

OPI Online Survey
(as of 11-04-09)

Fall 2009

(1) Should all local areas be required to offer the same range of services?

Yes: 150

No: 97

Depends: 1

Other: 19

- All should have to choose from the same range of service but flexibility is needed since some geographic areas have different needs than others.
- basic services with option of extra that meets the needs of the area served by the district center
- Depends on the area and what other available resources are in that region and city specific
- don't know what the range of services are
- Eligibility should be standard - benefits standard with exceptions. Each area of Oregon is unique and offices should be able to make exceptions depending on local needs.
- if available – choice
- Major metro areas = yes. The rest = no.
- No. Not all areas have the providers available to provide services or there are other community resources that provide them so do not need to duplicate.
- not all have same services
- Offer exceptions
- offer more services in areas with limited resources
- Perhaps local areas could choose to emphasize certain services within a standardized range
- possibly - in rural areas sometimes more things are needed, than in the cities
- Services of equal value
- Staff issues may not allow
- Strong communities in rural areas but what about isolated Seniors? just not feasible in a rural community transportation over 50 miles for daily tasks.
- There may be different circumstances in different parts of the state that would be necessary to include in one assessment but not in another
- There should be a minimum standard - more services offered where feasible
- Yes provided all agencies receive sufficient funding to provide the same service Statewide

(2) Should a mandatory minimum set of core services be available in every area?

Yes: 241

No: 27

Other: 2

- Yes, but if there are other resources in the area make use of those & put OPI dollars on the services without alternative resources
- Same answer as above.

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(2a) If a mandatory set of core services were required, which from the following list should be included?

Case Management	218	Personal Care	216
Home Care	219	Home Delivered Meals	179
Asst. Transport	148	Respite	106
Chore	107	\$\$ Management	107
Long Term Care Planning	95	Home Health	70
Adult Day Services	65	RN Services	75

(2a) Service Priority Level: Should the state adopt a uniform level of functional ability (Service Priority Level) in order to qualify for OPI services?

Yes: 199

No: 46

Other: 21

- yes with waiver authority at local level
- Yes with case manager discretion
- Yes there should be uniformity but not necessarily with the current SPL levels. The OPI levels might be tied to statistically valid predictors of long term care use, such as higher prioritization for those at risk of falls, need for multiple assists (not all full assists) in cognition, etc.
- Yes there should be a service priority level and I think it needs to reflect that at time if a care plan can not be developed that will keep the individual at home in a safe environment then they can be turned down for services.
- Yes so long as there is enough funding for the covered levels
- Yes but services should not be duplicated. If someone qualifies for services thru AAA/SPD that should be required as the prior resource. If they don't meet eligibility for AAA/SPD they can get assistance thru OPI
- Yes and no. To made it clear not waste resources CAPS doesn't capture vision problems, emotional problems
- What is the dementia criteria?
- Uniform guide lines but application of the SPL should be exercised locally, because knowing the details of persons modify the care provided
- Should be based on functional assessment that is broader and more inclusive than Medicaid.
- set by AAA
- serve people over level 18
- Needs to serve thru 18 like the rule states
- Need bathing assist
- must have a need for the task

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- may depend on what other services are available in each area
- It is my belief that OPI should not mirror the Medicaid Waiver program. It should have a different set of standards and allow people to be served on a different scale. We have several people who are on 24 hours oxygen and tire very easily. But because they have their wits about them and have not fallen in the last month, we cannot serve them. Often these are the folks who got to the hospital. If they had some help, a costly and often times traumatizing experience could be avoided. OPI could be used more creatively than the narrow boundaries set with the CAPS program. Again, this should be a separate program from the waiver and not just an adjunct to it.
- I think OPI should serve a minimum SPL, but those who can serve more, should be allowed to.
- I think it should be flexible
- do not use caps
- by populations of county/cities (disabled people only in population count)

(2b) Service Hours: Should the state provide an additional level of standardization related to the number of service hours authorized?

Yes: 157

No: 90

Other: 13

- Yes but with case manager discretion
- There should be no maximum hour amount
- There should be a minimum of one hour a week
- there should always be flexibility
- should be needs dependent up to a maximum
- set by AAA
- no thoughts on this
- No except that when people move county to county this can create problems if the receiving county does less hrs.
- I would like this to be done but with the input from the AAA's.
- Give the case manager the ability to be flexible and more person to person specific
- Depend on area funds
- CAPS put us in a rigid, clients talk to each other, give CM wasn't allow for discretion or intuition for CMS people not individuals don't like CAPS too rigid?
- a range including minimum and maximum

(2c) Wait List Policy: Should the state adopt a standard wait list policy that all AAAs use when OPI funds are limited?

Yes: 174

No: 67

Other: 23

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- Yes. It shouldn't be based on favoritism
- Yes, with room for emergency cases
- Yes with case manager discretion
- The State should collect the numbers of individuals on a wait list and the services that they need and are doing with out as a method of collecting data to support additional funding.
- Std only if allowances made for those needing more intensive care than others.
- Sounds good but the state's standard policies typically get it wrong.
- Should be standard policy based on level of need, not length of time on a list.
- set by AAA
- only to allocate funds to where \$ needed more
- Only if each local area has their own wait list. Otherwise, no.
- No - if someone is eligible they should receive service, not have to be on a wait list. That is part of the reason services should not be duplicated.
- Local
- in order of need
- Ideally there should be no wait list but it should be the same throughout the state
- Do a more need based, the higher the need the higher priority and maybe the higher to the top of the list they go.
- Depends on how well it is monitored and released
- decide with stakeholders
- Clients need to be assessed as to needs and safety.
- By most need and lower ADL level, then wait list policy take affect for those w/ less needs
- based on individual need
- again, depends on the area and other services available
- Again policy guidance for overall standardization with latitude for individual situations.
- AAAs are able to do this

(2d) Expenditure Limits: Should the state adopt a policy related to the amount an AAA may spend on other service categories such as Case Management?

Yes: 123

No: 123

Other: 15

- Yes, and 10% admin costs should be an adequate maximum
- So much more of what case management does is beyond the scope of OPI that to have ability to allocated money more freely between funding lines makes sense
- set by AAA
- recommendation of minimum and maximum but ability to serve own area's needs
- only limit admin costs
- No strong feeling

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- Much of case management is staff cost and this varies from metro areas to rural areas and are controlled by many factors i.e., a non-profit, COG or local government pay and benefit scales. I think there needs to be flexibility for the AAA's to set their CM costs.
- it is good to keep administrative costs below 20% but if you add monitoring for co-pays, then you'll have to fund more than 10% some of the time.
- In strong feeling
- I have no idea what would be reasonable
- CASE SPECIFIC
- Case Management only
- Case Management is the most important service provided due to referrals and on going information we provide the public.
- again, flexibility due to other resources offered in the area
- Administrative costs are not just case management, but also supervisors

(2e) Other ideas or concerns?

- With the problems inherent in funding programs OPI needs to be available to help folks who do not recognize they need help but are exhibiting risky living situation behaviors.
- While I like the idea of people throughout the state being given the same opportunities and eligibility info, I realize that there is a difference in the community services available from area to area. So I would not want to take services down to the lowest common denominator.
- We need to look at community standards and not just a standard number of hours to provide the service. For example, what is an acceptable minimum number of baths that a frail client needs per week? In our local community OPI case managers have continued to whittle away the number of hours of personal care that a client can get in order to conserve dwindling resources, so much that most eligible OPI clients are only getting one bath a week. Is this acceptable? Even when the client has no natural supports to fill in the rest of the week? This becomes a safety issue for some clients and so we must ask ourselves should we serve fewer people with more hours?
- Wait lists are for the birds. Let's just fully fund OPI, Section VIII housing, FS program, expand EA to cover elec/heat/water subsidized by income, day care subsidies, Medicare Part E, get wait periods for SSI/SSD down to 3 months or less and end TANF and UC to pay for it. With subsidized rent, day care, utilities, health care and food, the needed umbrella is there without any need for self-sufficiency cash programs--- basic needs are met and the incentive to have cash in hand in enough to motivate people towards employment/ self-sufficiency.
- There needs to be greater verification of resources. It is too easy to hide available funds by only reporting income. I have a relative in southern part of the state with

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huge resources but gets 40 hours per month with no pay-in. They see it as an entitlement program rather than need based.

- There needs to be flexibility regarding case management because clients needs are often very challenging.
- The current level 18 is too generous. The level should be 15 or below in order to encompass individuals with a real need. Most of all, staff need to be given the ability to turn away people who are able to pay privately. Income and resource limits must be set. We currently have clients on OPI with \$50,000.00 or more in the bank. They tell us they are saving it for their children - and the OPI program promotes this.
- The CAPS program is not the proper assessment tool for this fine program. Why has Oregon limited its ability to assist elders by tying OPI to the restrictive (and right so) Medicaid waiver program? Doing an assessment is an art form that CAPS reduces to sludge. In its attempt to categorize people into those who fall and those who are demented leave out a great many people who could flourish with six hours of help a month. But it seems we must wait for them to fall or become demented. If we do have to label people a number, then let OPI use a different assessment tool and numbering tool. Is OPI really a pre-Medicaid program? It could be so much more than what it is now. Turn the program loose and away from the context of the waiver program and get it back to its roots. So many more could benefit if we released form the CAPS trap and the federal goals of keeping people out of a nursing home. The aim is to keep people in their home. Quit with the federal standards and return OPI to a truly unique Oregon program.
- Sometimes the agency seems to be locked into the idea that Hours solves everything, but having Case Managers that are well trained in community resources and the ability to connect the customer or client to these services is far more important and beneficial to the communities we serve.
- Service policy: go by number of qualified people in cities/counties. Also go by the cost of living. (Some cities/counties have higher costs: ie: taxes, food, etc.
- Seems like services to the client should be at least 50% of the budget. Does the 10% include the case management costs? If so that seems pretty low actually.
- Our counties are so varied in their size, population, ability to serve their communities, that we should allow each County to establish its own priority of needs and levels of care and assistance that can be provided. What works in one county may not be appropriate in another.
- Oregonians should be able to get the same service in the large metro area as in rural E Oregon. No discrimination.
- OPI is meant to be an option other than Medicaid & Medicare for seniors AND people with disabilities...so stop trying to make OPI similar to Medicaid & Medicare, actually include people with disabilities on this OPI plan, & REMEMBER to cover durable medical equipment
- OPI is an important partner to SPD and has been used a lot more by us since our priority levels have been cut. It would be nice to see them as a closer partner so that they could be eyes for SPD and know when to call us in for in home care. When

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we had higher priority levels we had home care workers doing little more than housekeeping that would inform us when the client declined and needed more. This was a big help in keeping people out of the nursing home. It would be good to use OPI for this.

