REPORT OF THE
SECRETARY OF HEALTH AND HUMAN RESOURCES ON

Case Management System Development Activities

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 98

COMMONWEALTH OF VIRGINIA
RICHMOND
1994

PREFACE

House Joint Resolution 564 (HJR 564), agreed to by the 1993 Session of the General Assembly, requested the Secretary of Health and Human Resources to develop a consumer-responsive case management system to strengthen coordination of services, consumer choice, accountability of service providers, and cost-effectiveness of service provision. It was resolved by the House of Delegates, the Senate concurring, That the Secretary of Health and Human Resources be requested to direct the following:

1. That the state human agencies serving persons with physical and sensory disabilities adopt an interagency policy that allows consumers to designate the primary reimbursed case manager when the consumer is receiving services from more than one health and human service agency;

2. That the Department for Rights of Virginians with Disabilities conduct a feasibility study of maintaining and incorporating results from consumer satisfaction surveys to promote quality assurance in case management services within both the public and private sectors. This study shall also determine the need of establishing a central listing of complaints regarding the quality of services provided by case managers in both the public and private sectors. Consumers and providers of case management services, both public and private, shall be included in all phases of the study;

3. That the Department of Rehabilitative Services explore the feasibility of contracting with Centers for Independent Living as a way to increase accessibility to case management services; and

4. That all state human service agencies serving persons with physical and sensory disabilities and providing case management services conduct an analysis of the most cost-effective manner of the delivery of those services. This study shall compare the cost of providing case management services utilizing agency staff with that of contractual services.

This report responds to the requirements of HJR 564 with contributions from the state human services agencies serving persons with disabilities. There are four parts to this report, one for each of the four parts of the resolution.

TABLE OF CONTENTS

RESPONSE TO HOUSE JOINT RESOLUTION 564

CASE MANAGEMENT SYSTEM DEVELOPMENT ACTIVITIES OF THE SECRETARY OF HEALTH AND HUMAN RESOURCES

EXECUTIVE SUMMARY

As a result of the work of the 1992 Case Management Task Force and of the human services agencies reporting in this Response to House Joint Resolution 564, significant steps have been taken toward enhancing case management services in the Commonwealth of Virgina. Design and implementation of service delivery models that integrate technology, confidentiality forms, single assessment, etc., will move the Commonwealth further toward a comprehensive, consumer-responsive approach to case management.

House Joint Resolution 564 (HJR 564), agreed to by the 1993 Session of the General Assembly, requested the Secretary of Health and Human Resources to develop a consumer-responsive case management system to strengthen coordination of services, consumer choice, accountability of service providers, and cost-effectiveness of service provision. It was resolved by the House of Delegates, the Senate concurring, That the Secretary of Health and Human Resources be requested to direct the following:

1. That the state human agencies serving persons with physical and sensory disabilities adopt an interagency policy that allows consumers to designate the primary reimbursed case manager when the consumer is receiving services from more than one health and human service agency;

2. That the Department for Rights of Virginians with Disabilities conduct a feasibility study of maintaining and incorporating results from consumer satisfaction surveys to promote quality assurance in case management services within both the public and private sectors. This study shall also determine the need of establishing a central listing of complaints regarding the quality of services provided by case managers in both the public and private sectors. Consumers and providers of case management services, both public and private, shall be included in all phases of the study;

3. That the Department of Rehabilitative Services explore the feasibility of contracting with Centers for Independent Living as a way to increase accessibility to case management services; and

4. That all state human service agencies serving persons with physical and sensory disabilities and providing case management services conduct an analysis of the most cost-effective manner of the delivery of those services. This study shall compare the cost of providing case management services utilizing agency staff with that of contractual services.

This report responds to the requirements of HJR 564 with contributions from the state human services agencies serving persons with disabilities. There are four parts to this report, one for each of the four parts of the resolution.

PART 1: Interagency Policy On Consumer Designation of Primary Reimbursed Case Manager

Part 1 of HJR 564 requested that "the state human services agencies serving persons with physical and sensory disabilities adopt an interagency policy that allows consumers to designate the primary reimbursed case manager when the consumer is receiving services from more than one health and human service agency."

The Department of Rehabilitative Services facilitated a work group that included representation from state human service agencies, advocacy organizations and persons with physical disabilities. The work group developed an interagency agreement, the *Memorandum of Understanding, Consumer Choice for Primary Reimbursed Case Manager* (Appendix B).

The Memorandum of Understanding has been transmitted to the Secretary of Health and Human Resources. The next steps for the agreement include review from the Secretary and heads of participating agencies for signature. Once all parties have signed it, the Memorandum of Understanding will take effect.

PART 2: Consumer Satisfaction

Part 2 of HJR 564 requested that "the Department for Rights of Virginians with Disabilities conduct a feasibility study of maintaining and incorporating results from consumer satisfaction surveys to promote quality assurance in case management services within both the public and private sectors...[and] determine the need of establishing a central listing of complaints regarding the quality of services provided by case managers and their organizations in both the public and private sectors." Part 2 also requested that "consumers and providers of case management services, both public and private, shall be included in all phases of the study."

The Department for Rights of Virginians with Disabilities facilitated a Study Team composed of representatives from state agencies, private case managers, and consumers, which convened twice and came to a consensus on their report.

Conclusions

- State agencies are currently conducting consumer satisfaction surveys and utilizing the information to improve case management services.
- Private case management providers assure quality in case management through established industry standards and practices.

- It is more beneficial to encourage agency systems to continue to be consumer-responsive than to develop an additional process removed from the source of the problem.
- Establishing a central listing of complaints would create a new and unnecessary bureaucracy.
- Establishing a central listing would be of very limited usefulness in ensuring quality in case management.

Recommendations

1. State agencies which provide case management shall continue to conduct consumer satisfaction surveys and use the findings to promote quality assurance in case management.
2. Private providers of case management shall continue to maintain industry standards to promote quality assurance in case management.
3. A central listing of consumer complaints should not be established.

PART 3: Feasibility of Contracting for Case Management Services

Part 3 of HJR 564 requested that "the Department of Rehabilitative Services explore the feasibility of contracting with Centers for Independent Living as a way to increase accessibility to case management services."

The Long-Term Rehabilitation Case Management (LTRCM) Program of the Department of Rehabilitative Services (DRS) is the first phase of service system development for people with severe neurological disabilities. In evaluating the feasibility of contracting with Centers for Independent Living (CILs) for provision of case management, it is important to note that providing case management services to individuals is just one part of the broader system development mandate of the LTRCM Program, and that it is not possible to distinguish between the two in a manner which would be statistically or actuarially meaningful.

Conclusions

DRS determined that, although both LTRCM and CILs assist consumers to develop goals, establish plans to achieve those goals, facilitate or coordinate services, and concern themselves with consumer advocacy and empowerment, it is not feasible to contract case management services under current conditions. Nevertheless, DRS will continue to involve stakeholders in defining an overall system of service delivery for persons with severe functional and central nervous system disabilities. As an overall system of rehabilitative and support services is designed and implemented, there may be opportunities for contractual or fee-for-service relationships with CILs and other service providers. A comprehensive system will require additional funding and it may address differing levels of case management based on consumer need and on an array of service approaches that supplement or complement the highly specialized and centrally-managed LTRCM Program. The selection of service providers within the overall framework will relate to the individual provider's capacity to meet client needs and assure systemwide consistency and quality.

Recommendations

1. It is recommended that DRS, through the LTRCM Program, complete the first phase of systems development for coordination of services for persons with functional and central nervous system disabilities.

2. Regardless of strategies which may evolve for an overall system of services, it is recommended that DRS continue the provision and expansion of the highly specialized case management services currently available through its LTRCM Program. Clients with these most severe functional and central nervous system disabilities require an intensity of case management which is best provided through a program and staff with focused specialization, training, and expertise.

