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Risk Management and Independence Plus

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Risk Management & Independence Plus
Facilitator: Nirvana Huhtala
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Coordinator — Good day, ladies and gentlemen and welcome to the Risk Management conference call. My name is Sab and I will be your coordinator for today. At this time, all participants are in a listen-only mode. We will be conducting a question and answer session towards the end of this conference.

I would now like to turn the presentation over to your host for today's call, Ms. Nirvana Huhtala from the Community Living Exchange. Please proceed, ma'am.

N. Huhtala — Hello. Thank you all for joining us today. We are very happy that you were able to join us for this session on risk management sponsored by the Community Living Exchange at Rutgers Center for State Health Policy. This is a national technical assistance effort that is funded by the Centers for Medicare & Medicaid services to provide assistance to all of the Real Choice Systems Change grantees. This particular technical assistance effort is the result of feedback we received from the Independence Plus grantees on what you specified as one of the most important areas for assistance.

So, what we have done is divided this up into two sections. The first is with Suzanne Crisp. She is going to give an overview of risk management and how it relates Independence Plus. And the second section will focus on the state perspective. We have three states that will join us: Florida, Ohio and New York. And we have asked each of them to spend somewhere between 10 and 15 minutes or so to talk about what their risk management system is.

So we'll start with Suzanne Crisp from Medstat and she provides technical assistance on self-directed programs. Suzanne?

S. Crisp — Hello. Hello, everybody. It's really great to be here and to connect with you all again. I know you want to hear from the state so I'm just going to take a bit to set the context for our discussion. And I want to focus on four different questions, basically. First, what are risks? Secondly, why should state focus on risk and risk management? And then, how our states

developing and implementing risk management systems? And then what did those risk management systems look like? We'll be covering this in 10 to 15 minutes so hang on.

First of all, what are risks, what is a risk? There are many definitions out there, but the one I like the best is that a risk is any situation, action or decision that would place the waiver participant in a jeopardizing, harmful state, where the potential for loss, injury, damage, endangerment or exposure is probable. We all make bad decisions and take risk. There is such thing as the dignity of risk prerogative, which we should afford our waiver clients also. In other words, the right to make bad decisions and take risk.

The goal is not to eliminate risk here but rather to identify the likelihood that the harmful situation might occur and to develop a plan that is mutually agreed upon by the participant, the program representative and typically, that's the case manager, and a program that is in agreement with the state's risk management policy. While it's certainly is impossible to prevent all untoward incidences, a mindful and systematic approach to identification of risk and planning will minimize the probability of their occurrence, we hope.

Now, according to the National Quality Inventory Project in 2002, there are three general categories of risk and those are: health, behavioral and risk to personal injury. Let's give some examples of each of these. First of all, health risk can include disease, malnourishment, non-compliance with medications or diet, abuse of medicines or alcohol, skin integrity, dental or vision problems, problems with bowel and bladder control, and unsafe and unsanitary housing. Behavior risk includes exhibiting poor decision-making, cognitive limitations, violent or criminal behavior, substance abuse, suicide, depression, dementia, elopement or mental illness. Risk to personal safety can include issues that are individual to vulnerable and per persons. They can include abuse, exploitation and neglect. If an individual is unable to safely evacuate or prone to falls or are socially isolated. Another risk is something that we don't think about too often and that is the stress and neglect that the caregiver may give, or is under.

Now, why do we want to focus on risk management right now? We know that waiver program set standards to ensure health and welfare of the participants, and CMS has really focused on safeguarding health and welfare recently, particularly with the new application. Both CMS and states have identified a risk management system as an integral part of a safeguarding system. More specifically, if you all have Version 3.3 of the new application, and I believe this just came out last week. If you don't

have a copy of the latest 1915-C application, please call your Medicaid office first and then your regional office, but 3.3 is the version that we're all now working on. But Appendix C of that version of the draft application requires states to specify how potential risk to the participant are assessed during the service planning development process and how strategies to mitigate risk are incorporated in the service plan and are subject to participant needs and preferences. CMS is going to be looking in the approval and the renewal process. They're going to be looking for a structured approach to risk assessment and risk mitigation and must ensure that these risk mitigation strategies are sensitive to the preferences of the individual.

