

The background of the top half of the page features a large, light blue, semi-transparent seal of the State of Oregon. The seal is circular and contains an eagle with wings spread, perched on a shield. Below the eagle is a landscape with a sun rising over mountains and a river with a ship. The words "STATE OF OREGON" are written around the top inner edge of the seal, and "1859" is at the bottom. The text of the report is overlaid on this seal.

State of Oregon

Department of Human Services

Aging and People with Disabilities

**Consumer-Employed Provider
Program Needs Immediate Action to
Ensure In-Home Care Consumers
Receive Required Care and Services**

October 2017

Secretary of State
Dennis Richardson

Audits Division, Director
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Report 2017 - 23

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DHS – Aging and People with Disabilities: Consumer-Employed Provider Program Needs Immediate Action to Ensure In-Home Care Consumers Receive Required Care and Services

Report Highlights

The Secretary of State's Audits Division found that the Aging and People with Disabilities (APD) program should take immediate action to address gaps in program design and oversight in order to improve the safety and well-being of participants in the Consumer-Employed Provider (CEP) program.

Background

Oregon is a leader in providing in-home long-term care options for older adults and people with disabilities. The most used in-home care program is the Consumer-Employed Provider program, which positions consumers as employers of their homecare worker.

Purpose

The purpose of this audit was to assess the policies and processes used by APD to ensure the needs of consumers in the CEP program are met.

Key Findings

The effectiveness of the Consumer-Employed Provider program is dependent on the consumer, the case manager, and the homecare worker. If each is capable, competent, and supported in their role, the current model can be successful. Our audit found:

1. Some consumers are not receiving the support necessary to ensure required employer duties are being performed, which adds to case managers' and homecare workers' responsibilities.
2. Case managers are not consistently contacting consumers, or monitoring services consumers receive due to excessive workloads.
3. Agency requirements do not ensure that homecare workers are prepared to provide the care and assistance consumers need.
4. Due to current data collection and utilization practices, it is difficult for APD to determine if consumers are safe and receiving the care and services they need.
5. Current deficiencies in the program may put consumers' health and well-being at risk and keep the program from operating as intended.

To reach our findings, we conducted interviews and case file reviews, collected and analyzed CEP consumer data, and researched federal and state standards.

Recommendations

The report includes recommendations to improve Consumer-Employed Provider program implementation and support. Recommendations include consistently following existing monitoring policies, addressing case managers' excessive workload and responsibilities, and providing more support to consumers and homecare workers.

The Department generally agreed with our findings and recommendations. Its response can be found at the end of the report.



About the Secretary of State Audits Division

The Oregon Constitution provides that the Secretary of State shall be, by virtue of his office, Auditor of Public Accounts. The Audits Division performs this duty. The division reports to the elected Secretary of State and is independent of other agencies within the Executive, Legislative, and Judicial branches of Oregon government. The division has constitutional authority to audit all state officers, agencies, boards, and commissions and oversees audits and financial reporting for local governments.

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We sincerely appreciate the courtesies and cooperation extended by officials and employees of the Department of Human Services, Aging and People with Disabilities program during the course of this audit.



Consumer-Employed Provider Program Needs Immediate Action to Ensure In-Home Care Consumers Receive Required Care and Services

Introduction

APD provides services for people needing long-term care

The older adult population in the United States is increasing at a steady rate. The number of people over age 65 is projected to reach more than 72 million people by 2030, up from 40.2 million in 2010. In comparison, 13.9 percent of Oregon's population was 65 years or older in 2010. By 2030, the percentage is expected to increase to nearly 20 percent, or about 900,000. States, including Oregon, will need to be prepared to support the growing older adult population.

Medicaid is used to help fund long-term services and supports in Oregon

Many older adults and people with disabilities need help with basic daily activities to thrive. Paying for these services over prolonged periods of time can be challenging for many families, whether it's a daughter funding long-term care for an aging parent suffering from dementia or a mother providing care for her adult child with a physical condition caused by a traumatic spinal injury. The cost of care adds up quickly.

Some older adults find that they have outlived their savings to pay for health care. The Oregon Department of Human Services (DHS) uses federal Medicaid and state funds to pay for long-term support services (LTSS) for many individuals who have no other options.

Medicaid is a federal program funded jointly with states, who administer the program. The federal government allows states to be flexible in what Medicaid funded health care services they offer. Since the inception of Medicaid in 1965, Oregon has used Medicaid dollars to fund care for individuals living in nursing facilities (e.g., nursing homes). Recognizing the importance of offering other community-based options, in 1981 Oregon was the first state to apply for and use Medicaid to fund LTSS for

individuals who would otherwise qualify for nursing level treatment but want to receive care in their homes or other community-based settings.¹

In 2013, Oregon expanded its commitment to providing home and community-based care options by taking advantage of the federal Patient Protection and Affordable Care Act, Community First Choice option. Oregon's plan prioritizes an individual's choice and dignity by positioning the consumer as the driver in LTSS service planning. Consumers' preferences are paramount. This is referred to as person-centered planning.

The new plan increased the amount of federal Medicaid dollars for Oregon's LTSS programs. Federal Medicaid funding for in-home services for the 2015-2017 biennium was \$750,547,055 in comparison to \$323,271,398 in state General and Other funds.

APD assists older Oregonians and people with disabilities

DHS administers services to older adults and adults with physical disabilities through its Aging and People with Disabilities (APD) program and several public-private partnerships. The Aging and Disability Resource Connection of Oregon, a public-private partnership, provides information and assistance for individuals navigating options for care. If an individual is deemed likely to be eligible for Medicaid funded services, they are referred for an eligibility assessment (both financial and service needs) and case management. Once referred, local Area Agencies on Aging (AAA)² offices or APD local offices provide direct case management services depending on where the consumer lives (see Figure 1 on next page).