3. DRS should continue to involve stakeholders in defining an overall system of service delivery for persons with severe functional and central nervous system disabilities. Over time, this may include other aspects of case management that will supplement or complement LTRCM. Service providers might operate within a framework that ensures quality and consistency systemwide.

PART 4: Cost-Effectiveness of Service Delivery

Part 4 of HJR 564 requested that "all state human service agencies serving persons with physical and sensory disabilities and providing case management services conduct an analysis of the most cost-effective manner of the delivery of those services. . .[comparing] the cost of providing case management services utilizing agency staff with that of contractual services."

To address the intent of the resolution, each agency conducted its own review based on individualized evaluation methods and data collection.

Conclusions

Ideally, a least-cost analysis is an appropriate method to study the cost-effectiveness of case management service delivery. This approach identifies the least costly method to attain a pre-established, measurable level of an objective, by analyzing each of several alternative methods of achieving that level in terms of dollar expenditures needed to do so.

In the present situation, however, the multifaceted nature of case management services generally cannot be reduced to a single objective and, where multiple explicit objectives exist, costs cannot be meaningfully distributed to individual objectives. Reflecting its statutory definition (Section 51.5-3), case management incorporates diverse components such as advocacy, assessment, planning, facilitation, coordination and monitoring to create a dynamic collaborative process which utilizes and builds on the strengths and resources of consumers to assist them in identifying their needs, accessing and coordinating services, and achieving their goals. Statistical or actuarial efforts to isolate specific costs associated with a specific service component, be it that of a state agency or a contractual provider, become artificial, calling into question the validity of any comparative analysis.

RESPONSE TO HOUSE JOINT RESOLUTION 564

CASE MANAGEMENT SYSTEM DEVELOPMENT ACTIVITIES OF THE SECRETARY OF HEALTH AND HUMAN RESOURCES

INTRODUCTION

House Joint Resolution 564 (HJR 564), agreed to by the 1993 Session of the General Assembly, requested the Secretary of Health and Human Resources to develop a consumer-responsive case management system to strengthen coordination of services, consumer choice, accountability of service providers, and cost-effectiveness of service provision. It was resolved by the House of Delegates, the Senate concurring, That the Secretary of Health and Human Resources be requested to direct the following:

1. That the state human agencies serving persons with physical and sensory disabilities adopt an interagency policy that allows consumers to designate the primary reimbursed case manager when the consumer is receiving services from more than one health and human service agency;

2. That the Department for Rights of Virginians with Disabilities conduct a feasibility study of maintaining and incorporating results from consumer satisfaction surveys to promote quality assurance in case management services within both the public and private sectors. This study shall also determine the need of establishing a central listing of complaints regarding the quality of services provided by case managers in both the public and private sectors. Consumers and providers of case management services, both public and private, shall be included in all phases of the study;

3. That the Department of Rehabilitative Services explore the feasibility of contracting with Centers for Independent Living as a way to increase accessibility to case management services; and

4. That all state human service agencies serving persons with physical and sensory disabilities and providing case management services conduct an analysis of the most cost-effective manner of the delivery of those services. This study shall compare the cost of providing case management services utilizing agency staff with that of contractual services.

This report responds to the requirements of HJR 564 with contributions from the state human services agencies serving persons with disabilities. There are four parts to this report, one for each of the four parts of the resolution.

PART 1: Interagency Policy On Consumer Designation of Primary Reimbursed Case Manager

Part 1 of HJR 564 requested that "the state human services agencies serving persons with physical and sensory disabilities adopt an interagency policy that allows consumers to designate the primary reimbursed case manager when the consumer is receiving services from more than one health and human service agency."

The Office of the Secretary of Health and Human Resources requested the Department of Rehabilitative Services (DRS) to coordinate developing the interagency policy. DRS staff facilitated a work group that included representation from state human service agencies, advocacy organizations and persons with physical disabilities. The state agencies participating in the plan included:

- Department of Rehabilitative Services
- Department for the Visually Handicapped
- Department of Social Services
- Department for the Deaf and Hard of Hearing
- Department of Medical Assistance Services
- Department for the Aging
- Department of Health
- Department of Mental Health, Mental Retardation and Substance Abuse Services.
- Department for Rights of Virginians with Disabilities
- Governor's Employment and Training Department

The individuals who participated in the work group are listed in Appendix D.

Memorandum of Understanding

Consumer Choice for Primary Reimbursed Case Manager

The work group developed an agreement fashioned after the 1992 Memorandum of Understanding on Interagency Collaboration and Confidentiality. They named this interagency agreement the *Memorandum of Understanding, Consumer Choice for Primary Reimbursed Case Manager* (Appendix B).

The draft agreement has an educational, rather than a regulatory focus. Work group members felt they could achieve greater impact by first educating human service personnel regarding the need for primary case managers within interagency systems. Initially, some agency representatives questioned if their agency staff truly functioned as case managers for persons with physical and sensory disabilities. However, the group reached consensus by using broader parameters for case management. That is, case management is not a profession within itself, but rather an area of practice within one's profession or role as an advocate. They agreed that a reimbursed case manager is a provider who directly performs case management functions and receives a salary or fee for service.

The work group circulated the draft agreement among the participating agencies for review and improvements. Each agency representative reviewed the agreement within their agency's protocol.

Survey of Consumers Receiving Services from Multiple Agencies

Work group members suggested further review from additional consumers. DRS staff members surveyed nine individuals with physical disabilities or their family members. Each of the consumers had received services from multiple agencies.

Most of the consumers either liked the agreement or found it satisfactory. Seven of the nine respondents said they believed it would improve coordination of services. One respondent, a parent, said, "It's hard to tell, depends upon the individuals involved." Another respondent, also a family member, said, "I'm happy with the way it is now. The current system works very well." One individual made a suggestion, beyond the scope of this resolution, to recognize or compensate family members as case managers, perhaps through a tax credit.

A consumer asked, "Could there be a right to request a change in case manager included in the document?" The work group had discussed this option at length before the survey. They had agreed not to include the *right* because each agency has an internal process for changing direct service providers and because resource limitations would, in some cases, preclude the right to change case managers within one agency. Instead, work group members had developed a collaborative process as follows: *The consumer and the primary case manager will define the primary case manager's role, function and period of service. Consumer needs, preferences and capabilities will dictate to the greatest extent possible which approach is best to facilitate the consumer's desired outcomes.*

The results of the survey are shown in Appendix C.

Content of Agreement

The purpose of the proposed Memorandum of Understanding is to support the consumer's right to designate a primary reimbursed case manager and to strengthen interagency case management services. In order to ensure responsiveness and accountability, a consumer-responsive case management system does the following:

- Promotes consumer participation in the case management process
- Provides for a central point of contact and communication
- Strengthens advocacy efforts
- Supports the collaborative process
- Promotes accessibility to programs, services and resources
- Promotes efficiency and effectiveness

In signing the proposed Memorandum of Understanding, an agency agrees to the following Statement of Commitment:

The agencies participating in this agreement will support the consumer designation of a primary reimbursed case manager when the consumer receives services from more than one agency. The consumer and the primary case manager will define the primary case manager's role, function and period of service. Consumer needs, preferences and capabilities will dictate to the greatest extent possible which approach is best to facilitate the consumer's desired outcomes. The participating agencies also agree to:

- Inform consumers and support their right to designate a primary reimbursed case manager
- Serve as the primary reimbursed case manager, when requested by a consumer, and as appropriate within the designated agency's mission, scope of services, capacity and expertise
- Cooperate with any other public and private service providers designated by consumers as primary reimbursed case managers
- Work together to assist consumers in achieving their goals
- Reduce delays and barriers in accessing services
- Inform consumers of existing formal appeals processes to resolve consumer concerns
- Share information between providers, with the consent of the consumer, to reduce duplicate assessments
- Promote implementation of this agreement at the local level

Status of Agreement

The Memorandum of Understanding has been transmitted to the Secretary of Health and Human Resources. The next steps for the agreement include review from the Secretary and heads of participating agencies for signature. Once all parties have signed it, the Memorandum of Understanding will take effect.

