



the

HEADLINER

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The Newsletter of the Brain Injury Association of Oregon

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Brain injuries from war worse than thought

Scientists trying to understand traumatic brain injury from bomb blasts are finding the wound more insidious than they once thought.

They find that even when there are no outward signs of injury from the blast, cells deep within the brain can be altered, their metabolism changed, causing them to die, says Geoff Ling, an advance-research scientist with the Pentagon.

The new findings are the result of blast experiments in recent years on animals, followed by microscopic examination of brain tissue. The findings could mean that the number of brain-injured soldiers and Marines — many of whom appear unharmed after exposure to a blast — may be far greater than reported, says Ibolja Cernak, a scientist with the Johns Hopkins University Applied Physics Laboratory.

This cellular death leads to symptoms that may not surface for months or years, Cernak says. The symptoms can include memory deficit, headaches, vertigo, anxiety and apathy or lethargy. "These soldiers could have hidden injuries with long-term consequences," he says. Physicians and scientists are calling TBI the "signature wound" of the Iraq war because of its increasing prevalence among troops.

In the animal studies, scientists say they have found a fundamentally different wound than the "brain concussion" historically associated with undetected brain injuries. A concussion, essentially a bruise on the brain, is a wound that can heal over time, doctors say.

The newly discovered brain damage at the cellular level can be permanent — especially after repeated exposures to blasts — and lead to lasting neurological deterioration, Ling and Cernak say.

Military and civilian scientists worry whether a generation of servicemembers could emerge from the Iraq and

Afghanistan wars with some form of brain damage becoming steadily more severe.

Hidden injuries

Army Sgt. Gary Boggs may be such a case. When he was wounded by a roadside bomb in Iraq in 2003, doctors believed his worst injury was a blinded left eye, along with shrapnel wounds to his left arm and ruptured eardrums.

No one spoke of brain damage during his hospital treatment and convalescence. Boggs said he never considered the possibility until he took a medical retirement from the Army and started a job this year as a financial adviser. Boggs couldn't keep up with a job-study program, forgetting paragraphs he had just read.

TBI— The "Signature wound" of Iraq: Symptoms of traumatic brain injury, or TBI, include memory deficit, headaches, vertigo, anxiety and apathy or lethargy.

"It was really getting hard for me," says Boggs, 32, of Melbourne Beach, Fla. "I finally swallowed my pride and asked for help from the VA (Department of Veterans Affairs). I said, 'I think something is wrong with me.' "

He was diagnosed with mild traumatic brain injury and receives medication to focus his thoughts.

Brain injury experts such as Cernak fear Boggs may be at the front of a new wave of TBI victims.

Cernak's research on blast-related brain injury dates back to the study of wounded soldiers in her native homeland of the former Yugoslavia during the Balkans conflict of the 1990s.

It was in the Balkans where Cernak first discovered that soldiers exposed to blasts who suffered no apparent head wounds displayed brain damage symptoms over a period of months or more than a year.

"You can give her credit for being a pioneer," Ling says.

Can't be detected with imaging tests

When the war in Iraq began, clinicians treating the

(TBI From War Continued on page 5)

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We invite contributions and comments regarding brain injury matters and articles included in *The Headliner*.

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* Support Group Facilitator p. 22-23

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The Lawyer's Desk: A Look at TBI Legal

Representation

By David Kracke, Attorney at Law
Nichols & Associates, Portland, Oregon



The 2007 Brain Injury Conference was a tremendous success and we were fortunate to have attorney Tim Titolo from Nevada as the principal speaker for the legal track. Tim is a nationally recognized attorney who represents brain injured individuals throughout the state of Nevada, and he used his time at the conference to describe some of his legal battles and the strategies he uses to win his clients' cases. Tim used an automobile collision case as the foundation for much of his presentation in order to emphasize his strategy of pre-trial investigation to find the pieces of the puzzle needed to prove the all important hurdle of liability on the part of someone other than the injured person. From there he shared some of his secrets regarding how he evaluates a claim's damages, and how he presents those damages to a jury.

Tim is a master of using disparate statements from various individuals to paint a complete picture of the critical events surrounding the incident that led to the brain injury. In the car collision example he demonstrated how different employees of the liable employer didn't properly communicate (where the employees were literally speaking two different languages), didn't have a firm understanding of company safety policy and didn't follow state laws with respect to how and when vehicles are directed into and through construction zones. The deposition testimony that he played for the attendees would be comical if the results of the workers' incompetence weren't so tragic. In the end, Tim was able to secure for his client a settlement that will allow her to obtain all possible treatment and support as she recovers from her brain injury. It was an example of how the system works, and the dedicated hard work it takes to make the system work.

Tim's persistence and his ability to examine all the facts and wrap them into a coherent theory of liability are traits shared by all of the great lawyers. We are essentially puzzle solvers with the added twist that we have to find the individual pieces of the puzzle and

then work to fit the pieces together. This process is akin to a view point I bring to examining legal documents: I can analyze the words in a given document all day long, but I earn my stripes by figuring out what words are not included in the document, by figuring out what is missing. Similarly, a great brain injury attorney will figure out what facts are missing from a given scenario, what is hidden from view and what he or she needs to find in order to complete the liability analysis.

These hidden facts are difficult to discover and often we rely on the client, the client's family members and witnesses to discover them. In the example used by Tim, he discovered most of the hidden facts through the depositions of various witnesses. Depositions are opportunities to speak to witnesses under oath. As I've described in previous columns, they are one of the most valuable discovery tools available to lawyers to determine what happened in any given scenario. Tim's use of video recording of the various depositions in his case allowed him to piece together certain video excerpts from various witnesses into a montage that demonstrated his argument regarding who was at fault for the collision, and to do so in an effective and powerful manner. In other words, Tim created the puzzle pieces through his effective questioning techniques and then put the puzzle together in a way that convinced the liable party to settle the claim rather than risk a larger verdict in the event that a jury saw it Tim's way.

The conference also highlighted the efforts of my colleague and long time friend Rob Bovett, County Counsel for Lincoln County, Oregon. Rob almost single handedly closed meth labs in the state of Oregon. He did so by drafting legislation prohibiting the sale of over-the-counter pseudoephedrine, a main ingredient used by methamphetamine "cooks", and then lobbying the legislature into agreeing that the sale of the cold medicine should be regulated. The results have

been incredible and Oregon has seen a precipitous drop in the number of meth labs plaguing our state. In doing so, Rob has made Oregon safer for countless children caught in the vicious web of a parent's meth addiction. Our state is also cleaner than before Rob spearheaded this effort and the results have been tangible and beneficial on numerous other levels as well. Shortly after the conference a program aired on many television stations throughout the state highlighting the ways we can all fight the meth scourge in our community, and Rob was featured in that program.

Once again the Brain Injury Association of Oregon has delivered a powerful and exciting conference. Tim Titolo and Rob Bovett were instrumental in helping to make it so, and I want to thank them both again, here in this column, for their efforts. I encourage everyone to attend the up-coming conference in March of 2008 where other panelists and speakers will deliver important information that will help brain injured individuals, their families and support teams and the professional who are committed to helping them.

David Kracke is an attorney with the law firm of Nichols and Associates in Portland. Nichols & Associates has been representing brain injured individuals for over twenty two years. Mr. Kracke is available for consultation at (503) 224-3018.

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(TBI From War Continued from page 1)

wounded began noticing similar symptoms. Some screenings at military bases showed that 10% to 20% of returning troops may have suffered such head wounds.

"We've had patients who have been in a blast, who we tested. They looked OK. And they came back later, and they were not OK," says Maria Mouratidis, head of brain injury treatment at the National Naval Medical Center in Bethesda, Md.

To make matters worse, whatever damage occurred was so microscopic that it could not be found with imaging tests.

"This is a new beast," says Alisa Gean, a San Francisco-based traumatic brain injury specialist who treated soldiers this year at an Army hospital in Germany.

The microscopic damage changes brain cell metabolism, Cernak says, creating a cascading effect that leads to the premature aging and death of neurons that cannot be replaced.

