



# Brain Injury Business & Professional Council

*A Proposal*

March 2008

# Proposal for Brain Injury Business & Professional Council

## Executive Summary

At the suggestion of its corporate sponsors, the Brain Injury Association of America (BIAA) proposes the formation of a Brain Injury Business & Professional Council to set the standard for post acute rehabilitative care and to foster a sustainable, profitable business climate for service providers.

The lack of an evidence-based standard of care in concert with a payer-driven cost-containment healthcare system and detrimental public policies have resulted in suboptimal treatment for patients, greater economic burden to society and lost business opportunity for service providers. The Business & Professional Council will work to reverse these trends by launching an aggressive government relations campaign that will be supported by data-driven clinical outcomes and business management metrics.

The Council will operate as a member-funded special interest group within BIAA; its chairperson will have a designated seat on the national Board of Directors. Standing committees and work groups will be formed as necessary to achieve the Council's purposes. Membership dues will be set by Council leaders based on member-approved goals and objectives. BIAA's President/CEO will manage the Council's daily affairs, including its staff and budget.

## Industry Background

A traumatic brain injury (TBI) is a blow or jolt to the head or a penetrating head injury that impacts one or more parts of the brain, thereby temporarily or permanently disrupting normal function. New estimates from the CDC indicate 1.6 million people sustain a TBI in the US each year, and more than 125,000 individuals annually incur lifelong disability from TBI.<sup>1</sup> These figures do not include the incidence of stroke which is estimated at 780,000 Americans per year,<sup>2</sup> nor do the figures include meningitis, encephalitis, brain cancer or other acquired brain injuries and disorders.

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<sup>1</sup> CDC, Traumatic Brain Injury Facts (in press).

<sup>2</sup> American Heart Association, *Heart Disease and Stroke Statistics-2008 Update*. Dallas, TX: AHA, 2008.

During the last 30 years, advances in emergency medicine, diagnostic procedures, and treatment methods dramatically improved the brain injury survival rate and fostered the development of a complex continuum of post acute rehabilitation and long-term care programs. Today, there are more than 900 CARF-accredited post acute brain injury programs in the US,<sup>3</sup> and nearly 3,000 professionals are certified by the American Academy for the Certification of Brain Injury Specialists (AACBIS), a subsidiary program of BIAA.

Several organizations furnish services to the brain injury professional community (see Appendix A for a listing). None of the groups are dedicated to the preservation and growth of the post acute brain injury rehabilitation industry. Only one organization—the Brain Injury Association of America—reports successful federal-level lobbying on behalf of post acute providers in 2007 (i.e., the April 2007 Congressional fly-in leading to wounded warrior legislation that extends TriCare coverage periods and increases access to civilian treatment facilities).

In the absence of a strategic and coordinated voice for the post acute rehabilitation industry, service providers have unwittingly acquiesced to payer demands thereby relinquishing control of their clinical and financial destinies.

## **The Consequences of Acquiescence**

The 30-year history of the post acute rehabilitation field is replete with therapeutic breakthroughs leading to miraculous recoveries, extraordinary financial success, emergence and recognition of outstanding leaders, and generous support for consumer empowerment. The history also includes ethically-questionable practices, fraudulent billing, and the tragic loss of lives, although these features have been the exception rather than the norm.

Only recently has the concept of “co-opetition,”<sup>4</sup> which is the blending of cooperation and competition to build a stronger business climate, been introduced. The failure to embrace co-opetition before now has created three strategic challenges in the post acute rehabilitation industry: (1) the lack of data-driven standards of care; (2) a shift from patient-centered to payer-driven treatment; and (3) the emergence of detrimental public policies. Each of these is discussed in more depth.

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<sup>3</sup> Personal communication with Christine M. MacDonell, Managing Director, CARF on November 3, 2007.

<sup>4</sup> Brandenburge, A.M., Nalebuff, B.J., *Co-opetition*. New York: Doubleday. 1996.

1. *The lack of an industry-developed, data-driven standard of care for post acute rehabilitation.*

The Brain Trauma Foundation (BTF), an organization that is widely recognized for its expertise in creating practice guidelines, has developed four sets of guidelines for surgical and acute medical management of traumatic brain injury.<sup>5</sup> BTF has not published guidelines for post acute rehabilitation of TBI.

