Oregon
Kate Brown, Governor

Department of Human Services
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February 4, 2019

DHS Oregon Department of Human Services

The Honorable Senator Lee Beyer, Co-Chair
The Honorable Representative Rob Nosse, Co-Chair
Ways and Means Human Services Sub-committee
900 Court Street NE
H-178 State Capitol
Salem, OR 97301-4048

Re: Follow-up Questions

Dear Co-Chairs:

Thank you for the opportunity to present to your Sub Committee on January 30 and 31, 2019. This letter provides follow-up answers to the unanswered questions on those days.

Questions from January 30, 2019 Hearing

How long, on average does it take to determine eligibility?

For Medicaid, the State must reach an eligibility determination within 45 days. At this time, we are unable to generate accurate measurements of average eligibility determination time without substantial labor. This is intended to be corrected in the future for with the Integrated Eligibility project.

For Supplemental Nutrition Assistance Programs (SNAP), the State must reach an eligibility determination within 30 days, unless they qualify for an expedited decision. Most decisions are made very quickly.

What is the turnover rate for Surveyor positions and how many current vacancies do you have?

We are working on preparing this information, but could not complete it before the timeline to send this letter. The information should be provided within one week.

Please provide a status update on the implementation of House Bill 3359 (2017)

APD has made substantial progress in implementing this bill. We have attached a fact sheet which contains a significant amount of detail regarding the implementation of the numerous sections of HB3359.

Questions from January 31, 2019 Hearing

When does Oregon need to reapply for its waiver?

Oregon's 1915(c) waiver expires on 12/31/21. APD does not anticipate any issues with renewal of our waivers in future years.

Does a recipient of benefits (referring to SNAP or TANF likely) have the ability to take cash withdrawals from their supplemental nutrition assistance program (SNAP) benefits?

Generally, individuals may not withdraw cash from their SNAP benefits. However, there is a limited **SNAP Cash Out Project** that began in 1980 as a limited duration project. The project allowed the state to determine the cash value of food stamps for elderly clients and recipients of Supplemental Security Income and issue checks in lieu of food coupons. We have attached a fact sheet on this program for your information.

What are the income eligibility requirements for the Medicare Savings Programs (MSPs)?

We prepared the table below on the following page to assist in understanding the MSPs in Oregon. As a reminder, the policy and budget for these programs reside

within the Oregon Health Authority. DHS administers the programs to eligible Oregonians.

Name	Benefits	Income Eligibility Levels	Notes
QMB-BAS (Qualified Medicare Beneficiary Basic)	Covers Part B Premiums, deductibles and coinsurance.	$1,041 per month (100% of FPL)	May also cover Part A premiums under certain circumstances.
QMB-SMB (Specified Low Income Medicare Beneficiary)	Covers Part B Premiums Only.	$1,249 per month (120% of FPL)	
QMB-SMF (Qualified Individual Program)	Covers Part B Premiums Only.	$1,406 per month (135% of FPL)	Limited via federal appropriation: Not an entitlement program.

How is eligibility for Medicaid affected when an individual is awaiting a disability determination and receives a lump sum payment back to their application date?

For the General Assistance program, a participant must sign an interim assistance agreement. This agreement allows the State of Oregon to recoup the costs of the assistance provided while the individual was awaiting an eligibility determination. Therefore, resources are not generally a concern in these circumstances.

Other individuals who have not participated in the general assistance program generally have nine months to spend down their lump sum payment. Amounts remaining over the resource limit after nine months could potentially affect eligibility.

Some of the tobacco tax dollars were devoted towards the Special Needs Transportation Fund. What is the status of that project and how much money has gone back to communities from this fund?

We are unable to answer this question. We have forwarded your inquiry to our colleagues at the Oregon Health Authority and the Department of Transportation.

What was the impact of the mandated fund reductions? Also related – how many people did NOT receive relief from the extended waiver – in other words, how many people were forced to leave their homes or go without essential services?

As a result of a negotiated settlement with Legal Advocates, APD must periodically report on the effect of the policies implemented. The report is not complete yet. However, it should be available within the next two weeks; we will forward upon completion.

How does the cost of the 51-year old man contained in APD's Ways and Means presentation compare to the Oregon State Hospital?

Oregon State Hospital Officials report the following costs for Fiscal Year 2018:

- Hospital Level of Care: $1,324.88 per day or $40,290 per month.