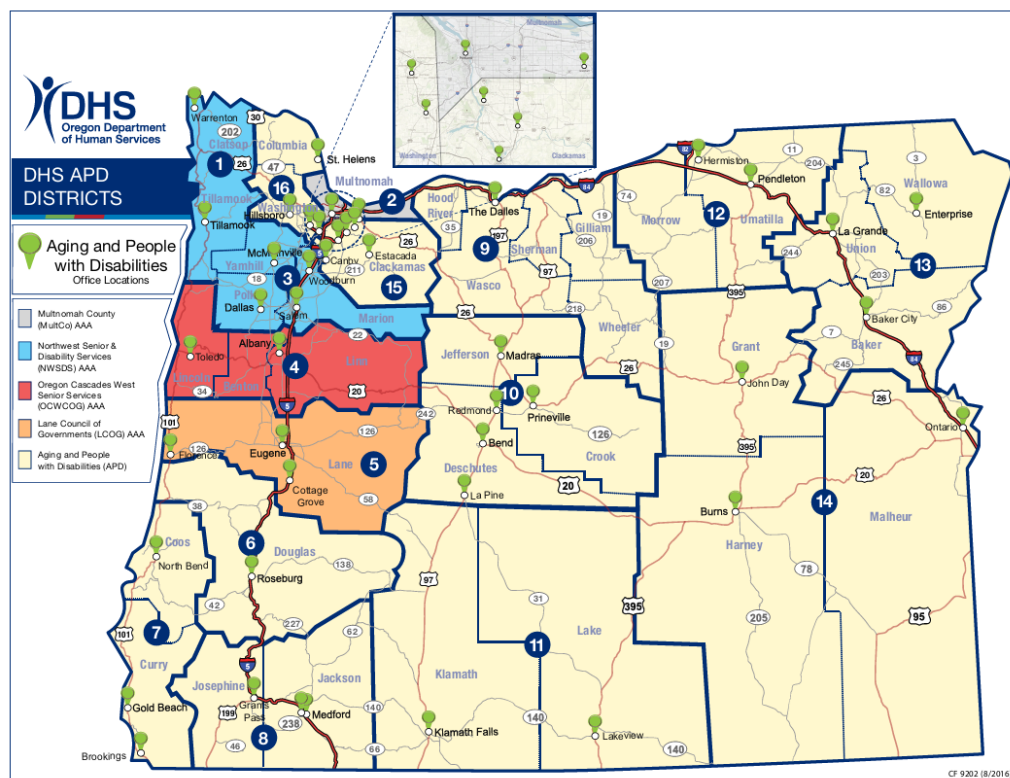
APD Mission:

The Department of Human Services Aging and People with Disabilities (APD) program assists a diverse population of older adults and people with disabilities to achieve well-being through opportunities for community living, employment, family support and long-term services and supports that promote independence, choice and dignity.

¹ Community-based settings include assisted living facilities, residential care facilities, memory care facilities, and adult foster homes.

² Area Agencies on Aging are either community focused non-profit or government entities that the state contracts with to provide services to people above the age of 65 and adults with disabilities in specific locations throughout the state.

Figure 1: DHS Aging and People with Disabilities District Map



Source: DHS Aging and People with Disabilities

APD management, along with program and policy staff located in the Salem central office, set policy and provide program oversight. Their role with AAA offices is otherwise limited. While still receiving state oversight, these offices are allocated case manager Full Time Equivalent (FTE) positions and make their own decisions on how to divide workload and manage the CEP program on a day-to-day basis.

Several other ancillary units within DHS provide support to APD programs. A quality control unit inside APD ensures that case managers are following state and federal guidelines. The Office of Adult Abuse Prevention and Investigation provides policy support, and specialized training and guidance for APD and AAA staff who investigate reports of abuse and neglect of older adults and people with physical disabilities in Oregon.

APD has several legislatively-approved key performance measures (KPM) that relate to the CEP program, including:

- KPM 10, which measures the percentage of seniors (65+) needing publicly-funded long-term care services;

- KPM 11, which measures the percentage of Oregonians accessing publicly-funded long-term care services who are living outside of nursing facilities; and
- KPM 16, which measures the percent of abuse reports assigned for field contact that meet policy timelines.

Consumer-Employed Provider Program Prioritizes Choice

APD offers a range of programs and facilities for individuals' long-term care needs. Of the available programs, in-home care options are the most utilized. They allow consumers to remain in the comfort of their homes while receiving services to meet their basic needs. As of June 2016, 53% of consumers who are eligible for long-term care chose in-home care services.

Options for in-home care services vary according to consumers' level of independence (see Figure 2 below). The following chart shows all in-home programs offered by APD. Of the 18,118 in-home care program participants, 13,230 are enrolled in the CEP program.³

Figure 2: APD In-home care programs descriptions

In-home care program type	Program description
Oregon Project Independence	State-funded program offering in-home services to individuals 60 years and older who have been diagnosed with Alzheimer's and related dementia. Recently expanded to include younger adults with physical disabilities. Consumers pay a sliding scale fee for services. Consumer responsibilities are similar to those in the Medicaid Consumer-Employed Provider program.
Medicaid Consumer-Employed Provider (CEP)	Medicaid and state-funded program. Consumers or their representative are responsible for selecting, hiring, training, and dismissing their homecare worker. Case managers provide ongoing support and monitoring.
In-home care agency	Consumers receive services from a homecare worker provided by a licensed in-home care agency. Case managers provide ongoing support and monitoring.

³ Figures were taken from APD's consumer count for the month of June 2016. For the purposes of this audit we include the consumers receiving in-home hourly paid care and consumers in the spousal pay program.

Medicaid Independent Choices	Consumers receive a cash benefit based on their level of need to pay a homemaker worker of their choosing. Case managers provide support and monitoring.
Medicaid personal care services	Consumers have the benefit of choosing their own homemaker worker. Consumers are limited to 20 hours per month of care. Case managers provide support and monitoring.
Other programs	Medicaid also funds home-delivered meals as well as half-or full day visits in a facility for consumers with functional or cognitive impairments. Additionally, consumers are offered access to emergency response systems that provide another level of security.

APD Consumer-Employed Provider program requirements

To qualify for the APD CEP program, an individual must meet the following requirements:

- Be 65 years or older, or an adult with physical disabilities⁴;
- Be eligible for Medicaid;
- Need a specific level of assistance with Activities of Daily Living (ADLs)⁵ and Instrumental Activities of Daily Living (IADL)⁶;
- Have no adequate alternative care service resources; and
- Have the ability to manage their care and responsibilities as a consumer-employer or have a representative that can manage their responsibilities.

The CEP program eligibility requirements also state that the consumer or a representative⁷ must be an active participant in the consumer's care.

⁴ Individuals who qualify for Modified Adjusted Gross Income (MAGI) through the Oregon Health Authority may also qualify for the APD CEP program. To qualify, they must have an assessed need for long-term support services, as determined by APD's assessment tool.

⁵ Oregon Administrative Rule (OAR) 411-015-0005, describes Activities of Daily Living as eating, dressing, grooming, bathing, personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel, and bowel management), cognition, and behavior.

⁶ OAR 411-015-0007, "Instrumental Activities of Daily Living" also referred to as "Self-Management Tasks" consists of housekeeping including laundry, shopping, transportation, medication management and meal preparation.

⁷ Representatives are individuals chosen by a consumer, or a court, to act on their behalf to assist with accessing and making decisions regarding long-term care services.

The consumer or their representative must be willing and able to screen, hire, train, supervise, and dismiss their care provider.