- OPI case management needs vary greatly. APS/MDT cases are frequently in need CM support from OPI and these cases can be very time consuming.
- One of the great things about OPI providers is that they are really a part of the community where they are located and serve. This does make for differences in the programs offered, but I believe that is a good thing as long as the basics are provided as well. Each geographic area serves a diverse population and it is important that the district center offerings meet those needs either by directly providing the service or working in coordination with agencies that do provide those services. Funding for non-profit agencies varies from area to area and agency to agency. I believe it is better to have each center provide the same basics and do them well on limited funds than to try to be all to everyone which will make it difficult to do any programs well and staff will have a high turn over because of it. Why waste money to duplicate programs already in the community? It will be more effective to support a local adult day care rather than create a smaller version that drains money from other programs to stay afloat.
- More needs to be done to incentive purchase of a LTC 'comprehensive' policy and more should be done to encourage aging in place. By offering respite programs and other services and offering incentives such as tax credits, less burden will be placed on taxpayer. Memory Care facilities need a reason to offer day care and respite vs. their current attitude which is it is not worth the effort. Consider a modification of regulations to encourage more respite, short-term opportunities for caregivers to get a break.
- Managing administrative costs ensures that the maximum amount of funding will remain in actual assistance to clients and their needs.
- Majority of time consists of finding natural resources and community resources to piece together a stable working environment for folks to stay in their own home. Since nothing is static it is an ongoing need and consumption of time for case managers.
- Lower age requirements for OPI, Medicaid program is being flooded with "younger" disabled folks who are aging into our system and are barely meet spl or miss it completely. These people will suffer negative outcomes from the lack of assistance and will be back through this system in worse shape later.
- Local flexibility is key. Services offered are often dependent on what other services are available in a given community. Resources available in large urban areas are much different from those available in rural parts of the state.
- In my opinion, standardization is very difficult because the needs vary between rural and metropolitan areas in the state.
- If OPI funding covered a wider area of what could be paid for, I think that would be beneficial to those folks that may only need a little bit of help. If someone only

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needed help with home delivered meals, then OPI should be able to cover that cost even if they don't need any other assistance other than meal preparation. In my experience, for folks that don't have the ability to pay on a donation basis through OAA funding, they would rather go without the food if they can't make a donation to pay for their meals. If a natural support was helping to meet most of someone's care needs but couldn't be available in the afternoons, OPI should be able to cover the cost of Adult day services alone in order to keep a person living at home and off of Medicaid services. If the program could be flexible and available state wide, giving a little help to more people may help out by keeping folks off of Medicaid longer until a major medical event happens to where there is no other choice but to go on Medicaid.

- If administrative costs are increased, then onsite services would have to be decreased.
- If a person requires more than 25 hours of service each month, then they need to pursue alternatives. OPI is ideal for people who have not reached a need for more care and may never reach a need for more than that.
- I don't understand these.
- I came from Ohio where PASSPORT is widely available and funded with bi partisan support. While there may be occasional holds on intakes, the program keeps many people out of institutional care.
- However the Program is handled needs to be standardized across the state, border to border - People talk and become angry if they find out people in the Portland area get better services than people in smaller areas.
- Flexibility of funding is important. Waiting lists and service levels served should be determined locally, to allow that area to develop guidelines appropriate to that region's needs.
- I would support a policy for restriction of Case Management only; to help assure that sufficient direct services are being provided.
- Expenditure limits need to be based on area needs.
- Each Service Area should have some flexibility in the population it serves. Rural areas have less resources and OPI programs are critical in the Health & Safety of our disabled and aged population.
- Having eligibility income guidelines and Pay In for the Services received may be beneficial. (up to 300% of poverty level)
- Some basic standardization of Services Provided thru OPI and transfer of those Services between counties would be great.
- Many aged move closer to families, and can loose independence due to OPI Services not available due to limited resource. Being near family does reduce the cost of most Services being provided to the OPI population as a natural resource. Exploring those unpaid resources and offering the stop gaps would be nice.
- Don't standardize benefits and policies. This is hard on citizens in rural areas because we frequently need things that other areas already have provided by other

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gov't departments- such as transportation. It may take a home care worker longer to get to their clients in a rural area. So it would be beneficial to give the homecare worker a travel stipend. This would not be advisable in a city with adequate public transportation.

- Concern some local areas use too much in administrative costs, specifically program managers and case manager for this program
- Community members that don't need assistance with personal care but need assistance with possibly shopping, housekeeping, med mgmt/set-up are not served through SPD. This is a real need in the community that OPI could meet.
- Common sense should prevail.
- Case management should be kept to initial assessment, after that you really can manage on your own.
- Case Management is an integral part of service provision and should not be limited at the state level. AAAs should have discretion to limit administrative costs or not, especially if OPI funds are insufficient to meet client needs.
- Case Management funds should not be limited to 10% unless adequate. If nobody is available to complete the assessments and manage clients, then what good is the program to have it funded but no delivery method?
- Case management can/should be partially funded with the federal Older American act dollars. OPI should assist with purchasing in-home services first, than Case Management.
- Case management is tricky, we do a lot of paper pushing to get/maintain eligibility for our clients, while this takes up the bulk of our time, we should work to change this so that the focus is need based, if case managers had more time to focus on the needs of the clients, I believe we would better serve our clients, have more successful outcomes and even help prevent in some cases the need to go to a nursing home. I believe waived services purpose is to improve quality of life for individuals in addition to providing support services the delay the need for nursing home services. It is inevitable in most cases that the client will eventually be in a nursing home facility, but time spent there could be significantly reduced.
- Because OPI does not require estate recovery or liquidating assets, the program has greatly assisted in ensuring some high risk seniors are able to receive services; therefore, making it safer to remain in their homes.
- At NWSDS we seem to rarely provide more than 10 monthly hours of PC and 10 hrs of HK. However, when cases transfer in to the local area they seem to have more extensive OPI hours. I agree with our agencies goal of providing limited services/ hours for a greater number of individuals: if creating a statewide limit it could relieve some budgetary concerns.
- Are there standardized minimum training requirements for OPI workers? I've experienced inconsistent knowledge and skill levels among OPI workers and between COGs.
- Again, OPI should do screening for all services they authorize instead of compounding the work of eligibility specialists.

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- Admin cost should be limited but because Case Management is critical in many situations and may be the only service needed or available, I recommend no limits be set.
- AAAs have to justify how they plan to use all funds, as part of the area plan process. The state can use this as a point of discussion to discuss local prioritization. There should also be a report on what local agencies are doing, including a "best practice" kind of exchange.

(3a) Should liquid assets be used in determining eligibility along with income? (Liquid assets are considered to be existing cash on hand, savings accounts and other assets than can be readily converted to use, such as CDs or savings bonds).

Yes: 163

No: 90

Other: 16

- A limit on income and resources with less restrictive financial requirements for verification so that this doesn't become a huge workload increase for the field staff.
- Appropriate cost sharing
- But same verification process because more work to verify! Whatever it is suggest pilot study to see always or random checks.
- I think they already are in interest payment per month.
- liquid assets should have amount limit that is excluded from OPI eligibility
- maybe set a resource limit
- Not CD's or savings bonds. Any limit should be high.
- only if OPI funds are limited
- Ranges are reasonable based on asset amounts.
- Some standard should be set on liquid assets more that a certain level that should be used to pay for care.
- the administrative costs for collecting the 5.00 far outweighs the benefit of receiving the money - Assets over 5K should be considered
- They can be considered but not a requirement for services.
- We should not count liquid assets but interest from those assets should be counted as income.
- Yes but much higher than the Medicaid standard and should be similar level if single or a couple
- Yes but some flexibility is needed due to individuals who have mental health or judgment problems that prevent them from understanding the need for help.
- Yes, with a total assets cap of 90%.

(3b) Should there be a standard requirement and rule related to the collection of fees?

Yes: 210

No: 42

Other: 14

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- Yes, with a lien on the estate for all unpaid balances.
- Yes, but only if fees are based on ability to pay (i.e. some eligibility criteria).
- Yes but only if there is a negative outcome if they don't pay. Just like in Medicaid.
- Yes - the fee appears to be very reasonable - if someone chooses not to pay they should not receive services. Again - this would ensure that no one would need to be wait listed.
- Suggested Contribution
- See answer above
- plan with stakeholders
- no, local AAAs should perhaps have a leveraging standard, but state should not limit creativity by managing input end
- No, each office should have the flexibility to collect if a way that works for them and is least expensive.
- no thought
- It is enough to inform the person of the cost of fees. Fee recovery may not be worth the cost it takes to recover
- If you are making it more difficult for clients and the case managers fees are not cost effective
- I think it should be a goal but not penalize the center if monies cannot be collected. Flat rate fee for urban areas & higher income clients, sliding fee scale for rural areas & lower income clients
- based on the amount of eligible assets or income the person has available

(3c) Should current law be amended to allow for estate recovery from OPI participants?

Yes: 110

No: 140

Other: 17

- Depends on the budget climate, OPI services reach more people, but also require additional funding, perhaps some estate recovery could help fund the program.
- Depends on the previous questions. If clients are getting services thru OPI the same as thru AAA/SPD then estate recovery should be the same. If services are separate, different, and not duplicated - in other words just getting a little help to get by then recovery should not be a requirement.
- Depends on whether or not a spouse needs those assets to function
- Depends on workload/Cost impact
- How would this work when you are also requiring them to pay a fee for services?
- I don't know enough to comment
- I support estate recovery. However, many OPI clients are in the program because they don't want assets pursued. Would the cost of estate recovery be worth it?
- limit estate amount, if over recover
- Needs a lot of work. Client care first and estate last; see answer above.
- no thought on this

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- not if there's a resource limit, including home value
- not sure
- Only for those over a certain income/asset standard, and only if other heirs are considered first.
- Possibly I don't know much about that
- this may keep some clients from applying
- upon clients choice
- Yes, if the recovery goes back into the OPI fund.

