Meeting Minutes

BIS Meeting Minutes
Date: 9-6-2022
Time: 1:00 – 3:00
Link:

Meeting Minutes

Attendees:

Izaak Funke	Jaime Swann	
Sonya Scott	Jason Young	
Angie Vardell	Joani	
Adam Goldman	John Cimino	
Amol Karmarkar	John Morgan	
Barbara Seymour	Karen Tefelski	
Bradley Shipp	Karin Addison	
Brian Campbell	Kathleen A Hardesty	
Carolyn Turner	Linsey Mangilit	
Chris Miller	Lisa McCarthy	
Christy Evanko	Lynette Thurston	
Daniela Pretzer	Marcia Tetterton	
Donna Boyce	Matthew Behrens	
Elizabeth Seward	Rachel Evans	
Heather Norton	Rashmi	
Heidi Dix	Steve Ford	
Ivan Velickovic	Tammy Whitlock	
Jamie Peed	Dana Parsons	

Agenda Items:

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Welcome and Introduction – Brian Campbell

- CMS Case management
- Data planning
- Survey content to be included in the report

Barbara Seymour – Deep dive into Case Management Delivery

- Case management and policy research findings
- Researched 15 states, narrowed down to 4 states with good components for case management services
  - Iowa
  - South Carolina
  - Vermont
  - West Virginia
- The case management review focused on the following categories:
  - Service Model
  - CM Definition
  - Services Reqs
  - Caseloads
  - License/Accreditation Reqs

    - TCM Staff Educational Reqs
- Case management definitions and responsibilities review examples by state – See TCM Services spreadsheet handout.
    - Iowa CMS: Activities and responsibilities of the case manager are clearly delineated and make it easier for managers to act on their role
        - Comment: Case management currently goes beyond scheduling, a lot of times our clients need someone to actually take them to their appointment and go with them. Some people may only need someone to help schedule it, but a lot need more assistance and may not have a caretaker or family member to help them.
        - Response: Of course. And these case managers will do that kind of assistance on an as needed basis for including care plans and other services. If they have cognitive deficits we
        - Comment: I think Iowa is a pretty basic model.
        - Comment: To build on that, we should also consider the role of linking people to natural supports within their communities so they aren't only reliant upon staff. Making those connections is a part of case management as well. Also, we do need to consider the way that case management changes in response to changing circumstances as well.
    - South Carolina CMS: Waiver Case Management defines case management as assisting participants regardless of the funding source. They'll look at everything a person needs. They also use a transitional case management system for people who are institutionalized. They also hold to a limit of 180 days. SC Responsibilities also include assessments on how to approach case management for that particular client.
        - Comment: South Carolina BI, Spinal Cord Injury, DD, IDD are all under one office
        - Comment: Currently we have a lot of limits on discharging someone from an institution into a community. We want to make sure that transitional function is viable for the model, and that's why I think we should look at the SC model where someone can test out transitional models as needed.
        - Comment: I believe mental health case mgmt includes this and it can be very helpful/important based on what we've heard from people's experiences of not knowing where to go when they get home. Mental health case mgmt in Virginia's state plan.
        - Comment: Transitioning a patient from inpatient rehab to a case manager is critical and we have seen success with patients that are quickly engaged with a CM at time of d/c
        - Comment: Transition services also need to be considered for those requiring a different living plan due to events, such as loss of a caregiver or those in unsafe conditions.
        - Response: Transition is a big key, especially for brain injury treatment. A lot of brain injury patients may get a lot of attention early on in the acute phase, but that will eventually trickle down. We usually say that with brain injury treatments we have to start creating a discharge plan on the date of admission.
        - Comment: I also receive a lot of people who can't get that kind of assistance through the DD Waiver. And then some people who can't get the DD Waiver may also not qualify for CCC+ care based on their physical needs. I have a lot of clients who will go home with family and then a few months in the family will come to me because they don't know what to do and can't care for the client. I have to tell them that housing could take 1-2 years and you have to do a lot of hunting just to find anywhere for them to move in. I did the Money Follows the Person program to help clients get into nursing facilities and they could have had as much as $5000 for transition services, but then I had one gentleman who had an injury and is living in an unsafe environment but can't afford to move somewhere else. I have another client who lives with his almost 90 year old mother and that's not a safe environment for either of them.