Originally, we thought that risk management and the consideration of back-ups and whatnot were …confined to those who were self-directing, but we have found that CMS has taken a broader approach and applied both risk management and back-up plans to the total population, so there's now language in the new application that speaks to all waiver participants.

So let's talk about how states are dealing with the risk and the risk requirements. Even before the language of the new application draft was introduced, states were developing risk management processes and systems for a number of different reasons. First, they wanted to protect their program participants from harmful situations. Secondly, they wanted to provide a consistent approach to dealing with risk. Third, they wanted to support managers and staff dealing with risk situations. And finally, they felt like having a risk management system reduced their threat of litigation.

What does a risk management system look like? We have a lot of background from interviewing several states and compiling all of that information in a report that Medstat recently distributed, and I'll talk more about that in a minute. But the information that we gleaned from other states was that generally, a risk management system begins with the individual and progresses into a systemic management of risk. Most states now are making this risk management system part of their broader quality management strategy that is a requirement of Appendix H in the new application.

The risk management system is composed of many parts. First, it consists of specific policies and procedures clearly outlining roles and responsibilities of the individual, the case manager, the state support staff and providers in managing risk. Next comes a process to formally identify risk and a means to assess those risks to determine the impact and consequences of those risks. Then, interventions are recommended generally by the case manager to reduce or eliminate the risk or risks.

Next, the solid monitoring system to oversee the implementation of the risk plan is necessary. Then, a process by which to ensure that due process of the participants is in place to protect their rights. And typically, this is an informal process that is not necessarily tied to the state fair hearing system. Next, the state must build a training curriculum to build competencies of front line staff in dealing with the identification and the assessment of risk and provide effective resources to safeguard health and welfare.

While all this happens on the individual level, states have found that they can collect information about risk. For example, the number of instances and what type of instances those are, investigations, case manager, documentation and planning efforts, and aggregate this information or combine the results of all this activity, and then analyze the findings. What happens is, they know more about their waiver population, they're able to identify trends and they begin to address risk on a system-wide basis rather than an individual one.

I took three of the hardest things and thought we'd talk more about those, so let's look more closely at the three components of the risk management system. One, identifying risk; two, assessing the extents of risk and outlining the consequences of the risk; and three, applying interventions to reduce or eliminate risk.

Risks typically are identified through a person-centered planning process. Understanding the individual's lifestyle, preferences, goals will all help determine not only the service plan, but represents the opportunity to find out about potentially harmful activities. During the process, the following information should surface: the availability or lack of unpaid support; a history of non-compliance with medication or diet; instances of abuse, neglect or exploitation; frequent hospitalizations over a short period of time or frequent visits to the emergency room; displaying inappropriate behavior; determining if an individual is at risk of isolation; and also, an assessment of the participant's abilities to make decisions or cognition should be determined at this time.

Next, the assessment process. This is the process that assesses the potential or the perceived risk to the individual. It's typically done during the development of the plan of care and on focused discussions about what services are needed to meet the individual's needs. Care should be taken to ensure that staff is sufficiently trained to recognize and document risk and to hold and check their own values. Is the risk tolerable? Truly, is at a foreseeable risk to participants that will result in a harmful occurrence? If the risk pursues, then what are the consequences, what are the negative consequences that will happen if this risk is not ameliorated?

Are participants' references honored and is there an appreciation for the participant's value?

Finally, many states are developing a risk screening or risk assessment tool to determine or document risk and capture data about risk. So after we assess, after we identify and assess, now it's time to apply our interventions or treatments to prevent or reduce the impact of serious risk. How can this be accomplished?

One method is to ensure that participants understand the consequences of their actions or the lack of taking actions. There should be an open discussion about risk and alternatives. Next, introduce a second opinion. Sometimes peer case managers can help. Oftentimes, supervisors, family, state supervisors, cannot be brought in to help a case manager deal with the intervention. Sometimes, an independent mediator or arbitrator using a neutral party is necessary.

