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KEEPING SENIORS SAFE FROM FALLS AND REAUTHORIZATION OF THE TRAUMATIC BRAIN INJURY ACT

DECEMBER 5, 2006.—Ordered to be printed

Mr. ENZI, from the Committee on Health, Education, Labor, and Pensions, submitted the following

R E P O R T

[To accompany S. 1531]

The Committee on Health, Education, Labor, and Pensions, to which was referred the bill (S. 1351) to direct the Secretary of Health and Human Services to expand and intensify programs with respect to research and related activities concerning elder falls, having considered the same, reports favorably thereon with an amendment, and an amendment to the title, and recommends that the bill (as amended) do pass.

CONTENTS

I. PURPOSE AND NEED FOR LEGISLATION

The purpose of "Keeping Elders Safe from Falls and Reauthorization of the Traumatic Brain Injury Act" is to direct the Secretary of Health and Human Services (HHS) to expand and intensify programs with respect to research and related activities concerning traumatic brain injury (TBI) and elder falls. In older Americans, falling is the leading cause of injury and death, and the main cause of TBI. Every year, of the 1.4 million people in the United States

who sustain a TBI, 50,000 die and 235,000 are hospitalized. According to the Centers for Disease Control and Prevention (CDC), falls among older adults and traumatic brain injuries cost the United States an estimated 80 billion dollars in 2000.

TBI is defined as brain damage from some externally inflicted trauma to the head that results in significant impairment to an individual's physical, psychosocial, and/or cognitive functional abilities. According to CDC, brain injuries are among the most likely types of injury to cause death or permanent disability. People ages 15 to 24 years and those over age 75 are the two age groups at highest risk for TBI. Motor vehicle accidents, sports accidents, falls, and violence are the major causes of TBI. Whereas motor vehicle accidents and violence, such as firearm assaults and child abuse, account for 70% of TBI in the overall US population, falling is the major cause in people aged 75 years or older. TBI is also caused by explosives, and medical experts have described it as the signature wound of the Iraq war. Long known as the silent epidemic, TBI can strike anyone—infant, youth, or elderly person—without warning and with devastating results. It is particularly common among young males and people of both sexes who are 75 years and older. TBI affects the whole family and often results in huge medical and rehabilitation expenses over a lifetime.

TBI is different from other disabilities due to the severity of cognitive loss. Most rehabilitation programs are designed for people with physical disabilities, not cognitive disabilities that require special accommodations. Finding needed services is typically a logistical, financial, and psychological challenge for family members and other caregivers, because few coordinated systems of care exist for individuals with TBI. The passage of the Traumatic Brain Injury Act of 1996 has improved TBI service systems at the state-level and also increased the overall visibility of TBI. However, more work needs to be done at both the national and State level to build an effective, durable service system for meeting the needs of individuals with TBI and their families.

More than one-third of adults aged 65 and older fall each year. According to the CDC, in 2002, more than 12,800 people aged 65 and older died from fall-related injuries. More than 1.6 million seniors were treated that year in emergency departments for fall-related injuries. Hospital admissions for hip fractures among the elderly have increased from 321,000 admissions in 1988 to 327,000 in 2001. Annually, more than 80,000 individuals who are over 65 years of age sustain a TBI as a result of a fall.

In addition to their effect on the quality of life of seniors and their families, falls also have an impact on healthcare costs due to increased physician visits, emergency room use and hospitalization. According to the CDC, the direct medical cost totaled 179 million dollars for fatal and 19 billion dollars for nonfatal fall injuries in 2000.

To address the impact of falls on seniors, their families, and healthcare costs, the Keeping Elders Safe from Falls and Reauthorization of the Traumatic Brain Injury Act of 2006 would focus ongoing Federal efforts to prevent falls among older adults on three priorities: (1) developing a national education campaign to reduce falls among older adults; (2) intensifying services and conducting research to determine the most effective approaches to preventing

and treating falls among older adults; and (3) directing the Secretary of Health and Human Services (HHS) to evaluate the effect of falls on health care costs, the potential for reducing falls, and the most effective strategies for reducing health care costs associated with falls.

II. SUMMARY

The purpose of this legislation is to expand and improve programs that authorize activities related to TBI and to reduce falls among the elderly. With respect to TBI, the legislation authorizes three federal agencies to carry out activities addressing TBI:

(1) The Centers for Disease Control and Prevention (CDC) carries out projects that reduce the incidence of TBI through research, public education, and a national education and awareness campaign, gives grants to States to operate TBI registries, and funds academic research supporting the development of registries.

(2) Supports basic and applied research conducted by the National Institutes of Health (NIH).

(3) Health Resources Service Administration (HRSA) awards grants to fund State demonstration projects to improve access to health and other services and for protection and advocacy service systems.

With respect to the issue of senior falls the legislation directs the Department of Health and Human Services (HHS) to:

(1) Develop public education programs on fall prevention for the elderly, family members, caregivers, and others involved with the elderly.