To evaluate an individual's level of need, case managers use an in-person assessment tool called the Consumer Assessment and Planning System. Case managers are required to assess individuals when they first apply for care services, every year they participate in the program, and when a consumer's condition changes. During the assessment, a case manager surveys the individual's physical, cognitive, and social abilities. The tool assigns a number value (Service Priority Level or SPL) to the individual's level of need. As the level of need increases, the number decreases. Currently, APD serves individuals with an SPL between 1 and 13 in the CEP program. Examples of CEP consumers are outlined in Figures 3 and 4.

Figure 3: CEP Consumer with SPL 1

Consumer is a 73 year old female who lives with her adult children. She is bedridden, and has bipolar disorder and depression. Consumer needs full assistance in areas of cognition, awareness, memory and judgement, and mobility, among other things.

Figure 4: CEP Consumer with SPL 13

Consumer has tremors and weakness in his legs due to nerve damage. However, he is able to use a quad cane to walk inside and outside his home. The tremors fluctuate in intensity based on his activity level and fatigue. He requires hands on assistance while walking to and from the bathroom at least weekly when the tremors are severe. The consumer is doing well cognitively, However, he is unable to perform IADL tasks (i.e., housekeeping, meal preparation, or shopping) because of the tremors.

Case managers are charged with authorizing services consumers receive

Case managers help ensure that a consumer's services are provided in a coordinated manner. This responsibility comes with a long list of duties.

Figure 5: APD case manager primary duties and responsibilities

APD Case Managers' Duties & Responsibilities:

- *Determine initial and on-going financial, medical, and Supplemental Nutrition Assistance Program (SNAP) eligibility*
- *Compute benefits and complete documentation necessary to issue benefits*
- *Assess consumer service needs through interviews and observation, and develop service plans*
- *Determine appropriate home and community-based setting or facility placement, and appropriate payment level*
- *Monitor all home and community-based and facility placements on a regular basis*
- *Update report narrative summarizing consumer contact, findings of home visit, and conclusions*
- *Coordinate care with consumer, consumer's family or representatives, care providers, and community partners*
- *Complete all necessary paperwork to document case management activities and service eligibility*
- *Arrange for appropriate durable medical supplies, prescription coverage, and community health support, and advocate for consumer when necessary*
- *Adjust service plans according to changing consumer needs*
- *Perform assigned desk duty to answer consumer questions, conduct consumer intake and screening, and make referrals when necessary*
- *Report suspected instances of fraud, neglect or abuse and participate in investigations as needed*
- *Attend all training and meetings*

One of the critical duties of a case manager is to monitor a consumer's service plan to ensure that their needs are met. Service plans include service and support needs, goals and desired outcomes, risk factors and measures to mitigate risks, and help consumers develop backup plans to ensure consumers never go without needed care. Consumers sign off on the service plan to show they are in agreement.

APD's consumer monitoring policy includes direct and indirect contacts, and risk-based monitoring. The direct contact policy states that consumers, or authorized representative, must receive direct contact with a case manager through emails, telephone or face-to-face meetings once a quarter. During the months that a direct contact does not occur, case managers must make an indirect case contact, such as communicating with a homecare worker, medical doctor, or other type of service provider. The direct and indirect contacts are intended for case managers to:

- assess consumer needs and adjust service plans to meet these needs;
- identify, eliminate or reduce, and monitor consumer risks;
- respond and intervene when consumers are in crisis;
- monitor service plan implementation;

- help caregivers and family members understand all available Medicaid home and community-based service options;
- facilitate access to community services and supports; and
- report suspected instances of abuse, fraud or neglect.

In addition to direct and indirect monitoring, a risk assessment is an essential tool for case managers to identify and mitigate risks to the consumer's safety. According to APD policy, the frequency of case manager contacts should increase along with the number and level of risks identified. Consumers who are assessed with high risks must be contacted every month.

Homecare workers assist consumers with their daily needs

While consumers direct their care and tell homecare workers how they want their care delivered, homecare workers are entrusted with providing care for CEP consumers. Their duties, which are tied to consumers' needs, include everyday activities such as help with toileting, mobility, and housekeeping. Nursing tasks are generally provided by certified nurses, but a nurse can train, delegate and monitor a homecare worker who provides those services. A nurse can also revoke any delegation for nursing tasks if they think a homecare worker cannot safely perform the delegated nursing tasks.

To be a homecare worker, an individual must be 18 years or older, complete a background check, attend an orientation, and enroll as a Medicaid provider. Often consumers choose someone they know, like a family member or friend, to provide care. In other cases, the consumer can choose to find a homecare worker elsewhere.

The Oregon Home Care Commission was established in 2000 to ensure the high quality of homecare services for older adults and people with disabilities. One responsibility is to coordinate a registry of available homecare workers and provide ongoing training opportunities. The Commission also works with DHS and the union that represents homecare workers⁸ to negotiate training requirements, minimum qualifications, and wages.

The base rate pay for a homecare worker is currently \$14.50 an hour. The Enhanced Homecare Worker Program gives a worker an opportunity to earn \$15.50 an hour if they complete a Readiness Assessment, pass several courses and serve consumers with more extensive needs. Additionally, the Oregon Home Care Commission offers a curriculum, resulting in a Professional Development Certification and an additional pay raise.

⁸ The Service Employees International Union (SEIU) represents homecare workers, as well as DHS case managers.

Objective, Scope, and Methodology

Objective

The objective of this audit was to determine how the Department of Human Services - Aging and People with Disabilities (APD) program ensures that their Consumer-Employed Provider (CEP) program consumers receive the care and services they need.

Scope

This audit focused on APD program policies and processes used for in-home care consumers receiving services through the Medicaid funded Consumer-Employed Provider program.

Methodology

We used multiple methodologies to achieve the audit objective. These included, but were not limited to, interviews, data analysis, review of APD case documentation, and research of similar programs in other states.

We interviewed 73 individuals who have knowledge or interest in the audit objective, including:

- APD and Area Agency on Aging Case Managers, District Managers, Program Managers, Policy Analysts, Compliance and Quality Assurance staff; and
- Stakeholders such as the Oregon Home Care Commission, Oregon Long-Term Care Ombudsman, AARP, Steps to Success (STEPS)⁹, SEIU, and Disability Rights Oregon¹⁰.

We randomly selected and reviewed 142 consumer case files from each of the 48 DHS and AAA offices that served consumers in 2016. The sample size was not intended to represent the entire CEP population.

We interviewed staff from state agencies in Texas, Vermont, Montana, and Colorado regarding case manager duties, consumer and case manager contact, management of homecare workers, program models, and challenges with program administration.

We reviewed Adult Protective Service data that included in-home care program participants.