PART 2: Consumer Satisfaction

Part 2 of HJR 564 requested that "the Department for Rights of Virginians with Disabilities conduct a feasibility study of maintaining and incorporating results from consumer satisfaction surveys to promote quality assurance in case management services within both the public and private sectors. . .[and] determine the need of establishing a central listing of complaints regarding the quality of services provided by case managers and their organizations in both the public and private sectors." Part 2 also requested that "consumers and providers of case management services, both public and private, shall be included in all phases of the study."

This section of the Response to HJR 564 is from the Part 2 Study Team's report, "Utilizing Consumer Satisfaction Surveys to Promote Quality Assurance in Case Management." The Part 2 Study Team was coordinated by the Department for Rights of Virginians with Disabilities.

Background

Following the 1992 session of the Virginia General Assembly, the Commission on Coordination of the Delivery of Services to Facilitate the Self-Sufficiency and Support of Persons with Physical and Sensory Disabilities in the Commonwealth (The Beyer Commission), requested the Secretary of Health and Human Resources to establish a task force (the Case Management Task Force) to study several issues germane to case management. One principal issue was to define case management. As a result of the work of the Case Management Task Force, Section 51.5-3 of the Code of Virginia was amended to define "case management" as the following:

> Case management is a dynamic collaborative process that utilizes and builds on the strengths and resources of consumers to assist them in identifying their needs, accessing and coordinating services, and achieving their goals.

Another issue was to identify ways to ensure quality assurance for consumers and payors of reimbursed case management services. The Case Management Task Force discussed certification of professionals, voluntary registration, utilization of consumer satisfaction surveys, and a central listing of complaints. The Task Force determined that the first two methods of assuring quality in case management would create new and unnecessary bureaucracy without guaranteeing improvement in case management services. The latter two methods, consumer satisfaction surveys and a central listing of complaints, were considered to hold the most promise for enhancing the delivery of case management services.

The Case Management Task Force concluded that using consumer satisfaction surveys and their results in program and policy development for both public and private organizations would provide the most efficient, most effective, and least costly means to ensure and monitor quality assurance. They also concluded that a central listing of complaints could provide individuals seeking case management services a means to acquire information on the "quality of services."

The Case Management Task Force recommended requesting the Secretary of Health and Human Resources to direct the Department for Rights of Virginians with Disabilities to conduct a feasibility study of maintaining and incorporating results from consumer satisfaction surveys to promote quality assurance in case management services within both the public and private sectors. They also recommended determining the need for establishing a central listing of complaints regarding the quality of services provided by case managers and their organizations in both the public and private sectors.

Issues

Case management is required by many persons with physical and sensory disabilities to assist them in accessing appropriate services. It is important that they receive case management services from qualified professionals. Many case managers in Virginia meet appropriate certification and/or licensure requirements; however, certification and licensure are not required by the state, nor do they guarantee the delivery of quality case management, as they are only a measure of an individual's basic knowledge of case management. Additionally, many human service professionals who currently provide appropriate and comprehensive case management to Virginians with disabilities would not be eligible for certification or licensure.

If licensure and certification do not guarantee the delivery of quality case management, then how does Virginia assure that persons with disabilities receive quality case management services? In the commercial marketplace customer satisfaction drives the industries. Would consumer-driven quality control ensure a more responsive system of case management services that meets the needs of consumers?

To address this question a Study Team (See Appendix D) composed of representatives from state agencies, private case managers, and consumers studied the following issues:

1. Do the public and private entities that provide case management services currently gather consumer satisfaction information?

2. How do public and private entities utilize consumer satisfaction information to ensure quality in case management services?

3. What instruments are being used to gather consumer satisfaction information?

4. Is there a need to improve the current system using consumer satisfaction information to ensure quality case management services?

5. Is there a need to establish a central listing of complaints regarding the quality of services provided by case managers and organizations that provide case management services?

The Study Team convened twice and came to a consensus on the issues, findings, and recommendations presented herein.

Quality Assurance

All state agencies represented on the Study Team currently gather quality assurance information through a variety of methods including consumer satisfaction surveys. Furthermore, the information collected is utilized to improve individual case manager performance and to improve the delivery of case management services on an agency-wide basis. These methods are discussed below.

The Department of Rehabilitative Services (DRS). DRS uses several methods to assure responsiveness to consumer concerns and needs. DRS service delivery is monitored through a quality assurance system of case audit and program evaluation. Identification of attitudes and levels of consumer satisfaction is a component of the program evaluation system. In addition, specific programs such as the Long Term Rehabilitation Case Management Program undergo separate program evaluations in which consumer satisfaction is studied. Through the program evaluation process the results of consumer satisfaction assessment can be communicated to program coordinators, planners and policy analysts. Thus, the service delivery system can be continually improved to meet the needs of the consumer.

Specific consumer concerns and problems needing immediate attention are addressed through a toll-free "hot line" system in the Office of Constituent Affairs. Constituent Affairs operates out of the Commissioner's Office and utilizes a variety of means to resolve concerns that may be raised by consumers. Stakeholder forums also provide valuable information from consumers concerned about case management issues. The Quality Assurance unit works closely with Constituent Affairs to identify these issues and trends relevant to program evaluation of case management services.

The Virginia Department for the Visually Handicapped (DVH). DVH uses consumer satisfaction surveys to assure quality in the delivery of services. The surveys are mailed to all consumers completing DVH adult service programs. The data collected from the surveys improves case management services in two ways. First, complaints by consumers about specific field staff (case managers) are sent to the Assistant Deputy Commissioner responsible for field services for investigation and resolution. Second, the data is tabulated and analyzed for systemic case management problems. The Deputy Commissioner for Services, the Assistant Deputy Commissioner responsible for field services and the Program Manager responsible for the program under study receive a report of the findings. If there are systemic problems identified, management makes the appropriate change in policy and/or procedure. To date, these studies have shown no systemic problems within case management.

The Department of Medical Assistance Services (DMAS). Quality assurance of the case management services funded by DMAS consists of a variety of interactions between the recipients and their caregiver(s). These interactions are designed to obtain information about appropriateness of services in relation to program policies and consumer satisfaction. Interactions with recipients and their caregiver(s) occur during home visits, telephone interviews, and letters requesting feedback on the quality of services. In addition, DMAS completes quality assurance via reports from case managers and other providers (e.g., personal care, adult day health care) that deliver direct services to the recipients served by case managers.

DMAS reimburses agencies that have a contract with DMAS for the provision of case management services. When completing quality assurance activities, DMAS provides oversight of the delivery of services. Any problems with services are followed up on several levels. Individual recipient complaints are addressed with the consumer and the case manager who provides the service. if complaints are present from multiple recipients receiving services from a particular provider agency, these are addressed with the provider agency (case manager and appropriate administrative staff), with the focus being correction of any systematic problems present at the agency. In cases of repeated problems at a provider agency, DMAS has the option to use financial and contract sanctions to assure correction of persistent problems or health and safety problem areas. DMAS is currently in the process of refining the use, at the statewide level, of information obtained during quality assurance activities. Although information is currently shared informally, DMAS is in the process of developing a more structured approach to capture information in a central location from all regions.

Private Providers. Consumer satisfaction surveys are not utilized by private providers of case management services; however, they have built quality assurance into the system through a variety of industry practices and standards. These include a Code of Ethics, professional licensure, strict hiring criteria, extensive training, professional expectations, and communication with consumers.