In a presentation before a committee of the National Academy of Sciences last month, Cernak said the damage was caused by the blast pressure wave, an invisible surge of compressed air traveling near the speed of sound. Kinetic energy from this pressure wave ripples through the body, injuring brain cells, Cernak said. All of this occurs in less than a second after the blast, she said. Moreover, she said, body armor is no protection against this blast wave.

Ling says other factors can contribute to TBI, not just pressure. "Pressure is our leading candidate for no other reason than it is the one we've studied the most," he says. "We are playing catch-up."

Concerned about the potential number of wounded, Congress this year authorized \$150 million for brain injury research in an emergency spending bill passed in May for the Iraq and Afghanistan wars.

Repeated exposure to blame?

Roadside bombs, also called improvised explosive devices (IEDs), are the

cause of most cases of brain injury and account for almost 80% of all wounds to U.S. troops. Many troops caught near these explosions can suffer symptoms such as perforated eardrums, ringing in the ears, blurred vision, memory lapses and headaches.

Soldiers often shake off the effects and return to combat.

Iraq and Afghanistan veterans treated by the Department of Veterans Affairs say they have been exposed to anywhere from six to 25 bomb blasts during their combat experiences, says Barbara Sigford, VA director of physical medicine. Ling and other scientists say repeated blast exposure can aggravate any brain damage.

Pentagon medical policy analysts have grappled with the idea of pulling troops out of combat after being exposed to multiple blasts.

However, the science is too preliminary for such a dramatic change in policy, says Army Col. Tony Carter, one of those analysts. "If (soldiers) could have damage and they were otherwise functionally OK, but the damage could show up much later, then essentially what we would be saying is, 'Anybody exposed to blast leaves theater,'" Carter says.

"That would be very, very difficult to do. You don't know (how many blast exposures are too many). Half a dozen? One? I mean, what's the tipping point?"

Source: Gregg Zoroya, USA Today, 9/24/07

2007-2008 BIAOR Calendar of Events

For updated information, please go to www.biaoregon.org

December	8th Annual Holiday Fundraiser and Play Dinner, Auction and Play, Lakewood Community Theater, Lake Oswego For more information see page 10-12	Dec. 9
Feb-March	Brain Injury Awareness See: http://www.oregonbrains.org/outreach/baw/	
Feb 29-Mar 1	6th Annual NW Brain Injury Conference Living with Brain Injury: Emerging Partnership Sheraton Airport Hotel, Portland OR	
March	Brain Injury Awareness Month Activities: Statewide Walk for Thought; Music at the Prairie House Inn ; Bike Rodeo	
July 18-20	1st Annual Camping and Rafting	
Aug	Awareness Concert-Multiple Bands	
Sept	9th Annual Fundraiser	



1st Annual Brain Injury Camping and Rafting Trip

Who: Persons with brain injuries and their family/caretakers
What: Camping and Rafting Trip, 1 mile Hike to Rainy Falls on Sunday
When: Friday-Sunday, July 18-20th, 2008. Rafting is on Sat the 19th
Where: Indian Mary State Park. 10 miles off of I-5 exit #61
Put on by: Southern Oregon Brainstormers

Campsites

Cost: tents \$17, Yurts \$28 per night
Rafting

Renting: \$10 per person and you will go in a 6-8 person raft. \$15 per person for Tahiti. The cost includes raft, lifejacket, oar and shuttle.

For Further Information and details:

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Long Term Disability Claim Under ERISA

Many brain injured individuals are covered through group long term disability plans through their employment. Most of these non-governmental employer plans are subject to the Employee Retirement Income Security Act ("ERISA"), a federal law which requires that administrators of such plans observe minimum procedural requirements and decide an individual's entitlement to benefits fairly. However, disability plans subject to ERISA provide many traps for the unsuspecting or inexperienced.

A brief review of other disability plans will serve to illustrate basic differences between ERISA and non-ERISA plans. Individuals who are covered by non-ERISA disability plans such as individual disability plans, Public Employee Retirement System disability, workers' compensation, and social security disability all have the right to contest the denial of the claim in a trial-like proceeding. This trial-like proceeding allows the individual to provide testimony regarding his disability, call live lay witnesses who have observed how medical impairments have disabled him, to present medical testimony through his physicians, and to call vocational consultants to provide testimony. In addition, in the trial-like proceeding the individual, usually through his attorney, may cross examine those individuals who testify against his interests or claim. However, under ERISA, depending on the precise language in the plan, typically an individual claiming entitlement to benefits does not have these rights.

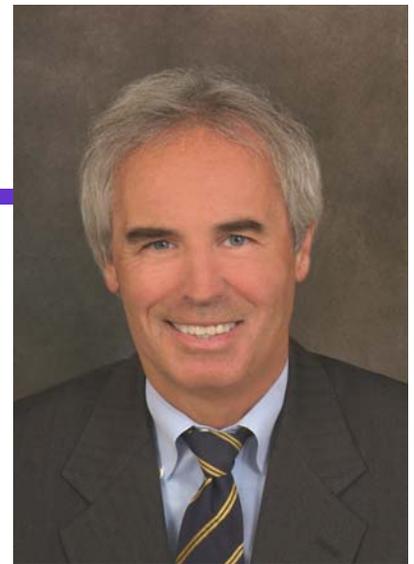
Under ERISA the evidence supporting the entitlement to benefits must be submitted to the plan administrator. This typically includes the submission of job descriptions, medical records and reports certifying disability, and, if necessary, vocational assessments. In some cases it is appropriate to submit affidavits from the individual seeking benefits, those who have observed him and can explain how his impairments prevent him from working, and other similar information, although in the

typical case the ERISA plan administrator will give submissions of lay affidavits little weight.

The ERISA plan administrator typically does not conduct review of the claim himself. The typical ERISA plan administrator employs claims examiners to gather medical records and to communicate with plan consultants who may or may not be physicians or certified vocational consultants. Although the law is currently in flux, in the past in the typical case there was no procedure under ERISA to cross examine the claim examiner, the consulting physicians or vocational consultants, or the plan administrator regarding the basis for his decision denying the claim. After an administrator finally denies the claim, an individual may appeal the denial to court.

However, the court will typically not provide the individual a trial-like proceeding. The claimant is typically limited to the evidence-paperwork that constitutes the claim and is in the claim file at the time of the denial.

However, in *Abatie v. Alta Health and Life Ins. Co.*, 458 F3d 955 (9th Cir. 2006), the Ninth Circuit opened the door to more vigorous litigation challenging a plan administrator's denial of an ERISA claim for benefits, even where the standard review is for abuse of discretion. For instance, the court held that when a plan both accepts premiums and decides the claim the plan administrator suffers from a conflict of interest. This is because the plan administrator's duty to decide claims fairly collides with the incentive to deny the claim to create or maximize profits. The *Abatie* court stated that other factors, such as the plan administrator's failure to observe ERISA claims processing requirements, a plan's parsimonious claims granting history, cherry picking of the medical record to support denial of the claim, misconstruing medical or psychological evidence, failing to have medical experts in the field of the claimant's medical



conditions or impairments review the claim, and failing to seek information or explanatory reports from plaintiff's treating physicians in an effort to understand how the individual claimant's conditions disabled him, are all factors the court should consider in determining how much deference to give the plan administrator's denial of the claim. The *Abatie* court stated further that in certain circumstances the court may allow supplementation of the record with evidence "extrinsic" to the administrative record to show evidence of the plan administrator's conflict.

Abatie is a first step in leveling the playing field for those who seek benefits from plans subject to ERISA. However, it is clear that individuals who seek such benefits must do so in a manner informed by the necessity of ensuring that the administrative claim file supports his entitlement to benefits because he will typically not have a chance to do so in court.

Ralph Wiser, III is an attorney in Portland and represents brain injured individuals. Mr. Wiser is available for consultation at (503) 620-5577.



