clinics or the MCH program is that there's brain injury there. It is a place to link. It is a place where families that are experiencing brain injuries go to for services. And that's why it's a good place to link.

GEOFFREY LAUER: Thank you. Anybody else?

AUGUSTA CASH: Geoffrey, I would add one thing. It's not exactly on the same topic. I cannot probably express how valuable I think the MCH program is in Alabama in working with this population. I know all of us that have been in brain injury a while, have seen especially young adults who were injured when they were three or four years old. They were misdiagnosed. They were diagnosed with manic depressive disorder, emotionally

conflicted. All sorts of things. And have been, a number of them, at least that I know, have been improperly medicated by psychiatrists who didn't do a screening and ask them if they had a brain injury. And by identifying these children at a young age, getting the proper identification and helping these children, they were grow up to be happier adults in terms of their brain injury. It would make life easier for me. So I guess identifying the children and working with them at an early age, I think the importance of that can't be over expressed. It makes a difference in the lives forever when it's done right early.

GEOFFREY LAUER: I'm going to put myself out there as an MCH staff person thinking, okay, does the TBI Program have the tools and the skill sets to help MCH identify, diagnose, and then provide a treatment regiment for children, people with brain injuries?

AUGUSTA CASH: I think we do now. I think the field does have -- we have screening tools. We have different sorts of interventions. Is it Oregon that has done such a wonderful job with school intervention? We have the Alabama program that has a pre discharge model in it. When we start working with the families and children when they're in the hospital. I do think there are tools out there. And probably can get NASHIA and the Technical Assistance Center to help out with pulling those things together, especially for children. I think they're there. I don't think we need to recreate the wheel. I don't know if you agree.

TOM BROWN: No, I agree.

AUGUSTA CASH: There are experts out there, there are specialists now in this part of the country that can help.

GEOFFREY LAUER: Just to reiterate again, if people do want more information, the traumatic brain injury Technical Assistance Center is available to provide the answers to where those resources are. Again, if you go to NASHIA, or type in NASHIA.ORG, you will find the links to the Technical Assistance Center. There are resources available for people in Serena. We have to look for them. That's part of the ever-changing -- if you have a brain injury, what wasn't there three or four years ago is emerging right now. I'm going to take a second and ask one of the questions from the field just to encourage some of our live broadcast web people to submit questions. Cindy Rogers has a question from the Massachusetts Department of Public Health. Hello Cindy, I feel like a talk show host here. Do any of the speakers have examples of successful collaboration focused on the prevention of TBI in terms of your state or knowledge of other federal programs, federally funded grants for TBI? Have you done prevention in Maine with any of your stuff or in Alabama or Iowa?

TOM BROWN: The way I would answer that, Tom, in Iowa here, the TBI Program has been focused on capacity-building strategies. It's not that our programs across the United States and Iowa haven't worked on prevention activities, but not as part of the TBI grant program. I think the grant program has offered the opportunity to say while we're here at the table doing capacity stuff, we can talk about prevention activities. You know, I think it's learning about the children's network that has come to us. And it's put us out in front of

new audiences, at meetings and conferences, distributing not only our information and resources, but also prevention materials. And specifically from the standpoint that once a person experiencing a brain injury, they're more likely to get a second injury. So part of making or assisting people becoming more functional after their injury is preventing second injuries.

GEOFFREY LAUER: Right.

JANE MARTIN HEPPEL: I know that in Pennsylvania, they are using their grant dollars now to set up a system of training across the state for coaches and physical education teachers so that they can talk to their students, student athletes about the importance of wearing safety equipment, helmets, and being safe in all that you do. So they're certainly making an effort to talk about this.

GEOFFREY LAUER: Again, if you want to find out about what's going on in Pennsylvania, they could go back to the Technical Assistance Center. One of the things we're trying to do today, folks, is show you where you can go for additional information. One last piece I'll share on that same topic, Cindy, is that the TBI Act has been funding programs for the Centers for Disease Control and Prevention. If you go to either the NASHIA website or the Brain Injury Association of America website you can link into the CDC national center for injury prevention and control and there are some specific products that have been developed about brain injury prevention and identification of brain injury in both physician's practices and now for coaches. Some terrific tools. And also, for example, the tools that

Augusta had. Augusta, can you hold that up for the people up there on the screen to see what you've been bragging about?

