Oregon
John A. Kitzhaber, MD, Governor

Department of Human Services
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March 29, 2013

DHS
Oregon Department of Human Services

The Honorable Alan Bates, Co-Chair
The Honorable Nancy Nathanson, Co-Chair
Ways and Means Subcommittee on Human Services
900 Court Street NE
Salem, OR 97301

Dear Co-Chairs:

This is in response to the committee's questions during Day One of the Aging and People with Disabilities (APD) Presentation on March 25, 2013.

Question: Please describe the transportation funding in Older Americans Act (OAA) programs.

Answer: OAA funding is a federal grant awarded to the state based on a population formula. The grant is not intended to fully fund any service and on average supports one-third the cost of a service. In 2012, 9 of 17 area agencies on aging used $270,212 in OAA funds to support transportation services. These expenditures represent 1.6 percent of the total 2012 OAA grant awarded to Oregon. Primarily the funds supported local Dial-a-Ride programs to provide older adults transportation to shopping, medical appointments, senior centers and congregate meal programs. One area agency provides these funds to support the cost of volunteers to provide rides through a local non-profit agency called Interfaith Volunteer Caregivers. OAA represents a small portion of funding needed for these programs; these programs are primarily supported through the county Special Transportation Program, Public Transit grants and fares.

Question: To what extent is ADRC being used? Could we see that plan and outcomes?

Answer: The Aging and Disability Resource Connection (ADRC) is a national initiative to improve consumer access to the existing aging and disability services

network. Beginning in 2008, Oregon received the first of several federal grants to improve our system. Key partners in the ADRC are Area Agencies on Aging, Centers for Independent Living, DHS Medicaid field offices and county developmental disability offices. Today we have four functioning ADRCs covering 50 percent of Oregon's population with plans for statewide coverage by 2014. **(See Attachment #1 – Map of Current & Proposed ADRCs)**

Core services of the ADRC are Information and Assistance, Options Counseling, Streamlined Access to Public Benefits, Promotion of Evidence-Based Health Promotion Program and Care Transitions Coaching. Infrastructure built to support these services include service standards with performance metrics, website with searchable resource database, toll-free phone number, identification of key skills needed and training curriculum for Options Counselors, adoption of an evidence-based care transitions intervention, statewide brand and marketing plan/materials, management information system to collect utilization data, annual consumer satisfaction surveys.

In 2012, the ADRC served 31,548 unduplicated consumers and received 50,294 calls. Who's calling?: 30 percent senior consumers, 25 percent consumers with a disability, 15 percent family, 10 percent agencies and 20 percent other, such as paid caregivers. Why are they calling?: 54 percent health needs, 37 percent home care needs, 35 percent food needs (SNAP), 35 percent help to pay for healthcare (including Medicaid), 33 percent transportation, 26 percent help with medication, 25 percent confusion or memory loss, 21 percent help to pay to heat home, 18 percent help with shopping, 17 percent subsidized housing and 12 percent licensed care facilities. In 2012, the ADRC Options Counselors completed 1,256 counseling session helping consumers discern their needs and develop an action plan to meet their needs and/or future goals.

Please see Attachment # 2 - Metric results to date based on two rounds of consumer surveys conducted by Portland State University - Titled: Information, Referral and Awareness

Question: Of the 11,619 (est.) investigations completed by Adult Protective Services (APS) in 2011, how many were completed by Aging and People with Disabilities State Offices versus Area Agencies on Aging (AAAs)?

Answer: See Chart following on Page 3 and Attachment #3 Statewide Data Highlights – Adult Protective Services (APS) Community and Facility Annual Report, 2011

2011 Data	Facility Investigations	Percent	Community Investigations	Percent	Total	Percent
AAA's	2081	60%	3869	47%	5950	51%
State Offices	1379	40%	4287	53%	5666	49%
Total	3460		8156		11616	

Question: Were any of the 28,000 complaints received by Adult Protective Services referred to the Long-Term Care Ombudsman (LTCO)?

Answer: Yes. In 2011, Adult Protective Services referred 142 complaints to the Long-Term Care Ombudsman

See Attachment #4a, Background document of Office of Adult Abuse Prevention and Investigations (OAAPI)

Question: In looking at the investigation piece (number completed), what role does the Ombudsman play?

Answer: The total number of Investigations or assessments (11,619) refers to those completed only by APS as the LTCO does not investigate abuse or neglect. Please see the role chart for both APS and the Long-Term Care Ombudsman for a brief description of these roles*. The number of investigations (11,619) does include abuse referrals received *from the Long-Term Care Ombudsman* as our offices collaborate closely to ensure appropriate responses to facility concerns.

(*See Attachment #4b Describing purpose and scope of Long Term Care Ombudsman (LTCO) and APS)

Question: How do you define investigation?

Answer: For a description of how APS defines investigations please see **Attachment #5 - "Definition of Investigation."** For referrals received by APS that do not result in an investigation, please see Page 9 of the "Statewide Data Highlights Report by APS" **(See Attachment #3)** for additional information on how these calls were referred, resolved or screened-out based on APS eligibility criteria. Here is the link: http://www.oregon.gov/dhs/spd/data/aps-report-2011.pdf

Question: How often does an APS investigation result in a criminal investigation?

Answer: Design limitations in our data reporting system do not support statewide tracking of this information. However, here is what we could share to give some indication of the connection between the criminal justice system or law enforcement and Adult Protective Services.

In 2011, 24 percent of the financial exploitation allegations investigated included law enforcement involvement in some capacity. In some cases, law enforcement (LE) was the referring agency. In others, APS referred to LE at the point they felt there was indication that a crime had been committed. Because these referrals can occur during the investigative process, and before a finding is reached, not all ultimately resulted in a substantiated abuse outcome.

Question: Is there a waitlist for investigations?

Answer: No. All reports of abuse are screened and those that rise to the level of needing an investigation are immediately assigned to an APS worker. Workers have timelines for making initial contact, which vary depending on the degree of alleged abuse – timelines range from 2 hours to 24 hours for initial contact. We also have timelines for completion of the investigation, which includes the writing of the report. Our target for timely completion of reports is 60 days. 80 percent of the time the investigation is completed, and the report written, within 60 days of initial contact.

Question: Is data available about the trends of abuse and self-neglect?

Answer: Yes. **See Attachment #3 entitled "Statewide Data Highlights, APS Community & Facility Annual Report for 2011."** The report contains trend information in the Community APS Section starting on page 10 and the Facility APS Report starting on page 20. Self-neglect information can be found on page 12 including a definition of "self-neglect" and a couple of examples.

Question: What are the primary reasons for the increase in disability beneficiaries?

Answer: The disability determination caseload is increasing across the county and Oregon is no different. This is primarily due to the baby boomers now reaching an age that is often associated with disabilities that prevent workers from continuing

gainful employment. It is also tied to the lack of available jobs in the economy. Workers who have physical disabilities are often able to continue working in existing employments. However, when they lose that employment it is often difficult to find new work. Once their unemployment benefits are exhausted, they turn to the Social Security Administration (SSA).

The Social Security Administration has been tracking and evaluating this rising demand for Social Security Disability (SSDI) and Supplemental Security Income (SSI). Their national study is available at:
http://www.socialsecurity.gov/policy/docs/chartbooks/disability_trends/sect03.html

National criteria determine who is eligible for SSDI and SSI disability benefits. The criteria include factors in age, education and past work experience in making a determination. Those with less education have fewer transferable skills thus increasing the likelihood that they will be found eligible for benefits. Older workers also have different criteria that accounts for the difficulties they face in finding employment.

As of December 2012, 126,077 SSDI beneficiaries received $127,002,000 per month; and 71,151 SSI recipients received $37,554,000 per month for a total of 197,000 Oregonians receiving $165 Million per month in benefits. The average SSI payment is $528 per month, plus Medicaid; the average DI payment is $1,007 per month, plus Medicare after 24 months. These benefits go directly into the local and state economies and generate jobs and revenue for businesses

Question: Need Updated Licensing Slide:

Answer: See Attachment #6 - APD Licensing Slide Updated

Question: What is the Licensing fee for various programs?

Answer: Please see Attachment #7 - "Licensing Fees"

Question: How does the Length of Stay (LOS) in Nursing Facilities (NFs) compare to Length of State in Community Based Care (CBC)

Answer: Nursing Facility Length of Stay (LOS)

Currently APD does not have detailed length of stay data by diagnosis. The chart

below provides length of stay by payer source. Medicaid only data includes post hospitalization skilled care and long term services and supports.

Payer Source	Average LOS in Days
All Residents	60.1
Medicare –Post Hospitalization	27.6
Non-Medicare (includes Medicaid and Private Pay)	81.1
Medicaid Only	72.9

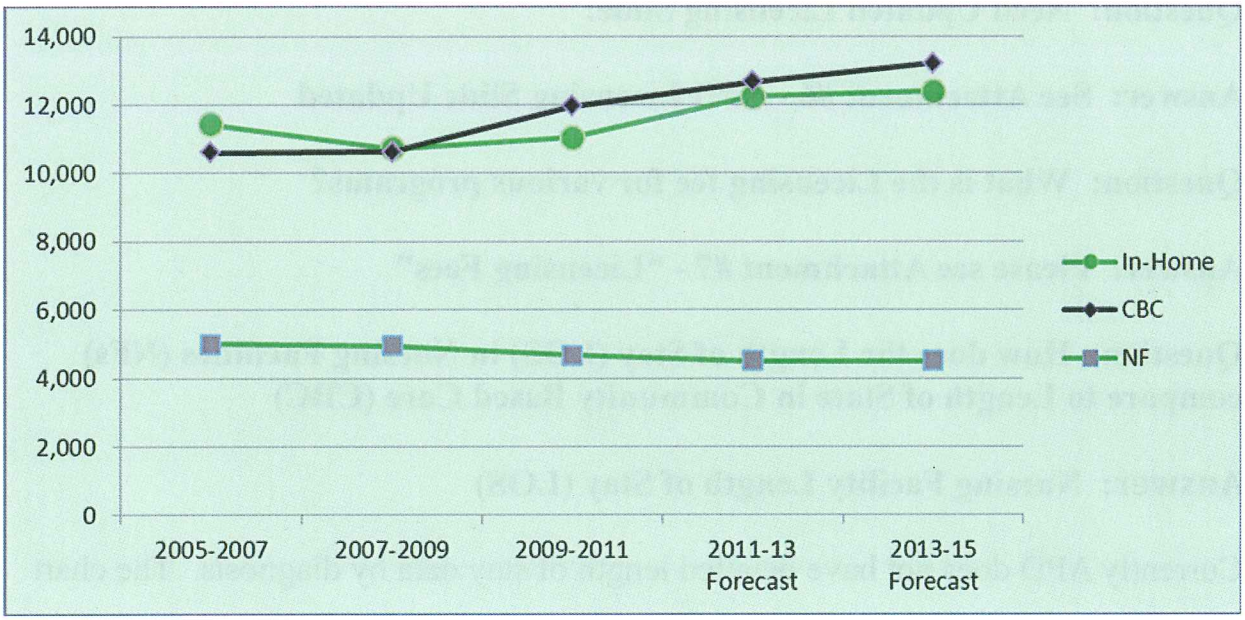
Connecticut Utilization and Cost Comparison

Senator Bates requested that APD modify the chart comparing Oregon and Connecticut to compare Oregon costs with Connecticut costs for nursing facilities (NF) and home and community based care (HCBC). **(Please see Attachment #8 Oregon Compared to Connecticut - Utilization and Costs)**

