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AoA Update

Dog Days Bring SMP Funding Growth

Barbara Dieker

By Barbara Dieker

Director, Office of Elder Rights, U.S. Administration on Aging

Greetings from Washington, D.C., where we are sweating through the "dog days" of summer! It wasn't any cooler in Kansas City for the first SMP regional conference, and I don't expect it to be much cooler in the remaining great SMP regional conference cities this month and next. But not to worry. With our full agenda and networking opportunities, we won't have much time to be out in the heat.

What an exciting and busy time the past months have been for the SMP program! Of course, the most thrilling recent development is that of the CMS commitment of additional funds to enable doubling of the SMP program. Peter Budetti, the new Deputy Administrator for Program Integrity at CMS, believes strongly in the value of educating beneficiaries as a key strategy in the arsenal of health care fraud-fighting tools. I first met Peter at the National Summit on Health Care Fraud in Washington, D.C., in late January, before he was appointed to this position. He participated in the breakout session "Developing Effective Prevention Policies and Methods for Insurers, Providers and Beneficiaries." The SMP program was represented in the same group: New Jersey SMP Coordinator Charles Clarkson and volunteer Ruth Candeub Avins, as panelists and myself as observer. We shared the SMP approach for empowering consumers to prevent health care fraud during this session. Mr. Budetti expressed interest in the SMP program to me afterwards, asking additional questions about our operations.

To my surprise, within a month or two, I learned that this same Peter Budetti had been appointed to lead Program Integrity efforts at CMS! Soon after, he contacted AoA to further discuss the SMP program. During an initial meeting with

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Assistant Secretary Greenlee, he requested AoA provide a proposal for expanding the program with increased funding. After a series of discussions and refinement of the focus and objectives of additional funding, AoA and CMS agreed on the funding level – $9 million to double the program size – and the programmatic priorities for the expanded funding.

The rest you know: a tight timeline for issuance of a program announcement and award of grants with 2010 funds. It has been gratifying to hear Secretary Sebelius refer in several speeches during the past several months about her commitment to "putting more boots on the ground" by doubling the size of the SMP program. Peter Budetti spoke on June 21 at the National Association of Area Agencies on Aging (n4a) conference and reiterated his support for the SMP program and its expansion. During the Q & A's following his speech, both Erin Weir, Illinois SMP director, and Shirley Merner, Hawkeye Valley AAA, went to the microphone to voice their thanks to Mr. Budetti for his support of the SMP program.

I am very excited about the new opportunities that increased funding will provide to expand the SMP program's capacity to empower more seniors to prevent, identify and report health care fraud. I look forward to working with each of you to implement new, innovative approaches toward that goal.

See you at the remaining regional conferences, and stay cool!

Texas SMP Speaks at Sebelius Event


Barbara McGinity

By Barbara McGinity

SMP Program Director, BBB Education Foundation (TX)

What an invitation: "We request your attendance at an event featuring Secretary Sebelius speaking to seniors about the Affordable Care Act and Medicare" and, oh, you may have to say a few words about the SMP.

While certainly no stranger to public speaking in just about every type of setting you can imagine, saying a few targeted words in front of the Secretary of Health & Human Services could be intimidating. But I love a challenge that pushes me to the next level.

If was fun to fly up to Dallas for the day to have this opportunity to make sure the SMP message stays in front of folks at HHS and CMS. To have a good visual impact, I took our blue bags emblazed with the Texas SMP logo, stuffed with SMP information. After the Secretary made her remarks, my turn was here. Focusing on our mantra – Protect, Detect and Report – and utilizing the handouts, it was not difficult to get the point across in my brief appearance.

What were the best parts of the day? I was able to have a few of the new Dallas-area volunteers come and they really enjoyed being part of it all; I met the HHS regional director and made a new contact; and everyone actually pronounced my last name correctly. Now that impressed me.

Sebelius Talks Health Care in WI, MN

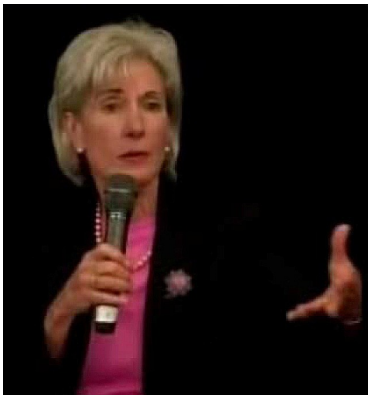

Elizabeth Conrad

By Elizabeth Conrad

SMP Project Director, Coalition of Wisc. Aging Groups

"We spend twice as much as any country on Earth on health care, but we live sicker and die younger than most developed countries," says U.S. Health & Human Services Secretary Kathleen Sebelius. "That is not a good place for the economy and our national security."

Secretary Sebelius was in Wisconsin June 3 for a closed-door event in La Crosse at the Southside Neighborhood Center to answer questions and discuss health care reform. Those present included 75 local seniors, Wisconsin Gov. Jim Doyle, Rep. Ron Kind of La Crosse, Rep. Tim Walz of Minnesota, myself and a group of SMP volunteer trainees.


Secretary Sebelius at the event

The Secretary also visited the Gundersen Lutheran Medical Center in La Crosse and Mayo Clinic in Rochester, MN. She cited their high-quality, efficient health care as modeling the best practices that the new health care reform law will put into effect. She said that although the law focuses primarily on giving people better access to health care, providing high quality-care at a low cost is also important.

Among the topics Secretary Sebelius discussed in La Crosse were the need for preventative care, moving to electronic patient records, closing the Medicare Part D coverage gap (doughnut hole) and "cracking down on fraud stealing billions of dollars out of the systems."

I received a last-minute invitation to attend the event along with SMP volunteers. Despite the late notice, five volunteers from the La Crosse area were able to join me at the meeting. It was a wonderful opportunity. These are people who were already interested, motivated and passionate about health care fraud, but it was great for them to see that passion reflected by someone at the Secretary's level.

When the panelists asked if anyone had a question, I personally stood up to thank all of the panelists for their hard work and dedication and mentioned that the Elder Law Center of the Coalition of Wisconsin Aging Groups has had a Senior Medicare Patrol project since 1997.

Gov. Doyle said that the health care reform law will mean 125,000 more Wisconsin residents will have access to health insurance, and taxpayers will save $745 million in the first 8 years.

Politically, health care reform is still controversial, but Secretary Sebelius commented, "The bill passed. It is the law of the land and I think our challenge is now to make sure we implement as quickly and as efficiently as possible, letting people know what their benefits are going to be and what kinds of things are going to happen."

Video

A video news article on the event can be found here: http://www.fox2548.com/dpp/news/metro/WLAX_NEWS_20100604

You Don't Always Have To Be South Dakota Nice!


