



Themes:

- **Prevention planning and early intervention and Support for + 95% of population without Medicaid including:**
 - Support family caregivers, increased availability of respite care
 - Increase public education and outreach about long term services and supports including the ADRCs
 - Support housing, transportation and employment resource development
 - Expand OPI, educate about LTC insurance and low cost, affordable LTSS for private pay
 - Support wellness, housing, stand-alone services for those just needing a little help

- **Person-centered services**
 - Address issues of social isolation, support holistic assessments and service planning, high priority is choice and flexibility in LTSS options

- **Independence enhancing technology**
 - Increase access (including equity issues), availability, training, resources, information and types of technology available to assist both consumers and workers

- **Service Settings and workforce development**
 - Support in-home and CBC options
 - Develop provider capacity and training (including career tracks) as well as increased monitoring and oversight to improve quality
 - Too much regulation of NFs and not enough of other facility types
 - Increase Medicaid rates to help assure continued capacity and access for Medicaid and low income people
 - Community Based care changes in proposed regulations
 - Support better coordination between providers and medical systems

- **Community engagement**
 - Grow programs that support community engagement such as gatekeepers, senior companions, employment and volunteer programs

- Leverage networking, coordination and partnership opportunities to build communities and community connections

- **Improved outcomes for all Oregonians**
 - Address provider capacity and training to serve people with mental health, dementia, cognition and other complex needs
 - Work of issues of health equity in access to care, culturally responsive providers and settings
 - Make sure there's funding for proposed changes: don't jeopardize the strengths of the current system for possible future benefits
 - Support for guardianship services

- **Miscellaneous**
 - Coordination of medical and social systems, not related to providers
 - Program changes/evolution, funding
 - Timeline for LTC 3.0
 - Comments on slide design
 - Miscellaneous

(W) = Comments made in answer to the question "What is working well?"

(I) = Comments made in answer to the question "What could be improved?"

During the LTC 3.0 presentations to Stakeholder groups in Oregon , a total of 311 comments were captured during the Stakeholder conversations. These comments do not include comments that were captured on the surveys. Each header captures the total number of comments related to that topic compared to the overall comments.

<p>Prevention Planning and Early Intervention and Support for + 95% of population without Medicaid 73/311=24%</p>
<p>Big concern about the LTC insurance industry – the premiums are unsustainable, and many are dropping their policies because it’s unaffordable. Can people who sank years of premiums get their money back?</p>
<p>Possible resource: senior forum is about to publish a detailed history of LTC in Oregon.</p>
<p>There is a common misperception that Medicare would cover one’s LTSS needs.</p>
<p>Transportation should be added – small communities don’t have what the metro areas have</p>
<p>Focus on lifespan and family-centered communities</p>
<p>Oregon should allow families to assist their relative on Medicaid services – supplemental payments that are allowed in other states</p>
<p>There needs to be focal points in the community – recognized places where people can go, and not necessarily just the ADRC.</p>
<p>Public has perception that there are programs for everyone for LTSS, especially when they turn 65.</p>
<p>Families, and younger people in general, need to plan better for their aging and possible LTSS needs.</p>
<p>Gen X and millennial generation with concerns of Social Security and Medicare’s future. Need for marketing and the uniforms are an excellent idea for getting out into the public.</p>
<p>Early intervention programs may include smoking cessation, alcohol abuse prevention, diabetes, money management, respite, transportation, home modifications, elder mediation (between seniors and/or their families), ADRC coordination with the health systems of their communities.</p>
<p>Nutrition supports – community garden example in congregate community setting</p>
<p>Education about aging needed for the general population</p>
<p>Streamline processes to get assistance – reduce those barriers</p>
<p>Wheelchair techs must be able to travel to consumer</p>
<p>Start with basics for outreach – what is long term care?</p>
<p>Support ADRCs and having zero misinformation</p>
<p>Emphasis on the private pay population and supports for family caregivers</p>
<p>Use private pay funds to help support additional services</p>
<p>More opportunity for family caregiver support and education</p>
<p>Big transportation needs – access issues</p>
<p>Education – Behavioral and product related</p>
<p>Employment support – partner with CILs</p>
<p>Need awareness of assistance options, get over myths such as having to lose one’s house to access LTC services and supports</p>