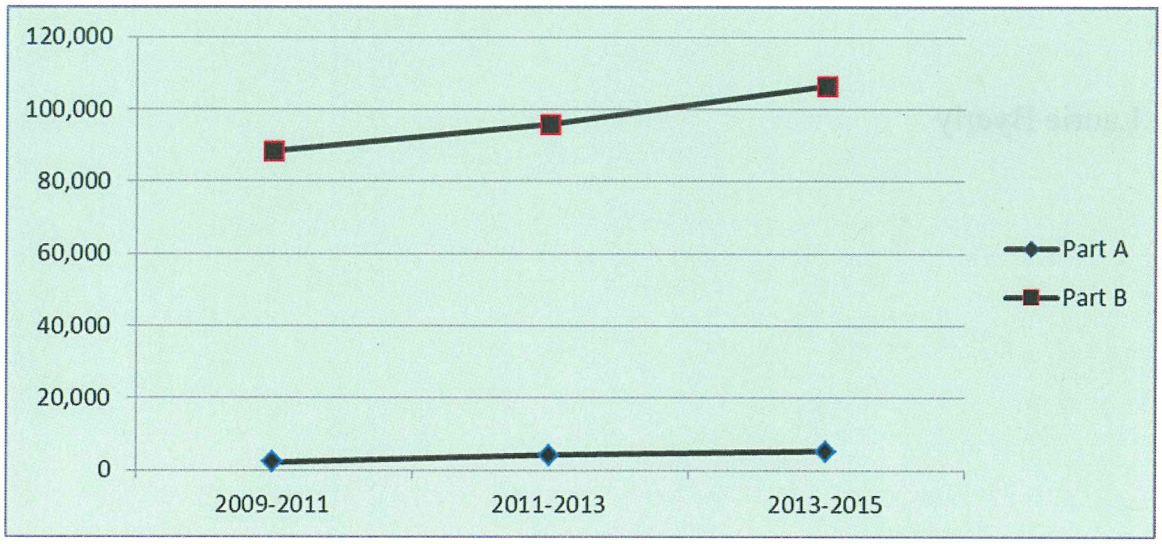
The following graphs show the utilization of NF versus HCBC options in each state. The second chart shows similar information as shown on March 25, 2013. However, the cost data in the Connecticut portion are now based on Connecticut costs. It appears from our review that the price difference between Oregon's HCBC services is due to Connecticut's more limited services in their HCBC program.

Question: Please provide the caseload growth graph over time.

Answer: Please see graphs below: APD Long Term Care Caseloads



APD Medicare Financial Eligibility



Question: In regards to AARP study, what is the criteria?

Answer: Please see Attachments #9 - Oregon, #10 - Washington, #11- Connecticut and #12 Minnesota for fact sheets and for the full report, access: http://www.longtermscorecard.org/

Question: In working with OHA, please describe medication management and the role of CCOs.

Answer: Medicaid-funded LTC provides needed assistance with Medication Administration and or reminders to take medications. DMAP/CCOs provide needed Prescription coverage and Medication Management.

Thank you,

Sincerely,

Eric Luther Moore
Chief Financial Officer
503-884-4701
Eric.luther.moore@state.or.us

Attachments

ELM/cw

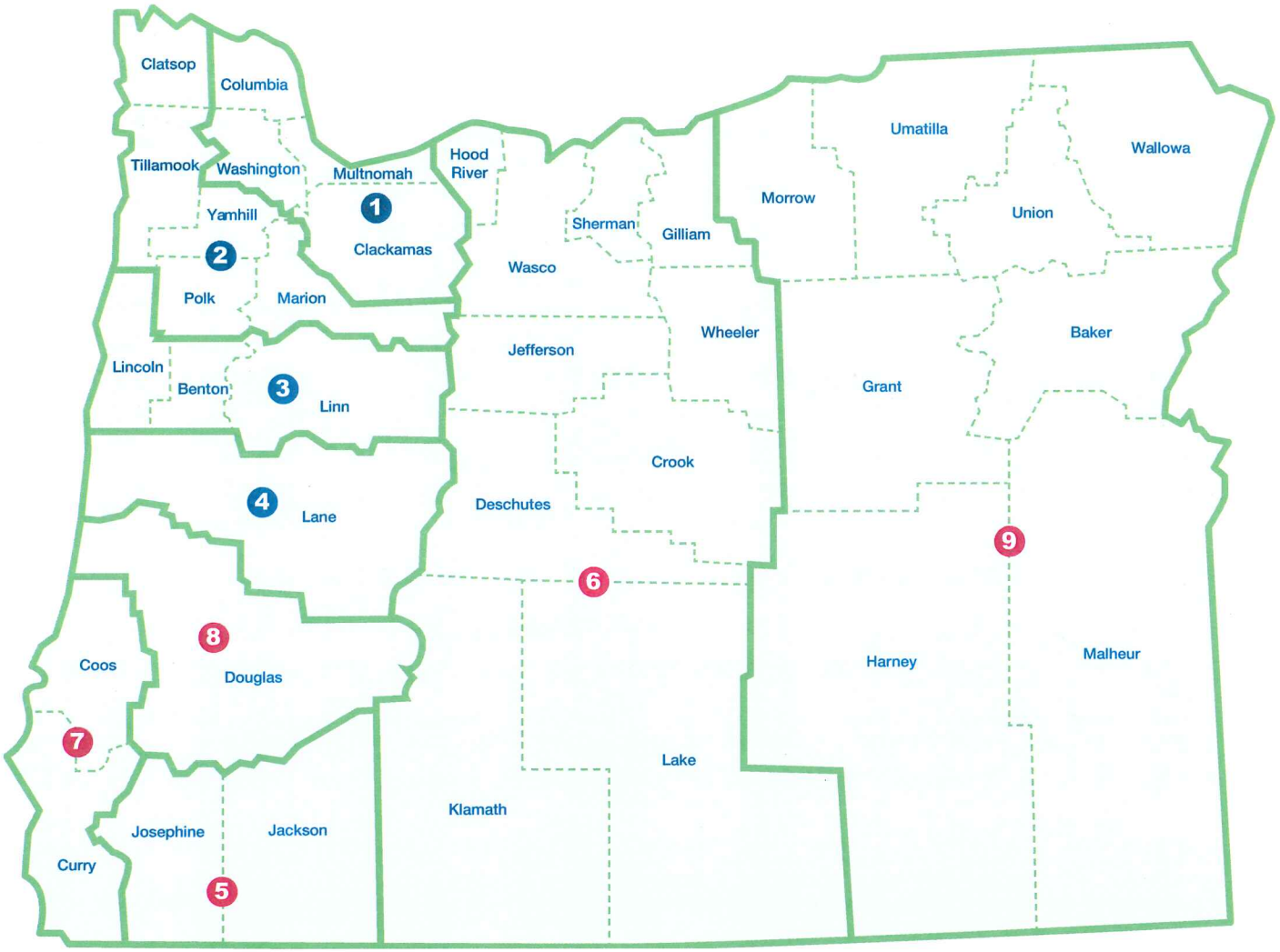
cc: Laurie Byerly

Attachment #1:

Oregon Map of Current and Proposed Aging and Disability Resource Connection (ADRCs)

Oregon ADRCs

Aging and Disability Resource Connection



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ADRC
Aging and Disability Resource Connection of OREGON

www.ADRCofOregon.org
1-855-ORE-ADRC (673-2372)

Current ADRCs

1. Multnomah, Clackamas, Washington and Columbia
2. Marion, Polk, Yamhill, Clatsop and Tillamook
3. Linn, Benton and Lincoln
4. Lane

Proposed ADRCs

5. Josephine, Jackson (2013)
6. Hood River, Wasco, Sherman, Gilliam, Wheeler, Jefferson, Crook, Deschutes, Klamath and Lake (2013)
7. Coos, and Curry (2014)
8. Douglas (2014)
9. Morrow, Umatilla, Union, Wallowa, Baker, Grant, Harney and Malheur (2014)

Attachment #2:

Metric Results by:
Portland State University
Information, Referral and Awareness

Information, Referral and Awareness

Call Center

Metrics:

- Of the people who leave a message, 85% get a call back within 24 hours based on the normal work week.
    - Not met in 2012 – 57%
- No more than 15% of callers report waiting "much too long" to receive a call back after leaving a message.
    - Metric not met in 2011-12 – 29%
    - Improved, but not met in 2012 – 20%

Access to the ADRC Building

Metrics: For those who go to the ADRC building:

- 90% report it is somewhat or very easy to find
    - Met in 2011-12 – 92%
    - Not met in 2012 – 87%
- 85% report that it was convenient to go to the ADRC
    - Not met in 2011-12 – 79%
    - Improved & Met in 2012 – 88%,
- 40% report that they waited less than 5 minutes to see someone
    - Not met in 2011-12
    - Improved & Met in 2012 – 42%)
- No more than 10% report waiting more than 20 minutes to see someone
    - Not met in 2011-2012 – 11%
    - Improved & met in 2012 –7%
- Fewer than 10% report it took "much too long" to see someone.
    - Met in 2011=2012 – 4%
    - Met in 2012 – 4%

Overall ADRC Experience

Metrics:

- 85% of consumers report that ADRC staff are very respectful
    - Met both years: 87% 2011-12; 88% 2012.

- At least 55% of consumers report receiving "all" of the information they needed; at least 35% of consumers report that they received "some" of the information they needed.
    - 2011-21: Nearly met – 55% received "all;" 34% received "some"
    - 2012: Nearly met –54% received "all;" 38% received "some"
- 75% of consumers report that it would be easy or very easy to contact the ADRC again.
    - Not met in 2011-12: 71%
    - Improved and met in 2012: 67% very easy, 15% somewhat easy to contact the ADRC again)

Information and Referral/Assistance

- 85% will report that the ADRC staff person was somewhat or very knowledgeable.
    - Met in 2011-12: 74% "very knowledgeable," 18% "somewhat knowledgeable
    - Met in 2012: 73% "very knowledgeable," 20% "somewhat knowledgeable"
- Of those receiving written materials, 90% will report they are relevant to their concerns.
    - Met in 2011-12: 92% reported relevant materials
    - Nearly met in 2012: 89% reported relevant materials
- 85% will report that ADRC staff were good or excellent at explaining how to get the help and information needed.
    - Not met in 2011-12, 80%
    - Not met in 2012: 78%
- 80% will report that the ADRC staff was good or excellent in helping to understand the service system.
    - Met in 2011-12, See Options Counseling section: 81% of OC consumers and those who received home visits rated ADRC staff as good or excellent
    - Met in 2012: 83%
- No more than 20% will report having to wait "much too long" to receive needed services.
    - Met in 2012. % of participants who reported waiting "much too long" for responses or services:
        - Receiving a call back: 20%
        - Time to see someone at the ADRC building: 4%
        - Received a visit at home: 7%

        - Housekeeping services: 4%
        - Home modification: 0%
        - Personal care: 7%
        - Meals services: 0%
        - Managing health: 4%
        - Transportation: 0%
        - Legal services: 0%
        - Other benefits: 0%
- 90% of consumers identified as needing follow up by the ADRC received follow up by ADRC staff. This is not available through the consumer satisfaction survey, however,
    - 2011-12: 46% of consumers reported getting a follow up call from the ADRC
    - Improved in 2012, although not met: 62%.

