MICHELLE CRAIN: So why is it necessary to identify consumers who are at risk?

First off, the most apparent answer is to assist consumers in maintaining their choice to live in a community based setting.

Next and now is to indicate compliance with the new core service of assisting individuals with significant disabilities who are at risk of entering institutions to remain in the community.

Isn't it just like the fed to say, just do it and we jump through hoops to get it done, with the exception that like Nike, we don't get paid millions of dollars do it.

Like many centers, my center, which is LIFE, Inc., was already convinced that the independent living services that we provide divert individuals from institutional settings.

So since it's an essential part of what we as CILs do, we never really thought, you know, to ask, do you think you are at right of going into an institution?

That's just something that we did, it was just part of who we were.

WIOA's requirements to indentify individuals who are at risk for institutional placement led to a dialogue among our centers in Texas and it prompted the questions, how do we demonstrate for certain that CIL services are the reason consumers are able to maintain their freedom in the community.

After all consumers may access numerous community resources that are not disclosed to CIL staff and are just as instrumental to institutional diversion.

And to answer that, is that there's no way to demonstrate that our services for certain are the reason that the individual stays out of a nursing home.

And I say that, because yesterday I said it takes a village, and so everyone, it's a matter of pulling those resources together to make sure that that individual does not lose their independence in the community.

How can CILs as objectively as possible, tie diversion to the independent living services we provide.

And I say objectively, because we already have that anecdotal information, because we're sitting down and getting to know that consumer.

When I say objectively, I'm looking at a way to measure, something to put in a report, so to speak, so I know that sounds kind of harsh, but that's part of the world we live in.

We have to report this, so we were looking for an objective way of doing that in the CIL PPR.

At that time, 704.

What are the at-risk factors associated with that institutional placement?

In 2015, I think 2014 is when WIOA was passed, but in 2015, we created an at-risk survey that we thought would serve several purposes.

I'm going to tell you there's nothing other than, you know, just put something together.

That's what we were trying to do.

There was nothing scientific really about it.

Did a little research, but there was nothing all that scientific about it.

We were just trying to prepare for that reporting and compliance.

The at-risk survey could be standardized tool to assist Texas centers in identifying consumers who because of their current life circumstance have increased odds for institutional placement.

So that is one reason why we were trying to put the survey in place.

Other questions.

During this time the Texas network of CILs in the state independent living council and the Texas department of assistive and rehabilitative services, which is our DSU or DSE were engaged in the common outcomes and return on investment project, and that was to develop a framework for consistently counting, collecting and reporting CIL services.

Diversion was a part of that, and diversion was a part of that because what we were trying to do is to put a return of investment value on CIL services.

So it easy to do that on transition, but it wasn't so easy to do on diversion.

So that was something that we were looking at as well.

The at-risk survey could also be used to help IL staff to better assist a consumer in developing an independent living plan that addresses those at risk factors, thus diverting the individual from institutional placement.

I would say that if you have new staff, and I know some of you refer to it as a check list or what have you, but if you have new staff, I think the survey is a good way of actually introducing that staff to diversion as well, and making sure that they are looking at all the at risk factors that some of your most experienced staff would get through the interviews.

In creating the LIFE at-risk survey we looked at several research studies and surveys that addressed nursing home placement of older adults.

Because there was nothing out there for CILs.

And so basically, what we saw with these surveys is that one: they were too lengthy.

Two, they were based on the medical model, so you had a lot of terms in there, and I don't know about you, I'm not a doctor.

So a lot of the medical terms were a turn off.

But one thing that we found that was useful were the at-risk factors.

So we did get that out of the studies.

What we wanted was for it to be short, we didn't want anything exhaustive, because again, we already sit down and talk with our consumers and we're getting this information already.

We wanted it to be simple and we wanted to get those common at-risk factors.

After the survey was completed, LIFE staff and other CIL directors reviewed the draft and we made recommendations for the changes.

The survey, and it is in your manual.

I think it is the last page.

And you can correct me if I'm wrong, I think it's the last page after the day one.

TIM FUCHS: Yes.

MICHELLE CRAIN: Okay.

