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A. Introduction and Goals

Oregon has led the nation, since 1981, in the development of lower cost alternatives to institutional care in both nursing and intermediate facility care. Oregon ranks first of the 50 states and the District of Columbia, in the proportion of Medicaid long-term care expenditures that are made for home care, and last among the 50 states and the District of Columbia in its nursing facility occupancy rate.

Like many states, Oregon was forced to make draconian reductions in its long-term service system in response to the recession in the early years of this decade. State funded prevention and outreach services were eliminated; community-based care provider payments were frozen, and Medicaid eligibility thresholds were tightened. At the same time, enactment of a nursing facility provider tax codified a reimbursement methodology that increased the average nursing facility daily rate more than 35 percent between 2003 and 2007. As illustrated by the following chart, Oregon’s historic pattern of declining nursing facility utilization has been significantly impacted by the combination of budget reduction actions.

<table>
<thead>
<tr>
<th>State fiscal year end</th>
<th>Medicaid Nursing Facility Residents</th>
<th>Growth/(Decline) from previous period</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 1996</td>
<td>7,306</td>
<td>N/A</td>
</tr>
<tr>
<td>June 1997</td>
<td>7,139</td>
<td>(2.28%)</td>
</tr>
<tr>
<td>June 1998</td>
<td>7,067</td>
<td>(1.02%)</td>
</tr>
<tr>
<td>June 1999</td>
<td>6,879</td>
<td>(2.66%)</td>
</tr>
<tr>
<td>June 2000</td>
<td>6,645</td>
<td>(3.41%)</td>
</tr>
<tr>
<td>June 2001</td>
<td>6,332</td>
<td>(4.71%)</td>
</tr>
<tr>
<td>June 2002</td>
<td>6,056</td>
<td>(4.35%)</td>
</tr>
<tr>
<td>June 2003</td>
<td>5,734</td>
<td>(5.32%)</td>
</tr>
<tr>
<td>June 2004</td>
<td>5,329</td>
<td>(7.06%)</td>
</tr>
<tr>
<td>June 2005</td>
<td>5,222</td>
<td>(2.02%)</td>
</tr>
<tr>
<td>June 2006</td>
<td>5,221</td>
<td>(0.03%)</td>
</tr>
<tr>
<td>June 2007</td>
<td>5,222</td>
<td>0.03%</td>
</tr>
<tr>
<td>November 2007</td>
<td>5,291</td>
<td>1.33%</td>
</tr>
</tbody>
</table>

Oregon’s Money Follows the Person project – “On the Move in Oregon” – aims to reverse the increase in nursing facility utilization seen above and continue this state’s historic rebalancing efforts using Home and Community-Based services. Project staff is housed within the Seniors and People with Disabilities (SPD) Division of the Oregon Department of Human Services (DHS). Oregon DHS is the single state Medicaid agency. SPD is the single State Unit on Aging and provides Medicaid funded long-term care services to seniors and adults with physical disabilities and to children and adults with developmental disabilities. The Division also serves as the state’s long-term care regulatory agency and as the state repository for the nursing facility Minimum Data Set (MDS) information. (Additional detail is presented in Section C of this Operational Protocol).
MFP staff studied longitudinal data from the following sources:

- Acute care hospital discharge data from the database maintained by the Oregon Office of Health Policy Research.
- Client assessment/planning system data (CA/PS) data for Medicaid-funded nursing facility residents for the 14-month period ended September 30, 2007. The CA/PS tool is used to assess functional eligibility criteria for all Medicaid-funded long-term care consumers who receive services in Oregon nursing facilities or who receive services through Oregon’s Home and Community-Based Services Waiver for Seniors and People with Physical Disabilities. Oregon ranks people into service priority levels 1 through 17 based on their needs for assistance with activities of daily living. Long-term services are currently funded for people in levels 1 through 13.

This longitudinal data analysis, coupled with open forum discussions with local program managers, providers, advocates and other stakeholders helped to inform project staff about specific groups of people who might benefit from the Oregon MFP project.

**Seniors** – Much of Oregon’s HCBS development over the past 25 years has been geared towards the needs of seniors. Economic pressures over the past 5 years have effectively closed community-based congregate care models to Medicaid residents, especially those with dementia and other cognitive difficulties. The problem is particularly acute in Eastern Oregon. Of the 13 Oregon counties located east of the Cascade Mountains, 11 are considered frontier counties as defined by the National Center for Frontier Communities of the Rural Assistance Centers. 2005 county population projections for these 11 counties, as estimated by the Oregon Office of Economic Analysis, show that on average, people ages 65 and over made up 15.9 percent of the population of frontier counties. By contrast, the average for the rest of the state’s 25 counties was 12.4 percent. Not only does demand outpace supply of senior care services, the flight of younger adults towards living wage jobs has led to a scarce supply of the direct care giving staff so crucial to the operation of dementia care facilities today.