Options Counseling

Metrics:

- 90% of consumers who receive Options Counseling (or home visits) report they were given the information they needed.
    - 2011-12: [not completed]
    - 2012: 52% received "all," 43% received "some."
- 90% of consumers report they were treated with respect felt the Options Counselor listened to their opinions and understood their specific circumstances [understood your concerns]
    - 2011-2012
        - [not completed]
    - 2012:
        - 96% rated "very respectful'
        - 62% excellent; 18% good
        - 94%, which is significantly higher than for all ADRC consumers, which was 84%.
- 80% of consumers report the options counselor helped them explore the choice available to them and their family members.
    - 2011-12: 81% (56% excellent, 25% good)
    - Improved. 2012: 87% (64% excellent; 23% good)
- 75% of consumers report they have better understanding about their options after working with the options counselor.
    - 2011-2012: Met, 78% have better understanding
    - 2012: Not met, 69% have better understanding

- 80% of consumers rate the options counselor as good or excellent in supporting them in their decisions.
    - 2011-12: Met, 31% (50% excellent, 31% good)
    - Improved. 2012: Met, 91% (63% excellent, 28% good)
- 70% of consumers report that the options counselor helped them to develop an action plan listing goals and next steps.
    - 2011-2012, Not met: 47%
    - 2012, Improved, but not met 54%
- 80% of consumers report their situation is stable or improved following options counseling. Specifically, 80% of consumers will report:
    - Having enough support to meet needs and choices
        - 2011-12, Not met 75% (27% strongly agree, 48% agree)
        - 2012, Not met: 74% (30% strongly agree; 44% agree)
    - being safer
        - 2011-12: Met, 82% (31% strongly agree, 51% agree)
        - 2012: Decline: Not met, 75% (28% strongly agree, 47% agree)
    - being more able to make decisions and direct assistance needed [question asked was: *I am more independent as a result of the information and services I received]*
        - 2011-12: Not met, 77% (29% strongly agree; 48% agree)
        - 2012: Decline and not met 70% (28% strongly agree; 42% agree)
- 70% of consumers will report:
    - living in a place they most desire
        - 2011-12: Met, 80% (34% strongly agree, 46% agree)
        - 2012: Improved, Met 86% (38% strongly agree, 48% agree)
    - making the most of personal money and resources
        - 2011-12: Not met 65% (18% strongly agree, 47% agree)
        - 2012: Not met 61% (17% strongly agree, 44% agree

Attachment #3:

Statewide Data Highlights
Adult Protective Services (APS)
Community and Facility Annual
Report - 2011

Statewide Data Highlights

Adult Protective Services (APS) Community and Facility Annual Report 2011

DHS | Safety, health and independence for all Oregonians

Adult Protective Services (APS) Community and Facility Annual Report 2011

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Message from the Director

I invite you to review the 2011 Oregon Department of Human Services (DHS) Adult Protective Services (APS) annual report. This is the second report we have published. We plan to present this information annually as a step to help us all better understand our state's adult abuse trends more clearly. Our goal is to use the information so that we can target our abuse-prevention efforts to have the greatest impact.

Here are a few key facts about adult abuse in Oregon in 2011:

- In 2011, the Department of Human Services, Adult Protective Services received more than 28,000 reports of potential abuse.
- Of 28,000 reports of possible abuse, 11,619 met the statutory definition of abuse, and were assigned for investigation.
- 2,935 seniors and adults with physical disabilities were victims of abuse in 2011.
- 76 percent of founded abuse happened to seniors and adults with physical disabilities in their own homes. 24 percent of founded abuse occurred in licensed care settings.
- Financial exploitation was the most common abuse found in the community. Neglect of care was the most common type of abuse experienced by seniors in Oregon facilities in 2011.
- In the community, family members or close friends were the most common perpetrators of adult abuse. In facilities, direct caregivers were the most common perpetrator.

Efforts continued in 2011 to strengthen protections for vulnerable adults in licensed care settings and in the community. These included developing enhanced training and support for abuse prevention and early detection; improving the Department's response to reports of abuse; and strengthening relationships with local law enforcement to ensure accountability for abuse perpetrators.

In the spring of 2012, the DHS Office of Investigations and Training (OIT) merged with Adult Protective Services to create the Office of Adult Abuse Prevention and Investigation (OAAPI). Oregonians will benefit from the sharing of dedicated staff who

will be more effective and have an increased capacity for outreach and education. In addition, this joining of investigative offices will help to standardized abuse investigations for all vulnerable populations, provide for more statewide consistency and improve the ability to compile and use data for identifying trends. The new office design is focused on results, accountable and well supported programs with a focus on customer service and client outcomes. Future annual reports will include adult-abuse data from the two newly merged programs to reflect a more comprehensive picture of abuse in Oregon.

OAAPI is directly linked to the outcome goal of safety for all Oregonians, and particularly for vulnerable adults and children. Individuals we serve are at the highest risk of abuse or neglect. When people live free from abuse, their medical, physical and psychological treatment needs are reduced, allowing them to live independent, productive lives in their communities. Considering the direct link between robust abuse prevention efforts and the positive impact to the lives of those we serve, our responsibility to respond quickly and thoroughly to reports of abuse is not only critical, but an investment in the future of vulnerable Oregonians.

All of us have a role to play to ensure that seniors and people with disabilities feel safe and are safe in our communities. My hope is that the information included in this report will raise awareness and inspire others to join us in our continued commitment to action on this important issue.

Marie Cervantes
Director
Office of Adult Abuse Prevention and Investigations
Department of Human Services

Introduction

The Oregon Department of Human Services (DHS) continues to provide necessary assistance to thousands of vulnerable adult Oregonians who are unable to protect themselves from abuse or self-neglect. Vulnerable adults include residents of long-term care facilities, adults age 65 or older, and adults with a physical disability.

The community report contains information about persons living in their own homes, while the facility report contains information about residents in all state licensed adult foster homes, assisted living facilities, nursing facilities, and residential care facilities.

This report will provide information on how abuse and self-neglect in the community are defined, and what the common elements and distinctions are between Community APS and Facility APS.

This report will also draw comparisons from the current year, to data from the 2010 report.

The next section of this report will provide background information on adult protective services, including abuse definitions, and common elements and distinctions between Community and Facility APS. The sections highlighted in the introduction of the report are as follows:

- What are adult protective services?
- What is abuse?
- What is self-neglect?
- Overview of Community and Facility complaint conclusions in 2011
- What happened to calls that were not investigated by APS?

What are adult protective services?

APS Specialists in local county offices provide protective services throughout the state. APS Specialists investigate abuse and provide protective services for older adults and adults with physical disabilities in community settings and licensed facilities. In order to protect victims, APS consistently and objectively performs the following standard activities:

- **Screening.** All contact involving the possibility of abuse or self-neglect are reviewed.
- **Consultation.** When a complaint is received, but does not involve abuse, specialized APS information may be provided to the caller.
- **Triage.** Once a complaint meets APS criteria, a response time is assigned based on the nature and severity of the complaint. Response times include within two hours, by the end of the next working day, or within five days.
- **On-site assessment.** APS Specialists visit the home or facility and see the reported victim to assess risk.
- **Investigation.** APS Specialists investigate all perpetrator-related abuse complaints. Investigations include interviewing witnesses, gathering evidence and making personal observations.
- **Intervention.** APS Specialists provide protective services to victims based on their assessed needs. The victim is offered options to reduce harm.
- **Documentation.** An investigation report is written after an objective analysis and weighing of evidence, resulting in a conclusion.
- **APS Risk Management.** Under specific circumstances, a victim may need continued intervention to reduce risks and harm. In these cases, APS works with the victim providing case management and intervention with the goal of stabilizing the situation.

APS authority

Oregonians are committed to protecting their most vulnerable citizens. Authority and responsibility is delegated through the following statutes to support the rights of older Oregonians and Oregonians with physical disabilities to be independent, healthy, and safe:
ORS 410.020(2); ORS 410.020(3); ORS 410.070(1); and ORS 124.050 to 124.095.

What is abuse?

Below are the general descriptions of the eight types of abuse that Adult Protective Services investigates in Oregon.

"**Abuse**" means:

- **"Abandonment":** A caregiver's desertion places the adult in serious risk of harm.
- **"Emotional or verbal abuse":** The infliction of anguish, distress or intimidation through verbal or non-verbal acts or threat.
- **"Financial exploitation":** Illegal or improper use of an adult's resources (including medications) through deceit, theft, coercion, fraud, undue influence or other means.
- **"Neglect":** The failure to provide basic necessary care or services when such failure may lead to harm or risk of serious harm.
- **"Physical abuse":** The use of physical force that may result in bodily injury, physical pain or impairment.
- **"Sexual abuse":** Non-consensual sexual contact, sexual harassment, inappropriate sexual comments and threats. These activities are considered non-consensual if the person does not make, or is incapable of making, an informed choice.
- **"Involuntary seclusion":** Confinement, restriction or isolation of an adult for the convenience of a caregiver or to discipline the adult.
- **"Wrongful restraint":** The use of physical or chemical restraint to limit the movement of an adult for the convenience of the care giver or to discipline the adult.

Detailed definitions are available at:
http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_411/411_020.html

What is self-neglect?

APS also provides assessment and intervention in cases of self-neglect, which do not involve a perpetrator. **"Self-neglect"** means the inability of an adult to understand the consequences of his or her actions or inactions when that inability leads to or may lead to harm or endangerment to self or others.

Overview of community and facility complaint conclusions

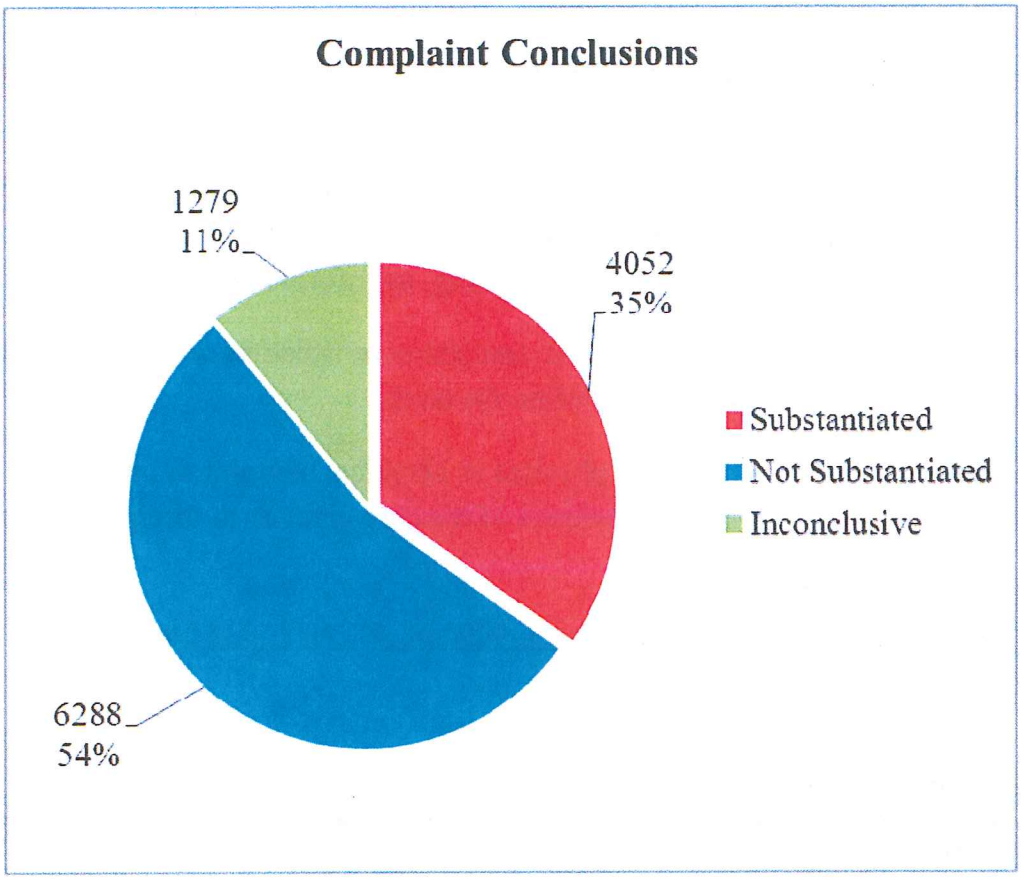
APS Specialists objectively review the evidence and come to a conclusion. Each investigation or assessment results in one of the following:

"Substantiated": Means the majority of the evidence indicates the complaint is true.