Bringing in representatives oftentimes helps to dilute the potential risk. They are able to help the representative with decision-making. Also, modifying the plan of care, either increasing the services or adding additional services and increase case management and monitoring can also serve as an intervention or a method by which to reduce the risk.

Many states are using risk agreements. If the individual actually understands the... but they feel—sorry, I just got a call. If they understand the consequence but they still want to—but they still are in risk, then a formal agreement, which recognizes that there is a difference of opinions, it's a documentation of the difference of opinion. While this is perceived as lessening liability, risk agreements are questionable as far as litigation or if they would hold up in court. Also, be concerned that a risk agreement does not relieve the provider from providing competent care.

It's difficult to talk about a comprehensive risk management system in just a few minutes, but I do know that there is a lot of additional information at hcds.org. Here you'll find the recent Medicaid letter, CMS Medicaid letter on risk and Medstat report. There's also a good report by Chas Mosley on negotiating risk agreements, and then there's a series of presentations on risk planning systems. But I know now you want to hear from our states and what really happens in real life. So, thanks very much and I think we'll entertain questions at the very, very end. So I'll turn it back over to Nirvana who can introduce our states. Hello?

N. Huhtala Thank you so much, Suzanne.

S. Crisp You're welcome.

N. Huhtala Next, I'd like to turn it over to Mick Ihlenfeld from Ohio. Mick is the Assistant Deputy Director for the Major Unusual Incidence and Registry Unit. Mick?

M. Ihlenfeld Good afternoon, everyone. Ohio serves 70,000 plus children and adults with mental retardation developmental disabilities who have been determined eligible for services through a standardized instrument, which each of our 88 county boards of mental retardation use. So our risk management system applies to all 70,000 plus folks. We haven't designated for particular waivers or anything it includes everybody that's in our system.

We've identified five components to our risk management system; rightfully or wrongfully so, these are just the things that affect risk of individuals. The first one is incident management system. Second one is risk assessment. The third component that we identified is the causal analysis, and that's looking at not only the root cause but contributing factors to a particular incident. Through some of our experience, we found a lot of folks were just addressing the root cause and incidents were continuing to happen over and over again. The fourth component is the prevention planning and the fifth component that we identified is the data analysis. I'll speak a little bit about each one of them.

All the components are in place but at varying levels across the State of Ohio. The Major Unusual Incident/ Registry Unit, which is what I'm in charge of overseeing all the components except for the risk assessment piece, and that pretty much falls with our Community Services people. The oversight of the other four components is done in conjunction with our staff who do accreditation of county boards and with our Licensure staff and with our staff who certify providers. So we work closely with all of those folks around our risk management system.

The first one, the incident management system, we've had it in place since 2001. We had a new director come in who recognized the need for a better system within our community programs and a waiver review by CMS that were the stimulus to these changes. We've worked pretty hard. We passed a rule that had very defined requirements for all of our providers, licensed and certified, and all our county boards on when, how, and what to report in terms of incidents and how to conduct investigations along with requirements for analyzing data. It's a web-based system where all the county boards report to us online. I won't spend a lot of time on that. It's an excellent system and it allows us to do a lot. It has worked well for us.

The risk assessment, is the second piece, like I mentioned earlier. We really don't have any authority to make people do stuff, but we have integrated this into our training that my Unit does across the state and felt that the risk assessment was the real beginning point to address risk in individuals. What we did was we developed a tool using quality indicators. We've been promoting it for the last six, seven months. When we talked to folks in our training, we find that most people have sort of an informal process. They really don't have a formal process of assessing risks, so we feel this is a good beginning point.

The risk assessment tool itself is organized by the quality indicators. For example, an individual receives wellness and health services as one of our indicators and under that, we've identified some risk factors like seizures, bowel function, gastrointestinal problems, skin breakdown. And as part of individual service planning, the team would identify is there a significant risk or not, then describe the circumstances of the risk, and also begin to develop some plans to intervene.

The second indicator is the individual is supported to maintain healthy habits and under this, some of the risk factors include excessive eating, smoking, drinking, substance abuse, diet.

The third one is individual is safe from abuse, neglect, injury, and exploitation. We have a number of risk factors identified under that.