**Adults with physical disabilities:** People ages 18 through 64 with physical disabilities make up an increasingly large percentage of the total population receiving Medicaid funded long-term care services in Oregon – Thirty-one percent of the total population receiving services through the Home and Community-Based Services Waiver for Seniors and People with Physical Disabilities in June, 2007. Seventeen percent of Oregon’s Medicaid nursing facility residents are under age 65, and three-quarters of these residents have lived in the facility 6 months or more. In many cases, data analysis and discussion suggest that people find themselves living in nursing facilities not because of a need for 24/7 skilled nursing supports but because the sorts of supports that they need for community living don’t yet exist.

**Adults with developmental disabilities:** Oregon traditionally provided services to people with developmental disabilities in institutional settings such as nursing facilities and intermediate care facilities for the mentally retarded. The Fairview Training Center
was opened in 1908, providing the first state-funded services to people with developmental disabilities. During the 1970s federal Medicaid funds became available for operation of “Intermediate Care Facilities for the Mentally Retarded” (ICF/MR) programs such as Fairview. About this same time, professional standards and public thinking about how to best serve people with disabilities began to change. Life in the community became more accessible. People with disabilities gained civil rights including the right to a public education. More of society became available to individuals with disabilities as structural accessibility increased and society began to accept people with disabilities. Fairview Training Center closed in February 2000, as part of a long-term plan to develop community placements and supports for its residents, improve wages for direct care staff in community homes, and expand community-based services for other people with developmental disabilities. Services for people with developmental disabilities are now delivered almost exclusively through regional and local partnerships, with the Eastern Oregon Training Center (EOTC) in Pendleton remaining as the only state institution for people with developmental disabilities. As the number of people living at the Training Center declines, the per-person cost of operating and maintaining the institution increases. More importantly, all of the residents could be equally well served in residential programs and would be better integrated into their communities. At the end of February 2008, 38 people lived at EOTC.

**Children:** Approximately 70 Oregon children with developmental disabilities live in several pediatric nursing units in Oregon. Many of these children could be cared for in their own homes, or in their communities, with appropriate care and supports. SPD is working closely with families, nursing facilities, foster care homes, state child welfare and local developmental disability agencies, schools, community organizations, family training and support centers, and community members to transition appropriate children back to their communities.

**People with Dual Diagnoses:** As many as 70 adults with medical and psychiatric needs live at the Oregon State Hospital (OSH) in Salem, Oregon’s capitol city. OSH is a long-term inpatient psychiatric hospital, that originally opened in the 19th century. Anecdotally, the OSH is said to be the inspiration for author Ken Kesey’s work ‘One Flew Over the Cuckoo’s Nest’. The film version, starring Jack Nicholson, was filmed there. The Oregon Legislative Assembly allocate funding over the next ten years to rebuild and replace the OSH, moving towards a community-based system of supports for those with severe mental illness (SMI). As part of that movement, the On the Move in Oregon project will work with OSH to move those 70 adults whose needs qualify them for the state’s 1915(c) waiver for Home and Community Based Services for Seniors and People with Physical Disabilities, effective with the 2010 calendar year.

“On the Move in Oregon” will push the envelope of home and community-based services still further. We plan to demonstrate that long-term institutionalized populations of people with complex medical and long-term care needs can be served in their communities with wrap-around packages of supports and services. The pre-planning process has allowed Oregon to revise, and expand, the number of people we propose to transition using “On the Move”. Our revised estimates of people to be served include:

- 40 children with developmental disabilities in pediatric nursing facilities,
• 260 seniors with ADL and other needs in nursing facilities,
• 500 adults with physical disabilities in nursing facilities, and
• 200 adults with developmental disabilities in nursing and intermediate care facilities.
• 70 adults with medical and psychiatric needs in the long-term inpatient psychiatric hospitals.

Oregon believes that successful transition of these individuals to the community will allow the state to strengthen and extend its 25-year rebalancing effort and will eliminate silos of funding that may exist between developmental disability services and services for seniors and people with physical disabilities. Successful demonstration of new care and service models will allow Oregon to begin building the next wave of a national model to provide home and community-based services to people not typically able to use these services.