"Not Substantiated": Means the majority of the evidence indicates the complaint is not true.

"Inconclusive": Means the evidence proving and disproving the complaint are equal and a determination of whether wrongdoing occurred cannot be reached.

This graph shows the complaint conclusions for all complaints opened for investigation or assessment, in both community and facility settings.



What happened to complaints that were not investigated?

APS received over 28,000 complaints in 2011, of which 11,619 were assigned for investigation or assessment. The table below depicts the calls that were not investigated by APS, but were referred to other agencies. Please note that Consultation, which is not included in the table, is used in cases that do not meet APS criteria for investigation, but typically involve issues that can be addressed or resolved by providing specialized APS knowledge to the caller. APS provided consultation to 2,950 callers in 2011.

Community	Local partners	1757
MH	Mental Health program	635
Licensor	AFH licensor in the local office	543
DOJ/MFCU	Department of Justice/Medicaid Fraud	455
CCMU	State survey agency	444
Other	Other referrals	424
DD	Developmental Disabilities program	406
CW	Child Welfare	401
LE	Law Enforcement	304
Other PS	Another APS program with jurisdiction	262
LTCO	Long-term care ombudsman	142
Licensing	Facility licensing in OLRO	78
Legal Services	Legal Aid, Oregon State Bar	66
Screened out	Does not meet APS eligibility criteria	7809

Community
Adult Protective Services

As you see yourself, I once saw myself; as you see me now, you will be seen. Protecting vulnerable adults from abuse, neglect, financial exploitation or isolation is everyone's business. It is the measure of your community. You could even save a life.

---from "Everyone's Business" Elder Abuse Campaign

The Oregon Department of Human Services is responsible for providing adult protective services (APS) to adults age 65 or older and adults with physical disabilities who are in danger of being mistreated or neglected and are unable to protect themselves. Community APS generally provides protective services to Oregon citizens living in their private homes.

2011 Community APS Fast Facts

Abuse:

- 5,992 allegations of abuse investigated
- 1,657 allegations of abuse substantiated

Self-Neglect:

- 2,164 self-neglect assessments completed
- 464 self-neglect assessments substantiated

The number of Community investigations and assessments increased by four percent or 369 allegations between 2010 and 2011. Substantiated allegations rose eight percent or 176 allegations during the same time period.

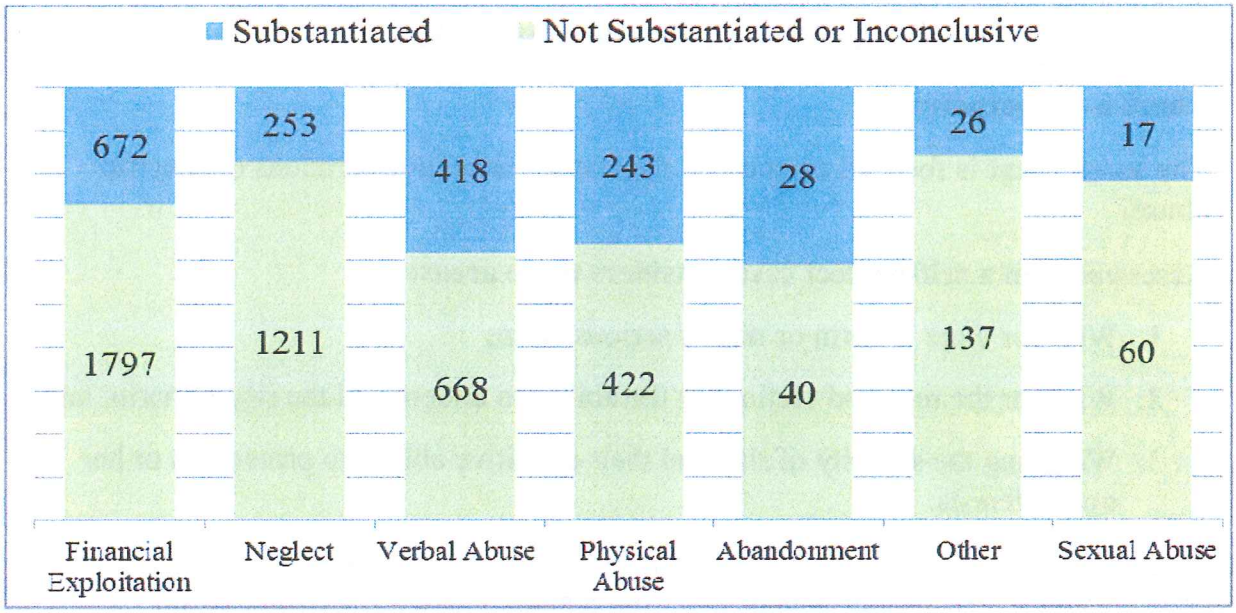
As in 2010, financial exploitation continues to be the most frequently reported, investigated, and substantiated type of abuse.

Abuse

2011 Statewide Community APS Abuse Substantiation

Type of Abuse	Number of Allegations	Number Substantiated	Percent of Total Substantiated
Financial Exploitation	2469	672	40%
Neglect	1464	253	15%
Verbal Abuse	1086	418	25%
Physical Abuse	665	243	15%
Abandonment	68	28	2%
Other	163	26	2%
Sexual Abuse	77	17	1%
Total	5992	1657	100%

Investigation Outcomes for 2011



NOTE: Involuntary Seclusion and Wrongful Restraint were types of abuse investigated in 2011, but due to limitations in the data system, these types of abuse were recorded within the categories provided. These are generally reflected in the categories of Physical Abuse and Neglect.

Self-neglect

"**Self-neglect**" is defined in OAR 411-020-0002(30) as the inability of an adult to understand the consequences of his or her actions or inaction when that inability leads to or may lead to harm or endangerment to self or others.

Examples of self-neglect complaints:

- An 81-year-old woman with Alzheimer's disease cannot consistently remember to take to her medications or may take them too frequently, resulting in unsafe medication levels and a worsening of symptoms.

- A 76-year-old man with increasingly impaired mobility due to severe arthritis and a stroke, which also impaired his decision-making ability, has fallen repeatedly, resulting in injury and delayed medical treatment.

- A 48-year-old man with traumatic brain injury utilizes an electric wheelchair in the community both during the day and after dark, but does not heed traffic controls nor utilize crosswalks.

Self-neglect is different from abuse in the following ways:

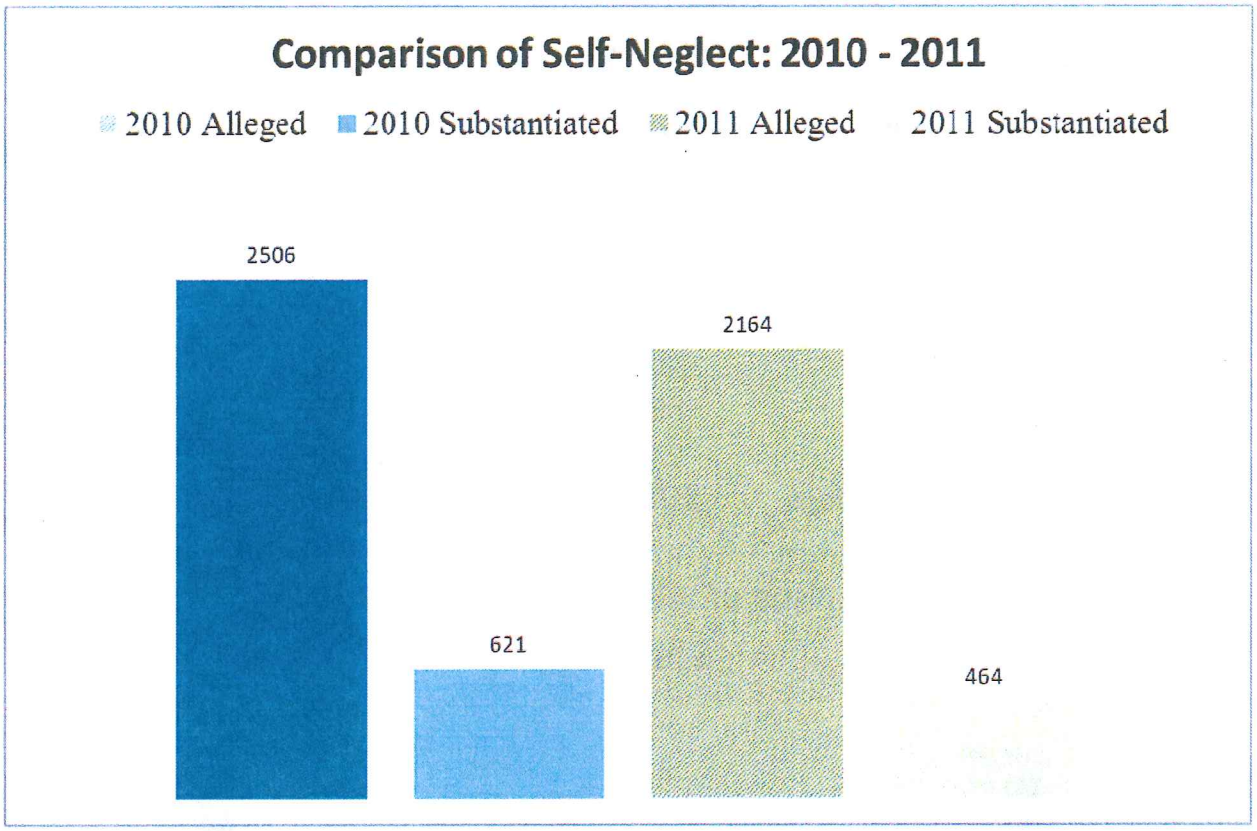
- **There is no perpetrator.**
- The **assessment** is focused on specific risks rather than investigations of specific abuse.
- **Assessment in a self-neglect case considers three areas:**
    1. Whether there is harm or risk of serious harm;
    2. Whether the reported victim has the ability to understand the risk or harm; and
    3. Weighing the severity of risk and their cognitive ability to protect his or her own interests.

A self-neglect case is substantiated when the reported victim does not recognize the risk or harm they face, and cannot plan or carry out a plan to lessen the risk or harm.

The definition of self-neglect rules out the person who makes choices others may not make, as long as they recognize the risk and understand the potential consequences of their actions.

Intervention for self-neglect

Intervention goals in self-neglect cases are to offer opportunities to improve safety and stability. The APS Specialist works with the reported victim to resolve any immediate crisis, reduce risk, and establish long-term stability.