Oregon State Hospital expenditures are generally not matchable in Medicaid, while community expenditures in Medicaid may be matched. The general fund contribution to serve the individual was approximately $13,500 in the APD program compared with the $40,290 in the Oregon State Hospital.

The Department hopes the answers to your questions were responsive and adequate. Please let us know if you have additional questions.

Sincerely,

Eric Luther Moore, Chief Financial Officer
Department of Human Services

ATTACHMENTS

FACT SHEET

Aging and People with Disabilities: HB 3359

Implementing House Bill 3359

Background

The Oregon Legislative Assembly in 2017 passed into law House Bill 3359. This bill enacted a variety of changes related to facilities licensed by the Department of Human Services Aging and People with Disabilities program (APD) that serve older adults and adults with disabilities, including:

- Residential care (RCF) and assisted living facilities (ALF);
- Adult foster homes (AFH) and Multnomah County Adult Care Homes (ACH);
- Nursing facilities (NF); and,
- Endorsed memory care communities (MCC).

The bill addresses a variety of topics, including:

- Increased licensing fees and penalties;
- Changes to regulatory enforcement;
- Changes in medication packaging;
- Required dementia training;
- Mandated annual quality metrics reporting for facilities; and,
- Creation of two new models of residential care facilities (RCF).

Progress to date

Updated administrative rules:
Administrative rules have been updated and most are now adopted to reflect the changes made by HB 3359 for adult foster homes, residential care and assisted living facilities, and nursing facilities. APD is in the process of adopting the rule around intensive intervention communities – all others have been formally adopted.

Established a Quality Measurement Council:
The mission of the Quality Measurement Council is to develop, in consultation with APD, a uniform quality metrics reporting system to measure and compare performance of residential care and assisted living facilities across the state. The council consists of eight individuals, appointed by the Governor of Oregon, who will establish a reporting system for, and review data supplied by, residential care and assisted living facilities including:

- Retention of direct care staff;
- Number of resident falls that result in injury;
- Incidence of use of antipsychotic medications for non-standard purposes;
- Compliance with staff training requirements; and,
- Results of annual resident satisfaction survey conducted by an independent entity.

The council has been meeting and is working with APD to build an online data portal that facilities will use to report data annually. The council and the department are also developing communication and training materials to educate facilities and the public about this new program.

Increased training requirements and training courses available through Oregon Care Partners:
As of September 2018:

- **36** dementia care custom/in-service trainings were delivered statewide by Positive Approach to Care (PAC) certified trainers; and,
- **1,301** certificates were issued for the pre-service dementia care training for direct care staff.

Courses developed include Pre-Service Dementia Care Training for Direct Care Staff that meets the training topics as outlined in Section 25 and 30 of HB3359 now codified in ORS 443.433, OAR 411-054 and OAR 411-050

Adopted new licensing and renewal fees for residential care facilities and nursing facilities of:

Licensing	Renewal
1-15 beds: $2,000	1-15 beds: $1,000
16-49 beds: $3,000	16-49 beds: $1,500
50-99 beds: $4,000	50-99 beds: $2,000
100-150 beds: $5,000	100-150 beds: $2,500
151 or more beds: $6,000	151 or more beds: $3,000

Residential care facilities must renew their licenses every two years; Nursing facilities must renew annually.

Penalties increased to the following:
Level 1 violation:

- A Level 1 violation exists when no actual harm has occurred to any resident(s), but there is potential for minor harm due to the violation.
- No penalty will be imposed for a Level 1 violation.

Level 2 violation:

- A Level 2 violation exists when there is minor harm or potential for moderate harm to any resident(s).
- Level 2 harm involves a penalty of no less than $250 per violation, not to exceed $500 per violation.

Level 3 violation:

- A Level 3 violation exists when there is moderate harm or potential for serious harm to any resident(s).
- Level 3 harm involves a penalty of no less than $500 per violation, not to exceed $1,500 per violation.

Level 4 violation:

- A Level 4 violation exists when serious harm or death occurs to any resident(s).
- Level 4 harm involves a penalty of no less than $1,500 per violation, not to exceed $2,500 per violation.

Elevated violation:
This most serious level of violation is defined by abuse that was:

- Deliberate or other than accidental;
- Caused by a person with a duty of care toward the resident; and,

- Resulted in serious injury, rape, sexual abuse, or death of resident.