So what are you not seeing in the in the manual, it's a work book, and so there are automatic calculations for the scores.

The survey consists of two components.

It's the summary of the risk factors and a tabulated score.

On the first page, what we do is we enter yes or no for each of those factors.

And that gives you, it tabulates a score.

The scoring detail captures the individual's score is to the at-risk factor, that's the second tab.

That is the tab that is not available to you, but it will be made available to you after the training.

So you can see those handouts there.

The survey itself consists of 14 questions that assess risk factors, these are the same factors that we have gone over or that we went over yesterday.

The first being does the consumer feel that he or she is at risk of institutionalization?

And that gives you that part where the consumer is telling you or has the opportunity to tell you, yes, I am at risk.

But also at the same time, they might not understand what makes them at risk.

Which is the reason why we want to fill out the whole survey.

And let me just back up.

When we found out, of course, that we had to do the at-risk factors, I went back and had my staff do it over all our consumers.

All the existing consumers, and for a lot of those individuals, they knew those individuals, so they could fill out this survey, and they were also encouraged, you know, that if you ran across some of these at-risk factors that you were not sure about, some of the questions that you were not sure about, make sure you go back to the consumer and get clarification on that.

We filled it out for every consumer at that point.

Has the consumer been institutionalized in a long-term care facility within the last 12 months.

That's important, because as you know, there's no one more vulnerable to go into an institution than those that have come out of an institution.

So is the consumer homeless?

And that was one of the factors we discussed yesterday as well.

Has the consumer been diagnosed with one or more of following health conditions?

That being coronary heart disease, fractures due to falls, a decubitus or pressure sore, or bedsore is what we call them, diabetes, stroke, cancer, incontinence, that includes bowel or bladder incontinence, mental illness, Alzheimer's, or any other type of dementia?

And these are medical conditions that we did research and those were most common as far as individuals ending up in nursing homes.

Has the consumer been homicide for any of the health conditions mentioned above within the last 12 months?

Because, again, as we discussed yesterday, if they are going in and out of hospitals, eventually that physician might recommend that they go into a nursing facility.

So has the consumer made six or more visits to the emergency room within the last 12 months?

Some of these figures are just arbitrary, it's like we were trying to put some things in place.

And so in visiting with some of the centers and getting feedback from some of the centers, that's where some of the numbers come up.

Does the consumer need assistance with three or more activities of daily living and they don't currently have a care provider?

So I would imagine you all understand what I'm talking about when I say activities of daily living.

Is the consumer 65 years of age or older?

With that one, 65 is not arbitrary.

That's part of the studies that we read.

So 65 had a lot to do with a lot of the statistics that we saw.

So does the consumer have difficulty taking medications as prescribed?

Does the consumer live alone?

That alone will not land an individual in a nursing home, really none of these alone, would land a person in a nursing home.

But any combination of these.

So we know if they live alone and they fall, then they're at risk.

Is the consumer's current housing situation suitable?

And we say suitable, is it affordable?

Is it accessible?

Is it safe?

Is the consumer's income sufficient enough to cover basic living expenses such as rent, utilities and food?

A lot of the consumers that we actually deal with, they are living or subsisting on Social Security.

So when we say sufficient, we're talking about to meet their basic needs.

Does the consumer have a history of drug or alcohol abuse?

I think what some of us that do transitions often, we find that a lot of the individuals, particularly the ones that are younger, are there in the nursing home have had substance abuse problems.

Does the consumer have informal supports?

Again, you know, that's important because I do know that with our state agency making that determination, at one point they were saying we can't let them out, they don't have any informal supports.

And so we knew that that was an issue as well.

So staff tested the at-risk survey prior to its implementation in September, and training has been ongoing, as well as discussions as to how to make the survey a little more efficient.

Yes, it's that second tab.

Maybe during lunch time we can put that up, Tim.

I'm not sure.

I know it will be available after the training.

I think you'll be able to go on the ILRU website and get that information.

TIM FUCHS: That's right.

MICHELLE CRAIN: That's the part you're not seeing, it automatically tabulates, and depending on the score, on that second page, it will tell you yes or no that person is at risk.

Like I say, we're in the process of revising that at-risk survey, so we might do different levels of at risk.