The private case management industry promotes hiring staff who possess a degree in either rehabilitation or nursing, hold appropriate credentials, and have previous experience in the field. Once hired, employees are expected to complete specialized training. Private providers encourage membership in professional organizations which operate under a strict Code of Ethics and Professional Certification which requires continuing education to maintain certification. Within companies, there are built-in quality assurance measures such as supervision of all case managers, with frequent communication and regular file reviews. All companies have procedure manuals which outline case management practices and professional conduct.

In addition to the above, if the consumer has a complaint against a private case management provider which can not be resolved at the supervisor level, the company manager or president will become involved in communicating with the consumer and resolving the situation on an individual basis. If services are appropriate, but there appears to be a personality conflict, there may be a change in case manager assigned to the case. Private case management companies are very responsive to resolving problems as the future of their business depends upon the reputation they develop for quality and results oriented rehabilitation services.

The majority of cases handled by the private rehabilitation providers involve Worker's Compensation injuries, obliging the provider to function under the Code of Virginia as it applies to vocational rehabilitation of the injured worker. Every effort is made to maintain open and honest communication with the consumer so the individual understands the process and their responsibility to the process. However, the injured worker may at times express dissatisfaction with services by choosing not to participate in the process. These situations are resolved either through referral to the claims adjuster, attorney, or Worker's Compensation Commission for clarification of the consumer's obligation or through a hearing before the Virginia Worker's Compensation commission.

Following deliberations on the above issues, the Study Team came to the following conclusions:

- State agencies are currently conducting consumer satisfaction surveys and utilizing the information to improve case management services, and
- Private case management providers assure quality in case management through established industry standards and practices.

Central Listing of Complaints

There are times in the best of organizations when consumers have problems. Usually the consumer wants these concerns handled as quickly as possible. In these instances what works best is a system developed to identify and solve the consumer problem as close to the source as possible through an internal complaint procedure which allows for resolving the issue at the lowest possible level which addresses the consumer's needs. Entities providing case management services currently utilize internal complaint procedures.

When this internal system fails and the consumer does not receive proper redress from the private or public provider the consumer might in some instances access the existing dispute resolution process provided by the Department for Rights of Virginians with Disabilities (DRVD). DRVD will assist the consumer in resolving alleged disputes pertaining to eligibility for and/or provision of case management services.

A system for the collection of complaints would show only one side of the issue - the complaint. The listing would not indicate how the issue was resolved or if the complaint had merit. Such a listing may not be a useful solution for helping individuals with service needs.

After considering the above findings, the Study Team drew the following three conclusions:

- It is more beneficial to encourage agency systems to continue to be consumer-responsive than to develop an additional process removed from the source of the problem,
- Establishing a central listing of complaints would create a new and unnecessary bureaucracy, and
- Establishing a central listing would be of very limited usefulness in ensuring quality in case management.

Recommendations

1. State agencies which provide case management shall continue to conduct consumer satisfaction surveys and use the findings to promote quality assurance in case management.
2. Private providers of case management shall continue to maintain industry standards to promote quality assurance in case management.
3. A central listing of consumer complaints should not be established.

PART 3: Feasibility of Contracting for Case Management Services

Part 3 of HJR 564 requested that "the Department of Rehabilitative Services explore the feasibility of contracting with Centers for Independent Living as a way to increase accessibility to case management services." This undertaking was recommended by the 1992 Case Management Task Force, which was convened to examine a range of programmatic, fiscal, and operational issues relating to case management services. In its deliberations, the Task Force endorsed continuation of DRS' Long-Term Rehabilitation Case Management (LTRCM) Program. The Task Force also noted that Centers for Independent Living (CILs) may provide some type of case management service in addition to or through their four core services, and addressed interest by CILs in carrying out additional case management services. The Task Force suggested that, because CILs are located in nine sites across the State, a center which is geographically located in an under-served area might be a source of purchased case management services, and recommended that DRS explore the feasibility of purchasing case management from the CILs.

Information for this inquiry came from a variety of sources, including:

- A review of the statutory base for case management and coordination of services for individuals with functional and central nervous system disabilities.
- A review of documents supporting the operation of DRS' LTRCM Program and the independent living services provided by CILs.
- Interviews with LTRCM and CIL staff.

Background

Section 51.5-9.1 of the Code of Virginia designates DRS as the state agency responsible for coordinating rehabilitative services to persons with functional and central nervous system disabilities. Section 51.5-9.1 also charges DRS with responsibility for system development to meet the needs of persons with such disabilities, which includes assessment of their rehabilitative and support service needs; identification of service gaps; promotion of inter-agency coordination; development of models for case management; and advisement on programmatic and fiscal policies and on service delivery.

In response to the legislative mandate, DRS developed the LTRCM Program, designed to develop a comprehensive system to meet the needs of persons with functional and central nervous system disabilities. As a source of service delivery it primarily provides service coordination through case management.

During its 1993 session, the General Assembly codified a definition of case management, noting in Section 51.5-3 that:

> Case management is a dynamic collaborative process that utilizes and builds on the strengths and resources of consumers to assist them in identifying their needs, accessing and coordinating services, and achieving their goals. The major collaborative components of case management services include advocacy, assessment, planning, facilitation, coordination and monitoring.

The General Assembly's definition does not further describe or define the major collaborative components of case management, nor does it identify the specific activities each component may encompass.

The statute also described a case management system as a system of services and supports which are available in a timely, coordinated manner; physically and programmatically accessible; and consumer-directed with procedural safeguards to ensure responsiveness and accountability.

Existing Case Management Services

Because individuals with disabilities frequently need assistance in identifying or accessing needed rehabilitative and support services, case management is critical to any organization charged with serving such individuals. Case management services provide the individual with a disability with a central point of contact who can coordinate the utilization of resources, develop new resources, avoid duplication of effort, promote collaboration between service providers and other community resources, and, overall, improve the efficiency of accessing rehabilitative and support services.

This section describes existing long-term rehabilitation case management services provided by DRS and the CILs. This section is included to provide a context for the discussion of the feasibility of DRS purchasing individual case management from the CILs. It is not intended as a definitive description of either program or as an evaluation or comparison of the two different approaches.

DRS. Case management services are provided as part of overall services to most DRS clients. DRS programs which expressly provide case management for individuals with physical and sensory disabilities include vocational rehabilitation, Woodrow Wilson Rehabilitation Center and Project NetWork.

As noted above, it is through its LTRCM Program that DRS carries out its statutory mandate for coordination of rehabilitative services for persons with functional and central nervous system disabilities and for system development to meet the needs of such persons and to support coordinated rehabilitative services. Thus, although a major component of the LTRCM Program is to provide long-term case management for individuals, the overall program is far broader in scope. The LTRCM Program's systems development efforts are designed to (1) promote consistency and collaboration between service providers and other community resources, and (2) expand system-level service options and opportunities. This systems development can be seen through recent initiatives such as Project PITON, a positive behavioral support model for survivors of traumatic brain injury, their families, and the community; and the home-based training project, creating more flexible outreach strategies for the integration and delivery of assistive technology services and vocational rehabilitation.

The individual case management provided by LTRCM is a highly specialized and selective service. The program accepts only those individuals with the most severe disabilities who have extensive, long-term needs for coordinated services. The disabling conditions which LTRCM clients present include, but are not limited to, traumatic brain injury, spinal cord injury, cerebral palsy, arthritis, muscular dystrophy, multiple sclerosis, and systemic lupus erythematosus (lupus).

LTRCM case managers do not have case services budgets for the purchase of services on behalf of their clients. Funds for needed services must be brought together from external sources. Frequently, case managers put together a package of funding in order to provide a client with a needed service. When no other resource can be found, the LTRCM Program Coordinator may release unencumbered operating funds, if available.

The LTRCM Program covers the entire Commonwealth of Virginia. With the 1993 budget addendum, the program now has five full-time case managers and one part-time case manager serving the four DRS regions. There is one case manager for the Northern Virginia region; one Williamsburg-based case manager for the Southeast region; one and a half case managers for the Southwest region, split between Abingdon and Roanoke; and two Richmond-based case managers for the Central region. All case managers report to the LTRCM Program Coordinator at DRS' Central Office.