Refer to Addendum A: Introduction and Goals on pages 93 and 94.

A.1 Case Studies

1. Children

History:
In Oregon, a person with a developmental disability is considered Medicaid eligible if they meet financial and functional eligibility requirements. To meet financial eligibility the person must be a “client in long-term care or in a waivered nonstandard living arrangement (OAR 461-001-0000), the countable income limit standard is 300 percent of the full SSI standard for a single individual. Other OSIP and OSIPM clients do not have a countable income limit” (OAR 461-155-0250). Functionally, the person must meet the definition for Mental Retardation (OAR 411-320-0020 (48)) or a Developmental Disability (OAR 411-320-0020 (23), (24), & (25)). The County Developmental Disability Programs (CDDP) are responsible for determining eligibility. The county where the adult resides is responsible for making the eligibility determination; in the case of a child, the county where the parent resides, or where the county court having jurisdiction for the child is, is responsible for making the eligibility determination.

The eligibility process should begin within 10 working days of receiving an application for services (OAR 411-320-0080 and 411-320-0170 for procedure for determining eligibility for people with Developmental Disabilities)

Any home wishing to certify as a child foster home must be certified by one of the following agencies:
   A. Seniors and People with Disabilities (SPD);
   B. The Department of Human Services (DHS)-Child Welfare (CW); or
   C. The Oregon Youth Authority (OYA)

*Children will only be placed in a certified child foster home. (OAR 411-346-0120)
Case management services are provided by the CDDP. Case management services have specific rule requirements for the monitoring of services provided to the individual. The CDDP will ensure that regular visits responding to DHS (The Department) questions are conducted at each child or adult foster home and each 24-hour residential program site licensed or certified by the Department to serve individuals with developmental disabilities. Visits will review areas of service and support to individuals with specific focus on areas addressing health, safety, behavior support or financial services to individuals. In January of each year the CDDP will establish a review schedule based on the number of individuals served in each home. Visits will be scheduled to occur as follows:

A. Homes or sites licensed or certified for one or two individuals will be visited at least quarterly.
B. Homes or sites licensed or certified for three or more individuals will be visited at least ten months each year. (OAR 411-320-0130)

Brandon Jeffries is a 15-year old young man who has lived in the pediatric wing of a nursing home since he was 7 years old. Brandon was born with several significant disabilities; among them were severe mental retardation, a seizure disorder, and cerebral palsy. His parents, Lauren and Kevin, were committed to providing care for Brandon at home. Lauren, who had worked prior to Brandon’s birth, decided to quit her job and provide her son with as much loving support as was possible. As a baby, Brandon’s care needs resulted in many late night trips to the emergency room. Even when an ER visit was not required, there were several sleepless nights for both Lauren and Kevin. As Brandon aged, his care needs continued to be extensive. During the day, Lauren rarely had down time, as Brandon would not engage in self-play. Nights out for Lauren and Kevin did not occur because babysitters were next to impossible to find. Lauren’s only respite was on weekends when Kevin shared more of the care giving responsibilities. As challenging and physically, mentally, and emotionally taxing, as it was to support Brandon at home, Lauren and Kevin remained committed to supporting their son in the most loving environment they could imagine.

When Brandon was six, Lauren gave birth to a baby girl, Natalie. In order to meet the care needs of both children, Kevin took 3 months off from work. When Kevin returned to work, the workload for Lauren became overwhelming. She found it increasingly difficult to meet the significant needs of Brandon as well as provide care for a newborn. Lauren would sometimes forget to administer critical medication necessary to manage Brandon’s seizure disorder, which, of course, increased seizure activity; this created significant stress on the family. Unsure where to turn for support the Jeffries contacted the local mental health agency to explore their options. They discovered that some support might be available to them pending an evaluation of eligibility and support needs conducted by a county case manager.

One week after Lauren made the call, a case manager assessed and approved Brandon’s eligibility and developed a support plan. The plan focused on supports Brandon’s family needed most in order to keep him living at home. The case manager worked with the family to creatively identify all family and community resources that might be leveraged to best support the Jeffries. With their support dollars, the Jeffries purchased some behavioral consultation and a respite weekend a month.
For a time, the additional services provided the emotional support the family needed. However, having the monthly respite made them realize just how desperately they needed an occasional break. Lauren started to get frustrated with Brandon, for which she felt guilty. As Natalie’s needs continued to increase, it became increasingly difficult to remember to deliver all of Brandon’s prescribed supports.