Prevention Planning and Early Intervention and Support for + 95% of population without Medicaid 73/311=24%
Definitely expand OPI to serve younger individuals with disabilities
Nutrition, housekeeping are two big supports that can help at risk non Medicaid population
Frame as expanding and enhancing family and community supports, including planning and early intervention (not sure what preventative means in this context)
Employment supports from non-profits (Goodwill and others) can be leveraged
Outreach to pre-dual eligible (age 50-64)
Support for caregivers
Promote private and public savings and planning with ADRCs, or DCBS or state treasurer, bankers, credit unions, etc.
Use supportive rather than preventative in these sets of programs
Buy – in – what would the cost of an OHP medical card?
Re-instate spend-down and get rid of the income cap trust
Independence strategy to ween from services (volunteers, etc)
Private or commercial funding for OPI
What are the conditions that bring people into the LTSS system?
Nutrition, food counseling - staff support and education for members (providers). – health and nutrition prevention programs that can lead to healthier living and healthier aging
LTSS packet to agencies just like there is a domestic violence information packet
Improved outreach – seek ideas from the community
Have sliding scale fees or cost sharing so non-Medicaid eligible individuals can access and pay for Medicaid covered services
Transportation needs should be considered
Employment supports – look at partnership with HUD so people can retain eligibility for public housing
Also, SSI retention
Family caregiver education, support and therapy
Look at breaking regulatory barriers to getting assistance
Individual planning – education, receptivity for assistance and getting over people’s denial that they may eventually need LTSS
Better funding to counties for family caregiver programs
OPI – big prevention and early intervention program that needs more stable funding, access to those under 60
When discussing employment supports, be sure to include older adults – they are suffering in the recession, and employment is a need for many
ore to Door program in other states is effective – helping with transportation for people with

<p>Prevention Planning and Early Intervention and Support for + 95% of population without Medicaid 73/311=24%</p>
go-outside disabilities
Family planning and education on aging and disabilities
LTC insurance – need to explain this. Connection to the health insurance exchange
Leverage sine CCO preventative programs to non-Medicaid population
Something akin to brokerage or family services for APD – respite, etc.
ADRCs and connectivity to resources – explain differences between I and R and OC
HUD grants and possibilities of develop housing with CCOs?
Planning services for individuals and family members
ADRC-CCO relationships should be explored
Education for families on important things – guardianship, wills, etc
LTC insurance – can there be options to buy cheaper, shorter term policies for lower incomes?
Have LTC insurance cover HCBS as well as it covers NFs (had to move someone from an AFH to a NF).
The right to be in the setting that best meets my needs, that is my choice
Having education, or third-party options counseling for those at risk of NF placement or long stay.
Access and outreach is needed for people to know where to go
How do the other 95 % “buy” services? Consider the menu of options
More assistance, or funding mechanisms, are needed for home modifications for those living at home – beyond those of the special needs funds.
In in-home and CBCs, there should be better enforcement mechanisms under ADA to get the modifications and accommodations people need.
One example – a simple daily call, just to make sure person is doing ok that morning.
Explore alternatives to the spousal support program (should spouses be paid)? Concerns also for families where the spouse must work, and natural supports are not as available.
Modifications possible as an in-home service?
Change relative caregivers to family caregivers
Lack of information for people in health care settings – pharmacies as an example, and a place where a lot of information can be shared as a potential to giving consumers more direction in their health care.