Other approachs of identifying at-risk individuals.

We talk about self-identification only, keeping it simple, some CILs may feel that they lack the staff capacity to engage in yet another form.

We talked about the endless amount of paperwork that we have to do in order to stay in compliance.

At my center, they call me the form queen.

Any time I can make a form, I do.

So, like, no, no, no, we don't need another form.

Like I say, keeping it simple.

Some CILs may feel they lack the staff capacity to engage in the completion of more forms and documentation, asking the consumer if he or she is at risk of losing independence in the community from the outset can save time.

The key to this approach is pretty much making sure that the staff as well as the consumer understands what makes the individual at risk.

Identifying at risk through referrals.

That's another approach.

For example, if a consumer is referred to you from like adult protective services, because as you know, adult protective services can take guardianship and they can place an individual in a nursing home.

If they contacted you pretty much to, as a measure of not going into a nursing home or making that decision right away to put that person in a nursing home, that makes that person at risk.

So that's what I mean by a referral from APS or even Social Security for representative payee services.

The CIL may identify the individual as at risk.

Early intervention programs, like the intervention program that they have at Ability360 that Darrel spoke about in Arizona, in which early intervention as far as collaborating with the rehabilitation hospitals to serve individuals after acquiring a profound disability.

That's something we're looking at, Darrel as well.

Relocation from nursing homes to community programs, CILs with relocation programs may routinely identify newly transitioned consumers as at risk.

So once you get them out, they are pretty much, you know, at risk, and we do the follow-up for those individuals.

Anyone who has been institutionalized automatically has at risk factors that can cause them to return to an institution.

And I think that pretty much goes without saying.

The at-risk survey is now part of LIFE's intake process, when we are opening a consumer service record, asking the consumer if he or she is at risk is only one aspect of the assessment and is not the only criteria for determining if the consumer is at risk.

We utilize the survey in conjunction with other information that we obtained during the intake process to get a better picture of the consumer's at-risk status.

Again, most of the consumers that come into our centers, they don't come into the center saying I want to stay out of a nursing home, or I'm at risk or anything like that.

If the assessment identifies that the consumer is at risk and he or she has a goal that does not address any of those factors, we simply inform the consumer of our concerns and offer to help develop a more comprehensive ILP.

To me, that's part of our job, as I said yesterday, to provide them with the information that they need to make informed decisions.

And again, if they decide that they do not want to engage any further, then we won't push the issue, because, again, it's all about choice.

Consumers always have the right to say no, but they should be aware of what their options are.

If an individual is only requesting information and referral, staff is not required to complete the survey.

However, you know that individuals, it all depends on how frequent those I & Rs are, and what our staff has been encouraged to do is to encourage the person to open a consumer service record.

By the way, if I used an acronym there, the consumer service record.

So we encourage the consumer to open a consumer service record in order to address any potential at-risk factors.

So if they're constantly coming into the center each month or each week needing help with utilities, needing help with rent or something like that, you might want to say, you know, let's open up a CSR, lets sit down and talk about this and see what we can do by way of providing them with the services they need in order to divert them possibly from an institutional setting.

So some of the issues with the at-risk survey and I've heard them from my staff and I have heard them from fellow CILs.

I think we hit on some of them yesterday.

One of the issues is why aren't more significant disabilities included in question 4?

If you notice in question 4, those are the medical conditions.

The significant disabilities, we provide services based on the fact that individuals have significant disabilities.

I'm of the school of thought and people might not agree with me, those chronic medical conditions are disabilities, but all disabilities aren't chronic medical conditions, and that's the reason why those significant disabilities are not included in that question 4.

The questions seem a little bit personal.

I think someone mentioned yesterday, these are personal questions, and some people just don't want to answer those questions.

Again, you establish that rapport, you establish that trust with the consumer, and a lot of the times they will open up simply because they don't feel like they can talk to anyone else about their disabilities, but you're giving them that leeway to talk to you about personal situations that they normally would not disclose to other individuals.

What if the score identifies the consumer is at risk, but the identified needs or services, the center does not provide?

The center doesn't have to provide those services in order to divert that individual from an institutional placement.