On a visit to Brandon’s pediatrician, Lauren related that Brandon had experienced increased seizure activity, as well as more episodes of screaming and crying. She felt that it might be related to her inability to give him her total attention and expressed concern that she was going to inadvertently put his health and safety in jeopardy. The doctor was concerned with Brandon’s declining health, but he was equally concerned with the toll Brandon’s care was taking on the entire family. The pediatrician delicately suggested that the Jeffries consider placing Brandon in a pediatric nursing home, temporarily. He felt that it would provide the family a needed respite and an opportunity to heal. He also felt that the more intense medical supports would benefit Brandon. Lauren immediately rejected the proposal, but thanked the doctor for his concern.

Matters did not improve at home and another seizure as a result of a med being administered late caused Lauren to break down in tears. Reluctantly, she discussed the option of placing Brandon in a nursing home with Kevin when he arrived home from work. After spending the night crying and debating, the Jeffries contacted the doctor and asked him to assist them in a temporary placement at nearby Meadowlawn Rehabilitation Center.

Brandon responded well to the care he received in the nursing home, and it appeared to the Jeffries that he was more comfortable. Lauren and Kevin were at the nursing home, daily, but found that having some time where they were not responsible for Brandon’s care had taken stress off of the family. As everyone began to heal, thrive, and accept the current arrangement, the plan for a temporary stay became a long-term placement.

Now fifteen, Brandon lives a very structured life. A bus picks him up at 7:00 a.m. for school (Brandon is in a special education class at a nearby high school). He returns home at 2:30 p.m. each day. After school, he usually naps in his room for a couple hours, has dinner, watches TV in a commons area, and goes to bed. In the summer and on weekends, he spends a lot of time watching TV or videos. Sometimes a nursing home staff person takes him for a walk or a country drive. Sometimes volunteers are around in greater numbers, so there are more arts and crafts, singing, and storybook activities. Brandon gets mild enjoyment from these activities, but is rarely animated during them. Lauren remembers taking Brandon to a University of Oregon football game when he was six and reports that he laughed a lot and clapped with excitement when the crowd got loud and excited. She also reports that he likes animals and has put pictures of zoo animals all over his room. Unfortunately, the Jeffries do not have a vehicle that is equipped to transport Brandon on such activities.

For Lauren and Kevin, the last seven years have been about putting the pieces of their lives back together. Being able to visit Brandon whenever they please, and knowing that
he is safe and healthy has eased some of the guilt they live with. Brandon appears happy, and that makes it worthwhile for them.

Sandy, a nursing facility diversion worker, made several visits to Meadowlawn Rehabilitation each month to work with the facility social workers. On several of her visits, she would see Brandon sitting in the commons area watching T.V. by himself. When she had a moment, she would sit and talk to him. She could see the interest in his face when she asked him about the television program he was watching. Occasionally, she would visit him in his room and saw pictures of different animals and University of Oregon banners on the walls.

On one such occasion, she met Lauren who was also visiting. Lauren and Sandy had a nice conversation about Brandon, and Sandy learned things about Brandon’s interests that she hadn’t previously known. She asked Lauren if Brandon had ever been to the zoo or to a U of O “Ducks” game. Lauren said these things hadn’t happened since Brandon was very young but that the family would like to see him able to have outside activities from time to time. Lauren also expressed some regret for not being able to keep Brandon at home where he could engage in more of these types of activities.

As Sandy listened, she wondered if Brandon might not be a good candidate for the Money Follows the Person (MFP) project —“On the Move in Oregon”. She asked Lauren if she had ever heard of the “On the Move” project; Lauren indicated that she was unaware of it. Sandy provided a brief description and asked Lauren if she could have a local MFP representative contact her with more information. Lauren hesitated, but consented. Before Sandy left, she gave Lauren an informational brochure regarding the MFP project.

When Sandy returned to her office that day, she contacted Emily Roberts, the transition coordinator in that area. Emily wrote down contact information, and called Lauren the next day to arrange a time to meet the Jeffries face-to-face. The meeting was scheduled in the Jeffries’ home later that week.