These cases will now result in a penalty of no less than $2,500 and no more than $15,000 per violation.

Increased cap on the total amount of civil penalties that may be imposed:
The Department may not impose civil penalties exceeding $20,000 for all violations in a single facility within a in 90-day period EXCEPT in cases that involve serious injury, rape, sexual abuse, or death; in these cases, DHA may not impose civil penalties exceeding $40,000 for all violations in a single facility within a 90-day period.

These caps increased the prior 90-day caps of $7,500 for regular violations and $15,000 for elevated violations. Penalties for adult foster homes have not changed.

Acuity tool:
An acuity tool to determine appropriate staffing levels in residential care and assisted living facilities is available. The Department is still working to place the tool online, which is required by the bill, so that it's easier to use by providers and staff. There is not an estimated date at this time, but APD is working with the Office of Reporting, Research, Analytics and Implementation to determine the best possible in-house solution. Meanwhile, the acuity tool is available for use in its current format.

Revised guidance for self-reporting of abuse:
As of January 1, 2018, if a facility does not self-report abuse, the Department may impose a $1,000 penalty. (This does not apply to adult foster homes.) The Department now identifies and tracks the number of self-reported incidents of abuse.

To help inform facilities about these new requirements, APD published the Abuse Reporting and Investigation Guide for Providers.

Updated practice for license conditions:
The Department now provides more specificity in its orders imposing conditions on licensure. This information includes:

- A specific description of how the scope and manner of the license condition is designed to remediate the violation; and,
- A specific description of the requirements for withdrawal of the license condition.

Also, the Department now adheres to specified timeframes when re-inspecting or re-evaluating − or the condition is automatically withdrawn.

- Within 15 business days of receipt of a facility's written assertion of substantial compliance, a facility is re-inspected or re-evaluated to determine substantial compliance;
- Within five business days of the reinspection or reevaluation, the facility is notified by telephone or email of the findings of the reinspection; and,
- Within 30 days after the re-inspection or re-evaluation, the facility is issued a written report notifying the facility of the Department's determinations regarding substantial compliance.

Regulatory framework:
The Department has been working closely with LeadingAge and the Oregon Health Care Association on the draft regulatory framework document. There are meetings upcoming and APD believes this will be finalized within the next couple of months. At that point, it will be published online.

The Oregon SNAP Cash Out Project

Historical Background
The 1977 Food Stamp Act included a provision requiring the Secretary of Agriculture to establish demonstration projects focusing on: the nation's elderly and persons with disabilities, lowering administrative costs, and increasing levels of participation.

This provision allowed the Secretary to approve projects in states which would give to elderly persons or those receiving Supplemental Security Income (SSI), the cash equivalent of SNAP benefits and:

- Reduce administrative costs,
- Reduce client travel costs and inconvenience,
- Eliminate the stigma of being seen using food stamps, and
- Increase utilization of the Food Stamp Program for Supplemental Security Income clients.

Demonstration Project in Oregon
In Oregon, **the SNAP Cash Out Project** began on August 1, 1980 as a limited demonstration project under Section 17 of the FS Act of 1977 in Clackamas, Washington, Multnomah, and Columbia counties. The project allowed the state to determine the cash value of food stamps for elderly clients and recipients of Supplemental Security Income and issue checks in lieu of food coupons. The SNAP Cash Out Project was ended, and Oregon was not allowed to expand it to other areas outside of those chosen for Oregon's Demonstration Project. However, the 2002 Farm Bill contained a provision to grandfather the project under the Demonstration's terms in Oregon and other states that employed the option.

The SNAP Cash Out Project's flexibility in meeting elderly and clients with disabilities' nutritional and household needs has made it a popular and successful project.

Current SNAP Cash Out Program Eligibility
Eligibility for the Cash Out Program includes the following criteria;

- SNAP eligible household;
- If living alone, individuals must be 65 years of age or older, or have been determined eligible to receive SSI benefits under title XVI of the Social Security Act;

- If living with others, everyone in the SNAP household must be 65 years of age or older, or have been determined eligible to receive SSI benefits under title XVI of the Social Security Act; and
- Living in Clackamas, Columbia, Multnomah, or Washington County.