The Department of Labor and Employment of the Division of Workers' Compensation of the State of Colorado developed *Traumatic Brain Injury Medical Treatment Guidelines* in January 1998, which were revised in September 2005 and adopted in January 2006. These guidelines include initial and follow-up diagnostic procedures, a comprehensive and broad array of non-operative therapeutic procedures, operative therapeutic procedures, and maintenance management guidelines. This is the only comprehensive set of guidelines that exist, they need to be reviewed, revised, updated, expanded, and endorsed by the industry.

In the absence of generally-accepted guidelines, post acute rehabilitation clinicians have developed facility-based treatment protocols based on studies of varying rigor published in brain injury journals, promising practices presented in educational symposia, and lessons gleaned through on-site facility visits. Similarly, business leaders have developed management practices based largely on conference networking and CARF standards, which seek to improve organizational efficiency in meeting stakeholder needs and provide a useful orientation and business practices paradigm. While based on sound principles, these protocols and operating procedures lack the rigor of "evidence-based" medicine now demanded by consumers, payers and policymakers.

The TBI Model Systems of Care, a federally-funded translational research program administered by the National Institute on Disability and Rehabilitation Research within the US Department of Education, maintain a nonproprietary database on the longitudinal outcomes of more than 5000 individuals with brain injury. Private sector clinicians report difficulty in accessing the database. Further, the dataset does not aid in the discernment of eligibility for specific treatment, continuation of treatment, access along an available treatment continuum, discontinuation of treatment or re-initiation of

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<sup>5</sup> Brain Trauma Foundation. *Guideline for Pre-Hospital Management of Traumatic Brain Injury (2<sup>nd</sup> Ed)*, 2006.

Brain Trauma Foundation. *Guidelines for Management of Severe Traumatic Brain Injury (3<sup>rd</sup> Ed)*, 2007.

Brain Trauma Foundation, *Guidelines for the Surgical Management of Traumatic Brain Injury*, 2006.

Brain Trauma Foundation, *Guidelines for the Acute Medical Management of Severe Traumatic Brain Injury in Infants, Children and Adolescents*, 2003.

treatment. Importantly, the dataset does not include relevant business management variables such revenue, costs, and earnings; human resources; or risk and financial management practices.

The American Medical Rehabilitation Providers Association (AMRPA) operates a subscription-based online database known as eRehabData and solicits enrollment among hospital-based acute rehabilitation providers. Utilizing the factual demographic, clinical and financial information in this dataset, AMPRA was instrumental in freezing implementation of Medicare's "75% Rule" at a 60 percent level. Additionally, the dataset has been used in a pilot project to demonstrate the efficacy of treatment for the Centers for Medicare and Medicaid Services. AMRPA's database is an example of a financially-viable tool that furnishes data-driven support to both clinical practice and business sustainability and profitability.

While post acute brain injury rehabilitation databases are in development in Pennsylvania and on the drawing board in Michigan, there's no doubt that the lack of a national dataset on individual health outcomes and business management metrics has inhibited the development of an evidence-based standard of care for post acute rehabilitation. As a consequence, entrepreneurial newcomers freely claim results comparable to or better than traditional rehabilitation using lower cost treatment devices and telephone or web-based therapeutic interventions.

Predictably, the efficacy debate has been re-opened, particularly in military and VA medicine. Established post acute rehabilitation techniques are once again labeled as "experimental." A primary goal of the proposed Brain Injury Business & Professional Council will be to establish an online database comprised of clinical and business datasets from which a standard of care can be developed and endorsed industry-wide.

## *2. The shift from patient-centered to payer-driven healthcare.*

The last three decades have borne witness to tremendous changes in healthcare delivery in the US. Shifts from pure health insurance to health maintenance and pre-paid medical care under the guise of "managed care" occurred just as the field of brain injury disease management emerged. Managed care's stranglehold combined with the field's relative naïveté proved deleterious to consumers, professionals and society as a whole.

In 1990, the average length of stay for hospital-based acute and rehabilitative treatment was 77 days nationally. By 1999, average length of stay dropped to 47 days. Patients

were not healing faster; they were simply being pushed out of acute settings. The insurance industry promoted the development of less expensive, non-hospital treatment settings as a cost containment strategy. Post acute rehabilitation providers obliged these requests but failed to secure contract language supporting alternative treatment settings (eg, residential rehabilitation).