Sharon Slaughter
Executive Director

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- 3! Traumatic Brain Injury: A Guide for Educators
- 3! Native People and Brain Injury
- 3! How Brain Injury Affects Families
- 3! Brain Injury for Medical and Legal Professionals-What you need to know.
- 3! Caregiver Training
- 3! Dealing with Behavioral Issues
- 3! Returning to Work After Brain Injury
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For more information contact Sherry Stock, Executive Director, Brain Injury Association of Oregon at sherry@biaoregon.org 503-413-7707 or 800-544-5243

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A full belly makes a dull brain.

Benjamin Franklin (from *Poor Richard*, 1758)

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People Helping People

People Helping People (PHP) is a 501(C)(3) non-profit organization providing services in the greater Portland metropolitan area. Their mission is to work to break the cycle of poverty and improve the quality of life for adults with disabilities.

Due to the reduction in publicly funded social service programs, more and more adults with disabilities are living on the edge and falling through the cracks in the system.

PHP is a comprehensive program includes a continuum of level of services provided. The intensity of the services provided is based on the need of each individual client. PHP assist clients by navigating existing service systems and coordinating services when a person is has multiple service providers. When a service is needed that does not already exist, they "think outside of the box" to come up with a solution.

Sample Service Cases

a. When Mohamed was referred to PHP he was living in a barren apartment with only a mattress on the floor. His apartment was in a bad neighborhood, and Mohamed was very frightened living there. It was winter when Mohamed's PHP case manager first visited

him at his apartment. His apartment was cold; Mohamed could not even afford heat. He had no income and was unable to work due to his disabilities. Mohamed's PHP case manager helped him get Social Security benefits. She then helped him find Section 8 subsidized housing in a neighborhood where he felt safe. Once safe and secure, his PHP case manager helped him to fulfill his dream of becoming a United States citizen. Mohammed later got married and is now the proud father of twin sons.

Our staff is trained to think "outside the box" in order to find creative, client centered solutions to tough problems.

b. Jo came to PHP with health problems that were making it more and more difficult for her to work at her part-time job. However, because Jo had no health insurance, she would not go to the doctor. Jo's advocate navigated local health systems to help her get the medical care she needed. She accompanied Jo to every doctor's appointment. After seeing several specialists,

Jo found out that without brain surgery she would become permanently disabled and

eventually confined to a wheelchair. With the help of her PHP advocate, Jo got the surgery she needed. Jo is now working full-time. As a full-time employee, Jo is now able to access the health insurance coverage that her employer offers. Jo has received recognition from her employer as an "honored employee."

Oregon Driver Manual Study Guide
Many people with disabilities have difficulty reading the Oregon (DMV) Driver Manual to prepare for the knowledge test required to get an Oregon driver license. This study guide is designed in an easy-to-read question and answer format that simplifies and synthesizes the content of the Oregon Driver Manual.

Jean had driven for years... before she was brutally beaten and received a traumatic brain injury. As part of rebuilding her life, she wanted to get her drivers license back. She had been given a car, but could not legally drive it. Due to her traumatic brain injury, she was unable to process all of the information in the Oregon Drivers Manual, in the way it was presented, to pass the written knowledge test. Using the Study Guide, Jean was able to prepare for and pass the written knowledge test.

Contact information:

Sharon Bareis
People Helping People
Phone: (503) 703-9051
Email: peoplehelpingpeople@comcast.net
Website: www.phpnw.org

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jgreenfield@oradvocacy.org

What is Brain Injury?

The brain controls the actions of the body and allows us to think, learn, and remember.

The brain has three main sections: the cerebral hemispheres, cerebellum, and brain stem.

There are left and right cerebral hemispheres. The cerebral hemispheres are divided into sections called lobes. Each section of the brain has special jobs to do and sections of the brain also work together.

The left cerebral hemisphere controls the right side of the body and is usually responsible for speech. The right cerebral hemisphere controls the left side of the body and is usually responsible for creative thinking.

WHAT TYPES OF BRAIN INJURY MAY OCCUR?

Every injury is different. Most injuries are a result of bruising, bleeding, twisting, or tearing of brain tissue. Damage to the brain may occur at the time of injury. It may also develop after the injury due to swelling or further bleeding. Patients may have more than one type of brain injury.

SKULL FRACTURE:

a break in the bone that surrounds the brain. These fractures often heal on their own. Surgery may be needed if there has been damage to the brain tissue below the fracture.

CONTUSION/CONCUSSION:

a mild injury or bruise to the brain which causes a short loss of consciousness. A contusion or concussion may cause headaches, nausea, vomiting, dizziness, and trouble remembering or concentrating. This injury will not need surgery.

COUP-CONTRA COUP:

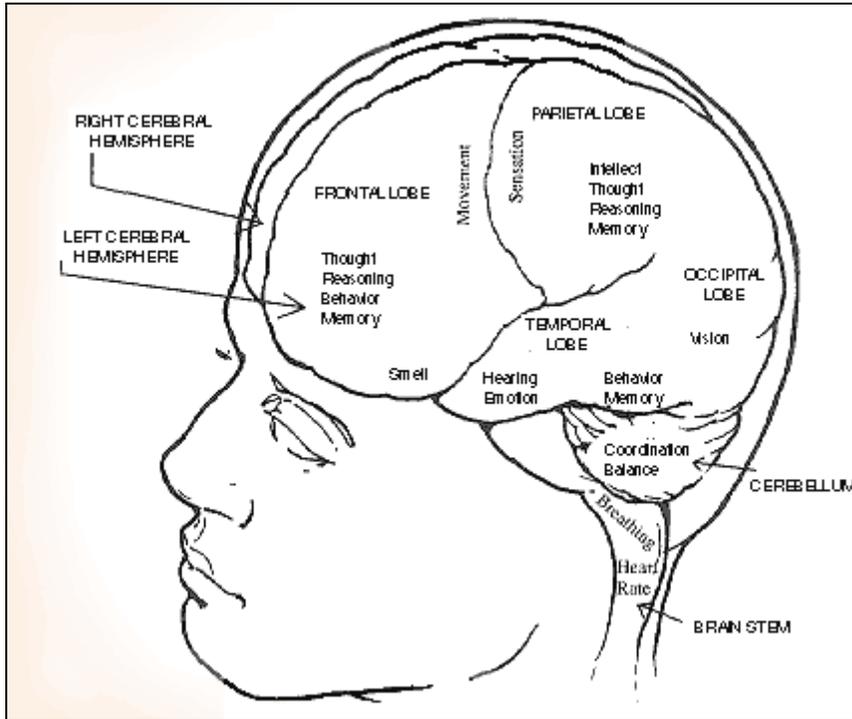
a French word that describes contusions that occur at two sites in the brain. The force of the impact causes the brain to bump the opposite side of the skull. Damage occurs at the site of impact and on the opposite side of the brain.

DIFFUSE AXONAL INJURY (DAI):

damage to the pathways (axons) that connect the different areas of the brain. This occurs when there is twisting and turning of the brain tissue at the time of injury. The brain messages get slowed or lost. Treatment is aimed at managing swelling in the brain because torn axons can not be repaired.

ANOXIC (Hypoxia) BRAIN INJURY:

an injury that results from a lack of oxygen to a part of the brain. The brain is more susceptible to injury through lack of oxygen (hypoxia) than any other part of the body. This is most often from a lack of blood flow due to injury or bleeding. This will cause swelling of the brain tissue. Hypoxia can occur in conjunction with other injuries (heart attack) or from any other situation where breathing or oxygen intake is impaired. Damage from hypoxia is often seen in the hippocampus, an area of the brain necessary for laying down new memories.



EPIDURAL HEMATOMA:

a blood clot that forms between the skull and the top lining of the brain (dura). This blood clot can cause fast changes in the pressure inside the brain. Emergency surgery may be needed. The size of the clot will determine if surgery is needed.

SUBDURAL HEMATOMA:

a blood clot that forms between the dura and the brain tissue. If this bleeding occurs quickly it is called an acute subdural hematoma. If it occurs slowly over several weeks, it is called a chronic subdural hematoma. The clot may cause increased pressure and may need to be removed surgically.

