Risk Management Policy and Procedure Manual

Massachusetts Department of Mental Retardation

Second Edition

June 2004

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Department of Mental Retardation

FOREWORD

In December 1998, The Department of Mental Retardation began implementation of a statewide risk management system. The Risk Management guidelines published at that time (Risk Management System, December 1998) laid out the framework and components of a comprehensive process to assess review and manage risk. The guidelines also detailed a system of support and consultation as well as oversight activities to assure that the new system was effective.

DMR has been implementing the risk management system for five years. Much has been learned about what works and areas and regions have brought significant experience and wisdom to the issues surrounding risk assessment and management.

The following manual builds upon the initial guidelines and principles set forth in 1998 and codifies a set of operational procedures and practices that borrows from best practices around the state and seeks to standardize the Department's approach to effective risk management.

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May 24, 2004

RISK MANAGEMENT

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**I.	Introduction to Risk Management - Finding the Balance**

The Department of Mental Retardation (DMR) Risk Management system balances the responsibilities of the Department to keep individuals with mental retardation safe, with the overarching aim of promoting personal independence and self-determination.   Individuals who are at risk are best served by an effective partnership between the DMR, service providers, individuals, guardians and families. Optimally, all involved parties must recognize the reality of risk in peoples' lives and the strengths and limitations of the service system, and work together to create an environment, which provides effective and appropriate safeguards and supports. Distinguishing between reasonable and unreasonable risk in the lives of individuals is sometimes obvious, however, more often, it is a complex task that requires the exercise of professional judgment and the guidance of practice standards.

Many individuals, served by DMR, are making their own choices, experiencing the fullness of community life in their work and home lives, assuming personal responsibility for their choices, and learning to evaluate and grow from the experience of those choices.   DMR and its oversight agencies have recognized, however, that there are many challenging aspects to the issue of individual choice, including competency and the capacity to make informed decisions, especially when such decisions result in an unreasonable risk to the individual.   Through the risk management process a direction is offered to staff and providers when the question of supporting an individual's choices appears ambiguous. This direction is especially important in supporting individuals who are competent to make informed decisions, but who continue to exercise poor judgment and place themselves or others at risk.

The Risk Management system has been attentive to the statement of the Investigations Advisory Panel, House Post Audit Report which in April of 1998, stated: "To assume that persons with mental retardation who are known or suspected to be in a potentially or blatantly risky, exploitative, or abusive situation are exercising their 'rights' to be at risk is to abandon a basic rationale for public services. The panel felt very strongly that no one with mental retardation should be abused or neglected as a matter of 'personal choice'."

Finding the balance between the responsibility to protect people while promoting their personal growth and autonomy must begin with the individual and

those who know him/her best. This responsibility must be approached as a partnership, based on a foundation of trust that does not attempt to limit freedom, but rather, assists the individual, when possible, to look at ways to be safe within the choices he/she makes.

Exposure to risk is a part of life and it is only through making choices and developing good judgment that we all learn and mature. People with mental retardation, however, can be vulnerable to neglect, abuse and a variety of other dangerous situations if they have not learned how to, or are not able to, keep themselves safe. People with disabilities share the same vulnerabilities as others, but they usually have less power to deal with their vulnerability and to access the support they need. The Department's Risk Management System promotes local autonomy, by supporting the Area Office connections and networks among all stakeholders to keep the individual and the community safe.

II.   Guiding Principles of Risk Management System

The DMR Risk Management system was developed through a process, which focused on the requests and needs of staff within all levels of the Department. This activity formulated a set of guiding principles, which still remain viable and applicable in managing risk in the lives of adults who have been deemed eligible for DMR services. Below are these principles as outlined in the 1998 manual.

- Risk management should emphasize safeguards and strategies that will address issues and create situations where risk is managed and reasonable, whenever possible.

- A risk management system must be based upon a clear process for identifying unreasonable risk.

- The process of identifying and addressing unreasonable risk should be respectful of an individual's rights while responsibly addressing questions of competency and capacity to make choices.

- The determination of who is at risk should involve, among others, those who know the individual best. It should be based on professional/clinical assessments, when indicated, and an understanding of any cultural and linguistic issues. Risk Management should be integrated with the ISP process.

- A risk management system should be locally based, user friendly and implemented by individuals trained, supervised and supported in making knowledgeable decisions through a collaborative group process.

- A risk management system must weigh the capacity of an individual to make informed choices and to learn from those choices with the necessity of assisting an individual to be safe.

- Those making determinations about responsive courses of action must have timely access to clinical, legal and administrative consultation and have access to individuals/groups with relevant training/expertise.

- The risk management system must include ongoing oversight and monitoring activities, based on accurate data and focused on promoting   institutional learning.

III. Goals of a Risk Management System

A strong primary prevention focus is an important component of a truly effective Risk Management system. The goals are as follows:

1. To take a broad pro-active approach in identifying risk, rather than a re-active response to crises as they arise.
2. To identify potential risks in order to minimize the impact if they arise.
3. To provide skilled effective interventions to mitigate risk.
4. To consider which potential risks factors might be the focus of a broad comprehensive system wide intervention.
5. To identify successful interventions which mitigate risk to generalize their use on an individual or community level.