It's about establishing those relationships with other disability service providers in a community that would help us to do that.

The scoring system seems to be a little technical.

Actually, it needs to be more technical.

There is nothing scientific about what I put together.

I won't lie to you.

Basically, it was pretty arbitrary, but that's something that we thought about looking at later, that maybe we need to have a more scientific measure there.

So anyone with that type of background, talk to me after the training here.

More at-risk factors need to be included.

I don't think that the survey needs to be exhaustive.

We're already talking to the consumer.

And by the time we get to the survey, we already know.

Again, we talked about maybe adding a couple more factors which would give us about 16 on that survey.

Again, the purpose of the survey is for CILs to implement a standardized approach in identifying consumers who are at risk from institutionalization and to assist CIL staff in developing an ILP with that consumer that will stabilize the consumer's living situation and maximize resources that will address those at-risk factors.

So one thing that we wanted to do, I know I kind of went through this fast, but one thing we wanted to do is to do actual interaction with you guys with each table at each table, and I have put a scenario here, and I would like for you guys to get creative.

This is something that we can start with now and maybe work through lunch over conversation, but the demographic is Martha M, at-risk exercise, she's a 53 year old female, she's divorced, she has no children or siblings.

She is temporarily residing in a Motel 6, no alternate contacts, and she was referred to the CIL by APS.

So what I would like to do is for each individual table to go to their risk survey, for each individual table, fill in the blanks, you might come up with a creative scenario, but go ahead and fill in the blanks, find out what those at-risk factors are, what services we need to put in place and what goals need to be established here.

So I would say that's your homework, but that's your break work.

So we can start that and if each table can have an individual spokesperson, we will go over this, probably after lunch, Tim?

As far as the results?

TIM FUCHS: We could probably fit it in before the lunch break, that will give us 45, if we work on it, we have 45 minutes, if we work on it for maybe 15 minutes and come back and do a report out, does that make sense?

MICHELLE CRAIN: That sounds good.

Okay.

Is everyone ready?

I know we usually start on this side of the room, so we're going to start on this side of the room now.

Yes, if you could go ahead and tell us who your spokesperson is.

AUDIENCE MEMBER: I guess I'm it.

MICHELLE CRAIN: Okay.

AUDIENCE MEMBER: At risk factors.

Well, after the interview, we found out that Martha has diabetes and depression.

Unstable living situation, no income.

So there's a lot of financial worries.

No informal supports.

She has no friends or family members of any type.

She was referred to us by APS and when we were talking to her, she said she didn't know how APS got involved, but we did learn about abuse by her ex-husband.

MICHELLE CRAIN: Good deal.

So what type of services and goals are you looking at?

AUDIENCE MEMBER: Two goals were established.

A diversion goal, of course, and then housing, and we are also providing, going to provide a lot of I & R, information and referral, to a woman's shelter or woman's housing that will help her, also provide independent living skills training, learning, of course, budgeting, money management, how to look for employment, those sort of things.

And some self-advocacy and peer.

MICHELLE CRAIN: Things you're doing already.

Good deal.

Next table.

Thank you.

AUDIENCE MEMBER: Hi.

So I interviewed Martha.

I almost called you by your actual first name.

I felt that I should get more information to figure out how to be able to help her.

So we just need to know, like, first of all, like her income, a little bit more about the back story and, you know, just from talking to her, it looks like she fits the at-risk factors.

She also said that she's, through our interview, she's had a stroke, she's had trouble caring for her needs, trouble taking medications, transportation is a big one.

She's been in the hospital, back and forth.

She uses the emergency room a lot.

She doesn't have any family.

No kids.

Yeah.

She has trouble reading and writing and understanding things, and she needs help with looking for apartments.

I'm assuming filling out applications and trying to get Section eight.

So I think first the goal is housing.

Housing.

She gets SSD she says, so she gets a little income enough for maybe a studio or maybe rent a room.

She said that was fine.

So working with that right away, and also helping her getting transportation and skills and medical providers and maybe something that's going to be easy for her to get to so she can have access to her medical care.

MICHELLE CRAIN: Okay.

Good deal.

Thank you.

AUDIENCE MEMBER: Okay.