INTRACEREBRAL HEMORRHAGE:

a blood clot deep in the middle of the brain that is hard to remove. Pressure from this clot may cause damage to the brain. Surgery may be needed to relieve the pressure.

HYPOXIA OR TOXIC SUBSTANCE EXPOSURE

Exposure to toxic chemicals (lead, toluene, carbon monoxide, toxic molds among many others) can also cause brain damage, depending on the level of exposure and the duration of exposure, the combination of which is called the "dose."



The Telehealth Idaho Virtual Grand Rounds Presents:

Veterans With Traumatic Brain Injury VGR Series, 7th Edition

A five week series that will be video-cast throughout Idaho. Speakers will cover topics on related treatment for returning Veterans with TBI, model programs, long term planning & advocacy. Family members, private providers, state agency personnel and the general public who work with or have an interest in traumatic brain injuries are invited.

All dates are from 10:00 am to 12:00 pm Mountain time (9:00 am to 11:00 am Pacific)



November 1, 2007 – *The True Welcome Home*: Pat Rowe Kerr, State Veterans Ombudsman & Director, Operation Outreach. Understanding how communities and agencies work together to outreach and address the needs of our service members, Ms. Rowe-Kerr will share the process Missouri has created for best practices in serving veterans and those who care for them.

November 8, 2007 – *Heart of a Hero: A Soldiers Return After TBI*: Mary Kelly LTC AN (Ret), Transition Assistance Advisor, Idaho National Guard; Katie Anderson, LCSW Brain Injury Program Director, Idaho Elks Rehabilitation Hospital; Dewayne & Jeannette Mayer (returning serviceman) This live session will consist of a panel presentation, highlighting a military family who has experienced the trauma of a battlefield brain injury, the treatment used and the military assistance provided.

November 15, 2007 – *Returning Veterans and Their Families: What Every Family Member Should Know*: Sherry Stock, Executive Director, Brain Injury Association of Oregon will give participant's information on Oregon's Brain Injury Resource Network, how it is attempting to meet the needs of Oregonians experiencing brain injury.

December 6, 2007 – *Cognitive Rehabilitation after Blast Injury & Polytrauma*: Don MacLennan, Minneapolis VA Medical Center. This presentation will describe the nature of blast injury and resulting polytrauma and outline the VA system of care for returning servicemen and women who have sustained polytrauma. As many of these injuries include coexisting brain injury, cognitive rehabilitation is a cornerstone of rehabilitation efforts.

December 13, 2007 – *Idaho's Traumatic Brain Injury Virtual Program Center (TBI-VPC)*: Russ Spearman, Project Director, ISU- Institute of Rural Health and Laura J. Tivis Ph.D. Project Manager will overview and demonstrate the development of a computer-based expert decision support tool - the Idaho TBI VPC constructed to guide users to best practice supports and resources in Idaho and nationally.

Locations

Pocatello: ISU campus, Eli Oboler Library, Room B-35 **Idaho Falls:** ISU Idaho Falls, 1776 Science Center Dr., Room 208 **Boise:** ISU Boise Center, 12301 W. Explorer Dr., Suite 102, Room 156 **Twin Falls:** Evergreen Bldg, 315 Falls Ave., Suite B-40, Room C-89 **Lewiston:** Lewis and Clark State College, Sam Glenn Complex, corner of 4th & 9th Ave, Room SG-50. **Coeur d' Alene:** North Idaho Center for Higher Ed., 1000 W. Hubbard, Suite 128

Registration

The session is FREE but seating is limited. To register, please go to the TeleHealth Idaho website: telida.isu.edu and click on the vgr registration tab on the left side bar.

Questions and Information

e-mail: tbi@isu.edu or contact Donna Parker, ISU-Institute of Rural Health at 208-373-1769

This project is supported in part by grant #1-H21-MC0006801, from the Department of Health and Human Services (DHHS), Health Resources Services Administration, Maternal and Child Health Bureau; Telehealth Idaho (HRSA Grant #5-D1BTM 00042) and Idaho State University- Institute of Rural Health. The contents are the sole responsibility of the authors and do not necessarily represent the official views of DHHS. This is the public domain. Please duplicate and distribute widely.



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Brain Injury Association of Oregon

Lakewood Community Theater



Sunday, December 9, 2007

Please Purchase tickets by November 30, 2007.



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4-5:00 pm: Balloon Sales, Silent Auction & Raffle

5:00 pm: Dinner

In the banquet room of the
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7:00 pm: Lakewood Community Theater Stage

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For further information please contact:
Sherry Stock at biaor@biaoregon.org

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Lakewood Community Theater • Sunday, December 9, 2007

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Please seat me at a no-host table • \$100.00 per person

If you have several friends that you would like to sit with, we encourage you to submit one check or multiple checks in one envelope. Tables accommodate 10 people. (\$50.00 tax deductible)

• **I NEED _____ PLAY TICKETS (one ticket per paid attendee).**

I am unable to attend. Please accept my donation for: \$ _____

I would like to donate to the auction Yes _____ No _____ Item: _____

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Return Registration to: Brain Injury Association of Oregon
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Shaken Baby Syndrome

All too often in today's news we hear of the tragic death of an infant from Shaken Baby Syndrome.



Over ten percent of all child abuse related deaths in this country are caused by Shaken Baby Syndrome, when an abuser shakes a child violently enough to cause brain damage. The whiplash type motion that occurs when an abuser shakes a baby causes what are known as acceleration-deceleration injuries, which can inflict terrible injuries to a baby or child. Shaken Baby Syndrome is classified as a non-accidental trauma, and even if it does not result in death, it can leave the child permanently and seriously brain-damaged for the rest of its life.

- 3! When a baby is shaken, its brain rebounds against its skull
- 3! The resulting damage can be lethal or permanent
- 3! Caregivers who have lost their tempers are responsible for almost all SBS cases.
- 3! 60% of shaken babies are male.

Shaken Baby Syndrome can occur in children that are up to five years old, but usually is seen in much younger toddlers and infants, with most cases being under the age of one. Even a few seconds of shaking a baby can produce the effects of Shaken Baby Syndrome. Injuries occur from the acceleration of the shaking and/or the deceleration of the baby's head hitting an object, even one as soft as a pillow. The whiplash effect produced has a profound impact on infants and toddlers because of the fact that their brains are softer and neck muscles and ligaments are not fully developed yet. Their heads are large in proportion to the rest of their body, and when a baby is shaken, the brain will rebound against the inside skull. This can have bruising, swelling, pressure, and bleeding in the brain as a consequence. The veins on the outside of the brain can tear, precipitating even more bleeding and swelling, with irreversible brain damage the end result. If the brain escapes injury, the neck, spine, and eyes may not be so fortunate.

Heads Up for Heroes

"Heads Up for Heroes", a free neurofeedback clinic for Afghan/Iraq veterans with TBI, will begin offering services in January 2008 at Natural Health Center – First Avenue, primary teaching clinic of the National College of Private Medicine (NCPM). Heads Up for Heroes is a cooperative effort among private practitioners and NCPM.

Mild to moderate brain injury patients have been seen to recover ability to take in information, improve short-term memory, organization, sequencing, prioritizing, sensory discrimination, initiation, confidence, assertiveness, and sense of humor. Depression, irritability, and explosiveness respond at the same time. People should know within eight sessions whether the neurofeedback is having an effect. More severe problems require longer treatments. The program is particularly interested in reaching veterans whose injuries are at least two years old.

Interested veterans should contact Kayle Sandberg-Lewis at 503.234.2733 or StressLess@PDXBetter-Brain.com

*He says where he's from is called Albertane.
There they use more than 10% of the brain.*

Hanson (from the song, *Man From Milwaukee*)

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Silence on Concussions Raises Risks of Injury

Many of the 1.2 million teenagers who play high school football are not quite sure what a concussion is, and would never tell their coaches if they believed they had sustained one.