IV. Who is at Risk?

Often, those most at risk are individuals who are the most capable, and who may receive minimal support. DMR provider programs and staff effectively support many individuals with complex needs and there is no single profile of individuals who are at risk. However, they generally fall into one of three categories:

➢ Individuals, who present significant challenges, require a high level of oversight and attention to a variety of potential risks, while receiving extensive DMR support. This would include individuals with complex medical needs.

➢ Individuals who often do not wish to be labeled as mentally retarded and do not perceive themselves as "clients" of the Department. Many of them are, or have been, in disadvantaged situations and face significant challenges, which may include poverty, unemployment, mental illness, substance abuse and/or involvement with the criminal justice system. The risk management process, allows DMR to consider a partnership with other public agencies, which may be better positioned to address these issues.

➢ Individuals who require more support than they are receiving and may accept additional assistance with their physical or mental health issues or other challenges in their lives if encouraged to do so.

Individuals who have high risk factors but who also receive extensive supports may not need a risk plan if those risk factors are "adequately managed" as a result of those services. Individuals who continue to have incidents of assault, victimization, and/or repeated psychiatric or medical hospitalizations have risk factors that are not "adequately managed". Individuals with significant or ongoing involvement with the criminal justice system are not considered "adequately managed".

V. Guideline Criteria for Identifying Risk Factors

While there is flexibility in the decision-making in most situations, based on the balance of competency, personal choice and risk, the following criteria represent situations where a **risk plan is always required:**

- o Individual is **listed with the Sex Offender Registry Board** (SORB)
- o Individual is **on probation and /or parole**,
- o Individual is **refusing supports, or has no ISP**, while having **high risk behaviors**, that involve the criminal justice system
- o Individual is **homeless**
- o Individual is **hospitalized frequently on an unplanned basis** and does not have a continuous period of 6 months free of hospitalizations.
- o Individuals **weighs in excess of 300 pounds** and has chronic medical problems
- o Individual **requires frequent emergency medical or emergency psychiatric assessments** in hospital emergency rooms or with crisis emergency teams

    **The Regional Risk Manager can always review exceptions in the above circumstances.

In addition, the following criteria are suggested as a guide for when the risk committee should review the risk factors in an individual's life and **consider a risk plan.**

- o An individual who is **dually diagnosed (MH/MR)**, refusing services, *and* accessing emergency services in order to meet basic needs
- o An individual with **serious/life threatening medical issues** (e.g. diabetes, a Body Mass Index (BMI) over 40, or Chronic Obstructive Pulmonary Disease (COPD) who has consistently demonstrated poor compliance with necessary treatment particularly if they are without primary caregivers.
- o An individual with **a substance abuse problem** who is refusing services, is not involved in any therapy/treatment *and* is experiencing health or safety issues.
- o An individual who has **sex offender behavior**, who is residing either independently or in less than adequate residential supports, particularly if they are refusing participation in treatment
- o An individual who is living independently, may be **victimized by persons other than a caretaker** (i.e. boyfriend), may be financially exploited and is resistant to breaking a pattern of abuse
- o An individual who has a **documented history of fire setting**, multiple court cases, or **frequent involvement with the police**
- o Individual is new to the Department, presents with **complex clinical issues** (i.e. fascination with fire, sex offending, substance abuse, SIB, and may have other public agency involvement (DSS, DYS, DOC, DMH)

VI.   Choosing Categories of Serious Risk

In order to quantify types and patterns of risk, the description of risk factors has been reclassified and integrated in the risk management database. This classification regroups specific risk factors under each category. The revised categories will allow the system to more accurately and consistently identify the frequency of specific risk types, enhancing the Department's ability to track patterns and trends.

A. Category I
Caretaker/Environmental Risk

A caretaker, relative, house mate, friend or any person who has a history of, or is determined to be capable of, physical, sexual, emotional, or financial abuse or exploitation, or regularly neglectful care or supervision; or a situation or environment in which these could occur.

- ✓ Housing Related to Family Dwelling
- ✓ Possible Sexual Exploitation
- ✓ Financial Exploitation
- ✓ Incapacitated Caretaker Or Loss Of Primary Caretaker/ Natural Supports
- ✓ Social Isolation /Poor Compliance History Of Neglect /Abuse/ Omission by Caretaker or refusal of services by caretaker/Criminal Activity By Caretaker

B. Category II
Individual Risk Behaviors
 (Risk factors are directly related to an individual's behavior not the behavior of others)

The individual's behaviors are dangerous to themselves or threaten public safety. Examples include: financial mismanagement, frequenting places where there are dangerous people, refusal of critical services or treatment, lifestyle choices that put them at serious risk or pose a serious risk to others, including substance abuse.
- ✓ Housing related or homeless (due to individual's behavior)
  - ▪ Threat of eviction /Frequent changes in address w/o cause
- ✓ Unsanitary / inappropriate living conditions
- ✓ Financial/Money Management issues
  - ▪ Loaning money/indebtedness/financial exploitation by others
  - ▪ Excessive Gambling
- ✓ Substance Abuse Related
- ✓ Significant Self Injurious Behavior
- ✓ Pregnancy and parenting issues
- ✓ History of fire setting or fascination with fire
- ✓ Issues With Personal Safety
  - ▪ Frequent victimization, uses poor judgment in unsafe situations
- ✓ Criminal Justice Involvement not related to sexual activity
- ✓ Reported History of Problematic Sexual Behaviors (including criminal)
- ✓ History of Aggression
  - ▪ Threats of violence or repeated destruction of personal or private property