(2) Intensify services and conduct research to determine the most effective approaches to preventing and treating falls among older adults; and

(3) Evaluate the effect of falls on health care costs, the potential for reducing falls, and the most effective strategies for reducing health care costs associated with falls.

III. HISTORY OF LEGISLATION AND VOTES IN COMMITTEE

S. 1531, Keeping Seniors Safe from Falls Act and Reauthorization of the Traumatic Brain Injury Act is a combination of two bills—The Keeping Seniors Safe from Falls Act and the Traumatic Brain Injury Reauthorization. On September 20, 2006, the committee considered and unanimously approved a manager's amendment to S. 1531. Senators MIKULSKI, HATCH, KENNEDY, DEWINE, MURRAY, and ISAKSON cosponsored the manager's amendment.

During the 109th Congress, S. 1531, The Keeping Seniors Safe from Falls Act was introduced by Senator ENZI for himself and Senator MIKULSKI on July 28, 2005. Senators BAUCUS, DOLE, GRASSLEY, COCHRAN, DURBIN, ISAKSON and MURRAY cosponsored the bill.

The legislation was first introduced during the 107th Congress, on February 7, 2002, by Senator HUTCHINSON, for himself and Senators MIKULSKI and ENZI, as S. 1922.

Senators BAUCUS, MILLER and MURRAY also cosponsored S. 1922. The Health, Education, Labor, and Pensions (HELP) Subcommittee on Aging held a hearing on S. 1922 on June 11, 2002.

The bill was reintroduced as S. 1217 during the 108th Congress on June 9, 2003, by Senator ENZI, for himself and Senator MIKULSKI. Senators MURRAY, BAUCUS, GRASSLEY, COCHRAN, LAUTENBERG, BINGAMAN, and BUNNING also cosponsored S. 1217. On September 22, 2004, the HELP Committee considered a substitute amendment to S. 1217 offered by Senators ENZI and MIKULSKI, which was approved by unanimous consent.

The Traumatic Brain Injury Act Reauthorization of 2006 was introduced by Senator HATCH for himself and Senator KENNEDY on July 16, 2006.

The original Traumatic Brain Injury Act, introduced by Senator HATCH for himself and Senator KENNEDY, was signed into law (P.L. 104–166) on July 29, 1996. On September 20, 2000, Senator HATCH introduced the Traumatic Brain Injury Act Amendments of 2000 to reauthorize the program. The bill was included as part of the Children's Health Act (P.L. 106–310), which was signed into law on October 17, 2000.

IV. Explanation of Bill and Committee Views

The Keeping Seniors Safe from Falls Act and Reauthorization of the Traumatic Brain Injury Act directs the Secretary of HHS to intensify and expand the Department's efforts to prevent and treat injuries. The legislation focuses on traumatic brain injury and reducing and preventing falls among older adults. The committee authorizes from 2007 through 2010 such sums as may be necessary for TBI programs and elder falls programs administered by the Centers for Disease Control and Prevention (CDC), the Health Resources Service Administration (HRSA) and the National Institutes of Health (NIH).

Minor changes are made to TBI activities administered by CDC and NIH to improve prevention and research activities. A collaborative study between CDC and NIH is authorized to determine the incidence and prevalence of TBI; collect, maintain and report national trends; identify common therapeutic interventions; and develop practice guidelines. The committee also sees it necessary for other Federal agencies such as the Department of Defense (DOD), which conducts TBI research, to be consulted for the report. This will more effectively coordinate and maximize efforts at the Federal level to better understand TBI.

The HRSA grant program was amended to improve access to rehabilitation and other services related to TBI. Recognizing that TBI is a leading cause of death and disability among American Indians/Alaska Indians, tribal communities are eligible to apply for grants. The efficiency of protection and advocacy grants is strengthened by directing HRSA and Administration on Developmental Disabilities (ADD) to coordinate data collection related to services. Payments for grants shall be distributed no later than October 1 of each fiscal year.

The legislation directs the Secretary of HHS to refocus the Department's efforts to prevent falls among older adults through public education and research, and to assess the impact that falls have on healthcare costs. The committee expects the Secretary to carry

out his authority through agencies, such as the CDC and its National Center for Injury Prevention and Control (NCIPC), which have the necessary experience and expertise to conduct and support such work.

The committee expects the public education campaign to be directed principally to older adults, their families, and healthcare providers, and to be focused on the twin goals of reducing falls among older adults and preventing repeat falls. HHS or its designated agency should consider organizations with expertise in designing and implementing large-scale programs to prevent injuries; experience in working in cooperation with government agencies, businesses and corporate organizations; and other non-profit organizations and institutions and the capability to carry out major public education campaigns on a national basis.

The committee believes that HHS should utilize the injury prevention and community health education expertise available at colleges and universities in carrying out provisions of this act. The committee urges HHS to involve these and other qualified organizations and institutions in the implementation of this legislation.