<p>Person-centered services 48/311=15%</p>
<p>Visiting hours reg – is this reasonable? Cities have noise ordinances, so isn't the rights of other residents to have quiet hours also respected under visitors at any time?</p>
<p>Need to frame better for LTC 3.0 – is it a call to really move more toward a home-based model, and away from congregate community setting?</p>
<p>Have to be flexible depending on the resident's needs</p>
<p>Safety vs. freedom and choice- where to balance?</p>
<p>How to maintain and balance security and privacy?</p>
<p>Incentives to shift to more person centered care</p>
<p>Is this really a push for in-home care?</p>
<p>On slide 10, be sure to include choice because it's in ORS 410. On slide 30, quality of life is not included in 410, so just put choice back in.</p>
<p>Add in chapter 410 – creation of a home and community based care model for LTSS in Oregon</p>
<p>Include consumer advocates – people actually receiving services</p>
<p>No civil rights policy exists for APD services like other DHS programs – need a policy statement, service rules that directly relate to civil rights</p>
<p>Flexibility in Medicaid program (light supports, buy in)</p>
<p>Understand barriers to assistance –need research on factors such as resistance to receiving assistance for older adult population</p>
<p>Issues with Senior centers for those who are aging in the Baby Boomer generation</p>
<p>Re-brand 'welfare' to avoid stigma among older populations</p>
<p>Need to educate people that they are responsible for their own choices</p>
<p>Need to plan around community engagement and people not wanting a "program," rather they just want their needs met</p>
<p>Transitions are key – all the way down to the details of whether someone can handle living alone (meds, meeting their needs with food, housekeeping) when they go home or to a community setting.</p>
<p>Observation – most individuals choose to be in HCBS; most families are the ones who choose NFs, out of ignorance or fear of HCBS</p>
<p>Point is that transformation encourages community integrations of individuals rather than the previous least restrictive alternative setting approach</p>
<p>Chronic care needs may require some level of institutional care – how to assure values are respected</p>
<p>Acute care gives up some of those core values of choice and autonomy</p>
<p>If an individual isn't able to access HCBS, where will they go?</p>
<p>Assurances of safety – what is the limit in an HCBS setting?</p>
<p>Perhaps frame this as right to services in the most appropriate setting?</p>

<p>Person-centered services 48/311=15%</p>
What about those in NF with no other choice?
Poor is also the mission that should be serving vs. focus on skilled beds
Assessment needs to include risk factors
Person centered services – future leaders of America, partner with high schools, integrating services for getting people out into the communities.
Use self-directed, rather than person – centered
Activities should be phrased as “meaningful pursuits.”
Too many choices or too much info may be overwhelming; keep it simply
On person centered services, coordination between the medical and the social models
Add the HC Navigator role to the coordination of services
Use of drugs not prescribed ought to be a consideration for eligibility
Provider perspective – person centered already practiced by rule in facilities
Issues with the case manager assessments – person is reassessed, not eligible, then can’t stay in their NF or CBC; need top to bottom examination of case management system – training, professionalism
“LTC Care Mart” – swipe card, access your choices – be able to get thing a la carte, not just the whole package
Assessment drives what the choices are
People need to know how to challenge their assessments if they find them inadequate – due process
Proposal to have some sort of consumer training for those in CBCs (much like the STEPS program for in-home).
Choice of providers – this could really help individuals who need services outside the facilities – in higher ed, employment, or recreational or other community inclusion settings for example.
Using the term of self-direction is key here for the new CFRs.
For many, the ideal is living in one’s own home, and providing resources for this.
With the new CFRs, perhaps the boundary blurs if not collapses between CBC and in home?
Revisit the 5/2 rule.
Reluctance to accept or receive help in one’s own home – not wanting even to share information for an assessment to be done.
Focus on person-centered services offered via medical providers – medication that works for the individual, for example

Independence enhancing technology 6/311= <1%
Education on computer literacy programs for employment supports (possibly online)
Need more access to information for those who don't have computers – community centers can play a role
Focus on web-based approaches (and technology)
What about examples of costs higher in HCBS than if the person was in a NF?
Discussion on the ways technology may help in some of the new CFRs.
Positives and negatives of technology for remote monitoring of health conditions, such as blood pressure, etc.

Service settings and workforce development 67/311=22%
Growth and risk of certain guaranteed increases in rates and reimbursement
Support was given for proposed CFRs on CBCs.
There were concerns expressed for safety, coordination, the transition from current to future state of CBCs (transition time to comply with CFRs), and perspectives from the consumers.
The proposed CFRs: Are these part of the ACA? What is the status of the CFRs?
New CBC rules should apply to NFs
Resistance to rules fiscally oriented
New CBC rules should apply to NFs
Resistance to rules fiscally oriented
What is missing in CFR slide is what's considered an institutional settings – skilled setting attached to CBC, or CBC's proximity to a hospital
Rates of private room (private pay vs. Medicaid) force one to go to a NF, higher cost setting, when you force single rooms in a CBC
Used to have landlord-tenant in ALFs, but didn't work out – this would be a step backward
If you grandfather existing CBCs, and subject new ones to the regs, then there would be a two-tiered system and new CBCs wouldn't be competitive
Locked doors and food at any time if resident has dementia?
If providing care, need access if doors are locked
Cost or need of proposed regs, keeping the kitchen open 24/7?
Possible high costs with AFH – one person on duty – there would need to be increased staffing
Many items in CFRs already in place in some facilities
Concern about provider regulation even if qualified may not be choice due to an individual's psyche

Service settings and workforce development
67/311=22%
Concern about shared risk if the provider only provides housing and/or limited services
These CFRs are counter-intuitive – safety, business model of CBCs with service provision
Survey should be conducted for provider readiness if these CFRs go into effect
CFRs – devastating effects on some CBC providers. Frame right to lockable doors, etc, unless there is a demonstrable risk
Is this something that can promote a housing with services model? Is CBC now merely a boarding house?
Sensitivity training for providers
Model Medford Caregiver 101, powerful tools for caregivers and Star – C
Hard for Medicaid to get into ALF – need resources
Build up workforce to provide more preventative services (skills, education)
Educate health care providers about where to refer people
Element of changing communities building networks
Expand CCR Model beyond boundaries of Facility without Walls
PACE model that does not require NF eligibility
Health professionals are not aware of the options in LTSS
General support for the new roles of nursing facilities.
Some concern that some NFs do not have a rehabilitation focus, and they'll not be able to adjust their business model.
Establish training centers for CNAs.
General support for the new roles of nursing facilities and flipping the entitlement.
Each facility have a third party monitor who doesn't work for the facility
More monitoring and surveys on experience of care
NF – Poor staffing rations
For NFs, stability and alternatives to hospitalization
Other possible NF business – Home Health, Respite
NF vs. CBC costs – give the numbers to show savings
Revise and simplify the regulations across settings
Big trend in NFs is already short stay – the focus in innovations lie in the rates for CBCs
NF entitlement is an important bargaining chip for better CBC rates – since it's mandatory, incentive is to build and sustain a viable CBC capacity and rates to prevent NF utilization.
Need to look at length of stay data for NF residents
How to attract good providers to LTC in subacute settings
Staff ratios need to increase in NFs
NF regs drive up costs, make them less desirable, so need to reduce regulatory excesses and barriers

<p>Service settings and workforce development 67/311=22%</p>
NF transformation slide – it’s already happening, not news
Current NF residents may be too frail for CBCs, and have already tried it
Entitlement switch is a good idea
Resistance to change of entitlement may be reflective of medical model perspective
Careful on the language here – access should be stressed, not entitlement, to NF; don’t gloss over the details
Greater protections for residents in NF under federal law; none there for CBCs
Would this set up a two – tiered system? Title XIX eligible with fewer choices than private pay?
NF transformation – see VA model integrated into Oregon’s waiver system
Waivers for hospitals and certain NFs
ALFs and RCF surveys and regulations need to follow person centered changes, state regs are pushing them to be more like NFs than CBCs
Concerns echoed on the proposed CFRs.
Supports for CBC means provider training
Coordinate access and money and support from health advocates and CCOs – workforce development efforts
CBC provider concern – would entitlement change force CBCs to take on residents for which they don’t have enough capacity
Regulations in CBC often limit the choices of residents
New CFRs present a whole set of issues in trying to balance resident rights and risks (liability)
Regulations often pass on costs – example of wireless vs. hard wired call system
Training really needed for new providers to individuals with intense care needs

<p>Community Engagement 27/311=9%</p>
Add – as world changes, demands grow for better coordinated, proactive planning between the public and private sectors
Community engagement is key – the difference between existing and actually living.
Oregon needs to preserve the public/private partnership in LTSS
In addition, better coordination and collaboration is needed; too often resources are duplicated, when more collaboration can make it more efficient.
Better coordination with other community organizations, such as partnering with programs that already exist with faith-based organizations.
Promising models – peer supports (especially senior volunteers out in the community as resources – going to where the people are, rather them coming to us), coordination with local

Community Engagement 27/311=9%
resources.
Outreach to the health care sector – education to doctors, especially around gerontology
Need hospital social service workers and educate them on the Non-medicaid population
Need multiple agency collaboration for whole person conversation (Dept. of Ed, etc)
There is a need to better educate hospital social workers for people who are transitioning to community.
Add community planning and community design for livable communities
More collaboration with the VA is needed
Partner ADRCs with other national organizations
CNCS – Senior Corps – collaboration/partnership at the federal, state, local levels
Link volunteerism to healthier, happier, more involved individuals
Easter Seal – and other low cost program utilizations
Wash. Co. Benefit enrollment center (volunteer based)
Use interns as volunteers (PSU, etc)
Learn from Wash. CO. Project Reach (volunteer-based outreach)
Need incentives and private funding partnerships
More LTSS materials needed in doctor offices
Community engagement – use partnerships with community organizations, getting the word out
For non-medicaid, services for employment and community engagement supports is key
Think of coordination between ADRCs, SHIBA, private or non-profit care managers coordinate work
Talk to private sector groups and other groups with differing ideas – how will they step up?
Regarding affordable housing, there may be a need to have access of housing provider to shared medical record with CCO and other providers
Villages concept – getting at community design

Improved outcomes for all Oregonians 38/311=12%
We should look to other nations for models (social safety net), such as Scandinavian nations.
In general, we should not lose focus of what we do well in Oregon in our current LTSS system.
Are the needs of Northern and Southern Oregon different? Planning taking differences in area, region into account?
Add – especially growth of the 85 + cohort
What are the drivers for the increase in disability population?

<p>Improved outcomes for all Oregonians 38/311=12%</p>
<p>There may also be a big population with disabilities missed – invisible disabilities. Vets with TBI or other invisible disabilities fall through the cracks of the social safety net.</p>
<p>Add slide showing the very slow rate of growth of LTSS rates – slower than acute and primary health care</p>
<p>Show growth of the 75 and 85+ cohorts</p>
<p>Who is defined in the chart of younger individuals with disabilities? Frame the chart to be more positive on people being active and living longer with disabilities</p>
<p>Chart on service population – pay me now or pay me later proposition. Also calls for need to create equity, uniformity, and assessment processes.</p>
<p>Have an 85+ graph</p>
<p>With these charts, illustrative of need to have benefits for what people have, not what they don't have (ie, employment for individuals with disabilities)</p>
<p>It may be helpful to show the growth of SSB vs. SSDI in Oregon, too – showing the aging and disabilities populations</p>
<p>What were the tracking measures of individuals affected by the cuts of 2002-2003?</p>
<p>Concerns of CFRs: safety issues; incompatible with AFH settings (homelike settings); concerns for those with severe behavior health needs; they seem to go too far on the safety/independence continuum, on the side of independence.</p>
<p>CBC rules are a stumbling block to all of our specialized living facilities (lockable doors, etc)</p>
<p>Access issues – focus on equity related to communities of color</p>
<p>Oregon has an income disparity with other states – that can be done better so Oregon can have a stronger system, and stronger outcomes</p>
<p>Add to the list of what we can do better: mental health and addictions services to seniors and people with disabilities – balance and partnerships between physical and mental health</p>
<p>APD – create or partner to build this partnership with community MH</p>
<p>Use thinking of current workgroups on MH and addictions services and incorporate into future planning (Monnes Anderson workgroup)</p>
<p>Better information sharing is needed across the systems.</p>
<p>Rural needs are big – oftentimes it's the gatekeepers who are critical in connecting people to getting assistance – postal workers, firefighters.</p>
<p>Target specific populations for outreach and education</p>
<p>Coordinate with CCOs and OHA on outcomes</p>
<p>Access for individuals who are undocumented</p>
<p>Identify what works for prevention and EI in urban vs. rural communities</p>
<p>Programs needed for individuals with mental illness who are homeless; also, work needed on accessible affordable housing</p>
<p>80+ stigma of being on 'welfare'</p>