When we did our at-risk factors, we came out with seven nos, seven yeses.

MICHELLE CRAIN: I will show you how this at-risk survey works.

Each one of these factors are actually assigned a point value.

Like I said, you didn't have access to the second tab, so we have the second tab up.

I will go over that after we go through everyone.

AUDIENCE MEMBER: Martha has PTSD from her divorce.

Sources, source income for her is she gets SSI.

We need to get her IL skills.

Counseling.

We need to find permanent housing.

We need to get her peer support, transportation, medical, Medicaid, Medicare, food stamps, pantry, nutrition and health.

We need to get her squared away.

Once we get more information at the initial contact with Martha.

Initial contact is very important.

It's listening to her story so we can move forward to help her ASAP.

MICHELLE CRAIN: All right.

Thanks.

AUDIENCE MEMBER: We really didn't get too much further than just what the risk assessment on the front page was.

We identified the fact that she is living in a Motel 6, which is roughly speaking we're probably looking at $500 a week for her to stay there.

So we identified her as being at risk just for that.

She has no other family, there's nowhere else she can stay at this point.

MICHELLE CRAIN: So no informal supports.

AUDIENCE MEMBER: So no informal supports.

At this point, we identified right out of the chute, she's vulnerable.

What that means, in as much as we haven't really talked to Martha, we weren't just going to spit ball and assign things to her.

But just on a most superficial level she's identified as being at risk for those factors, we don't know if she's on SSI or SSDI, we couldn't say.

Obviously whether she is or not is going to guide us as to what her goals are going to be, long-term housing, again, we weren't sure if we were to do a mock interview or something like that.

MICHELLE CRAIN: Yeah.

That's part of it.

Yeah.

Sorry about that.

AUDIENCE MEMBER: We failed.

She's at risk.

That's it.

Where we go from here is going to be dependent on what sort of benefits she gets.

We identified long-term goals as being of course housing first.

And then from there, transportation.

We're just assuming she's on some sort of government benefit, either SSI or SSDI, but of course that's going to dictate which route we take from there.

MICHELLE CRAIN: Okay.

AUDIENCE MEMBER: Hi.

We know she's at risk.

She's living in a Motel 6, that's not a good thing.

So first meet with Martha and get some trust with her right away because for sure she's not happy, she's scared, alone, more or less.

We thought of calling up the APS social worker and see what they know about her, getting a release signed.

And then talking to Motel 6 and tell them we're involved with her, trying to find some county funds, emergency funds to keep her at Motel 6 at least for a while longer so she's not on the street and not homeless.

She is at Motel 6, get her laundry done for her, get some food into her, get some trust built up with her over next couple days, and then interview Martha and find out what the heck is going on with Martha.

Honey, why are you here?

What happened?

We will help you.

And find out you have no children?

Really?

You have children?

She might say, well, I have a daughter who's not in state.

Does she know where you are?

And yes or no.

Well, the daughter doesn't know she's in a Motel 6.

Daughter would probably be there and say, mom why are you in Motel 6?

So build that trust up with Martha, get her to a doctor, possible some medical attention to her.

Does she have diabetes, does she have health issues, does she have mental health issues.

And just slowly get some trust.

If we keep her at Motel 6 for a while longer and you have SSI is your ex-husband around?

Is he abusive or not, where is he at?

Do you have any family at all?

Where are you working in the past?

Do you have any co-worker friends?

Do you have a pension?

Do you have bank, checking account, any place at all?

I think you'll spend at least a good week or two learning more about her as a person, get her trust built up with you, then move on forward and get her those services she will need long-term.

For us, I thought just keeping her where she can get that place.

It's a clean place and safe place, talk to the Motel 6 manager, get her in there so she's safe and then slowly get her off at risk things.

Find out the physical, the emotional, the health issues, the job issues, money issues, but take it day by day with her.

I'm sure she is not at all happy where she is, but how she got there probably put her in a very uncomfortable place, she's embarrassed to be there.

You're 50 years old and living in a Motel 6.

That's not where you would want to be at that time if I was her.

So it's a process.

MICHELLE CRAIN: It is a process.

Okay, thank you.