By 2007, the average length of stay for hospital-based care for individuals with brain injury decreased to less than 26 days nationally and was as low as 14 days in some hospital systems. Research demonstrated that 64 percent of all persons hospitalized following TBI were released to the care of their families with no further rehabilitation treatment plan. In the meantime, accident and health insurers that once favored less expensive settings had systematically eliminated “substitution of benefits” clauses within their policies.

Concurrent with these moves, insurance carriers sought to contain costs by limiting treatment plans to disability accommodation rather than disability amelioration/reduction. More recently, health policies have been issued that exclude rehabilitation of any kind. By delaying and denying access to treatment that enables many individuals with brain injury to return to independence and work, private sector insurers have increased joblessness, homelessness, medical indigence and poverty.

Many experts attribute the dramatic growth in Medicaid and Medicare expenditures to private insurers’ failure to adequately meet the care needs of their policyholders. In response, the Centers for Medicare and Medicaid Services (CMS) required workers’ compensation and third party litigation settlements to indemnify the Medicare program for costs incurred on behalf of its beneficiaries. Ironically, no such indemnification is required of accident and health insurers.

Patients with cardiac conditions are allowed ongoing treatment regardless of the cost or duration, as are cancer patients, and those individuals with any other system involvement. Because brain injury disease management is relegated to “rehabilitation,” long-term treatment and care is not covered under the major medical benefits of most insurance policies.

There are successful models for boomeranging the burden of care back to insurance carriers. They include federal protections (eg, coverage mandates for pregnancy/birth delivery); state protections (eg, coverage mandates for cognitive rehabilitation in Texas) as well public and private sector lawsuits (eg, action by State Attorneys General against the tobacco industry and resulting settlements).

A primary goal of the proposed Brain injury Business & Professional Council is to identify potential opportunities to engineer accident and health insurance policies and regulations that will improve the quality of care for individuals with brain injury and offer reasonable and sustainable revenues for providers.

### *3. The emergence of detrimental public policies.*

With healthcare costs spiraling out of control, federal lawmakers have opted to mirror the private sector's pattern of cost containment for rehabilitation and related services. For example, CMS regularly issues Proposed and Final Rules restricting access to rehabilitation and related services. Recent Medicare rules include narrowing the definition of outpatient hospital services, limiting access to mobility devices, and extending the use of fiscal intermediaries to determine medical necessity. A recent Medicaid rule limits access under the rehabilitative services option.

In a misguided attempt to contain and recoup expenditures, CMS enacted a pilot project in three states (NY, CA, FL) whereby retrospective reviews of all rehabilitation hospital admissions would be conducted by recovery audit contractors (RAC). RAC personnel examining orthopedic admissions in California retrospectively denied more than 97.5 percent of admissions with repayment drawn from current billings. The California Hospital Association estimates that the CMS RAC audits will result in a loss of 30 to 40 percent of the rehabilitation beds in the state. AMRPA reports that more than 7,000 rehabilitation beds were lost in the US in 2007.

These actions signal the Federal government's reluctance to provide medical coverage for the orthopedic and neurological conditions that inevitably will arise with our nation's burgeoning baby boomer population. A key goal of the proposed Brain Injury Business & Professional Council will be to fight threats to CMS programs and to position the industry with a strong, well-choreographed voice in the upcoming healthcare/insurance reform debate.

## **Tapping the Untapped Business Opportunity**

Increasingly catastrophic brain injury is recognized as a disease-causative and disease accelerative costing society more \$60 billion per year.<sup>6</sup> And yet, BIAA *very conservatively* estimates that only 2.5 percent of all persons who sustain brain injuries in the US access

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<sup>6</sup> CDC, Traumatic Brain Injury Facts (in press).

post acute rehabilitation. As shown in BIAA’s “Brain Injury By the Numbers” Table 85,000 or more people with lifelong TBI-related disability may go untreated.