C. Category III
Medical Complications

Individuals who have a medical condition(s) and are in need of significant medical safeguards, which may include, but not be exclusive to, the following:

- ✓ Multiple unplanned hospitalizations
  - ▪ The individual does not have a 6-month period without a hospitalization
- ✓ Complex post hospital care needs not psychiatric issues
- ✓ Significant negative change in medical status: mobility impairment, eating/sleeping
- ✓ Refusing medically related supports
- ✓ Medication related issues
  - ▪ i.e. insulin/diabetic care
- ✓ Chronic eating disorders and /or including obesity
- ✓ Swallowing /choking /aspiration disorders
- ✓ Infectious disease processes including STD's, Methicillin Resistant Staphylococcus Aureus (MRSA), Hepatitis, Chronic cellulitis

VII.   Who can identify individuals who are at risk?

Service Coordinators and SC Supervisors review the status of people served by DMR on a regular basis, and as such, have primary responsibility for bringing individuals who are at risk to the attention of the Area Office risk committee. (See VIII A) Any unsafe situation, however, may also be identified by families/guardians, service providers, and a variety of others, both internal (e.g., quality enhancement surveyors, investigators) and external (e.g. neighbors, police) to the Department. When issues of risk are brought to the attention of the Department, they will be referred to the appropriate Area Office/Facility. The Area/Facility Director may choose the risk management system, as an expedient and effective way to provide a comprehensive review of the individual's needs and/or an opportunity for key contacts to present their concerns.

Normally, the decision on "who should be referred to the risk committee" is made by the Area Director (AD), supervisory staff within an area office, the Regional Director or Regional Risk Manager.   However, it is the practice of the Department of Mental Retardation that any professional staff person should have access to an Area office risk committee when they are concerned about an individual. The risk committee then makes the determination regarding the need for a formal risk plan or other supportive interventions.

VIII. <u>Implementation of the DMR Risk Management System</u>

Risk management is an integral part of the daily work of the Department in Area Offices and Facilities. The system is designed to complement regular planning and clinical processes. The risk management system, however, provides for a more focused and intensive review for eligible adults, who remain actively engaged with the Department but continue to be vulnerable and/or are at risk.

A. Risk Review

Determining whether an individual should be referred to the Risk Committee for a risk plan requires professional judgment by people who know the person well. Assessing for risk factors is an ongoing process, usually conducted during regular supervision between the Service Coordinator and their Supervisor in an Area Office or between the QMRP and their Supervisor in a Facility. A review of potential risk factors for each individual will be conducted at least every 6 months, concurrent with the semi-annual progress review for each ISP. All supports designated for the individual's health and safety should be documented in the ISP. The electronic ISP will include a designation that documents whether the individual's risk factors have been reviewed and whether the individual needs or has a risk plan.

B.   Physical or Behavioral Health Complications and Risk

1.   Nursing Clinical Consultations

While many individuals with mental retardation enjoy stable health and require only routine and episodic health care interventions, a small percentage of the population have complex health care issues or newly diagnosed conditions that require a more sophisticated clinical review and an in depth health care management plan.

A Clinical Consultation (See Protocol Appendix B) is used for individuals with physical health care issues that by virtue of their complexity or need for management require a more in depth review than is typical of the standard ISP or other planning processes. Its primary purpose is to provide an opportunity for a clinician, in most cases an RN or NP to offer valuable guidance to those supporting an individual regarding the specific issues a particular condition might present. It would also include an assessment of the types of programs and supports that will assist the person to manage effectively.

All individuals eligible for DMR services may receive a Clinical Consultation, if deemed appropriate, regardless of whether they live in DMR funded residential supports, live independently with minimal assistance, or live with their families. Guardians and families interested in having a Clinical Consultation for an individual should contact the individual's service coordinator who will initiate the consultation with the area office nurse or psychology clinician.

For individuals living in DMR funded residential supports, the Clinical Consultation will be completed either by the provider or by the DMR area office nurse if the provider does not have access to appropriate clinical support. The Area office nurse may also complete a consultation, if the provider would find a consultation by the DMR Area nurse helpful. The Clinical Consultation includes the following elements:

- o   A review of specific conditions identified
- o   A general assessment of the supports needed to effectively assist the individual and/or provider to stabilize and support the individual
- o   An assessment of the supports in place to meet the individual's needs
- o   A determination of how often the support plan should be reviewed to determine its efficacy in meeting the individual's health care needs.
- o   A recommendation regarding staff training needed to support the person

2. Clinical Consultations and Risk Plans

A Clinical Consultation may result in a determination that certain conditions pose chronic risks to a person's health and well-being. When it is established that significant health risk factors will remain in the person's life, a risk plan is indicated. The risk plan is an opportunity for DMR staff to succinctly document health specific interventions and their efficacy, in addition to the Service Coordinator progress notes. Continuous review of these interventions assures that all possible choices have been considered to support optimum health for an individual.

C. Composition of the Facility / Area Office Risk Committee

The Area/Facility Director designee facilitates the risk committee. The committee includes the Facility or Area Director or Designee, Facility/Area and Regional administrative and clinical professionals. Risk Managers and attorneys from the Region frequently attend. Professional experts in particular areas related to risk management such as human rights, substance abuse, forensics, and health care attend on an as needed basis. Service Coordinators and SC supervisors always participate. DMR providers are always invited to participate in the meeting if they are involved in implementing recommendations from the Committee.