Issuance of Cash Benefits
Participants in the Cash Out program have the following issuance options available:

- Via EBT – direct deposit into a participant's EBT account on the first day of each month accessed as cash transactions.
- Via Direct Deposit – direct deposit into a participant's private bank or credit union account on the third bank day of the month.
- Via Check –mailed the first mailing day of the month to a participant's mailing address. (This option is limited to participants with known barriers to using EBT and bank accounts for Direct Deposit).

SNAP Cash Out Benefits by the Numbers
Supplemental Nutrition Assistance Program (SNAP) Cash Out Program Data from December 2018[1]:

- Total number of households receiving SNAP Cash Out = 34,301
- Total amount of benefits received = $4,402,926
- Average monthly benefit per SNAP Cash Out household = $128.36
- SNAP Cash Out as a percent of total SNAP households = 8.97%[2]

The Supplemental Nutrition Assistance Program (SNAP) benefits may be used:

- to purchase food and nonfood items **OR**
- for cash withdrawals.

Oregon Administrative Rules Related to Cash Out Program
In Oregon, OAR 461-165-0082 was made effective 01/01/2010 and it states the following:

SNAP households in Clackamas, Columbia, Multnomah, and Washington counties receive SNAP benefits in cash if all persons in the filing group are 65 years of age or older or are eligible to receive SSI benefits under Title XVI of the Social Security Act.

[1] USDA FNS State Issuance and Participation Estimates Report 388 SSI for December 2018
[2] SNAP County Tables by FIPS December 2018

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February 6, 2019

DHS Oregon Department of Human Services

The Honorable Senator Lee Beyer, Co-Chair
The Honorable Representative Rob Nosse, Co-Chair
Ways and Means Joint Subcommittee on Human Services
900 Court Street NE
H-178 State Capitol
Salem, OR 97301-4048

Re: Follow-up Questions

Dear Co-Chairs:

Thank you for the opportunity to complete the Aging and People with Disabilities presentation on February 5, 2019. This letter provides follow-up answers to the unanswered questions on that day.

Questions from February 5, 2019 Hearing

Please provide the rate sheet APD utilizes for its long term care system.

We have attached the latest rate sheet, effective January 1, 2019, to this letter.

What is the average age of individuals in long term care?

We elected to provide several different data points that will assist in understanding the age distribution of individuals in long term care:

- The average age of a new entrant to long term care is 71.6.
- The average age of all long term care recipients is 71.2.
- The youngest recipient is 20 years old, while the oldest recipient is 102 years old.

The following table contains the distribution of individuals by age who are currently accessing long term care services:

20-39	40-59	60-69	70-79	80-89	90-99	100+
1,034	5,832	7,721	8,347	7,297	3,207	156

Please provide data on why individuals are accessing long term care.
The following table represents the distribution of individuals by their service priority level. Recall that service priority level is the category of service an individual is determined to belong to after qualifying for long term care after their assessment. Lower numbers indicate greater levels of impairment while higher numbers represent lower levels of impairment.

Service Priority Level (Driver of Needs)	Percent of Caseload
(1) Requires Full Assistance in Mobility, Eating, Elimination, and Cognition.	5.83%
(2) Requires Full Assistance in Mobility, Eating, and Cognition.	0.16%
(3) Requires Full Assistance in Mobility, or Cognition, or Eating.	54.85%
(4) Requires Full Assistance in Elimination.	3.82%
(5) Requires Substantial Assistance with Mobility, Assistance with Elimination and Assistance with Eating.	1.36%
(6) Requires Substantial Assistance with Mobility and Assistance with Eating.	0.41%
(7) Requires Substantial Assistance with Mobility and Assistance with Elimination.	15.87%
(8) Requires Minimal Assistance with Mobility and Assistance with Eating and Elimination.	0.09%
(9) Requires Assistance with Eating and Elimination.	0.08%
(10) Requires Substantial Assistance with Mobility.	13.51%
(11) Requires Minimal Assistance with Mobility and Assistance with Elimination.	1.95%

Service Priority Level (Driver of Needs)	Percent of Caseload
(12) Requires Minimal Assistance with Mobility and Assistance with Eating.	0.11%
(13) Requires Assistance with Elimination.	1.97%

Do we have information on how many relatives are providing in-home long term care to consumers?

We do not currently have a way to pull data easily out of our system to know how many relatives are becoming home care workers to provide care to consumers. Because this program allows consumers to employ whom they select, we do not necessarily know the relationship. We may be able to know by reading detailed narrative in our system, but there is no data field that indicates that the worker is a relative.