AUGUSTA CASH: Yes.

GEOFFREY LAUER: There you go. [LAUGHTER]

GEOFFREY LAUER: You say there is a pre discharge framework?

AUGUSTA CASH: Yes.

Moderator: If somebody wants to get a hold of that?

AUGUSTA CASH: Give me a call.

GEOFFREY LAUER: These resources are available to M.C.H. programs. They're also -- [INAUDIBLE] Available to you. I have another question and then we're going to wrap up. So I'm sure I'm not going to get to all the questions. This one is to us here. Who are the members of the TBI advisory committees at the state level? Are there representatives from various leadership organizations? Who makes appointments to these advisory committees? What's the membership function like? How does that work at the state level? Who wants to take that?

AUGUSTA CASH: Well, I will answer that, because we've had our head injury task force for so long. But Cassie, what is it, you've said if you've seen one state, you've seen one state. So these task forces are different in every state.

CASSIE LAUVER: Right.

AUGUSTA CASH: This is one of the early task forces and she invited other agency and department heads, heads of foundations, representing consumers and bringing them to the table. So she established that. In a number of states it's established by executive order or legislation. So it's different in different states. But we have also the major departments. We have the department of health, we have minority health, we have our CRS programs, stop and help me with some others. We have education, special ed, we tried to get important players to the table. TBI is everywhere. There is not one department or agency that shouldn't know about this. I've heard people say well your task force is too big. We don't think it's too big in Alabama. I think again every state has to work it out for themselves. Again, if it's legislation or executive order, you might be more limited than we are in Alabama. We're pretty free. We have all the major legislators and we have VA represented. We have anybody that wants to come and be a part of what we're doing. It's been very effective.

TOM BROWN: I would like to add that in addition to the professionals at the table, because we have a counsel of 15 appointed by the governor and six ex officio members that are appointed by the directors of the department and then our ad hoc members that

we added because we wanted to have a larger membership, that we also maintain, at least in the state of Iowa, an unwritten rule of 50% family members and persons with brain injuries on the council. As well, we also try and maintain an establishment of representatives from different levels of care. So we have acute care hospital representatives, post acute rehabilitation providers, brain injury waiver community-based service providers, physicians, neuropsychologists, but we try to have a broad spectrum representing patients on the council. And it's that broad spectrum representation that helps us keep that full Iowa perspective, if you will, as opposed to being focused in any one given area.

AUGUSTA CASH: I guess I would add, too, Tom, we also have positions in psychologist -- . We have a represent from . They got the TBI money. We have that group, too.

GEOFFREY LAUER: Well, I'm sorry to say that we are out of time, folks. That went much more quickly than I thought it would, which is good. I would like to thank you and thank HRSA for these ongoing webcasts. I know the brain injury association affiliates find them valuable for learning. I know other people say the same thing. I want to thank you very much Tom, and Augusta and Toni for getting up early in the morning, very early in the morning Augusta to come in here and spend the time with us today. A few housekeeping things, those of you online, stay online until the browser closes by itself. An evaluation will follow. Please fill out the evaluation. Comment on my tie, whatever you need to, or Tom's. And also, please also know that there will be an archive of this webcast at

mchcom.com in a week or so that you can direct your colleagues to. I'm going to turn it over to Jane for closing.

JANE MARTIN HEPPEL: Well, I just would like to say again, please see your evaluations. That helps us very much. I would like to add my personal thanks to Toni, Augusta, Cassie, and Tom, and of course Geoffrey for helping to make this a very informative webcast. And we hope that you will use the information you've gotten today to work closely with each other out there in the state for your mutual benefit. Thank you all.

GEOFFREY LAUER: Thank you to the University of Illinois, Chicago, for being our technical folks to pull this off. With that, we bid you adio.