The fourth one is individuals with challenging behavior have appropriate measures in place and positive behavior plans. We look at risk factors and self-abuse, aggression towards others, aggression towards property. We look at is the individual safe in the home environment and we have risk factors such as stairs, people doing transfers, toileting, housemates, fall hazards, temperature of the water heater, safety alarms, things of that nature.

The next one is the individual is safe in their neighborhood and we look at issues of traffic, things like ponds and lakes nearby, the terrain, vehicle safety and transportation, neighbors, and neighborhood visitors.

The last one is safeguards are in place to protect the individual's resources. So this again was just a tool that we drafted and I think we borrowed from some other folks and we pieced it together. We've been promoting it in our training just to try to get some systematic way for people to begin to do risk assessments. We just tell them to take this tool and do whatever they want to with it; to adapt it to meet their own needs. So that was the second piece.

The third piece to our risk management system is the causal analysis, and as I mentioned earlier, we were having problems. For instance, we would see theft of an individual's funds and we would see that the person was fired as the prevention plan without looking at how the staff had access to the funds to begin with to be able to steal from the person. So the causal analysis approach looks at all the contributing factors, as well as the root cause, and this helps people come up with better solutions, better long-term solutions to prevent the incidents from reoccurring . We've tied this into our training for our investigators and also my staff do a lot of oversight and review of cases. We built it into our reviews to make sure people are trying to identify the contributing factors.

The fourth area is prevention planning. This is a requirement when the county boards submit an incident to us. Just to give you an idea, we had some 22,000 incidents last year. We have 17 categories of major unusual incidents. It seems like a lot, but I think it's partly a quality assurance process, as well as a risk management type of program that ensures health and safety of the folks in our service delivery system.

The prevention planning, some of the requirements, are to make sure that it's verified, whatever the team has come up with at the local level. We made sure that it has been implemented before we'll close a case at our end; make sure the contributing factors have been addressed in the prevention plan. We want to make sure that they consider it more than just at the individual level but look at their system for that particular agency. Are they addressing it system-wide versus just on a one-on-one basis? Then we look to see is the plan realistic when we review it, is it something that is doable and are they communicating it to all the environments that that particular person is involved in.

The fifth part of our risk management program is data analysis. This is a component that's in early stages of—I would say, for the last couple of years, we've been sort of stuck at the number stage where people do an analysis of the numbers, which really doesn't tell you a whole lot. We've been doing a lot of work with our county boards to look past the numbers and identify where can they make an impact, where have they seen increases, decreases, where are people getting hurt, where are they getting abused, and then digging deeper into those incidents to figure out why. Why are they happening and then how can we begin to prevent them? We anticipate this year with the annual reports that we get from county boards to see a lot more in-depth analysis with this data analysis piece.

We've sent out a number of Alerts to try to assist the county boards and providers We've done analysis on a statewide basis for neglect, physical

abuse, sexual abuse, and tried to identify who are the main perpetrators in these kind of cases, what seems to be the circumstances as to what's happening and then try to provide some ideas in terms of, "Here are some ways that you might begin to prevent these."

We do have administrative rules and statutes in place to support what we do. That's always helpful. We're more than happy to share those with folks that are interested.

We looked at some of our most common risks. On an every six-month basis, we do what we call a Nickel/Dime Report and we look at people that have had five incidents in six months and ten in a year. We do a little bit more analysis and see what is being done to try to help those people. Probably individuals with mental health, psychiatric issues which I don't think is a surprise, are some of our folks with the most common risks, along with people who frequently get into trouble with the law. We see a lot of individuals with unplanned hospitalizations, individuals with inappropriate sexual behavior with other individuals. We've seen a lot of neglect incidents tied to staff behavior such as not showing up when they are supposed to or sleeping when they should be awake because there's a risk to the individuals, or not following their assignments. They may be placed on a one on one with the particular individual and they leave their post and something happens to that person or it creates a risk of harm for the person.