AUDIENCE MEMBER: Okay.

I think we did a little more extensive of an interview, that's mostly because Justin has such a trusting face, she opened up to him quickly.

We were able to discern in our interview with her that she did recognize that she was at risk of going into an institution.

There was no institutionalization within the last 12 months, but we learned about familial abuse, which obviously factors into our decision.

We said that we learned that she was not homeless, but had limited resources, only had a couple days left with respect to Motel 6 stay.

She disclosed to us that she had had a stroke due to co-occurring mental illness and addiction, and had been discharged from the hospital to a cousin, which is where the abuse occurred, which is how APS got involved.

That told us a lot of things about what she needed.

She also reported that she needed assistance with ADLs.

So we went through our factors and she was clearly identifying as having multiple at-risk factors.

Our goals, I think, echo what everybody else is discussing, which is housing is the primary one, because of the expense and the likelihood of eviction, she's obviously very vulnerable in the housing department.

We were looking into diversion, peer support, information and referral services.

And we were also hoping to build her circle of support on a temporary organizations in the community while we're trying to identify who the familial contacts outside of the abuse situation would be.

We presumed that we were in a state where she had SSI and that linked her to Medicaid, but then it would be about finding food resources as well, whether that's through the food stamps program where she could apply for that and we could help her with that.

Again, we want to not lose focus on the fact that she is directing the process and kind of follow her lead and help her identify resources and move her along and try to create as much stability as possible while she tries to stay independent in the community.

MICHELLE CRAIN: Good deal.

I like that.

AUDIENCE MEMBER: Okay.

We made no assumptions about Martha.

We just went with what we had, and with what we had, we identified at least four risk factors.

The fact that she was referred by APS, she has no suitable housing, she lives alone and has no supports.

As far as goals, of course we would need to go and do a whole risk factor to identify other factors that might be in place.

But with the information that we have, we know that we need to help her find suitable housing and connect her with other community supports, whether that be helping her to get Social Security benefits if maybe she has none, food stamps, that type of thing.

It sounds like she needs financial management, because as someone mentioned staying at Motel 6 isn't cheap.

See if maybe she might need a payee source if she does have Social Security benefits already.

And then to connect her with some peer support and socialization.

MICHELLE CRAIN: Good deal.

AUDIENCE MEMBER: Okay.

So what we came up with is this lady actually, she lost her housing because of being a hoarder.

She stretched her meds.

That's the reason why she was self-medicating herself with drugs and alcohol.

I'm sorry, we probably are farfetched with some of the things we got, but that's what we got.

So we asked who she was seeing as far as mental health agency to get her possibly back in touch with them.

She has five at-risk factors.

The goals we established were trying to get her some housing, mental health agency probably trying to connect her with that.

Peer supports, discounting, well, finding some type of source where it can be a discount of medicine programs, because we're sure that her medicines probably are expensive.

That's the reason why she's self-medicating herself.

And possibly connecting her with Medicaid and food stamp sources.

MICHELLE CRAIN: All right.

AUDIENCE MEMBER: So I really don't know how much more we can add.

I will say that this table to my right said everything exactly like what we had said, we just used what was on the sheet and determine she was at risk because she is homeless, she does not have any informal supports, her current housing situation is not stable, and that we would need to of course interview her in depth and we would want to talk to APS and talk to the Motel 6 and possibly try and get her funding to stay there for a little while until we could put those supports in place.

I don't really have much else to add.

MICHELLE CRAIN: That's fine.

AUDIENCE MEMBER: We're kind of like these two tables up here.

We didn't assume anything, we just took the information we had.

We did not believe that she was at immediate risk for a nursing home.

I guess that was part of the question too is what are we looking at risk for?

Is she going to jail?

Is she going to a nursing home?

What's the risk here of where she might end up?

The fact that APS made the referral to the CIL, APS is going to make some kind of conclusion or make some kind of referral to somebody, and probably a CIL is not going to be the emergency referral.

So we didn't believe that she was at risk of going to anything immediately.

We did believe that she's appropriate for IL services, however, we don't know for sure if she has a disability.

If somebody is referred to APS, it could just be the perceived disability.