What work are we doing around workforce development for in-home workers and is there a career ladder for these workers?

The Oregon Home Care Commission has released a very comprehensive Workforce Development Plan that details much of the work that is being done collaboratively with stakeholders and others. – the link is here: https://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCC/Documents/OHCC-Workforce-Development-Plan.pdf

The Department hopes our answers to your questions were responsive and adequate. Please let us know if you have additional questions.

Sincerely,

Eric Luther Moore
Chief Financial Officer

Attachments:
Rate Schedule
Oregon Home Care Commission: Getting it Right

RATE SCHEDULE

(Effective January 1, 2019)

Rates apply to Medicaid Services funded by Aging and People with Disabilities.

Room & Board	In-Home Maintenance Allowance	Personal Incidental Funds
AB $599.00	$1,271	NF $63.10
AD/OAA $599.00	$1,271	CBC $172

Community-Based Care (CBC) Monthly Rates

	Residential Care Facilities	Adult Foster Homes
Base	$1,549	$1,557
Base plus 1 add-on	$1,849	$1,840
Base plus 2 add-ons	$2,149	$2,123
Base plus 3 add-ons	$2,449	$2,406
Hourly Exception Rate	$12.00 / Hr.	$13.70 / Hr.

Assisted Living Facilities	
Level 1	$1,243
Level 2	$1,541
Level 3	$1,933
Level 4	$2,428
Level 5	$2,922

Memory Care (Endorsed Units Only)	$4,063

Nursing Facility (NF) Daily Rate	
Basic	$312.94
Complex Medical	$438.12
Pediatric	$702.70

Comparable Monthly NF Rate	
Basic	$8,935.70
Complex Rate	$12,743.17

Homecare Workers (HCW)	Hourly	Enhanced
HCW Hourly Wage	$14.65	$1 over rate
Mileage, Non-Medical	$.485 per Mile	

*HCW who are certified by the Home Care Commission (i.e. successfully completed the Professional Development Certification) will receive an additional $.50/hr.
*Central Office will code the cases.

Providence ElderPlace Monthly Capitated Rate: (PEP) Statewide Rate - $4,643.43

Home Delivered Meals: $ 9.54 / meal

Long Term Care Community Nursing Services: $17.50 / 15-minute unit of service

In-Home Agencies: $24.61 / Hr.
Mileage, Non-Medical: $.485 per Mile

HK Shelter: $59.09/ month $1.94 / Day

Adult Day Services: Refer to Contracted Rates

In-Home Service Plan Max. Hour Local Office Tier 2 Hours Approval

ADL: 73
IADL: 35

Tier 2 = May also approve plans previously approved by Central Office.

Getting it Right:

Right Worker. Right Place. Right Time.

June 2017

OREGON HOME CARE COMMISSION

Workforce Development Strategic Plan

THOMAS P. MILLER & ASSOCIATES

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Acknowledgements

This report was prepared by Thomas P. Miller and Associates, LLC (TPMA). TPMA would like to thank the many individuals and organizations who provided input to help with the design and development of the following strategic plan and recommendations.

This report was completed with the guidance and leadership of the Oregon Home Care Commission and the Workforce Development Workgroup, who participated in planning sessions and provided valuable details, connections, and information throughout the planning process.

Oregon Home Care Commission
Jenny Cokeley

Joanna Gould

Roberta Lilly

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Lindsay Vanderworker

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Oregon Home Care Commissioners
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Nakeia Daniels, Governor's Office

Ruth Geislinger, Advocate

Lee Girard, Oregon Association of Area Agencies on Aging and Disabilities (O4AD); Oregon Home Care Commission Commissioner; Multnomah County Aging, Disability, and Veteran Services

Mark King, Former Oregon Home Care Commission Commissioner

Ruth McEwen, Governor's Commission on Senior Services, and Oregon Home Care Commission Commissioner

Sara Jane Owens, Association of Oregon Community Mental Health Programs

Laura Probst, Pac/West Communications

Katie Rose, Oregon Support Services Association

Tina Treasure, State Independent Living Council

We would also like to thank the Multnomah County Aging, Disability, and Veteran Services Division, NorthWest Senior and Disability Services, and the Seniors & People with Disabilities program in Florence for organizing, participating in, and hosting focus groups.