⁹ Steps to Success (STEPS) is a voluntary training opportunity for in-home care program recipients to teach them how to properly employ their homecare worker.

¹⁰ Disability Rights Oregon is a nonprofit organization that advocates on behalf of people with disabilities.

We researched federal and state rules and regulations pertaining to the administration of in-home services for older adults and people with disabilities.

We reviewed leading practices in performance management and in-home care program implementation.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained and reported provides a reasonable basis to achieve our audit objective.

DHS Aging and People with Disabilities: Program Enhancements Needed to Consumer-Employed Provider Program to Ensure In-home Care Consumers Receive Required Care and Services

DHS should take immediate action to strengthen the Consumer-Employed Provider (CEP) program to ensure the vulnerable consumers it serves receive adequate care and services. There are several factors contributing to inadequate oversight of this program. Specifically, certain program elements are problematic and need to be enhanced.

Aging and People with Disabilities (APD) is not adequately monitoring consumer care, and staffing levels are not sufficient to do so. APD does not effectively use program data to ensure consumer health and well-being. Additionally, minimal training is required for in-home care providers. Leading practices provide guidance for how to enhance this important program. We make several recommendations in this regard.

Current Program Design and Deficient Monitoring Put CEP Consumers at Greater Risk

The CEP program has risks, as it requires that consumers who need assistance to meet their basic needs direct their own care, including managing a homecare worker. Possible risks to the health and well-being of consumers are magnified by program design challenges and deficient program monitoring.

The consumer-as-employer component strains critical aspects of the program

The CEP program was intentionally designed to allow the consumer to be able to complete employer duties such as hiring, training, and dismissing their homecare worker as part of the program eligibility criteria.

We found that some CEP consumers are unable to perform employer duties due to physical and cognitive conditions, or are unwilling due to the nature of their employer-provider relationship. Additionally, APD does not always take action when consumers are not able or willing to perform required employer duties, putting them at greater risk.

For example, one CEP consumer in her thirties has uncontrolled diabetes and is unable to retain information due to brain lesions caused by Multiple Sclerosis. Because this consumer does not have support from friends or family, it is challenging for her to be solely responsible for directing her own care. Consumers with serious conditions such as this may have difficulty completing necessary employer functions. They may struggle to correctly submit homecare worker payment vouchers, address poor homecare worker performance, or direct homecare workers to complete tasks.

In other situations, consumers simply feel uncomfortable performing employer duties. Often, homecare workers are family members or friends and consumers feel reticent to address poor work performance like being late or not showing up at all.

Other consumers may not speak up when a homecare worker acts inappropriately. Since case managers rely heavily on consumers to tell them if their care and services are being provided, case managers are often unaware until something serious happens.

APD is not adequately monitoring consumers in the CEP program

Given some consumers may be vulnerable and potential risks, it is imperative that APD monitor services to ensure they are provided as intended. However, our audit found consumers are not receiving monitoring contacts as required by state¹¹ or federal rules and program policy, putting them at greater risk that their basic needs are not being met, and making them more susceptible to fraud, abuse, and neglect.

There are two essential monitoring requirements of the CEP program: direct and indirect monitoring, and risk-based monitoring. In our CEP consumer file reviews for the year 2016, we found roughly a third of consumers (49 of 142) did not receive all of their required case manager direct or indirect monitoring contacts. The results of our file reviews align with comments from case managers regarding the impacts to monitoring from high caseloads and the need to assist consumers with employer related tasks, such as managing their homecare worker.

For example, two consumers did not receive any case manager phone calls, emails, or in-person visits for 11 months. One lives alone and has complications from kidney failure, memory issues, Parkinson's disease, and diabetes. This consumer is dependent on insulin and requires dialysis three times a week. The other has a history of stroke and heart attack and suffers from chronic obstructive pulmonary disease and emphysema causing on-going shortness of breath. Due to problems with memory this consumer cannot successfully manage their medication.

In addition, while direct contacts are not required to be in person, having face-to-face contact helps to build trust and rapport, and allows case managers to assess the consumer's home to get additional information on the level of care provided and any unmet service needs. We found roughly two-thirds of consumers (89 of 142) in our sample did not receive any in-person visits in 2016 from their case managers, other than the yearly needs assessment.

Risk-based monitoring is another critical CEP program element that helps ensure the safety and well-being of consumers. This monitoring

¹¹ Oregon Administrative Rule 411-028-0020

requirement identifies those most at risk, and establishes a plan to mitigate those risks. Consumers are screened based on their risk associated with 13 categories, including natural disasters, cognitive functioning, challenging service needs, failure of necessary medical equipment, and situations in which a homecare worker does not report to work. If a consumer has higher risk, the case manager must increase the number of direct monitoring contacts each year.

Case managers must document in a consumer's case file results of a risk assessment, including risk factors, at the time a service plan is created. However, we saw examples where a case manager was able to create a service plan without conducting a risk assessment.

Case managers must also indicate in the case file if a consumer's direct contact is associated with risk management. However, this policy is not consistently applied. In our file reviews, insufficient documentation kept us from determining whether high risk consumers received additional direct contacts as required. Also, current data reports do not allow APD central management to easily identify high-risk consumers and determine if they are monitored as required. APD central management confirmed that the current data system does not easily provide information for them to ensure that case managers are in compliance with the risk-based monitoring policy.

Even if case managers are able to meet with consumers, they may be unable to spend enough time with them. When case managers contact consumers, interactions are short and may not be meaningful. One case manager explained that direct communication can be rather brief, between 1 to 30 minutes for in-home visits and 30 seconds to 10 minutes for telephone calls.

Short visits and limited consumer contact mean that many case managers may not have sufficient time to ensure their consumers' needs are met. Numerous case managers told us that conducting in-person visits with consumers helps to ensure that their service plan is working, that their needs are met, and that consumers are not falling victim to abuse, fraud or neglect.

Several Factors Contribute to Inadequate Program Oversight

APD management is tasked with ensuring that each of the three parts of the CEP system – the consumer, the case manager, and the homecare worker -- are working together as intended. If each party is capable, competent, and supported within their designated role, the consumer-as-employer model can be successful. To accomplish this, management must adequately oversee the program.

Several factors contribute to inadequate oversight of the CEP program. Certain program elements are problematic and need to be enhanced. Additionally, APD lacks comprehensive program data and management has not adequately addressed excessive caseloads and ensured adequate case manager staffing levels.

Consumer limitations not always identified, and additional assistance not provided

Consumer independence and choice is paramount to the CEP program, including self-determination. APD has a policy to assess and document program eligibility requirements, and can provide additional assistance when consumers are no longer willing or able to perform aspects of the employer duties. Additional assistance is available by referring the consumer to a voluntary employer-training program, offering the consumer the option to shift to the in-home care agency model, or asking the consumer to pursue assistance from an authorized representative. This last option may not be possible for some consumers who have little or no support from friends or family.