And so, then the next question was, does she want our assistance?

I haven't heard anybody say that.

We're a self-help, I mean, we don't force our services on people, and somebody obviously called APS.

APS made the referral, but does she want the assistance?

We could have made it go any direction we wanted it to go to, but we felt like with the information we had, we just were going to leave it alone.

MICHELLE CRAIN: Okay.

AUDIENCE MEMBER: We also didn't make any assumptions, and the only thing we could get from the description that she was referred by APS, which means she is at some risk according to APS to her health, safety, or welfare.

She also has no stable housing or she wouldn't be in a Motel 6.

We obviously felt the need to do an intake to get the answers to a lot of the questions on the risk factor example we had been given.

We did have two yes to that, and the yes were she is homeless and lives alone.

We had two nos on that, and that was is the consumer's current housing situation suitable is no and does the consumer have informal supports, no.

The rest of it we don't know until we talk to her, you can find a number of things, and we can build a different scenario in many different matters, but we felt the best thing to do is identify what risk factors she has from those other 10 questions, and what are they and what kind of community support system do we need to help her build to be on her own and independent.

Anybody else?

AUDIENCE MEMBER: I agree with everything you just said.

That's how we looked at it.

We looked at this as just a referral with not very much information, with that, we kind of look at this person and go, there seems to be some risk here, what we need to follow up with them, figure out.

We don't have a phone number or anything, do we have to meet with them in person?

What do we need to do?

Are they even eligible for our services, we don't know if they have a disability or not.

Really, as far as any goals to be set without meeting with the individual, we don't create any goals.

We don't make any assumptions on any of this, so the goal for, I guess for ourselves would be to follow up with this person to find out more.

AUDIENCE MEMBER: So much like a couple of the other tables, we also felt we didn't have enough information, we went basically from the scenario we were provided.

We didn't feel necessarily that she was homeless.

She was living in a motel.

That is expensive, although it not being suitable in some persons mind, it was temporary, maybe suitable in her mind at that time.

It was an APS referral.

We did not feel there was enough information, so we were going to make contact and go from there.

So we also did not establish any goals or anything at that time.

MICHELLE CRAIN: Okay.

And I guess that falls back on me.

I thought I had kind of mentioned something about you can get creative with the scenario if you wanted to, but that was up to the individual tables.

One thing that I did find was the recurrent thing, we need housing.

We need transportation.

Of course we want to get to know this person.

That's just as important.

We want to get to know this person before we make any assumptions.

Does the person have a disability at all?

I would say that for APS to refer them, if you're familiar with your APS referral, they know that the centers deal with individuals with disabilities.

I just wanted to go over, and thank you for participating.

One thing that I will say is that, I hope you have realized this.

We're already doing this, this is something Darrel mentioned over and over, and Bruce has mentioned.

We're already doing this, this is nothing new.

Basically it's going to be how do we capture this?

How do we get this across to our grantors?

That's basically what all this is about.

As far as the at-risk survey, I want to go through this quickly.

On the first page of the survey, this is one that I want to, no this is the one that I modified.

Say for instance, if the individual, does the consumer feel that he or she is at risk, put a yes, has the consumer been institutionalized.

I am just arbitraily going through here.

Yes, and if you scroll down, and this is without even completing the whole thing, you have an at risk score of 130, we said 50 for us would be the cut off.

So what will happen is the at risk will indicate yes.

Now, if you go to the second tab on there, this is where the score is broken down, and it just feeds into that first tab, basically.

So pretty much, that's how that would work.

I know some of you say you've got two at-risk factors.

But you didn't have the scoring available.

And again, like I said, this is arbitrary.

And maybe a University or someone like you were talking about, Bruce, would kind of take this on as a project to get something a little bit more scientific.

I slept on it, dreamnt about it.

It came back.

I tell you, there's no scientific measure with those.

Basically, we put the scores in place and then we kind of tested it on staff, actually, because our staff, are diverse individuals with disabilities, and I would say a lot of times as harsh as it sounds, a hole in the butt, the death of a care provider, from going into a nursing home.

We tried it on staff, we have consumers that we knew pretty much were at risk.

Those individuals we had just transitioned from nursing homes.

