

Michigan Department of Community Health Traumatic Brain Injury (TBI) Waiver Stakeholder Meeting

Meeting Minutes

September 29, 2014

9:30 a.m. – 11:30 a.m.

Capitol Commons Center – Lower Level

Eligibility and Assessment

Facilitators: Carol Hansen, Elizabeth Gallagher

Attendees: Mary Free Bed Hospital, Hope Network Rehab Center, Michigan Brain Injury Provider Council, Special Tree Rehab Center, Brain Injury Association of Michigan, University of Michigan Hospital, Region VII Area Agency on Aging, MDCH, Life Skills Village Home Care, Origami Rehab Center, Eisenhower Rehab Center, Rainbow Rehab Center, Feinberg Consulting (Guardianship Services), Rehab Without Walls HCBS Home Care, Region 1B Area Agency on Aging, HHS Health Options Home Care, Siporin & Associates, Inc., Sparrow Hospital, Rescare Home Care(on phone)

I. Welcome and Introductions – Carol Hansen

II. Open Discussion – All

Eligibility

- If the waiver target population is opened up to people with Acquired Brain Injury (ABI), having a waiting list is OK
- It appears that the waiver could serve more slots than are currently listed in the waiver application
 - A rough figure of 68.5 people could potentially be served if beds that open up are filled immediately
- There are two ways to handle slots for the waiver application
 - One slot equals one person per fiscal year (MI Choice does this)
 - Slots are re-filled as they become available
- There has not been as many referrals right now for TBI as there has been in the past
 - Most TBI referrals come from Mary Free Bed
- If we include ABI, we need to take away steps in approval process
- People who are screened out should have other options and use openings to provide in-home supports to individuals
- In current TBI Program, most providers want a discharge plan in place prior to admission to program, waiver agencies are involved early so when discharge transition happens, waiver takes over

- Instead of decline due to discharge barrier, can MI Choice be involved sooner if discharge is only barrier to access MOU program?
 - Referrals are made now to waiver program even if not qualify for MOU program
- Due to inpatient stays being shorter, there is concern that a lot of people are not aware of MOU program and are discharged from inpatient facilities without information
- Admission Criteria - Does a 15 month post TBI injury still sound ok ?
 - Two year post TBI injury suggested
 - Doctor can overrule; example - someone in coma 2 years and wakes up
 - Group of people who develop neurobehavioral complications that keeps them from living in community. Some people really need intense program related to behaviors being appropriate in community. This group is at greater risk going to corrections system than nursing facility. Two-fold problem people have after brain injury. This kind of problem arises after being in community after a couple of years.
 - Suggestion to extend to 24 months and put caveats in so that more people can be served. Literature now supports idea and data supports moving out to 24 months.
- If we had ABI waiver and a waiting list, how would you prioritize waiting list?
 - Get criteria on who will most benefit. Those coming right out of acute care would be first priority.
 - Can be based on location of injury, etc., social and complex factors that indicate success
 - Initial scores on Mayo Portland Adaptation Inventory are good indicators of success, this could be a useful tool
 - Prioritize TBI over ABI as possibility
 - Look at when people go back to work recovering from stroke. Part of brain affected can determine outcome
 - What can we do to limit the cost on the bottom as well? If someone is in nursing facility and you can get them out and save a lot of money, the person may not progress well, but you are saving a lot of money – response that this is already happening
- A lot more ABIs seen recently than TBIs – tumors, aneurysm, stroke, etc.
- Suggestion to find out what provider criteria is, start there, find common denominator, and move forward. Response is that common denominator is that person has funding.
- Some people need longer to recover. Average length of stay 16-17 days in acute rehab center like Mary Free Bed. Average is 21 days, but this is also dropping.
- Process of referrals, needs discussion as everyone wants it to move faster. What can we make efficient about approval process so extra stops are not made (going into nursing facility)?
- Budget will affect if we move to ABI
- Would more field assessment be possible? Instead of faxing paperwork, would hands on assessment be possible for transitioning?
 - Acute rehab moves fast, something to consider
 - Waiver program mandates person be seen in person
- What happens when private insurance ends?

- Sparrow staff stated inpatient rehab stay averages 7 days. Only core medical services are covered (for example does not cover residential stay).
- Statistics are not accurate because there are so many unrecorded calls.

Assessment

- MI Choice uses the InteRai Home Care (iHC) assessment
 - This assessment is long and can take up to two hours to perform, from waiver perspective. The in person/on site assessment covers a lot of the body system/function status. Does not cover TBI. If a TBI comes through as the primary diagnosis, the Waiver Agents know to look at the MOU program first.
- Mayo Portland Adaptability Inventory assessment used for TBI and ABI
 - To measure outcomes and used as initial assessment
 - 3 subscales: ability scale, adjustment scale (anxiety, depression), participation scale (self-care, leisure)
 - Re-administer tool after interventions to see change
 - Easy to use, providers embrace tool
 - Used most often throughout the country
- Some are using the Functional Independent Measure (FIM) assessment
 - First assessment at discharge from acute setting
- Bigger tools: disability rating scale, Mayo Portland Adaptability Inventory, FIM
- MDAl (Maine, Texas) use for TBI program, Medicaid programs
 - Helps with documentation, VA uses this too
- Who completes the assessment?
 - Team completes assessment now
 - Can be completed by anyone, does not have to be social worker, nurse, etc.
- Who should complete?
 - A trained clinician
- How often?
 - Every 6 months or at discharge. PA requires every 3 months.
 - Some providers use Mayo Portland at admission and discharge. Another bases it whether or not long term. Not done as often on long term.
- Assessment is done electronically
- Supervision rating scale looks at how much supervision person requires. Helps determine if someone can go home and what services and/or supports needed. Developed by Boek.
- What would assessment be used for and who would data be shared with?
 - Used to track progress, determine on aggregate basis how successful rehab program has been, establish target for what should be accomplished.
 - In the long term, what can be handled in residential setting versus home and community based setting. Helps determine what services people need.
 - Will give picture of progress and what program best meets needs.

- Biggest issue is employability and isolation, learning to live below poverty level.
- CMS application talks about assessment of level of care
 - Must be done at least once a year
 - How often should we evaluate LOCD?
 - Stay at one year minimum requirement.
- Assessment if program successful? This would be part of quality measures.

V. Next Steps

- Next TBI Stakeholder meeting to be held on Monday, November 3, 2014 from 10:00 a.m. – 12:00 p.m., Capitol Commons Center
- Topic will be: Finance and Reimbursement