As of September 1, 1993, prior to the addition of the second Richmond-based case manager, the LTRCM Program was serving 98 clients in either active or follow-along status, with an additional 50 individuals on waiting status. Because of the long-term needs that these clients present, the LTRCM Program typically does not close cases. Rather, as new needs emerge, the client and the case manager set new goals to address those needs. Cases are moved into a follow-along status as a client's need for services decreases. It should be noted that state budget constraints have prevented the continued development of the LTRCM program and even access to the waiting list has therefore been tightly controlled. Increased funds to hire additional case managers would allow the LTRCM Program to provide services to consumers on the waiting list and to other individuals needing this intensive service.

CILs. There are currently nine private, not-for-profit centers across the Commonwealth that provide independent living services. These programs provide a wide array of services to assist persons with disabilities in leading independent, productive lives as full members of their communities. They also work with communities and the public to create an environment accessible and open to all.

CIL operations are funded by the Department of Rehabilitative Services with state general fund appropriation and/or federal Title VII, Part C funds. Three of the nine centers receive both state and federal funds; two receive only federal funds and the remaining four centers operate with only state funds. In addition, DRS provides sub-grants of federal Title VII, Part B funds to all nine CILs, enabling the centers to purchase goods and services for individual participants.

Center programs are structured around the independent living movement philosophy of consumer direction and control over one's own decisions. An equally important value for CIL service delivery is that an individual with a disability may be best assisted in living an independent life by another individual with a disability.

With a target population of individuals with severe disabilities, CILs provide the four federally established core services of information and referral, peer counseling, independent living skills training, and systems and individual advocacy. In general, these core services are directly provided to participants by CIL staff. As noted above, each CIL receives an allocation of federal Title VII, Part B funds, between $10,000 and $30,000, which can be used, if necessary, to purchase equipment or special services.

In some instances, an independent living specialist may work with a participant who requests coordination of services. Under one or more of the center's core services, a CIL staff member may perform activities that may be considered case management. CIL directors report that center provision of case management is a routine activity. Of the five CIL directors interviewed for this analysis, all reported that they provided case management services to at least 25% of their participants; one CIL director reported providing case management services to at least 50% of that center's participants. Such case management is provided through existing state and federal grants/subgrants from DRS to the CILs.

Opportunities for Contracting

In evaluating the feasibility of contracting for provision of case management, it is important to note that providing case management services to individuals is just one part of the broader mandate of the LTRCM Program. LTRCM is the first phase of service system development for people with severe neurological disabilities. Critical components of this system development include the establishment of highly specialized case management for consumers with the most severe disabilities, programs to promote consistency and collaboration between service providers working with this population, and an array of initiatives to expand and promote opportunities. At this time, the individual case management component of LTRCM is a carefully rationed service, controlled in large part because fiscal limitations have not permitted the growth expected for this initial phase of development.

Funding for the LTRCM Program, and the expenditures of the Program, are not apportioned between individual case management and system development, making it impossible to distinguish between the two in a manner which would be statistically or actuarially meaningful. Even if it were possible, it would not provide a valid programmatic representation because the design of the LTRCM Program establishes the broader activities of system development, such as creation and facilitation of inter-organizational and interdisciplinary teams, as a means of creating opportunities for individual case management clients.

An additional concern is the very specific and intensive set of client needs. Although LTRCM serves individuals with a wide range of disabilities, case management for individuals with acquired brain injuries and multiple disabilities is an area of particular program specialization and expertise; approximately 60% of active LTRCM clients have traumatic brain injuries and some other type of severe head injury. CILs also work with individuals with brain injuries, although that population represents a much lower proportion of the participants that they serve.

Conclusions

Although both LTRCM and CILs assist consumers to develop goals, establish plans to achieve those goals, facilitate or coordinate services, and concern themselves with consumer advocacy and empowerment, it is not feasible to contract case management services under current conditions. Nevertheless, DRS will continue to involve stakeholders in defining an overall system of service delivery for persons with severe functional and central nervous system disabilities. As an overall system of rehabilitative and support services is designed and implemented, there may be opportunities for contractual or fee-for-service relationships with CILs

and other service providers. A comprehensive system will require additional funding and it may address differing levels of case management based on consumer need and on an array of service approaches that supplement or complement the highly specialized and centrally-managed LTRCM Program. The selection of service providers within the overall framework will relate to the capacity of individual providers to meet client needs and assure systemwide consistency and quality.

Recommendations

1. It is recommended that DRS, through the LTRCM Program, complete the first phase of systems development for coordination of services for persons with functional and central nervous system disabilities.

2. Regardless of strategies which may evolve for an overall system of services, it is recommended that DRS continue the provision and expansion of the highly specialized case management services currently available through its LTRCM Program. Clients with these most severe functional and central nervous system disabilities require an intensity of case management which is best provided through a program and staff with focused specialization, training, and expertise.

3. DRS should continue to involve stakeholders in defining an overall system of service delivery for persons with severe functional and central nervous system disabilities. Over time, this may include other aspects of case management that will supplement or complement LTRCM. Service providers might operate within a framework that ensures quality and consistency systemwide.

PART 4: Cost-Effectiveness of Service Delivery

Part 4 of HJR 564 requested that "all state human service agencies serving persons with physical and sensory disabilities and providing case management services conduct an analysis of the most cost-effective manner of the delivery of those services. . .[comparing] the cost of providing case management services utilizing agency staff with that of contractual services." The need for this analysis was identified by the 1992 Case Management Task Force, which was convened to examine a wide range of programmatic, fiscal, and operational issues relating to case management services. The Task Force noted the importance of ensuring cost-effectiveness in the delivery of case management services and therefore recommended cost-effectiveness analyses be conducted.

Case management services for individuals with physical and sensory disabilities are available through eight agencies within the Health and Human Resources Secretariat. These agencies are:

- Department for the Deaf and Hard of Hearing
- Department for the Visually Handicapped
- Department of Health
- Department of Medical Assistance Services
- Department of Mental Health, Mental Retardation and Substance Abuse Services
- Department of Rehabilitative Services
- Governor's Employment and Training Department
- Long-Term Care Council

Although other agencies such as the Department of Social Services may also provide some forms of case management, their services generally are not focused toward individuals with disabilities.

To address the intent of the resolution, each agency conducted its own review based on individualized evaluation methods and data collection.

Department for the Deaf and Hard of Hearing (VDDHH)

Case management is provided by a VDDHH Outreach Specialist when a hearing impairment is the primary disability, and service parameters or restrictions imposed by funding sources prevent referral of the consumer directly to an appropriate state or local agency. Although the position description for the Outreach Specialists designates 10% of the time for case management, no specific dollars are budgeted for case management activity.

Department for the Visually Handicapped (DVH)

Case management for DVH is provided by the agency's rehabilitation counselors and teachers. The analysis conducted by DVH compared the median cost per hour for salary plus fringe benefits for its rehabilitation counselors and teachers, with the average cost per hour for rehabilitation specialists in the field of private rehabilitation. The rationale for this comparison is that the vocational emphasis in private rehabilitation case management represents the closest parallel to

the process and goals of DVH's rehabilitation counselors and teachers. It must be emphasized that this parallel is not exact. For example, a significant portion of a private rehabilitation specialist's time and effort is spent preparing for litigation, which is not the situation with DVH rehabilitation counselors and teachers.

Since private rehabilitation companies generally limit specific information on their salary/wage and fringe benefits, verifiable hard data are not available. DVH staff did, however, contact representatives of several local and regional private rehabilitation companies and inquire about "average" salary/wage and fringe benefits costs for private rehabilitation specialists. Given the difference in service patterns, available data do not suggest significant current benefits.