So basically, we kind of played around with the numbers to see if that would work.

And we didn't want to make just any particular factor alone to put that person at risk.

And hopefully what I can do is get the revised version to Darrell where she can put put it up on ILRU.

That's all I have.

Do you have any questions?

AUDIENCE MEMBER: I didn't notice when you had it up a minute ago, what numeric value did you give to the first question about does the consumer feel like they're at risk?

MICHELLE CRAIN: Thirty.

And that, 30 was the highest actually, and we went back and forth as to whether or not we wanted to say, okay, well, if the person said that I'm at risk, then that's it.

But the truth of the matter is if you stop and think about it, whether this person, you find this person to be at risk or not, they're going to tell you what they need, what they need from you.

You're going to set up a consumer service or you are going to go about providing those services, no matter whether they're at risk or not.

I mean, this at risk thing is simply because they told us we need to do this, but for the most part, we're doing this, we're going to address their needs, no matter what.

AUDIENCE MEMBER: I have a question I haven't been able to figure out when to ask, so I guess I will just ask it.

Do we count diversions that are I & R only?

Or do we have to just count somebody who has an open CSR?

MICHELLE CRAIN: This right here is something that we're going to tackle this afternoon with the reporting.

AUDIENCE MEMBER: I just wanted to get it out there.

MICHELLE CRAIN: If you open up a CSR, you get to count those goals and those services.

If you do not open up a CSR, it's just I & R.

So you would not get to address that particular goal.

AUDIENCE MEMBER: There are some diversions that can be just I & R.

I mean, if I provide a piece of information that keeps somebody from being homeless or that keeps somebody from going into a nursing home because they can't handle an ADL or something, then I am diverting them.

I'm just not, I mean, that's why I needed to know.

In a lot of I & R calls, where an at risk situation can be handled with one or two referrals or maybe an idea about AT or something, and I don't want to pad the number, but I do want to see if I can recognize that, I may spend a half an hour on the phone and give somebody an option that they didn't know they had.

That's a diversion in my opinion, whether we can document it as one, I don't know.

MICHELLE CRAIN: That's part of the push, I think, in order to be able to establish, you know, the at risk and being able to measure that.

I mean, some people that you provide an I & R to, I mean, that's it.

You never hear from them again, and some of them don't give you that information to call them back.

So you don't know for sure if the information that you provided actually diverted them from an institutional setting.

And that's going to be part of the issue as well, when you start, and it's something that goes on now with our consumers is that you lose contact with that individual, so you don't know what, I mean that services you've provided have actually diverted them from an institution, because you can't follow up.

So.

AUDIENCE MEMBER: Question, what is the 30, the value of that, what does that mean?

MICHELLE CRAIN: Pretty much it is just putting a measure on that particular at-risk factor.

And that's the reason I said there's nothing scientific about it.

So if you're trying to get something scientific out of it, you'll probably have to beat your head against a wall, because there's nothing scientific about it.

AUDIENCE MEMBER: Okay.

MICHELLE CRAIN: You might find that if you used a tool or put your own tool together, or what have you, you might find that this particular factor is enough.

I mean, seriously, you might find that that's enough for someone to come and they're homeless in a wheelchair or quadriplegia or whatever, you might find that's enough.

The thing of the at-risk survey for us is trying to put something standardized in place for the network, but we're not there yet.

We're not there.

And who is to say that ACL will not come in and say, okay, we want you to use this information or we want you to use this form, we don't know that yet.

So it's just a time where they said do this and didn't give us really any direction, didn't really give us a whole lot of terminology or definition.

Got terminology, but not definition.

AUDIENCE MEMBER: I was curious about the logic of 30 and like when it sums down, what number is it that.

Like what's the logic between the 30 or could have been a 10, you know, or you have 15 on number 6.

And 25.

MICHELLE CRAIN: I think a lot of that was the weight of the factor.

If you scroll down, you know, being 65 is not enough to really just get you put in a nursing home or for anything like that.

So if you go over here, and maybe say yes to that, that's only 10 point.

So it's basically I guess in the going by what would be a more immediate factor, basically is how I weighted the points.

That's good.

And a minute to spare.