The committee sees it necessary to raise the authorization of appropriations level for Part J—PREVENTION AND CONTROL OF ACTIVITIES, which is the authorization of appropriations line for injury prevention activities, including TBI and Elder Falls Activities, to be increased from $50 million to $58,361,000 for fiscal year 2007 and such sums from 2008–2010. The increase is to meet the level appropriated by appropriators in fiscal year 2007, not to authorize new money.

V. COST ESTIMATE

S. 1531—Keeping Seniors Safe From Falls and Reauthorization of the Traumatic Brain Injury Act

Summary: S. 1531 would authorize appropriations for activities related to injuries and traumatic brain injury (TBI) conducted by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA). It also would authorize and expand certain ongoing activities at CDC related to injuries due to falls experienced by older Americans, and would allow consortia of American Indians to receive HRSA grants for improving access to TBI services.

Assuming the appropriation of the authorized amounts, CBO estimates that implementing S. 1531 would cost $126 million in 2007 and $1.6 billion over the 1007–2011 period. Enacting S. 1531 would not affect direct spending or revenues.

S. 1531 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary impact is shown in the following table. The costs of this legislation fall within budget function 550 (health).

Basis of estimate: For this estimate, CBO assumes that S. 1531 will be enacted near the start of fiscal year 2007, that the necessary amounts will be appropriated for each fiscal year, and that outlays will follow the historical spending rates of similar NIH, CDC, and HRSA programs.

	By fiscal year, in millions of dollars—					
	2006	2007	2008	2009	2010	2011
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law:						
Budget Authority [1]	391	0	0	0	0	0
Estimated Outlays	391	260	44	15	1	0
Proposed Changes:						
Estimated Authorization Level	0	399	411	417	426	0
Estimated Outlays	0	126	349	388	410	281
Spending Under S. 1531:						
Estimated Authorization Level [1]	391	399	411	417	426	0
Estimated Outlays	391	386	393	403	411	281

[1] The 2006 level is the amount appropriated that year for trauma- and injury-related activities at NIH, CDC, and HRSA.

S. 1531 would modify the Public Health Service Act to authorize funding through fiscal year 2010 for NIH and HRSA activities related to trauma and for CEC activities related to injuries and TBI. The bill would expand the scope of HRSA's program of grants to improve access to TBI treatment by allowing consortia of American Indians to receive grants that currently are restricted to states. The bill would also require the CDC and NIH to conduct a study on the prevalence of TBI and the efficacy of medical interventions against it. CBO estimates that the NIH, CDC, and HRSA would require budget authority of $399 million for 2007 and $1.7 billion for the 2007–2011 period to carry out the activities specified in S. 1531. That total is equivalent to the 2006 appropriation level with an adjustment for anticipated inflation. Assuming appropriation of the necessary amounts, CBO estimates that implementing S. 1531 would cost $126 million in 2007 and $1.6 billion over the 2007–2011 period.

The NIH estimates that it will allocate $325 million to trauma-related activities in 2006. S. 1531 would authorize the appropriation of such sums as are necessary for such activities over the 2007–2010 period. Based on historical program expenditures at NIH and adjusting for inflation, CBO estimates that it would require budget authority of $333 million for 2007 and $1.4 billion over the 2007–2011 period to conduct the authorized activities.

Implementing S. 1531 at the NIH would cost $99 million in 2007 and $1.3 billion over the 2007–2011 period, CBO estimates, assuming appropriation of the necessary amounts and that spending for the programs would follow historical patterns for similar activities.

Based on information from the CDC, CBO estimates that for 2006 the CDC allocated about $58 million to research, education, and prevention activities described by S. 1531, including activities related to TBI and falls among the elderly. S. 1531 would authorize the appropriation for those activities of $58 million for 2007, and such sums as are necessary for those activities for fiscal years 2008 through 2010. The bill also would direct CDC to engage in new research, education campaigns, and demonstration programs related to the effects and prevention of injuries due to falls among seniors. CBO estimates that CDC would require $250 million in budget authority over the 2007–2011 periods, including the $58 million that would be authorized for 2007, to implement those previsions. Based on historical spending patterns for similar activities, and assuming appropriation of authorized and necessary amounts, CBO estimates that implementing continued CDC activities would cost $23 million in 2007 and $236 million over the 2007–2011 period.

HRSA allocated $8 million in 2006 for grants to states to expand access to care for TBI. S. 1531 would authorize the appropriation of such sums as are necessary for those activities over the 2007–2010 period, and would expand the program to allow consortia of American Indians to receive such grants. Based on historical spending of the programs, VBO estimates that the agency would require budget authority of $8 million in 2007 and $36 million over the 2007–2011 period to carry out activities specified during the period specified by the bill. CBO estimates that implementing those provisions of S. 1531 would cost $4 million in 2007 and $36 million over the 2007–2011 period, assuming appropriation of necessary amounts and that future rates of spending follow historical patterns for similar activities.