- Response: We do have to be a little careful because we do have to adhere to our policy criteria and we aren't going to be able to catch everyone, but I understand. We have to try. As an example, we have people placed out of state that we want to get back into Virginia. All we can do is look at what we believe will be the best for the people that we serve. But this is going to be challenging, case management is almost never cut and dry.
- Comment: We also need to pay attention to CMS/Medicare's VBP, especially episode-based payment programs, ACOs, and ACHO. These program have improved TCM for those in these bundles and also for others (Medicaid enrollees via system-level improvement).

- Vermont CMS: Coordinates comprehensive services prior to consumer discharge from a facility or admission to the program. Having the family included and involved early on may help as well. They monitor the quality of care linked in to those programs as well. Vermont also includes information regarding schools which helps catch younger people with brain injuries. Responsibilities include developing and coordinating a comprehensive program. They are all-inclusive and don't only cover one aspect of their lives. Vermont also emphasizes the need for TCM to be individualized, and includes the need to evaluate the developed program either quarterly, semi-annually, or annually.
  - Comment: Will TCM be limited to age 18 and over OR will it be open to both pediatrics and adult populations?
  - Comment: The services that (one VA provider) offers, we check in quarterly, but our ISP plans are fluid documents that constantly change. So even though we report out on our program quarterly, we document how everything relates to the ISP and it's consistently in the forefront.
  - Comment: The Vermont examples are useful because they include the way they monitor and report in the program responsibilities so that the outputs are integral parts of the program.
  - Response: We do show benefits of services received, we use surveys and each individual agency issues these kind of surveys in their own way but we do track outcomes in a regular way.
  - Response: We all do the goal achievement rate, but then with our certifications we have different outcomes that we set. We're left to our own on how to set those outcomes and measure them, but we do set them as part of our CARF certification.
  - Q: Do you have an example?
  - A: Each program has their own, but for service access we look at wait times and how long our clients stay employed. We look at client and caregiver satisfaction, we look at stakeholder satisfaction, and we measure outcomes as well.
  - A: We've just started using a QoLaBI (Quality of Life after Brain Injury) to measure if we're affecting that quality of life at all. One of the things we need to be aware of though is the fact that people with brain injuries have a much higher degree of inconsistency, and so a lot of times what we're doing is sustaining them.
  - Comment: IN IA, they use the Mayo Portland Adaptability Inventory for the TBI individuals as an assessment tool as well.
  - Link: https://www.medicaid.gov/medicaid/long-term-services-supports/teft-program/functional-assessment-standardized-items/index
  - Response: We do use this as well, but using the whole thing would probably be a little overkill. We adapt it to our needs.
  - Comment: Would be helpful to identify an outcome measure used at time of d/c from inpatient/outpatient therapy program with a measurement over time to those transitioning to community support
  - Comment: That has been some conversation adapting this to be more functional. I saw that Medicaid has starting implanting that, though I don't know if VA has started that, but it seems useful for Home and Community Based Services as a functional assessment.

- Comment: I think goal achievement is the best indicator of success. It's really hard to show ROI for case management services. We use open-ended goal-oriented person-centered services. And if you look at our metrics you see that the number of people living in their own communities is really high because of that.
- Comment: The challenge for us is that with patients connected to one of our agencies we struggle to follow up when they leave and I can't follow up with all of the patients. Having some way to track discharge through the community would be great.
- Comment: I agree with the comments regarding focusing on the individual's outcomes related to his/her goals. CSBs have a multitude of required "outcome measurement" tools, only a few of which actually speak to individual goal attainment. Most only assess whether the plans are updated, meetings are taking place, etc.