Executive Summary

In the coming years, demand for homecare and personal support workers is expected to experience significantly as Oregon's population ages and policy and legislative changes will increase the number of individuals with developmental disabilities who are eligible for in-home services. Thanks to the wage and benefits afforded these workers through membership in the Service Employees International Union (SEIU), attracting a workforce to these occupations in Oregon has definite advantages over other states. However, attracting and retaining more of the right workers at the right time in the right place means enhancing and modernizing both the image of the occupations and the Oregon Home Care Commission's (OHCC) administrative processes and culture that supports them.

Imagine Brian, a recent graduate of a local technical high school healthcare program pulls out his smart phone and opens the OHCC Registry app to begin looking for his first consumer-employer. He has just completed his orientation to become a homecare worker. This morning he received an email notifying him his background check was complete, and he is approved to start working.

Or Mary, a personal support worker and Romanian immigrant mother of two, who is logging on to the library computer to take the last online course she needs to receive a certification that will boost her pay and elevate her status as a professional. She is especially encouraged by all the notes of support her colleagues in the Florence area posted on their Facebook ® group page. She is now on a pathway to fulfilling her dream of becoming a Certified Nursing Assistant.

While these stories are just imagined possibilities today, successful implementation of the recommendations in this plan could make them a reality for thousands of Oregonians.

Supporting homecare workers, personal support workers and consumer-employers by: defining qualifications of homecare and personal support workers; providing a statewide Registry of homecare and personal support workers; providing training opportunities; and serving as the "employer of record" for collective bargaining for homecare and personal support workers who receive service payments that are from public funds, is the mission of the OHCC. But, as this plan asserts, OHCC cannot and should not take on sole responsibility for realizing that mission and the vision for its workforce strategy; many partners have value to offer and hold the potential expand the impact of the OHCC exponentially. While ultimately accountability of much of this work lies with the Department of Human Services (DHS) and the Oregon Health Authority (OHA), the more partners that are involved in implementation, the better.

The OHCC's Workforce Development Vision states Individuals will have access to supports and services from a qualified, trained and diverse workforce through the OHCC Registry.

In order to realize this vision, three strategic goals and supporting strategies must be achieved:

Goal 1: Position homecare and personal support workers as trained, credentialed professionals.

Strategy 1.1 - Build a recognized and transferable credentialing or certification system to assure continuous improvement in the quality of the workforce and opportunities for workers.

Strategy 1.2 - Use a variety of platforms and vetted sources to increase access to high-quality training, reduce costs, respond to the changing technological and schedule preferences of targeted workers and candidates.

Strategy 1.3 - Create a supportive environment among peers and administrators for workers.

Goal 2: Attract and retain a diverse and appropriate pipeline of qualified workers to meet the demand for homecare and personal support workers.

Strategy 2.1 - Simplify and streamline the processes for candidates to become homecare or personal support workers and existing workers to continue in the occupation.

Strategy 2.2 - Market of career opportunities to attract a diverse group of candidates to become homecare or personal support workers that match the diverse cultural, ethnic, gender, and support needs of the current and projected consumer-employer demand.

Strategy 2.3 - Partner with other healthcare, support, and workforce agencies to develop and promote clear career pathways.

Goal 3: Facilitate user-friendly approaches to connecting homecare and personal support workers with prospective employers

Strategy 3.1 - Continuously enhance the OHCC Registry platform to become more user-friendly, effective, and competitive with alternative platforms.

Strategy 3.2 - Build upon and enhance the quality, reach, and effectiveness of existing employer education programs and tools.

Throughout this workforce development strategic plan, specific Action Initiatives are described in detail, which are designed to drive implementation at the agency level with partner participation requiring the collaboration of partner agencies, local field offices, and outside organizations.

There are several major themes in the action plans, including better use of technology to leverage existing resources in a more efficient manner, improved communications, and steps to professionalize the workforce through integration with Oregon's career pathway initiatives, enhanced training, and certifications.

Thomas P. Miller & Associates has provided a series of recommendations which address organizational challenges and, if implemented, will better position the agency to succeed in meeting the expectations of workers, administrators, and consumer-employers. Additionally, Best Practices have been identified where possible to provide the Commission with examples of similar work in other places, which can be adapted and replicated.

Successful implementation depends on the OHCC leading a culture change and requires the support and full participation of the identified partners in the plan.