Emily worked methodically with the Jeffries for several months exploring ideas, providing information, and anticipating concerns. The Jeffries believed they had done what was best for Brandon by allowing him to live in the nursing home. They had real doubts that a foster home could provide better care than they had provided Brandon, and they felt they were being judged for placing their son in a nursing facility. These meetings with Emily required that the Jeffries revisit the past, which meant reliving painful incidents. Slowly, Emily was able to gain the trust of the Jeffries, who began to open up and seemed more willing to consider other options. Emily was good at listening with her heart instead of her head and Lauren and Kevin could see they were being guided by someone who had genuine interest in their feelings as well as what was best for Brandon. Three months after first meeting with Emily, the Jeffries agreed to look at some community alternatives.

After looking at a wide range of community options, the Jeffries asked Emily to arrange a tour of two – a non-profit agency operated several small homes for people with medically involved needs and a local foster provider that supported two other people
with significant medical needs. Kevin and Lauren found the tours to be very informative. There were aspects of each model they really liked. The agency run home seemed to have structure more like the nursing home and was very amenable to visitors at any time of the day and without notice. The Jeffries' were concerned, however, by the high staff turnover experienced by the provider. The staffing stability of Brandon’s nursing home made them more comfortable.

Emily’s next step was to have the Jeffries sign the informed consent document that included information regarding the details of the MFP project, benefits for participating, information regarding long-term waiver options at the conclusion of the MFP year, potential risks for participating (including the possibility that Brandon may not be able to qualify for nursing home supports if he left), confidentiality agreements, an option to withdraw from the project, a complaint process, and the option to decline participation. Because Brandon was a minor, his parents were assumed to be his guardian. Emily double checked with the facility to make sure there was no other guardian, and then documented her process and findings in the case narrative. Once signed, Emily contacted the nursing facility to let them know the Jeffries’ intention to move Brandon within 45 days. She also asked for a meeting with nursing home personnel no later than 30 days prior to the move as a necessary step for facilitating effective communication and ensuring a smooth transition for Brandon.

The foster home was not what Kevin and Lauren had expected. It resembled the agency home in many ways and had shift staffing as well. The significant difference was the couple that ran the home, Jim and Carol Walters. They were parents of a child with disabilities as well. Their child had passed away 10 years ago from some complicated medical issues, and they felt it was their calling to help other families and children with disabilities. They were able to anticipate many of the Jeffries’ questions and concerns, and they were able to relate to the struggle the Jeffries were experiencing as they considered community placement. Lauren and Kevin were so impressed with the Walters’ values and commitment that they decided to pursue a placement with the Walters for Brandon.

At the transition meeting with the nursing home, the Jeffries, and the Walters, Emily helped the team establish a task timeline as well as helping the group identify Brandon’s equipment and support needs using the important to/important for tool. Through the tool, they established the need for a doctor’s order that would allow Brandon to purchase his own wheelchair, medical bed, prone stander, and mechanical lift; these were all items typically covered under Brandon’s medical card. The team also felt it was important to and for Brandon to have additional avenues by which he could attempt to communicate. Through MFP, Emily was able to purchase a loop tape with a few command buttons. She was also able to pay for a speech language pathologist to evaluate Brandon and develop a communication board. Although offered, the Jeffries felt trial visits would confuse Brandon and create significant stress for him. Instead, a schedule was developed that would allow the Walters and the staff that worked at their home to receive training from nursing home personnel. Built into the training schedule was an opportunity for the foster home staff to shadow nursing home staff during high care times. Additionally, Emily worked with the nursing facility and the Walters to make
sure all community services (doctors, dentist, physical therapist, speech pathologist, etc.) were in place prior to his move. There was no need to pursue environmental modifications or housing deposits, as the Walters’ home was already designed to support Brandon’s needs. The team agreed to reconvene 30 days prior to the move to check in on progress and finalize Brandon’s move plan.

When the team reconvened, there was very little to coordinate. Emily gave a progress report on activities that had taken place over the last 60 days. She discussed the professional relationships with new doctors; the assessment of the PT/OT for the wheelchair, prone stander, and mechanical lift; the work of the speech language pathologist; and training the Walters and their employees had received. As part of the training, the Walters and the foster home staff were in-serviced on medication administration, as OAR 411-346-0180 (9) authorizes foster home providers to administer medications and train foster home employees regarding changes to those medications occur. As they concluded the meeting, Emily reiterated that a third party 24 hr. back-up provider would not be needed, as the Walters had staff onsite at the home 24 hrs. a day/7 days a week that would be able to respond to any emergency that may arise.