Why? Because the coaches would take them out in a second. They either do not know what a concussion is or they simply do not care. Their code of silence, bred by football's gladiator culture, allows them to play on and sometimes be hurt much worse — sometimes fatally.

The National Football League has recently faced questions about its handling of concussions after four former players were found to have significant brain damage as early as their mid-30s. But teenagers are more susceptible to immediate harm from such injuries because, studies show, their brain tissue is less developed than adults' and more easily damaged. High school players also typically receive less capable medical care, or none at all.

At least 50 high school or younger football players in more than 20 states since 1997 have been killed or have sustained serious head injuries on the field, according to research by The New York Times.

Experts say many of these accidents could have been prevented by simple awareness of and respect for their gravity.

Poor management of high school players' concussions "isn't just a football issue," said Robert Sallis, president of the American College of Sports Medicine. "It's a matter of public health."

Interviews with players indicate that even those aware of the dangers of concussions ignore them. Coaches, trainers and parents can detect a gimpy knee or a separated shoulder, and act. But a concussion is often the player's secret. It is the one injury no one sees.

A senior quarterback at a High School in Memphis, said he sustained a concussion

last year when he was briefly knocked unconscious when a linebacker picked him up and threw him to the ground on his head. No flag was thrown. He said he wobbled to the huddle, took the next snap and dropped back to pass before his vision blurred completely.

"I couldn't come out — my team needed me," he said. "You have to keep playing — until you can't."

Concussion is typically followed by:

- 3 ! dizziness,
- 3 ! headache,
- 3 ! nausea,
- 3 ! lethargy,
- 3 ! impaired vision or
- 3 ! other disruptions in brain function.

Some players airily guessed at describing a concussion: "You feel dizzy and stuff"; "when you're cross-eyed"; "when you feel real sleepy"; "it's like when you turn into someone else." Only a few of more than 50 players interviewed at the tournament came close to defining the injury: a blow to the head that causes the brain to crash into the skull. Concussion — the word derives from the Latin *concutere*, meaning shake violently — is typically followed by dizziness, headache, nausea, lethargy, impaired vision or other disruptions in brain function.

Studies show that concussions are drastically underreported in high school football in part because many youngsters — even adults — still mistakenly think the injury requires the player to have been knocked unconscious. Athletic trainers report about 5 percent of high school players as having had a concussion each season, studies show, but formal widespread surveys of players strongly suggest the number is much higher.

Anonymous questionnaires that ask specifically about concussions have reported rates among high school football players at about 15 percent each season; when the word

concussion is omitted and a description of symptoms is provided instead, close to 50 percent of players say they had one, with 35 percent reporting two or more. Although concussions remain one of the more imprecise diagnoses in sports medicine — magnetic resonance imaging exams and CAT scans cannot detect them — the players' testimony has been taken by experts to indicate that a vast majority of concussions are not treated.

Doctors call it second-impact syndrome. Almost solely among teenagers, sustaining another blow to the head — even a seemingly benign one — before a first has healed can set off a devastating chain of metabolic events: Cerebral blood flow increases, arteries swell past capacity, and pressure builds inside the brain, often leading to coma and death. Helmets can do only so much to keep youngsters' brains from sloshing inside their skulls, like the yolk inside an egg.

A recent study in The American Journal of Sports Medicine led by Barry P. Boden of the Orthopaedic Center in Rockville, Md., found that catastrophic football head injuries were three times as prevalent among high school players as college players — and that "an unacceptably high percentage of high school players were playing with residual symptoms from a prior head injury."

For many victims, staying alive is only the first challenge. Some may have: trouble holding down a job because of short-term memory problems; mood swings and cognitive problems; those who emerge from a coma maybe reading at a kindergarten level.

Second-impact syndrome is relatively rare, however. Experts said that for every such case there can be hundreds of victims of postconcussion syndrome, leaving youngsters depressed, irritable and unable to concentrate, and they sometimes miss school for weeks or perform poorly on tests.

(Concussion Continued on page 15)

(Concussion Continued from page 14)

With no limp or wince to advertise most concussions, coaches and sideline medical staff must be keenly aware of their signs; waiting for gross disorientation or nausea invites disaster.

Diagnostic methods vary in science and scope, but most involve asking questions to gauge a player's awareness, testing short-term memory by repeating strings of words and numbers backward and forward, and administering short pencil-and-paper tests. Players are encouraged to be re-examined after physical exertion to see if headache or cognitive problems return.

Many school districts require an ambulance and paramedics to be on-site in case of emergencies, but a sideline physician is

often a luxury. Only 42 percent of high schools in the United States have access to a certified athletic trainer, according to the National Athletic Trainers' Association.

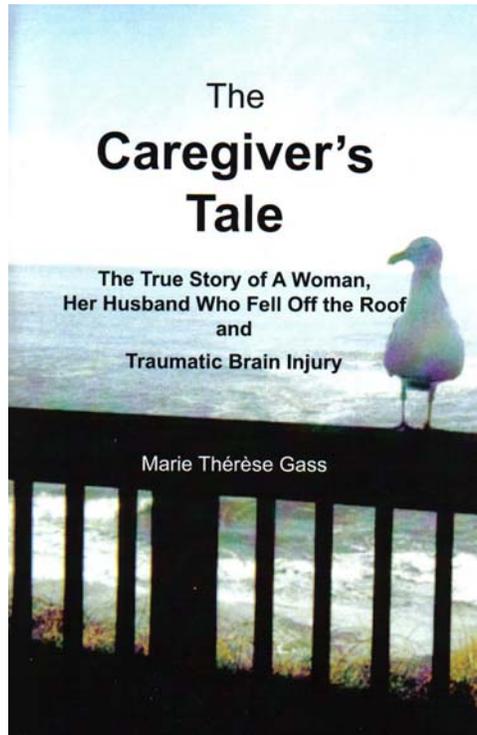
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Kampfe Management Services

Kampfe Management Services (KMS) is a community based rehabilitation program focused on providing cognitive retraining for traumatically brain injured adults.

For over 10 years, KMS has stood out in the Portland metropolitan area as a pioneering program designed specifically for brain injury and the readjustment of life for survivors of head trauma.

KMS's goal is to facilitate traumatically brain-injured adults to become as independent as possible from a functional and behavioral base. Their program is individually based. They write a habilitation plan (IHP) for each client. When a client enters the program, they run a 30 day assessment plan which becomes the basis for the habilitation plan. This plan focuses on their cognitive deficits and strategies that need to be learned to compensate for the barriers. The IHP describes their programs, deficits that they are addressing, strategies they are employing, and a time frame. Each program is documented from which they compile data at the end of the month to track their progress.

Listed below are the basic services they provide. Since KMS are individually based, other programs could be added to meet the specific need of each client. These programs are all done one-on-one with staff.



Daily Hygiene

Medication Management: Client fills med cassette for the week. staff administers medication.

Budgeting and Money Management: Client learns to budget and manage his or her money.

Menu Planning: Client makes a menu for the week.

Shopping list: Client makes a grocery list based on the menu.

Grocery Shopping: Client goes shopping with staff for the week's food.

Laundry: Client does laundry once weekly.

Cleaning: Client cleans their apartment.

Survival Skills Street: Safety, path finding, transportation and emergency procedures.

Book Usage: For memory, time management, goals and interpersonal relationships.

This is done one-on-one with a case manager. At this time each week, they evaluate the progress and behavioral choices of each client. At this time they also evaluate the week in terms of meeting short

term goals.

Vocational Placement: This consists of job development, job placement and job coaching.

For more information contact:

Pam Griffith

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Portland OR 97202

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Conference Wrap Up

By

Sherry Stock, Executive Director



By any measure, the 2007 Conference was a success.

The most exciting thing about the conference was the involvement of the Veterans Administration interacting with attendees and exhibitors! "This has been the most successful conference we have attended," stated one exhibitor.

Ramona Ahto, WA, opened the conference both mornings with a Traditional Tribal Bell Ceremony.