Melissa Wood

By Melissa Wood

Program Director, West River, East River Legal Services (SD)

Working with Medicare beneficiaries is a pleasure in the state of South Dakota. The seniors of this state are very caring, polite and respectful. They come from a generation that pays a bill the day it comes in the mail and know what it means to put in a hard day's work with no complaints. They trust and respect their physicians and rarely question their doc's advice or services.

My peers and I have started referring to this behavior as "South Dakota Nice." As strange as it sounds, it's made my job of preventing Medicare fraud, waste and abuse a lot more challenging.

Our "South Dakota Nice" attitude keeps Medicare beneficiaries on the phone too long, thinking they should not ask too many questions and not question the answers given because that might seem rude. They don't want to be rude and certainly don't want to hang up the phone on someone.

My advice of hanging the phone up or closing the front door on a sales pitch hasn't gone over well. We at the South Dakota SMP have been adapting our approach for a few years and are starting to get the message across to say no, but in a more comfortable way. I recommend that my clients ask for the information in writing if they are uncomfortable hanging the phone up. I also recommend that they NOT give out their address and NEVER give out any other personal information; rather, that the caller probably already has this information.

Saying no gets much harder for my clients when a salesperson comes to their home. The reason it is so tough is that the seniors are such good people! They want to help anyone they can. They want to help the kind person in their living room earn an income for his family.

Many times this trusting nature makes people believe what a nice, clean-cut sales person is telling them – even if common sense says it sounds too good to be true. My challenge is making my clients understand that it is OK to just say NO.

When I do home visits I often leave with a great feeling of how sweet my client was, but also with a feeling of worry because people are so trusting. Many of my clients tell me their life story, pull out photo albums and proudly show me pictures of their children, grandchildren and great-grandchildren. They are more than willing to show me any information I request in order to help resolve their problems.

I am constantly reminding clients not to give their personal information to just anyone. I encourage them to have a family member with them when they are listening to a sales pitch. I also recommend that they not make a decision the day of the meeting with an insurance agent or salesperson, but, rather, wait a few days and think about it. This gives people time to read over all materials and weigh the pros and cons with no pressure to be "South Dakota Nice." It is a more graceful way out of the situation. Most times this works and makes it easier for the senior to turn down the sales pitch.

Hawaii SMP Volunteer Honored

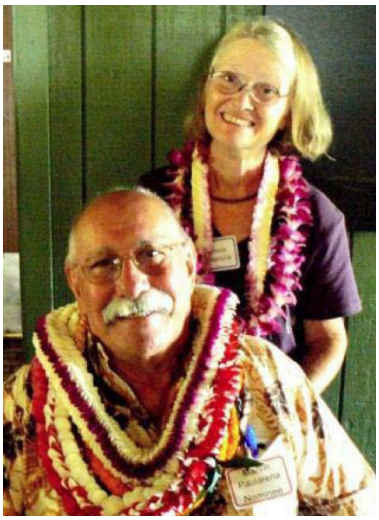

Adele Ching

By Adele Ching

SMP Coordinator, Hawaii Executive Office on Aging

On May 20, the state of Hawaii celebrated Older Americans Month with a ceremony and luncheon in Honolulu to honor eight Outstanding Older Americans. The awards ceremony took place at Washington Place, the historic residence of the Hawaiian Kingdom's last reigning monarch. Gov. Linda Lingle proclaimed May as Older Americans Month in Hawaii and presented a letter of commendation to each honoree.

I nominated two outstanding SMP volunteers for recognition in their respective counties: Mollie Chang from Honolulu and Marvin Paularena from Maui. "Marv" was bestowed the distinction of being one of the state's eight Outstanding Older Americans. In my nomination, I wrote, " 'Marv' Paularena was 68 years old when he and his wife, Michele, pulled up stakes and moved from Seattle to Hawaii. That might not seem out of the ordinary, but Marv and Michele have physical disabilities." Marv is a wheelchair user because of paralysis that resulted from falling off a Navy ship. Michele has cerebral palsy.


SMP volunteer Marv Paularena and his wife, Michele, pictured here, have persevered through physical disabilities to volunteer many long hours in service of others.

Marv serves as SMP Hawaii's lead volunteer on the island of Maui. He maintains SMP supplies and equipment, sets up the laptop computer and LCD projector for presentations, contacts volunteers who do not have e-mail, staffs the SMP booth at fairs and gives presentations. What Marv does for SMP Hawaii is part of the more than 100 hours a month he and Michele volunteer for eight different organizations. They are truly inspirational examples of the kind of volunteers we have in the Senior Medicare Patrol program.

Fountain of Youth

Giving is a way of life for SMP volunteer

By Maureen Patterson

SMP Resource Center Media Manager

Studies have shown that staying physically and mentally active is key to healthy aging.

No one needs to explain that to Arnold Lear, age 86. He knows from experience.

In 40 years as a licensed physician, his dedication to service included house calls decades after others had stopped making them. When he finally retired from practice at age 70, he wanted to keep active and to continue to help people, so he jumped into volunteering for SHIP and SMP; he has been with SMP since the program began.

He once attended a conference at which volunteers were honored in Washington, D.C., with his wife, who was also an active volunteer. "This one little red-faced lady got up after all the speeches and said, 'I don't understand why everybody is talking about this the way they are. We the volunteers should be thanking you for the opportunity to do things because it keeps us young and active and going. We're the ones that should be grateful,'" he says. "I stopped to talk with the lady afterwards. I found out she was 85."

Lear has a thorough understanding of Medicare. He was an internist and hematologist before the program began. He'd make house calls to the elderly and others who couldn't get out. Sometimes they couldn't pay. Sometimes they'd give him a dollar or two. "When Medicare came into being in '65 those people were suddenly paying me for my services," he says. He continued to make house calls until he retired. He is also a professor emeritus of medicine at George Washington University School of Medicine in Washington, D.C.

He works out of the SHIP/SMP office in Montgomery County, MD, occasionally giving speeches at senior centers. He was a volunteer for 3 years but has been a paid part-time staff member the last 12 years – he calls himself a "paid volunteer."

His experience in medicine comes in handy. Colleagues approach him with questions about drugs and disease processes. When clients sometimes assume he doesn't understand their condition, such as high cholesterol, his knowledge of the subject makes him feel like a friend. When clients send him their drug lists, he sometimes catches potentially dangerous drug interactions. "I indirectly alert the client and say, 'This is your drug list but I think you ought to check with your doctors about x, y, z because these may be duplications,'" he says.

Lear also finds duplications and other errors on hospital bills. When his wife was hospitalized years ago he found $8,000 of inappropriate charges that were mostly due to bookkeeping mistakes. Clients sometimes bring in their itemized bills for the same type of scrutiny.