We tried to provide some examples of interventions and I believe that's a lot harder to do than what we have recently thought because these are difficult individuals . People have mental health issues. We have been able to get county boards to work on cluster issues with other agencies. We get mental health involved. We might get the criminal justice system involved, work on a joint plan with everybody sharing in the prevention plan for that particular person.

When it comes to individuals involved with the law, our success rate hasn't been very high there. We see a lot of repeat incidents. The only time they don't repeat is, unfortunately, when they've been placed in jail due to their behaviors. But some of the prevention ideas in this particular area that we've noticed have been in the area of counseling and court involvement.

Another risk area is that of Inappropriate Sexual Behavior. the major examples of interventions, I think, have been with changes in supervision level or changes in living arrangements for those individuals , which, of course, make a lot of sense.

I think the main thing we try to do with Neglect is to educate our providers and our county boards on what was happening. Why was Neglect occurring and then try to give them some ideas on what they might do. So again, we sent out those Alerts to the system to try to help educate them on ways that they might prevent Neglect.

The most difficult issue to manage, again, I would say individuals with MHMR issues, and people involved with the law, or in the court system and probation, things of that nature.

One of the questions we were asked to respond to is, "What challenges are there in implementing a risk management system?" There are many challenges to this, but probably the major one that we faced was making sure with 88 county boards that we had a common understanding of the expectations and then a consistent application of the requirements for county boards and providers. That took a lot of doing. You just can't get that by looking at the rule, reading a piece of paper. We've spent a lot of time training county boards and providers. We've done a tremendous amount of that over the last four years. We developed an investigative agent role so that each of the county boards has a group of people that are responsible for doing the investigations, and they have to be certified by the Department. We provide annual training, which is a requirement for them. We've seen some nice improvements by having that particular group of folks doing investigations.

My Unit does an annual assessment of every county boards system for insuring health and safety. We'll issue findings and expect prevention plans from the county board to correct those situations. That has been pretty effective. We also do provider reviews. We assess providers systems, particularly when there are health and safety issues, or we see trends with our number of incidents happening in a particular agency.

I think relationship building was an interesting part that we started out with, because we felt that if we're ever going to get anywhere in our system, we need to develop relationships with the other stakeholders. My staff have done a very good job at doing that. We have a single goal and that's to ensure the health and safety of people, and then we work from there. When we first started probably five years ago, there was a lot of "we/they" going on. I think there's still some of that but we've come a long way.

So my advice to others in putting together a system, I would give you maybe five things to look at. One is to develop your system with your stakeholders, make sure they're part of whatever it is you're putting together. That's really critical for the buy-in and the implementation. I

think being as clear and prescriptive as you can in rules, that leaves less room for "I thought this meant this. ." If it's clear and prescriptive, then people know what it is they're supposed to do. Support that with laws to ensure that you can hold people accountable. Try to be as consistent as you can in the implementation. I would really suggest the visits and the oversight that we do have helped tremendously. And the last thing, which is probably the most important, is to build a partnership with those that are affected and eliminate the "we/they". We're all here for the some reason and that's to protect the health and safety of individuals.

So I guess I'll finish on that note and be available for questions here after the presentations are all completed. Bruce?

Bruce

In New York State, I was the former director for the TBI Waiver Program. That program now has 2,000 people in it. I want us to talk just a little bit about some of the things that we did to look at risk management.

First, I think it's important for everybody to understand the difference between safety and welfare. CMS focuses us on health and welfare and not health and safety. When I worked in an inpatient rehab hospital, we recognized that the only way we could keep everybody safe was to tie them up downstairs in the basement and just feed them food. Of course, life is full of risks and that's basically how we look at the waiver participants that they have the right to risk as Suzanne was talking about. Welfare is significantly different than safety. Welfare includes the people's ability to live life and all of us have experienced positive and negative as we try to go and do things.

Specifically in our waiver program, our external management structure is contracted individuals who are responsible for providing administrative case management, which means they don't work with the waiver participants on a day-to-day basis, but they'll get to interview those folks before they come on to the program. We call these individuals Regional Resource Development Specialists. And then when they review service plans, they'll have a good sense of whether the service plan fits the individual's needs or not.