Harriet Zeiner, PhD, launched the conference by discussing the issues affecting returning military with brain injury, in her talk., "The Changing VA Population: Young, Active Duty and Brain Injured." From there, we learned about PTSD & TBI, in a discussion with Dr. Harriet Zeiner, VA, CA; Major Jim Sardo, PhD, VA, OR; Dan Storzbach, PhD. The returning military with brain injury was a major focus throughout the conference. We were honored to have the renowned Muriel B. Lezak, PhD, (Families Need Care Too), addressing family caregivers. Marie Therese Gass, Author of *The Caregiver's Tale: The True Story of A Woman, Her Husband Who Fell Off the Roof, And Traumatic Brain Injury, was the Keynote Saturday morning emphasizing our second focus – caregiving.*

Of course, we also had presentations from many people working in the brain injury field. This included Mary Pepping, PhD, UW (Utilization of Neuropsychological Evaluation Results in Development of Treatment Plan and Long-Term Psychosocial Outcomes for TBI Survivors in Relationship to Different Treatment Methods); Kathy de Domingo, PRA, Laurie Ehlhardt, PhD, TR-Eugene, Julia Greenfield, JD, OAC, Jan Johnson, CRSO (Managing the funding crisis in cognitive rehabilitation: Practical tips and advocacy); Martin Russo (Rehab Alternatives: Using the BIRK in rural areas); Martin Russo, Daytimer and Clara Holguin,

ED, BIANM (How to use the Brain Injury Recovery Kit with mentors: The New Mexico Model); Will Levin, PhD (Practical Coping Skills for Survivors and Their Supporters and Using Interactive Self-Help Homework For Emotional Wellness); Lisa Millet, MA, OR Dept of Epidemiology; Robert Tell, LCSW, VA suicide prevention coordinator (Suicide after a Brain Injury); Eilis A. Boudreau, MD (Sleep Problems in TBI: Diagnosis and Management); Dorothy Cronin, ED BIAW, WY (Leveraging Community Resources: How to Get What Your Client Really Needs); Kevin Kalama, Service Center Manager, Brenda Gordon, Dept of Veterans Affairs, Portland Oregon Regional Office (Rating decisions for veterans with TBI); Sandra Stafford, LMT (Craniosacral Therapy); McKay Moore Sohlberg, PhD, UO; Bryan Ness, UO (Practical Strategies for Serving Students with TBI in the Schools); Janet Mott, PhD, WA (Returning Military: Life Care Planning, What Is It? Why It Is Important); Bob Butler, Ph.D., ABPP (Pediatric Brain Injury Rehab: A New Standard of Care); James Sardo, PhD, and Adam Nelson, PhD (Substance Abuse and TBI); Kevi Ames, PRA (Stop the Spinning: Dizziness After Brain Injury); Kayla Aalberg Eklund, Linda Rask, and Lee Rask (Structured Settlements – Security for Healing); Russ Spearman, M. Ed, Idaho TBI Project Director (Idaho's TBI Virtual Program Center); Rob Johnson, DC (Neuro-toxin exposure and Brain Injury/TBI for a Practitioner); Bruce McLean MA CRC, Guy Goode MS, CRC, state voc. rehab. OR VRD, Sara Kendall, Project Manager, Oregon Competitive Employment Project; and Celia Wren, VA voc. rehab. (Panel: Getting people with TBI back to work); Paul Cordo, PhD (Stroke and TBI physical retraining of brain – neuro plasticity); Curtis Brown and Jeri Cohen (Creating a Successful Support Group); Aleyna Reed, RN MS, Psy.D (Children and Brain Injury: A Road Map); Tootie Smith, BIAOR; Gene van den Bosch, MA, ED, BIAWA; Sherry Stock,

MA, CBIS, ED, BIAOR; Clara Holguin, ED, BIANM; Dorothy Cronin, CBIS, ED, BIAWY (Advocacy Training - How to Keep the Momentum going); and our Native Peoples track featuring: Ramona Ahto, WA (TBI Needs and the Challenges in Recovery Among Native Americans); Beverly Francisco James, BIANM (Native People and Health Prevention Activities).

Successful multi-hour education trainings were provided by Rob Bovett, JD, OR Narcotics Enforcement Assoc (Methamphetamine and TBI); Traci Adair, TBI/MH Program Manager and TBI Grant Director Washington State Aging and Disability Services Administration; Cheryl Sanders, Executive Director, Oregon Home Care Commission (TBI Caregiver Curriculum: A collaboration in progress) and David Kracke, JD, OR; Tim Titolo, JD, NV (What It Takes to Be A TBI Lawyer). Presentations were so powerful and informative that we will continue with follow-up sessions in the next conference (Feb 29-March1, 2008).

The Conference was co-sponsored by The Oregon Competitive Employment Project, which is part of the Oregon State Department of Human Services, Office of Vocational Rehabilitation Services, is funded through a Medicaid Infrastructure Grant from the U.S. Centers for Medicare and Medicaid Services (CFDA #11-P-92415-0/03). Daytimer sponsored the reception on Friday night, and Swanson, Thomas and Coon sponsored the breaks on Saturday.

The conference provided an unprecedented opportunity for the VA, working with

(Conference Continued on page 18)



Steve Dehner, Conference AV Specialist, Sherry Stock, BIAOR Executive Director, Frank Bocci, BIAOR Board President

Thank you to our Conference Sponsors and Exhibitors

Sponsors

The Oregon Competitive Employment Project
Day-Timers
Swanson, Thomas and Coon

(Conference Continued from page 17)

returning military who have sustained brain injuries, to get together and exchange ideas and compare approaches with the brain injury community of professionals and service providers. Hopefully this pooling of knowledge and connections will result in more services being offered to the returning military with brain injury and the VA working with local providers to administer those services.

Some more fun facts from the conference:

- 3! The furthest-travelling attendees came from Illinois, Pennsylvania, New Mexico, Arizona, Wyoming, and Alaska.
- 3! We had more walk-ins than we have ever had - the down side is that we ran out of packets.
- 3! We had more crashers than ever before – it is great that people want to attend, now just getting them to pay...
- 3! We had a group of 8 Japanese visitors sitting in on the sessions-who were those guys!?!.
- 3! Thom Dudley was outstanding as our Friday night entertainment and he even was asked to play the next night for another group.

The true conference star, however, was Steve Dehner, AV & Instructional Technology Coordinator, National College of Natural Medicine. Steve single handedly managed all AV for the three simultaneous sessions. For the first year ever, we had almost flawless AV. We thank Steve and National College of Natural Medicine for his time and expertise.

The Annual Conference is moving to March in honor of the Oregon Legislature passing SJR 21 in 2007 which designates March as Brain Injury Awareness Month. We will hold the 6th Annual Pacific Northwest Brain Injury Conference 2007 on February 29 and March 1, 2008 at the Sheraton Portland Airport Hotel. If you are interested in being a speaker or if you would like more information, please let me know. Registration is on the next page.

Exhibitors

Brain Injury Association of Oregon	The Oregon Advocacy Center
Brain Injury Association of Washington	Performance Mobility
Centre for Neuro Skills	Second Step, Inc.
Highland Heights Home Care	Teaching Research Institute
Homeward Bound	Wy'East Medical
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The Oregon Competitive Employment Project, which is part of the Oregon State Department of Human Services, Office of Vocational Rehabilitation Services, is funded through a Medicaid Infrastructure Grant from the U.S. Centers for Medicare and Medicaid Services (CFDA #11-P-92415-0/03): Conference Co-Sponsor.

Thank you once again to everyone who made this conference so successful: our program committee Wayne Eklund, RN, Dr. Tom Boyd, Laurie Ehlhardt, Jeri Cohen, Dr. Paul Cordo, Dave Kracke, Diane Vinson, Andy Ellis, Dr. Janet Hart Mott, BIAWA; and our many volunteers including our AV superstar Steve Dehner, courtesy of the National College of Natural Medicine (I can't thank them enough), and all of our sponsors and exhibitors and especially our attendees. Until next year...