<b>Brain Injury by the Numbers</b>	
CDC estimate of annual incidence of TBI in the US	1,600,000
Generally accept rate of moderate-to-severe Injuries (15% of Total)	240,000
CDC estimate of persons who are permanently disabled	125,000
Less BIAA estimate of post acute rehabilitation beds (10,000 w/quarterly turnover)	40,000
Equals patients who are permanently disabled and do not receive treatment	85,000
Cost range for post acute rehabilitation per person	\$22,000 - \$212,000
<b>Lost opportunity to Brain Injury Business &amp; Professional Community</b>	<b>\$1.8 Billion to \$18 Billion ANNUALLY</b>

As frightening as these numbers are for individual health and quality of life, they represent an enormous untapped business opportunity for post acute providers. The goals of the proposed Brain Injury Business & Professional Council are designed to penetrate the heretofore untapped market by overcoming the lack of data-driven standards of care; reversing payer-driven treatment to patient-centered disease management; and warding off detrimental public policies.

### **Council Function, Structure & Dues**

Charter membership in the proposed Brain Injury Business & Professional Council will be limited to 25 of the nation’s leading rehabilitation providers. These “cabinet-level” members will:

- Set the Council’s national legislative agenda, *Access to Care*, which is envisioned as a nationwide lobbying and public relations initiative to transform public and private third-party payer policies to appropriately compensate post acute service providers,
- Guide the development and adoption of care standards that preserve the health and maximize the function of individuals with brain injury and support arguments for equitable compensation, and

- Select the clinical outcomes and business benchmarking datasets and oversee the development of an online database that delivers real-time comparable clinical outcomes and business benchmarks.

Initial annual dues of \$15,000 are proposed if a database is constructed and \$10,000 annual dues are proposed if a database is not constructed. Dues would be payable on a monthly basis (\$1,250 or \$833.33). A 3-year commitment is sought. See Appendix B for a proposed budget with database and Appendix C for a proposed budget without database.

It is envisioned that charter members will attend four meetings per year, including an annual Congressional Fly-in and the Brain Injury Business Practices College. Charter members are also expected to participate in the periodic teleconferences of one or more workgroups that are aligned with the goals described above.

Importantly, charter members would be required to contribute data (with the source held confidential from other members and staff) to accurately characterize clinical populations, services, effort, and outcomes, combined with business management metrics to discern operational parameters and, in time, conduct retrospective analyses on a variety of topics to inform and support legislative efforts that enhance individual access to care and corporate profitability.

During the next three years, charter members may be asked to assist in the design and recruitment of additional members. For example, post acute facilities may be targeted for corporate level memberships that would participate in outcomes and business benchmarking while individuals who desire affiliation with the Council and limited access to select data reports may be slated for future professional level memberships.

Workgroup chairpersons and two additional charter members who are duly elected will serve as the Council's executive committee, which will then select the Council's representative to BIAA's Board of Directors.

## **Why the Brain Injury Association of America?**

The Brain Injury Association of America, which was founded by family members and professionals in 1980, is the oldest and largest brain injury advocacy organization in the country. BIAA has been a driving force behind federal legislation and millions of dollars appropriated for bench science, translational research, state level system coordination and individual protection and advocacy. BIAA is a well-respected and firmly entrenched voice for brain injury on Capitol Hill.

BIAA's history also includes the operation of a Providers Council, delivery of world-class education and training programs and periodical publication aimed at clinicians. Regrettably, BIAA's Professional Council was disbanded in the mid 1990s and financial constraints at the start of the millennium forced the downsizing of many of the Association's professional programs and services.

Beginning in 2005, BIAA engaged new governance and management that fully embraced the professional community through AACBIS expansion, introduction of innovative educational programming, publication of pro-business position papers and direct lobbying on behalf of post acute professionals. With BIAA's financial turn-around now completed, the Association is poised to formalize its service to and representation of the post acute industry.

The Brain Injury Business & Professional Council is not intended to supplant BIAA's Corporate Sponsors Program, which provides an effective mechanism for advertising to consumers and aligns corporate brands with BIAA's mission to create a better future for individuals and families whose lives are forever changed by physically, cognitively, psychosocially, and financially devastating brain injuries.