Within the service plan, we have a form called the Plan for Protective Oversight, which really looks at some specific activities of daily living which can cause the most difficulty for an individual in terms of their welfare; things like cooking and money management and being able to manage their own medications, and in particular, their own time when they're by themselves. And we try and be very specific about who is responsible for assisting the waiver participant if they have that particular need and how severe a problem it is.

The waiver participant team, which are waiver providers and other providers, have the opportunity to meet at least once a month if they need to, to be able to assure that everybody is working together and this minimizes risk also. The team is not being split and everybody approaches the waiver participant from the same perspective.

Another contractor that we have is a group called the Statewide Neurobehavioral Program. This is a group headed up by a behavioral psychologist who we hired about a year or so into the program. Their responsibility is to go out and meet potential participants, understand what kind of risks they may pose to the community, and what kind of interventions we may be able to put in place to assist that participant and assist the community. We clearly have a policy where we believe that anyone on the waiver may live next door to one of our families, and if that's the case, how safe are our families? We also want to make sure that we supply those potential participants with enough opportunity.

So the Statewide Neurobehavioral Project staff will go out to various places; psychiatric centers, jails, substance abuse facilities and understand from the interview process just what kind of risk this person may pose to themselves and the community. And they will report that back to the and Regional Resource Development Specialist that I mentioned before.

In our waiver program, we have a specific service called Intensive Behavioral Program, which we're going to rename Positive Behavioral Intervention and Support. That service is specifically targeted to work with people whose behaviors will, if they continue in the intensity and frequency, will result in the participant not being able to remain in the community. These are specific plans of intervention.

Most of those plans focus on being able to recognize situations that will trigger some of that inappropriate behavior. We recognize that for many people with brain injuries it may be easier to change the environment and situation as opposed to changing the person's responses, and we need to be able to do that. We look at methods of intervention. I think another important thing is being able to match appropriate staff to clients who are going to be working with them. If you have somebody who is sexually acting out, exposing themselves, you need someone in there who is very capable of dealing with that in a kind of nonchalant manner. If you have somebody who calls up their supervisor every two minutes when the person is doing that, you wind up in a significant problem.

We also have six months service plans, and the team is able to communicate about those services plans as need be during that six-month

period. That allows us the opportunity to understand what's going on and plan on a short-term basis. In the future, the service plans will include a listing of incidents that have occurred in the last six months so that the service coordinator and the participant have a real good sense of what it is that has been causing difficulty, as will the rest of the team. All providers are responsible for giving the state an annual incident report, which includes not only the type of incidents that occurred, but a description of what did they do on a provider level to change policy or procedure so that those incidents could occur less frequently and less intensively.

When you have this whole concept of health and welfare, as a major responsibility of the state, and you have the philosophy of the waiver participant right to risk, you're going to have some natural friction that occurs. There is no question about that. One of the things that has already been talked about was the idea of risk agreements, and I think that that's an excellent thing to pursue and we're in the process of wanting to do that. We really think what that can do is just create an open conversation between the provider and the participant so they're both on the same page about what may cause difficulty for either one of them.

A couple of other quick things; I think one of the challenges that we faced when we were implementing this risk management system was the whole balancing of the right to risk versus health and welfare that we were responsible for, and where is the line that you draw and how do you work with an individual? We've had many provider agencies who have come over to work with us having worked with other special populations, and they have been extremely paternalistic wanting to control the waiver participants' lives and making decisions around sexual behavior and where people can go in a way that I don't think any of us would allow our lives to be determined. And the other problem is the funding for specific activities or for contractors such the Statewide Neurobehavioral Program.

One of the things that we've experienced over the course of time very clearly is whenever there has been a person with a brain injury and we've gathered other supports in the room, mental health system or substance abuse system or the criminal justice system, as soon as they hear those words, "brain injury," they leave and say, "This is your responsibility." And clearly, what we need to continue to work on is making sure that the whole service system recognizes their part and responsibility to serve this person, otherwise, they won't be able to be living in the community.

One of the other things I think you need to look at when you're developing this process of risk management is what is the risk tolerance of the state staff that's responsible for administering the program. We've been fortunate here that we've had some like-minded people who really focus in

on the rights of participants to live as full a life as possible rather than being overly concerned about litigation and other causes for providers to be concerned.