Registration Form

6th Annual Pacific Northwest Brain Injury Conference 2008

Living with Brain Injury: Emerging Partnerships Sheraton Portland Airport Hotel

Please register before **February 28, 2008** to assure admittance and facilitate check-in.
 (Note: A separate registration form is needed for each person attending. Please make extra copies of the form as needed for other attendees.
 Members of BIAAWA receive member rates)

First Name _____		Last Name _____	
Badge Name _____		Affiliation/Company _____	
Address _____	City _____	State _____	Zip _____
Phone _____	Fax _____	Email _____	
Please check all that apply:			
<input type="checkbox"/> I am interested in volunteering at the conference. Please call me. <input type="checkbox"/> Call me about sponsorship/exhibitor opportunities.			
<input type="checkbox"/> I am requesting continuing education credits (CLE's, CEU's and CME's) for the conference.			

Please check: Survivor Family Member/Friend Student Medical Professional Legal Professional Military

Educator Service Provider State Employee Other _____

Conference Registration Fees: Registration fees include: continental breakfast, lunch & conference related materials. Meals not guaranteed for on-site registrations

The following fees are per person:

<u>BIAOR Membership-Join and Save Money—see below</u>	<i>Before Feb 15</i>	<i>After Feb 15</i>	Amount
<input type="checkbox"/> Professional Non-BIAOR Member 2 Day	\$450	\$525	\$
<input type="checkbox"/> Professional Non-BIAOR Member 1 Day: <input type="checkbox"/> Friday <input type="checkbox"/> Saturday	\$300	\$375	\$
<input type="checkbox"/> Professional BIAOR Member 2 Day	\$350	\$475	\$
<input type="checkbox"/> Professional BIAOR Member 1 Day: <input type="checkbox"/> Friday <input type="checkbox"/> Saturday	\$200	\$275	\$
<input type="checkbox"/> Saturday Only 10/6 Courtesy (Brain Injury Survivors with limited means)	\$25	\$35	\$
<input type="checkbox"/> Saturday Non-BIAOR Member Survivor/Family	\$150	\$225	\$
<input type="checkbox"/> Saturday BIAOR Member Survivor/Family	\$100	\$175	\$
<input type="checkbox"/> Scholarship Contribution (donation to assist in covering the cost of survivors with limited funds)			\$

Accompanying Person: If you have a guest who will not attend the conference but would like to attend meals and breaks including continental breakfast, lunch and exhibition only. Fee does not include admission to conference sessions. \$75 per day

I want to become a BIAOR member NOW to receive the discounted registration fee:

Student-\$25 Survivor Courtesy³-donation Basic-\$35 Family-\$50 Non-Profit-\$75 Professional-\$100
 Sustaining-\$250 Corporation-\$300 Sponsorship Bronze-\$250 Sponsorship Silver-\$500 Sponsorship Gold-\$1000
 Sponsorship Platinum-\$2000 Lifetime—\$5000

Sponsorships (2 day) and Exhibitors: Diamond \$5,000 Silver \$1,000 Gold \$1,500 Platinum \$3,000 (2 day) \$2,000 (1 day)
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 Keynote Speaker: Friday Keynote Speaker: Saturday Other: _____

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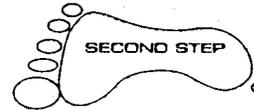
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Brain Injury in the Movies

Looking for a good movie to watch—how about ...



50 First Dates (2004)

Lucy Whitmore (Drew Barrymore) suffers from anterograde amnesia due to a car accident she was in a year earlier with her father, rendering her incapable of forming new long-term memories. Her condition leaves her with no memory of anything between the day of the accident and the present as she cannot convert short-term memories into long-term memories as she sleeps.

The Majestic (2001)

Peter Appleton (Jim Carrey) gets drunk at a seaside bar and gets into a car accident. When he wakes up, his memory is lost.

Finding Nemo (2003)

Nemo is caught by fisherman. His father Marlin, and Dory (who has short term memory loss) set out to find him in this great animated story..

The Lookout (2007)

Chris Pratt (Joseph Gordon-Levitt) has an auto accident which results in Chris' brain damage affecting his short-term memory. Four years later, Chris has to write things down to remember them. Chris works at the Noel State Bank & Trust as the night janitor. A man befriends him and then forces him to help in robbing the bank.

Memento (2000)

Leonard Shelby (Guy Pearce), a former insurance fraud investigator searching for the man he believes raped and killed his wife during a burglary.. Leonard suffered a severe head trauma during his wife's attack. This renders his brain unable to store new memories. To cope with his condition, he maintains a system of notes, photographs, and tattoos to record information about himself and others, including his wife's killer.

Regarding Henry (1991)

Henry Turner (Harrison Ford), is a successful lawyer who has little time for his wife or daughter, until one night when he receives gunshot wounds to the head and chest, resulting in brain damage. One bullet hit the right frontal lobe, which controls some behavior and restraint. The more serious injury, however, was the bullet to the chest, which hit the sub-clavian artery and caused excessive internal bleeding and cardiac arrest. Henry experienced anoxia (also known as hypoxia), lack of oxygen to the brain, which caused most of the damage. Henry survives, but he initially cannot move or talk or remember anyone or anything. He regains movement and speech with help from Bradley, his physical therapist. Henry returns home and discovers that he did not like the person he was before.

While You Were Sleeping (1995)

Peter Callaghan (Peter Gallagher) is mugged and falls into a coma. When he wakes up he has amnesia.

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---	---

Do not call for black power or green power. Call for brain power. - Barbara Jordan

Summer 2007 Sudoku Answers

4	8	1	7	6	3	9	2	5
6	9	3	5	8	2	1	7	4
2	7	5	9	4	1	6	3	8
3	5	9	8	2	7	4	6	1
1	2	6	4	3	5	8	9	7
8	4	7	1	9	6	2	5	3
9	3	4	6	7	8	5	1	2
7	1	8	2	5	9	3	4	6
5	6	2	3	1	4	8	7	9

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620 S.W. Fifth Ave. 5th Floor
Portland, Oregon 97204-1428

Fall Sudoku

The object is to insert the numbers in the boxes to satisfy only one condition: each row, column and 3x3 box must contain the digits 1 through 9 exactly once. (Answer will be in next issue)

	6			2		5		
8		3	4		5			2
1		2			6	9		3
3				6	7			
	9	6				7	3	
			9	1				6
5		1	3			2		4
4			6		1	3		8
	3		8				9	

Oregon Brain Injury Support Groups

Bend

CENTRAL OREGON SUPPORT GROUP
2nd Saturday 10:30am to 12:00 noon
St. Charles Medical Center
2500 NE Neff Rd, Bend 97701
Rehab Conference Room, Lower Level
Joyce & Dave Accornero, 541 382 9451
Accornero@bendbroadband.com

Brookings

BRAIN INJURY GROUP (BIG)
To be announced
1-877-469-8844, 541-469-8887

Cottage Grove

BIG II (Brain Injury Group II)
Thursdays 11 a.m. to 12:30 p.m.
Jefferson Park Recreation Room
325 S. Fifth St, Cottage Grove
For directions and information,
Anna, 541-767-0845.