Although their presence is not required, the individual and /or his or her guardian or family, may also be asked to participate. No action recommended by the risk committee that requires the knowledge and consent of the individual or the guardian can be implemented without their consent. Individuals should be encouraged to attend when appropriate.

D.   Function of the Area Office/Facility Risk Committee

The Area/facility Risk Management Review Committee has the following essential responsibilities:

- To meet at least monthly. Most Area offices find that to be effective the group meets biweekly.

- To review risk factors related to an individual and make decisions regarding the need for a risk plan.

- To recommend specific actions and designated responsibilities to mitigate the risk factors.

- To regularly review the efficacy of existing risk plans and suggest those that could be closed. Risk Plans for individuals on the SORB need to be reviewed every six months and should not be closed.

- To refer uniquely challenging and unresolved risky situations to the Regional Risk Manager.

- To review Area Office Critical Incident Reports, which may indicate the need for a risk plan for individuals.

- To propose individuals to be designated a status other than active, per the DMR Case Status Policy (See appendix D)

- To maintain a monthly record of risk management activity re: who was reviewed, outcome of review (e.g. continue plan, new plan, no plan) and to forward this record (Appendix C) to the Regional Risk Manager.

E. Central Office Risk Advisory Committee

The Central Office (CO) Risk Advisory Committee membership includes the Director of Risk Management, the Director of the Office for Human Rights, the Director and Deputy Director of DMR Investigations, the Director of Survey and Certification, a Senior Project Manager of the Office of Field Operations, the Director of Health Services, the Deputy General Counsel for the DMR Legal Office and the Director of Management Information and Evaluation from the Office of Policy and Planning. This group facilitated by the Director of Risk Management, periodically reviews, with the Area office team, the risk plans of individuals who present compelling legal, medical, human rights and self-determination challenges.

An Area Office Risk Committee should consider a Central Office Risk Advisory Committee review of a risk plan for individuals who have had the benefit of the risk management process but continue to have serious risk issues and are at risk of harming themselves or others. A Regional Director/designee, Facility Director/designee and/or the Regional Risk Manager may all refer individuals to the Central Office Risk Advisory Committee. Referrals to the Central Office Risk Advisory Committee should be directed through the Regional Risk Manager.

At the time of the CO risk review, the Regional Risk Manager or Area Office designee will document the recommended actions in the electronic Risk Management Plan. A brief outcome of the meeting with action steps and issues will be forwarded by the Director of Risk Management to the Regional Director, Regional Risk Manager, Area Director, CO Risk Advisory Committee and other attendees to the review.

IX. Role of the Regional Risk Manager

Regional Risk Managers support Area office risk committees to effectively implement the Department's risk management system. Regional Risk Managers perform the following functions:

- Participate at area office risk committee meetings

- Review monthly reports from the Area Office risk committees (see Addendum X) on what individuals were reviewed, and dispositions

- Review risk plans and Critical Incident Reports

- Participate in other OQM activities such as Root Cause Analysis, Regional Mortality review, MAP

- Serve as the Regional Director's designee to CO Risk Management regarding on going communication related to Critical Incident Reports and risk situations.

- Schedule and facilitate regional meetings related to risk situations

- Provide a link to other DMR offices: Investigations, Legal, Survey and Certification, and Complaint Resolution Team processes

X.   Role of the Director of Risk Management

The Director of Risk Management has the following primary responsibilities:

- Oversight of the Risk Management and Critical Incident Reporting systems

- Standardizes policy as related to Risk Management and Critical Incident reporting

- Participates and facilitates other review such as Root Cause Analysis

- Facilitates the Central Office Risk Advisory Committee review of plans related to   complex and challenging individuals

- Facilitates monthly strategy meetings with Regional Risk Managers

- Analyzes databases related to risk management and Critical Incident Reports for trend analysis

- Provides clinical consultation and support to the Regions and Area Directors

- Contributes to risk management related trainings offered at the Service Coordinator Institute

- Participates in Department activities related to the identification and mitigation of risk factors linked to forensic issues, substance abuse, and domestic violence.

- Works with DMR staff and the staff of other agencies to develop programs to systemically address populations at risk

XI.   Risk Management Information System

A.   Risk plan documentation

DMR has developed an electronic database for documenting the risk plan. (Appendix A) This database is linked to the Consumer Registry System (CRS) and automatically draws key information into the electronic document. The narrative sections of the plan ask for information that the committee needs in order to make good clinical judgments and recommendations regarding appropriate actions and interventions. The action plan grid details the recommendations and timelines of the risk committee and the completion date for these actions. The meeting dates are noted and the participants in the ongoing meetings are identified at the end of the document.

Typically, Service Coordinators / QMRP's or their supervisors are responsible for the initial documentation and for on going updates within the risk plan. They should assure that updates to plans are always written before regularly scheduled individual risk reviews. While the risk management system was designed to encourage an individual's Service Coordinator/QMRP to be the primary author and editor of a risk plan, for consistency and clinical accuracy many Area Directors designate one staff person to originate all risk plans. In addition to Service Coordinators or their supervisors, other individuals, such as a Program Monitors, Psychologists, Clinical Directors and Asst. Area Directors may be responsible for on going updates and information within the risk plan. All documentation should be respectful, factually based and written in a neutral non-judgmental style.