Appendices:

- A – List of Brain Injury Organizations
- B – Proposed 3-Year Budget with Database
- C – Proposed 3-Year Budget without Database

## Appendix A – Organization Listing

Organization Name	Website	Mission Statement (or similar statement of reason for being)	Annual Meeting
American Academy of Neurology	<a href="http://www.aan.com">www.aan.com</a>	<p>The American Academy of Neurology is a medical specialty society established to advance the art and science of neurology, and thereby promote the best possible care for patients with neurological disorders by:</p> <ul style="list-style-type: none"> <li>• Ensuring appropriate access to neurological care.</li> <li>• Supporting and advocating for an environment which ensures ethical, high quality neurological care.</li> <li>• Providing excellence in professional education by offering a variety of programs in both the clinical aspects of neurology and the basic neurosciences to physicians and allied health professionals.</li> <li>• Supporting clinical and basic research in the neurosciences and related fields.</li> </ul>	Chicago, IL April 12-19, 2008
American Congress of Rehabilitation Medicine	<a href="http://www.acrm.org">www.acrm.org</a>	The mission of the American Congress of Rehabilitation Medicine (ACRM) is to enhance the lives of persons living with disabilities through a multidisciplinary approach to rehabilitation, and to promote rehabilitation research and its application in clinical practice.	Toronto, ON October 15-19, 2008 (Joint with ASNR) BISIG Mid-Year: Philadelphia, PA March 28-29, 2008
American Medical Rehabilitation Providers Association	<a href="http://www.amrpa.org">www.amrpa.org</a>	<p>AMRPA is a nonprofit trade organization representing freestanding rehabilitation hospitals, rehabilitation units in general hospitals, outpatient rehabilitation facilities, several skilled nursing facilities, and home health agencies that provide medical rehabilitation services to over 700,000 people annually. We now number over 450 members.</p> <p>AMRPA has emerged from the traditions of medical rehabilitation and stands poised to renew the power of collective advocacy. Standing shoulder to shoulder, the Board of Directors have identified a singular purpose for the new organization -- active advocacy about what people with disabilities need in their medical rehabilitation recovery.</p>	Washington, DC April 16-17, 2008 Amelia Island, FL September 24-26, 2008
American Occupational Therapy Association	<a href="http://www.aota.org">www.aota.org</a>	<p>AOTA is the national professional association established in 1917 to represent the interests and concerns of occupational therapy practitioners and students of occupational therapy and to improve the quality of occupational therapy services.</p> <p>AOTA advances the quality, availability, use, and support of occupational therapy through standard-setting, advocacy, education, and research on behalf of its members and the public.</p>	Long Beach, CA April 10-13, 2008
American Physical Therapy Association	<a href="http://www.apta.org">www.apta.org</a>	The mission of APTA, the principal membership organization representing and promoting the profession of physical therapy, is to further the profession's role in the prevention, diagnosis, and treatment of movement dysfunctions and the	San Antonio, TX June 11-14, 2008

		enhancement of the physical health and functional abilities of members of the public.	
American Psychological Association – Div. 40 Clinical Neuropsychology	<a href="http://www.apa.org/about/division/div40.html">http://www.apa.org/about/division/div40.html</a>	Clinical Neuropsychology provides a scientific and professional forum for individuals interested in the study of the relationships between the brain and human behavior. As such, Division 40 promotes interdisciplinary interaction among various interest areas including physiological cognitive, developmental, clinical rehabilitation, school, forensic, and health psychology.	APA Annual Convention Boston, MA August 14-17, 2008
American Society of Neurorehabilitation	<a href="http://www.asnr.com/">http://www.asnr.com/</a>	The mission of the ASNR is to promote the medical and social wellbeing of persons with disabling neurological disorders, to advance training and research in the basic and clinical sciences that can lead to functional recovery of neurologically impaired persons, and to disseminate the knowledge of this research among professionals and the general public. <b>The ASNR promotes:</b> <ul style="list-style-type: none"> <li>• Specialty training and identification of those with expertise in neurorehabilitation</li> <li>• Professional and public education</li> <li>• Basic science and clinical research in neurorehabilitation</li> <li>• Communication and collaboration with people with neurological disorders related organizations</li> <li>• Mission of Neurorehabilitation Research</li> </ul>	Toronto, ON October 15-19, 2008 (Joint with ACRM)
American Speech-Language-Hearing Association	<a href="http://asha.org/default.htm">http://asha.org/default.htm</a>	ASHA is the professional, scientific, and credentialing association for more than 127,000 members and affiliates who are speech-language pathologists, audiologists, and speech, language, and hearing scientists in the United States and internationally. The purposes of this Association shall be <ol style="list-style-type: none"> <li>1. To encourage basic scientific study of the processes of individual human communication with special reference to speech, language, hearing, and related disorders;</li> <li>2. To promote high standards and ethics for the academic and clinical preparation of individuals entering the discipline of human communication sciences and disorders;</li> <li>3. To promote the acquisition of new knowledge and skills for those within the discipline;</li> <li>4. To promote investigation, prevention, and the diagnosis and treatment of disorders of human communication and related disorders;</li> <li>5. To foster improvement of clinical services and intervention procedures concerning such disorders;</li> <li>6. To stimulate exchange of information among persons and organizations, and to disseminate such information;</li> <li>7. To inform the public about communication sciences and disorders,</li> </ol>	Chicago, IL November 20-22, 2008