(3d) If you answered yes to the previous question, should estate recovery be limited to participants who do not pay their assessed fees or should it include entire cost of services delivered? Should estate recovery only be applied above a certain dollar amount?

Yes: 65

No: 43

Other: 34

- Yes to both. If that was the case, then we would have less people on OPI and only those truly needing the service would request it. Treat OPI recipients as you treat the Medicaid recipients. Fair's fair.
- Yes, but their spouse needs to be considered.
- Yes, include entire cost to be applied above a certain dollar amount
- When it makes fiscal sense
- Those who don't pay fees
- This is a very poorly worded question. Actually includes 3 questions and the last one is very unclear.
- There are three questions here: Yes to those who do not pay assessed fees, no to entire amt, no to above a certain dollar amt.
- Since the majority of people we deal with have little or no resources or income I think that estate recovery would only provide limited funds to the program
- Should include entire cost
- Should be limited to pay for unpaid assessed fees
- Participants who do not pay their participation amt for that amount
- OPI clients have often declined DHS SPD assistance due to fear of Estate recovery. We are doing clients a disservice if we attach them from OPI criteria as well.
- Only assessed fees above a certain dollar amount
- Only applied above a certain dollar amount
- NO, YES, NO (applied to the entire cost) (*answers to the 3 questions)
- limited to fee non-payment
- It should include ENTIRE cost of services - no minimum.
- Include entire cost of service and no, not only over a certain dollar amount.
- I am not sure how this would work. If you pay a fee and this is set based on income and NW then the fee should be set to cover costs if no fee then they would more tan likely have no estate to recover costs from.

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- I am not sure
- I agree with the concept of limited estate recovery to participants who do not pay assessed fees and only above a certain dollar amount because the cost to collect could otherwise exceed the gain.
- For those who did not pay their fees.
- Entire cost of services delivered
- Entire cost of services
- Entire cost of services
- Entire cost
- Cost of service, applied above certain dollar amount only.
- certain dollar amount... services not paid for should not continue
- As noted above, it should be based on some sort of means test. It should be based on the entire cost of services.
- All bad ideas
- Again, upon client choice but entire cost of services delivered if client chooses
- Again, based on some level of services.
- Again, based on some level of services.
- 75K

(3e) The OPI sliding fee schedule is only based on the hourly rate paid to in-home care providers. Should the fee schedule also include the cost of Case Management and other authorized OPI services?

Yes: 104

No: 144

Other: 17

- Depends on the cost of case management, is it based on # of hrs allowed per person on OPI or is case management a salaried position
- A percentage of other costs perhaps?
- Again, AAAs should have flexibility to be creative
- By including the cost of CMs, clients may limit that option. However, CMs are still mandated to complete reviews, visits, authorizations, etc. HDMs have become so expensive that it's cheaper for the client to eat out. Maybe it's not healthier but I have no clients accepting HDMs if they have to pay the cost of them.
- Case Management should be excluded
- Case management should remain free; all other services should apply to the fee schedule.
- I think the hourly rate the sliding scale is based on should be based on the total cost of service. That is how private agencies calculate costs.
- It could include cost of case management for people who already pay for their in-home care - a very small percentage of those who receive OPI services
- May be hard to quantify
- Not Case Management but could be applied to other services

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- Not necessarily all services, but some like transportation
- Not sure how to answer this
- Sliding fee should not be based on service - it should be based on income
- Yes as long as the in home care is not affected negatively
- Yes based on income & resources
- Yes for some programs but not all
- Yes, based on a total assets cap of 90%. Individuals whose income is at or below poverty level should remain at a \$5 annual fee assessment.

(4) How can OPI be delivered differently to further the goals of the program?

117 Responses:

- We've had waiting lists and threats of total cutting of the program too often in recent biennia. We need to find a method of making it more self-sustaining, including collection of fees, if we want it to be a reliable resource. We need to go after any federal match for ADRC/pre-Medicaid activities.
- We need to develop a more stable funding source. The current "roller coaster" system does not allow for the program to be fully developed in all areas.
- We can not provide everything to everyone, but we do need to try and provide the basics so that these people can stay in their own homes as long as possible and be independent.
- Use liquid resources cash on hand, checking & savings accounts, CDs or savings bonds etc in the OPI pay-in calculation. It would be nice if OPI could serve disabled persons under 60.
- To include Disabled persons as well
- This program is used when individuals do not meet the eligibility for Medicaid services.
- The service should be delivered in a uniform standardized focus throughout the individual AAAs.
- The program simply needs more money, it's doing an excellent job already but resources are too scarce.
- The goals stated are good ones. This program serves people who would not otherwise be eligible for help. We need to keep this program without strings.
- The dollar amount for Case managers shouldn't be lumped into the entire program cost. Case managers should be a separate core service as without this service people will not have access to OPI.
- The current stated goals work well. It gives freedom for each area to use the program how it best services seniors. Our county often uses the OPI hours for risk clients because we have no volunteer agencies in our community to fill the gaps. It's important to keep the program fluid.
- The current functional assessment categories 1-18 needs to be expanded. I recommend one additional category. Simply a category that would be limited to a very low number of hours. There are many people who simply need someone to

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come to their homes once a week or once every two weeks to clean their house and perhaps help do the laundry. There are some who simply need someone to monitor their medications. The cost of a very low number of hours would be minimal. However, when these very limited services are not provided, the person will become sicker and then the cost is much higher.

- Statewide think tank to bring together ideas, plans, goals for the increased number of adults that need assistance....updated web based for resources
- Standardize the program so that it can continue.
- Standardize the entire state to preserve funds and provide equal services to the entire state.
- Staffing should be increased to allow more time for case management only. Offering case management only is a wonderful concept and would save a lot of money by assisting people up front, but it has not been reasonable (in my experience as a former OPI case manager) when staffing ratios have left case managers struggling to do even the basics with their clients receiving services.
- Sorry, don't have that much experience with the program to give input.
- should be standardized across the State
- Set up in all areas to ensure that OPI is not providing any services to any clients that would qualify for Medicaid Waivered Services to allow all in-home hours to go to clients who are falling through the cracks.
- Set a resource limit to save funding for those that have resources exceeding Medicaid limits and truly need the assistance to remain @ home.
- Serve people with physical disabilities, have RN services available as well as education (classes, flyers, ??) for med mgmt, nutrition, etc.
- Serve people with disabilities.
- See above. a resource limit would spread the program, also prohibiting people who are Medicaid eligible from using OPI
- Secure more funding to serve more people and to increase services to those already on the program.
- Increase public awareness.
- Incorporate more natural supports to assist clients when possible.
- Train clients in the skills that would help them to provide for more of their own care.
- Resource development
- Raise the age for senior participation to 65 years, the same as Medicaid. Persons under age 65 would have to be disabled to participate. Decrease the emphasis on quality of life and independence. Anyone receiving any services is actually "dependent" in some respect. Emphasize preventive measures to concentrate on nutrition, essential personal care and transportation.
- Provide more technical assistance and specialized training for staff.
- Provide more funding to meet the goals outlined above, and also provide funding for people with disabilities within OPI program (currently unfunded).

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- Promote dementia diagnosis and education. Screenings, education, support groups, our helpline, access to resources - all of this supports the caregiver.
- I just spoke to Providence Hospital who will charge \$189 for their caregiver course. This is prohibitive. Perhaps the course can be offered free online or by telecourse - much easier for caregivers.
- Lastly, a couple of other ideas such as caregivers receiving a support call 1 x per week could delay the need for placement and prolong the health of both caregiver and person w/dementia.
- Program seems to be meeting and addressing needs in this local area.
- Presently, there is no money allocated to assist persons with disabilities-Presently, many OPI clients receive a very minimal amount of services i.e. 1 bath assistance per week, home making services once per week or every other week. The OPI program needs additional, steady revenue to adequately fund the program.
- Payment of Lifeline/Responselink or other emergency call system would be very beneficial.
- Payment of an Emergency Response System like Lifeline would be a good addition to the program. Many seniors rely on this tool to remain at home.
- Our OPI program does not serve people under age 60, even if they are disabled. They have a lot of services that coordinate with the needs of seniors such as SHIBA, AARP Money Management program. Having a chores program for persons who need things done in or around the home would be really good. Or even helping people get bids for fixes that they need for their home. Some SPD clients need and would qualify for help, but they need to get the 3 bids and that stops them from continuing with the process.
- OPI should be considered as a mechanism for providing Long-Term Care options counseling to consumers, regardless of income. There should be no charge to consumers for this service.
- OPI should be case managed per county especially in remote rural areas where weather and mountain passes limit the travel to OPI clients in winter, late fall and early spring. There are clients out there who need OPI services but they are not being provided. More public awareness of the OPI program.
- OPI should be better staffed, managed and standardized in terms of eligibility and services provided.
- OPI has been efficiently and effectively delivered in southern Oregon. The only problem has been the limited funding it has received in recent years making unavailable to new referrals.
- Open it up to younger disabled
- ok AS IS
- Offer wider range of care. Locally, only 20 hours are authorized per month, even for higher care needs.
- Offer more preventative support services and information about the programs to seniors in our community through senior centers, such as money management.