Intergovernmental and Private-Sector Impact: S. 1531 contains no intergovernmental or private-sector mandates as defined in UMRA. State governments and Indian consortia would benefit from grant funding authorized by the bill. Any costs incurred by those entities to qualify for such grants would be incurred voluntarily as conditions of federal assistance.

Estimate prepared by: Federal Costs: Tim Gronniger, Camile Williams. Impact on State, Local, and Tribal Governments: Leo Lex. Impact on the Private Sector: Paige Shevlin.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

VI. Regulatory Impact Statement

Pursuant to the requirements of paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the committee has determined that the bill will not have a significant regulatory impact.

VII. Application of Law to the Legislative Branch

The Committee has determined there is no impact of this law on the legislative branch.

VIII. Section-by-Section Analysis

Section 1. Short title

Section 1 provides the short title of the bill, the Keeping Seniors Safe from Falls and Reauthorization of the Traumatic Brain Injury Act.

Section 2. Conforming amendments relating to restructuring

Section 2 redesignates (1) Section 393B as section 393A, (2) Section 393A as section 393B; and (3) section 393B as section 393C.

Section 3. Traumatic Brain Injury Programs of the Centers for Disease and Prevention

Section 3 amends Part J of Title III of the Public Health Service Act as redesignated (42 U.S.C. 280b–1b) to authorize the dissemination of information related to TBI and the sequelae of secondary conditions arising from TBI upon an individual's discharge from hospitals and emergency centers.

Section 393C of the Public Health Service Act, as redesignated (42 U.S.C. 280B et seq.) is amended to change the heading of the

section to "National Program for Traumatic Brain Injury Surveillance and Registry." This section authorizes grants to States or their designees to develop or operate the State's TBI surveillance system or registry to determine the incidence and prevalence of TBI. The Secretary is authorized to ensure the uniformity of reporting information. Also directs individuals with TBI to be linked with academic institutions to conduct applied research that will support the development of such surveillance systems and registries as necessary.

Sec. 4. Study of traumatic brain injury

This section authorizes the CDC to conduct a study in coordination with the NIH to study activities related to TBI. Activities include determining the incidence and prevalence of TBI in all age groups; collecting, maintaining and reporting national trends; identifying interventions used for rehabilitation and their effectiveness; analyzing the adequacy of existing measures of outcomes and knowledge of factors influencing differential outcomes; and developing guidelines for patient rehabilitation after TBI.

The report shall be submitted to Congress no later than 3 years after the date of enactment.

Sec. 5. Traumatic Brain Injury Programs of the National Institutes of Health

This section reauthorizes the current grant program to conduct basic and clinical research on trauma, including diagnosis treatment rehabilitation, and general management of trauma and TBI.

This section authorizes such sums as may be necessary for each fiscal years 2007–2010.

Sec. 6. Traumatic Brain Injury Programs of all Health Resources and Service Administration

This section reauthorizes the Secretary to award grants to States, and authorizes the Secretary to award grants to American Indian Consortia, for the purpose of carrying out projects to improve access to health and other services regarding TBI.

This section authorizes the Secretary to submit to the committees of jurisdiction no less than bi-annually, a report describing the findings, and results of the programs established under this section, including measures outcomes and consumer and surrogate satisfaction. The surrogate refers to the individual who has the authority to make decisions on behalf of the individual receiving TBI services.

Definitions in this section include American Indian consortium and TBI.

Grants are authorized for such sums as may be necessary for each of the fiscal years 2007 through 2010.

This section authorizes the Secretary to award grants to protection and advocacy systems for the purpose of enabling such systems to provide services to individuals with TBI.

This section directs the Administration to pay directly to any protection and advocacy system that complies with the provisions of this section, no later than October 1.

This section requires the Administrator of Health Resources Service Administration and the Commissioner of the Administra-

tion of Developmental Disabilities to enter into an agreement to coordinate the collection of data by the Administrator and the Commissioner regarding protection and advocacy services.

This section requires for any fiscal year for which the amount appropriated is $6 million or greater, the Administrator to use 2 percent of such amount to make a grant to an eligible national association for providing training and technical assistance for protection and advocacy systems.

In this section, eligible national association means a national association with demonstrated experience in providing training and technical assistance to protection and advocacy systems.

This section gives a protection and advocacy system the same authorities as such a system would for the purpose of providing services under subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000.

Sec. 7. Amendments to the Public Health Service Act Relating to Elder Falls

Section 7 amends Part J of Title III of the Public Health Service Act to add a new section 393D, Prevention of Falls Among Older Adults.

Subsection (a) directs HHS to establish a national public education campaign to prevent falls among older adults and prevent repeat falls. It also establishes authority for HHS to make grants or enter into contracts or cooperative agreements to assist state-level coalitions in conducting local education campaigns to reduce falls among older adults.