B.   Confidentiality and access to risk plans

Access to the plans at the Area Office or Facility, Regional and Central Office levels is restricted to protect the confidentiality of the individuals involved and allows key DMR staff to provide oversight and support to the risk management system. The Central Office Management Information System staff manages the Risk Management Information System. Through this electronic system, on a regular basis, interested parties with designated access throughout a Region can be updated on the progress of interventions and the status of individuals and their risk plans. Periodic review and routine updates can be regularly documented within this system. Plans can be developed and edited by Service Coordinators who have access only to the plans of the individuals for whom they have responsibility. Regional Risk Managers can review and edit all plans within their designated Region, as necessary. The Director of Risk Management can delete individual plans, only after recommendation by the Regional Risk Manager.

C.   Storage and distribution of plans

All Risk Plans should be stored in a separate section in the consumer's confidential record and or/ a separate storage area in a DMR office. Copies of Risk Plans should routinely be made available to those responsible for implementing components of the plan, including providers and most members of the risk review

process. All readers should be reminded that risk plans contain confidential clinical information and are subject to all the applicable laws and regulations related to confidentiality. Some plans may contain clinical information, which need not always be routinely available to all staff in an individual's home.

D. Transferring of existing

   1.   Transferring plans between Service Coordinators in the same Area Office

Describe with MIS input

XII.   <u>**Risk Management Consultations and Support**</u>

The Risk Management Director and Regional Risk Managers participate in training activities designed to introduce the Risk Management system to new DMR staff. Often the Risk Managers respond with resources and educational materials, directed at the specific risks identified within the Risk Management System, local to their Region. Supported by good data management, a prospective review of the risk management system is expected to reveal patterns of risk, which would indicate further study for the Department.

Future monitoring and oversight activities will attempt to answer the following questions, related to the risk management system:

- Is there a description of clinical, legal, human rights and other resources accessed in addressing this issue?

- Is the ISP team involved/informed for their input? ISP modified?

- Are all the appropriate parties apprised of the plan?

- Is necessary support and training in place?

- Is it clear who is responsible for implementation/oversight of specific aspects of the plan?

- Is there a process for ongoing review and evaluation of supports and interventions used?

- Are plans being modified as needed?

- Is the individual's personal interests upheld and balanced against risk to self and others?

XIII. Risk Management System Oversights And Quality Monitoring

The primary aim of the Department of Mental Retardation Risk Management system is the early identification and mitigation of risk to individuals. Achievement of this goal is regularly demonstrated on the area, and regional level as risk to individuals is identified and addressed through the risk committee process. To further assure that the Risk Management system is achieving the five specific goals designated by the Department, the Office of Quality Management and the Regional Risk Managers will conduct periodic reviews.

The first review is will examine whether committees follow good practice in prompt and accurate documenting. This review will attempt to answer the question "Are DMR consumers with significant risk being identified within the current process in each Area office?" The risk management process will be evaluated by asking targeted questions regarding the method of developing, monitoring and implementing existing plans. Using a sampling technique this first phase of review will examine existing plans to determine: a) if plans have completed actions, periodic updates and documented outcomes from plan activity, and b) the efficacy of the Area Office risk review system in identifying individuals at risk. A sampling of individuals with and without risk plans will be done to ascertain whether individuals at risk and in need of a risk plan have been identified and reviewed.

APPENDICES

Revised Risk Plan Document (Blank)

Protocol For A Clinical Consultation

Area Office Risk Committee Monthly Review Form

Procedure For Designating Case Status

REVISED RISK PLAN DOCUMENT (Blank)

DEPARTMENT OF MENTAL RETARDATION
RISK MANAGEMENT PLAN

Date of Plan:
Date(s) of Meeting(s):   **Next Scheduled Meeting:**

Region: **Regional Risk Contact Person:**
DMR Area/Facility: **Local Contact Person:**
Phone: **Assigned To:**
                                                     (As assigned SC/QMRP on CRS):

MR Diagnosis

Name of
Individual:

Date of Birth: Gender: SS#

Risk Plan Status	CLOSED OPEN
Central Office Risk Review	**Yes /No**
Substance abuse issue	**Yes / no**
SORB	**Yes / no**
Problematic sexual behavior	**Yes /no**
ISP	**Yes /no**
Probation/parole/pre-trial probation	**Yes /no**

1. Reason for current concern/Why is the individual or others at risk?

UPDATES

2. Please describe any relevant past events or history.

3. Describe the person's current living arrangement and social networks (family, friends, cultural issues).

UPDATES

4. Highlight any relevant clinical assessments (include level of functioning, dangerousness, ANY ADDITIONAL diagnoses, if known, competency status, capacity to make informed decisions, behavioral challenges, psychiatric issues).

5. Describe relevant medical issues, and include current MEDICATIONS if known (psychiatric medications also).

MEDICATION   Provider: Internist /psychiatrist /PCP (if known)

6. Describe current supports in place, including: residential, day or work, transportation, clinical, family support, case management, family, other. DMR Services Received. Please update as necessary: DROP DOWN MENU FORMERLY ABOVE

Program Name	Program Code	Contract #	Provider
EMPLOYMENT SUPPORTS	3168	540318	Attleboro Enterprises

    A. **Narrative as needed**

7. Describe supports/services previously rejected, how and when they were offered

UPDATES

Risk Classification   {pull down menu}

The following sub categories are suggestions to help reporters and others to categorize the type of risks related to an individual. Only one category can be designated. If the risk committee is unable to choose a category, refer to the Regional Risk Manager, who will make that determination.