After the move, Emily visited the Walters’ foster home weekly for the first month and monthly after that. As questions about Brandon’s care arose, she was able to facilitate answers and solutions. Brandon seemed happier than ever and interacted well with his housemates. He learned how to use his communication device and board to express basic thoughts. On one visit to the home, Emily ran into Lauren who was sitting with Brandon as he communicated with her using the board. Tears welled in Lauren’s eyes and she threw her arms around her son. Then she wrapped Emily in a big hug and thanked her for helping her and Kevin to have the courage to make the move. She expressed how happy Brandon was and that she was able to communicate with her son as she had never before.

After 9 months, Emily worked with the county case manager assigned to Brandon to assess which waivers would provide the best support for Brandon’s needs. To ensure ongoing eligibility, the county case manager completed a Title XIX Waiver Form, and conducted an eligibility determination to assure that he continued to meet the Level of Care and eligibility requirements for waiver services. They determined he would be best supported under Oregon’s Comprehensive Developmental Disability waiver. As the 365th day came and went, everyone marveled at the progress Brandon had made over the past year, and everyone celebrated that nothing about Brandon’s supports would be different as the second year began.

2. Adults with Physical Disabilities

Mary
Mary is a 56-year-old female from Eugene, Oregon. She is married to Glenn and they have two children, Bob, age 38, and Toni, age 36. Mary and Glenn have been separated for many years, but Glenn remains supportive and involved in Mary’s life. Although Glenn is not Mary’s legal guardian or representative, she is glad that Glenn is
willing to assist her and give her advice when she asks for it. Her children are supportive, but both are married, have children, and work outside the home. Mary is 5’4” and weighs 350 pounds. She suffers from multiple conditions including diabetes type II, hypertension, peripheral neuropathy, osteoarthritis, bladder incontinence and sleep apnea. In addition, Mary has been diagnosed with an anxiety disorder, depressive disorder and with developmental delay, which causes her to experience some behavioral problems, including food hoarding. Mary had bariatric surgery approximately 20 years ago.

Mary has been a Medicaid client of the Department of Human Services since 1996. She received long-term care services through Oregon’s Home and Community-Based Waiver for Seniors and People with Physical Disabilities in her rented apartment until September 2006. During that month, Mary was in a motor vehicle accident and suffered bilateral leg fractures and a right forearm fracture, and was admitted to Green Valley Nursing Home. Due to her non-weight bearing status and obesity, Mary requires a two plus person transfer and needs a heavy-duty patient lift. Mary was unable to keep her apartment after going to the nursing home. Glenn moved most of Mary’s belongings into a storage unit and gave the rest away to the children or charitable organizations. Mary has wanted to leave the facility for some time, and although her fractures have healed, has been advised that this is not possible until she is weight-bearing and has gained strength. Mary’s behavior has deteriorated since being in the nursing facility. She argues with the staff, refuses to get out of bed and does not comply with therapy. Mary had a good support network of family, friends and members of her church prior to the accident. It is believed that her social network was, at least in part, responsible for her functioning at a higher level than her physical capacity alone would suggest. During her time in the nursing facility, Mary has had less contact with her friends and fellow church members, possibly contributing to her behavior issues.

Transition Coordinator, Bill was given Mary’s name by the On the Move project team. The project team used a combination of MDS data and CA/PS (Client Assessment and Planning System) assessments to identify potential participants for the project. Bill visited Mary at Green Valley and explained the “On the Move in Oregon” program. Mary was interested in knowing if she would be able to move back to an apartment. Mary missed going to church and being able to visit with her friends. Bill told her that this could be explored, and that other options might exist as well. He left Mary with some “On the Move” literature to review and told her he would be back for a follow-up visit within the week and would have some additional information available at that time.

The following week Bill visited Mary to discuss the information he had gathered. Bill told Mary that her options were limited due to her non-weight bearing status and need for a two plus person transfer using a lift, as well as for modifications necessary to accommodate a bariatric wheelchair and bed. Bill had located an accessible two-bedroom apartment that he thought would accommodate her needs, as well as a new congregate care model specifically designed for persons with bariatric needs. Due to the type of funding used to build the residence, people with low incomes would qualify for a subsidy, thus making it affordable for Mary. He asked her if she would like to see them. Mary was hesitant to consider the bariatric model, but did agree that a visit couldn’t hurt since she did want to move out of the nursing home. Bill arranged for
transportation and the following day a van picked up Mary to take her for a tour. Mary’s husband, Glenn, accompanied them at Mary’s request.