Subsection (b) directs HHS to conduct and support research in areas such as identifying older adults who have a high risk of falling; designing, implementing, and evaluating the most effective ways to prevent falls; improving diagnosis, treatment, and rehabilitation of older adults who have fallen; tailoring proven fall reduction strategies to specific populations of older adults; and eliminating barriers to adopting proven fall prevention methods. It also directs the HHS Secretary to make grants or enter into contracts or cooperative agreements to provide professional education for physicians, allied health professionals and aging service providers in fall prevention, evaluation and management.

Subsection (c) gives HHS the authority to conduct and support demonstration programs to assess the utility of targeted fall risk screening and referral programs; programs that use multiple approaches to prevent falls; and programs targeting newly discharged fall victims at high risk for second falls. HHS may also conduct and support demonstration programs to develop technology to prevent falls among older adults and prevent or reduce fall-related injuries, and to implement and evaluate fall prevention programs using proven intervention strategies in different settings.

Subsection (d) directs the Secretary to evaluate the effect of falls on health care costs, the potential for reducing falls, and the most effective strategies for reducing fall-related health care costs.

Sec. 8. Authorization of Appropriations

This section authorizes the appropriation of $58,361,000 for fiscal year 2007 and such sums as may be necessary for fiscal years 2007 through 2010.

IX. CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

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TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

PART A—RESEARCH AND INVESTIGATION

* * * * * * *

PART J—PREVENTION AND CONTROL OF INJURIES

RESEARCH

SEC. 391. (a) * * *

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INTERPERSONAL VIOLENCE WITHIN FAMILIES AND AMONG ACQUAINTANCES

SEC. 393. (a) * * *

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SEC. [393B] *393A*. USE OF ALLOTMENTS FOR RAPE PREVENTION EDUCATION.

(a) PERMITTED USE.—* * *

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PREVENTION OF TRAUMATIC BRAIN INJURY

SEC. [393A] *393B*. (a) IN GENERAL.—* * *

(b) * * *

(1) * * *

* * * * * * *

(3) the implementation of a national education and awareness campaign regarding such injury (in conjunction with the program of the Secretary regarding health-status goals for 2010, commonly referred to as Healthy People 2010), including—

(A) the national dissemination of information on—

(i) incidence and prevalence; and

(ii) information relating to traumatic brain injury and the sequelae of secondary conditions arising from traumatic brain injury upon discharge [from hospitals and trauma centers] *from hospitals and emergency departments*; and

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NATIONAL PROGRAM FOR TRAUMATIC BRAIN INJURY *SURVEILLANCE AND REGISTRIES*

SEC. [393B] *393C*. [(a) IN GENERAL.—]The Secretary, acting through the Director of the Centers for Disease Control and Prevention, [may make grants to States or their designees to operate the State's traumatic brain injury registry, and to academic institutions to conduct applied research that will support the development of such registries, to collect data concerning—] *may make grants to States or their designees to develop or operate the State's traumatic brain injury surveillance system or registry to determine the incidence and prevalence of traumatic brain injury and related disability, to ensure the uniformity of reporting under such system or registry, to link individuals with traumatic brain injury to services and supports, and to link such individuals with academic institutions to conduct applied research that will support the development of such surveillance systems and registries as may be necessary. A surveillance system or registry under this section shall provide for the collection of data concerning—*

* * * * * * *

SEC. 393C–1. STUDY ON TRAUMATIC BRAIN INJURY.

(a) STUDY.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention with respect to paragraph (1) and the Director of the National Institutes of Health with respect to paragraphs (2) and (3), shall conduct a study with respect to traumatic brain injury for the purpose of carrying out the following:

(1) In collaboration with appropriate State and local health-related agencies—

(A) determining the incidence of traumatic brain injury and prevalence of traumatic brain injury related disability in all age groups in the general population of the United States, including institutional settings, such as nursing homes, correctional facilities, psychiatric hospitals, child care facilities, and residential institutes for people with developmental disabilities; and

(B) reporting national trends in traumatic brain injury.

(2) Identifying common therapeutic interventions which are used for the rehabilitation of individuals with such injuries, and, subject to the availability of information, including an analysis of—

(A) the effectiveness of each such intervention in improving the functioning, including return to work or school and community participation, of individuals with brain injuries;

(B) the comparative effectiveness of interventions employed in the course of rehabilitation of individuals with brain injuries to achieve the same or similar clinical outcome; and

(C) the adequacy of existing measures of outcomes and knowledge of factors influencing differential outcomes.

(3) Developing practice guidelines for the rehabilitation of traumatic brain injury at such time as appropriate scientific research becomes available.

(b) DATES CERTAIN FOR REPORTS.—Not later than 3 years after the date of the enactment of the Keeping Seniors Safe from Falls and Reauthorization of the Traumatic Brain Injury Act, the Secretary shall submit to the Congress a report describing findings made as a result of carrying out subsection (a).