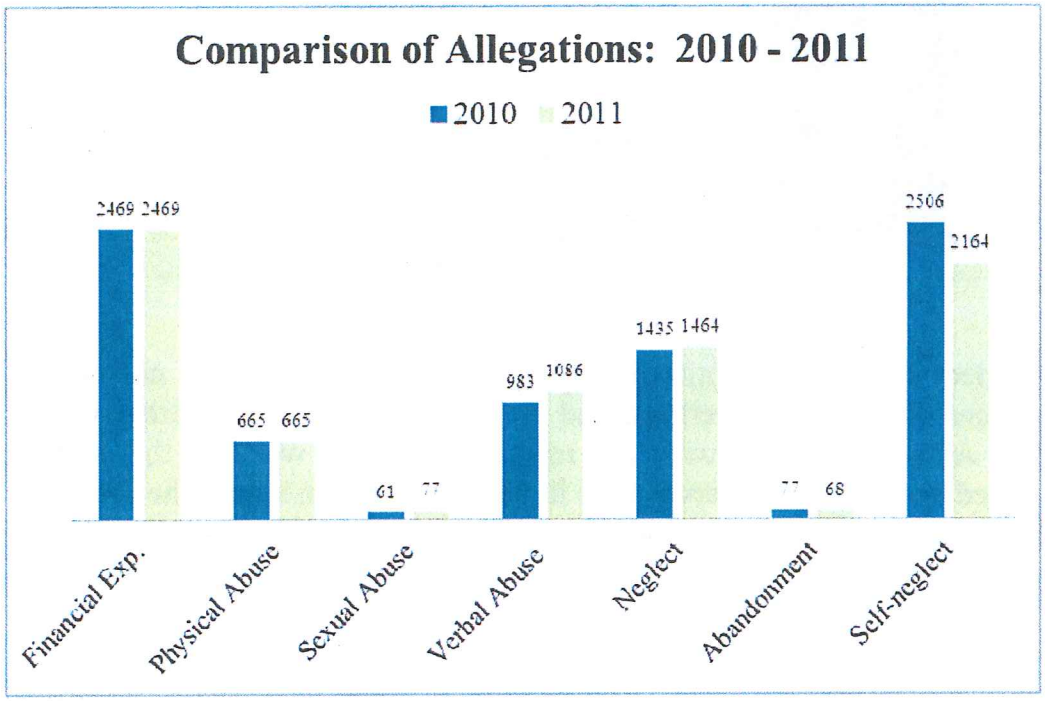


A self-neglect case is substantiated only if a reported victim does not understand the consequences of his or her actions, and the actions place the reported victim at risk. However, APS will work with all reported victims, whether the self-neglect is substantiated or not, to put interventions in place that reduce harm. The focus for all self-neglect referrals is on small, but meaningful interventions, which can be sustained when APS is no longer involved.

Summary of community APS investigations

2011 Community APS
Comparison of all Substantiated and Unsubstantiated Investigations for Abuse and Self-Neglect

Types of Abuse	Number of Allegations	Percent* of Total Investigations
Financial Exploitation	2469	30%
Self-neglect	2164	27%
Neglect	1464	18%
Verbal Abuse	1086	13%
Physical Abuse	665	8%
Other	163	2%
Abandonment	68	1%
Sexual Abuse	77	1%
Total Investigations	**8156**	**100%**



Summary continued

2011 Community APS
Four Year Trend of Complaints and Substantiations
for Abuse and Self-neglect

	2008		2009		2010		2011	
Types of Abuse	**Complaints**	**Sub.**	**Complaints**	**Sub.**	**Complaints**	**Sub.**	**Complaints**	**Sub.**
Financial	2376	698	2153	612	2469	685	2469	672
Self-neglect	2333	623	2297	581	2506	621	2164	464
Neglect	1376	300	1347	301	1435	290	1464	253
Verbal Abuse	881	378	815	349	983	399	1086	418
Physical Abuse	652	253	592	266	665	253	665	243
Other	286	64	251	54	275	62	163	26
Abandonment	88	34	71	32	77	32	68	28
Sexual Abuse	70	13	62	16	61	17	77	17
Total	**8062**	**2363**	**7588**	**2211**	**8471**	**2359**	**8156**	**2121**

NOTE: "Other" represents situations that do not meet the criteria for investigation or assessment, but there are serious concerns about the welfare of an individual. Typically, APS will partner with other agencies to evaluate the degree of risk, ensure the person has the ability to make choices, and offer protection.

This chart reflects the consistency with which the issues of financial exploitation and self-neglect have impacted the health and safety of Oregonians. Although the most frequently reported types of abuse and neglect, they are the most difficult to investigate and reach conclusive results. 21% of self-neglect allegations and 27% of financial exploitation allegations were substantiated in 2011. This compares to much higher substantiation rates in the areas of abandonment (41%), verbal abuse (38%) and physical abuse (36%).

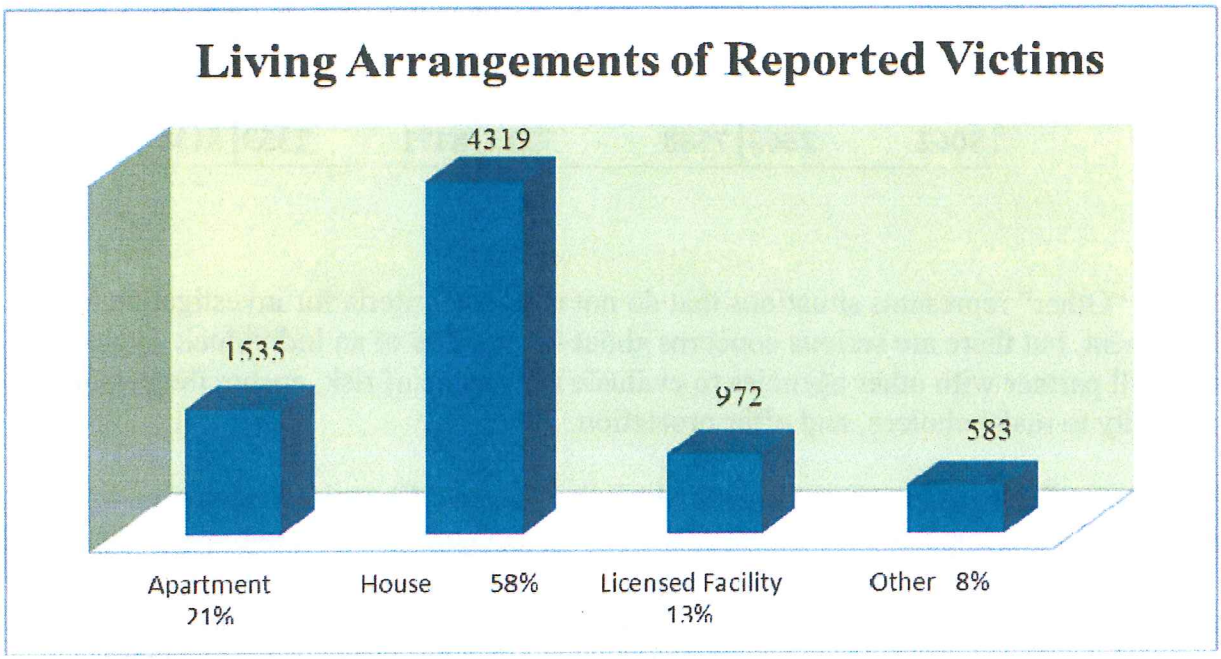
Descriptions of reported victims

"Reported victim" is the individual for whom a complaint of abuse or self-neglect is reported to APS. In 2011, Community APS provided investigation or assessment to 6,900 reported victims.

Note: Some reported victims experience more than one type of abuse.

Characteristics of Reported Victims

Gender			Age Categories		
Female	4197	(61%)	Age 65 and older	5231	(76%)
Male	2587	(37%)	Under 65 with Physical Disabilities	1501	(22%)
Other	116	(2%)	Unknown	168	(2%)



In a Community APS complaint, a reported victim may live in a licensed facility. Community APS investigates when the reported perpetrator is not an employee or volunteer of the facility.

Those counted as "other" include living situations such as someone else's home, homelessness, or temporary housing.

Complaint outcomes

Adult Protective Services offers a variety of interventions that may result in many different outcomes. All complaints that are investigated or assessed are assigned an outcome, whether the abuse or self-neglect was substantiated, or not. While there may be several interventions and outcomes in an individual case, the table below represents the single most identifiable outcome in all Community APS complaints.

Outcomes	Incidence
Problems resolved	1995
Refused services/intervention	1951
Risk significantly reduced	1633
Accepted other services	929
Entered care facility	483
Referral to the District Attorney	283
Services no longer needed	209
Victim/client died*	197
Services not available	196
Moved out of service area	155
Guardian/conservator	120

* "Victim/client died" captures reported victims that died from many causes, and does not represent the number of victims that died from abuse.

Relationship of the reported perpetrator

"Reported perpetrator (RP)" means any individual reported to have committed wrongdoing against an adult age 65 or older or a person with physical disabilities.

In 36% of the reports of possible abuse against a protected individual, the person(s) reported to have committed the alleged abuse is the son or daughter of the protected person. In comparison, a non-relative is the reported perpetrator in 31% of the reports.

Reported Perpetrators	Number of Complaints
Non-relative	1118
Son	1076
Daughter	1068
Other family member/relative	734
Non-relative caregiver	671
Other/not available	588
Spouse	577
Parent	64
Guardian/Conservator	36

Who reported abuse and self-neglect in 2011?

The source of the complaint ranges from public officials and medical personnel to family members and neighbors. Complainants marked with an * are mandatory reporters.

Source of Complaints		
Who reported?	**Number**	**Percent**
Family members	1228	16%
Friend/neighbors	791	11%
*Law enforcement officers	671	9%
Other	611	8%
*Area Agency on Aging/ Senior and Disabled Services	610	8%
*Health care professionals	527	7%
*Social Service Staff	520	7%
Self/victims	439	6%
Facility staff	352	5%
*Hospital	331	4%
Bankers	319	4%
*Home health personnel	305	4%
Anonymous	273	4%
*Physicians	131	2%
*EMT/fire fighters	119	2%
*Mental health workers	114	2%
*Public officials	98	1%
Attorneys	30	<1%
*Clergy	20	<1%
Long-term care ombudsman	14	<1%
Pharmacists	3	<1%

Facility
Adult Protective Services

"APS provides safety and protection for Oregon's most vulnerable citizens--those who live in long term care facilities across our state. They offer all Oregonians assurance that protection and safety of our fellow citizens is their highest priority."

-Mary Jaeger MSG/MPA
Oregon Long Term Care Ombudsman

The Oregon Department of Human Services (DHS) Office of Adult Abuse Prevention and Investigation (OAAPI) is responsible for responding to complaints of abuse in Oregon's long-term care facilities, including adult foster homes (AFH), assisted living facilities (ALF), nursing facilities (NF), and residential care facilities (RCF). OAAPI Adult Protective Services (APS) works closely with the Office of Licensing and Regulatory Oversight to maintain safe environments in 2,485 licensed facilities.

2011 Facility APS Fast Facts

Abuse facts:

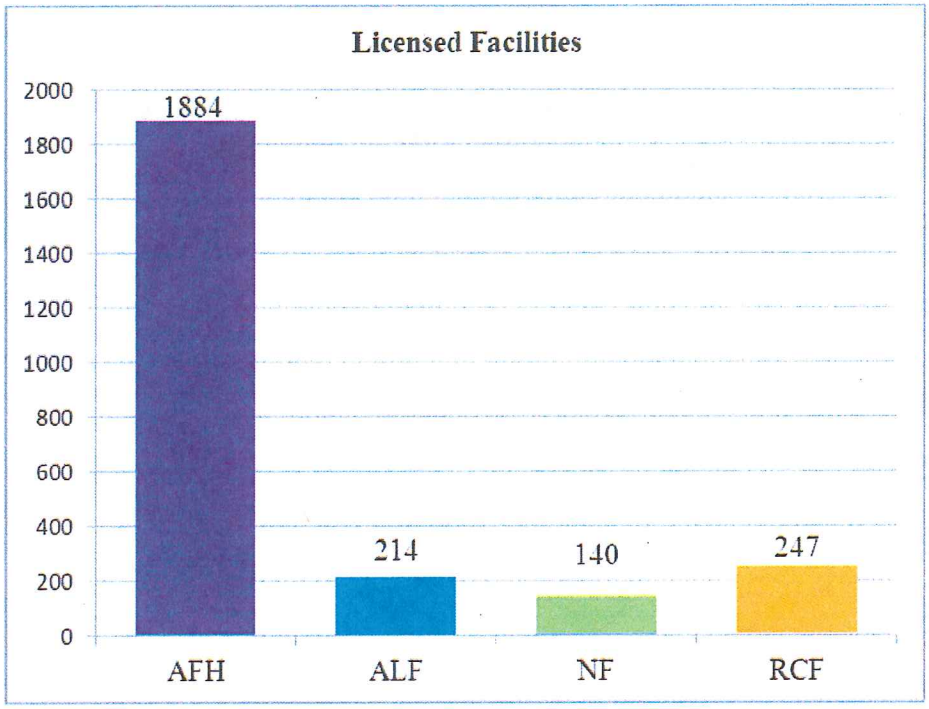
- 3,463 allegations of abuse were investigated.
- 654 allegations resulted in an abuse substantiation.
- 1,277 allegations resulted in non-abuse licensing violations.
- 2,777 neglect allegations were investigated, making neglect the type of abuse most often reported.

In 2011, there were approximately three percent, or 100 fewer allegations investigated as compared to 2010, however substantiated abuse outcomes increased by 38 percent or 180 in 2011.

As in 2010, Neglect continues to be the most frequently reported concern, representing 80 percent of all complaints. Neglect covers a wide range of incidents including injury when a caregiver does not follow the care plan, failure to implement preventive measures for a resident with a history of falls, or failing to supervise a resident prone to wandering.

Licensed facilities by type

The Office of Licensing and Regulatory Oversight (OLRO) and local office staff license and monitor Oregon's long-term care and community based care facilities. OLRO, APS, and the Office of the Long-Term Care Ombudsman (LTCO) work together to ensure and improve safety and quality of life in these facilities.



Facility Type	Count
Adult Foster Home (AFH)	1884
Assisted Living Facility (ALF)	214
Nursing Facility (NF)	140
Residential Care Facility (RCF)	247
Total Licensed Facilities:	2485

Note: The number of Adult Foster Homes in the table above includes commercial and limited licensed homes. Community APS responds to complaints in approximately 1,500 Relative Foster Homes.

Complainants

The person contacting APS to report abuse, neglect or exploitation is called the complainant. The facility (administrator, licensee or staff) is required to report abuse, neglect and exploitation to the APS local office. Therefore, facility staff are the largest group of complainants. The identity of the complainant is protected by law, but can be released to law enforcement or by judicial order. There may be more than one complainant per allegation.

Complainants for all Facility Complaints
2011 and 2010 Comparison

Attachment #4a:

Office of Adult Abuse Prevention and Investigations (OAAPI) Background

DHS
Oregon Department
of Human Services

OAAPI
Office of Adult Abuse Prevention and Investigations

OAAPI
Office of Adult Abuse Prevention & Investigations

What is OAAPI?

OAAPI is the new office, created in March 2012, responsible for conducting and coordinating abuse investigations and providing protective services statewide in response to reports of abuse and neglect of vulnerable adults, including:

- Adults over the age of 65
- Adults with physical disabilities
- Adults with developmental disabilities
- Adults with mental illness, and
- Children receiving residential treatment services

Who is OAPPI?

OAAPI has a core staff of 51 employees, including trainers, coordinators, investigators, screeners, policy analysts, researchers and data analysts. In addition to conducting around 500 investigations annually in-house, OAAPI oversees and coordinates the work of over 200 abuse investigators around the state working for many different entities, including DHS, county mental health and developmental disability programs, Area Agencies on Aging, and others.

The funding for those non-OAAPI investigators is provided by their respective programs, including DHS/Aging & People with Disabilities, DHS/Developmental Disabilities, OHA/Addictions & Mental Health, and Child Welfare.

What are OAAPI's core functions?

OAAPI provides standards, policy, data analysis, research, prevention services and program coordination statewide, related to abuse of vulnerable adults. OAAPI trains abuse investigators and protective service workers across the state, coordinates and reviews their work, and investigates certain abuse referrals itself using in-house investigators.

What are OAAPI's primary goals?

OAPPI strives to:

- Respond in a prompt, consistent and equitable manner, statewide, to all reports of abuse of vulnerable adults (and children in certain settings)
- Provide proactive prevention training and services to vulnerable populations and those who care for them, to prevent abuse from happening in the first place.

What types of abuse are investigated?

OAAPI receives and investigates reports of physical, sexual, verbal, emotional and financial abuse, as well as caregiver neglect, self-neglect, involuntary seclusion and wrongful restraint. Reported victims may live in licensed facilities or in their own homes. The applicable definition of abuse may vary depending on the person's living situation and the nature of the person's vulnerability.

How many referrals of abuse does OAAPI receive and investigate?

In 2011, the investigative units now coordinated by OAAPI received over 28,000 reports of abuse of vulnerable adults, and conducted nearly 14,000 investigations, broken down as follows:

Adults over 65 and adults with physical disabilities:	11,619	83%
Adults with developmental disabilities	1,611	12%
Adults with mental illness	550	4%
Children in residential treatment *	161	1%
Total	**13,941**	**100%**

*Reports of abuse of children living in their own homes or in foster care are investigated by Child Welfare.

What are the most common types of abuse in Oregon?

In 2011, the most common types of abuse for the different populations served by OAAPI were the following:

- Elders and adults with physical disabilities living in the community: **Financial Exploitation**
- Adults with developmental disabilities living in the community: **Caregiver Neglect**
- Adults with mental illness living in the community: **Physical Abuse**
- Adults living in licensed settings: **Caregiver Neglect**

In the community, family members, friends and caregivers were the most common perpetrators of abuse.

Where do reports of possible abuse come from?

Family members and friends are the most common source of abuse referrals (27%). Next are health care workers (24%), social service staff (10%), and law enforcement (9%). National studies indicate that abuse of vulnerable adults is vastly under-reported.

What are the consequences of abuse? Abuse has been shown to:

- Increase the use of healthcare services by vulnerable adults
- Greatly increases the likelihood of admission to a care facility
- Increase the dependence on Medicaid services following financial exploitation
- Hasten the death of senior victims
- National research shows that more than half of people with developmental disabilities or mental illness will experience repeated physical or sexual abuse in their lifetime.
- Freedom from abuse is critical to benefiting from services.

Where can I learn more about abuse of vulnerable adults in Oregon?

Visit our webpage at http://www.oregon.gov/DHS/abuse/pages/index.aspx

Attachment #4b:

Roles, Purpose and Scope of Long-Term Care Ombudsman (LTCO) and Adult Abuse Prevention and Investigations

Aging and People with Disabilities
Ways and Means Follow-up
Prepared by Office of Adult Abuse Prevention and Investigations
March 26, 2013

Function	LTCO	APS
Purpose	The goals of the Ombudsman Program are to identify and be responsive to citizen needs and concerns with respect to all aspects of Oregon's Long Term Care System, including but not necessarily limited to the sufficient quality of provider service, government rules and regulations, and any administrative or other actions impacting Long Term Care residents. [1]	**Responsibility**: The Department of Human Services (DHS) Office of Adult Abuse Prevention and Investigation has responsibility to provide Adult Protective Services to older adults and to adults with disabilities whose situation is within its jurisdiction to investigate. [2] **Intent**: The intent of the program is to provide protection and intervention for adults who are unable to protect themselves from harm and neglect.
Scope	To cause or promote such change in the Long Term Care System that would be of benefit to Long Term Care Residents. "Long term care facility" means any licensed skilled nursing facility intermediate care facility, as defined in rules adopted under ORS 442.015, adult foster homes with residents over 60 years of age and residential care facility as defined in ORS 443.400.	**The scope of services includes:** (a) Receiving reports of abuse, neglect or self-neglect; (b) Providing and documenting risk assessment of reported victims; (c) Conducting and documenting investigations of reported wrongdoing; and (d) Providing appropriate resources

[1] Web-link to LTCO web site-http://www.oregon.gov/LTCO/docs/OutcomesV3N1.pdf

[2] Web-link to ORS 410.020- http://www.leg.state.or.us/ors/410.html

	Investigate and resolve complaints made by or for residents of long term care facilities about administrative actions that may adversely affect their health, safety, welfare or rights, including subpoenaing any person to appear, give sworn testimony or to produce documentary or other evidence that is reasonably material to any matter under investigation.	for victim safety. **Adult protective services as defined in OAR 411-020-0040 are available for:** (a) Adults aged 65 and older; (b) Adults aged 18 and older who have a physical disability as defined in these rules; and (c) Anyone living in a nursing facility when they are reported to be victims of "abuse" as defined in these rules. Eligibility for protective services is not dependent upon income or source of income. Adult Protective Services are available from the Department to any adult resident of a DHS-licensed facility, to Nursing Facility residents regardless of age and to any adult residing in the community (their own home) who meet the eligibility criteria listed in OAR 411-020-0015.

Attachment #5:

Definition of Adult Protective Services Investigation

Definition of Adult Protective Services Investigation

Investigation for the purpose of Adult Protective Services (APS) means a systematic inquiry to determine whether abuse or neglect occurred as defined in ORS 124.050. The investigation is civil in nature, evidenced-based, and the methods are set forth in rule:

- Identify reported victims, reported perpetrators, and other parties with knowledge about the complaint,
- Conduct unannounced interviews with parties,
- Gather and review relevant documentary and physical evidence,
- Create investigatory aids (diagrams) and take photographs as appropriate,
- Maintain records of evidence,
- Analyze evidence to determine facts of the complaint,
- Draw a conclusion based upon preponderance of the facts, and
- Write a report of evidence and findings.

Statutory Authority for Investigation

ORS 410.070 9 (1) (k)
ORS 410.020 (3) (d)
ORS 124.050
ORS 124.055
ORS 124.070

Administrative Rules for Investigations

OAR 411-020-0100 Community Investigations
OAR 411-020-0120 Facility Investigations

Attachment #6:

APD Licensing Slide Updated

APD Licensing Slide Updated

Programs	Facilities	Residential Capacity*	Review Frequency
Nursing Facilities (NF)	139	12,205	Every 1 Year
Assisted Living & Residential Care	467	23,876	Every 2 Years
Adult Foster Homes (AFH)	3467	11,092	Every 1 Year

Attachment #7:

Office of Licensing and Regulatory Oversight – Licensing Fees

OFFICE OF LICENSING AND REGULATORY OVERSIGHT

LICENSING FEES

	Adult Foster Home	ALF/RCF	Nursing home
Licensing Period:	Annual	2 year	Annual
Licensing Fees:	$20.00 per bed $10.00 per change for Resident Manager/Shift Caregivers	1 – 15 beds: $360.00 16 – 49 beds: 520.00 50 – 99 beds: $1,040 100 – 150 beds: $1,340 151 or more beds: $1,500	1 – 15 beds: $180.00 16 – 49 beds: $260.00 50 – 99 beds: $520.00 100 – 150 beds: $670.00 151 or more beds: $750.00

***CIVIL PENALTY RANGE**

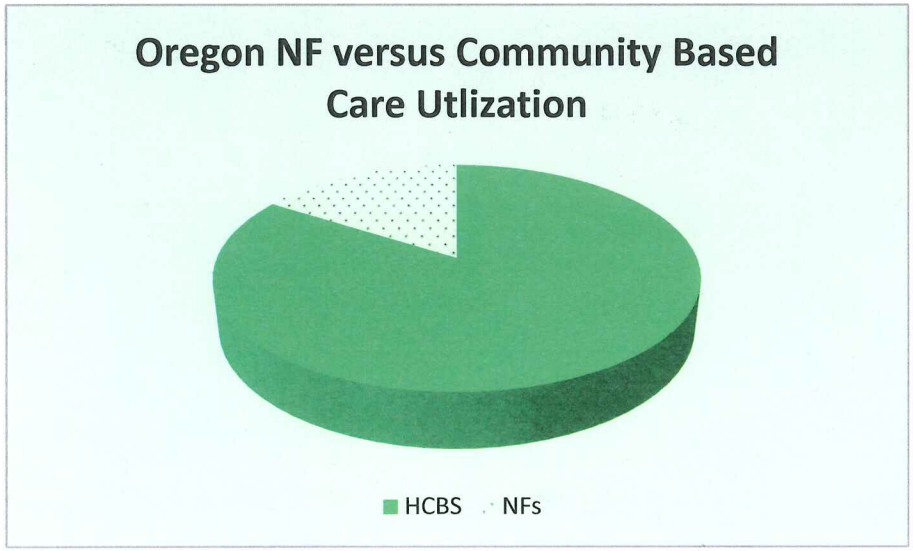
	Adult Foster Home	ALF/RCF	Nursing Home
Abuse of any type: Level 1 - 4	$200 - $1,000	$200 - $500	$200 - $1,000
Rule Violation: Potential for Harm Level 1- 4	$100 - $250	$100 - $500	$100 - $500
Enhanced Civil Penalty: **Legislation passed in 2009 mandated**	$2,500 - $15,000	$2,500 - $15,000	$2,500 - $15,000

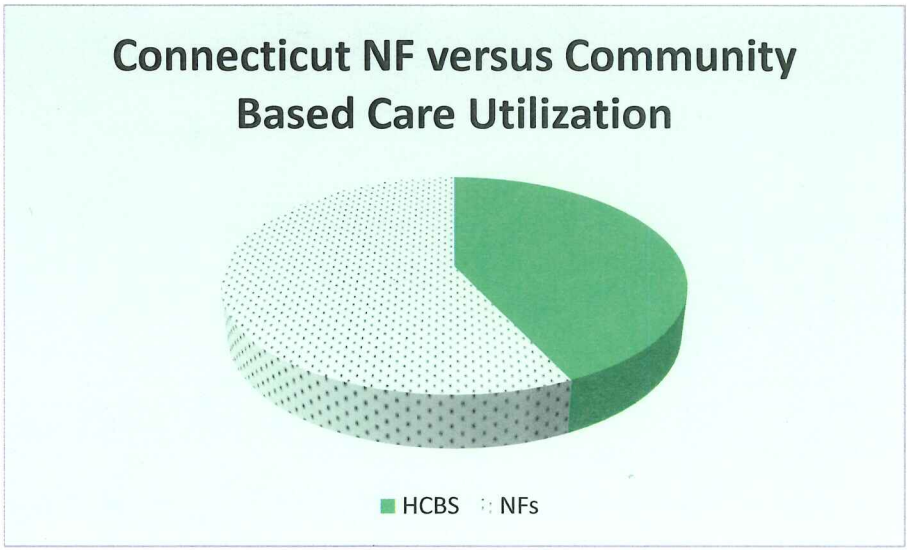
* Civil Penalties are based upon severity and can escalate to a condition on the facility license or license revocation.

Attachment #8:

Oregon Compared to Connecticut Utilization and Costs

Department of Human Services Response to Ways and Means
Oregon Compared to Connecticut
Utilization and Costs





Oregon	% of Long Term Care Caseload	Individuals	Average Monthly Cost - Actual	Total Biennial Cost
HCBS	84.00%	23,575	$ 1,603	$ 906,977,400
Nursing Facility	16.00%	4,486	$ 5,512	$ 593,443,968
Oregon Total				**$ 1,500,421,368**
Connecticut	**% of Long Term Care Caseload**	**Individuals**	**Average Monthly Cost - Actual**	**Total Biennial Cost**
HCBS	43%	12,066	$1,339	$ 387,752,976
Nursing Facility	57%	15,995	$6,810	$ 2,614,222,800
Total (Based on CT Utilization and Costs)				**$ 3,001,975,776**
OR Biennial Savings Compared to CT model based on costs and utilization				**$ 1,501,554,408**

Attachment #9:

AARP
Oregon: 2011 State Long-Term Services and Supports Scorecard Results

Oregon: 2011 State Long-Term Services and Supports Scorecard Results

Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers is the first of its kind: a multi-dimensional approach to measure state-level performance of LTSS systems that provide assistance to older people, adults with disabilities, and family caregivers. The full report is available at www.longtermscorecard.org

Scorecard Purpose: Public policy plays an important role in LTSS systems by establishing who is eligible for assistance, what services are provided, how quality is monitored, and the ways in which family caregivers are supported. Actions of providers and other private sector forces also affect state performance, either independently, or in conjunction with the public sector. The *Scorecard* is designed to help states improve the performance of their LTSS systems so that older people and adults with disabilities in *all* states can exercise choice and control over their lives, thereby maximizing their independence and well-being.

Results: The *Scorecard* examines state performance across four key dimensions of LTSS system performance. Each dimension is composed of 3 to 9 data indicators, for a total of 25 indicators. All 50 states and the District of Columbia were ranked. Oregon ranked:

Overall **3**

- Affordability and access **26**
- Choice of setting and provider **5**
- Quality of life and quality of care **13**
- Support for family caregivers **1**

State ranks on each indicator appear on the next page.

Impact of Improved Performance: If Oregon improved its performance to the level of the highest-performing state:

- 11,890 more low- or moderate-income (<250% poverty) adults age 21+ with activity of daily living disabilities would be covered by Medicaid.
- 1,041 more new users of Medicaid LTSS would first receive services in home and community based settings instead of nursing homes.
- 577 nursing home residents with low care needs would instead be able to receive LTSS in the community.
- 135 unnecessary hospitalizations of people in nursing homes would be avoided.

OREGON

State Long-Term Services and Supports Scorecard Results

	2011 Scorecard				
Dimension and Indicator	State Rate	Rank	All States Median Rate	Top 5 States Average Rate	Best State Rate
OVERALL RANK		3			
AFFORDABILITY AND ACCESS		26			
Median annual nursing home private pay cost as a percentage of median household income age 65+ (2010)	252%	36	224%	171%	166%
Median annual home care private pay cost as a percentage of median household income age 65+ (2010)	95%	35	89%	69%	55%
Private long-term care insurance policies in effect per 1,000 population age 40+ (2009)	44	23	41	150	300
Percent of adults age 21+ with ADL disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance (2008-09)	46.0%	43	49.9%	62.2%	63.6%
Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community (2007)	42.1	15	36.1	63.4	74.6
ADRC/Single Entry Point functionality (composite indicator, scale 0-12) (2010)	10.1	4	7.7	10.5	11.0
CHOICE OF SETTING AND PROVIDER		5			
Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities (2009)	56.6%	4	29.7%	59.9%	63.9%
Percent of new Medicaid LTSS users first receiving services in the community (2007)	69.7%	6	49.9%	77.1%	83.3%
Number of people consumer-directing services per 1,000 adults age 18+ with disabilities (2010)	52.2	3	8.0	69.4	142.7
Tools and programs to facilitate consumer choice (composite indicator, scale 0-4) (2010)	2.20	33	2.75	3.79	4.00
Home health and personal care aides per 1,000 population age 65+ (2009)	32	29	34	88	108
Assisted living and residential care units per 1,000 population age 65+ (2010)	64	2	29	64	80
Percent of nursing home residents with low care needs (2007)	8.3%	13	11.9%	5.4%	1.3%
QUALITY OF LIFE AND QUALITY OF CARE		13			
Percent of adults age 18+ with disabilities in the community usually or always getting needed support (2009)	73.9%	5	68.5%	75.5%	78.2%
Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life (2009)	86.1%	20	85.0%	90.9%	92.4%
Rate of employment for adults with ADL disability age 18-64 relative to rate of employment for adults without ADL disability age 18-64 (2008-09)	29.9%	9	24.2%	42.4%	56.6%
Percent of high-risk nursing home residents with pressure sores (2008)	10.8%	22	11.1%	7.2%	6.6%
Percent of long-stay nursing home residents who were physically restrained (2008)	4.2%	35	3.3%	1.3%	0.9%
Nursing home staffing turnover: ratio of employee terminations to the average no. of active employees (2008)	49.3%	27	46.9%	27.2%	18.7%
Percent of long-stay nursing home residents with a hospital admission (2008)	11.1%	4	18.9%	10.4%	8.3%
Percent of home health episodes of care in which interventions to prevent pressure sores were included in the plan of care for at-risk patients (2010)	85%	44	90%	95%	97%
Percent of home health patients with a hospital admission (2008)	24.8%	6	29.0%	23.2%	21.8%
SUPPORT FOR FAMILY CAREGIVERS		1			
Percent of caregivers usually or always getting needed support (2009)	84.0%	1	78.2%	82.2%	84.0%
Legal and system supports for caregivers (composite indicator, scale 0-12) (2008-09)	6.43	1	3.17	5.90	6.43
Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks) (2011)	16	1	7.5	16	16

* Indicates data not available for this state.

Notes: ADL = Activities of Daily Living; ADRC = Aging and Disability Resource Center; HCBS = Home and Community Based Services; LTSS = Long Term Services and Supports.

Refer to Appendix B2 in *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* for indicator descriptions, data sources, and other notes about methodology. The full report is available at www.longtermscorecard.org

Attachment #10:

AARP
Washington: 2011 State Long-Term Services and Supports Scorecard Results

Washington: 2011 State Long-Term Services and Supports Scorecard Results

Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers is the first of its kind: a multi-dimensional approach to measure state-level performance of LTSS systems that provide assistance to older people, adults with disabilities, and family caregivers. The full report is available at www.longtermscorecard.org

Scorecard Purpose: Public policy plays an important role in LTSS systems by establishing who is eligible for assistance, what services are provided, how quality is monitored, and the ways in which family caregivers are supported. Actions of providers and other private sector forces also affect state performance, either independently, or in conjunction with the public sector. The *Scorecard* is designed to help states improve the performance of their LTSS systems so that older people and adults with disabilities in *all* states can exercise choice and control over their lives, thereby maximizing their independence and well-being.

Results: The *Scorecard* examines state performance across four key dimensions of LTSS system performance. Each dimension is composed of 3 to 9 data indicators, for a total of 25 indicators. All 50 states and the District of Columbia were ranked. Washington ranked:

Overall **2**

- Affordability and access **6**
- Choice of setting and provider **2**
- Quality of life and quality of care **18**
- Support for family caregivers **2**

State ranks on each indicator appear on the next page.

Impact of Improved Performance: If Washington improved its performance to the level of the highest-performing state:

- 11,272 more low- or moderate-income (<250% poverty) adults age 21+ with activity of daily living disabilities would be covered by Medicaid.
- 2,174 more new users of Medicaid LTSS would first receive services in home and community based settings instead of nursing homes.
- 1,077 nursing home residents with low care needs would instead be able to receive LTSS in the community.
- 744 unnecessary hospitalizations of people in nursing homes would be avoided.