<p>Improved outcomes for all Oregonians 38/311=12%</p>
<p>In light of the new role of NFs, there is a need to build capacity for families and community based facilities, especially in rural areas, and to do so for individuals with intense needs.</p>
<p>Realization that there is a subset that may still be appropriately served in a NF, and what about rural communities when it's the only provider that's viable, under a rural community's current capacity?</p>
<p>NFs not good for people with disabilities (attitudes need change, execs need to care about residents, state should require reporting of falls and other incidents)</p>
<p>Possible NF focus for LTC is advanced cognitive and behavioral issues</p>
<p>Move to ICF is those who need protection if they wander – where else can they go? For some, ICF is best choice, should remain an option and ICF can meet some community need that is important for people</p>
<p>Don't want what happened in deinstitutionalization of MH institutions – not spending to expand community care to meet those needs</p>
<p>NF is the default for those with behavioral needs – this must change</p>
<p>Dichotomy is false – with a growing population still need NF beds for intensive needs such as advanced dementia</p>
<p>What about those who need round the clock custodial care? Does HCBS have capacity?</p>
<p>Is there rural capacity? State needs better support for CBCs</p>
<p>Not serving the homeless well</p>
<p>Assessments should also consider culturally responsive aspects – perhaps the role of culturally responsive navigators</p>
<p>Local area witnesses a lot of service denials – why is that the case?</p>
<p>Service assessment and planning does not address people with cognitive impairments well enough, as well as people with hearing impairments</p>
<p>Assessment tool needs to be improved for race, ethnicity and language diversity</p>
<p>In large county with rural areas, access is more challenging, feels uneven</p>
<p>Look at income eligibility – other disregards to consider – legitimate expenses, etc</p>
<p>Tough cases when someone is declared ineligible, they move out of CBC, decline, and are eligible again</p>
<p>Transitioning from DD to APD, people fall through the cracks</p>
<p>Cultural competency is critical with providers in CBCs (and home care) Have cultural competency inclusive of disability, lifestyle, and interaction of the two</p>
<p>Impoverishment a big issue for someone staying in home, with pay in</p>
<p>Watch for another public guardian bill this session.</p>
<p>Needs to be a process for vetting guardians – current state is not adequate.</p>
<p>Discussion of MFP savings being reinvested into behavioral supports.</p>

Improved outcomes for all Oregonians 38/311=12%
Expand behavior coaching and supports statewide
Guardianship – diversion programs, enact Durable Health and Financial Power of Attorney model legislation – alternatives like AARP Money Management Programs, CASA model for adults
Guardianship – beware of requests to set this up when not justified or when family wants to sell the house or keep family member in a facility
Ombudsman program to support those with guardianship needs
Guardianship/provider conflicts
Discussion on the AMH side – under 65 rule for LTSS access
There should be a consideration of Elderplace (PACE) as a model to expand across the state.
Some initial concerns of whether they are focusing on high risk individuals, or if there will be a concerted effort (at least in the future) on prevention and transformational coordination for a broader population.
Medical model vs. social model: perceptions that the medical model is still privileged over the social model.
Still, there is a need for case managers in the social model to do a better job in having facility with the medical model.
Promising changes in some curriculum of medical providers to look more at the social determinants of health (nutrition, transportation, environment, and community involvement).
Importance of physicians being clued in – doctor needs to understand our system and need for better coordination, education
Collaborate with other Medical associations

Miscellaneous 52/311=17%
Has there been a decision yet to move from using ‘LTC’ to ‘LTSS’? The concern, when talking with the legislature, is that they can be confused if two terms are used interchangeably.
LTC 3.0 – what is its relation to the state’s pursuit of the State Plan Option K?
How does this material relate to previous, and very involved, planning efforts in the future of LTC in Oregon? Is all that previous planning going to waste?
State budget issues – how will LTC 3.0 play in the zero-sum game of Oregon’s budgetary politics (schools vs. social services)?
Is this a legislative mandate? Whose idea is this LTC 3.0 initiative?
Goal is admirable – how do we get policy makers on board?
Why change now? Why is 2.0 broken?
Share scorecard link – Oregon is still number 1!
What are the reasons for going to the legislature?
Note to update the demographic slides – try as best as possible to focus specifically on APD and

<p>Miscellaneous 52/311=17%</p>
<p>AAA clients, and to make it clear who is represented on the slide.</p>
<p>Slides such as the disability one (with SNAP “onlys” included) can raise the issues of government growth; SNAP in particular (as well as other programs) can be a distraction from the discussion.</p>
<p>In slide 8, when caseloads rose from 2008 on, did cost of care per individual increase as well (perhaps demonstrating that people re-entered services but with a higher service need than when they lost eligibility in prior cuts)?</p>
<p>State the context of major recession on the all-inclusive growth chart of individuals served by DHS under APD</p>
<p>Show rate of increase of other state services compared to the portion of state budget to LTSS expenses</p>
<p>On SNAP – clarify that it’s seniors and people with disabilities</p>
<p>You should have a side-by-side chart to show the difference between medical inflation and LTSS inflation</p>
<p>Cost of implementing regs, but also the consequences of losing federal match if the CBC does not meet the regulatory guidelines.</p>
<p>These are guidelines that are mutable</p>
<p>How do we get adequate funding for all of this? State funding, as well as prevention services under Older Americans Act</p>
<p>Slanting system fosters dialogue and conversation which is good</p>
<p>Consider changing story from a Veteran to an individual injured in a car accident, and with a traumatic brain injury.</p>
<p>Should health care, as part of its services, provide transition assistance and support when one leaves the hospital?</p>
<p>Tort reform is necessary – risk is a mutual responsibility and risk management must be a community conversation</p>
<p>There should be a state survey to find out need and awareness of LTSS</p>
<p>Improve the APD model to be more robust, like the DD model</p>
<p>Entitlement has negative connotations – use the word standard instead</p>
<p>LTC 1.0 – paradigm used by most states – NF bias. LTC 2.0 – Paradigm Oregon enacted where choice was created, bias is HCBS. LTC 3.0 – Paradigm for Oregon – HCBS is the default (beyond bias), with further investment in non-Medicaid home and community based support</p>
<p>How is this different from the status quo? HCBS is essentially already the entitlement in Oregon</p>
<p>Consider the relations between Medicaid and the private pay market. Does Medicaid drive private pay market changes, or does the private pay market place limits or structural barriers to Medicaid access and changes to Medicaid LTSS policy?</p>

<p>Miscellaneous 52/311=17%</p>
<p>One should have rights to both types of care, but NF after all CBC options are excluded as unable to meet the individual's needs</p>
<p>System approach and perception needs to change</p>
<p>Concern about costs if assessments change, more access</p>
<p>Conflict of interest – free discharge planning key here</p>
<p>There should be more mind paid to income standards and disregards</p>
<p>Assessment often does not account for costs of service delivery</p>
<p>There is such a gap between DD and APD assessments – can be instructive to look at these differences</p>
<p>CBC and person centered services – how to finance this?</p>
<p>Have a Medicare Part E – like the CLASS Act - \$5 a month for LTSS</p>
<p>Maybe a federal waiver to break the under 65 barrier on LTSS access?</p>
<p>When CCOs go away, is it just fee for service? And how do they find a doctor who will take them?</p>
<p>Where is care management and coordination including licensure or certification of private care coordinators?</p>
<p>MOUs should be put on the website</p>
<p>Instead of continuum of care – change to array – dump the continuum visual</p>
<p>Timeline – need more time in 2014 to fully debate and assess alternatives for proceeding. Plus, there must be time to engage the public. Have those public hearings in 2014, then get legislative approval in 2015 session.</p>
<p>Present outside big cities – Besides Eugene, someplace like Junction City</p>
<p>What is the problem for which these ideas are a solution? Need to prioritize a more limited list of problems and ideas to solve them</p>
<p>Data-driven problem solving needed on this project; example of getting data of spend-down vs. direct entry of people into Medicaid LTSS can go far in framing assumptions, and problem solving</p>
<p>Consolidate the APD and DD provider payment systems</p>
<p>Reach out and include Gerontologists – OHSU, OSU, PSU, PCC and Marylhurst</p>
<p>Don't use the continuum chart as a visual – use pie chart for funding visuals instead</p>
<p>Hold strategically placed sessions – all advocate communities together</p>
<p>Incorporate cost-benefit approaches to these concepts: trade-offs, efficiencies, budget neutrality – and public-private partnerships</p>