However, case managers may not know how to support consumers who are unable or unwilling to complete employer duties. There is little training available to case managers on how to identify and address a consumer who needs additional assistance. When limitations are not identified and procedures to provide support are not clear, referrals for assistance are not made.

Additional employer tasks often times fall to the case managers; taking them away from regularly assigned duties such as coordinating care with community partners. In addition, this problem can be compounded when case managers are not able to perform monitoring requirements, including face-to-face contacts with consumers. This leaves consumers more vulnerable to inadequate care, abuse, neglect and fraud.

CEP consumers may not receive adequate support

CEP consumers receive a Consumer Employer Guide to help them manage their responsibilities. But some consumers may need additional support to hire, train, and manage their homecare worker. To address this concern, case managers offer Steps to Success (STEPS) as a solution.

This program provides one-on-one coaching to assist consumers in taking on the role of an employer. Consumers are referred to the program when they are first eligible for services, and may be referred at each needs assessment, or when case managers feel it is beneficial. In our file reviews, we saw evidence of consumers who needed additional support and were offered STEPS, but declined. In these instances, the program cannot require consumers to participate in the training because it is prohibited by federal rules. Additionally, STEPS may not be effective for consumers with declining cognitive abilities.

Outside of APD, CEP consumers and their families have very few options for support to address program concerns. Under the federal Older Americans Act, the state's Long-Term Care Ombudsman must investigate complaints and advocate on the behalf of individuals receiving care from licensed care facilities. However, Oregon law does not include in-home care consumers within the purview of the Long-Term Care Ombudsman. Currently, there is no entity serving CEP consumers in this capacity. To include these consumers within the Ombudsman's scope, the Legislature would need to modify state law and provide enough financial resources to adequately support thousands of potentially new consumers and fund efforts to recruit volunteers.

Homecare Worker supports are minimal

Current APD support systems do not ensure that homecare workers are prepared to provide needed care and services, and APD has not taken sufficient action to address this program flaw. Outside of an initial orientation, Oregon Administrative Rules do not require a homecare worker to receive any formal training. Consumers are responsible for ensuring the homecare worker has the skills, knowledge, and abilities to meet their unique care needs and personal preferences.

Information provided in the initial orientation does not address homecare worker competency to complete required job duties. Orientation is limited to information on CEP program roles and responsibilities, as well as basic job requirements. There is no required assessment to determine the skills and abilities of a homecare worker. Also, there are no refresher courses covering the information provided in the initial orientation.

Consumers are responsible for training their homecare workers. For some tasks such as light housekeeping and meal preparation, this may be less challenging. However, homecare workers may be required to do strenuous and complicated tasks, like lift consumers from a chair or assist them with a range of conditions, from traumatic brain injuries to dementia to mental health issues. If not done properly, some tasks can be harmful to both consumers and homecare workers. One case manager we spoke with knew of two homecare workers who were injured when lifting consumers, one ended up requiring surgery and is receiving workers' compensation.

The Oregon Home Care Commission offers some training for homecare workers, but it is voluntary. Training subjects include communication, providing care such as bathing, appropriate boundaries, working with consumers with challenging behaviors and conditions, as well as other skills courses.

If the consumer is unable to provide the homecare worker sufficient information about completing work duties or the homecare worker is having difficulties with the relationship, they often reach out to case managers. Case managers do their best to empower the consumer and

homecare worker to resolve issues, but it does not always work. In these cases, consumers may be referred to STEPs or to other supports.

Key APD data practices do not adequately address consumer safety and well-being

Due to current data collection and utilization practices, it is difficult to determine whether CEP consumers are safe and receiving the care and services they need, or even if the current program model is best.

Existing data focus on case managers' performance but do not capture consumers' satisfaction with their care, if their needs are met, or changes in their health and well-being.

For example, the quality assurance reviews conducted bi-annually by APD look at the accuracy and appropriateness of case manager determinations for program eligibility, service plans, and service payments. CEP data reports on consumer monitoring and needs assessments, are analyzed from the perspective of case managers' performance. There is no aspect of the quality assurance process or consumer monitoring or assessment reports that looks at consumers' well-being.

Additionally, in discussions with APD management, we learned that consumer monitoring reports document whether each case manager has conducted their required consumer monitoring contacts. While this is helpful, the reports do not indicate whether each individual consumer is receiving the indirect and direct monitoring contacts they should.

Another limitation is that APD does not report CEP consumer data separately from other populations. Monitoring data for CEP consumers is combined with data for consumers living in other community-based care settings. Also, abuse and neglect data for CEP consumers is co-mingled with data on victims who are not receiving APD services. In both of these situations, data is not easily extracted. Because data is co-mingled, it is difficult to evaluate individual program performance and status of CEP consumers.

Although the agency does track data for compliance measures, including data for federal assurances, APD can do more data analysis, including establishing trends across programs. For example, with additional efforts, data regarding hospitalizations could be reviewed to help determine if CEP consumers are safe in their homes, compared to other community-based settings.

APD has taken steps to address some data challenges. After a preliminary business assessment in 2014, the Legislature allocated funding in 2015 to adopt a central, comprehensive system to document all abuse and neglect investigations. After interviewing and visiting other states and local municipalities, and obtaining input from staff, APD selected an information technology system that best fits Oregon's needs. After months of system

testing, APD plans to incrementally implement the Centralized Abuse Management system beginning January 2018. It is intended to improve data analysis and as a result, APD should have the ability to better understand the status and safety of CEP consumers.

Additionally, APD reported they will survey consumers in all care settings in 2017. CEP consumers were not included in the recent customer survey of long-term care service recipients.

APD has not effectively addressed excessive case manager workloads

APD management has not effectively addressed excessive case manager workload. Case managers reportedly do not have the time necessary to consistently monitor consumers' care because of excessive workload and additional responsibilities.

Case managers' duties are excessive and shift focus from consumer support and monitoring. For example, some case managers are required to do financial and eligibility redetermination for medical insurance coverage and Supplemental Nutrition Assistance Program (SNAP), which are time-consuming and have strict deadlines. In contrast, case managers who do similar work in the agency's Intellectual and Development Disability programs do not have to do financial and medical insurance eligibility work.

Issues related to homecare workers also dominate case managers' time. Consumers contact case managers about issues related to homecare worker management, which forces case managers to function as an intermediary, a task that exceeds their role and available time.



Consumers are not the only ones who contact case managers regarding employer/employee issues. Homecare workers also frequently contact case managers with challenges and complaints regarding their employment, taking up considerable case manager time. Some common issues are personality conflicts with employers, difficulty recording their time, and subsequent payment for hours worked.