Leta Blank, program coordinator for SHIP and SMP of Montgomery County, doesn't promote the fact that Lear is a retired physician because she doesn't want clients to call and ask medical questions. She does, however, note that his skills are convenient. "He's very thorough, he reads everything, he's very intelligent and wonderful with peo-

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Fountain of Youth *(continued from page 6)*

ple. He brings that unique ability that he can decipher some of the bills and some of the issues that someone without a medical background has more difficulty doing," she says.

When giving presentations, Lear talks about health issues, emphasizing personal responsibility. He says, "Do your exercises and do all the basic health-protecting things. Then, when you do have to go see a doctor, be your own ombudsman and make sure you track what is done, keep a record and understand what your drugs are for, how to take them. Don't go to three different doctors and get three prescriptions with three drugs that have different names but do the same thing. You've got to be responsible for yourself."

As with most people in SMP, he sees a lot of scams. One that he notes is a laboratory whose workers purposely miscoded tests so Medicare wouldn't cover them; patients would have to pay the full retail cost and the lab would receive much more money than the reduced price Medicare would pay.

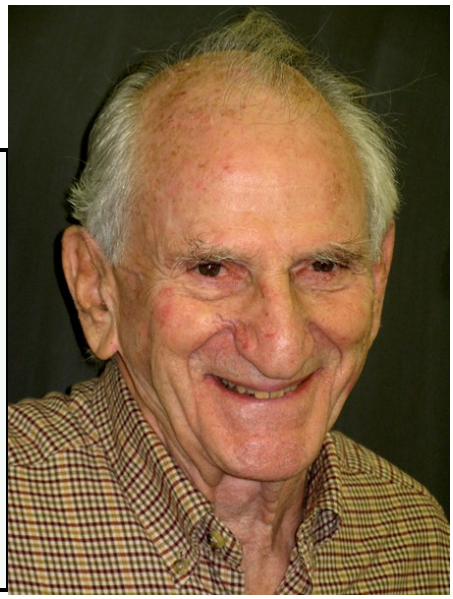
Another scam is when workers go to senior citizen housing complexes and give "free" individual presentations about nutrition to residents. They need the Medicare number, of course, supposedly to document that the worker was there. Later, Medicare is billed for nutritional supplements. They work a housing development for a couple months before moving to another state.

Whatever the latest scam, you can be assured that Arnold Lear will be on top of it. He reads prolifically and stays engaged. He sounds 20 years younger than his age on the phone – part voice, part wit, part personality.

He's never lost his love of helping others. What's the most rewarding part of his work? "The occasional phone call where some frail elderly soul calls and says, 'I've spent the last 3 months trying to get this bill straightened out and they're threatening to turn me over for collection. I don't know what to do and I've always been a good guy,' he says. "Three hours on the phone I can straighten it out. I get a call back saying, 'I slept last night for the first time in 3 months.'" ⬢

Why Should They Care?

If Medicare pays incorrect bills, why should beneficiaries care? It doesn't affect them, right? "They should care because it's their tax dollars that are going away," says paid SMP volunteer Arnold Lear. "Don't complain about the government being bad if you're not responsible yourself. This whole business depends on the doctor, the hospital, the patient, the laboratory, the drug company. Everybody has to be aware of what's going on and contribute to doing the right thing. Patients are included in that."



Arnold Lear

Q & A: Volunteer Risk and Program Management

At the 2009 national conference, AoA Director of Elder Rights Barbara Dieker introduced a 3-year program, now called the Volunteer Risk and Program Management Project. Linda Graff, president of Linda Graff and Associates, spoke about trends in volunteerism. A story on the project ran in the February edition of The Sentinel*, beginning on page 3:* http://www.smpresource.org/Content/NavigationMenu/Media/The_Sentinel_(February2010).pdf*. Here, consultants Linda Graff (**LG**) and Steve McCurley (**SM**) give background on risk management and an update on the project.*

How has the role of the volunteer changed in the last decade?

LG: That's a good place to start this discussion because risk management relating to volunteering has as a lot to do with the evolution of volunteering and its coordination.

The important transitions that have lead to the more recent attention to risk management have been in progress for a couple decades at least. If we went back 30 or so years, volunteerism would look quite different. Volunteers tended to be confined to more menial work: stuffing envelopes and working behind the scenes. In the 1970s and 1980s, many nonprofit and other public, health and community-service organizations began to recognize that volunteers – everyday people – have a wealth of talents, skills and experience, that they can be trusted with important and confidential information and can be relied upon for high-quality work. The notion of "they're just volunteers," connoting only low-level workers doing unimportant work, eroded as volunteers were increasingly invited to move onto the front lines of service provision.

We are now seeing volunteers take on highly skilled tasks, a trend I think will continue as Baby Boomers seek out volunteer opportunities in which they can apply their considerable expertise and influence.

More often than not, volunteer work is now important, complex, sophisticated, "real" work. In many organizations one would be hard-pressed to distinguish the work of paid staff from the work of volunteers. "Volunteering" increasingly refers to the pay scale, not to the nature or importance of the work or of the person performing it.

You mentioned that volunteer coordination has also changed in this time.

LG: Yes, that's certainly true. When organizations were asking volunteers to do routine, low-level work, the coordination of those efforts was fairly straightforward. Lining up a few folks to show up at a designated time to complete a task was no big deal. Now, when you're asking volunteers to offer what amounts to professional-level services, such as representing the organization, delivering presentations to the public and providing critical information about health care fraud and abuse to vulnerable beneficiaries (and gaining access to confidential information along the way), the organization and coordination of that kind of work is, itself, increasingly complex and demanding. It takes considerable specialized knowledge and skills to do this work well.

For example, screening becomes a terribly important volunteer program function when you

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Volunteer Risk, Program Management *(continued from page 8)*

ask volunteers to undertake demanding, highly skilled work or fulfill positions of trust.

Positions of trust?

SM: That is a term we use to denote positions that involve one or more of three things: unsupervised access to vulnerable people; access to private, privileged or confidential information; and/or access to money or other valuables such as property or artifacts. These days we need to also think about access to data and identity.

Millions of volunteers are occupying positions of trust in hundreds of thousands of organizations across the country, and now, really, worldwide. It is critical to ensure that the right people are in the right positions. While screening connotes the need to ensure that inappropriate or potentially harmful people are not accepted into positions from which they can do harm, it is equally important that the people we place in important roles have the skills, ability and willingness to do the work that will be expected of them.

LG: But it isn't just screening. Getting the right people in the right jobs is just the beginning. Ensuring that our screening decisions were correct is an ongoing function. Because the work that volunteers do is so important, it is critical that organizations ensure that volunteers meet the required standards, are reliable and dependable and generate intended outcomes. That means that volunteers in important roles like those at SMPs need to be monitored, supported and guided. Recognition of work well done is critical, but so too is corrective action if a volunteer is not doing a good job. Some people will think that's a tough approach to volunteer management, but it's absolutely necessary when volunteers are doing important work. With SMPs, the work of volunteers is *extraordinarily* important. Mistakes can have a negative impact on beneficiaries, the SMP organization and others in the community. Don't get me wrong: It's not that we don't trust volunteers! It's that the work they do is so important that we absolutely must oversee that work closely.

How are organizations adjusting?

SM: It means recognizing that engaging volunteers effectively requires specific knowledge and skills. Even experienced managers of paid employees do not necessarily have the specialized expertise needed to engage, coordinate and support volunteers. The most obvious, and logical, adjustment is allocating more time to paying attention to what volunteers are doing and how they are doing it. This typically means having a designated manager for the volunteering effort who pays attention to areas such as screening and appropriate training; it may also mean making sure that all staff who work with or supervise volunteers are also trained in carrying out their responsibilities.

If you look at some of the more effective volunteer programs, such as Court Appointed Special Advocates, you will see as much attention paid to ensuring that staff are capable of

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Volunteer Risk, Program Management *(continued from page 9)*

supervising and supporting volunteers effectively as you will see in ensuring that volunteers are capable of performing their own roles. It is truly becoming a "partnership" and neither paid staff nor volunteers can succeed without the other.

You will also see in other progressive volunteer organizations such as Big Brothers/Big Sisters much greater attention to the interviewing and screening of prospective volunteers to ensure that you've got the right people to begin with, and careful, ongoing follow-up with volunteers to ensure that their work is meeting program objectives.

Is there a link between program management and risk management?

LG: The two are integrally entwined. In truth, a well-organized and well-managed volunteer program is a program in which many, if not most, risks will be well-managed.

Can you explain?

LG: Sure. When an organization is thoughtful about the work that will be assigned to volunteers and when it develops positions that are well-planned and appropriate for volunteer involvement, the chances of success are better, and by implication, the chances of failure or harm are less. Thorough screening (and by that I mean not too much *as well as* not too little) helps to place the right people in the right job, resulting in quality services and less chance that things will go wrong. Well-trained volunteers will perform to a higher standard and make fewer mistakes. When volunteers are well-supervised and well-supported, the organization not only provides quality programming but also can intervene sooner and help volunteers perform best.

Showing appreciation of work well done means more than just a certificate or a once-a-year reception. It means regularly noticing the work of volunteers, recognizing efforts and achievements, saying thanks in a genuine, heartfelt, personal, day-to-day way. That's not just good management. It produces more satisfied volunteers who feel productive and motivated to their best. It helps to reduce potentially harmful errors.

SM: The point is that good volunteer program management goes a long way to reducing and managing risks related to volunteer involvement. If volunteers are performing low-level or less-important work, then the management of their efforts is similarly less demanding. But when volunteers, like our SMP volunteers, are doing complex, responsible work, their efforts deserve good and careful management. To do less is to disrespect volunteers, their efforts and contributions. As the trends Linda mentioned continue and we involve more volunteers with higher skills and higher expectations, the need for volunteer management to improve will continue. The rule of the future will be "skilled volunteers require skilled management."

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Volunteer Risk, Program Management *(continued from page 10)*

Why is this an important topic for SMPs to address at this time?

LG: There is never a wrong time to ensure that programs are well run and services are of the highest quality. But right now, with escalating attention to health care fraud and abuse, SMP is evolving into a program with further reach. More attention and higher funding are putting SMPs in the public eye. It is likely that higher expectations will accompany both the attention and the resources.

SM: It is amazing how many programs don't address this issue until after there is a disaster or a scandal. Not to press the point too far, but the more responsible the work that volunteers do, the more they connect directly with "clients," the greater the likelihood that something of significant consequence will go wrong. I think it's commendable that SMP has decided to address this in a preventative fashion and can thus avoid the knee-jerk approach that usually follows the catastrophe. With SMP we'll be able to incrementally introduce improvements and build program infrastructure, making it a lot easier on everyone.

You've both mentioned "infrastructure." What is that?

LG: It is all of the volunteer program management functions and systems – communication, evaluation, accountability, policies, procedures, standards – that we have been talking about. That includes conscious and deliberate attention to risks involved in delivering SMP programs: risks to beneficiaries, risks to volunteers, risks to the SMP organizations. Risk management has become an integral function in volunteer programs today and I would suggest it has never been more important in the SMP system.

What is the progress of the SMP risk management project?

LG: We have been taking an orderly, systematic approach to risk management in the Volunteer Risk and Program Management Project. We have identified a range of risks related to the SMP volunteer work. We have developed an inventory of risks (and the list is fairly lengthy, reflecting, again, the importance of the work SMP volunteers do and the degree of access they are granted in the course of their work). We have carefully prioritized those risks, taking into consideration the likelihood of occurrence and magnitude of harm of each.

SM: Right now we are looking at a range of strategies that *could be* implemented to reduce and control each risk. We have made no decisions – that will begin to happen in the fall – but it is likely that many risk control strategies will take the form of policies, procedures, standards, guidelines and recommended (but not necessarily mandatory) exemplary practices in volunteer program management. We had planned to make some risk control decisions early this summer, but we then had the opportunity to attend the regional conferences. Because that will allow us to talk directly to SMP staff from across the whole system, and more importantly, the opportunity for SMPs to share directly with us the risks they experience and their ideas about potential solutions, we decided to hold off our decision making.

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Volunteer Risk, Program Management *(continued from page 11)*

LG: Another development is that we have expanded the membership of the steering committee that is advising AoA on this project. We're pleased to have more input, again, from SMPs. We've also created a review team, which is a collection of six SMP representatives who have agreed to work with us over the winter of 2010 and spring of 2011, reviewing and providing feedback on proposed risk control strategies and draft products (policies, procedures, and so on). As Steve said to me when we first started this project, we've been working way too long in this field to want to produce a bunch of products that won't be helpful or adopted. We're trying to be practical by looking for realistic, doable ways that SMPs can make their programs both more effective and safer.

Center Compiling SMP-reported Scams, Success Stories for AoA and HHS

Ginny Paulson

SMP Resource Center Director

The list of prominent persons wanting to hear from AoA's health care fraud "eyes and ears" (SMPs) and Medicare's "boots on the ground" (SMP volunteers) has been quite long this past year, ranging from the media (the Associated Press, *The Wall Street Journal*, *AARP Bulletin*, CNN, *Time* magazine) to appointed officials (Secretary Sebelius, Assistant Secretary Greenlee) to federal agency partners (the Centers for Medicare & Medicaid Services, the Federal Trade Commission). As you know, this has resulted in many communications from The Center out to the SMP network, most of them from Maureen Patterson, our media manager.

Because of the frequent requests for SMP stories and anecdotes, it has become necessary for us to develop procedures. In addition to helping us be efficient, we also must ensure that no sensitive information is leaked or shared inappropriately. During the July mentor call, we explained that Maureen is supplying a weekly scams compilation list to AoA. This compilation is not meant to replace or duplicate your reporting of complex issues in SMART FACTS. Instead, it's a way for us to collect and categorize the more informal reporting of scams and fraud within our network so that we and AoA can quickly respond to requests from HHS speechwriters, the media and others.

The primary scope is scams and fraud described in the monthly mentor calls, shared on the SMP listserv and reported in the news media. The names of individual victims, perpetrators and com-

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Center Compiling Scams, Successes *(continued from page 12)*

panies are removed from the compilation. Instead, the contact information for the SMP reporting the scam is provided so that further inquiries can be made to the SMP directly. On the same note, The Center does not forward e-mails that contain any sensitive information, such as the names of individuals, perpetrators or companies, unless that information is already published in the media or some form of public record in relation to a specific scam or fraud.

Another way that we have collected information necessary for AoA and HHS is through the recent "SMP Success Stories" survey. The survey was very effective, so we intend to recirculate it periodically.

I realize that completing surveys and responding to our requests takes time. The time you spend, however, pays off. Here are some examples of ways your sharing of scams and successes has been used nationally:

- The Associated Press featured SMP in late December 2009, including an interview with a Texas beneficiary. The article was published by ABC and many news outlets across the country.
- The AARP Bulletin featured an Iowa SMP volunteer in April 2010.
- The ObamaCare scam, first reported by the Missouri SMP, was referenced in many health care reform webcasts, speeches, press releases and news articles. Subsequent reports from other states were later included.
- Health care reform-related scams reported from Kansas, Michigan, Utah and Wyoming were posted to the federal government's website dedicated to health care reform (www.HealthReform.gov, which has since been changed to www.HealthCare.gov).
- Secretary Kathleen Sebelius used information provided by SMPs to prepare her speech at the 2009 SMP National Conference and in several subsequent speeches related to health care reform, including President Obama's June 8, 2010, town hall meeting, which was webcast live.
- Secretary Sebelius invited a Delaware SMP volunteer to speak at a press conference in October 2009 after reviewing her profile in the volunteer awards booklet from the 2009 national conference.
- Assistant Secretary for Aging Kathy Greenlee referenced both scams and success stories reported by the Iowa, Michigan, Missouri and North Carolina SMPs in her presentation at the July 16, 2010, health care fraud summit in Florida, which was webcast live.
- SMP success stories were reviewed by AoA leadership in preparation for their 2010 SMP regional meeting speeches.
- Scams compilations and SMP success stories will be used to prepare leadership at HHS for the remaining six health care fraud summits in 2010, all of which will be webcast live like the Florida summit.

Though we all certainly need to be vigilant about confidentiality, if handled appropriately, SMPs' unique relationship with beneficiaries can provide valuable insights for government leaders, the media and the general public. Real-life examples, shared respectfully and with permission by SMPs, make the subject of health care fraud – how it works, how it impacts individuals and how it can be prevented – something people can understand, care about and do something about.

Massachusetts SMP Program Conference


Lucilia Prates

By Lucilia Prates

SMP Director, Elder Services of the Merrimack Valley Inc. (MA)

The Massachusetts SMP program held the first-ever SMP statewide conference on May 21 in Taunton. Keynoted by AoA's Barbara Dieker, the conference broadened the visibility of the SMP program and created momentum among service providers to encourage health care consumers, in particular Medicare and Medicaid beneficiaries, to become actively engaged in their health care and to gain a better understanding of the critical role we each have in preventing health care errors, fraud and abuse. These cost billions of dollars annually.

I opened the conference by welcoming all conference participants, presenters and esteemed guests. The Secretary of the Executive Office of Elder Affairs, Ann Hartstein, greeted those in attendance and recognized the MA SMP program's valuable contribution in building the linguistic and cultural capacity of the state's SHINE (Serving Health Information Needs of Elders) program through SMP/SHINE partnerships across the Commonwealth.

Sen. Marc R. Pacheco, a native of Taunton, member of the Senate Ways and Means Committee and Vice Chair of the Committee on Health Care Financing, greeted participants and conference presenters and acknowledged the SMP program's efforts and its important mission of educating consumers about becoming engaged and protecting, detecting and reporting health care fraud. Sen. Pacheco also offered anecdotal highlights of elder constituents who contact his office for assistance in navigating their health benefits and who are often at risk of being targets of deceptive marketing tactics.

In the spirit of partnership, the Centers for Medicare & Medicaid Services (CMS) also collaborated with the SMP program by convening the SafetyNetworking Group on the same date and same location as the statewide conference. This collaborative approach and shared venue by the SMP program and CMS facilitated CMS' outreach to service providers from the aging services delivery network and advanced the SMP program's visibility to members of the SafetyNetworking Group, leveraging future collaborations with the following diverse federal agencies: U.S. Department of Agriculture; Food and Nutrition Services; Federal Deposit Insurance Corporation; U.S. Department of Health & Human Services; U.S. Administration on Aging; Administration for Children & Families; U.S. Department of Housing and Urban Development; Internal Revenue Service; Small Business Administration; U.S. Department of Labor; Employment & Training Administration; Small Business Administration; and the Social Security Administration.

Fifteen different workshops were offered at this conference. There were three different workshop sessions with five workshops taking place concurrently in each session. One of the five workshops offered in each of the sessions was the SMP program message: Empowering Seniors to Prevent Health Care Errors, Fraud and Abuse. The other workshops addressed the following topics:

- Protecting Against Scams, Deceptive Marketing Tactics and Financial Exploitation

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- Reaching and Working with Culturally Diverse Communities
- The Impact of Health Reform on Elders
- Medication Reconciliation
- End of Life Care Choices and Decision Making
- Electronic Medical Records

Each of these workshops took place in breakout rooms off the foyer where the SafetyNetwoking Group displayed information regarding its programs and distributed promotional items. At the conclusion of the third session of workshops, conference participants,
presenters and other guests came together for a networking luncheon and the keynote address.

Rosanne DiStefano, executive director of Elder Service of the Merrimack Valley, the lead organization of the MA SMP statewide collaboration, spoke of the program's evolution during the last 10 years and how it has increased its linguistic and cultural capacity to serve 19 different language groups. She introduced the conference's keynote speaker, Barbara Dieker, director of the Office of Elder Rights, U.S. Administration on Aging, Washington, D.C.

Barbara Dieker spoke of the important work of the SMP programs across the country. She informed conference attendees that the current administration is committed to intensify efforts to protect Medicare and Medicaid for future generations and to stop the errors, fraud and abuse in the health care system that contribute to the waste of billions of dollars each year. She publicly recognized the Massachusetts SMP program as a national model for its innovative approaches in fostering collaborations between mainstream entities and community-based grassroots organizations that serve limited English proficient (LEP) and other vulnerable, hard-to-reach populations.

Left to Right: Lucilia Prates, MA SMP, Terrie Drew, MA SMP, Barbara Dieker, AoA, and Pat Sadre, MA SMP, at the conference

Immediately following the keynote address, Health Care For All's health quality program manager, Deborah Wachenheim, and

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Linda Klein, a member of the consumer health quality council (CHQC) made a presentation on the mission and ongoing efforts of the CHQC, of which I am a founding member. This presentation made the connection between the financial cost of health care errors and the human cost.

Health care errors cost billions of dollars annually, but, most importantly, they can cost you your life or the life of a loved one! I know this only too well. As the director of the MA SMP program, educating consumers on the prevention of health care errors, fraud and abuse, I could not help my father, who died as a result of a series of health care errors and a fragmented delivery system.

At the end of the program conference I asked attendees to pull out the salmon-colored paper from their folders and to commit to one or more of the following:

- Host and/or organize an SMP informational session
- Host and/or organize an SMP program presentation
- Become an SMP volunteer
- Assist with the dissemination of SMP program materials

This "Call to Action" approach proved to be successful in raising awareness among providers about the important role we each have in promoting consumer engagement. Since the conference, the number of the SMP educational sessions and SMP program presentations has already significantly increased. Interest in volunteer opportunities has also heightened.

I thanked all those who attended, collaborated in the planning and implementation and/or presented at the first-ever statewide SMP Program Conference. I expressed particular gratitude to the SMP program counselors and volunteers because they are an essential linchpin to the success of this program. I said, "Without you this work cannot be done!"

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Some articles, already broken out individually in a PDF format, can be found at: http://www.smpresource.org/Content/NavigationMenu/ResourcesforSMPs/Newsletter/Newsletters/default.htm

In Their Shoes


Vicki Weld

Knowing the immigrant experience makes SMPs better able to serve

Editor's Note: *For more than 20 years, Vicki Weld has supervised building projects, advocacy projects and training and service delivery projects, mostly abroad. With a relief and development background, she served for many years as a disaster response coordinator, most recently with Medical Teams International, in a variety of cultures in places such as Afghanistan, Kosovo, Sri Lanka and India.*

By Vicki Weld

SMP Project Director, Dept. of Human Services-Seniors & People with Disabilities (OR)

Acculturation occurs any time people take on behaviors, viewpoints or values after interfacing with others from a different country or regions of the same country that they either wouldn't have taken on in their culture of birth or wouldn't have adopted as deeply.

For instance, here in the States, we are generally known as a time-oriented culture. We schedule our events so that they don't overlap yet we also maintain some flexibility. When I lived in Germany, however, where the time orientation is even stronger, I had to increase my time orientation to participate in community life. There wasn't as much flexibility as I was used to in the United States.

Conversely, when I lived in the South Pacific, we were on "island time." Events occurred once everyone showed up. Weddings, birthdays and other occasions regularly started 3 hours later than planned. I would show up on time just in case but would always carry something to occupy myself until the fun truly began. I wasn't going to change anything by stressing over something beyond my control. I adapted. That's acculturation.

Immigrant populations can be difficult to reach not because they refuse to assimilate, but because assimilation into a new culture is just plain hard. Anthropologist Marv Mayers, PhD, asserts that it takes a minimum of 8 years for an individual to fully assimilate into a different culture, and that's only if the person is completely immersed, spending significant amounts of time outside of his or her cultural enclave.

Put yourself in the shoes of a new immigrant. In your birth country, you are a fully functioning adult, possibly also a well-respected community leader. Then you come to a new country, only to find yourself relegated to the same status as a child. All your years of training, your civic reputation, your previous skills useless. To navigate your life you must rely on the kindness of strangers and hope that you can either speak enough language to cover basics or your skills in pantomime shoot up exponentially.

You find every nerve rubbed raw. You try to carry your pack of frustrations in a gracious manner only to be undone by something as simple as trying to switch on a light. (Did you know that it's not a universal principal that UP = ON for light switches? Ever know anyone who has ever cried about it? You do now.)

Many immigrants do not fully acculturate, often due to adverse experiences suffered within their adopted country. In addition, they may receive a

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"Learn English!" command from the host country, sparking fear and humiliation that can paralyze them.

There are four distinct mile markers along the acculturation highway — signposts that break up the journey, inform us of our progress and signal that one is close to arrival. These come from Kalervo Oberg, PhD.

Honeymoon Phase

This is the exciting period where the sights, sounds, tastes and smells of the new culture bring a rush of fascination to the individual. New observations and discoveries abound.

Negotiation Phase

Cultural differences begin to dampen that honeymoon glow. Things don't seem so fascinating, just irritating. Immigrants don't know why they feel so out of sorts – so frustrated, so angry. Focus centers on behaviors, particularly those deemed intolerable. Tension builds and even minor incidents seem major. Depression often occurs.

This is the phase where many immigrants stop making progress on their journey. The negativity they feel from the culture and fear they feel within drive them to tunnel under and set up their own little culture within a culture. Rejection is their mechanism for coping. They stop negotiating with the host culture because they feel so hopeless.

Adjustment Phase

Those who keep moving forward do eventually make it to a place where they establish routines and garner enough linguistic skills to feel more in control of their lives. Things begin to normalize and problem-solving skills emerge. The culture starts to make sense and the values beneath the surface of behavior are more evident. Acceptance begins.

Mastery Phase

Also known as biculturalism, this phase begins when immigrants behave, think and feel like those in their host countries. They feel as at home in their adopted culture as in their culture of origin, regardless of whether or not they decide to maintain certain values or actions from their mother country. Upon re-entry to one's mother country, a bicultured person actually feels homesick for the adopted culture (reverse culture shock).

The mastery phase alone is not acculturation. Acculturation is the process that's been occurring throughout each phase.

How does that relate to SMP work?

SMP and SHIP/SHIBA folks have heart. They show compassion for seniors and society's most vulnerable. That compassion is needed with hard-to-reach populations. Imagine how disheartened and isolated people in culture shock feel. Often, they have no idea why they feel so terrible or why the bottom dropped out of their world. If they are of refugee status, they may also have a disability or post-traumatic stress disorder (PTSD).