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- Transportation should be available to allow seniors who are able to come to various functions offering information, food and socialization.
- Of course, an increase in funding would allow more than skeletal care plans and less wait for services. Additionally, in Southern Oregon, transportation has become an issue for seniors especially, since the local transportation district cut back on areas served, including the main route to the hospital as well as multiple doctor offices surrounding the hospital.
 - Not change at this time.
 - Not become dependent on the state agencies to determine eligibility and expect a denial from the state agencies before they agree to call and schedule an initial assessment.
 - no thought on this
 - need more workers
 - Need flexibility.
 - My preference has been to work with an OPI Case Manager who can stay involved with folks who are at risk and need services and care. Not everyone can qualify for or wants Medicaid. State Protective Services are not funded well enough to keep an eye on all of the 'at risk' folks. Someone needs to be around to step in when the risk rises....
 - More standardization.
 - More of the population who really need it could be served if those with resources could be redirected to private pay services.
 - More money and smaller caseloads so could be visited more often. Some seniors will refuse Medicaid and a good foster home will be better.
 - More individual sensitivity as it relates to seniors in need.
 - More communication of what services and resources are offered by AAA, OPI, Senior Center, etc. Communicate to others what each community member is in need of w/ other agencies that assist same clientele.
 - Working more with sister agencies to offer information on area resources, more assistance in tapping into area resources. 'rather than 'cant help, maybe go see ...'
 - Maybe raise the standard on the assessments so that only the most needy get the services as right now funding has been so low that a small percentage of applicants are served. Some that are served are less needy than others that apply at a later time.
 - mandatory fees
 - Make it the same program eligibility & benefits across the state.
 - Let people know that they will have an Estate Claim. People should have to pay for services, even if it is at a reduced rate. Yes, these people did work all their life but in reality, nothing is for free & most people are willing to & want to pay towards the help they need.

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- Legislature should raise the funding priority level of OPI. Consistent, stable funding would eliminate the uncertainty some areas experience, from year-to-year, and sometimes month-to-month. (Clackamas!!)
- Leave it as is with minor tweaking, increase funding, include people with disabilities, stop cutting services, evaluate & make use of current services..using alternative resources when possible to save OPI dollars which can be used in return to improve &/or increase services to current & new clients
- Leave administrative costs at 10 percent
- Just advertise what services are available, to which groups and what the eligibility requirements are.
- It has often been used as a stop gap for client's who are unable to cooperate to the extent needed to complete a Medicaid application. Too many restrictions and complications prevent us from reaching the group of consumers who might benefit the most from the service. Limiting the hours to 25 monthly serves to put a check and balance on the service.
- Involve the providers of case management and actual service providers in a forum to elicit ideas.
- Increased standardization for core PC and HK services with flexibility to bypass those services to provide supportive services of money management, nurse involvement, and/or daycare services in limited situations where client already has caregiver or SPL is driven by cognitive deficits only.
- Increase OPI funds to provide increased in-home help.
- include top of the list for people already on OPI and their condition warrants more support to avoid slipping through the cracks and ending up in a nursing home.
- In the future OPI can include a income cap and fee for service case management.
- If we look at people's resources there would be more money to go around to help more people.
- If estate recovery and fee recovery means that services can be extended to more people then I believe this methods need to be incorporated. My experience with estate recovery is that it does keep some people from accessing the services. Having said that, on balance, since the program cannot accept any new clients, cost sharing is inevitable.
- If clients have resources they are able to hire privately to pay for their care. I feel a resource limit should be put into place for OPI. Perhaps a higher resource limit than regular Medicaid, but a limit should be put into place. I also feel their should be a claim on their estate.
- If a client meets the requirement for Medicaid elig, they should have to use that resource. Choosing OPI over Medicaid so they have no Estate Claim should not be an option. This would help maintain the funding for OPI to help those who either are not service elig or financially elig for Medicaid but truly need the help.
- I would put more of an emphasis on providing preventive care. OPI should be utilized to provide a little bit of help to help keep folks off of state services for as

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long as possible. By widening what could be provided with OPI funds, more folks may be able to sustain without the need for placement into a care setting or at least delay the time when someone may need routine round the clock in home care in their own home on Title XIX services.

- I would like to see more local community discussion about the use of OPI. Having flexibility to meet those goals, based on local needs and resources, is best. In that regard, the program should be more like the Older Americans Act and less like Medicaid.
- I would like to see it be more available for folks discharging from the hospital or SNF who need help to return to their baseline and then reassess the need. There is a need for folks to get a small amount of care and not jeopardize their homes or farms they want to remain in the family but when there are assets over in the millions there needs to be a pay-in that reflects the amount of resources.
- I think there should be limits to liquid assets but it shouldn't be as strict as Medicaid requirements. I think fee assessments and spending time and resources trying to collect small fees is not feasible given the workload of case managers. If there is a fee, I think it should be a set amount for folks over a determined income amount which is above the Medicaid standard. I think local offices need to determine the services offered and income limits based on their population as incomes and needs vary by area.
- I think the OPI program should be strengthened to achieve the stated goals as they are now and we shouldn't add to it. It is hard enough to receive funds to achieve these stated goals.
- I think the emphasis should be on 2 and 3 above with focus on prevention and access to services for those who otherwise could not afford it and who do not qualify for Medicaid services. I do not think OPI should be used to provide services to Medicaid-service eligible persons who don't want to apply for Medicaid.
- I think the current delivery system is just fine. It is working well in our area. Just need more funding to serve those we are unable to help due to lack of money in program.
- I think that having the flexibility to have different looking programs in different parts of the state are very important to promote quality of life and independence to seniors. Each area is unique in what natural supports they provide. If we standardize programs we maybe duplicating natural supports in some parts of the state and not in others. It could be a waste of our small resources. I really believe it should be independent as to how and what services are provided, depending on where in the state the client resides.
- I think some increased standardization around the state will be good because it will enhance OPI program staffs' credibility with legislators. It's been a constant struggle to educate legislators about the OPI program; the need for local flexibility and that the OPI program is not means tested like Medicaid, therefore, eligibility criteria is different.
- I think services are meeting goals as best they can considering the shaky funding.

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- I think OPI should be allowed if the client has a Service Level between 14 and 18. This would help the people who do not meet criteria for our SPD program, but still need help. It would also help to standardize the program across the state and make it fair for all.
- I think it can have a basic set of services with individuals paying more for additional services. I like the idea of having net worth part of the eligibility process as well as a priority service level. The care plan not only has to provide a safe plan in order to keep a person in their own home but we should not write plans that are not safe just to keep individuals from higher care settings. OPI should as much as possible connect individuals to community resources when ever practical.
- I think individuals need to be looked at as a whole system (micro), I believe there should be a way of looking at resources. To often folks can withhold financial information. Information does not come forward until SPD gets involved. There must be some ceiling on savings so that we as Case Managers can better serve those that truly do not have the resources to spend on help in the home.
- I like the idea of OPI being administered more routinely state wide. It would be nice if OPI workers had to follow a similar format, narrate in Access and attend trainings.
- I have no suggestions at this point.
- I feel all the county's should follow the same rules so if anyone moves they can keep their services.
- I believe the YWCA East program works very well. I understand there is not consistent services or training at other offices and problems with service delivery exist.
- I believe that county support should be given to all district centers because there is such a need for their programs to serve those who are not eligible for Medicaid. This program saves the state money by helping keep elders in their homes longer. Funding needs to include case management as a paid service rather than something that is a statistical category to put things that don't fit into other categories. Case management keeps people in their homes, helps to prevent evictions, and is there to offer services when the individuals are finally ready to accept them.
- I am sure there are many innovations and lessons that can be shared, but the overall goals and package of services are on target. Technology, the boomers, etc. will transform demand in some areas, but the goal of independence is likely to have even greater value.
- Having a more formalized referral process.
- Good, qualifies Case Management is critical
- Fund it so that PWD can be served in the same way Seniors are served in different areas of the state with case management, HC/PC and HDMs.
- First - you could fund OPI so that people with physical disabilities are actually able to access the program. Second - OPI is a very important program. However it isn't more important than other programs. Find a way to stop having DHS related programs and education compete for money. Third - keep it as flexible as possible which

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means trusting case managers to do the right thing instead of having 2-4 layers of okays before a case manager can do anything.

- Educating clients and families to utilize other community supports available to help them meet their needs. Provide/offer trainings to individuals that would enhance their ability to obtain assistance with meeting their basic needs. (Health Care, diet, exercise, money management, stretching food dollars, cooking wisely on a budget, encouraging family friends to assist with natural support etc.).
- By using natural supports and by looking at all assets. This would leave the program resources available to help folks who do not have resources and natural supports. Oregon can no longer provide services for anything based on "need" alone. Families need to step up and care for family members and people with money need to pay.
- By providing services to the disabled people in need under the age of 60... That is not happening in our community and it is a need.
- By implementing a Pay in for OPI, and aggressively collecting. Many folks may be assessed a fee but if they can't pay there is no penalty. In fee's we do need to take in consideration outstanding debts, medication costs, health care costs etc. If a client's income is such that due to excessive bills, to work with money management with these persons to help reduce their debt, and apply for other programs that may be of assistance. This could allow for client to be able to share part of costs of services in the future, and developing a financially more secure resident.
- Better supply of information should be made available to all persons so that everyone knows about the program.
- At this time our current agency receives a small amount of funding, so we try and keep the hours to at least 10 for the housekeeping, and 20 for the more vulnerable clients, so that we can serve more clients.
- As stated earlier, NO CA/PS for OPI. Let us be more creative in the use of these limited funds. Kick the federal and state standards out of the home grown program. It is being stragled with an officious, non-creative, unhuman categorizing tool that CMS loves, but knocks out too many frail elders that need assistance. Surely there was a tool before the dreaded CA/PS came on board. We can do that again and serve 5-20s or some such. Let us not be a slave to this convoluted, pigeon-holing program. Amem.
- Apply uniform use across state, contain costs wherever possible, streamline eligibility and access to the program for all seniors and people with disabilities regardless of age, ensure program's viability and survival, and incorporate it as a first-line consideration in all long-term planning before entertaining any other care option.
- Allow local agencies to coordinate with other community groups who are providing services- maybe there is a great church program for disabled people or a day care service for elderly people. The state should allow maximum flexibility for local service agencies to innovate and make unique connections that will work for their specific local and population. No rigid rules

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- Advertise the services. Provide more support and money to the case managers who work in the district centers.
- Additional funding to address historic needs and to allow for projecting budgets to cover a greater part of the fiscal year. Also, uniformity of eligibility, application of waiting lists for services themselves.
- Add services for people with disabilities.
- 1. Standardization of processes. 2. Write rules related to clients transitioning over to Medicaid when they exceed service capacity. 3. Provide RN support to small AAAs to help manage medical costs of care.
- - More consistency in services offered across State - More consistent funding source
- work more with informal supports the same as the SPD programs do
- Working closer with other community partners. Oftentimes seniors have assumed responsibility for grandchildren even when the senior is frail. Community action networks; church groups; support groups could be better utilized. Seniors caring for spouses could benefit from attending support groups and/or training. Providing respite or day care would allow the caregiver to attend such groups.