ORACCESS is the primary data system case managers use to document consumer demographic information, health conditions, eligibility assessment information, and on-going case monitoring narration. This system is cumbersome and outdated. Case managers frequently adjust consumer service plans to account for new homecare workers and to change homecare worker hours. To do this in ORACCESS requires multiple steps and is time intensive.

Consumer needs vary widely within the CEP population, which requires case managers to use a variety of skills to effectively help their consumers. Although this program is intended for persons with physical or cognitive limitations, case managers are seeing an increase in consumers with multiple health issues, including mental health conditions. Case managers often provide additional support and counseling to consumers to help them

participate in case planning. When time is constrained, it makes helping consumers with exceptional needs more difficult.

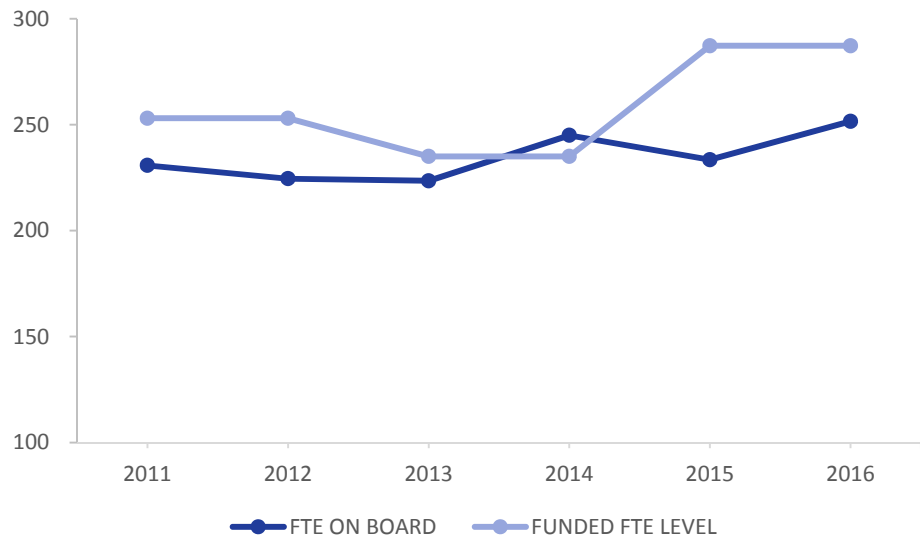
APD management has attempted to take steps to alleviate excessive workload and additional responsibilities case managers are experiencing. This includes transitioning to a workload model that looks at the time case managers need for specific tasks.

Case managers told us they often feel overwhelmed with the amount of work they must handle. Increasingly, their time is divided, which means consumers may suffer.

Full time case managers we interviewed had between 52 and 135 cases. According to APD, there is no set caseload target for case managers. Caseload size varies depending on how many consumers each case manager has in each care setting and whether the field offices are fully staffed. We found, however, that other states set caseload targets or benchmarks. This may assist in aligning resources and better articulating staffing shortfalls.

Additionally, according to APD management, budget constraints and hiring freezes have impacted DHS's ability to consistently fill vacancies to the level funded by the Legislature. While an average of 258 full time equivalent (FTE) case manager positions were funded from 2011 to 2016, only an average of 235 were actually staffed. See Figure 6.

Figure 6: APD Case Managers FTE on board versus FTE funded¹²



¹² The data used for this graph is limited to APD. AAA case manager FTE is not comparable.

Program Design and Deficient Monitoring Pose Risks to Consumers' Health and Well-being and Diminish Program

Critical program design challenges and deficient program monitoring create uncertainty that CEP consumers are receiving the care and services they need. Without the ability to determine that the three critical components of the CEP system - the consumer, case manager and homecare worker - are working as intended, consumers may not receive needed care and may be more susceptible to fraud, abuse, or neglect.

Consumers may experience increased risk to health and well-being

It is hard for APD to know if consumers are receiving the care and services they need when data is insufficient to monitor consumer care, consumers can be reticent to contact case managers about concerns, and case managers are too busy to contact their consumers about their health and well-being.

These circumstances create a heightened risk that:

- consumers are not achieving their intended outcomes as outlined in their service plans,
- high-risk consumers may not have their needs identified and met, and
- consumers may be subject to fraud, abuse, neglect, and safety risks that could go undetected by APD.

We heard a number of reports regarding how these issues have negatively impacted consumers. For example, a case manager we spoke to knew of an instance in which the previous case manager suspected something inappropriate was going on in a consumer's home but was unable to visit the consumer for months. Once the new case manager conducted a home visit, the consumer acknowledged that her homecare worker had not reported to work for several months. During those months, the consumer continuously told the case manager that her service needs were being met when in fact she was not receiving any of the needed services.

In another situation, an insulin dependent, bed-bound consumer nearly died. A relative was his paid homecare worker. On a routine in-home visit for an annual needs assessment, a case manager became concerned about the homecare worker's ability to meet the consumer's needs due to the poor condition of the residence, the homecare worker's own health challenges, and his ongoing struggle to correctly determine the consumer's insulin dosage. Because the required risk assessment was not done, this consumer was not formally earmarked for additional monitoring contact to mitigate these risks.

When a new case manager was assigned he was informed of the concerns and told that monthly in-person visits may be needed to ensure the consumer's safety. But, high workload impacted the way he managed the case and he did not attempt in-person contact with the consumer.

Approximately six months later, the police responded to the home when the consumer gave himself a potentially fatal dose of insulin. The consumer was resuscitated, admitted to an intensive care unit, and survived. When questioned, the homecare worker reported he did not provide services for which he was paid and subsequently lost his ability to be employed as a homecare worker.

Lack of program oversight undermines program intent

When the consumer is no longer able or willing to function as an employer, it causes strain within the CEP program. In some cases, case managers and homecare workers fill in the gap, taking on many of the employer duties.



Consumers who are unable to manage their care may rely on their homecare workers to manage it for them. This could be beneficial to the consumer, especially if the homecare worker is competent and willing. However, homecare workers could take advantage of the situation. For example, a homecare worker could have the consumer approve payment for hours the homecare worker did not work. In other instances, case managers take on employer duties. But this is outside of assigned tasks and adds to their workload.

In these situations, the consumer is no longer the driver in directing their care, a basic tenet of the CEP program. By not addressing these issues, APD is not able to provide the support that is needed to fulfill the intent of the program.

CEP Policies and Alternative Program Models Provide Options for Improved Program Implementation

APD can address program design challenges and improve oversight by ensuring it follows existing rules and policies. In addition, other programs inside and outside of APD provide alternatives for handling challenging homecare worker employment functions and case management duties. Last, to align with leading practices in performance management, APD should collect and analyze data to better manage the program.