- West Virginia CMS: Case management are indirect services that assist in achieving waivers regardless of the funding source. They focus on explaining their roles and resources to the member, they discuss budget and options based on finances, ensure that someone is monitoring the providers and that members are getting the services they signed up for, and notifies relevant personnel regarding concerns about the health status of the member. They communicate with the program/member representative with information in terms they can understand.
  - Comment: We also utilize our "satisfaction surveys" to ask questions about has their mental health, access to community, access to services improved, independence in home, productivity improved. It is highly individualized with feedback provided directly by the clients/family members/caregivers on the individualized services provided. This is way more insightful than trying to use a standardized tool to try and measure progress.
  - Q: Would there be an opportunity to talk about the way we've done case management in VA for context? These examples look a bit lighter than what we already provide. We provide our level of intensity for case management because we believe this is what our community needs, what case management looks like and what it means for our population.
  - A: When we do a survey on this meeting we'll see if we can do a meeting about that.
  - Comment: I think that Program Representative may be what Virginia calls an Authorized Rep. Not full on guardian. I'd love to see Supported Decision Making encouraged.
  - Comment: Having our current VA CMS discussed for context would be useful so we can develop the service to meet the definitions we want. It could range from something very basic and broad like Iowa, or it could be more detailed like WV.
  - Comment: I hear what you're saying about getting down to a more granular level. A lot of providers, myself included, may be feeling anxious about it regarding logistics, time frames, whether our current staff can do regular case management and TCM. TCM is supposed to go live on July 1st, and or some of us this is going to invoke a lot of change ahead of time, so we have a lot of questions and concerns. Do you know when we can start tackling those kind of questions?
  - Response: Letting us hear what we have now and how that operates and seeing a comparison of where it needs to go versus what is already in existence and whether we can just fine-tune that. Maybe one of the first steps that needs to happen should be how we can meet those goals by defining what exactly TCM is/should be, and whether or not that's even distinct enough from what our providers are already doing. So that may be our next step is to start getting into the weeds about what we have here already (perhaps include the Brain Injury Alliance?).
  - Comment: Just looking at the template provided, I'd love to have the opportunity to talk about what we have developed and available here in VA already.

- Comment: We'd like to see a few more state examples, some of the states we got recommended we weren't able to include just for time. We know there are a few more interesting models out there that would be interesting to include here as examples. One of the examples is going to be what we do now. These are coming from Medicaid in other states, so these may look a little different. Alternatively, states like Tennessee wrap their waivers under 1115 and they're really member focused and have some really good outcomes, so we want to look at examples and see what's working.
- Q: Is there a timeline for having these conversations and figuring out who's good to include as a presenter and what to share?
- Q: Are we meeting next week?
- A: We're meeting next week, but don't feel like you need a fully finished presentation by then, we're talking about just beginning that, and we have a couple months on that, so maybe by the end of September we can have a presentation about the DARS services, and that will buy us some time on the research of other states' accreditation and caseloads. We could include the Western Tidewater and maybe see what else we're doing.
- Comment: One of the points of anxiety is that we don't know the definition of "severe TBI" or when we'll get that definition. We require medical documentation but these details can be hard to find so when we talk about these services and getting them up and ready in under a year we're also still dealing with all the other services and members we serve. Even with "severe TBI," that doesn't include all of our members under any definition.

Wrap-up – Brian Campbell

- For our case management next steps we're going to work on getting our definitions, responsibilities, accreditation requirements, MCO business impacts, costs, caseloads, and so on. There are a lot of things we need to resolve and figure out exactly how to go about that. For today in particular, stand by for a survey to be sent out either Wednesday or Thursday focusing on the transition from community to service supports and other transitional service windows. We want to figure out what currently exists for these times as well as what providers would want to see here.
- We're hoping to get a deep dive on case management from our technical managers as well as figuring out what exactly is in the state of VA. Once we start really gathering things and making decisions we'll start sharing and posting things online.
- I would like to post some of the workgroup materials on the DMAS website as well.
- Next meeting is on the 13th to talk about the report draft and survey results.

Conclusion/Next Steps –

Chat Log:
