State of Oregon
Health Professionals' Services Program

Performance Audit of the
Health Professionals' Services Program

January 2021

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Table of Contents

REPORT HIGHLIGHTS

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RESULTS

IBH met most contractual requirements, generally met required minimal success rate standards, and submitted to the Boards invoices and reports that were accurate and supported by substantiating documentation. However, this audit also revealed instances of minor mis-calculations in reporting one (1) performance metric and several instances in which IBH did not meet certain contract provisions related to outreach and training, quality assurance program requirements, and reporting requirements.

BACKGROUND AND PURPOSE

In 2010, the Oregon State Legislature established the Health Professionals' Service Program (HPSP) to assist health providers with substance abuse and/or mental health disorders and to protect the public from licensees unable to practice safely due to one or both disorders.

In 2017, the Oregon Medical Board, Dental Board, Board of Nursing, and Board of Pharmacy ("the Boards") collectively executed a contract (MSA) with Integrated Behavioral Health Solutions, LLC (IBH), to provide the following services:

- Licensee monitoring, including licensee enrollment and case monitoring, workplace monitoring and reporting, and random toxicology testing.
- Outreach and training to licensees, third-party evaluators, consultants, treatment providers, and licensee supervisors.
- Quality assessment and performance improvement, including establishing formal policies and procedures, required minimum staffing levels, obtaining and reporting licensee and stakeholder input, and performance measurement.
- Periodic reporting on licensee enrollment, compliance, and other factors.

The Boards compensate IBH, and each Board is responsible to pay a proportional share, based on a formula accounting for total licensees and those enrolled in the program.

KEY FINDINGS

- Amounts invoiced by IBH adhered to contract payment provisions. Monthly program fees were correctly calculated based on the number of licensees and enrollees of each Board, and each Board was billed their proportional share of the monthly program fee.
- IBH employed sound controls over licensee monitoring, including administering the appropriate number of toxicology tests, establishing a monitoring agreement with the licensee, ensuring routine communication between the monitor and licensee, and establishing protocols for agreement and workplace monitors.
- IBH could not demonstrate that it provided all required educational materials and outreach presentations to licensees, third-party evaluators, consultants, treatment providers, and Licensee supervisors (workplace monitors), and stakeholders.
- IBH met most Quality Assessment and Performance Improvement Program requirements, but opportunities for improvement remain. This includes ensuring it adheres to MSA provisions regarding the frequency of licensee surveys—which conflicted with informal agreements—and Agreement Monitoring staffing levels. Between July 2017 and June 2020, IBH did not meet staffing requirements 17 percent of the time.
- IBH met many, but not all, MSA reporting requirements. Monthly reports did not always include adequate information regarding licensees in compliance with monitoring agreements and geographical information. IBH did not regularly submit quarterly reports on outreach activities; bi-annual reports on licensee or stakeholder input were not always submitted timely; and IBH did not submit annual financial reports at all. In some cases, this resulted from conflicts between existing MSA requirements and informal agreements between IBH and the Boards.
- Opportunities exist to better clarify contract language and expectations, including ensuring the frequency of licensee survey reporting (along with exit interviews and stakeholder surveys) and reporting requirements reflect actual practice and meet the needs of the Boards.

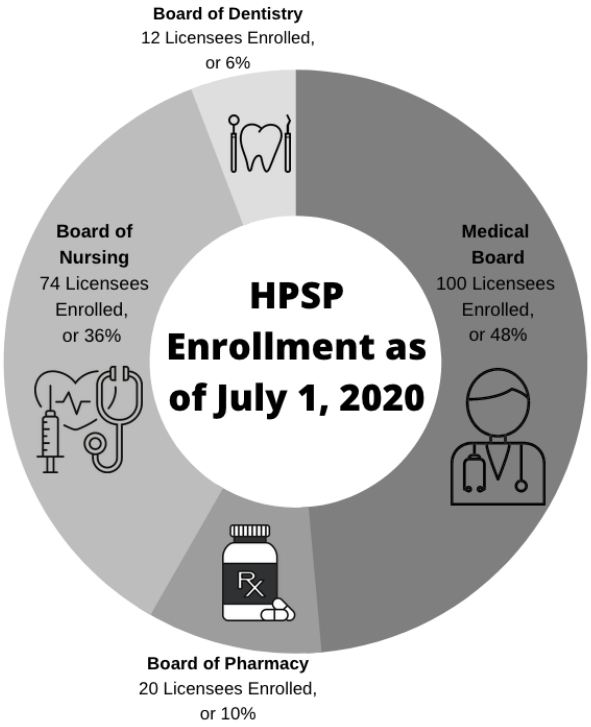
KEY RECOMMENDATIONS

- Evaluate MSA provisions, where IBH non-compliance was noted in this report, to ensure the provisions reflects the Boards' expectations and desired practice, and monitor compliance accordingly.
- Ensure IBH provides all required educational materials and outreach efforts. In doing so, we recommend that this include creating a formal training manual for potential workplace monitors.
- Ensure IBH provides adequate FTE levels for each year's pricing tier; consideration should be given to the inclusion of FTE levels in the required benchmark reporting and penalty structure.
- Ensure accuracy in reporting performance statistics; while only one reporting inaccuracy was identified, consistent methodologies for calculating success rates against performance benchmarks is essential for program monitoring.

Introduction and Background

The Oregon Health Professionals' Services Program (HPSP or Program) was established in 2010 to provide assistance to all licensed health providers in the State of Oregon. The following four (4) licensing boards elected to offer the Program as an alternative-to-discipline: the Oregon Medical Board, Oregon State Board of Nursing, Oregon Board of Pharmacy, and Oregon Board of Dentistry (herein referred to collectively as "the Boards"). The HPSP was established to protect the public from Licensees who are unable to practice safely due to substance abuse and/or mental health disorders.

The administration of the Program has evolved over the past decade. Prior to 2010, each licensing board managed its own program to monitor Licensees that were diagnosed with substance abuse and/or mental health disorders that could impede their ability to practice safely. In July 2010, the Oregon State Legislature designated the Oregon Health Authority to oversee the Program. The Oregon Health Authority contracted with Integrated Behavioral Health Solutions, LLC (IBH), formerly doing business as Reliant Behavioral Health, LLC, to serve as a third-party administrator for the Program. In 2016, the Oregon Legislature adopted House Bill 4016, which shifted responsibility to manage the Program from Oregon Health Authority back to the licensing boards.



In 2017, the Boards entered into a Master Service Agreement (MSA) with IBH for a four-year term (July 1, 2017 through June 30, 2021) and an optional four-year extension through June 30, 2025. This agreement detailed general requirements related to service delivery and compensation, and included four (4) subordinate Work Order Contracts (WOC) between IBH and each board detailing board specific requirements for monitoring Licensees. Under this agreement, IBH is responsible for providing monitoring, toxicology testing, and group meetings for enrolled Licensees, along with various administrative duties, such as maintaining the HPSP website, creating HPSP brochures, providing informational presentations annually, and maintaining a database of HPSP enrollees. Of the four (4) licensing boards, the Medical Board serves as the contract manager, while oversight of the HPSP and IBH's administration of the Program is performed by a Program Advisory Committee (PAC), comprising of Board and IBH representatives, which meets quarterly to discuss HPSP daily operations, challenges, contract compliance, and opportunities for improvement. In addition, MSA and Oregon Revised Statute §676.194 also established a Program Work Group that meets as needed to "facilitate the establishment and continuation of the HPSP."

Program Overview

Individuals licensed through any of the Boards must be diagnosed with a substance abuse or mental health disorder and be "referred" to the HPSP in order to participate in the Program. Generally, a Licensee may be referred to the Program in one of two ways: Board-referred enrollment or self-referred enrollment. When a Licensee is Board-referred by the Board of Dentistry, Board of Nursing, and Medical Board, HPSP serves as an alternative to discipline. The Board of Pharmacy utilizes HPSP as a required element of their disciplinary program. The Board-referral and self-referral processes are described below.

- ✓ Board-Referred Enrollment: Individuals may be referred to the HPSP through investigation or through their License application, in which a Licensee must divulge if they have a substance abuse disorder or mental health diagnosis that may impair their ability to practice safely. The Board will obtain a third-party evaluation of the Licensee to receive a diagnosis of a substance abuse disorder and/or mental health disorder, and treatment options. The licensing board will then refer the Licensee to the HPSP by submitting the referral (including a description of any Board-imposed or recommended restrictions on Licensee's professional practice), the evaluation documentation, and the Licensee's written consent, to IBH. IBH then enrolls the individual; informs the Licensee of Program requirements, benefits, risks, and confidentiality limitations; and obtains the Licensee's signed consent for services agreement, signed Monitoring Agreement, and a deposit to cover all costs associated with toxicology testing. Within three (3) business days of enrollment, IBH assigns an Agreement Monitor to serve as the case manager for the enrolled licensee, meet regularly with the Licensee, and monitor compliance with the established monitoring agreement.

- ✓ Self-Referred Enrollment: In general, individual Licensees recognizing that they have been diagnosed with a substance abuse or mental health disorder that may impede their ability to practice in a safe manner may, without being subject to a disciplinary proceeding, enroll themselves into the HPSP as a way to get the help they need. Consistent with the purpose of the Program, allowing the self-referral of Licensees further protects the public from Licensees who may be unable to practice safely due to substance abuse and/or mental health disorders. Participation in the Program is largely similar for those that are self- or Board-referred. However, the Licensee's entry and enrollment into the Program differs from the Board-referral process.

  A Licensee initiates the first steps of self-referred enrollment by contacting IBH, either through e-mail or telephone. At this point, IBH confirms eligibility by ensuring the Licensee is licensed in good standing by their respective board and, similar to the Board-referral process, submitting the Licensee to an independent evaluation for diagnosis and treatment plan, at the Licensee's expense. If the Licensee is in good standing with their respective board and is independently diagnosed with a substance abuse and/or mental health disorder, IBH will obtain the Licensee's signed consent and monitoring agreements; authorization for disclosure and exchanges of confidential information between IBH, the licensing board, and the Licensee's employer; and conduct a safe-practice investigation, which may include interviews with employers, co-workers, family, and significant others, to determine if a Licensee has practiced while impaired or has presented a danger to the public. If the investigation finds that a Licensee presents, or has ever presented, a danger to the public, IBH must immediately notify the licensing board.

If a Licensee begins steps towards enrollment in HPSP, but fails to progress through the steps of self-enrollment, IBH is mandated to report the Licensee to the Board within one (1) business day for substantial non-compliance for failure to complete enrollment. A self-referred Licensee's participation in HPSP will remain confidential from their licensing board unless the self-enrolled Licensee is substantially non-compliant, at which point IBH must notify the licensing board and the Licensee is re-categorized as Board-referred.

Licensees from the Medical Board, Board of Pharmacy, and Board of Nursing can be enrolled in the Program through a Board-referral or a self-referral. Licensees from the Board of Dentistry may only be Board-referred. Regardless of whether a Licensee is Board-referred or self-referred, the individuals' participation in the Program remains largely the same. Once enrolled, IBH establishes an individualized monitoring program, which requires the Licensee to take a toxicology test within ten business days and meet with their Agreement Monitor within five business days. Throughout the enrollment period, Licensees must meet with their assigned Agreement Monitor as required by their monitoring agreement—either weekly, semi-monthly, or monthly—and must take periodic and randomly scheduled toxicology tests. For the Medical Board, Board of Dentistry, and Board of Pharmacy Licensees must receive a minimum of 36 randomized toxicology tests their first year in HPSP, 24 in their second year, and 18 in their third year, unless modified by the licensing board. The Board of Nursing requires Licensees to receive a minimum of 24 randomized toxicology tests their first year in HPSP, and 18 in their second year. The duration of a Licensee's enrollment varies by licensing board—typically between two (2) and five years. After completion of HPSP, IBH e-mails the Licensee an exit interview survey.

EXHIBIT 1. LICENSEE HPSP ENROLLMENT LIFECYCLE

Source: Auditor-generated from interviews with Board and IBH.

Contract Services & Compensation

The Boards' contract with IBH sets forth annual compensation ranges—between $1.1 million and $1.2 million—for IBH's services. In return, the MSA requires IBH to provide specific services and provide a variety of deliverables that can generally be categorized into four (4) categories: outreach and training, Licensee monitoring, quality control and performance measurement, and periodic program reporting. On the following pages, we provide an overview of each.

Contractor Compensation

The Boards' contract with IBH provides for a not-to-exceed maximum compensation limit of $4,550,000, though actual compensation is based on the number of Licensees served through the Program. The Boards compensate IBH through a monthly service fee, which is assessed and re-calculated based on a tiered fee structure tied to enrollment every six (6) months in January and July. As shown in Exhibit 2, tiers are assigned by calculating the median number of Licensees enrolled in the Program at a point in time, and total Licensees that were enrolled and participating in HPSP during the fiscal year.

EXHIBIT 2. CONTRACT TIERED ANNUAL PROGRAM FEES

Tier	Licensees	Agreement Monitor FTE	Annual Compensation	Monthly Compensation
Tier One	0-250	5.65	$1,098,056	$91,505
Tier Two	251-300	5.80	$1,106,306	$92,192
Tier Three	301-350	6.80	$1,161,306	$96,776
Tier Four	351-400	7.80	$1,216,306	$101,359

Source: Master Service Agreement.

Once the tier is determined, the share each licensing board is required to pay is prorated based on the number of eligible and enrolled individuals licensed through each Board. To calculate the proportion each board is responsible to cover, the Boards split the total monthly fee in half, allocating 50 percent of the cost to Board eligible Licensees and 50 percent of the cost to Board participating Licensees. In Exhibit 3, we provide an example of the fee calculation from December 30, 2018 that was used to set the monthly invoice amount for the period of January 1 through June 30, 2019. During this period, there were 216 participating Licensees—Tier One—at the time the fee was calculated and the Annual Program Fee was set to $1,098,056, or a monthly fee of $91,505 (see the purple highlighted cells in Exhibit 2 and Exhibit 3).

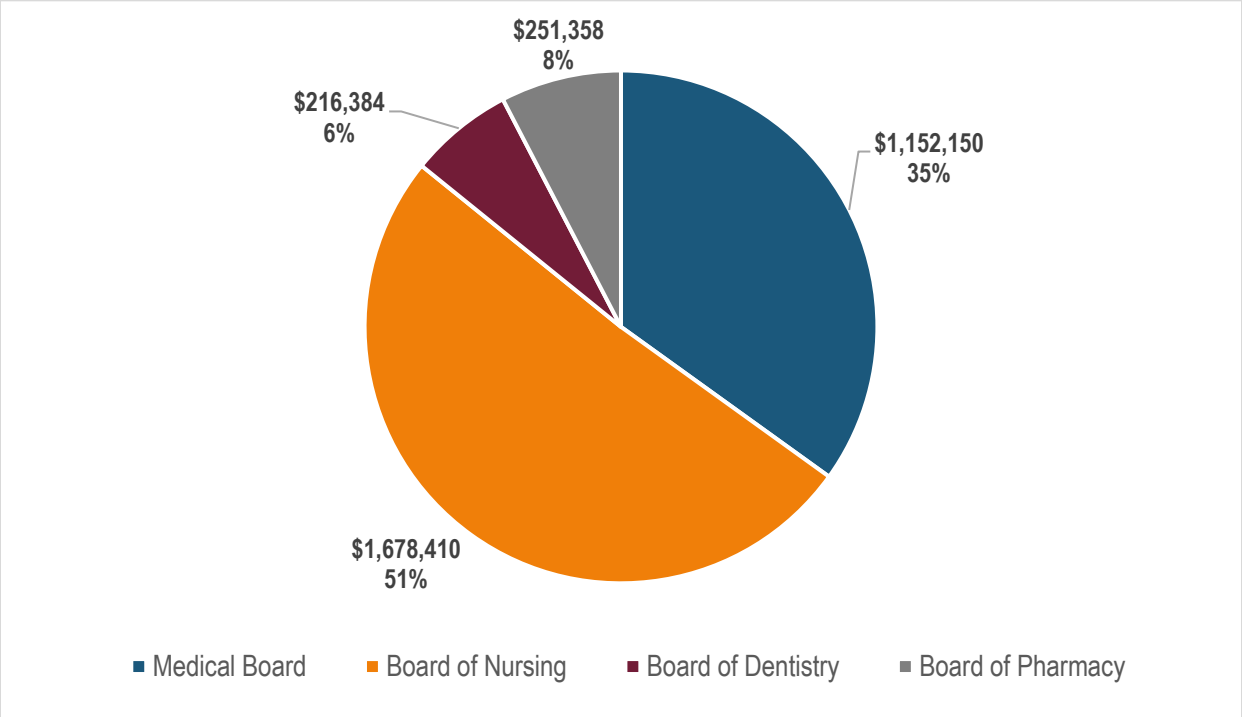
EXHIBIT 3. EXAMPLE PROGRAM FEE DISTRIBUTED BY BOARD, JANUARY THRU JUNE 2019

Board	Board's Eligible Licensees	Board's Participating Licensees	Fee Eligible Licensees	Fee Participating Licensees	Board Total Fee	Percentage
Board of Nursing	48,891	87	$27,036	$18,428	$45,464	49.7%
Medical Board	22,702	97	$12,554	$20,546	$33,100	36.2%
Board of Pharmacy	4,515	22	$2,497	$4,660	$7,157	7.8%
Board of Dentistry	6,629	10	$3,666	$2,118	$5,784	6.3%
Total	**82,737**	**216**	**$45,753**	**$45,752**	**$91,505**	**100%**

Source: Oregon Medical Board.

Between July 1, 2017 and June 30, 2020, the Boards were invoiced nearly $3.3 million as compensation to IBH, with the Board of Nursing and the Medical Board collectively paying 86 percent of the total cost of the Program, as illustrated in Exhibit 4.

EXHIBIT 4: HPSP COST DISTRIBUTION AMONG LICENSING BOARDS, JULY 2017 THROUGH JUNE 2020



Source: Auditor-generated from IBH Weekly Report as of July 1, 2020.

Licensee Monitoring

IBH is required to operate a statewide standardized monitoring program for Licensees who have been diagnosed with a substance abuse and/or mental health disorder. IBH must monitor Licensees to assess whether Licensees are at risk of not practicing safely or professionally due to their substance abuse, mental health disorder, or dual diagnosis. If Licensees pose a risk, IBH must report the Licensee to the Boards. The contract stipulates that this must be done through a combination of:

- ✓ Case Monitoring: Licensees are subject to a formal individualized Monitoring Agreement. IBH develops the Monitoring Agreement by reviewing a Licensee's relevant information and the third-party evaluator's evaluation report and recommended treatment plan. The Monitoring Agreement outlines the minimum length of time a Licensee must be enrolled in HPSP, which must be two (2) years or longer; a Board-approved treatment plan designed by a third-party evaluator; limits on a Licensee's discretion to practice; and toxicology testing requirements. Agreement Monitors are employed and assigned by IBH to monitor Licensees' compliance with Monitoring Agreements. Licensees must meet at regularly scheduled intervals with Licensees (either weekly, semi-monthly, or monthly basis); the frequency of meetings is Licensee and Board dependent. Meetings must be voice-to-voice—which may be by telephone, face-to-face, or by internet or video communications. At least one (1) time per year, IBH must send a Licensee status report to the Boards' oversight staff for review (MSA §2.10-2.11).

- ✓ Workplace Monitoring and Reporting: IBH is responsible for implementing a process to assess a Licensee's employer's ability to supervise Licensee. This includes establishing minimum educational or training standards and requirements for supervisor and workplace monitor skills and knowledge that can be used by employers to ensure effective supervision of Licensees in practice. IBH is also required to provide online training to licensee supervisors and workplace monitors, including education and information to Licensee employers and other stakeholders regarding the signs and symptoms of relapse, including, but not limited to regional seminars and educational programs. IBH does this by finding, where applicable, workplace monitors for Licensees.

IBH provides workplace monitors with training early within a Licensees enrollment in HPSP. Workplace monitors submit reports to IBH monthly, which must include information relating to the Licensee's performance, changes in behavior, and lack of attendance or tardiness, or other issues of concern. If a workplace monitor notices something significant, they are required to contact IBH within 24 hours (MSA §2.8).

- ✓ Random Toxicology Testing: The MSA requires Licensees to receive at least 24 randomized toxicology tests in the first year of enrollment, and at least 18 for their remaining years in the Program. At least 55 percent of the testing must be completed on Mondays, Fridays, or Saturdays. IBH does not notify Licensees in advance of a scheduled toxicology test; rather, Licensees are required to call IBH's Interactive Voice Response (IVR) system, app, or web portal daily (except Sunday) to see if they have been scheduled for a test that day. The notification also informs the Licensee of the panel they need to test. A missed toxicology test, inconclusive results, or a refusal to take a test are all considered instances of non-compliance and must be reported to the Licensing Board. Licensees with a mental health diagnosis receive randomized toxicology tests only if recommended by the third-party evaluator or the Licensing Board.

Outreach and Training

The MSA requires IBH to provide Board-approved educational materials to Board Licensees; third-party evaluators, consultants, and treatment providers; and Licensee supervisors. This is intended to ensure that

all Licensees, their employers, and potential treatment providers are aware of the HPSP and relevant Program benefits and requirements. In addition, the Boards and IBH agreed to amend the outreach requirement to include outreach to other stakeholders, such as health professional students and schools. This agreement was formally memorialized in writing through a written waiver approved by Board representatives. There must be at least 12 outreach presentations each year (one (1) per month and two (2) per year per region), and all content must be Board-approved. At each presentation, there must be a sign-in sheet that IBH retains for two (2) years. Additionally, IBH must provide orientation for all Board-approved independent third-party evaluators, consultants, and treatment providers. Any orientation material must be reviewed by the Board during the Program Advisory Committee to ensure that the materials are generic enough to be used by all four (4) Boards. In instances where Licensees have supervisors, IBH shall provide Board-approved training to supervisors, and this training must be posted online to IBH's HPSP webpage.

Quality Control and Performance Measurement

The MSA requires IBH to maintain an effective, on-going, data-driven Quality Assessment and Performance Improvement Program (QAPIP), which must include four (4) facets. First, as part of the QAPIP, IBH must establish formal and updated policies and procedures to which all IBH Program staff, subcontractors, and other service providers are trained and adhere. Second, IBH must incorporate into the policies and procedures protocols addressing the retention of staff, subcontractors, and other service providers, and ensuring IBH will dedicate a minimum number of staff to serve the Board's enrollees.

Third, the MSA requires IBH to give stakeholders and Licensees opportunities to provide feedback on IBH's administration of the Program, including administering (a) exit interviews of all Licensees who have successfully completed the Program within three (3) months of their completion of the Program; (b) a quarterly satisfaction survey of a representative sample of Licensees enrolled in the Program; and (c) a semi-annual stakeholder satisfaction survey of a representative sample of professional health associations, other employers, independent third-party evaluators and treatment providers, and the Boards.

Lastly, IBH must measure and report on its performance under the MSA. Each month, IBH is required to submit a self-assessment report on its adherence to 16 performance benchmark criteria established in the contract, as shown in Exhibit 5. If IBH does not meet or exceed the minimum success rate, the invoiced amount must be reduced by five (5) percent for each benchmark that was missed, with a maximum of 15 percent reduction per month or termination of contract. Two (2) out of the 16 performance benchmarks are based on the reporting month's actual performance, while the remaining 14 performance benchmarks are evaluated on a six-month average during the first year and rolling 12-month average in subsequent years. In the event that the Boards believe IBH did not meet a performance measure the Boards will notify IBH of the perceived missed benchmark. If IBH disagrees with the Boards assessment, it must respond within five days to contest. As of June 2020, there has been no reduction in compensation.

EXHIBIT 5: PERFORMANCE METRICS FOR MSA

No.	Contract Requirement	Minimum Success Rate	Performance Period
1	Enroll Board-referred Licensee in Program on date all Licensee signed specific consent forms are received. (MSA § 2.2.2)	100%	Multi-Month Average[1]
2	Report Licensee to Board if Licensee fails to contact HPSP within one (1) business day after Licensee is scheduled to report to HPSP. (MSA § 2.2.3)	90%	Multi-Month Average[1]
3	Conduct self-refereed Licensee safe-practice investigations within 15 days. (MSA § 2.4.3)	90%	Multi-Month Average[1]
4	Ensure Agreement Monitor meets with Licensee within first five business days of enrollment (exception if licensee is in treatment program). (MSA § 2.11.2.a)	90%	Multi-Month Average[1]
5	Ensure Agreement Monitor meets with Licensee on weekly, semimonthly, or monthly basis, as determined by IBH oversight or referring-board (exception if Licensee is in treatment program). (MSA § 2.11.2.b)	85%	Multi-Month Average[1]
6	Conduct at least 55 percent of toxicology testing on Mondays, Fridays, or Saturdays. (MSA § 2.12.2)	90%	Multi-Month Average[1]
7	Ensure Licensee receives baseline toxicology test with 10 business days of the date IBH enrolls Licensee. (MSA § 1213.1.a)	90%	Multi-Month Average[1]
8	Provide minimum toxicology testing for all Licensees with substance use disorders. (MSA § 1213.1.b)	95%	Multi-Month Average[1]
9	Ensure that Licensee with substance use disorder or dual diagnosis receives a minimum of 24 customized, random toxicology tests per year during first year of enrollment in HPSP with a minimum of 18 customized, random toxicology tests per year thereafter unless otherwise specified by Board. (MSA § 1213.1.c)	90%	Multi-Month Average[1]
10	Ensure Licensee diagnosed with a substance use disorder or who are dually diagnosed with a co-occurring mental health disorder receive a final customized toxicology test, and the sample test is negative, before Licensee is deemed to have successfully completed HPSP. (MSA § 1213.1.e)	100%	Multi-Month Average[1]
11	No later than 5:00 p.m. PT on Thursdays, provide the following (MSA § 2.17.1.a): • List of Licensees who are enrolled in the Program during the subject week to all participating Boards • List of Licensees who have successfully completed the Program during that week to all participating Boards	90%	Monthly
12	Submit noncompliance reports to participating Boards within one (1) business day after IBH learns of and confirms the noncompliance. (MSA § 2.17.2)	95%	Multi-Month Average[1]
13	Conduct initial and update reviews within 14 business days of Licensee's enrollment in Program or update. (MSA § 3.2.c)	85%	Multi-Month Average[1]
14	Report unusual or critical Program noncompliance incidents to affected Board and Program Work Group within one (1) business day. (MSA § 4.5)	90%	Multi-Month Average[1]
15	Ensure Licensee has the opportunity to have exit interview. (MSA § 4.7)	90%	Multi-Month Average[1]
16	Disclose to the Licensee's board within one (1) business day of any information the court authorizes it to disclose. (MSA § 10.4)	100%	Monthly

Source: MSA between the Boards and IBH.
Note: (1) Performance assessed every six (6) months the first year, then assessed based on a rolling 12-month average in subsequent years.

Periodic Reporting

The MSA requires IBH to submit five standardized and periodic reports, as illustrated in Exhibit 6.

- ✓ Weekly Reports: IBH submits a weekly census of Licensees enrolled in the Program, indicating the Licensees' respective licensing board and the Licensees' status as self- or Board-referred, as well as any instances of non-compliance with Licensee monitoring agreements.

- ✓ Monthly Reports: Along with monthly invoices, IBH submits a Monthly Report that focuses on the services rendered on behalf of each licensing board and a self-assessment of its own performance with respect to a series of performance benchmarks. This includes information related to:
  - Active Licensees
  - Enrollment and Disenrollment Data
  - Safe-Practice Investigations
  - Assessment of Licensee Employers
  - Compliance Reports Submitted
  - Weekly Reports Submitted
  - Monthly Reports Submitted
  - Reports Sent to Employers
  - Non-Compliance Reports Submitted
  - Bi-Annual Stakeholder Survey Reports
  - Annual Utilization Reports
  - Court Orders Requested

- ✓ Quarterly Reports: The MSA requires IBH to provide quarterly presentations to the Program Advisory Board on outreach presentations conducted. In addition, the MSA requires IBH to send surveys to Licensees quarterly to gauge their satisfaction with the Program.

- ✓ Bi-Annual Reports: In January and July of each year, IBH must report the results of its Licensee and stakeholder exit interviews and surveys.

- ✓ Annual Reports: IBH must submit, once a year, financial records for the fiscal year related to HPSP-related revenues, expenses, and profit percentages.

EXHIBIT 6: REGULAR CONTRACTOR REQUIRED REPORTS

Source: MSA between the Boards and IBH § 4, 7, and 11.1.c.

In addition to these regularly scheduled reporting requirements, IBH is required to report to the Boards within 24-hours of when IBH becomes aware of instances of substantial noncompliance or when IBH is presented with a court order.

Scope and Methodology

Sjoberg Evashenk Consulting was hired by the Boards to conduct an independent performance audit of IBH compliance with the MSA and each of the four (4) subordinate WOCs through which IBH provides services to each licensing board. Specifically, the objectives included whether:

- IBH (a) met required minimal success rate standards as defined in the MSA (Exhibit A, 5. Program Performance Criteria); (b) provided invoices and reports that are accurate and supported by substantiating documentation; and (c) based reported results and invoices on sound and appropriate calculation methods.
- IBH and each licensing board complied with the WOCs (Scope of Work, including MSA § 3.2, and Exhibit A-1 Board Modifications to Exhibit A) established by each Board.

To meet the audit's objectives, we performed the following audit evaluation procedures:

- Interviewed management and staff at each of the four (4) licensing boards to gain an understanding of HPSP program requirements, roles and responsibilities, expectations of IBH, and practices in place to oversee and manage the contract.
- Interviewed IBH management and staff to gain an understanding of processes, internal controls, systems, and tools in place to administer the HPSP program and fulfill MSA and WOCs requirements; this included practices to oversee participating Licensees, conduct and report the results of required surveys, invoice the Boards, and prepare and submit management and performance reports.
- Conducted a comprehensive review of the MSA as well as the four (4) WOCs, and identified all performance and deliverable obligations of IBH, including any Board specific provisions and required minimal success rate standards (or "benchmarks") as defined in Exhibit A, 5. Program Performance Criteria.
- Selected a sampled of 48 monthly invoices and examined all relevant underlying support to determine whether invoices were mathematically accurate, amounts and services invoiced were allowable per the MSA and WOCs, and information reported were accurate and reliable; this included verifying performance reported tied to underlying documentation and determining whether penalties were accurately calculated and assessed when established targets and requirements were not met.
- Selected a sample of weekly, monthly, quarterly, bi-annual, and annual reports submitted by IBH to the Boards in Fiscal Years 2017-18, 2018-19, and 2019-20 to ensure required information and elements were reported, reports were submitted timely, and amounts reported tied to underlying supporting documents.

Audit fieldwork was performed between July and October 2020. On November 18, 2020, a draft of this report was provided to IBH management for review and discussion and an Exit Conference was held on December 22, 2020. Responses and feedback provided by IBH management were considered and incorporated where applicable in the final report. IBH management generally agreed with the findings

and recommendations presented in this report and provided a written response to the report, which is incorporated as Appendix A of this report.

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

Audit Findings

Overall, this audit found that IBH materially complied with its contract with the Boards. With relatively few exceptions, IBH submitted to the Boards invoices and reports that were accurate and supported by substantiating documentation; reported results and invoices were based on sound and appropriate calculation methods; and IBH generally met required minimal success rate standards as defined in the MSA and complied with many relevant provisions of the respective WOCs. However, this audit also revealed instances of minor mis-calculations in reporting one (1) performance metric and several instances where IBH could not demonstrate it met certain contract provisions, particularly those related to outreach and training; quality assurance program requirements; and reporting requirements. Because of this, IBH did not provide the full level of service as described in the contract and, in one case, compensation to IBH could have been reduced as a result. The remainder of this report describes each of these conclusions in more detail.

Amounts Invoiced Adhered to Contract Payment Provisions

A review of all six (6) program fees calculated every six (6) months during the audit period found that the Boards and IBH appropriately calculated and distributed the fee amongst the Boards in compliance with MSA fee calculation provisions, as shown in Exhibit 7. In addition, our review of invoices submitted by IBH to the Boards for 12 sample months (48 invoices total) found that amounts invoiced complied with contract payment provisions.

EXHIBIT 7. PROGRAM FEE CALCULATION AND MONTHLY INVOICE TESTING RESULTS

Invoice Period	Monthly Program Fee	Annual Program Fee Correctly Calculated?	Months Reviewed	Number of Invoices Reviewed	Amounts Invoiced Accurate and in Compliance with MSA?
July - December 2017	$91,505	Yes	2	8	Yes
January - June 2018	$91,505	Yes	2	8	Yes
July - December 2018	$91,505	Yes	2	8	Yes
January - June 2019	$91,687	Yes	2	8	Yes
July - December 2019	$91,505	Yes	2	8	Yes
January - June 2020	$92,192	Yes	2	8	Yes

Source: Auditor-generated based on review of invoices submitted by IBH to the Boards and Medical Board documentation supporting program fee calculations.

IBH Employed Sound Controls Over Licensee Monitoring

Each licensing board serves different constituencies and Licensees in different healthcare professions serving different populations. To enable each Board to impose monitoring requirements that each finds necessary to best protect the public from their respective Licensees who may be unable to practice safely due to substance abuse and/or mental health disorders, the MSA establishes subordinate WOCs between each licensing board and IBH that define these unique monitoring requirements. As described previously,

this includes case monitoring, workplace monitoring and reporting, and random toxicology testing. For instance, some of the specialized monitoring requirements imposed by the licensing boards include:

- The Medical Board, Board of Pharmacy, and Board of Dentistry all require a minimum of 36 toxicology tests for a Licensee's first year, 24 the subsequent, and 18 for the remaining years in HPSP.
- The Medical Board requires Licensees who must go to Consultation Group Meetings to have an attendance rate of 90 percent.
- Board of Dentistry requires Licensees to be enrolled in HPSP for a minimum of five years.

Our review of IBH's protocols for establishing Licensees in HPSP showed that once a Licensee is enrolled, IBH's staff create an account for the Licensee with their toxicology contractor in order for the Licensee to receive their first toxicology test within ten days of enrollment. The Licensee must have their first meeting with the Agreement Monitor within five days of enrollment. For the duration of their time enrolled in HPSP, Licensees will meet regularly with their Agreement Monitor and call the IVR line Monday-Saturday for a toxicology-testing notification.

While WOC-specific requirements are not measured or reported as part of the Quality Assessment and Performance Improvement Program (QAPIP), we evaluated IBH's processes for establishing individual monitoring agreements and selected a sample of 10 Licensee records to assess the manner in which IBH implemented the agreements. Overall, we found that IBH's practices for monitoring Licensees is generally compliant with the MSA and subordinate WOCs. All 10 Licensees received the appropriate number of toxicology tests and were enrolled in HPSP for the necessary duration, with the exception of two (2) Licensees who left the Program early due to suspension.

While this audit found that IBH met toxicology testing requirements set forth in the MSA and WOCs, we found that its reporting on case monitoring activities did not always adhere to contractual requirements. As mentioned previously, Licensee monitoring agreements and the MSA § 2.11.2.b require Licensees to communicate with their Agreement Monitor at least once a month through voice-to-voice contact. The frequency of Licensee's compliance with this requirement is reported monthly to the Boards through their performance measures. As discussed later in this report, our review of 12 of the 36 reporting periods identified five (5) instances of inconsistencies in IBH's calculation and reporting of this requirement. This included instances in which IBH included voicemail and e-mail communications, along with voice-to-voice, in their monthly performance reporting. In addition, the Medical Board requires licensees attend Consultation Group Meetings with an attendance rate of 90 percent, our review found that IBH had a process in place to schedule and to track Consultation Group Meeting attendance.

IBH Could Not Demonstrate that it Provided All Required Educational Materials and Outreach Presentations

The MSA requires IBH to provide outreach presentations to Licensees and training materials to third-party evaluators, consultants, treatment providers, and Licensee supervisors (workplace monitors). In addition, the Boards issued a written waiver that expanded the audience for outreach presentations to include

students. The purpose of this outreach is, in part, to provide education and information to Licensee employers and other stakeholders, such as students, regarding the signs and symptoms of relapse, including but not limited to, regional seminars and educational programs (MSA 2.8.5). Below, we describe outreach- and training-related requirements and our assessment of IBH's compliance. We found that IBH generally did not meet established outreach and education requirements set forth in the MSA.

Outreach Presentations

The MSA § 11.1 requires IBH to conduct a minimum of one (1) outreach presentation per month and at least 12 outreach presentations per year throughout the term of the contract; to provide a minimum of two (2) outreach presentations per region per year; to obtain pre-approval of the presentation materials by the Program Advisory Committee at least one (1) week prior to the presentation; and to retain signed attendance sheets for a minimum of two (2) years following the presentation. On a quarterly basis, as described later in this report, IBH must "provide a list of outreach presentations conducted including location, time, and number of participants to the Program Advisory Committee" (MSA § 11.1.c).

- ✓ Minimum Outreach Presentations: To assess whether IBH conducted at least one (1) outreach presentation per month as required by the MSA § 11.1.a, we requested a list of outreach presentations conducted for five sample months. Our review found that for two (2) of the five (5) months sampled IBH did not conduct at least one (1) outreach presentation, as required. We also found that in other months during the audit period, IBH provided more than the minimum required outreach. For example, in May 2018 IBH conducted three (3) outreach presentations.

  While the contract does not specifically state the purpose or intent of this outreach, it appears that the purpose is threefold: (a) to ensure Licensees, as well as their peers and their supervisors, are aware of the HPSP and are informed regarding its purpose and potential benefits; (b) to inform Licensees, their peers, and supervisors of the signs and symptoms of mental health disorders and/or substance abuse; and (c) to ensure health professional students are informed of available programs and issues they may face in the workplace. In this respect, the minimum outreach requirements contained in the MSA are important to ensuring the success of the HPSP in protecting the public from Licensees who are unable to practice safely due to substance abuse and/or mental health disorders.

  According to IBH, although the contract required one (1) outreach presentation per month, this requirement was interpreted to mean an average of one (1) outreach presentation per month.

- ✓ Quarterly List of Outreach Presentation Provided to the Program Advisory Committee: As discussed later in this report, our review of four (4) quarters found that IBH did not provide any written lists of outreach presentations to the Program Advisory Committee. To assess whether IBH verbally discussed outreach presentations and presented the required information we reviewed meeting minutes for the quarters sampled. Our review found that for two (2) of the four (4) sampled quarters there was no discussion of outreach presentations in the meeting minutes. For the remaining two (2) quarters, the meeting minutes indicated that outreach presentations were discussed; however, it was unclear if all required information, including the location, time, and

number of participants, was discussed based on the meeting minutes alone. It does not appear IBH consistently meets this requirement as defined in MSA § 11.1.c.

While IBH provided an internal tracking log of outreach presentations conducted between July 1, 2017 and June 25, 2018, the list provided did not always include the location, time, and number of participants, as required by the MSA. We also found no indication that this list was provided to the Boards, as required.

- ✓ Pre-Approval of Presentation Content: According to IBH, the Boards pre-approved the outreach content prior to the execution of the MSA. While IBH provided documentation demonstrating pre-approval of one presentation and indicated the presentation slides were used as a basis for developing future presentation content, it was unclear whether presentation materials had changed over the years and no subsequent pre-approvals were provided. Regardless, the Program Advisory Committee does not pre-approve presentation content in writing at least one (1) week prior to the presentation as required by MSA § 11.1.d.

  The Program Advisory Committee pre-approval is an important control established in the MSA as it provides the Boards with an opportunity to review current outreach material and assess whether materials are relevant to the current environment, whether gaps exist is in presentation materials, and whether modifications are necessary. As the Program and environment in which the Program is operating change over the years, and as gaps in stakeholder understanding of the Program become evident, it becomes increasingly important to ensure presentation content remains relevant.

- ✓ Outreach Presentation Attendance List: Although MSA § 11.1.f requires IBH to ensure each presentation has an attendance sign in sheet, provided by location or by Contractor, and requires IBH to maintain a copy of attendance sign-in sheets for two (2) years, IBH was unable to provide sign-in sheets for the seven (7) presentations sampled. According to IBH, the requirement for sign-in sheets was deemed unnecessary by the Program Advisory Committee prior to the MSA. While we found no documentation that the Boards agreed to amend the contract or to no longer require the retention of sign-in sheets, the absence of sign-in sheets makes it difficult to verify whether scheduled presentations actually occurred and to assess the coverage actually achieved through IBH's outreach efforts.

The purpose of the HPSP is to protect the public from Licensees who are unable to practice safely due to their diagnosis, and self-referral is an important aspect of the Program for most licensing boards, allowing Licensees that recognize a potential problem and the potential assistance the HPSP may offer to participate in the Program. As noted earlier, these requirements were designed as an essential element of the Program by informing employers and other stakeholders regarding the signs and symptoms of relapse and help to ensure Licensees enrolled in the program adhere to program requirements. Any shortage in outreach or training could undermine the effectiveness of the Program, and could increase the risk that stakeholders and workplace monitors may not recognize the signs and symptoms of relapse and could potentially impact the safety and quality of care provided.

Training Materials

For Licensee supervisors and workplace monitors, IBH must provide orientation, educational, and training materials. Minimum educational and/or training standards and requirements for supervisor and workplace monitor skills and knowledge that can be used by employers to ensure effective supervision of Licensees in work settings must be established (MSA § 2.8.4). This training must be pre-approved by the Program Advisory Committee and available in both electronic and physical format. There must also be online training materials for workplace monitors.

According to IBH, workplace monitors receive training on their first phone call with the Licensee's Agreement Monitor. During the initial call, the Agreement Monitor informs the workplace monitor of the requirements. IBH has a list of assessment questions that covers the potential workplace monitor's relationship with the Licensee, any potential conflicts of interest, and the notifying and reporting responsibilities of a workplace monitor. Additionally, the monthly report that the workplace monitor submits to IBH serves as a monthly reminder of the responsibilities and requirements of a workplace monitor.

While this is generally a sound practice and appears compliant with the MSA and WOCs, IBH could not provide evidence that all trainings were pre-approved by the Program Advisory Committee or that it made trainings for all licensing boards available online, as required. IBH indicated that the Program Advisory Committee waived the requirement for the other licensing boards to have online training materials during the July 2017 committee meeting; however, a review of the meeting minutes only indicated that the "Board of Nursing training [will be] updated on IBH website" and did not indicate that the requirement was waived for the other three Boards.

IBH Met Most Quality Assessment and Performance Improvement Program Requirements, but Opportunities for Improvement Remain

The MSA requires IBH to evaluate and maintain an effective, on-going, data-driven QAPIP that includes ensuring staff, subcontractors, and other service providers meet health profession standards necessary for credentialing. In addition to retaining qualified staff, IBH must maintain, update, and implement formal QAPIP policies and procedures; obtain stakeholder and Licensee input and feedback; maintain minimum levels of staffing; and measure and evaluate service levels in accordance with established benchmarks. Our conclusions regarding IBH's performance with respect to each of these requirements is presented below.

Policies and Procedures

IBH must maintain and update a fully-implemented QAPIP policies and procedures manual, and ensure that all of their staff, subcontractors, and other service providers are trained on the QAPIP. According to IBH, the QAPIP policies and procedures are published on IBH's website as HPSP's guidelines. These 31 guidelines cover many topics related to IBH, such as guidelines for hair testing, confidentiality and record release, criminal background checks, and medical director responsibility for case review. In addition, IBH developed a number of internal policies and procedures to guide its operations, including checklist and written processes for non-compliance reporting.

Stakeholder and Licensee Feedback

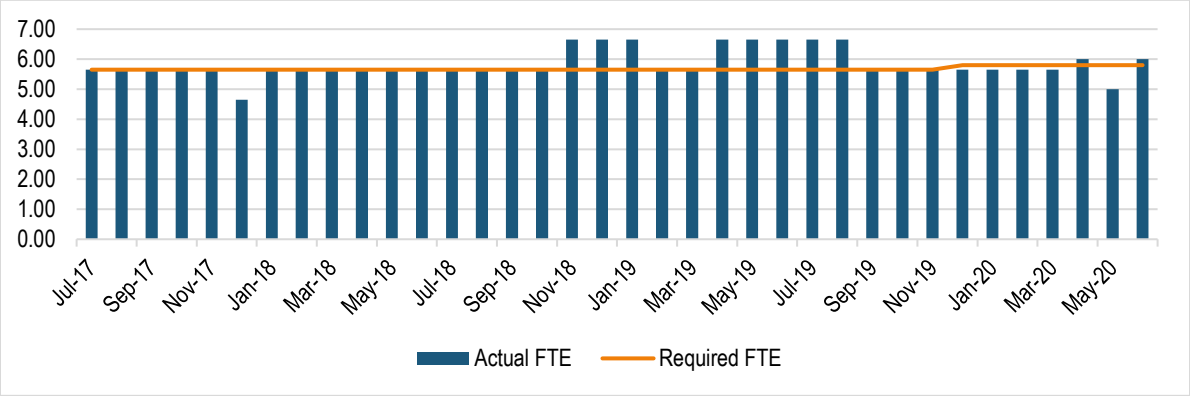
IBH must ensure stakeholders are given routine opportunities to provide feedback to IBH's administration of HPSP, and communicate that feedback to the Boards. IBH accomplishes this in two ways: feedback forms and regular surveys. Beginning in 2017, each of the Boards has a complaint and feedback form for HPSP accessible on their website. The Board of Dentistry and Board of Pharmacy allow for feedback through an online browser survey form, while the Board of Nursing and Medical Board both utilize the same feedback form that Licensees must download and fax or mail to their respective licensing board.

The MSA requires IBH to also send surveys to Licensees participating in HPSP, Licensees who have successfully completed HPSP, and HPSP stakeholders. Licensees, according to the MSA, must be sent surveys every quarter. However, IBH only sends surveys bi-annually, referencing an informal decision made by the Program Advisory Committee that changed the requirement from quarterly to twice per year. According to IBH, this change from quarterly to bi-annual surveys occurred in 2012 because generally low response rates from survey participants resulted in relatively little to report on a quarterly basis. This would have occurred during the term of the prior contract—between IBH and the Oregon Health Authority—preceding the current MSA. While it is possible that this requirement was a remnant of the prior contract and that it was not the intent of the Boards to require quarterly surveys, we were unable to substantiate this. If the Boards have indeed changed this contractual requirement, we recommend memorializing the decision in a formal committee resolution or contract amendment. IBH meets the exit-interview and stakeholder satisfaction survey content requirements.

Staff Levels

The QAPIP must have a policy to retain sufficient Agreement Monitor staffing levels. Additionally, IBH compensation is tied to how many Licensees are enrolled in HPSP and how many Agreement Monitors must be employed. During the 36 months of the audit period, IBH only had six (6) months where they did not meet the required FTE, or about 17 percent of the time. According to IBH, in the six (6) months where the requirement was not met, they were actively recruiting to hire additional Agreement Monitors to comply with the minimum contractual requirement. In the months that IBH did not have the required FTE, the Boards were paying for costs that IBH at the time was not incurring. The contract does not include provisions for liquidated damages or penalties if this provision is not met.

EXHIBIT 8. AGREEMENT MONITORS FULL-TIME EQUIVALENT STAFFING LEVELS: REQUIRED VS. ACTUAL



Source: Auditor generated based on FTE reported by IBH

IBH Generally Met Performance Requirements

We reviewed and validated all 16 performance benchmarks for 12 of the 36 months, or one-third of the monthly performance reports between July 2017 and June 2020 submitted by IBH. As discussed earlier, IBH submits monthly performance reports that report IBH's actual performance for the reporting month, and average performance over time. Penalties and damages are evaluated based on either the actual performance for the month or the average performance over the period specified dependent on the benchmark metric. Generally, we were able to validate all data that IBH reported to the Boards, and any discrepancies noted were still within the margin of IBH meeting the minimum performance required, as shown in Exhibit 9.

EXHIBIT 9: PERFORMANCE BENCHMARK SAMPLE TESTING RESULTS

Contract Requirement	July 2017[1]	Oct 2017[1]	Dec 2017	Feb 2018[1]	June 2018	July 2018	Dec 2018	March 2019	June 2019	Aug 2019	Dec 2019	June 2020
Benchmark 1. §2.2.2	N/A	N/A	✗	N/A	✓	✓	✓	✓	✓	✓	✓	✓
Benchmark 2. § 2.2.3	N/A	N/A	✓	N/A	✓	✓	✓	✓	✓	✓	✓	✓
Benchmark 3. § 2.4.3	N/A	N/A	✓	N/A	✓	✓	✓	✓	✓	✓	✓	✓
Benchmark 4. § 2.11.2.a	N/A	N/A	✓	N/A	✓[3]	✓	✓	✓	✓	✓	✓	✓
Benchmark 5. § 2.11.2.b	N/A	N/A	✓	N/A[2]	✓	✓	✓	✓[2]	✓[2]	✓[2]	✓[2]	✓
Benchmark 6. § 2.12.2	N/A	N/A	✓	N/A	✓	✓	✓	✓	✓	✓	✓	✓
Benchmark 7. § 1213.1.a	N/A	N/A	✓	N/A	✓	✓	✓	✓	✓	✓	✓	✓
Benchmark 8. § 1213.1.b	N/A	N/A	✓	N/A	✓	✓	✓	✓	✓	✓	✓	✓
Benchmark 9. § 1213.1.c	N/A	N/A	✓	N/A	✓	✓	✓	✓	✓	✓	✓	✓
Benchmark 10. § 1213.1.e	N/A	N/A	✓	N/A	✓	✓	✓	✓	✓	✓	✓	✓
Benchmark 11. § 2.17.1.a	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Benchmark 12. § 2.17.2	N/A	N/A	✓	N/A	✓	✓	✓	✓	✓	✓	✓	✓
Benchmark 13. § 3.2.c	N/A	N/A	✓	N/A	✓	✓	✓	✓	✓	✓	✓	✓
Benchmark 14. § 4.5	N/A	N/A	✓	N/A	✓	✓	✓	✓	✓	✓	✓	✓
Benchmark 15. § 4.7	N/A	N/A	✓	N/A	✓	✓	✓	✓	✓	✓	✓	✓
Benchmark 16. § 10.4	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Source: Auditor-generated based on review of sample of monthly reports and supporting performance data.

Note (1): During the first year of the contract, performance was to be evaluated every six (6) months (December 2017 and June 2018). Following the first year, the performance was to be evaluated monthly based on a rolling year average.

(2) Amount reported in monthly report did not agree with underlying support.

(3) Amount reported in monthly invoice was lower than the performance requirement; missed monthly performance was waived by the Medical Board.

Key: ✓ = requirement was met, ✗ = requirement was not met, N/A = not applicable

IBH did not meet one (1) of the performance measures during the first six-month period of the contract. The MSA requires 100% of Licensees to be enrolled on the same day a Licensee signs the last consent form (MSA § 2.2.2); in July 2017, IBH only enrolled three (3) of four (4) Licensees (75 percent) by the day of their last consent form. When the performance was averaged in December 2017, IBH reported that the requirement was not met, with 26 of the 27 Licensees enrolled (96.3 percent). If the Boards had determined to assess penalties, management would have needed to send a letter to IBH listing the performance requirements missed by IBH. The Boards never reached out to IBH to recover penalties.

The largest variation we observed was the calculation of Licensee compliance with Agreement Monitor check-ins. The performance measurement requires at least 85 percent of Licensees have voice-to-voice contact with their Agreement Monitor (MSA § 2.11.2.b). When reporting in the months February 2018, March 2019, June 2019, August 2019, and December 2019, we found that the performance IBH submitted was incorrectly calculated. For four (4) of the months, IBH included contact that cannot be considered voice-to-voice, such as voicemail or e-mail communication. In the other month, the calculation appears to be an arithmetic issue, where IBH incorrectly counted the number of Licensees who reported weekly. Despite these errors, we found that IBH still performed within the performance criteria—in many cases actual performance was better than performance reported.

While IBH Met Many of the Reporting and Deliverable Requirements Established in the MSA, It Did Not Meet Several Requirements

The MSA requires five (5) separate reporting intervals and reporting requirements for IBH to meet. As described previously, IBH is required to submit weekly, monthly, quarterly, bi-annual, and annual reports, each of which is designed to demonstrate compliance with key performance requirements set forth in the MSA and to help ensure quality program service delivery. To assess whether IBH met reporting requirements, including required information and timelines where applicable, we requested support for each reporting requirement for sample periods over the audit period. While our review found that while IBH met many of the reporting requirements, we noted instances where some required reports were not submitted or submitted timely and/or required information was not reported as required. Below, we present the results of our review of IBH's compliance with each of the five reporting intervals and requirements for periods sampled.

Weekly Reporting Requirements

The contract requires IBH to submit a weekly report to the Boards, by 5:00 p.m. each Thursday. The weekly report must include the number of Licensees enrolled in HPSP, including the number of Licensee that are Board-referred and self-referred, and a breakdown of Licensees enrolled in HPSP by Board, including the number of Licensees Board-referred and self-referred. Our review of six (6) weekly reports submitted during the audit period, found that all six (6) reports were submitted by the deadline and contained the required information, as shown in Exhibit 10. In addition, although not required in the MSA, in all six (6) weekly reports selected for review, IBH reported the number of licensees with compliant and non-compliant status as of the time of the report.

EXHIBIT 10. WEEKLY REPORTING REQUIREMENTS SAMPLE TESTING RESULTS

Reporting Requirement	Fiscal Year 2017-2018		Fiscal Year 2018-2019		Fiscal Year 2019-2020	
	December 21, 2017	June 7, 2018	July 19, 2018	March 28, 2019	August 8, 2019	June 4, 2020
List of Self-Referred and Board Licensees by Health Board						
Reported Submitted Timely?	Yes	Yes	Yes	Yes	Yes	Yes
Required Information Included?	Yes	Yes	Yes	Yes	Yes	Yes

Source: Auditor-generated based on review of a sample of weekly reported submitted by IBH.

Monthly Reporting Requirements

Each month, IBH is required to report its compliance with the 16 Program Performance Criteria established in the MSA (as shown in Exhibit 4 in the Program Overview MSA § of this report) and the following five (5) enrollment statistics:

- Number of Licensees referred to HPSP during the month, including each Licensees referral source, health profession, and Oregon county of residence, or if living in a different state, the state
- Number of Licensees IBH enrolled during the month, including each Licensee's referral source, health profession, and state geographic region
- Number and percentage of Licensees who are in compliance with their monitoring agreements for the subject month
- Number and percentage of Licensees, by Board, who received substantial non-compliance (as defined by Oregon Statute)
- Number of Licensees who successfully completed the Contractor's monitoring program during the month

IBH includes this information as an attachment to the monthly invoices it submits to each Board by the 15th of each month. As shown in Exhibit 11, our review of six (6) sampled monthly reports over the audit period found that while IBH submitted the reports on-time, the monthly reports submitted did not always include all required enrollment statistics.

EXHIBIT 11. MONTHLY REPORTING CONTRACT COMPLIANCE

Reporting Requirement	Fiscal Year 2017-2018		Fiscal Year 2018-2019		Fiscal Year 2019-2020	
	July 2017 Medical Board	February 2018 Nursing Board	December 2018 Pharmacy Board	March 2019 Dental Board	August 2019 Medical Board	June 2020 Board of Nursing
Enrollment Figures						
Reported Submitted on Time?	Yes	Yes	Yes	Yes	Yes	Yes
Required Information Included?	No[1]	No[1]	No[1]	No[1]	No[1]	No[1]
Performance Benchmarking						
Reported Submitted on Time?	Yes	Yes	Yes	Yes	Yes	Yes
Required Information Included?	Yes	Yes	Yes	Yes	Yes	Yes

Source: Auditor-generated based on review of monthly reports submitted by IBH.

Note: (1) Monthly report was missing three (3) required data elements required by MSA § 7.2.d, 7.2.e, and 7.2.b.3

Specifically, the monthly reports were all missing the following three (3) required data elements:

- ✓ Number and Percentage of Licensees in Compliance with Monitoring Agreements (MSA § 7.2.d): IBH is required to report the number and percentage of Licensees who are in compliance with Monitoring Agreements for the month. While the percentage of Licensees who were in compliance with their monitoring agreement was not reported in the monthly report, our review of weekly reports found that IBH reported the number of Licensees who were in compliance with their Monitoring Agreements in all six (6) weekly reports sampled.
- ✓ Number and Percentage of Licensees with Substantial Non-Compliance Reports (MSA § 7.2.e): IBH is required to report the number and percentage of Licensees who received substantial non-compliance reports during the month. IBH reports the number of substantially non-compliant (and compliant) Licensees on the weekly reports. On the monthly report, IBH instead reports the number of substantial non-compliance reports submitted to each Board that month.
- ✓ Licensee Geographical Location (MSA § 7.2.b.3): IBH is required to report the numbers of Licensees enrolled by geographic region or number of Licensees referred to HPSP by county of residence.

According to IBH, the monthly invoice and report were submitted in the format specified by each of the WOCs. Specifically, the individual WOCs include a monthly invoice and reporting template which does not include the three (3) missing enrollment statistics in the template although required by the MSA. In this case, the MSA and WOCs are in conflict.

Quarterly Reports

The MSA requires IBH to report to the Program Advisory Committee on all outreach activities on a quarterly basis, and to perform and report on the results of quarterly Licensee satisfaction surveys. Specifically, MSA § 11.1.c requires IBH to provide a list of outreach presentations conducted including location, time, and number of participants to the Program Advisory Committee quarterly and MSA § 4.8 requires IBH to send quarterly satisfaction surveys to Licensees participating HPSP. As shown in Exhibit 12, our review of four (4) quarters sampled found that IBH did not meet at least one (1) reporting requirement in each of the four (4) quarters reviewed.

EXHIBIT 12. QUARTERLY REPORTING REQUIREMENTS COMPLIANCE

	Fiscal Year 2017-2018		Fiscal Year 2018-2019	Fiscal Year 2019-2020
	Q1	Q4	Q3	Q3
List of Outreach Presentations				
Required Information Included?	Yes	No[2]	Yes	No[2]
Written List of Outreach Conducted Provided to Program Advisory Committee?	No[1]	No[1]	No[1]	No[1]
Licensee Satisfaction Surveys				
Reported Submitted on Time?	No[2]	Yes	No[2]	No[2]
Survey Conducted During Quarter?	No[2]	No[2]	No[2]	No[2]

Source: Auditor-generated based on review of reports submitted by IBH and Program Advisory Committee meeting minutes.
Notes: (1) IBH did not provide a list of outreach events; meeting minutes did not include a discussion of outreach conducted.
(2) IBH conducted licensee survey and reported licensee survey results bi-annually with other bi-annual survey results.

To determine IBH's compliance with the outreach presentation reporting requirement, we selected four (4) of the 12 quarters between July 1, 2017 through June 30, 2020 to assess compliance. IBH did not provide a written list of outreach presentations conducted with the required information for any of the quarters reviewed. To assess whether IBH verbally reported this information, we reviewed the Program Advisory Committee meeting minutes for the sampled quarters. For two (2) of the four (4) quarters sampled we saw evidence that information on outreach conducted was presented; however, we could not confirm whether all required information was presented based on the minutes provided. For the remaining two (2) quarters sampled, there was no indication in the meeting minutes that outreach conducted by IBH was discussed.

As noted previously, although the MSA also requires quarterly licensee satisfaction surveys, IBH indicated that these are conducted bi-annually and that the Boards agreed that sending the surveys quarterly was excessive and informally agreed to adjust the licensee satisfaction surveys to bi-annually; however, this informal agreement was not documented and the MSA was not amended. According to IBH, this

agreement was made prior to the execution of the current MSA; however, the requirement was not adjusted in the executed contract.

Bi-Annual Reporting Requirements

IBH is required to conduct licensee exit surveys (MSA § 4.7 and 7.3) and stakeholder satisfaction surveys (MSA § 4.9 and 7.3). The stake holder satisfaction surveys include surveys of professional health associations, other employers, independent third-party evaluators and treatment providers, and participating Boards. Our review of all six (6) bi-annual periods over the audit period, found that while IBH generally conducted all required surveys, the summary of survey finding results were not submitted to the Boards timely and, for two (2) periods, the exit-interview results were reported to the Boards annually instead of bi-annually, as required by the MSA. The results of this assessment are depicted in Exhibit 13.

EXHIBIT 13. BI-ANNUAL REPORTING REQUIREMENTS COMPLIANCE

Reporting Requirement	Fiscal Year 2017-2018		Fiscal Year 2018-2019		Fiscal Year 2019-2020	
	July-December	January-June	July-December	January-June	July-December	January-June
Stakeholder Survey						
Reported Submitted on Time?	No, submitted January 31, 2018	No, submitted July 31, 2018	No, submitted January 31, 2019	No, submitted July 31, 2019	No, submitted January 31, 2020	No, submitted July 31, 2020
Required Information Included?	Yes	Yes	Yes	Yes	yes	Yes
Exit-Interview Survey						
Reported Submitted on Time?	No, submitted January 31, 2018	No, submitted July 31, 2018	No, report submitted July 31, 2019	No, submitted July 31, 2019	No, report submitted July 31, 2020	No, submitted July 31, 2020
Required Information Included?	Yes	Yes	No, report submitted annually	Yes	No, report submitted annually	Yes

Source: Auditor-generated based on review of survey reports submitted by IBH during the audit period.

Specifically, MSA § 7.3 requires IBH submit the results of the two (2) surveys within 30 days preceding June 30 or December 31 of each year. Our review found that the survey results were submitted 30 days succeeding the dates specified in the MSA. According to IBH, IBH sends the surveys to participants and stakeholders at the end of December and June each year and reports survey results to the Boards at the end of January and July.

In addition, although IBH reported the results of the Licensee exit-interview bi-annually during Fiscal Year 2017-2018, in the two subsequent fiscal years IBH only submitted the survey results to the Boards annually. Licensees who successfully complete HPSP are required to be sent an exit-interview within three (3) months of their completion (MSA § 4.7). This requirement was evaluated as part of our review of the performance measurement and benchmarks. IBH met the timeliness requirement for sending exit-interviews each month sampled; however, IBH did not synthesize these results and report them to the

Boards as frequently as the MSA requires. According to IBH, in 2018 the Program Advisory Committee informally agreed that the exit survey results should be reviewed by the Program Advisory Committee each January and formally presented by IBH to the Boards and Program Advisory Committee each July. This informal agreement was referenced in an e-mail sent on January 31, 2019 from IBH to the Boards.

Annual Reports

The MSA has one (1) annual reporting requirement for a financial report. Specifically, MSA § 7.4 requires IBH submit financial reports annually that include summaries of Program-related revenues, expenses, and profit percentages for each HPSP service during the year. According to IBH, this requirement was waived during the contract negotiation process; however, neither the Medical Board (the contract manager) nor IBH provided documentation demonstrating the provision was formally waived and the reporting provision was included in the executed MSA. In the monthly reports submitted by IBH, IBH notated that it interprets the "Annual Financial Report" requirement to mean annual utilization reports. Nevertheless, the contract was never amended to reflect this interpretation and the requirement to submit financial reports remained in the contract throughout the entire audit period.

In addition, although not required by the MSA, IBH submits an annual utilization report which provides a summary of aggregate data from HPSP for the year, including HPSP Agreement Monitor check-ins that took place in person, termination reasons, noncompliance instances and reasons, and non-negative toxicology tests. To assess the accuracy and reliability of information reported in the annual utilization report, we traced information reported in three (3) of the 15 figures back to underlying support for the 2019-2020 Annual Report. As shown in Exhibit 14, our review found that information reported by IBH in the three (3) figures reviewed agreed with underlying support.

EXHIBIT 14. DATA VERIFICATION OF TABLES PROVIDED IN ANNUAL PERFORMANCE REPORT FOR 2019-2020

Figure	Data Reported Tied to Underlying Data?
Figure 12: Drugs resulting in positive tests	Yes
Figure 13: Missed Test Details	Yes
Figure 15: Workplace Safe Practice Reports	Yes

Source: Auditor-generated based on review of annual report and underlying source data.

Based on our review of each of the reporting requirements set forth in the MSA, we found that, if utilized, the information contained in the reports would be sufficient to ensure appropriate oversight of IBH's performance and the quality of the services provided. However, as noted earlier, we found multiple instances where information required by the Board was either not provided at all or not within the timeframes specified in the contract. At the same time, we found that the same or similar information was reported quite frequently in various required reports, and thus could be considered redundant. This suggests that there may be opportunities to streamline and improve upon the existing reporting structure by reducing redundancies and removing elements that the Boards no longer find useful.

Opportunities Exist to Better Clarify Contract Language and Expectations

In reviewing IBH's compliance with contract provisions and reporting requirements over the three-year audit period, we noted multiple instances where IBH indicated contract provisions were informally waived either before or after the MSA was executed. Yet, contract provisions and reporting requirements remained in the MSA and were never formally amended. In addition, we noted instances where contract provisions were either unclear or did not align with current practices. In both scenarios, IBH was not complying with all provisions and reporting requirements established in the contract and the Boards were not actively enforcing certain contract requirements. Below we provide a brief overview of several areas that are discussed throughout this report where the Boards should assess whether the current contract provisions and requirements accurately reflect the Boards' expectations of IBH, or whether provisions should be formally amended.