Mary, Glenn and Bill toured the apartment. It was built to be wheelchair accessible and appeared to be able to accommodate Mary’s wheelchair and bed. However, Mary didn’t think the bedroom was large enough to accommodate a bed, a commode and a patient lift. Also, it was quite far from the church she used to attend and she was hoping that she would be able to renew her connection there. The apartment’s second bedroom could be used to house a live-in home care worker, which would provide Mary the oversight she needs. Next, they toured the new bariatric care setting. The equipment needed to transfer Mary was available for the use of all four residents. Mary would have her own bedroom, living room and bathroom, all built to accommodate bariatric equipment. The rooms had wide doorways and roll-in showers. Meals were prepared and served in the common dining room and staff was available on-site. Housekeeping services were also provided. Since the staff is on duty, and available to residents 24 hours a day, no additional emergency back up system is required. Bill told them that transportation was available via a new van equipped with wider doors and weight capacities, which was just purchased by another community non-profit agency. The van would be available for medical transportation, and for non-medical transportation as well on a limited basis. That way, Mary could use the van to attend her doctor’s appointments as well as church on Sundays. Mary was introduced to one of the other residents who had moved in one month before and thought that she seemed nice. Bill suggested that Mary talk things over with Glenn and others in her network of support and let him know if either of these options appealed to her. He emphasized that the decision was hers, and that she had the choice of staying in the nursing home if that is what she preferred. In addition, if she moved to a community setting and decided it was not meeting her needs, she could return to the nursing home at any time.

Less than a week later Mary contacted Bill and reported that she wanted to move to the bariatric congregate care setting she had toured. She had talked things over with Glenn, who agreed, that even before the accident, Mary had difficulties living at home due to her weight and the extent of her care needs. Now it would be even more difficult. Since her children were so busy with their own lives, they didn’t have the time to visit as frequently as she would have liked. She decided that these new quarters would be much easier for her to get around in and that she would have the security of knowing that staff was there when she needed help. She also liked the idea that she would be able to socialize with the other residents. Bill reassured Mary, however, that if she did decide upon the apartment, a plan would be developed to meet her needs. She would still receive physical therapy, dietary and behavioral support. Since it was a two-bedroom apartment, Mary could hire a live-in home care worker and additional home care workers, if needed, to assist her with mobility and transfers. He agreed that the size of the equipment she required would make the apartment feel more crowded, but felt the space would still be adequate for her care needs. She would still qualify for medical and non-medical transportation. In spite of this, Mary decided that the congregate care setting was where she wanted to move. Bill agreed on a time to meet with Mary to sign the application and other paperwork required for moving, including a low-income housing application, and the informed consent document. Bill also notified
the nursing home administration in writing of Mary’s intent to participate in the demonstration project, including a timeline for departing.

After the paperwork had been completed, Bill met with Mary to select the services from the benefit package she would receive in her new home. Although direct care staff, meals and housekeeping were provided, weekly visits from a nurse were set up to make sure Mary was managing her diabetes and medication regimen, and to monitor dietary intake. Mary’s physical therapist would continue to make visits three times weekly for weight bearing and strengthening. A behavior specialist was also contacted who would meet with Mary on a weekly basis to ensure her adjustment to life in the community was going well and to deal with any behavioral issues that came up, including her depressive symptoms and food hoarding. Glenn arranged to get some of Mary’s furnishings out of the storage unit. Bill contacted Mary’s physician in order to have prescriptions written for a bariatric bed, bariatric wheelchair and commode, and he arranged for Mary’s medications to be delivered by a local pharmacy. Bill also provided Mary with a “community tree,” a directory of phone numbers for the people in Mary’s life who she indicated are important to her and who could provide her with informal support. The “tree” also included local activities that may interest her and community resources in her area of town. Glenn called Mary’s pastor to see if he could pay her a visit after she moved in. Glenn also made sure the children knew that they could visit Mary at any time, and bring the grandchildren.

After the move, Bill visited Mary on a weekly basis. At first, Mary was not sure that she had made the right decision. She had made friends with a couple of the residents in the nursing home and missed talking to them. Also, she had misunderstood the instructions for reserving the van and had missed going to church one Sunday. Bill contacted the nursing home to arrange a time for Mary to visit her friends. Bill arranged to have someone meet Mary at the van and wheel her into the dining room for the visit. He also reviewed with Mary the instructions for calling the van to make sure that she didn’t miss church again. Mary also needed to contact one of the church members to meet her at the van and assist her into the church. A few weeks later during Bill’s visit, Mary indicated that she was much happier. She was adjusting to her new life and had made some new friends in addition to keeping in touch with her family and old friends.