		<p>related disorders, and the professionals who provide services;</p> <ol style="list-style-type: none"> <li>8. To advocate on behalf of persons with communication and related disorders;</li> <li>9. To promote the individual and collective professional interests of the members of the Association.</li> </ol>	
Brain Trauma Association	<a href="http://www.braintrauma.org/">www.braintrauma.org/</a>	The Brain Trauma Foundation was founded to improve the outcome of Traumatic Brain Injury (TBI) patients by developing best practice guidelines, conducting clinical research and educating medical personnel.	
Case Management Society of America	<a href="http://www.cmsa.org/">http://www.cmsa.org/</a>	<p>The mission of CMSA is to positively impact and improve patient wellbeing and healthcare outcomes. To execute this mission, the Society will base its efforts on the following three ideologies:</p> <ol style="list-style-type: none"> <li>1. To inform consumers about the services case and care managers provide</li> <li>2. To educate physicians and other providers about improved patient outcomes through the services case and care managers provide</li> <li>3. To educate payors and regulators about improved patient outcomes that case and care management services can provide</li> </ol>	Orlando, FL June 17-20, 2008
Insurance Rehabilitation Study Group	<a href="http://www.irsg.us/">http://www.irsg.us/</a>	<p>The IRSG's mission is to provide an educational forum for the insurance industry to explore and develop concepts and programs of effective medical and rehabilitation services that pertain to all lines of insurance.</p> <p>The vision of IRSG is to serve as an innovative leader by promoting and advocating quality care and service delivery; through education and shared knowledge between members, the insurance industry and the healthcare community.</p>	Westminster (Denver), CO April 20-23, 2008
National Academy of Neuropsychology	<a href="https://www.nanonline.org/">https://www.nanonline.org/</a>	<p>As stated in the original Constitution of NAN, the purpose of the Academy shall be to:</p> <ol style="list-style-type: none"> <li>(a) preserve and advance knowledge of the assessment and remediation of neurological impairments by psychological means.</li> <li>(b) foster the development of neuropsychology as a discipline, science and profession through meetings, training institutes, research and dissemination of findings.</li> <li>(c) join with other professional groups to exchange information and further the preceding goals.</li> </ol>	New York, NY October 22-25, 2008
National Association of State Head Injury Administrators	<a href="http://www.nashia.org/">http://www.nashia.org/</a>	<p>NASHIA's mission is to assisting state government in promoting partnerships and building systems to meet the needs of individuals with brain injury and their families. NASHIA's Board of Directors and staff are committed to working in partnership to achieve the following goals and objectives:</p> <ol style="list-style-type: none"> <li>1. Build an effective, sustainable national organization.</li> <li>2. Build partnerships that positively impact members and persons who</li> </ol>	Williamsburg, VA September 9-12, 2008