(c) DEFINITION.—For purposes of this section, the term "traumatic brain injury" means an acquired injury to the brain. Such term does not include brain dysfunction caused by congenital or degenerative disorders, nor birth trauma, but may include brain injuries caused by anoxia due to trauma. The Secretary may revise the definition of such term as the Secretary determines necessary.

SEC. 393D. PREVENTION OF FALLS AMONG OLDER ADULTS.

(a) PUBLIC EDUCATION.—The Secretary shall—

(1) oversee and support a national education campaign to be carried out by a nonprofit organization with experience in designing and implementing national injury prevention programs, that is directed principally to older adults, their families, and health care providers, and that focuses on reducing falls among older adults and preventing repeat falls; and

(2) award grants, contracts, or cooperative agreements to qualified organizations, institutions, or consortia of qualified organizations and institutions, for the purpose of organizing State-level coalitions of appropriate State and local agencies, safety, health, senior citizen, and other organizations to design and carry out local education campaigns, focusing on reducing falls among older adults and preventing repeat falls.

(b) RESEARCH.—

(1) IN GENERAL.—The Secretary shall—

(A) conduct and support research to—

(i) improve the identification of older adults who have a high risk of falling;

(ii) improve data collection and analysis to identify fall risk and protective factors;

(iii) design, implement, and evaluate the most effective fall prevention interventions;

(iv) improve strategies that are proven to be effective in reducing falls by tailoring these strategies to specific populations of older adults;

(v) conduct research in order to maximize the dissemination of proven, effective fall prevention interventions;

(vi) intensify proven interventions to prevent falls among older adults;

(vii) improve the diagnosis, treatment, and rehabilitation of elderly fall victims and older adults at high risk for falls; and

(viii) assess the risk of falls occurring in various settings;

(B) conduct research concerning barriers to the adoption of proven interventions with respect to the prevention of falls among older adults;

(C) conduct research to develop, implement, and evaluate the most effective approaches to reducing falls among high-risk older adults living in communities and long-term care and assisted living facilities; and

(D) evaluate the effectiveness of community programs designed to prevent falls among older adults.

(2) EDUCATIONAL SUPPORT.—The Secretary, either directly or through awarding grants, contracts, or cooperative agreements to qualified organizations, institutions, or consortia of qualified organizations and institutions, shall provide professional education for physicians and allied health professionals, and aging service providers in fall prevention, evaluation, and management.

(c) DEMONSTRATION PROJECTS.—The Secretary shall carry out the following:

(1) Oversee and support demonstration and research projects to be carried out by qualified organizations, institutions, or consortia of qualified organizations and institutions, in the following areas:

(A) A multistate demonstration project assessing the utility of targeted fall risk screening and referral programs.

(B) Programs designed for community-dwelling older adults that utilize multicomponent fall intervention approaches, including physical activity, medication assessment and reduction when possible, vision enhancement, and home modification strategies.

(C) Programs that are targeted to new fall victims who are at a high risk for second falls and which are designed to maximize independence and quality of life for older adults, particularly those older adults with functional limitations.

(D) Private sector and public-private partnerships to develop technologies to prevent falls among older adults and prevent or reduce injuries if falls occur.

(2)(A) Award grants, contracts, or cooperative agreements to qualified organizations, institutions, or consortia of qualified organizations and institutions, to design, implement, and evaluate fall prevention programs using proven intervention strategies in residential and institutional settings.

(B) Award 1 or more grants, contracts, or cooperative agreements to 1 or more qualified organizations, institutions, or consortia of qualified organizations and institutions, in order to carry out a multistate demonstration project to implement and evaluate fall prevention programs using proven intervention strategies designed for single and multifamily residential settings with high concentrations of older adults, including—

(i) identifying high-risk populations;

(ii) evaluating residential facilities;

(iii) conducting screening to identify high-risk individuals;

(iv) providing fall assessment and risk reduction interventions and counseling;

(v) coordinating services with health care and social service providers; and

(vi) coordinating post-fall treatment and rehabilitation.

(3) Award 1 or more grants, contracts, or cooperative agreements to qualified organizations, institutions, or consortia of qualified organizations and institutions, to conduct evaluations

of the effectiveness of the demonstration projects described in this subsection.

(d) STUDY OF EFFECTS OF FALLS ON HEALTH CARE COSTS.—

(1) IN GENERAL.—The Secretary shall conduct a review of the effects of falls on health care costs, the potential for reducing falls, and the most effective strategies for reducing health care costs associated with falls.

(2) REPORT.—Not later than 36 months after the date of enactment of the Keeping Seniors Safe from Falls and Reauthorization of the Traumatic Brain Injury Act, the Secretary shall submit to Congress a report describing the findings of the Secretary in conducting the review under paragraph (1).