Category I   Caretaker/Environmental Risk

- **Housing Related to Family Dwelling**
- **Possible Sexual Exploitation**
- **Financial Exploitation**
- **Incapacitated Caretaker Or Loss Of Primary Caretaker/ Natural Supports**
- **Social Isolation /Poor Compliance History Of Neglect /Abuse/ Omission by Caretaker or refusal of services by caretaker/Criminal Activity By Caretaker**

Category II   Individual Risk Behaviors

(Risk factors are directly related to individual's behavior not the behavior of others)

- **Housing related or homeless (due to individual's behavior)**
- **Financial/Money Management issues**
- **Substance Abuse Related**
- **Significant Self Injurious Behavior**
- **Pregnancy and parenting issues**
- **History of fire setting or fascination with fire**
- **Issues With Personal Safety**
- **Criminal Justice Involvement not related to sexual activity**
- **Reported History of Sexual Behaviors (including criminal)**
- **History of Aggression**

Category III. Medical Complications

- **Multiple unplanned hospitalizations (does not have a 6 month period without a hospitalization)**
- **Complex post hospital care needs not psychiatric issues**
- **Significant negative change in medical status: mobility impairment, eating/sleeping**
- **Refusing medically related supports**
- **Medication related issues (non compliance or MAP related,) i.e. insulin/diabetic treatment**
- **Chronic eating disorders and /or including obesity**
- **Swallowing /choking /aspiration disorders**
- **Infectious disease processes including STD's, MRSA, Hepatitis,**

List all new actions

Action	Date of Decision	Person responsible	Actual completion date	Comments
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				

Does this plan or action impose any restriction or limitation of a person's liberties or rights? If so, it should be reviewed by the HRC and/or the Human Rights Specialist responsible for the individual.

Risk Management Plan Meeting Attendance

Date	**Attendee**

Additional Routing:
Area Risk Committee:
Regional Risk Manager
Regional Director
Central Office

PROTOCOL FOR A CLINICAL CONSULTATION

Purpose of Protocol
While many individuals with mental retardation enjoy stable health and require only routine and episodic health care interventions, a small percentage of the population have complex health care issues or newly diagnosed conditions that require a more sophisticated clinical review and an in depth health care management plan.

This document sets forth a protocol for a clinical consultation for individuals with physical health care issues that by virtue of their complexity or need for management require a more in depth review than is typical of the standard ISP or other planning processes. Its primary purpose is to provide an opportunity for a clinician, in most cases an RN or NP, to offer valuable guidance to those supporting an individual regarding the specific issues a particular medical condition might present. It would also include an assessment of the types of programs and supports that will assist the person to manage effectively.

To Whom Does this Apply?
All individuals eligible for DMR services may receive a clinical consultation, if deemed appropriate, regardless of whether they live in a DMR funded residential support, live independently with minimal assistance, or live with their families.

The clinical consultation will be completed either by the provider, if they have a nurse on staff, or by the DMR area nurse if the provider does not have access to nursing support. It could also be completed if the provider nurse would find a consultation by the DMR area nurse helpful.

Health Status Indicators that Require Clinical Consultation
The following list represents several conditions or factors which should trigger the need for an in depth clinical consultation. The list is not meant to be all-inclusive. Providers and/or service coordinators may request clinical consultations if in their professional judgment, there are issues, which require further attention.

1) Frequent Emergency Room Visits or hospitalizations (This would apply to ER visits and hospitalizations that are not expected as a result of a particular chronic condition or as part of a protocol for management of a chronic condition. For example, visits and hospitalizations for pneumonia or sepsis would be included. Visits and hospitalizations to manage G/J tube placement or side effects from cancer treatment would not be included.

2) Newly diagnosed conditions including: (The conditions listed below typically require some major adjustment in the support structure for the individual especially around staff training, clinical support and appropriateness of current placement)
   a) Diabetes
   b) Cancer
   c) Dementia (including Alzheimer's Disease, organic brain syndrome)
   d) Cardiac or Pulmonary condition (For example, angina, congestive heart failure, emphysema, asthma, pulmonary edema, coronary artery disease)

e) Autoimmune Condition (AIDS, HIV positive, Lupus)
f) CVA (stroke)
g) Dysphagia (swallowing difficulties that require specific intervention as ordered by the Health Care Provider or speech or occupational therapist)

3) Major chronic condition with deteriorating outcome (Conditions that would be included here are those that, other than those listed above and below, create major lifestyle adjustments for individuals and their care providers and are likely to change the level of support an individual requires. Some examples are: Traumatic Brain Injury, Multiple Sclerosis, Parkinson's Disease, Huntington's Chorea, kidney disease requiring dialysis, Cirrhosis, amyotrophic lateral sclerosis)

4) Recently placed G/J tube or other implantable device (This would include pacemakers, implantable seizure management devices, devices for pain management)

5) Large bone fracture or multiple fractures (The issue of safety needs changes as a result of aging or a disease process may need to be considered. Underlying cause of fractures will also need to be evaluated; for example, osteoporosis.)