		<p>have experienced brain injury.</p> <ol style="list-style-type: none"> <li>3. Enhance State capacity to provide services and supports to individuals with brain injury and their families.</li> <li>4. Influence public policy.</li> </ol>	
National Association of Rehabilitation Providers and Agencies	<a href="http://www.naranet.org/">http://www.naranet.org/</a>	<p>Founded in 1978, NARA functions as a trade association representing the interests of a approximately 75 organizations consisting of over 10,000 healthcare professionals dedicated to providing a multitude of skilled rehabilitation therapy services to individuals in a variety of settings, (i.e. inpatient, outpatient, skilled care, assisted living, educational systems, industry / occupational health). Although tenured with a vast and successful history, the association continues to evolve and invigorate its dynamics and infrastructure to positively represent and affect change in the rehabilitation therapy industry. The purpose and continued efforts of NARA focuses upon the following foundation: Mission: To provide service, support, knowledge, and unity to a diverse group of rehabilitation therapy companies and professionals by bridging the gaps between clinical excellence and the ability to thrive as business entities within an ever-changing healthcare environment.</p>	Washington, DC May 14-16, 2008
National Neurotrauma Society	<a href="http://www.neurotrauma.org">http://www.neurotrauma.org</a>	<p>The National Neurotrauma Society promotes neurotrauma research by enhancing communications, providing a forum, and increasing support on the national and international level. The Society seeks to accelerate research that will provide answers for clinicians and ultimately improve the treatments available to patients. The Society promotes excellence in the field by providing opportunities for scientists, establishing standards in both basic and clinical research, encouraging and supporting research, and promoting liaisons with other organizations that influence the care and cure of neurotrauma victims.</p>	Orlando, FL July 27-30, 2008
National Rehabilitation Association	<a href="http://www.nationalrehab.org">http://www.nationalrehab.org</a>	<p>The National Rehabilitation Association (NRA) is a member organization that promotes ethical and state of the art practice in rehabilitation with the goal of the personal and economic independence of persons with disabilities. As the oldest and strongest advocate for the rights of persons with disabilities, our mission is to provide advocacy, awareness and career advancement for professionals in the fields of rehabilitation.</p>	St. Louis, MO October 23-26, 2008
North American Brain Injury Society	<a href="http://www.nabis.org/">http://www.nabis.org/</a>	<p>NABIS is a society comprised of professional members involved in the care or issues surrounding brain injury. The principal mission of the organization is moving brain injury science into practice. Whether it is in the area of clinical care, research, policy or litigation, the organization stands behind the premise that advances in science and practices based on application of the scientific evidence will ultimately provide the best outcomes for those with brain injuries and the community as a whole. NABIS was created specifically to address the needs of professionals dedicated to brain injury - providing education programs, scientific updates and a platform for</p>	New Orleans, LA October 2-4, 2008

		communication and professional exchange. NABIS is also the link to the international brain injury community for professionals in North America. NABIS works with other IBIA chapters on international outreach projects and education as well as addressing the key issues for professionals in North America.	
Society for Cognitive Rehabilitation	<a href="http://www.cognitive-rehab.org.uk/">http://www.cognitive-rehab.org.uk/</a>	The Society pursues practical innovation in cognitive rehabilitation therapy To assist professionals across disciplines to meet the CRT needs of consumers around the world To promote evidence-based practices, outcome-oriented research, and competency based continuing education in CRT To offer specialty credentials of CPCRT	

## Appendix B - Brain Injury Business & Development Council Proposed Budget With Database

<b>Proposed Budget - Year 1</b>	
<b>Revenue</b>	
Dues, Charter Members (25 x \$15,000)	\$ 375,000
Grant(s) for Database Development	150,000
	<b>\$ 525,000</b>
<b>Expense</b>	
Salaries & Benefits (15% Connors & Schiebelhut + 30% Abashian & Admin)	\$ 75,000
Legal (15 hrs @ \$300/hr)	4,500
Lobbyist (\$10,000/mo)	120,000
Lobbyist Expenses (\$250/mo)	3,000
Database (Turnkey Development/Operation)	300,000
Teleconferences (Bi-weekly Workgroup Calls, Quarterly Updates, Monthly Exec Cmte)	2,000
Travel Expenses (Local & 2 Trips)	2,500
Rent, Utilities, Insurance, Equipment, Supplies (\$1500/mo)	18,000
	<b>\$ 525,000</b>

<b>Proposed Budget - Year 2</b>	
<b>Revenue</b>	
Dues, Charter Members (25 x \$15,000)	\$ 375,000
Dues, Corporate Members (75 x \$5,000)	375,000
	<b>\$ 750,000</b>
<b>Expense</b>	
Salaries & Benefits (10% Connors, 100% Director, 50% Admin)	\$ 115,000
Legal (15 hrs @ \$300/hr)	4,500
Lobbyist (\$10,000/mo)	120,000
Lobbyist Expenses (\$250/mo)	3,000
Database (Maintenance & Expansion)	400,000
Publicist/Public Relations (\$3000/mo)	36,000
Promotion - Exhibit Booth, Materials Design & Print, List Rental & Mail	24,800
Teleconferences (Bi-weekly Workgroup Calls, Quarterly Updates, Monthly Exec Cmte)	2,000
Travel Expenses (Local & 10 Trips)	8,700
Rent, Utilities, Insurance, Equipment, Supplies (\$3000/mo)	36,000
	<b>\$ 750,000</b>