Department of Health (DOH)

DOH conducted an analysis of the cost of the delivery of case management services to individuals with physical and sensory disabilities in the Children's Specialty Services Program. These services are provided by nurses and social workers employed by DOH in full-time and part-time positions. The tabulation of the annual cost of the case management services included professional salaries and fringe benefits; clerical salaries and fringe benefits; support costs (travel, postage, staff development, printed materials, office supplies, and equipment); and cost of administration (rent, phone, utilities, malpractice/liability insurance, workers' compensation, and supervisor's salary and fringe benefits). No similar intensity of medical case management could be identified at a comparable or lower cost.

DOH concludes that its case managers are not only beneficial in enhancing the treatment and well-being of patients, but are very cost-effective as gatekeepers in pre-authorizing and monitoring the costs of medical services provided to patients.

Department of Medical Assistance Services (DMAS)

Prior to June 1993, DMAS case management services to children enrolled in the Technology Assisted Waiver Program were provided exclusively by several contracting agencies in Virginia which were reimbursed on a flat rate fee schedule. Reimbursement rates were based on an hourly cost of $15.60, multiplied by the estimated number of hours needed to provide services to these children.

The following data reflect the amounts paid by DMAS for contracted case management services from September 1, 1992 to March 31, 1993.

Agency	Cases	Cost
Children's Hospital of the King's Daughters	24	$26,220
Community Hospital of Roanoke Valley	14	16,125
Henrico Doctor's Hospital	9	11,187
Medical College of Virginia	34	42,450
University of Virginia	34	23,410
Visiting Nurses Assn. of Northern Virginia	12	11,337
TOTAL	127	$130,729

On June 1, 1993, DMAS started a pilot program for providing case management services to children in the Technology Assisted Waiver Program, in

order to analyze the actual cost of providing these services as well as to remedy problems related to the use of outside contractors. Two DMAS analysts began to provide case management services to half of the children formerly served by the Medical College of Virginia and all the children formerly served by the University of Virginia. Data collected on this pilot project from June 1, 1993 to August 31, 1993 revealed that 334.17 staff hours were spent on 48 cases, at a cost of $6,214.87 based on a staff hourly wage.

Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)

DMHMRSAS provides community-based case management services to persons with a diagnosis of mental retardation, mental illness or substance abuse through Community Services Boards. The cost to provide this service in FY 1992 was:

Program	Total Cost*	Unit Cost	Number of Clients	Cost per Client
Mental Health	$20,090,221	$43	35,981	$558
Mental Retardation	$ 9,779,532	$39	10,959	$892
Substance Abuse**	$ 5,402,629	$46	13,748	$393

* Includes state, local and federal funds and fees (including Medicaid).
** Does not include methadone clinics.

Department of Rehabilitative Services (DRS)

Case management services are provided as part of overall services to most DRS clients. DRS programs which expressly provide individuals with physical and sensory disabilities with case management services include vocational rehabilitation, Woodrow Wilson Rehabilitation Center and Project NetWork. DRS carries out its statutory mandate for coordination of rehabilitative services for persons with functional and central nervous system disabilities and for system development to meet the needs of such persons through its Long-Term Rehabilitation Case Management (LTRCM) Program.

Because case management is embedded in the overall provision of services, it is not possible to apportion expenditures between case management and other components of DRS service delivery in a manner which would be statistically or actuarially meaningful. With specific regard to LTRCM, such a breakdown would not provide a valid programmatic representation because the design of the LTRCM Program establishes the broader activities of system development, such as creation and facilitation of inter-organizational and interdisciplinary teams, as a means of creating opportunities for individual case management clients.

Governor's Employment and Training Department (GETD)

While a few Service Delivery Areas in the Job Training Partnership Act (JTPA) system may provide some services reflective of case management, case management has not been an integral feature of the delivery of job training services. No further analysis was therefore carried out. The amendments of the JTPA, which

became effective on July 1, 1993, include case management as an authorized service. GETD anticipates that case management will begin to play a larger role in the JTPA system of service delivery.

Long-Term Care Council (LTCC)

The Long-Term Care Council provides case management through the Case Management for Elderly Virginians Pilot Project. The initial structure of the pilot project was not designed to provide a comparative analysis of the cost effectiveness of the services. However, LTCC examined several issues related to overall cost and outcomes. During the evaluation period, LTCC noted an overall increase in the cost efficiency of the projects, with respect to cost per client month.

LTCC also compared the public cost of case management and related services to the public costs of nursing home and personal care clients (Year 1 - 2nd Interim Report) When all three pilot sites were considered together, the total public cost of case management clients was considerably less than that for nursing home residents and personal care clients.

In addition, there is evidence that the program is delaying or avoiding nursing home use. For example, relatively few case management discharges are to nursing homes (Year 1 - Final Report), in spite of a high level of impairment, which indicates a risk of admission (Year 1 - 2nd Interim Report).

Based upon the information gathered during the evaluation, LTCC believes that the pilot project offers strong evidence that case management is cost effective, provided that there are careful controls on both the cost of case management and the client service packages. Recommendations that have been made by the evaluation team and the Secretary's Task Force on Long-Term Care and Aging should promote cost-effective case management services.

Conclusions

Ideally, a least-cost analysis is an appropriate method to study the cost-effectiveness of case management service delivery. This approach identifies the least costly method to attain a pre-established, measurable level of an objective, by analyzing each of several alternative methods of achieving that level in terms of dollar expenditures needed to do so.

In the present situation, however, the multifaceted nature of case management services generally cannot be reduced to a single objective and, where multiple explicit objectives exist, costs cannot be meaningfully distributed to individual objectives. Reflecting its statutory definition (Section 51.5-3), case management incorporates diverse components such as advocacy, assessment, planning, facilitation, coordination and monitoring to create a dynamic collaborative process which utilizes and builds on the strengths and resources of consumers to assist them in identifying their needs, accessing and coordinating services, and achieving their goals. Statistical or actuarial efforts to isolate specific costs associated with a specific service component, be it that of a state agency or a contractual provider, become artificial, calling into question the validity of any comparative analysis.

CONCLUSIONS AND RECOMMENDATIONS

As a result of the work of the 1992 Case Management Task Force and of the human services agencies reporting in this Response to House Joint Resolution 564, significant steps have been taken toward enhancing case management services in the Commonwealth of Virgina. Design and implementation of service delivery models that integrate technology, confidentiality forms, single assessment, etc., will move the Commonwealth further toward a comprehensive, consumer-responsive approach to case management.

This section of the Response to HJR 564 summarizes the action taken in response to Part 1 of the General Assembly's request, and presents conclusions and, where appropriate, recommendations from Parts 2, 3, and 4.

PART 1: Interagency Policy On Consumer Designation of Primary Reimbursed Case Manager

Part 1 of HJR 564 requested that "the state human services agencies serving persons with physical and sensory disabilities adopt an interagency policy that allows consumers to designate the primary reimbursed case manager when the consumer is receiving services from more than one health and human service agency."

DRS staff facilitated a work group (See Appendix D) that included representation from state human service agencies, advocacy organizations and persons with physical disabilities. The work group developed an agreement fashioned after the 1992 Memorandum of Understanding on Interagency Collaboration and Confidentiality. They named this interagency agreement the *Memorandum of Understanding, Consumer Choice for Primary Reimbursed Case Manager* (Appendix B).

The work group circulated the draft agreement among the participating agencies for review and improvements. Each agency representative reviewed the agreement within their agency's protocol. DRS staff members surveyed nine individuals with physical disabilities or their family members. Each of the consumers surveyed had received services from multiple agencies.

The Memorandum of Understanding has been transmitted to the Secretary of Health and Human Resources. The next steps for the agreement include review from the Secretary and heads of participating agencies for signature. Once all parties have signed it, the Memorandum of Understanding will take effect.