6) Lack of consensus re: diagnosis, treatment, treatment options or support needs (The Clinical Consultation may provide objective analysis of the situation that can help clarify and unify efforts in providing appropriate care for the individual involved.)

7) Unexplained DNR (This would refer to DNRs that are put in place when there is no diagnosis or condition that would indicate a need for one.)

8) Multiple pneumonias (The purpose of the Clinical Consultation in such a case would be to determine if due effort was being made to determine cause of recurring pneumonias as in chronic aspiration due to gastroesophageal reflux disease (GERD) or swallowing disorders or in management of early symptoms of respiratory infections.)

9) Sudden, unexplained behavior change (Underlying medical conditions that are undiagnosed or not appropriately treated should be ruled out prior to exploring any type of behavioral intervention)

10) Rapid decline in functional skills (Underlying medical conditions that are undiagnosed or untreated should be ruled out before other non-medical interventions are explored.)

When is a Clinical Consultation Initiated?

A clinical consultation should be requested whenever any of the following situations occur:
1) Any of the abovementioned **10** factors occur
2) The ISP team determines that the individual's health care status requires a more intensive clinical review than is possible by the team
3) The completion of the provider generated "Health Review Checklist" as part of the annual ISP process reveals health issues that the team feels is of concern.

Who Initiates a Request for Clinical Consultation?

A clinical consultation request may be initiated by any of the following:
1) A supervisor, manager, health care coordinator, RN from the provider agency,
2) A family member
3) Any member of the ISP team
4) DMR nurse

Process/Flow for Clinical Consultation

1) The individual's service coordinator or service coordinator supervisor should be contacted whenever any of the abovementioned indicators are present.
2) If the provider has a nurse on staff who is assigned such duties, the provider will conduct the initial clinical review with consultation and support from the DMR area nurse, if requested by the provider
3) The service coordinator will forward a request for a clinical consultation to the DMR area nurse, if the provider does not have an RN or NP assigned such duties
4) The DMR area nurse will respond to a request for a clinical consultation in a timely manner
5) Findings and/or recommendations from the clinical consultation will be forwarded to the provider and service coordinator whose responsibility it will be to consider its inclusion in the individual's plan of care
6) Each area office will maintain a record of individuals who have received physical health care clinical consultations.
7) The area office nurse shall review and update each individual consultation at a minimum, in conjunction with the ISP process.

Elements of the Clinical Consultation

The clinical consultation is comprised of the following elements:
1) A review of specific conditions identified
2) A general assessment of the supports needed to effectively assist the individual and/or provider to stabilize and support the individual
3) An assessment of the supports in place to meet the individual's needs
4) A determination of how often the support plan should be reviewed to determine its efficacy in meeting the individual's health care needs.

A recommendation regarding staff training needed

AREA OFFICE RISK COMMITTEE MONTHLY REVIEW FORM

RISK COMMITTEE MONTHLY ACTIVITY

AREA OFFICE:

MONTH & YR:

REPORTER:

DATE OF MEETING	NAME OF PERSON REVIEWED	RISK PLAN OPEN	RISK PLAN CLOSED	NEW RISK PLAN	NO PLAN NEEDED	COMMENTS

PROCEDURE FOR DESIGNATING CASE STATUS

The purpose of this procedure is to create a standard practice for designating case status on CRS, focusing specifically on Inactive status. This procedure will involve some or all of the following variables: assessment of risk, competence, eligibility for DMR supports, frequency of contact, assignment of a service coordinator, and refusal of supports.

Procedure

In situations where an individual refuses supports, the Department must make reasonable efforts to secure participation by the individual and to provide adequate follow up. In such situations, the following procedure should be followed.

1. When an individual/guardian rejects all supports and services offered by the Department, including service coordination, the service coordinator must inform the Area Director. Efforts must have already been made by DMR staff to inform the individual/guardian of the supports being offered and why it would be in the person's best interest to receive them. Such efforts must be documented in the individual's case file. The individual is then referred to the Area Risk Management Team.

2. The Area Risk Management Team will review the situation in order to assist in the decision concerning termination of services (including service coordination). This review will include:

   a. Examining risk factors in the context of the individual's capacity to make informed choices in activities of daily living;

   b. Making a referral for a Clinical Team assessment of the need for guardianship, if appropriate;

   c. Analyzing potential harm in the areas of personal victimization, medical complications, and legal and public safety issues;

   d. Assessing the level of risk to the individual if they refuse services, including the refusal of service coordination;

   e. Considering issues that may require review by DMR legal counsel; and,

   f. Reviewing other possible services for referral purposes.

3. The Area Risk Management Team will make a recommendation to the Area Director concerning contact, including frequency, to be maintained with the individual/guardian when there has been a refusal of services. The Team will consider the degree of risk to personal and public safety in making its recommendation. If the recommendation is to maintain ongoing contact and the Area Director concurs with this recommendation, then the individual will be given an **ACTIVE** status. If the Area Risk Management Team recommends no contact, and thus **INACTIVE** status, the Area Director will forward this recommendation, in the form of a written report, to the Regional Director and the Regional Risk Manager for final disposition. The Regional Director makes the final decision and informs the Area Director.

4. For those with whom the Department will maintain contact (designated **ACTIVE**), the individual/guardian will be contacted at least annually, or in some cases more frequently. If the individual or guardian provides written notification that they do not want such contact, the Regional Director and the Regional Risk Manager will review all such requests for less frequent contact with regional legal counsel in order to determine the necessary steps to be taken. The Regional Director will make the final decision and inform the Area Director.