- ✓ Deadlines for Submitting Stakeholder Surveys and Summaries of Licensee Exit Interviews: MSA § 7.3 of the MSA required IBH to "prepare and submit written stakeholder survey and the summary of findings from the Licensee exit interviews within thirty (30) days preceding June 30 and December 31 of each year during the term of this Contract. Contractor shall submit stakeholder surveys in a format acceptable to Board." According to IBH, although this requirement states the survey and results be submitted 30 days *preceding* June 30 and December 31, in practice the summary of findings have been reported 30 days *succeeding* June 30 and December 31. As discussed in the previous section of this report, IBH consistently submitted the results of each survey after the deadlines established in the contract and the Boards did not enforce the deadlines outlined in the MSA. If the Boards agree with the current practice for submitting required surveys, the deadlines in the contract should be formally updated to align with current practice.

- ✓ Frequency of Required Surveys: As discussed earlier in this report, IBH shifted from conducting quarterly licensee satisfaction surveys to conducting these surveys bi-annually, although the contract requirements were never formally amended. According to IBH survey participation rates have been declining over the audit period. Exhibit 15 shows the participation rates for the Licensee and Stakeholder survey responses from Fiscal Years 2017-2018 through 2019-2020. The Licensee response rate declined nearly 8 percent, from 24.6 percent in Fiscal Year 2017-2018 to 16.8 percent in Fiscal Year 2019-2020. If the Boards agree with conducting surveys less frequently, the Boards should formally memorialize this expectation through a contract amendment.

EXHIBIT 15. SURVEY RESPONSE RATES BY GROUP FROM 2017-2018 THROUGH 2019-2020

Fiscal Year	Licensees Response Rate	Workplace Monitor Response Rate	Providers Response Rate[1]	Health Associations Response Rate
2017-2018	24.6%	14.3%	26.9%	12.5%
2018-2019	20.1%	12.4%	14.8%	20%
2019-2020	16.8%	18.1%	19.6%	0%

Source: Auditor-generated from Survey Response Reports provided by IBH.

Notes: (1) Includes GGMC, PMC, and third-party evaluators.

- ✓ Annual Financial Report Requirement: As discussed earlier in this report, the contract requires IBH to submit an annual financial report detailing program expenses, revenues, and profit margins; however, this requirement has never been enforced. Although IBH indicated that this requirement was removed during the contract negotiation process, the requirement remains in the executed agreement and the Boards are not actively enforcing this requirement. If the Boards do not expect IBH to submit an annual financial report, the MSA should be formally amended to eliminate this requirement. However, if this information is valuable to the Boards to assess the cost of the Program and expectations related to profit margins the Boards should enforce the contract provision and ensure IBH submits the annual financial report.

- ✓ Annual Utilization Report: Although not required by the MSA, IBH submits an annual utilization report to the Board's detailing HPSP program activities and outputs. The Boards should consider incorporating this report, the required statistics, and a deadline for submission into the MSA to better ensure IBH is providing the Boards with desired information and expectations are consistently met.

- ✓ Outreach and Education Requirements: As discussed earlier in this report, IBH could not demonstrate that it was meeting all of the outreach and education requirements established in the contract and, in many cases, indicated that the Boards informally waived certain requirements and provisions. If the Boards intended to waive these requirements, the MSA should be formally amended to reflect the agreed upon changes; however, if it is the intent that IBH provide these services and adhere to contract provisions, the Boards should work with IBH to ensure required outreach and training provisions are met.

- ✓ Monthly Invoice and Reporting Template: The monthly invoice and reporting template included in the individual WOCs does not include three (3) required enrollment statistics. If the Boards want IBH to include this information in its monthly invoices and reports, it should consider updating the template and ensure IBH provides all required information.

- ✓ Administrative Costs: Although not specifically required in the MSA, IBH indicated that during the contract negotiation process the Boards established a maximum percent of program costs that could be related to administrative overhead costs. As a result, IBH applies and reports a split of the monthly program fee between service delivery costs and administrative costs. If it was the Boards intent to cap the amount fees that could be charged for administrative overhead costs, the Boards should consider working with IBH to incorporate this requirement into the contract and require IBH to report actual service delivery costs and administrative cost instead of an arbitrary percent allocation.

Recommendations

While this audit found IBH to be generally compliant with the MSA and subordinate WOCs, with few exceptions, this report does present several opportunities for improvement. In order to better ensure compliance with all contract requirements and to enhance overall service delivery, we recommend that the Boards:

1) Ensure accuracy in reporting performance statistics by requiring IBH to adopt consistent methodologies when calculating the success rates against performance benchmarks. This includes calculating the success rate of Licensee voice-to-voice contact with Agreement Monitors, ensuring that IBH only include true voice-to-voice communication, not e-mail or voicemail, when reporting performance results against benchmark requirements.

2) Provide all required educational materials and outreach efforts. In doing so, we recommend that this include creating a formal training manual for potential workplace monitors, with MSA sections covering responsibilities as a workplace monitor, signs and symptoms of relapse, and any provisions specific to each licensing board; and publish this training manual on IBH's HPSP website for reference by workplace monitors.

3) Ensure adequate FTE levels for each year's pricing tier; consideration should be given to the inclusion of FTE levels in the required benchmark reporting and penalty structure.

4) Review the MSA and WOCs provisions and requirements noted throughout this report where either current practice does not align with contract provisions or IBH indicated the Board informally waived or amended contract provision to assess whether the current contract accurately reflects the Board expectations and requirements for IBH. If the contract does not reflect current expectations and requirements, the Boards should work with IBH to formally amend the contract. However, if it's the Boards' intent that IBH follow the provisions outlined in the MSA, then the Boards should work with IBH to enforce contract provisions and requirements. Below are several of such MSA and WOC provisions:

    a. Outreach Presentations:

        i. Meeting minimum outreach requirements established in the MSA § 11.1.a.

        ii. Providing lists of outreach presentations with the location, time, and number of participants to the Program Advisory Committee quarterly as required by MSA § 11.1.c.

        iii. Submitting outreach presentation content to the Program Advisory Committee at least one (1) week prior to the presentation for pre-approval are required by MSA § 11.1.d.

        iv. Retaining sign-in sheets for all outreach events as the primary method for substantiating outreach efforts and reach.

    b. Training (MSA § 2.8):

        i. Pre-approval of trainings by the Program Advisory Committee.

        ii. Online training for workplace monitors of the Medical Board, Board of Pharmacy, and the Board of Dentistry, in addition to the Board of Nursing.

    c. Monthly Reports, including the number and percentage of licensees in compliance with their monitoring agreement, the percentage of licensees with substantial noncompliance reports, and the geographic location of referred and enrolled licensees. If the Boards feel it

is inappropriate to report on the geographic location of referred and enrolled licensees, amend the contract accordingly.

d. Deadline for submission of the bi-annual survey findings reports.

e. The frequency and deadlines for conducting surveys and submitting surveys results to the Boards and Program Advisory Committee (MSA §4,8, 7.3, and 7.4).

f. Submission of annual financial reports and use this information to evaluate the cost-effectiveness of the MSA and the existing compensation structure.

g. Submission of the Annual Utilization Report, including the submission deadline and content of the report.

h. Administrative overhead costs, including potential caps, reporting requirements, and the calculation of service delivery and overhead costs.

Appendix A: Integrated Behavioral Health Solutions' Response

Integrated Behavioral Health Solutions' January 12, 2021, response to the audit recommendations is presented on the following page.

Response to Performance Audit of the HPSP
as Completed by Sjoberg Evashenk Consulting, Inc.
Completed December 2020

IBH appreciates the opportunity to have an objective look at our delivery of services for the Health Professionals' Services Program (HPSP.) We are pleased to see in the audit a reflection of the strength and importance of the program we provide to the Oregon Health Boards and the licensees. We do take seriously the few deficiencies found in our performance and will work quickly to rectify these moving forward. We propose the following action plan:

1. **Calculation of success rate of licensee voice-to-voice contact**: IBH Monitoring will revise the search criteria used to calculate the success rate in order to ensure accurate and consistent reporting. This will be put into place for the December 2020 report (submitted in early January 2021.)
2. **Workplace Monitors:** IBH Monitoring will develop a formal document for potential (and current) workplace monitors that provides background information on HPSP, reviews the role of the Workplace Monitor and explores the signs/symptoms of relapse. This document would be provided to the Advisory Committee for feedback. Once finalized, it will be posted to our website, provided to all current Workplace Monitors and be provided as part of the onboarding process moving forward. Special consideration will be taken of the existing OSBN training during the development of this document.
3. **Staffing**: Ideally, IBH will retain all our existing staff members as they are of the highest quality and well-trained. Despite employing strong retention strategies, however change is inevitable. As such, IBH will partner with our HR department to develop options for more quickly filling any Agreement Monitor staffing gaps moving forward. We will look at borrowing appropriately credentialed staff from other departments, using staff from a temp agency to provide relief to our existing monitors and of course using the most effective hiring strategies.
4. **Outreach**: IBH will increase our efforts to provide outreach as required by the contract and will provide a list at each Program Advisory Committee meeting. We request that this be a standing agenda item for each meeting.
5. **Contract clarifications**: IBH looks forward to a conversation with the boards regarding amending the contract to address the discrepancies between the contract and the informal agreements that have governed practice for the last 3.5 years. Agenda items should include:
    a. Outreach Presentations (Audit report page 28, #5a iii. And #5a iv*) Discussion points should include if the Program Advisory Committee wants sign-in sheets for all outreach events and wants to pre-approve each presentation. Further, we should document that there need to be 12 presentations per year, an* ***average****, of 1 per month and the previously agreed upon intended audiences (e.g. associations, societies) and modes of outreach that can be used for outreach (e.g. articles, papers)*
    b. Content of monthly reports (Audit report 28, #5c)
    c. Frequency of satisfaction surveys and timing of reports (Audit report page 29, #5d and 5e)
    d. Annual reporting expectation (Audit report page 29, #5f and 5g)

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