(4a) How could OPI be incorporated into a larger vision for meeting Oregonians' Long Range Planning Needs as we move into the future?

Yes: 2

Other: 99

- - Closer collaboration, communication with SPD / Medicaid services - Coordinate eligibility criteria with Medicaid Services so those not able to be served by Medicaid can be served by OPI
- 1) Better and more stable funding so each year deep cuts are made or threatened, thus taking its toll on the non-profit agencies and their staff. They do valuable work in the community and meet the needs of those who cannot get served by the Medicaid programs because of financial ineligibility or not meeting service criteria. As more and more community resources are cut the district centers are in place to meet the needs of the ever-growing population that are cut off from Medicaid or Mental Health programs.
- 1. Incorporate technology to improve independence of clients instead of fostering dependency on the systems. 2. Look at home modifications to help people stay in their homes. (many seniors are forced to move into facilities because they can no longer use the bathroom because of access issues...or stairs become hazards for falls...etc
- Adopting a big bang for the buck theory in providing moderate care to Oregonians at risk for the least amount of money, and encouraging the client to be part of their solution/care by paying their share.
- Again, staff to allow much more of the case management services that are not tied to services: case management only, long term care insurance counseling, advisement on how to use resources to best advantage, etc...

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- An assessment could be developed to explain the cost of a range of services and individualize the income and resources to what that person has. Seniors like to have the facts of what things cost. They also like to receive value for their money. It would not be difficult to put together a cost analysis of different kinds of long term care options.
- As a Senior Center Social Services staff I preferred to work with the local County (Clackamas)staff instead of having to move to another level; the State. County staff are closer to their clients and more creative and flexible to be able to respond more quickly and effectively. State government is bigger, centralized administration and less able to respond creatively.
- Be considered part of the care continuum.
- Better, more consistent funding
- By leaving out any ideas that would make OPI resemble Medicaid & Medicare (liquid assets, estate recovery, etc as example)
- Case management could be a key. If everyone who applies received at least one case management planning session some long term care issues and questions could be addressed. So many folks have no plan at all and need basic information about the options.
- Consider OPI as part of a pre-Medicaid program.
- Continue to cooperatively work together.
- Don't allow administrative costs get out of control.
- Encourage people to utilize OPI services sooner, while the cost of doing so would be less. This would require more public outreach and education about the program.
- Estate recovery might bring in funds to keep hours up. We're in a rural area and our OPI program has a VERY limited number of hours. If estate recovery funds went into a general fund that could be dispersed to such an area as ours, the needs of our community would be better met. Could OPI share the same EAU that Medicaid uses?
- Expand to include services to disabled between the ages of 18-59.
- Fill in the gaps that Medicaid services does not.
- First everyone needs to recognize that the current demand for OPI is a drop in the bucket. Everything including OPI will have to be funded at a higher level. If OPI were to have a mandatory repayment from estates, then the funding would improve. However OPI also needs to have the flexibility to allow people significantly above Medicaid standard to qualify. Something along the area of \$4000 per month for a couple and \$3000 for a single individual. That amount allows a person to keep their home, pay their co-pay and get by w/a few hrs. per month. Hours need to be allowed up to 100 per month too. The more people that stay in their homes, the less everyone will have to pay in the long run. Facility costs will bankrupt us all.
- Fund it generously
- Funding and structured directly into SPD.
- Funding should be increased.

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- Guardian/Conservatorship programs, Case management to follow through on independent private pay referrals until services with private pay agency have begun.
- Have a strong budget in place.
- Have more \$ and smaller case-loads so that clients are visited more often recognize when people do need to be institutionalized in good homes to meet their needs not always about independence if living situation is a hazard "if not able to make good choices.
- Home based services are to me the most vital, dynamic, necessary part of aging in Oregon. It incorporates the basic needs people require to live out their lives where they wish.
- I am concerned that it not become so structured that it is just another version of Medicaid. Keep the flexibility.
- I don't know what this question is asking. Who's larger vision? I would have assumed OPI is already incorporated into a 'larger vision' in relation to DHS goals. Short answer - I don't know.
- I feel the program need to be able to have clients that can transfer from county to county if they move.
- I see more and more folks that do not qualify for SPD their service levels are too high. Folks with mental illness are denied service because of their primary diagnosis being Mental Health issues. Regardless of a persons diagnosis the outcome is inability to perform daily living tasks. I do not believe the state should judge which diagnosis denies clients service but rather a holistic approach to keeping clients stabilized in their environment.
- I thought it WAS part of Oregon's long range planning. Having stable funding would help meet the larger vision of serving growing numbers of older adults and people with disabilities.
- I work for SPD. I think our understanding of OPI is that they serve people who do not meet our services levels 1-13, meaning they will meet needs of the people at levels 14-18 and they provide the services people at those levels need. OPI also meets the needs of persons whose resources are too high for our service programs. These services are part of a continuum. When service needs become heavier, or they start looking at other options rather than being at home, OPI refers them to SPD.
- There are a lot of younger disable folks who fall through the cracks and it would be helpful in our community if they also served disabled adults who are younger than age 60.
- I would like to see it viewed as a cost cutting program for Medicaid. If we prevent people from having to go on Medicaid it would be a substantial saving for the state..... Viewed as a pre Medicaid program.
- If considering using asset "cap" to determine eligibility for OPI it should be based on some criteria/level that would indicate higher risk of spend down to Medicaid if

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- individual's long term care needs accelerate. Asset cap could be based on an amount that would reflect 6 - 9 months spend-down in a nursing facility.
- If the program had the participants contribute and the benefit be assessed in short periods as the need changes although the program to only fund where there was need. It is easily available for a few to take advantage and many to be left out or on wait lists.
 - If the program has EAU for recovery, we may be able to fund it longer, so that it remains a viable long term program.
 - If there were some kind of network or agency available to specifically be the first point of contact, sort of like a Statewide Information and Referral. With each county providing their own I&R, there is no uniformity. There is the Network of Care but not all seniors are internet savvy in order to navigate it to get information from it. OPI could be promoted as a first step. Case Management is key to address potential issues early on, to catch things before things might happen. Often people don't think about long term care until they are in the middle of a crisis and that is when folks usually go onto Medicaid. Case management to help figure out a plan and to help get people thinking about future care needs before necessarily needing any bathing assistance in their own home would be beneficial. I think a public service announcement promoting awareness ahead of time, directing people to a facility that could provide case management would be a good way of getting the word out.
 - If they were working the client's who meet the Service Levels 14 to 18, and the client start to fail and drops into the 13 and lower levels, they could then refer them to the SPD office for services and we would a more accurate record of the client's needs and what they were receiving through OPI and why. Now, we don't know why or how much they receive through OPI because there is no record.
 - In order to qualify for OPI, I believe a client should need assistance with personal care, such as bathing (not just housekeeping or shopping). This could be either a paid or unpaid need. This would help stretch the OPI dollars and allow the program to assist more people that really need the services.
 - Incorporating all the information and availability of necessary care needs provided by the OPI Program, which assist in the independence of the individuals in their own homes.
 - Interact better w/ other agencies service same clientele. DHS, VRD, Veteran's. Utilize volunteers more from programs available such as Interfaith Volunteer Caregivers, Girl Scouts, Boy Scouts, ROTC units, Community Service partners. Volunteers for easier thing such as yard clean up, wood chopping, errands, items that don't require too much of younger volunteers such as driving or in home assistance.
 - Is there any staff training - more info need to be given upfront when folks call offices for help.
 - It is not the only solution it needs to work hand in hand with other programs and resources in the community as well as with SPD programs.
 - It must be preserved and incorporated as a part of any long-range/term planning needs program.

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- It should be a step in the continuum of care, and the place where initial planning for the future needs of the individual can be done. Of course, not everyone will enter the system through the OPI door, so that planning piece needs to be available at every door. And, of course, that wellness component is vital.
- It should be seen as a Medicaid prevention service. The eligibility criteria should remain looser than Medicaid to encourage its use as it is cheaper than Medicaid.
- Leave the Medicaid program in the dust and turn to what folks really need—a nice person coming on in and doing a little bit of help like the laundry and some shopping and some visiting while dusting. Dare we mention relationship building, human warmth and contact? Now there's the stuff of a true care, innovative program. And you can get your workers into the field and out from behind the computer.
- Long term care planning.
- Look at the change in lifestyles and needs of the new generation of folks who will need to apply for OPI services.
- Make it a state program, counties are too single minded. By having case managers & intake case managers have more input in to the actual needs of folks who are not eligible for Medicaid.
- Make OPI more visible to the senior/disabled population thru community support resources, media, public awareness. Increased funding to employ more OPI caregivers for in home care, respite, and personal care, etc., keeping the seniors/disabled in their homes and preventing institutionalization and LTC placement. By doing so, it would reduce health care costs and insurance premiums as a preventative care measure.
- Maybe have a program to help case manage private pay clients that need help. This may save client's resources & use them more wisely to care for themselves. They need help finding, hiring, managing CBC.
- More communication coordinating with SPD.
- More congregate housing should be available to low income citizens to allow them to live in a community live setting to allow easier service delivery and to enhance socialization and a sense of community.
- More funding of course.
- More people could receive some necessary services if OPI were expanded to be more of a pre-Medicaid option.
- Much of the ADRC could be accomplished through existing OPI admin rules and statutes.
- No ideas, sorry
- no thought on this
- not sure
- Older people and people with disabilities do not need every program to be cookie cutter versions of some statewide ideal. Conditions vary around the state. The larger vision here is active community participation in planning the best way to provide services and opportunities consistent with the legislative goals.