* * * * * * *

AUTHORIZATIONS OF APPROPRIATIONS

SEC. 394A. For the purpose of carrying out this part, there are authorized to be appropriated [$50,000,000 for fiscal year 1994, and[1] such sums as may be necessary for each of the fiscal years 1995 through 1998, and such sums as may be necessary for each of the fiscal years 2001 through 2005.] *$58,361,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2010.*

* * * * * * *

SEC. 1252. STATE GRANTS FOR DEMONSTRATION[1] PROJECTS REGARDING TRAUMATIC BRAIN INJURY.

(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, [may make grants to States] *may make grants to States and American Indian consortia* for the purpose of carrying out projects to improve access to [health and other services] *rehabilitation and other services* regarding traumatic brain injury.

(b) STATE ADVISORY BOARD.—

(1) IN GENERAL.—The Secretary may make a grant under subsection (a) only if the [State] *State or American Indian consortium* involved agrees to establish an advisory board within the appropriate health department of the [State] *State or American Indian consortium* or within another department as designated by the chief executive officer of the [State] *State or American Indian consortium*.

(2) FUNCTIONS.—An advisory board established under paragraph (1) shall advise and make [recommendations to the State] *recommendations to the State or American Indian consortium* on ways to improve services coordination regarding traumatic brain injury. Such advisory boards shall encourage citizen participation through the establishment of public hearings and other types of community outreach programs. In developing recommendations under this paragraph, such boards shall consult with Federal, State, and local governmental agencies and with citizens groups and other private entities.

(3) COMPOSITION.—An advisory board established under paragraph (1) shall be composed of—

(A) representatives of—

(i) the corresponding [State] *State or American Indian consortium* agencies involved;

(ii) public and nonprofit private health related organizations;

(iii) other disability advisory or planning groups within the [State] *State or American Indian consortium*;

(iv) members of an organization or foundation representing individuals with traumatic brain injury in that [State] *State or American Indian consortium*; and

* * * * * * *

(c) MATCHING FUNDS.—

(1) IN GENERAL.—with respect to costs to be incurred by a [State] *State or American Indian consortium* in carrying out the purpose described in subsection (a), the Secretary may make a grant under such subsection only if the [State] *State or American Indian consortium* agrees to make available non-Federal contributions toward such costs in an amount that is not less than $1 for each $2 of Federal funds provided under the grant.

(2) DETERMINATION OF AMOUNT CONTRIBUTED.—* * *

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(e) CONTINUATION OF PREVIOUSLY AWARDED DEMONSTRATION PROJECTS.—[A State that received a grant under this section prior to the date of the enactment of the Children's Health Act of 2000 may compete for new project grants under this section after such date of the enactment.] *State or American Indian consortium that received a grant under this section prior to the date of the enactment of the Keeping Seniors Safe from Falls and Reauthorization of the Traumatic Brain Injury Act may complete the activities funded by the grant.*

(f) USE OF STATE *AND AMERICAN INDIAN CONSORTIUM* GRANTS.—

(1) COMMUNITY SERVICES AND SUPPORTS.—A [State] *State or American Indian consortium* shall (directly or through awards of contracts to nonprofit private entities) use amounts received under a grant under this section for the following:

(A) * * *

(i) * * *

(ii) shall be designed for [children and other individuals] *children, youth, and adults* with traumatic brain injury.

* * * * * * *

(E) To support other needs identified by the advisory board under subsection (b) for the [State] *State or American Indian consortium* involved.

(2) BEST PRACTICES.—

(A) IN GENERAL.—[State] *State or American Indian consortium* services and supports provided under a grant under this section shall reflect the best practices in the field of traumatic brain injury, shall be in compliance with title II of the Americans with Disabilities Act of 1990, and shall be supported by quality assurance measures as well

as state-of-the-art health care and integrated community supports, regardless of the severity of injury.

(B) DEMONSTRATION BY STATE AGENCY.—The [State] *State or American Indian consortium* agency responsible for administering amounts received under a grant under this section shall demonstrate that it has obtained knowledge and expertise of traumatic brain injury and the unique needs associated with traumatic brain injury.

(3) STATE CAPACITY BUILDING.—A [State] *State or American Indian consortium* may use amounts received under a grant under this section to * * *

* * * * * * *

(E) tailor existing [State] *State or American Indian consortium* systems to provide accommodations to the needs of individuals with brain injury (including systems administered by the [State] *State or American Indian consortium* departments responsible for health, mental health, labor/employment, education, mental retardation/developmental disorders, transportation, and correctional systems);

(F) improve data sets coordinated across systems and other needs identified by a [State] *State or American Indian consortium* plan supported by its advisory council; and

* * * * * * *

(h) REPORT.—[Not later than 2 years after the date of the enactment of this section, the Secretary] *Not less than bi-annually, the Secretary* shall submit to the Committee on Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report describing the findings and results of the programs established under this section, *section 1253, and section 1254,* including measures of outcomes and consumer and surrogate satisfaction.