PART 2: Consumer Satisfaction

Part 2 of HJR 564 requested that "the Department for Rights of Virginians with Disabilities conduct a feasibility study of maintaining and incorporating results from consumer satisfaction surveys to promote quality assurance in case management services within both the public and private sectors...[and] determine the need of establishing a central listing of complaints regarding the quality of services provided by case managers and their organizations in both the public and private sectors." Part 2 also requested that "consumers and providers of case management services, both public and private, shall be included in all phases of the study."

The Department for Rights of Virginians with Disabilities facilitated a Study Team (See Appendix D) composed of representatives from state agencies, private case managers, and consumers. The Study Team convened twice and came to a consensus on the issues, findings, and recommendations presented in this report.

Conclusions

The Part 2 Study Team came to the following conclusions:

- State agencies are currently conducting consumer satisfaction surveys and utilizing the information to improve case management services.
- Private case management providers assure quality in case management through established industry standards and practices.
- It is more beneficial to encourage agency systems to continue to be consumer-responsive than to develop an additional process removed from the source of the problem.
- Establishing a central listing of complaints would create a new and unnecessary bureaucracy.
- Establishing a central listing would be of very limited usefulness in ensuring quality in case management.

Recommendations

1. State agencies which provide case management shall continue to conduct consumer satisfaction surveys and use the findings to promote quality assurance in case management.
2. Private providers of case management shall continue to maintain industry standards to promote quality assurance in case management.
3. A central listing of consumer complaints should not be established.

PART 3: Feasibility of Contracting for Case Management Services

Part 3 of HJR 564 requested that "the Department of Rehabilitative Services explore the feasibility of contracting with Centers for Independent Living as a way to increase accessibility to case management services."

Conclusions

DRS' Long-Term Rehabilitation Case Management (LTRCM) Program is the first phase of service system development for people with severe neurological disabilities. In evaluating the feasibility of contracting for provision of case management, it is important to note that providing case management services to individuals is just one part of the broader mandate of the LTRCM Program. Funding for the LTRCM Program, and the expenditures of the Program, are not apportioned between individual case management and system development, making it impossible to distinguish between the two in a manner which would be statistically or actuarially meaningful.

DRS determined that although both LTRCM and CILs assist consumers to develop goals, establish plans to achieve those goals, facilitate or coordinate services, and concern themselves with consumer advocacy and empowerment, it is not feasible to contract case management services under current conditions. Nevertheless, DRS will continue to involve stakeholders in defining an overall system of service delivery for persons with severe functional and central nervous system disabilities. As an overall system of rehabilitative and support services is designed and implemented, there may be opportunities for contractual or fee-for-service relationships with CILs and other service providers. A comprehensive system will require additional funding and it may address differing levels of case management based on consumer need and on an array of service approaches that supplement or complement the highly specialized and centrally-managed LTRCM Program. The selection of service providers within the overall framework will relate to the individual provider's capacity to meet client needs and assure systemwide consistency and quality.

Recommendations

1. It is recommended that DRS, through the LTRCM Program, complete the first phase of systems development for coordination of services for persons with functional and central nervous system disabilities.

2. Regardless of strategies which may evolve for an overall system of services, it is recommended that DRS continue the provision and expansion of the highly specialized case management services currently available through its LTRCM Program. Clients with these most severe functional and central nervous system disabilities require an intensity of case management which is best provided through a program and staff with focused specialization, training, and expertise.

3. DRS should continue to involve stakeholders in defining an overall system of service delivery for persons with severe functional and central nervous system disabilities. Over time, this may include other aspects of case management that will supplement or complement LTRCM. Service providers might operate within a framework that ensures quality and consistency systemwide.

PART 4: Cost-Effectiveness of Service Delivery

Part 4 of HJR 564 requested that "all state human service agencies serving persons with physical and sensory disabilities and providing case management services conduct an analysis of the most cost-effective manner of the delivery of those services. . .[comparing] the cost of providing case management services utilizing agency staff with that of contractual services."

To address the intent of the resolution, each agency conducted its own review based on individualized evaluation methods and data collection.

Conclusions

Ideally, a least-cost analysis is an appropriate method to study the cost-effectiveness of case management service delivery. This approach identifies the least costly method to attain a pre-established, measurable level of an objective, by analyzing each of several alternative methods of achieving that level in terms of dollar expenditures needed to do so.

In the present situation, however, the multifaceted nature of case management services generally cannot be reduced to a single objective and, where multiple explicit objectives exist, costs cannot be meaningfully distributed to individual objectives. Reflecting its statutory definition (Section 51.5-3), case management incorporates diverse components such as advocacy, assessment, planning, facilitation, coordination and monitoring to create a dynamic collaborative process which utilizes and builds on the strengths and resources of consumers to assist them in identifying their needs, accessing and coordinating services, and achieving their goals. Statistical or actuarial efforts to isolate specific costs associated with a specific service component, be it that of a state agency or a contractual provider, become artificial, calling into question the validity of any comparative analysis.

APPENDIX A

GENERAL ASSEMBLY OF VIRGINIA--1993 SESSION

HOUSE JOINT RESOLUTION NO. 564

Requesting the Secretary of Health and Human Resources to develop a consumer-responsive case management system to strengthen coordination of services, consumer choice, accountability of service providers, and cost-effectiveness of service provision.

Agreed to by the House of Delegates, February 26, 1993
Agreed to by the Senate, February 26, 1993

WHEREAS, 351,000 citizens in the Commonwealth are affected by physically disabling conditions; and

WHEREAS, goals and coordinated plans are required to ensure that persons with physical and sensory disabilities have access to appropriate levels of care and opportunities for optimum self-sufficiency and employment; and

WHEREAS, case management is a dynamic collaborative process which utilizes and builds on the strengths and resources of consumers to assist them in identifying their needs, accessing and coordinating services, and achieving their goals; and

WHEREAS, it is recognized that case management is not a profession in itself, but rather an area of practice within a profession or role as a consumer or advocate; and

WHEREAS, multiple state and local agencies and private organizations provide case management services to persons with physical and sensory disabilities; and

WHEREAS, public agencies and private organizations offer a wide range of case management services and various approaches to persons with physical and sensory disabilities; and

WHEREAS, clients often are thwarted in meeting their goals because of a gap in services, lack of information about existing services, or the limited availability of natural support systems; and

WHEREAS, opportunity for consumer participation and choice in the case management process should be enhanced; and

WHEREAS, there are no mechanisms to monitor qualifications of case managers and to ensure accountability of services provided by case managers; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Secretary of Health and Human Resources be requested to direct the following:

1. That the state human services agencies serving persons with physical and sensory disabilities adopt an interagency policy that allows consumers to designate the primary reimbursed case manager when the consumer is receiving services from more than one health and human service agency;

2. That the Department for Rights of Virginians with Disabilities conduct a feasibility study of maintaining and incorporating results from consumer satisfaction surveys to promote quality assurance in case management services within both the public and private sectors. This study shall also determine the need of establishing a central listing of complaints regarding the quality of services provided by case managers in both the public and private sectors. Consumers and providers of case management services, both public and private, shall be included in all phases of the study;

3. That the Department of Rehabilitative Services explore the feasibility of contracting with Centers for Independent Living as a way to increase accessibility to case management services; and

4. That all state human service agencies serving persons with physical and sensory disabilities and providing case management services conduct an analysis of the most cost-effective manner of the delivery of those services. This study shall compare the cost of providing case management services utilizing agency staff with that of contractual services.

All of the above directives and studies shall be completed by October 1, 1993, and a report be provided to the Governor and the 1994 Session of the General Assembly according to the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Memorandum of Understanding
Consumer Choice for Primary Reimbursed Case Manager

I. PURPOSE

The purpose for this memorandum of understanding is to support the consumer right to designate a primary reimbursed case manager and to strengthen interagency case management services.