**Proposed Budget - Year 3**

**Revenue**

Dues, Charter Members (25 x \$15,000)	\$ 375,000
Dues, Corporate Members (125 x \$5,000)	625,000
Dues, Professional Members w/access (120 x \$1,000)	120,000
Dues, Professional Members w/out access (250 x \$200)	50,000
	<b>\$ 1,170,000</b>

**Expense**

Salaries & Benefits (Director - 100%; Staff Lobbyist - 50%; Admin 60%)	\$ 173,000
Legal (15 hrs @ \$300/hr)	4,500
Lobbyist (\$15,000/mo)	180,000
Lobbyist Expenses (\$300/mo)	3,600
Database (Maintenance & Expansion)	425,000
Publicist/Public Relations (\$4000/mo)	48,000
Promotion - Exhibiting, Materials Design & Print, List Rental & Mail	33,000
Public Awareness Campaign (Turnkey)	240,000
Teleconferences (Bi-weekly Workgroup Calls, Quarterly Updates, Monthly Exec Cmte)	2,450
Travel Expenses (Local & 15 Trips)	12,450
Rent, Utilities, Insurance, Equipment, Supplies (\$4000/mo)	48,000
	<b>\$ 1,170,000</b>

## Appendix C - Brain Injury Business & Development Council Proposed Budget Without Database

<b>Proposed Budget - Year 1</b>	
<b>Revenue</b>	
Dues, Charter Members (25 x \$10,000)	\$ 250,000
	<b>\$ 250,000</b>
<b>Expense</b>	
Salaries & Benefits (15% Connors & Schiebelhut + 30% Abashian & Admin)	\$ 75,000
Legal (15 hrs @ \$300/hr)	4,500
Lobbyist (\$10,000/mo)	120,000
Lobbyist Expenses (\$250/mo)	3,000
Teleconferences (Bi-weekly Workgroup Calls, Quarterly Updates, Monthly Exec Cmte)	2,000
Travel Expenses (Local & 2 Trips)	2,500
Rent, Utilities, Insurance, Equipment, Supplies (\$1500/mo)	18,000
Profit & Reinvestment	25,000
	<b>\$ 250,000</b>

<b>Proposed Budget - Year 2</b>	
<b>Revenue</b>	
Dues, Charter Members (25 x \$10,000)	\$ 250,000
Dues, Corporate Members (75 x \$1,000)	75,000
	<b>\$ 325,000</b>
<b>Expense</b>	
Salaries & Benefits (10% Connors, 100% Director, 50% Admin)	\$ 115,000
Legal (15 hrs @ \$300/hr)	4,500
Lobbyist (\$10,000/mo)	120,000
Lobbyist Expenses (\$250/mo)	3,000
Promotion - Exhibit Booth, Materials Design & Print, List Rental & Mail	13,050
Teleconferences (Bi-weekly Workgroup Calls, Quarterly Updates, Monthly Exec Cmte)	2,000
Travel Expenses (Local & 7 Trips)	6,450
Rent, Utilities, Insurance, Equipment, Supplies (\$3000/mo)	36,000
Profit & Reinvestment	25,000
	<b>\$ 325,000</b>

**Proposed Budget - Year 3**

**Revenue**

Dues, Charter Members (25 x \$10,000)	\$ 250,000
Dues, Corporate Members (125 x \$1,000)	125,000
Dues, Professional Members w/out access (250 x \$150)	37,500
	<b>\$ 412,500</b>

**Expense**

Salaries & Benefits (Director - 100%; Staff Lobbyist - 50%; Admin 60%)	\$ 173,000
Legal (15 hrs @ \$300/hr)	4,500
Lobbyist (\$12,000/mo)	144,000
Lobbyist Expenses (\$250/mo)	3,000
Promotion - Exhibiting, Materials Design & Print, List Rental & Mail	12,100
Teleconferences (Bi-weekly Workgroup Calls, Quarterly Updates, Monthly Exec Cmte)	2,450
Travel Expenses (Local & 15 Trips)	12,450
Rent, Utilities, Insurance, Equipment, Supplies (\$3000/mo)	36,000
Profit & Reinvestment	25,000
	<b>\$ 412,500</b>