Program eligibility and monitoring policies help ensure consumer well-being

Program eligibility requirements should be followed to identify consumers who are best suited for the program. Procedures should be in place that align with program requirements. These procedures are a critical component of program oversight.

Indirect and direct monitoring policies provide a baseline for case managers to monitor consumers' care. And required, risk-based monitoring addresses the safety of consumers who are more vulnerable. Working together, these policies could allow case managers to monitor CEP consumers more effectively. When either policy is not followed consumers are not sufficiently monitored.

Similar programs handle homecare workers and case manager duties differently

Oregon is a leader in providing services to support older adults and adults with disabilities to safely remain in their homes. However, challenges the CEP program faces may benefit from fresh perspectives. Similar programs within APD and across the country have ways of handling aspects of in-home services that provide more support for program participants, homecare workers, and case managers. Specifically, APD could look at better ways to handle employer duties related to homecare workers and the work of case managers.

We contacted states with similar in-home care services and found that none had Oregon's high level of case manager involvement in duties related to homecare worker employment. As outlined previously, case managers spend a significant amount of time addressing homecare worker human resource and payroll issues. Other states avoid this by using home care agencies or outside payroll services to manage these functions.

In Colorado, initial employment eligibility determinations and payroll for homecare workers are done through one of three private payroll service organizations. In Vermont, all homecare workers are screened for employment and paid through a single contracted agency. Even programs within APD, such as the Intellectual and Developmental Disabilities program, use outside services to handle payment of workers.

Oregon is also unique in the extent of case manager duties compared to other states. Oregon case manager duties include determining if a consumer is financially eligible for the CEP program. Case managers report that the workload associated with making these income-based determinations lessens the time they have to make meaningful contact with consumers. In contrast, none of the states we contacted require case managers to handle financial eligibility determinations. Instead, this duty is handled by other state or county employees or, as in Texas, by a centralized work unit.

Case managers in some states we contacted also have different roles in assessing the level of services consumers need. In Oregon, case managers are responsible for conducting consumer needs assessments. In other states, assessments are completed by someone other than a case manager, such as a third party, for example, a contracted agency.

Data should be used to improve program performance

Leading performance management practices emphasize the importance of using data for ongoing program improvement. Collecting and utilizing meaningful data will allow APD to track and analyze the overall effectiveness of the program, learn from challenges, and focus efforts on areas in need of improvement. Following leading data practices will also help APD meet CEP program expectations.

Without data on the extent of fraud, abuse and neglect of CEP consumers, or the effectiveness of risk-based monitoring, APD is missing opportunities to maximize limited resources, ensure the integrity of the program, and improve the safety and well-being of this vulnerable population.

Recommendations

Consumer independence and choice is paramount in the CEP program. Each program element, working as intended, will better ensure the success of each consumer. Measures should be in place to mitigate risks to consumers' well-being and support them as an employer when appropriate. Homecare workers should demonstrate the skills necessary to care for consumers and should be supported in their role. Case managers' duties should allow time to sufficiently address each consumer's needs.

APD should take the following actions to address inherent program risks and improve program implementation:

1. Train case managers to recognize when consumers need additional assistance in completing employer responsibilities.
2. Develop and implement procedures for taking action when consumers are no longer able or willing to perform necessary employer duties.
3. Monitor consumer care to ensure direct and indirect contacts are occurring according to the Center for Medicare and Medicaid Services requirements and Oregon Administrative Rules.
4. Utilize APD's current risk assessment tool to identify consumers most at risk for fraud, neglect, and abuse.
5. Track compliance with risk-based monitoring in accordance with current APD policies.
6. In coordination with the Oregon Home Care Commission and SEIU, establish minimum homecare worker training requirements and develop refresher courses for topics covered in orientation.
7. In coordination with the Oregon Home Care Commission and SEIU, implement a new model for managing the Homecare Worker program that lessens the workload of APD staff working in the CEP program.
8. Establish a skills assessment for homecare workers to assure that they have the skills, knowledge, and abilities to provide consumer care.
9. Take steps to ensure that case managers have the time to perform all necessary person-centered planning activities, including reassigning financial eligibility determinations for medical programs and SNAP to other staff.
10. Work with the Legislature to ensure case managers are staffed at the level funded.
11. Track and use data to improve the CEP program and inform decision making, including:
 - CEP abuse and neglect data separately from other settings,
 - CEP consumer direct and indirect monitoring frequency separately from all other care settings, and
 - CEP consumers who are considered high risk and whether or not they are getting the required risk-based monitoring



Oregon

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September 29, 2017

Kip Memmott, Director
Secretary of State, Audits Division
255 Capitol St. NE, Suite 500
Salem, OR 97310



Dear Mr. Memmott:

This letter provides a written response to the Audits Division's final draft audit report titled, "Consumer-Employed Provider Program Needs Immediate Action to Ensure In-Home Care Consumers Receive Adequate Care and Services."

Thank you for the opportunity to respond to your audit. The Department appreciates the work of the Secretary of State Audit's Division. We generally agree with the recommendations contained in the audit report.

Below is our detailed response to each recommendation in the audit.

RECOMMENDATION 1		
Train case managers to recognize when consumers need additional assistance in completing employer responsibilities.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	June 30, 2018	Jane-ellen Weidanz 503-602-8399

Narrative for Recommendation 1

The Department will convene a workgroup in the coming months to develop training to:

- Develop criteria to standardize assessment of individuals who are not completing their employer responsibilities;
- Identify individuals who are not, or who may be at risk of not, completing their employer responsibilities; and
- Identify interventions for consumers who are not completing their employer responsibilities.

Once completed, the Aging and People with Disabilities Program (APD) will require the training for all case managers. We will also implement this requirement into our "Case Manager Essentials Training."

"Assisting People to Become Independent, Healthy and Safe"

RECOMMENDATION 2		
Develop and implement procedures for taking action when consumers are no longer able or willing to perform necessary employer duties.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	December 31, 2017	Jane-ellen Weidanz 503-602-8399

Narrative for Recommendation 2

OAR 411-030-0040 (8) already contains the requirements and remedies for consumers who cannot perform necessary employer duties.

In addition to the training referenced in recommendation 1, APD will strengthen standard protocols and procedures for case managers. APD will also issue an Action Request reminding our field structure of this responsibility no later than December 31, 2017.