I have a dear friend whose PTSD marred her first few years here in the United States. Every time she heard a helicopter, Marg couldn't help but take

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cover. Marg had lived and worked on the Thai-Cambodian border. She knew the terror of Pol Pot's regime and the spray of gunfire from a random helicopter. It took time for her to feel safe in her own body, let alone a new country.

My purpose in sharing all this is simply to remind us what we already know: to reach out with empathy and humility, to try to place ourselves in the shoes of another and realize that as we combat fraud, we can encourage people to continue in their journeys of acculturation. The more positive interface immigrants have with their adopted countrymen and women, the more encouraged they are to step outside their comfort zones. The more positive interfaces they have with representatives of their adopted government (like those who serve with SMP), the more open and transparent they become. We actually can do quite a lot more than empower seniors with tools to shield them from fraud and abuse. We can empower immigrant seniors to step out into the lifeblood of their communities simply by being kind.

Though it takes more effort and creativity on our part, outreach to the numerous communities of immigrants is also an opportunity to be a bridge – not only to knowing Medicare, but also a bridge for some of these folks to finally come home.

Medical Identity Theft Can Harm You

By Bill Benson and Nancy Aldrich

Health Benefits ABCs

Medical identity theft is a form of Medicare fraud. It occurs when someone steals personal medical information, such as a name and Medicare number, and uses the information to obtain medical care, to buy drugs or supplies or to fraudulently bill Medicare using that patient's stolen identity, according to the U.S. Department of Health & Human Services (HHS).

Such identity theft can affect your medical and health insurance records, according to the Federal Trade Commission (FTC). Every time a thief uses your identity to get care, a record is created with the imposter's medical information that could be mistaken for your medical information. That information might include a different blood type, an inaccurate history of drug or alcohol abuse, test results that aren't yours or a diagnosis of an illness, allergy or condition you don't have. Any of these could lead to improper treatment which, in turn, could lead to injury, illness or worse, the FTC warns.

"Medical identity theft can disrupt your life, damage your credit rating and threaten your health if inaccurate information ends up in your medical records," HHS Inspector General Daniel R. Levinson explained in October 2009 when the Obama administration announced its new anti-fraud effort for the Medicare program. The Office of Inspector General's special agents frequently uncover fraud schemes that involve the sale and use of stolen Medicare identification numbers, Levinson added.

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Medical ID Theft *(continued from page 19)*

How does identity theft occur?

Identity thieves use various methods to obtain information, such as personal data obtained from stolen wallets, mail or trash; personal information obtained by pretending to be a representative from a credible company; or information stolen from a data storage device.

Fraudsters also may convince a Medicare beneficiary or Medicare provider that there is a legitimate reason to disclose a Medicare or Social Security number.

In addition, individuals may "sell" their Medicare number by providing it to an unauthorized person in exchange for gifts or cash.

How do people learn they are victims of identity theft?

According to the FTC, warning signs that you may be a victim of medical identity theft include:

- You get a bill for medical services you didn't receive.
- A debt collector contacts you about medical debt you don't owe.
- You order a copy of your credit report and see medical collection notices you don't recognize.
- You try to make a legitimate insurance claim and your health plan says you've reached your limit on benefits.
- You are denied insurance because your medical records show a condition you don't have.

What can beneficiaries do to avoid having their ID stolen?

- Protect your Medicare and other health insurance cards in the same way you would protect a credit card.
- Only give personal information to Medicare-approved doctors, other providers and suppliers; your State Health Insurance Assistance Program or SMP program; or Social Security. Call 1-800-MEDICARE (1-800-633-4227) if you aren't sure if a provider is approved by Medicare; TTY users should call 1-877-486-2048.
- Don't give your Medicare number to anyone who calls you, e-mails you or comes to your door, regardless of who they say they are. Medical identity thieves may pose as employees of insurance companies, doctors' offices, clinics, pharmacies and even government agencies.
- When linking to medical providers online, be sure to check for website security, such as a URL that begins with "https," before providing your medical identity or account number.
- Remember that e-mail is not a secure way of communicating medical identification numbers.
- Beware of offers of free medical equipment, services or goods in exchange for your Medicare number.
- Review your Medicare Summary Notices, Explanations of Benefits statements and medical bills for suspicious charges and report suspected problems.
- Shred papers with your medical identity before putting them in the trash.
- Remove or destroy labels on prescription bottles and packages before you put them in the trash.
- If you find incorrect information in your records, insist that it be corrected or removed.
- Report a lost or stolen Medicare

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Medical ID Theft *(continued from page 20)*

card right away. Call Social Security at 800-772-1213 (TTY: 800-325-0778).

What should you do if you suspect your medical identity has been stolen?

- Check your MSN and call your health care provider to ask about the service or charge in question.
- Ask your health care provider for a copy of your current medical files and report anything suspicious. (Your provider may charge you a fee for reproducing your medical records).
- File a report with your local police department; send copies of the report to your health plan's fraud department, your health care provider(s) and the three nationwide credit reporting companies. Information on how to file a report is at http://www.ftc.gov/idtheft/consumers/defend.html..
- Contact your local Senior Medicare Patrol.
- File a complaint with the Federal Trade Commission: online at https://www.ftccomplaintassistant.gov or by calling 877-ID-THEFT (877-438-4338); TTY: 866-653-4261.
- Write to your health plan or provider detailing the information that seems inaccurate and ask for a correction.
- Ask your health care providers or health plans to reveal any disclosure made of protected health information during the preceding 6 years. The HIPAA Privacy Rule requires health plans, health care clearinghouses and covered health care providers to provide one free accounting per year upon the request of the consumer for information that is not related to treatment, payment and health care operations.
- Place a fraud alert on your credit report maintained by the three nationwide credit report companies (TransUnion, Equifax, Experian).

For More Information

Defend: Recover from Identity Theft

http://www.ftc.gov/bcp/edu/microsites/idtheft/consumers/defend.html

FTC Facts for Consumers: Medical Identity Theft

http://www.ftc.gov/bcp/edu/pubs/consumer/idtheft/idt10.shtm

You Can Help Protect Yourself and Medicare from Fraud Committed by Dishonest Suppliers

http://www.cms.gov/Partnerships/Downloads/BeneFactFraudPrevention11442_508.pdf

Medical Identity Theft and Medicare Fraud

http://www.stopmedicarefraud.gov/fightback_brochure_rev.pdf

Medicaid Fraud: Who You Gonna Call?

By Bill Benson and Nancy Aldrich

Health Benefits ABCs

Almost every state has a Medicaid Fraud Control Unit (MFCU) that investigates and prosecutes Medicaid fraud. Federal law requires each state to have a MFCU to investigate and prosecute Medicaid provider fraud, as well as patient abuse and neglect, in health care programs and home health services that participate in Medicaid. Medicaid is a state-federal health insurance program for qualifying low-income and needy people, including certain older adults.