Corvallis

STROKE & BRAIN INJURY SUPPORT GROUP
1st Tuesday 1:30 to 3:00 pm
Church of the Good Samaritan Lng
333 NW 35th Street, Corvallis, OR 97330
Call for Specifics
Amy Nistico, (541) 768-5157
aeasterl@samhealth.org

Eugene (2)

COMMUNITY REHABILITATION SERVICE OF OREGON
3rd Tuesday 7:00 to 8:30 pm
Central Presbyterian Church
15th & Patterson, Eugene, OR. 97401
Call for Information
Jan Johnson, (541) 342-1980
comrehabjan@aol.com

BIG (BRAIN INJURY GROUP)

Tuesdays 11:00am-1pm
Hilyard Community Center
2580 Hilyard Avenue, Eugene, OR. 97401
Curtis Brown, (541) 998-3951
BCCBrown@aol.com

Hillsboro

HOMEWARD BOUND SUPPORT GROUP
1st Monday 7-8 starting in August
Tuality Hospital
Carol Altman, (503)640-0818

Klamath Falls

SPOKES UNLIMITED TBI GROUP
4th Friday 3:00pm to 4:30pm
415 Main Street
Klamath Falls, OR 97601
Dawn Lytle, (541) 883-7547
dlytle@spokesunlimited.org

Lebanon

BRAIN INJURY SUPPORT GROUP OF LEBANON
1st Thursday 6:30 pm
Lebanon Community Hospital
525 North Santiam Hwy, Lebanon, OR 97355
Conf Rm #6
Lisa Stoffey 541-752-0816
lstoffey@aol.com

Medford

TURNING POINT
3rd Tuesday 4:00pm-5:00pm
11 W. Jackson St, Medford, 97501
Pam Ogden, (541) 776-3427
Pamela.Ogden@sogoodwill.org

SOUTHERN OREGON BRAINSTORMERS SUPPORT AND SOCIAL CLUB

1st Tuesday of every month, 3:30 – 5:30 PM
Providence Medical Center
Birthplace Conf Rm (Main Entrance, turn left),
1111 Crater Lake Avenue, Medford
Lorita Cushman-541-772-6528
LORITAMICKCUSH@aol.com

Molalla

BRAIN INJURY SUPPORT GROUP OF MOLALLA
3rd Monday 6:30-7:30 pm
Son'light Vital Foods, Inc.
123 Robbins St., Molalla, OR 97038
Raeleah Brensen, 503.829.9456
Skeeter@molalla.net

Newport

BRAIN INJURY SUPPORT GROUP OF NEWPORT
2nd Saturday 2-4 pm
4909 S Coast Hwy Suite 340
South Beach, Oregon 97366
(541) 867-4335 or progop541@yahoo.com
www.progressive-options.org

Pendleton

Inactive at this time.
For more information contact:
Joyce McFarland-Orr (541) 278-1194
jmcfarland@Oregontrail.net

Portland (11)

BRAINSTORMERS I
2nd Saturday 10:00 - 11:30am
Women's self-help group
Wilcox Building Conference Room A
2211 NW Marshall St., Portland 97210
Next to Good Samaritan Hospital
Northwest Portland
Jane Starbird, Ph.D., (503) 493-1221
drstarbird@aol.com

BIRC Alumni Support Group

Last Tuesday of every odd month
1815 SW Marlow, Ste 110, Portland, 97225
Contact Doug Peterson for additional information
503-292-0765 or doug@progrehab.com

BRAINSTORMERS II

3rd Saturday 10:00am-12:00noon
Survivor self-help group
Emanuel Hospital, M.O.B.-West
2801 N Gantenbein, Portland, 97227
Northeast Portland
Steve Wright (503) 413-7707
biaor@biaoregon.org

CROSSROADS (Brain Injury Discussion Group)

2nd and 4th Friday, 1-3 pm
Independent Living Resources
2410 SE 11th, Portland, OR 97214
Southeast Portland
Christopher Eason, 503-232-7411
christopher@ilir.org

FAMILY SUPPORT GROUP

3rd Saturday 1:00 pm-2:00 pm
Self-help and support group
Currently combined with **PARENTS OF CHILDREN WITH BRAIN INJURY**
Emanuel Hospital, Rm 1035
2801 N Gantenbein, Portland, 97227
Northeast Portland
Joyce Kerley (503) 413-7707
joycek1145@aol.com

FARADAY CLUB

Must be pre-registered -
1st Saturday 1:00-2:30pm
Peer self-help group for professionals with brain injury
Emanuel Hospital, Rm. 1035
2801 N Gantenbein, Portland, 97227
Northeast Portland
Arvid Lonseth, (503) 680-2251 (pager)
alonseth@pacifier.com

HELP

(Help Each Other Live Positively)
4th Saturday - 1:00-3:00 pm
TBI Survivor self-help group (Odd months)
TBI Family & Spouse (Even Months)
Cognitive Enhancement Center
15705 S.E. Powell Blvd. Portland Or.
Brad Loftis, (503) 760-0425
bcmuse2002@yahoo.com

PARENTS OF CHILDREN WITH BRAIN INJURY

This group will meet once a month, and is a self-help support group. Currently combined with **FAMILY SUPPORT GROUP**
Emanuel Hospital, Rm 1035
2801 N Gantenbein, Portland, 97227
Joyce Kerley (503) 413-7707
joycek1145@aol.com

TBI SOCIAL CLUB

Location varies, call for times & locations
Meets twice a month - days and times vary
call for information
Sandra Ward, (503) 735-4857
slwsundance@qwest.net

Toastmasters Club for People with Brain Injury
Every Wednesday 6:00-7:00 pm
Open to all including family members
2145 NW Overton St, Portland OR 97210
Caleb Burns, (503) 913-4517

Roseburg
UMPQUA VALLEY DISABILITIES NETWORK
2nd Monday 12 noon - 1pm
419 NE Winchester, Roseburg, OR 97470
Tim Rogers, (541) 672-6336 x202
timrogers@udvn.org

Salem (2)
SALEM BRAIN INJURY SUPPORT GROUP
4th Thursday 5pm-7pm
Salem Rehabilitation Center
2561 Center Street, Salem OR 97301
Carol Mathews-Ayers, (503) 561-1974
carol.mathews-ayres@salemhospital.org

SALEM SOCIAL CLUB
Temporarily inactive
Windsor Place
3005 Windsor Ave. NE, Salem, OR 97301
Sharon Slaughter, (503) 581-0393
sharonslaughter@qwest.net

Vancouver Washington
VANCOUVER TBI SUPPORT
2nd and 4th Thursdays 2-3 pm
disAbility Resources of SW Washington
2700 NE Andresen, Suite D5
Contact: Charlie Gourde charlie@darsw.com
10-4 Monday – Friday 360-694-6790 ext. 103

They did something once that slurred my speech, and I thought, "Oh, man, you're messing with my brain. It's freaking me out."

Michael J. Fox, actor (quoted in *People* magazine, December 7, 1998, p. 135; talking about his surgery for Parkinson's disease)

ARE YOU A MEMBER?

The Brain Injury Association of Oregon relies on your membership dues and donations to operate our special projects and to assist families and survivors. Many of you who receive this newsletter are not yet members of BIAOR. If you have not yet joined, we urge you to do so. It is important that people with brain injuries, their families and the professionals in the field all work together to develop and keep updated on appropriate services. Professionals: become a member of our Resource Referral Service. Dues notices have been sent. Please remember that we cannot do this without your help.

Your membership is vitally important when we are talking to our legislators. For further information, please call 503-413-7707 or 1-800-544-5243 or email biaor@biaoregon.org.

Brain Injury Association of Oregon

- New Member Renewing Member

Name: _____
Street Address: _____
City/State/Zip: _____
Phone: _____
Email: _____

Type of Membership

- Basic \$35 (\$50 for family) Students \$25 Lifetime \$5000
 Non Profit \$75 Professional \$100 Sustaining \$200
 Survivor Courtesy \$ 0 (Donations from those able to do so are appreciated)

Sponsorship

- Bronze \$250 Silver \$500
 Gold \$1,000 Platinum \$2,000

Additional Donation/Memorial: \$ _____
In memory of: _____
(Please print name)

Member is:

- Individual with brain injury Family Member
 Professional. Field: _____
 Other: _____

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If you are receiving unwanted or multiple newsletters or have errors in your name or address, please contact BIAOR 503-413-7707 or biaor@biaoregon.org. Thank you.



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Vehicle Donations



Vehicle Donation Program

Through a partnership with VDAC (Vehicle Donations to Any Charity), The Brain Injury Association of Oregon, BIAOR, is now a part of a vehicle donation system. BIAOR can accept vehicles from anywhere in the country. VDAC will handle the towing, issue a charitable receipt to you, auction the vehicle, handle the transfer of title, etc. Donations can be accepted online, or call 1-866-3321778. The online web site is <http://www.v-dac.com/org/?id=930900797>

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