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- OPI cost the State less dollars to provide than other types of interventions and should receive dedicated funding to keep pace with a growing population, maybe pilot a program using Federal dollars to increase the number of clients being served, reducing the amount of dollars needed for the higher level of services provided by Medicare/Medicaid services. Without recover by the Feds as part of the pilot program.
- OPI funding should be protected. There should never be a risk of the program being cut.
- OPI is a contact point to other resources for folks that are somewhat still independent and therefore trained case managers that look for and "plug" folks into these resources is the main importance of OPI
- OPI is such a needed program and costs incredibly less to taxpayers than Medicaid. Working toward receiving federal match for this program would be most beneficial to OPI clients and Oregonians in general.
- OPI must be flexible to meet changing needs of seniors that are living longer in a more technological world. Baby boomers are more apt to use computers, etc to communicate needs and/or ask for help.
- OPI needs a permanent funding source so it will always be available and can be included in long range planning.
- OPI needs its own line item in the state budget and not have to every year or so beg for dollars and get a small amount from some Christmas bill, the average person uses like 200 dollars a month in services, would you prefer we go into nursing homes.
- OPI presents the strongest face to the public, I believe, when it is presented as a gap-filling program to meet the needs of those for whom there are no affordable, comparable community services. I also believe it needs to have enough flexibility built into it that local case managers have leeway to use the funds somewhat creatively as needed, although they should have to go through an approval process to justify the need and someone locally should be monitoring the expenditure of the local allocation so as to assure it is being spend wisely and broadly.
- OPI saves the Medicaid/Medicare system money and also provides services for those who would slip through the cracks. Make OPI funding more stable.
- OPI should be a portion of a long term plan to care for the elderly and people with disabilities.
- OPI should be incorporated with the cost of care programs and require the same rules as Title XIX.
- Possibly a 10 or 12 hour monthly maximum of assigned hours.
- Possibly one central spot(similar to the OHP branch) that determines financial eligibility for OPI and then have a local person do the assessment and help with finding a care provider and doing all that paperwork.

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- Provide a stable funding source, perhaps even a special tax that is only to be used for OPI. Perhaps a very small % of people's earnings from age 40 and older that goes into the OPI fund like for social security.
- Public Awareness, Survey's, utilize and train volunteers,
- Public policy needs to talk about communities and what makes good ones. I am sick of the kids vs. elders trade-off. It is not a case of which, but both. We need to be much more creative using the existing empirical evidence to tell the OPI story.
- Put more emphasis on OPI. The program serves SPL 1-18 and keeps people from having to move into costlier settings. Increase CM capability and fund it so seniors and hopefully PWD will have access to RN services. Serving OPI clients should dovetail in with the Aging and Disability Resource Center concept which is where people should receive options on Long Term Care planning.
- Question not clear
- Same as above.
- Same implementation throughout state.
- See above.
- Serve the people that Medicaid is unable to serve. There should be eligibility criteria; in other words, an income & resource eligibility. People who have lots of resources, should pay privately or pay for their entire cost of care. This program should be for the folks that SPD is unable to serve & the folks that can't afford to pay privately.
- Single payer system that allows billing for case management and long term care planning incorporated into a home health provider system.
- Specific qualifications to ease eligibility process and case management to assure level of care is necessary and being provided accordingly.
- Stable / funding / budget to at least maintain or be able to expand program and public education concerning eligibility, availability and benefits of service.
- Start by adequately funding the program. Don't set it up as a pre-Medicaid program but rather a program where individuals with a moderate/low income can receive supplemental in-home assistance and the short term case management to assist the senior with achieving independence. Family members need the expertise of community based care managers to assist them with keeping their family members in a safe, secure home.
- The community is largely unaware of the program, so it needs to be promoted/advertised.
- The larger vision can include funding for Adults with Disabilities and HH income clarification.
- The OPI budget needs to be increased and maintained so there are no times of having to have a wait lists, reduced hours, or the threat of no funding for OPI services at all. OPI could be a more preventative service, capturing more clients before they decline to the Medicaid service elig level. This, in turn, could keep folks home, and avoid more cost to Medicaid for CBC or facility placement. Sometime

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- folks decline simply because they have not had that little bit of help to maintain their level of functioning.
- The state needs to recognize that OPI is an important service for the senior and disabled citizens of Oregon and needs to be treated as such.
 - The state should develop and implement innovative processes that will financially support the OPI program for the influx of new seniors in need.
 - This is really for folks who are not yet eligible for Medicaid, but do not have income and resources to last very long until they need to apply for Medicaid. Some folks have used OPI when they could be eligible for Medicaid. I believe this saved the state money for the medical and services as the client was very careful with services hours as they had to pay for them and they continued to have their own health insurance. This saved state and federal monies.
 - Well, we are striving to keep the aging and disabled out of nursing homes, etc. So this program would help keep individuals more "independent" and possibly able to live in their own homes. Sounds like it works well with the "diversion/transition" aspect of the agency.
 - With long term stable funding i.e. not in jeopardy at every budget cycle the effort by AAA talent may be applied to addressing the issue how OPI as one in the array of LONG TERM CARE PLANNING can focused more sharply.
 - We are so distracted by having to defend the OPI budget at every biennium we cannot adequately bring our emphasis on a longer term Vision if we do not know if the money is there next year.
 - Work more closely with Retirement Facilities and Senior Centers to provide to provide information, referral, and support for in-home providers working in facilities that do not provide their own caregivers.
 - Years ago I was part of a focus group that offered suggestions for future services and how they could be met. Unfortunately, I did not see any of our suggestions come to fruition. So, I'm at a loss as to what is being considered now.

(4b) What strategies should be pursued to assure people with disabilities are able to access OPI services?

110 Responses:

- - Partner with regional Disability and Business Technical Assistance Center for training, resources, help developing accessible events. - Partner with other agencies who serve disabled individuals... Voc Rehab, QuadInc., other local agencies serving the disabled. - Link web page to other internet sites such as www.disabilityresources.org to be more easily located as a resource.
- 1. Seek Federal funding for Medicaid Prevention. The Child Welfare Foster Care system has funding for Foster Care Prevention. Medicaid should have something similar for Medicaid Prevention. 2. Establish some avenue of stable funding at the state level. OPI cannot function if it remains a hostage to GF. It also cannot pit seniors against the disabled (i.e. we only serve disabled on OPI at the expense of seniors, or vice versa).

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- A formalized referral process.
- AAA informing applicants of options, same for senior centers and community resources –
- Add money to the existing program.
- Advertise it more.
- Advertise and train those working with the elderly to make referrals- i.e. pastors, social workers at hospitals, home health RN's, Doctors.
- Again, increased funding for the program is needed to serve people with disabilities.
- Again, make it a state wide program, supervised by state authority. Have OPI implemented by Medicaid Case managers the same way food stamp information and intake is done by case managers who do intake. Pay intake workers more for the requirement to be familiar with more programs.
- Again, Public Awareness, Health Fairs, Seminars, Media Coverage
- Assure adequate funding of case management for AAA's as well as state SDS agencies.
- Better outreach at shelters; better education of those that serve them what the possibilities are and how to make the connection.
- CHANGE THE RULE THAT DISQUALIFIES THEM
- Change the rules. Media blitz and training for all persons who work with physically disabled. Mental Health & DD should still work with someone who has a Mental Health or DD diagnosis.
- Collect fees for service on a sliding scale based on income and liquid assets and through Estate Administration collection.
- Communication with community care providers like home health & hospice social workers, hospital social workers and discharge planners, senior center staff, retirement residences, St Vincent DePaul and geriatric case managers.
- Community education/information
- Develop partnerships with: 1) local health care providers; 2) local mental health providers. This will create connections to help to identify those individuals who need care. However, with OPI funding shrinking, I ask why we would increase the eligible pool of people to the detriment of an already underserved senior population.
- Disability insurance / option
- Disabled adults should be eligible for OPI the same as aged people in our state.
- Disabled persons generally are receiving SSI and/or SSDI. Informational information could be targeted to that population.
- Don't adopt proposals being considered that go after the persons estate or assets. Bill them on sliding scale and be done with it, many of us need reserves for security, MS gets worse when you are constantly being stressed out over not having enough money to buy medications, or being stressed out thinking that when I need OPI it wont be there. Long term care planning a must.

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- Don't know what they are doing to reach people now. Hopefully discharge planners are educated regarding OPI services.
- Educate Spokes unlimited, SPD employees, and other community partners so we can give correct information when we are out in the community. Educate clients who come to Sr. Center for meals, or include flier w/ meals on wheels.
- Establish a larger, dedicated funding source for OPI.
- First define what that population is. I would think that includes persons under age 60. Do dog and pony shows with partners such as local hospital, SPD office, physicians. Program Brochures in lobbies, etc.
- Folks who are deemed disabled by Soc Security, tend to need more services then OPI can provide. The program may need to be re-done to capture their particular needs. But how to do that, I have no idea.
- Fund the services. Increase the maximum hours allowed. Consulted actively with Disability Advocate Councils around the state and really listen to them.
- Funding = improved outreach and "marketing".
- Funding seems to be the main barrier to assuring people with disabilities receive OPI services. Taxes seems to be the main source. Perhaps having a recovery system would assist in funding the program in the future.
- Funding, direction and rules that include them.
- Get the word out as to availability in each county (media)
- Giving case managers that serve client's under 65 more info. about Oregon Project Ind.
- Good communication & advertisement to the community.
- Good, qualifies Case Management
- Have no rules about age or impairment. If a person wants to use OPI, let them.
- I am sorry, but I think Oregon mad an error in including this group into OPI. It is my belief that to constantly lump seniors and the disabled together modifies and dilutes both programs.
- I believe the last revision of the OPI OAR's did a good job of addressing this area but as we have never had the funding to provide services there may be areas that need adjusting but until we can test the OAR's I can not say at this time.
- I believe the OPI program should have the same liquid asset requirements as Title XIX does. I have never understood why people with (for example) \$200,000 in CDs, should get free housekeeping services from the tax papers. I also think the sliding fee scale portion should be mandatory and that if clients don't pay it, their OPI services should be closed.
- I believe the program should become age neutral. People already receiving services are stated as a top priority, so no senior need lose service to add a person with disabilities. But the next people to be added should be assessed in an age neutral way.
- I can't speak with knowledge.