I think clearly that it is an ongoing process, that you need to not jump at particular incidents and over-respond, but to be able to take that incident in the context of the rest of the program and try and understand where the difficulty is. This I think can get to be difficult when the state has an extremely embarrassing incident occur or when people get hurt and the public looking at some policies or procedures which may have contributed strongly to that.

That's all. I want to be able to have the other folks talk and have the audience have a chance to ask some questions. Nirvana?

N. Huhtala Next, I'd like to ask Horatio Soberon from Florida to speak.

H. Soberon This is Horatio Soberon. I'm the Director of Planning, Research and Evaluation at the Florida Department of Elder Affairs. Ron Taylor, the other person who provided the input to this study, he is the former director of the office of the Statewide Community Services that has the quality assurance unit. He resigned as of last week and the person who was in charge of the quality assurance unit is also no longer with the department. Her name is Anna Garcia. So I'm kind of filling in for both of them.

My perspective is quite limited as I was only supporting their efforts with statistical analysis and with the designs of tools to assess quality. But let me tell you how we address the issue of risk at the Florida Department of Elder Affairs, this is with our waiver populations.

First, we prioritize services based on risk. We have an algorithm that takes the data collected during the assessment process that assigns the risk score to each individual. That risk score relates to things such as, whether a caregiver is present or not, the types of ADLs and IADLs that the person has, and based on that risk score, we prioritize access to services.

Once the person is determined to be eligible and is going to start receiving services, he will receive some assessment and the assessment has to address each of the risk items identified in the assessment process. Then for their boundary line, they say a process, a protocol by which a monitoring team makes sure that the services described in the care plan that address risk are being delivered.

We also have a continuous customer satisfaction measurement process and we have a call center in the department and we are constantly calling

people to make sure that they're receiving services and that they are okay. All of our services, by the way, are delivered through contractors. The Department of Elder Affairs was not to employ case managers. Instead, everything is subcontracted to county organizations called lead agencies. These are the case management lead agencies. Many of them are county government entities, others are local nonprofit council… and in some other cases, it may be nonprofit but not necessarily council…

We have among priorities, we have a category called APS. An APS case is a case that has been identified by the Department of Children and Families that investigates potential abuse situations. An APS designation gets the highest priority for services. Some people have to be served within 48 hours of the incidence report. Additionally, we have a process of performance measures. Some of our performance measures address the issue of the remediation for risk in the environment. We have one of our performance measures that looks at the percent of individuals who had been assessed as living in a risky environment and whose environment has improved due to intervention. We hold our contractors accountable on those measures.

We have one, again, for the environmental risk, but also we have another one for situations of potential abuse and exploitation. And again, I'll be willing to take any questions. I'm sorry this is so short, but really, the people who are in charge of the quality assurance unit are no longer in the department.

N. Huhtala Thank you. And thank you to all of our speakers. Sab, we'd like to open up the line for questions.

Coordinator We'll pause a moment to compile a list. Nirvana, there are no questions in queue.

N. Huhtala Thank you. Suzanne, did you have any questions?

S. Crisp No. I just wanted to thank our speakers. I think Ohio and Florida and New York have done a real good job with dealing with a tough subject. I would like for us to all stay tuned to Ohio and see what kind of progress you can make on developing data and analyzing your data. I know you talked about collecting numbers and so I'd like to know more about what you can do with those numbers. I think everybody is wanting to have that question answered.

M. Ihlenfeld Sure. I'd be happy to share that.

S. Crisp Yes. That would be great.

N. Huhtala	If there are no questions, I'd like to thank you all for joining us today. If any questions do come up, please feel free to send them to me via e-mail. We're very happy that you were able to join us. Future topics coming up include representative in consumer direction and guardianship and looking at case manager training. We look forward to talking to you soon. Thank you.
S. Crisp	Thank you.
N. Huhtala	Bye.
Coordinator	Thank you for your participation in today's conference. This concludes the presentation. You may now disconnect. Have a wonderful day.