The following agencies enter into this agreement:

Department of Rehabilitative Services
Department for the Visually Handicapped
Department of Social Services
Department for the Deaf and Hard of Hearing
Department of Medical Assistance Services
Department for the Aging
Department of Health
Department of Mental Health, Mental Retardation and Substance Abuse Services
Department for Rights of Virginians with Disabilities
Governor's Employment and Training Department

II. RATIONALE

The participating agencies intend this agreement to enhance consumer participation and choice in the case management process. Case management is a dynamic collaborative process that utilizes and builds on the strengths and resources of consumers to assist them in identifying their needs, accessing and coordinating services, and achieving their goals.[1] Case management is not a profession, but rather an area of practice within one's profession or role as an advocate. A reimbursed case manager is a provider who directly performs case management functions and receives a salary or fee for service. A consumer is, with respect to case management services, a person with a disability or his designee, guardian or committee.[2]

Effective case management often involves coordinating the services of multiple agencies or organizations. To ensure responsiveness and accountability, a consumer-responsive case management system does the following:

- Promotes consumer participation in the case management process
- Provides for a central point of contact and communication
- Strengthens advocacy efforts
- Supports the collaborative process
- Promotes accessibility to programs, services and resources
- Promotes efficiency and effectiveness

1, 2 Code of Virginia § 51.5-3

III. STATEMENT OF COMMITMENT

The agencies participating in this agreement will support the consumer designation of a primary reimbursed case manager when the consumer receives services from more than one agency. The consumer and the primary case manager will define the primary case manager's role, function and period of service. Consumer needs, preferences and capabilities will dictate to the greatest extent possible which approach is best to facilitate the consumer's desired outcomes. The participating agencies also agree to:

- Inform consumers and support their right to designate a primary reimbursed case manager
- Serve as the primary reimbursed case manager, when requested by a consumer, and as appropriate within the designated agency's mission, scope of services, capacity and expertise
- Cooperate with any other public and private service providers designated by consumers as primary reimbursed case managers
- Work together to assist consumers in achieving their goals
- Reduce delays and barriers in accessing services
- Inform consumers of existing formal appeals processes to resolve consumer concerns
- Share information between providers, with the consent of the consumer, to reduce duplicate assessments
- Promote implementation of this agreement at the local level

IV. SIGNATURES

Secretary of Health and Human Resources	Date
Commissioner, Department of Rehabilitative Services	Date
Commissioner, Department for the Visually Handicapped	Date
Commissioner, Department of Social Services	Date
Director, Department for the Deaf and Hard of Hearing	Date

Director, Department of Medical Assistance Services	Date
Commissioner, Department for the Aging	Date
Commissioner, Department of Health	Date
Executive Director, Governor's Employment and Training Department	Date
Director, Department for Rights of Virginians with Disabilities	Date
Commissioner, Department of Mental Health, Mental Retardation and Substance Abuse Services	Date

APPENDIX C

Survey Comments on the
Memorandum of Understanding,
Consumer Choice for Primary Reimbursed Case Manager

Survey Questions

1. What do you see as the purpose of the policy?
2. Do you think the policy might improve coordination of services?
3. Is there anything you like or do not like about the policy?
4. Do you think we should change the policy in any way?
5. Do you have any additional comments regarding the policy?

Survey Responses

Respondent 1

1. For case workers and consumers to work hand-in-hand in achieving goals set up by consumers.
2. Yes, as long as you don't get too many professionals involved.
3. No, I like the policy, it's putting the consumer to the forefront, getting the consumer involved in the decision making, and letting them take control of their lives to the best of their ability.
4. No.
5. Family needs to be involved, it has some impact on the family. Perhaps it needs to be taken into consideration. There's a lot the family does not know, they don't know what's out there.

Respondent 2

1. To better serve consumers.
2. Yes.
3. No, I think everything is good.
4. No.
5. No.

Respondent 3

1. To make it simpler for family members to find what they need.
2. Yes, case management should be in every realm of service delivery.
3. I have a fear that DRS might leave, it's scary. I hope it stays.
4. I liked the statement of commitment.
5. No, I'm satisfied with what I see.

Respondent 4

1. Instead of Departments having control, consumers have more choice in services.
2. Probably, yes. Now it's real difficult to go through the process.
3. People need more choices if they are able to make them on their own.
4. No.
5. Question: How do they decide about funds? They may save money in the long run if they provide needed services in the beginning (short run). Example: Providing supported employment in the early stages will prevent the need for costly services later.

Respondent 5

1. Agencies helping other people.
2. I believe it would.
3. No, it seemed to be in order.
4. No.
5. It seemed to be pretty sound.

Respondent 6

I'm happy with the way it is now. The current system works very well. I don't see the need to complicate it. I would not like to see the system be Social Services oriented (they're more difficult to work with). I would rather it stay the way it is. If it ain't broke, don't fix it.

Respondent 7

1. Fairness.
2. It's hard to tell, it depends upon the individuals involved.
3. I think for consumers it's hard to tell our story to so many professionals and agencies. This would eliminate unnecessary energy, would be the most efficient use of time for consumers.
4. No.
5. No.

Respondent 8

1. Basically, the draft is good, if properly implemented and executed. To put down criteria for case management, to describe it would be generally helpful.
2. I think it will improve coordination of services. One case manager, one stop shopping.
3. People working with individuals with disabilities don't realize that when an individual has a brain injury, they don't always have decision making abilities. A lot of professionals fail to recognize the resources and information a care giver can provide and the utilization of that information in achieving goals of the consumer. There is a serious flaw in leaving out the family. You have to expand upon the statement: "A consumer is, with respect to case management services, a persons with a disability or his designee, guardian or committee."

Respondent 8 (cont'd)

People, the family, often has [sic] a greater grasp of needs for services than the consumer. The family is an advocate for the consumer, you need to make it clear and put it into the document. It can't always be the person with the injury working with the case manager, and family members don't always want to become guardians or designee. You should change "Promotes consumer participation in case management process" to "Consumer and/or family member."

4. In some situations there is not always a case manager, it's the family. How can the family get recognized by agencies for serving in the capacity as a primary case manager? Some recognition or compensation should be given (tax credit).
5. Could there be a right to request a change in case manager included in the document?

Respondent 9

1. To make it legally binding.
2. Definitely.
3. Parents should be knowledgeable as to what services are available to make informed decisions regarding the selection of a primary case manager. The document did not address this issue.
4. How much impact will this policy have on how agencies do business? What is the consequence? Are they not doing this now?
5. No.

APPENDIX D

Interagency Work Group Members, Parts 1 and 2

Part 1: Interagency Policy On Consumer Designation of Primary Reimbursed Case Manager

Cynthia Smith	Department of Mental Health, Mental Retardation and Substance Abuse Services
Clayton Bowen	Department for the Deaf and Hard of Hearing
Bonita Pennino	Department for Rights of Virginians with Disabilities
Gail Nottingham	Governor's Employment and Training Department
Lee Morowitz	Virginia Department of Social Services
Carter Hamlett	Department for the Visually Handicapped
Catherine Saunders	Long-Term Care Council
Paul Melvin	Endependence Center, Inc.
Raymond Graesser	Department of Rehabilitative Services
Betty Sparrow	Department of Rehabilitative Services
Tim Olive	Department of Rehabilitative Services
Keith Enroughty	Department of Rehabilitative Services
Dolores Martin	Department of Rehabilitative Services

Part 2: Consumer Satisfaction

Barbara Green	Consumer
Melissa Wirt	Department of Medical Assistance Services
John Granger	Department for the Visually Handicapped
Gail Honea, Ed.D.	Department of Rehabilitative Services
Kathleen Magill, Ph.D.	Department of Rehabilitative Services
Kathleen Lynch, Ph.D.	Virginia Commonwealth University
Betty Overbey, R.N., CRRN,CIRS	Medical - Rehabilitation Resource Consultants, Inc.
Bonita Pennino	Department for Rights of Virginians with Disabilities