5. For those with whom the Department will not maintain contact (designated **INACTIVE**), the individual/guardian will be informed that they may contact the Department at any time to request supports. At that time, if the request is made within 3 years of the written Inactive status notification date, the individual is considered to be eligible and may receive appropriate DMR supports, when available. If the request is made after 3 years of the written Inactive status notification date, the individual will need to reapply for services; and, if determined to be eligible, the individual may receive appropriate DMR supports, when available. The individual's status designation may change at this time.

Application of This Procedure to Children Under 18 Years of Age

1. This procedure is applicable to children under 18 years of age on a limited basis as further described herein. If the child is receiving DMR supports they must be designated as **ACTIVE** and they must have an assigned service coordinator. Contact by the service coordinator may be less frequent than annually, however, as the family is contacted periodically throughout the year by the family support provider.

2. Children who are receiving residential supports through a Local Education Authority (LEA), through Medicaid state plan services, or are living out of state, and are not in transition to or from DMR supports, and therefore are not in need of service coordination, will be designated as **INACTIVE**.

3. The review by the DMR risk management system to determine status and frequency of contact is <u>not</u> applicable to children under 18 years of age.

<u>Area of Service Requirements</u>

1. If an individual remains eligible for DMR supports, and contacts the Department in the future to request supports, the city or town where the person has a permanent residence will determine the Area Office responsible for following the request for supports.

2. If the individual intends to reside in an area other than the area where they originally received services, the tie will change to the new area where they reside. The new area should contact the old area to inform them of the change, obtain any relevant information, and proceed with the tie change.

CRS/Documentation/Service Coordination Assignment Requirements

1. A DMR eligible individual will be given an **ACTIVE** status in the following situations:

    a. An adult is DMR eligible and is receiving DMR supports.

    b. A child under 18 years of age is eligible and is receiving DMR supports.

       c. All Ricci class members <u>except</u> those who are living out of state and those whose whereabouts are unknown.

       d. An adult is not DMR eligible but is receiving DMR supports.

       e. Those individuals who are designated as Active in accordance with this procedure.

2. All **<u>ACTIVE</u>** consumers are assigned to a service coordinator and those who will receive only annual contact are assigned to a service coordinator supervisor. It should be noted, however, that all adults who are included in the DMR HCBS Waiver must be assigned a service coordinator.

3. All **<u>ACTIVE</u>** consumers must receive contact from the assigned service coordinator/supervisor at least annually unless less frequent contact has been approved consistent with this procedure.

4. A DMR eligible individual will be given an **<u>INACTIVE</u>** status when they are refusing services and when it is determined through this procedure that there will be no contact with the individual/guardian.

5. Individuals who no longer need supports, as determined through the ISP process, and who are determined to not need annual contact, will be designated as **<u>INACTIVE.</u>**

6. Where an individual's status designation remains **<u>INACTIVE</u>** for three years following the date of notice of Inactive status, the individual's case is designated as "closed," and the individual must reapply for DMR eligibility determination and services**.**

7. **<u>INACTIVE</u>** status will also be used for individuals who have moved out of state and are receiving no services. This includes Ricci class members who are living out of state.

8. **<u>INACTIVE</u>** consumers are not assigned to a service coordinator.

9. The **<u>CONSUMER SERVICES</u>** ("S") status will no longer be utilized in CRS as a designation.

10. The **<u>REFUSING</u>** ("R") status will no longer be utilized in CRS as a designation.

11. The **<u>DECEASED</u>** status will remain in use in CRS as a designation.

The DMR Legal Office will issue standard letters that DMR staff must use with individuals/guardians at each step of the process outlined herein, in order to document offers of support and plans for follow-up contact. The dates on these notification letters will serve as the applicable status date or status change date. Written documentation is required in order to change an individual's CRS status, and must be provided to the CRS data entry person.

Individuals Who Are Ineligible

1. **New applicants for supports are entered in the Intake & Eligibility data base. If the applicant is found eligible for DMR supports they are entered into CRS. This procedure is then triggered for use at that point.**

2. **If the new applicant is found ineligible for DMR supports then they are not entered into CRS. They remain in the Intake & Eligibility database as ineligible. This procedure is not applicable.**

3. **If an ineligible individual is later "assigned" to DMR they will be given an** ACTIVE **status and added to CRS.**

B. CRS STATUS SUMMARY

Status Category	Definition
Active	• **Eligible and receiving DMR funded supports**. • Refusing all other DMR funded supports but receiving service coordination contact at least annually, unless less frequent contact is approved. • Child under 18 years receiving DMR funded supports. • All Ricci class members (except whereabouts unknown and out of state). • Not DMR eligible but receives DMR funded supports (assigned cases).
Inactive	• Eligible and refusing services and determined to not need contact. • Child under 18 years not receiving DMR supports. • Ricci class members living out of state or whose whereabouts are unknown. • Moved out of state and not receiving DMR funded supports. • Determined to no longer need supports from DMR.
Deceased	• Individual is deceased.
C. Refusing	• **THIS STATUS IS NO LONGER IN USE IN CRS.**
D. Consumer Services	• **THIS STATUS IS NO LONGER IN USE IN CRS.**