[(i) DEFINITION.—For purposes of this section, the term "traumatic brain injury" means an acquired injury to the brain. Such term does not include brain dysfunction caused by congenital or degenerative disorders, nor birth trauma, but may include brain injuries caused by anoxia due to trauma. The Secretary may revise the definition of such term as the Secretary determines necessary, after consultation with States and other appropriate public or nonprofit private entities.]

(i) DEFINITIONS.—For purposes of this section:

(1) The terms "American Indian consortium" and "State" have the meanings given to those terms in section 1253.

(2) The term "traumatic brain injury" means an acquired injury to the brain. Such term does not include brain dysfunction caused by congenital or degenerative disorders, nor birth trauma, but may include brain injuries caused by anoxia due to near drowning. The Secretary may revise the definition of such term as the Secretary determines necessary, after consultation with States and other appropriate public or nonprofit private entities.

(j) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through

2005*, and such sums as may be necessary for each of the fiscal years 2007 through 2010.*

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SEC. 1253. STATE GRANTS FOR PROTECTION AND ADVOCACY SERVICES.

(a) IN GENERAL.—* * *

* * * * * * *

(d) APPROPRIATIONS LESS THAN $2,700,000.—

(1) IN GENERAL.—With respect to any fiscal year in which the amount appropriated under ⟦subsection (i)⟧ *subsection (l)* to carry out this section is less than $2,700,000, the Administrator shall make grants from such amount to individual protection and advocacy systems within States to enable such systems to plan for, develop outreach strategies for, and carry out services authorized under this section for individuals with traumatic brain injury.

(2) * * *

(e) APPROPRIATIONS OF $2,700,000 OR MORE.—

(1) POPULATION BASIS.—Except as provided in paragraph (2), with respect to each fiscal year in which the amount appropriated under ⟦subsection (i)⟧ *subsection (l)* to carry out this section is $2,700,000 or more, the Administrator shall make a grant to a protection and advocacy system within each State.

(2) AMOUNT.—The amount of a grant provided to a system under paragraph (1) shall be equal to an amount bearing the same ratio to the total amount appropriated for the fiscal year involved under ⟦subsection (i)⟧ *subsection (l)* as the population of the State in which the grantee is located bears to the population of all States.

(3) * * *

* * * * * * *

(4) INFLATION ADJUSTMENT.—For each fiscal year in which the total amount appropriated under ⟦subsection (i)⟧ *subsection (l)* to carry out this section is $5,000,000 or more, and such appropriated amount exceeds the total amount appropriated to carry out this section in the preceding fiscal year, the Administrator shall increase each of the minimum grants amount described in subparagraphs (A) and (B) of paragraph (3) by a percentage equal to the percentage increase in the total amount appropriated under ⟦subsection (i)⟧ *subsection (l)* to carry out this section between the preceding the fiscal year and the fiscal year involved.

* * * * * * *

(g) DIRECT PAYMENT.—Notwithstanding any other provision of law, *each fiscal year not later than October 1,* the Administrator shall pay directly to any protection and advocacy system that complies with the provisions of this section the total amount of the grant for such system, unless the system provides otherwise for such payment.

(h) * * *

* * * * * * *

(i) DATA COLLECTION.—The Administrator of the Health Resources and Services Administration and the Commissioner of the Administration on Developmental Disabilities shall enter into an agreement to coordinate the collection of data by the Administrator and the Commissioner regarding protection and advocacy services.

(j) TRAINING AND TECHNICAL ASSISTANCE.—

(1) GRANTS.—For any fiscal year for which the amount appropriated to carry out this section is $6,000,000 or greater, the Administrator shall use 2 percent of such amount to make a grant to an eligible national association for providing for training and technical assistance to protection and advocacy systems.

(2) DEFINITION.—In this subsection, the term "eligible national association" means a national association with demonstrated experience in providing training and technical assistance to protection and advocacy systems.

(k) SYSTEM AUTHORITY.—In providing services under this section, a protection and advocacy system shall have the same authorities, including access to records, as such system would have for purpose of providing services under subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000.

[(i)**]** *(l)* AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $5,000,000 for fiscal year 2001, and such sums as may be necessary for each the fiscal years 2002 through **[**2005**]** *2010.*

[(j)**]** *(m)* * * *

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PART F—INTERAGENCY PROGRAM FOR TRAUMA RESEARCH

SEC. 1261. ESTABLISHMENT OF PROGRAM.

(a) IN GENERAL.—* * *

* * * * * * *

(d) CERTAIN ACTIVITIES OF PROGRAM.—The Program shall include—

(1) * * *

* * * * * * *

(4) * * *

(A) * * *

* * * * * * *

(D) the development of programs that increase the participation of academic centers of excellence in **[**head brain injury**]** *brain injury* treatment and rehabilitation research and training; and

* * * * * * *

(i) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through

2005*, and such sums as may be necessary for each of fiscal years 2007 through 2010*.

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