Most MFCUs are located in state offices of the attorney general, but seven are housed in other state agencies such as law enforcement units, according to the National Association of Medicaid Fraud Control Units (NAMFCU). MFCUs receive most of their referrals for suspected Medicaid fraud from their state Medicaid agency's program integrity or surveillance units. "That is the main source of our referrals," NAMFCU Executive Director Barbara Zelner said. MFCUs also have ongoing relationships with AARP, state ombudsman programs and adult protective services agencies, Zelner added. Some state MFCUs have hotlines for reporting Medicaid fraud, do public outreach and produce brochures.

Unlike the federally operated Medicare program, states hold the primary responsibility to detect and control Medicaid fraud and abuse, according to the U.S. Government Accountability Office (GAO). Only one state, North Dakota, has a waiver from having a MFCU because it demonstrated that there is a minimal amount of Medicaid fraud and that Medicaid beneficiaries are protected from abuse and neglect, according to NAMFCU.

How much Medicaid fraud is there?

According to GAO, there are no estimates of Medicaid fraud. Zelner said she was unaware of anyone who collected data on Medicaid fraud against older adults. GAO estimated in 2003 that a nationwide improper Medicaid payment rate as low as 3 percent would have meant a loss of almost $4.6 billion in federal funds. In that year, Medicaid covered nearly 54 million people, and the program's benefit payments totaled $261 billion, of which the federal share was about $153 billion.

Anti-fraud activities by MFCUs in the last fiscal year amounted to more than $1.3 billion in recoveries, Assistant Attorney General Tony West said at the NAMFCU 2009 Annual Training Program in Louisville, KY.

What is Medicaid fraud?

According to NAMFCU, Medicaid fraud can be perpetrated by individual practitioners, such as submitting claims for services they did not provide, or by large institutions that claim to have provided higher levels of care or more care than was actually provided. Medicaid fraud can also be committed by beneficiaries, although this type of fraud is not within the jurisdiction of the MFCU. It would be a state welfare fraud bureau that would investigate Medicaid fraud by individuals, Zelner explained.

"Fraud in nursing homes can range from cost report fraud (billing for unnecessary medical services or services never provided), to theft of patient trust funds, to theft of patients' private funds whether a credit card, piece of jewelry, cash that is in their room," Zelner said. "Also in the nursing homes, MFCUs can investigate complaints of resi-

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Medicaid Fraud *(continued from page 22)*

dent abuse and neglect," she noted. One of the difficulties for detecting Medicaid fraud is that patients do not receive an Explanation of Benefits like they do under the Medicare program, Zelner added.

GAO reported in 2009 that Medicaid paid for controlled substance prescriptions filled for deceased beneficiaries or "written" by dead doctors. "The extent to which these claims were paid because of fraud is not known," GAO said. That is because, for example, certain nursing homes use long-term care pharmacies to fill prescriptions for drugs and these nursing homes may not notify pharmacies of a resident's death.

A new survey by the National Governors Association and National Association of State Budget Officers indicates that 28 states plan to reduce Medicaid payments in fiscal year 2011 to health care providers. Another 20 states have proposed freezing provider payments, 25 states plan to eliminate or limit benefits, nine states plan to delay expansions and eight states plan to institute new or higher copayments. (The survey is online at http://www.nga.org/Files/pdf/FSS1006.PDF).

To report Medicaid fraud, contact your state MFCU. You can identify a state MFCU by going to http://www.namfcu.net/states. ⬢

Medicaid Fraud Schemes

The following are typical schemes that providers use to defraud the Medicaid program, according to NAMFCU:

- Billing for services not provided - A provider bills for blood tests, x-rays or other services that were not given, or a nursing home continues to bill for services rendered to a patient who is no longer at the facility either because of a death or transfer.
- Double billing - A provider bills both Medicaid and a private insurance company (or recipient) for treatment, or two providers request payment on the same recipient for the same procedure on the same date.
- Billing for phantom visits - A provider falsely bills the Medicaid program for patient visits that never take place.
- Billing for more hours than there are in a day - A provider inflates the amount of time spent with patients; for example a psychiatrist bills for more than 24 hours of psychotherapy treatment on a day.
- Falsifying credentials - Misrepresenting the qualifications of a licensed provider in order to defraud Medicaid. For example, a physician allows a non-physician to impersonate a licensed doctor who medically treats patients and prescribes drugs and then bills the Medicaid program.
- Substitution of generic drugs - A pharmacy bills Medicaid for the cost of a brand-name prescription but actually supplies a generic substitute.
- Billing for unnecessary services or tests - A provider falsifies the diagnosis and symptoms on recipient records and billings to obtain payments for unnecessary laboratory tests or equipment.
- Billing for more expensive procedures than were performed - A provider bills for a comprehensive procedure when only a limited one was administered or bills for expensive equipment but supplies lower-cost substitutes.
- Kickbacks - A nursing home owner or operator requires another provider, such as a laboratory, ambulance company or pharmacy, to pay owner/operator a certain portion of the money received for rendering services to patients in the nursing home. Examples of this type of payment include vacation trips, personal services and merchandise, leased vehicles and cost payments.

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For more information about the National Consumer Protection Technical Resource Center, please visit us at www.smpresource.org.

All newsletter submissions and inquires should be directed to mpatterson@hvaaa.org.

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A Great Time for SMART FACTS Training

By Heather Flory

SMP Resource Center Training Manager

Expanding the capacity of the SMP program, increased media scrutiny of Office of Inspector General (OIG) reporting data and recent changes to the SMART FACTS system and OIG reporting requirements; they all add up to make this is a great time for SMPs to think about SMART FACTS training needs and review available SMART FACTS training resources.

The SMP Resource Center offers many SMART FACTS resources, including a self-paced, online SMART FACTS training curriculum that can be used by both new and experienced SMART FACTS users. SMART FACTS training topics include:

- Getting Started and Simple Inquiries
- Outreach and Education
- Volunteer Tracking and Management
- Reviewing and Editing your Data
- Complex Issues
- Reporting
- Site Administration
- Partnership Development
- Dissemination Activities

The SMART FACTS training curriculum consists of training recordings, job aides, the *SMART FACTS Operations Manual* and supplemental materials. Job aides and recordings are currently being updated to reflect changes in the SMART FACTS system. The entire curriculum can be completed in order, or participants can choose to review any topic(s) as needed. The curriculum is available to anyone who enters or reviews data in SMART FACTS. It allows participants to complete the training at their own pace, on their own schedule, making any time a great time for SMART FACTS training.

The SMART FACTS training curriculum is available on the SMART FACTS Training page of the SMP Resources website (www.smpresource.org). This page can be accessed by clicking Resources for SMPs>SMART FACTS>SMART FACTS Training.