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- I do not have a comment in this regard except to say that priorities need to be established to triage the needs of the client so that younger disabled are not dependent on the system for all of their services and that encouragement, technology, and other resources are used first before a care giver is used.
- I do not think this is necessary. A younger disabled person qualifies mostly for Medicaid and can pay in, be epd etc.
- I think the system needs to be fixed before thinking about adding additional potential clients. A functional assessment would level the intake process and allow persons with disabilities to be evaluated in the same fashion as persons over 60. In the ideal world both populations would be served.
- I think there would be better communication and understanding on both sides, AAA and SPD. We would be working closer with them regarding the client's they have that are getting closer to our care limits.
- Include emotional disabilities in CAPS assessment can write policy to assess mental health and behavior issues like hoarding addictions to alcohol and drugs,
- Increase funding for the OPI program, allowing for the serving of more people and to give more service to those already on the program. More funding would also allow the program to serve the under 60 disabled population as was directed 3 years ago.
- Increase funding
- Increase funding via Measures 66 & 67, HR 2069, etc. .Also, evaluate & make better use of current OPI dollars...biggest thing to remember is once you start accepting people with disabilities onto OPI then you MUST cover durable medical equipment
- Increase funding. Prioritize waiting lists.
- Inform staff working in geriatric units about OPI
- In-home appointments available
- Insure that the program is adequately funded on an on-going basis so that it's not in jeopardy every two years.
- It should be incorporated into the regular state budget and should not be considered an extra service.
- KNOWLEDGE OF THE PROGRAM AND THE INSTRUCTION TO ACCESS IT
- Lets get some dedicated and stable funding!! And once this is in place, training for case managers so that they learn how to work with younger disabled adults.
- Look at all focuses.
- Lower age requirements
- Lower the eligible age limit to 18. However make sure that the service are not already provided A(if they are SSI and meet the service eligibility and have a need they can get 20 hours personal care as a benefit of their medical card.
- Mailings with brochures, Public Service Announcements on TV and on the Radio, Posters in Senior Centers, News Story promoting awareness and where to get help, Flyers
- More funding for services but also more informational activities.

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- More funding, goods and services should be secured through corporations, private individuals, volunteers (private individuals, students from high schools and undergrad/grad schools).
- More mental health assessment.
- More outreach and publication.
- More public awareness that OPI and AAA offices offer assistance. At this time in the local area, OPI and AAA is only for those above 65. Younger individuals w/ disabilities are left unassisted in the area unless they have lower ADL levels and meet Title XIX program In Home Services from the DHS office.
- More publicity and referrals from agencies serving this population.
- None
- Not sure
- Not sure, they seem to be getting their message out to the community just fine.
- Obtain direct funding for those people with disabilities.
- Office policy to offer the program to all persons, regardless of 'extra' work issue for case managers who are already overloaded. My office does not promote the program as it involves more details for the workers to case manage.
- One idea is to increase the phone surcharge for Deaf and Speech Impaired services
- Open program to physically disabled 18 and over
- OPI is no secret in our county - however you must be 60 or older to access services, unless you have a dx of Alzheimer's/dementia. It appears to be easily accessed by all over the age of 65. People know they can get a "free housekeeper" through this program. Again, the CAPS tool is too generous - allowing mostly independent people on this program. We have a waiting list of nearly 25 people - all whom are very capable. And - I can't say it enough - there needs to be an income/resource limit to encourage people who have the funds available to pay privately for their care.
- OPI needs a more stable funding source in the State budget. The Administrators and Case Managers should have to fight for funding every two years as this takes away from services.
- OPI potential clients need to be denied state services first. OPI has no way of validating income. People with disabilities were to be able to be serviced under OPI. Stable Funding is a must. We are currently operating in crisis mode every 18 months. Perhaps a federal model needs to be pursued.
- OPI should be referred by SPD to OPI services. Local case management per county throughout the state. People with disabilities should be able to access OPI personally or thru a representative. Increased public awareness of the OPI program thru media, etc.
- OPI would need a secure and stable funding source that would continue to increase over time. If this was in place it might be possible to expand the services to include younger people with disabilities into the program.
- Outreach

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- Outreach where ever appropriate in each community. Educational info to key community workers, such as hospital discharge planners, Social workers and PT/OT workers. If they know Medicaid income/resource rules, they might think there's nothing available for a client who insists on remaining at home. If they know about OPI, they could refer.
- People with disabilities are able to access their OPI moneys if they fit into the eligibility and there isn't a waiting list. The more money OPI has the more people it can assist. I would like to see the program expand to provide more assistance to people with disabilities under 60.
- Perhaps by linking to SPL or diagnosis.
- Persons with disabilities need assistance with getting durable medical equipment.
- programs within OPI for people with disabilities as well as aged
- Provide funding.
- Provide funding. The rest will fall into place.
- Public awareness through public information similar DHS tobacco campaign.
- Public service announcements, and community outreach.
- Public Service Announcements. Consistent referrals for people who might be eligible and are not eligible for Medicaid programs. Social service training at medical clinics, hospitals etc.
- Publicize through all the various service providers -- hospitals, Social Security, ILCs, college disability offices, etc. Get into the current culture by putting profiles/blogs, etc. up on Facebook, Twitter and whatever the next generation is.
- Publicize through all the various service providers -- hospitals, Social Security, ILCs, college disability offices, etc. Get into the current culture by putting profiles/blogs, etc. up on Facebook, Twitter and whatever the next generation is.
- Reduce the age requirement for program access.
- Screening and assessment of individuals in their homes, which includes information from all providers involved in care to get a through picture of the service needed.
- See above. More community outreach.
- Seek to be humanistic rather than bureaucratic.
- Seniors must know that there are these services available.
- Simplistic answer is to fund the program and correct the rules and begin to incorporate disabled folks.
- simply let the public know the program is there
- STABLE and FULLY ADEQUATE FUNDING BASED UPON THE RECOGNIZED NEED (NUMBERS OF PERSONS REQUIRING ASSISTANCE) TO SERVE QUALIFIED PERSONS REFLECTING THE OPI (STATUES) OBJECTIVES. PERHAPS SOME PUBLIC RELATIONS AIMED AT GARNERING SUPPORT- MONETARY OR IN-KIND- FOR THE PROGRAM MAY RESULT IN GREATER ACCESS TO THE PROGRAM
- Strategies should include funding, training for case managers, outreach to community, intake workers, streamlining the referral process and decreased duplication of services.

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- The services such as OPI and case management should be offered to persons under age 60, either by the same agency or by another. This population is underserved and have some of the highest needs because agencies that provide services to homeless or individuals who have mental health issues (but are not enrolled in MH programs) are no longer available.
- The State needs to fund this part of OPI so that the disabled population has access to these services, under no circumstances should Senior funding be reduced or targeted to serve other than the Senior population.
- There's not enough funds as is, until funding is more stable and plentiful, the program should remain for older adults only.
- They should not, just keep it for people over the age of 65.
- This would be difficult given this is an Older American Act program.
- Use medical avenues to get information on these benefits. (Dr. offices, hospital lounges, etc.) If using State benefits (food stamps etc.) use the course of receiving benefits to get the info. out. (if receiving benefits, every now and then send info. to the person. With old age, memories go bad, and this stuff gets "lost".
- Use the same standards of assessments as for the seniors. I don't know how the state currently funds their services, so can't speak to a funding source.
- We could do better at marketing...but then you would likely have more than we could serve.
- Will need additional funding for OPI to implement this provision. If implemented Case Managers would benefit from additional training on self-direct care, strengths-based case management and motivational interviewing.
- You could provide some kind of notice to let them know you are out there, most people do not know this is available

(5) Other ideas or concerns related to services?

69 Responses:

- Actually include the disabled adults as well in the program focus and eligibility.
- advocacy and coordination of health care
- All services are needed for our aging population, but many benefits and services are abused within the current structure.
- allow home care without personal care
- assisted living facilities need better monitoring - too many times of neglect, high turn over, mismanagement, lack of communication between family and administrator and too high of costs
- Case management is critical to ensuring the health & welfare of all clients and should be the core of all OPI cases. All other services are developed based on the information and need obtained from the case management component.
- Chore services? Does that include shopping-in my years as a Case Manager for SPD there is a huge need for the elder and disabled to get out of their apartment or

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house and shopping is an excellent avenue for this with mileage reimbursement to the providers or volunteer.

- Citizens in rural areas have different priorities than those who live in cities. Transportation is a real vital part of our survival. Possible connections with Oregon Dept of Transportation services would make our lives a lot easier. Coordination with Senior Centers would make the most of every available dollar.
- Common sense should prevail.
- Core Services - What do these services currently consist of?
- Depending on living situation and available informal support system program is limited / lacks the ability to expand as needs any increase even for short term disability to maintain independence or quality of life.
- Eligibility Pre-Screening/Screening to deal directly with the public instead of depending on SPD office to screen for OPI
- Even with a required list of services there may be other community resources available which would not require OPI to pay or provide the service but there should be a way to show that and receive a waiver.
- Every time OPI staff changes so do the local rules - on what levels they will help and not help. In my area the staff is unsure what they are doing especially when it comes to CAPS - they will do a CAPS and refer someone to our office and their caps will be way different from how we were trained to follow the CAPS rules. Most of the time they are not eligible for Medicaid per our CAPS.
- Flexibility of the program for the local office has helped us greatly to tailor services to specific needs, however minor.
- From the core list of services above, it doesn't seem like all those are available to staff to use. Due to budget concerns, perhaps services available to the client could be limited to a certain number? (Removing case management from list since those services are mandated for completing review, follow up, and ensuring payment.)
- Funding. Service priority levels.
- Good, qualified Case Management would determine the actual need per case. Although all of the needs checked are critical to health, safety and quality of life, some persons may not require the full range checked here; Case Management would be able to establish the high-low priorities on a case by case basis. 'Adult Night Services' could be considered for inclusion. A dependent person may be able to be up & take care of daytime needs but may require someone present at night.
- Having more than a few core services available could potentially create a hardship in certain areas, as all services are not necessarily available in all areas of the state.
- Housekeeping is major request from clients.
- Housing assistance with strict qualifications.
- I do not support a mandatory minimum core of required services because of the great variety of needs individual have. The most valuable aspect of any funding is the ability to use the money as best assists and individual - not to fit program requirements that may not serve the individual.