WASHINGTON

State Long-Term Services and Supports Scorecard Results

	2011 Scorecard				
Dimension and Indicator	State Rate	Rank	All States Median Rate	Top 5 States Average Rate	Best State Rate
OVERALL RANK		**2**			
AFFORDABILITY AND ACCESS		**6**			
Median annual nursing home private pay cost as a percentage of median household income age 65+ (2010)	221%	23	224%	171%	166%
Median annual home care private pay cost as a percentage of median household income age 65+ (2010)	93%	30	89%	69%	55%
Private long-term care insurance policies in effect per 1,000 population age 40+ (2009)	48	18	41	150	300
Percent of adults age 21+ with ADL disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance (2008-09)	52.1%	18	49.9%	62.2%	63.6%
Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community (2007)	54.5	5	36.1	63.4	74.6
ADRC/Single Entry Point functionality (composite indicator, scale 0-12) (2010)	9.6	7	7.7	10.5	11.0
CHOICE OF SETTING AND PROVIDER		**2**			
Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities (2009)	62.7%	2	29.7%	59.9%	63.9%
Percent of new Medicaid LTSS users first receiving services in the community (2007)	66.5%	11	49.9%	77.1%	83.3%
Number of people consumer-directing services per 1,000 adults age 18+ with disabilities (2010)	30.8	7	8.0	69.4	142.7
Tools and programs to facilitate consumer choice (composite indicator, scale 0-4) (2010)	3.70	3	2.75	3.79	4.00
Home health and personal care aides per 1,000 population age 65+ (2009)	41	17	34	88	108
Assisted living and residential care units per 1,000 population age 65+ (2010)	55	5	29	64	80
Percent of nursing home residents with low care needs (2007)	6.7%	4	11.9%	5.4%	1.3%
QUALITY OF LIFE AND QUALITY OF CARE		**18**			
Percent of adults age 18+ with disabilities in the community usually or always getting needed support (2009)	72.9%	8	68.5%	75.5%	78.2%
Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life (2009)	85.9%	21	85.0%	90.9%	92.4%
Rate of employment for adults with ADL disability age 18-64 relative to rate of employment for adults without ADL disability age 18-64 (2008-09)	28.1%	14	24.2%	42.4%	56.6%
Percent of high-risk nursing home residents with pressure sores (2008)	11.3%	29	11.1%	7.2%	6.6%
Percent of long-stay nursing home residents who were physically restrained (2008)	2.1%	16	3.3%	1.3%	0.9%
Nursing home staffing turnover: ratio of employee terminations to the average no. of active employees (2008)	72.0%	44	46.9%	27.2%	18.7%
Percent of long-stay nursing home residents with a hospital admission (2008)	14.4%	13	18.9%	10.4%	8.3%
Percent of home health episodes of care in which interventions to prevent pressure sores were included in the plan of care for at-risk patients (2010)	87%	40	90%	95%	97%
Percent of home health patients with a hospital admission (2008)	23.6%	4	29.0%	23.2%	21.8%
SUPPORT FOR FAMILY CAREGIVERS		**2**			
Percent of caregivers usually or always getting needed support (2009)	79.2%	18	78.2%	82.2%	84.0%
Legal and system supports for caregivers (composite indicator, scale 0-12) (2008-09)	5.63	3	3.17	5.90	6.43
Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks) (2011)	14	8	7.5	16	16

* Indicates data not available for this state.

Notes: ADL = Activities of Daily Living; ADRC = Aging and Disability Resource Center; HCBS = Home and Community Based Services; LTSS = Long Term Services and Supports.

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Attachment #11:

AARP
Connecticut: 2011 State Long-Term Services and Supports Scorecard Results

Connecticut: *2011 State Long-Term Services and Supports Scorecard Results*

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Scorecard Purpose: Public policy plays an important role in LTSS systems by establishing who is eligible for assistance, what services are provided, how quality is monitored, and the ways in which family caregivers are supported. Actions of providers and other private sector forces also affect state performance, either independently, or in conjunction with the public sector. The *Scorecard* is designed to help states improve the performance of their LTSS systems so that older people and adults with disabilities in *all* states can exercise choice and control over their lives, thereby maximizing their independence and well-being.

Results: The *Scorecard* examines state performance across four key dimensions of LTSS system performance. Each dimension is composed of 3 to 9 data indicators, for a total of 25 indicators. All 50 states and the District of Columbia were ranked. Connecticut ranked:

Overall **11**

- Affordability and access **8**
- Choice of setting and provider **25**
- Quality of life and quality of care **17**
- Support for family caregivers **20**

State ranks on each indicator appear on the next page.

Impact of Improved Performance: If Connecticut improved its performance to the level of the highest-performing state:

- 3,796 more low- or moderate-income (<250% poverty) adults age 21+ with activity of daily living disabilities would be covered by Medicaid.
- 4,180 more new users of Medicaid LTSS would first receive services in home and community based settings instead of nursing homes.
- 3,907 nursing home residents with low care needs would instead be able to receive LTSS in the community.
- 2,058 unnecessary hospitalizations of people in nursing homes would be avoided.

CONNECTICUT

State Long-Term Services and Supports Scorecard Results

	2011 Scorecard				
Dimension and Indicator	State Rate	Rank	All States Median Rate	Top 5 States Average Rate	Best State Rate
OVERALL RANK		**11**			
AFFORDABILITY AND ACCESS		**8**			
Median annual nursing home private pay cost as a percentage of median household income age 65+ (2010)	345%	48	224%	171%	166%
Median annual home care private pay cost as a percentage of median household income age 65+ (2010)	83%	12	89%	69%	55%
Private long-term care insurance policies in effect per 1,000 population age 40+ (2009)	52	14	41	150	300
Percent of adults age 21+ with ADL disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance (2008-09)	57.0%	8	49.9%	62.2%	63.6%
Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community (2007)	54.9	4	36.1	63.4	74.6
ADRC/Single Entry Point functionality (composite indicator, scale 0-12) (2010)	7.5	27	7.7	10.5	11.0
CHOICE OF SETTING AND PROVIDER		**25**			
Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities (2009)	27.4%	31	29.7%	59.9%	63.9%
Percent of new Medicaid LTSS users first receiving services in the community (2007)	38.3%	30	49.9%	77.1%	83.3%
Number of people consumer-directing services per 1,000 adults age 18+ with disabilities (2010)	7.3	28	8.0	69.4	142.7
Tools and programs to facilitate consumer choice (composite indicator, scale 0-4) (2010)	3.00	10	2.75	3.79	4.00
Home health and personal care aides per 1,000 population age 65+ (2009)	42	16	34	88	108
Assisted living and residential care units per 1,000 population age 65+ (2010)	*	*	29	64	80
Percent of nursing home residents with low care needs (2007)	15.5%	35	11.9%	5.4%	1.3%
QUALITY OF LIFE AND QUALITY OF CARE		**17**			
Percent of adults age 18+ with disabilities in the community usually or always getting needed support (2009)	70.9%	18	68.5%	75.5%	78.2%
Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life (2009)	85.4%	23	85.0%	90.9%	92.4%
Rate of employment for adults with ADL disability age 18-64 relative to rate of employment for adults without ADL disability age 18-64 (2008-09)	29.0%	11	24.2%	42.4%	56.6%
Percent of high-risk nursing home residents with pressure sores (2008)	9.6%	14	11.1%	7.2%	6.6%
Percent of long-stay nursing home residents who were physically restrained (2008)	2.6%	18	3.3%	1.3%	0.9%
Nursing home staffing turnover: ratio of employee terminations to the average no. of active employees (2008)	18.7%	1	46.9%	27.2%	18.7%
Percent of long-stay nursing home residents with a hospital admission (2008)	18.7%	23	18.9%	10.4%	8.3%
Percent of home health episodes of care in which interventions to prevent pressure sores were included in the plan of care for at-risk patients (2010)	89%	31	90%	95%	97%
Percent of home health patients with a hospital admission (2008)	33.7%	45	29.0%	23.2%	21.8%
SUPPORT FOR FAMILY CAREGIVERS		**20**			
Percent of caregivers usually or always getting needed support (2009)	79.6%	14	78.2%	82.2%	84.0%
Legal and system supports for caregivers (composite indicator, scale 0-12) (2008-09)	3.37	24	3.17	5.90	6.43
Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks) (2011)	1	36	7.5	16	16

* Indicates data not available for this state.

Notes: ADL = Activities of Daily Living; ADRC = Aging and Disability Resource Center; HCBS = Home and Community Based Services; LTSS = Long Term Services and Supports.

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Attachment #12:

AARP
Minnesota: 2011 State Long-Term Services and Supports Scorecard Results

Minnesota: 2011 State Long-Term Services and Supports Scorecard Results

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Scorecard Purpose: Public policy plays an important role in LTSS systems by establishing who is eligible for assistance, what services are provided, how quality is monitored, and the ways in which family caregivers are supported. Actions of providers and other private sector forces also affect state performance, either independently, or in conjunction with the public sector. The *Scorecard* is designed to help states improve the performance of their LTSS systems so that older people and adults with disabilities in *all* states can exercise choice and control over their lives, thereby maximizing their independence and well-being.

Results: The *Scorecard* examines state performance across four key dimensions of LTSS system performance. Each dimension is composed of 3 to 9 data indicators, for a total of 25 indicators. All 50 states and the District of Columbia were ranked. Minnesota ranked:

Overall **1**

- Affordability and access **4**
- Choice of setting and provider **3**
- Quality of life and quality of care **4**
- Support for family caregivers **4**

State ranks on each indicator appear on the next page.

Impact of Improved Performance: If Minnesota improved its performance to the level of the highest-performing state:

- 7,895 more low- or moderate-income (<250% poverty) adults age 21+ with activity of daily living disabilities would be covered by Medicaid.
- 4,249 nursing home residents with low care needs would instead be able to receive LTSS in the community.

MINNESOTA

State Long-Term Services and Supports Scorecard Results

	2011 Scorecard				
Dimension and Indicator	State Rate	Rank	All States Median Rate	Top 5 States Average Rate	Best State Rate
OVERALL RANK		1			
AFFORDABILITY AND ACCESS		4			
Median annual nursing home private pay cost as a percentage of median household income age 65+ (2010)	219%	21	224%	171%	166%
Median annual home care private pay cost as a percentage of median household income age 65+ (2010)	110%	48	89%	69%	55%
Private long-term care insurance policies in effect per 1,000 population age 40+ (2009)	71	9	41	150	300
Percent of adults age 21+ with ADL disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance (2008-09)	53.9%	12	49.9%	62.2%	63.6%
Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community (2007)	74.6	1	36.1	63.4	74.6
ADRC/Single Entry Point functionality (composite indicator, scale 0-12) (2010)	11.0	1	7.7	10.5	11.0
CHOICE OF SETTING AND PROVIDER		3			
Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities (2009)	60.0%	3	29.7%	59.9%	63.9%
Percent of new Medicaid LTSS users first receiving services in the community (2007)	83.3%	1	49.9%	77.1%	83.3%
Number of people consumer-directing services per 1,000 adults age 18+ with disabilities (2010)	12.2	20	8.0	69.4	142.7
Tools and programs to facilitate consumer choice (composite indicator, scale 0-4) (2010)	2.90	16	2.75	3.79	4.00
Home health and personal care aides per 1,000 population age 65+ (2009)	108	1	34	88	108
Assisted living and residential care units per 1,000 population age 65+ (2010)	80	1	29	64	80
Percent of nursing home residents with low care needs (2007)	14.5%	32	11.9%	5.4%	1.3%
QUALITY OF LIFE AND QUALITY OF CARE		4			
Percent of adults age 18+ with disabilities in the community usually or always getting needed support (2009)	73.9%	5	68.5%	75.5%	78.2%
Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life (2009)	86.3%	18	85.0%	90.9%	92.4%
Rate of employment for adults with ADL disability age 18-64 relative to rate of employment for adults without ADL disability age 18-64 (2008-09)	36.0%	5	24.2%	42.4%	56.6%
Percent of high-risk nursing home residents with pressure sores (2008)	6.6%	1	11.1%	7.2%	6.6%
Percent of long-stay nursing home residents who were physically restrained (2008)	1.9%	11	3.3%	1.3%	0.9%
Nursing home staffing turnover: ratio of employee terminations to the average no. of active employees (2008)	36.8%	12	46.9%	27.2%	18.7%
Percent of long-stay nursing home residents with a hospital admission (2008)	8.3%	1	18.9%	10.4%	8.3%
Percent of home health episodes of care in which interventions to prevent pressure sores were included in the plan of care for at-risk patients (2010)	88%	35	90%	95%	97%
Percent of home health patients with a hospital admission (2008)	31.3%	37	29.0%	23.2%	21.8%
SUPPORT FOR FAMILY CAREGIVERS		4			
Percent of caregivers usually or always getting needed support (2009)	81.7%	3	78.2%	82.2%	84.0%
Legal and system supports for caregivers (composite indicator, scale 0-12) (2008-09)	3.70	17	3.17	5.90	6.43
Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks) (2011)	13	13	7.5	16	16

* Indicates data not available for this state.

Notes: ADL = Activities of Daily Living; ADRC = Aging and Disability Resource Center; HCBS = Home and Community Based Services; LTSS = Long Term Services and Supports.

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