RECOMMENDATION 3		
Monitor consumer care to ensure direct and indirect contacts are occurring according to the Center for Medicare and Medicaid Services requirements and Oregon Administrative Rules.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	Ongoing	Jane-ellen Weidanz 503-602-8399

Narrative for Recommendation 3

APD's Medicaid Long Term Services and Supports Unit is regularly monitoring this requirement via reports. APD agrees that we can always work toward 100 percent compliance. We follow up with local offices that have an unacceptable level of non-compliance and require action plans for increasing compliance. As an example, in the aggregate our data shows contacts reviewed against the frequency documented in the service plan to determine if appropriate case manager contact was made based on the frequency listed in the plan. For the past 6 months we have ranged between 94-96 percent compliant. This is the information that will go to CMS around our federal assurances.

RECOMMENDATION 4 Utilize APD's current risk assessment tool to identify clients most at risk for fraud, neglect, and abuse.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	September 30, 2018	Jane-ellen Weidanz 503-602-8399

Narrative for Recommendation 4

APD has been requiring case managers to do this consistently since July 2012. Case managers are expected to perform enhanced follow-up on these clients. We will be developing a tracking system to monitor compliance.

RECOMMENDATION 5 Track compliance with risk-based monitoring in accordance with current APD policies.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	September 30, 2018	Jane-ellen Weidanz 503-602-8399

Narrative for Recommendation 5

Because of the additional risk associated with these consumers, we are going to build new tracking reports that will facilitate enhanced monitoring of this population. This will require system changes, which is the cause of the timeline being pushed to September 30, 2018.

RECOMMENDATION 6 In coordination with the Oregon Home Care Commission and SEIU, establish minimum homecare worker training requirements and develop refresher courses for topics covered in orientation.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	December 31, 2018	Mike McCormick 503-945-6229

Narrative for Recommendation 6

In response to requirements contained in SB774 (2015), APD commissioned a “Workforce Development Strategic Plan.” The contractor, Thomas P. Miller & Associates worked with a wide variety of stakeholders and state staff in the development of this plan.

We intend to work with SEIU, the OHCC and the legislature to establish minimum training requirements and refresher courses in alignment with the strategic plan.

RECOMMENDATION 7		
In coordination with the Oregon Home Care Commission and SEIU, implement a new model for managing the Homecare Worker program that lessens the workload of APD staff working in the CEP program.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	December 31, 2019	Ashley Carson Cottingham 503-947-1100

Narrative for Recommendation 7

APD recognizes that the continued management of more than 20,000 unique Home Care Workers each month is not sustainable. This is especially true in light of the demographics and consumer preferences that will consistently grow this workforce. We believe there are better, more efficient ways to monitor this workforce and are committed to long term efforts to overhaul it.

APD will be initiating broad stakeholder meetings (in collaboration with SEIU and the OHCC) and conducting Legislative discussions on alternate models for managing and supporting this workforce on behalf of consumers.

This is a large undertaking that potentially results in a complete transformation of how this program is administered by both APD and the Office of Developmental Disability Services at DHS.

RECOMMENDATION 8		
Establish a skills assessment for homecare workers to assure that they have the skills, knowledge, and abilities to provide consumer care.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	December 31, 2019	Mike McCormick 503-945-6229

Narrative for Recommendation 8

In response to requirements contained in SB774 (2015), APD commissioned a “Workforce Development Strategic Plan.” The Contractor, Thomas P. Miller & Associates worked with a wide variety of stakeholders and state staff in the development of this plan. The very first recommendation from the plan follows:

Pre-employment testing will provide the OHCC with benchmarking data for the quality of the workforce upon entry, allow for better guidance on professional development, and inform others who may refer individuals to the OHCC as potential candidates for the occupation.

An assessment will need to be developed or adapted from an existing one developed elsewhere. SEIU and the OHCC should jointly develop and evaluate the testing tool. Once developed and approved, the initial year or two should be used for benchmarking and professional development guidance. In later years, the assessment should be evaluated as a potential screening tool.

We intend to implement this action in accordance with the above plan.

RECOMMENDATION 9		
Take steps to ensure that case managers have the time to perform all necessary person-centered planning activities, including reassign financial eligibility determinations for medical programs and SNAP to other staff.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	December 31, 2018	Ashley Carson Cottingham 503-947-1100

Narrative for Recommendation 9

APD had already begun a process to reassign financial eligibility determinations for Medicaid programs and SNAP to other staff. Additionally, we are separating the responsibility for service assessment and eligibility from ongoing case management in order to promote efficiency, effectiveness and program integrity.

This work is being governed by the “Balancing Case Manager Responsibilities Steering Committee.” The pilot is scheduled to begin in January 2018. The results of that pilot will drive the final decisions on program design.

RECOMMENDATION 10 Work with the Legislature to ensure case managers are staffed at the level funded.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	Ongoing	Ashley Carson Cottingham 503-947-1100

Narrative for Recommendation 10

The Department regularly presents workload reports to the Legislature and the Legislative Fiscal Office. These reports identify “gaps” where staffing levels are insufficient to complete all required work. APD and other invested stakeholders, often advocate for adequate staffing and funding. Ultimately, difficult funding decisions need to be made by the Legislature in consideration of all the priorities they face on a statewide basis.

RECOMMENDATION 11 Track and use data to improve the CEP program and inform decision making, including:		
<ul style="list-style-type: none"> • CEP abuse and neglect data separately from other settings, • CEP consumer direct and indirect monitoring frequency separately from all other care settings, and • CEP consumers who are considered high risk and whether or not they are getting the required risk-based monitoring 		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Partially Agree	September 30, 2018	Ashley Carson Cottingham 503-947-1100

Narrative for Recommendation 11

In 2016, APD initiated a process to procure a new adult protective services system referred to as the Centralized Abuse Management (CAM) system. The CAM system is scheduled to be active in mid-2018 and will partially address bullet 1 in the above recommendation, in that we will have better APS data across all systems.

We have analyzed the costs/benefits of modifying our methods for monitoring direct and indirect monitoring. Ultimately, while there are some potential benefits, we have decided not to pursue this recommendation at this time. The purpose of the tracking report is to monitor compliance

with critical federal regulations. The existing reports accomplish that requirement effectively. Additionally, we maintain the option to order ad-hoc reports to track this, if determined necessary.

Because of the additional risk associated with these consumers, we are going to build new tracking reports that will facilitate enhanced monitoring of the high-risk population. This will require system changes, which is the cause of the timeline being pushed to September 30, 2018.

I would like to thank you and your Audit Team for your efforts on this audit. The Department values the objective and independent evaluation that audits such as these provide. We look forward to implementing these recommendations to enhance the quality of services provided to Oregonians.

Please contact Ashley Carson Cottingham at 503-947-1100 if you have any questions.

Sincerely,



Fariborz Pakseresht
Director

cc: Ashley Carson Cottingham, APD Director
Dave Lyda, Chief Audit Officer