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- I find the CAPS system to be overkill, especially the part about medications. I also have concerns with the lack of oversight and supervision of the home care workers. There have been instances where this lack of oversight has caused concern. Lastly, many of our clients technically lack the "ability" to be an employer as outlined by the statutes. Either they lack the skills necessary to interview and hire independently, there may be a language barrier or another social barrier. It seems in this case that the case manager should be allowed to do more for the client.
- I think Chore Services is important. Can see problems trying to get that in every location.
- I think the emphasis should be serving those who don't quite meet the criteria re ADL needs to qualify for Medicaid but who have some ADL and also IADL needs, and who need a subsidy to be able to afford services. I strongly feel that an income and resource assessment should be completed and that services should be offered on a sliding scale from 0- 75% of market rate. I think services should be offered that are not typically covered by Medicare. If the program was structured more carefully, I believe it would be self-supporting and more people would benefit.
- I think the focus is missing many other services. We should be promoting services for people with disabilities that are already independent, not just providing services to help people with disabilities to be independent. A lot of these services are needed for seniors and people with severe disabilities. Still, the state of Oregon is missing the boat for our people with disabilities who are independent in many ways but still need services. Communications, legal services, employment, and so forth are services that are badly needed.
- I will be eligible for OPI in seven years and am hoping that this much needed program receives the stable funding it deserves. The baby boomer population alone will be huge and putting us in nursing homes or assisted living will be costly. I have Multiple Sclerosis which is progressing steadily, I want to remain in my own home. I do not qualify for Medicaid. In the two year wait to get Medicare after getting social security i am spending on cobra health benefits from former employer over 9200.00 dollars, last year alone i spent 9400 dollars on medical expenses and i have health insurance with me paying for twenty percent. I worked 35 years in service to people with disabilities and now my hard earned nest egg is dwindling. I hope they do not change asset regulations as any extra assets i do have i will need over my lifetime to pay for medications and possible in home care. I did not want to go on Medicaid, I would like my home and assets to go to the people i want them to go to who volunteer in my home care right now. Cities with larger populations should receive more funding than counties that are low in population. I am trying to stay independent and want to know that OPI will be in existence in 7 years for me to tap into. I know I may have to put in some dollars but I don't want my assets upon death to be given to the state , or if it is just like Medicaid I would go on total state support and get rid of my assets. I really don't like the Medicaid Oregon health care plans who dictate who you can be referred to and hardly ever give you physical therapy.

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- Why pay all that cobra and end up losing everything due to medical expenses, medications transportation, and reg home maintenance?
- I would add that Home Care and Personal Care should only be core services if it's not to the detriment of smaller counties/areas. All should offer case management at a minimum, and if affordable, home care and personal care. Other services should be added as affordable.
 - If OPI could do these services, SPD would be very grateful as would our community members. You probably would need to case managed these services.
 - If the areas would evaluate their services & recognize which services can be provided via alternative resources & make use of those resources, then the OPI dollars they'd save could go to improving & offering more services to more people.
 - Important for this program to remain client -centered. Why would we require services that an individual may not need?
 - In my way of thinking, it would be good to have a wide range of core services available to all folks that qualify for OPI services, but have a Case Manager determine what services are needed. (Much like how we do determine what services someone needs through Medicaid). Take Natural supports into account and fill in the gaps and areas where they need the help the most. With the funding for OPI being so scarce, it would be good to use OPI in a manner to meet a multitude of different needs before the situation gets so bad that Medicaid is needed. It would be a wise idea to make OPI the same for all counties so it is uniform throughout the state. It would also be nice to fund this program enough with permanent funding and ideally there would be no waiting list in order to receive a little help. If funding were secure, there should not be an hour maximum per se, but the amount of hours should be based upon what a client needs are after all other supports are taken into account.
 - In our large rural county (Douglas) there are many people in outlying areas who need services. However, their locations are often beyond service areas; i.e., home delivered meals, transportation.
 - In some areas, the funding is limited or services are not available. This limits what each area can offer. Offering a case manager to do problem solving, resource development and coaching would allow for the most flexibility in dealing with limitations at the local level.
 - In the future, when there is a "waiting list" because funds are low, there is a need to cut or even out services to those already on OPI, or find more funding. It is proven that folks with even a minimal amount of help in home either from Medicaid or OPI are able to reside independently for longer. Truly, nationwide, folks in LTC facilities are a small minority to the larger population. However we continue to fund more expensive programs, partnering with ALFs, Nursing homes, rather than pour more funds into keeping people in their own homes with minimal OPI hours and minimal Medicaid hours.
 - Information and Referral, assistance to get on to other programs such as Medicaid and Medicare A-B-D, and socialization programs. And have access to or hosting of

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- the following programs: SHIBA, LIEAP, Senior Law Project, Loaves and Fishes meal site, food box programs, housing, transportation, and Mult Cty programs like HCW programs, HCW respite program, housing and emergency need programs.
- I've had a few clients that tried the Money Mgmt Program, but found it too intrusive and too difficult to meet all the requirements & rules.
 - Local AAA's do not get training needed such as to administer the home care worker program correctly, specifically knowing how to work with providers when they have respite hours available.
 - Many of the core services listed can be provided by type "B" agency based on other support funding, however it would deplete type "A" funding to even attempt to provide the same level and areas of services as the type "B's".
 - Many people can fall under SPD's services and therefore do not need services to be "doubled up". The optimal services would be for OPI to cover what SPD can not. Such as, home services for those who do not meet for personal care needs. Grocery shopping, housecleaning, med mgmt, etc. Some just needs rides to the doctor or to the store.
 - Many Services are available thru other agencies, such as Home Health RN Services, Adult Day Services and LTC Planning.
 - Most of the clients in our region on OPI are very independent, yet qualify due to the generosity of the recent CAPS tool. Many of them also have large amounts of liquid resources available to them to hire privately. However, this cannot be considered when opening an OPI case. Staff need rule backing that allows them to collect for monthly service fees. Currently there is no mechanism for this. Clients are aware that they can refuse to pay yet still remain opened for services.
 - Need for Mental Health information and resources.
 - Not to overlap services when another agency already provides that service in the area (such as Home Health, Respite Care, Money Management), but to partner with the already-existing service.
 - Offering case management to everyone who applies without having any services available isn't a good use of funding. I think each area in the state needs to identify the most needed services for their elderly population and then target their program to meet this need. I think there needs to be some flexibility so Case Managers can determine how best to use the limited funds for the clients (i.e. paying for less service for one client who has a great deal of support and more service for someone with no support).
 - OPI is meant to be a supplemental in-home services program for individuals who do not meet the Medicaid eligibility criteria. Medicaid should be viewed as a prior resource for those who functionally are in the priority code level and very close to the resource/income level. It should not be a clients' choice to receive OPI over Medicaid as there are many individuals who aren't as functionally impaired or within the financial guidelines who don't qualify for Medicaid and need OPI.
 - OPI should retain its flexibility. That was part of the original intent.

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- People who meet our service criteria need all the above services if they have no family or friends to provide or help with. The alternative to not providing them is that they require a higher level of care or go without because of the resource requirements of most other programs,
- Prioritize personal care
- Programs need to be geared to area needs. It is ridiculous to put money and time into programs that are used only minimally.
- Resource assistance person; what is out there to meet the client need? As case managers we do not always know what is available in the community to meet needs.
- RN services for med mgmt and delegation for provider.
- Rural areas do not receive the funding to offer a wide range of services. I believe OPI should provide core services which enable folks to stay in their home and put off the need for Medicaid. Assisting with services that are not available in another way. For example - Home Health is offered thru Medicare and there are agencies that provide transportation options.
- Sometimes the confused elderly that can pay for services need help acquire private pay services, it would be nice if case management could be available to assure they get through all the steps needed to access private services initially. We could really benefit from a program that can provide Guardian/Conservatorship duties to clients that have that need and no one to serve in that capacity.
- taxes, all home ownership
- The above is not an either or list. A set of services that help seniors/disabled remain independent and at home for as long as safely possible is key.
- The above list seems overly ambitious. With limited funding, the most essential needs should be addressed first and other needs included as funding allows. Home Health, money management, long term care planning, and case management in my opinion should not be OPI issues.
- The beauty of the OPI program is the flexibility at the local level to meet the needs of people at the local level. The rural parts of Oregon have challenges in service delivery different from the urban parts of Oregon and we need to consider this before making sweeping changes that will reduce this flexibility.
- The flexibility to purchase non-Medicare covered equipment, household goods, minor home repairs, etc. would significantly increase the value of this program. Of course, adequate funding (as with all programs including Medicaid) is the crucial piece.
- The same OPI service should be available throughout the state. The same SPL level across the state should be used to determine eligibility. This program should be used to keep vulnerable clients from having to access nursing facility care.
- There are many Medicaid based waiver services available throughout the country. I am saddened to see Oregon's OPI virtually frozen. Let's get back to when Oregon was on the cutting edge of services to our elders.

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- There needs to be greater verification of need and resources. In the Metropolitan Areas there seems to be monitoring but in rural areas not so. The hours are being used for transportation for medical and social. There needs to be some Medical verification of needs.
- There should be standardization of personal care and home care hours in other words.. service priority levels matching hours of in-home service allocated. Some sort of rule process to encourage clients to move to Medicaid when hours of OPI are exhausted or client is above service priority and care needs exceed OPI levels of service.
- These core services checked above should fall under the umbrella of case management. Areas throughout the state differ in the particulars of services needed and those available. Community partnerships and natural supports are quintessential in developing truly effective person centered care plans which of course begin with competent case management. Realistically OPI stands as one of an array of service options all of which contribute to keeping seniors and disabled persons in home as long as possible.
- This should be a federal program used to reduce Medicare costs and help finance Medicare Part E. Facility care is more expensive- wake up DC!
- We have some seniors who need most of these services. With the home delivered meals that is just one more person checking on them. Some also need to have help with home chores to be able to stay in their home. It makes that person feel independent if they can stay in their own home and costs less than being confined to a nursing home. Especially when many will end up on Medicaid which has limited funds.
- We need licensed adult day care in Southern Oregon (not Foster Homes). We need a social/medical model + transportation. This absence of licensed adult day care as a respite resource greatly impacts caregivers and contributes to placements in memory care facilities.
- Wellness education. Dementia and/or Alzheimer's support groups
- While I understand the range of services varies county to county based on what is available and monies available for those services, I believe some core services need to be in every county. This creates a more stable transition for clients who may move from one county to another.

(6) Please let us know if you are:

AAA Staff: 97

AAA Board: 1

Citizen: 10

DHS Staff: 130

Other: 29