Bill continued to make monthly visits to Mary’s home. During those visits, Bill checked with Mary to see how she was doing, and also checked Mary’s progress with the staff. Mary found this setting adequate to meet her care needs, and enjoyed the socialization and freedom of living in the community. In the ninth month of “On the Move,” Bill arranged for Mary to meet a case manager, Sylvia, from the local Department of Human Services office who would eventually be in charge of her Medicaid benefits. Sylvia and Bill would work together to make sure that Mary’s transition to the Home and Community-Based Services waiver for Seniors and People with Physical Disabilities would be seamless. Mary was asked to complete an application to determine if she remains financially eligible for Medicaid. In addition, Sylvia reviewed the services and benefits Mary has received during the MFP year. If she remains financially eligible for Medicaid, she will continue to receive the same services and benefits she has been receiving. The difference will be that Bill’s relationship as Mary’s Transition Coordinator will end after 12 months and Sylvia will become Mary’s case manager. As her case
manager, she will be responsible to make sure that Mary’s care plan remains adequate to meet her needs. Sylvia will conduct a new CA/PS assessment every 12 months, or more often if there are changes in Mary’s condition. Her care plan will be modified to accommodate her needs any time a change is warranted. All the benefits Mary currently receives are available as part of Oregon’s 1915(c) waiver. (A Medicaid financial eligibility determination is conducted when there is a change to any factor and whenever eligibility for benefits becomes questionable. If Mary had income over 300% of the SSI income standard or countable resources over $2000, she would be ineligible for long-term care services. However, Mary has been Medicaid-eligible since 1996, and does not foresee a significant change in income or resources. If her financial circumstance does change, Oregon will re-determine eligibility at that time.)

**Matthew**

Matthew is a 37-year old male who sustained a traumatic brain injury in a motor vehicle accident when he was 20 years old. Matthew was a junior at Central Oregon State College. He was on a date with his girlfriend when a drunk driver slammed into the car he was driving one summer night as they were returning to their dorms from a movie. Matthew’s girlfriend was killed instantly and he was left with serious physical and mental impairments. He is a paraplegic, and suffers from deficits in memory and judgment. He has lived in nursing facilities for most of the last 17 years since he was discharged from the hospital after the accident. His parents are both deceased. He has an aunt who lives in the same city and who visits him regularly. Matthew actually lived with his aunt for a period of three years. His aunt is older with physical limitations of her own, and because Matthew suffers from occasional anger outbursts and inappropriate behavior, which his aunt could no longer manage, Matthew returned to the nursing facility five years ago, this time to Glen Forest Nursing Home.

Matthew spends most of his day in his wheelchair, usually in the common room watching television. He participates in activities offered by the facility but has difficulty completing most activities due to his impatience. He requires assistance with bathing and washing his hair and some assistance with dressing, especially dressing his lower body and with buttons and zippers. He is able to eat independently as long as his meals are prepared for him. His medications must be managed and he must be reminded to take them. He is able to independently use his wheelchair both inside and outside the nursing home. Matthew receives no therapy or other services to address his behavioral problems, as this is not a Medicaid covered service in Oregon.

As Transition Coordinator for central Oregon, Lisa had been given the names of some residents at Glen Forest who potentially could participate in the “On the Move in Oregon” project. The patients were identified from MDS data provided to the MFP project team. Lisa had contacted the Glen Forest administrator and arranged to make a general presentation of “On the Move” to their residents. Matthew, among others, attended. Lisa provided brochures and general information about the project and offered to answer any questions one-on-one, if contacted. As soon as the presentation ended, Matthew approached Lisa and told her that he was very interested in “On the Move,” that he hated Glen Forest and wanted to get out of there as soon as possible. He wanted to know if he would qualify. Lisa set up an appointment to meet with Matthew the following week.
During the next week, Lisa reviewed Matthew’s case file in the local DHS office, and confirmed that he is eligible for and receiving Medicaid benefits. She discovered that Matthew had a history of causing problems with other residents at Glen Forest, and in the nursing facilities where he had lived prior to moving in with his aunt. She noticed that case managers had tried to find alternative, less restrictive living situations for Matthew at different times over the years, but always ran into barriers in providing supports for his behavioral issues. Since moving to Glen Forest five years ago, no real effort had been made to move Matthew, in spite of the fact that his physical impairments were of the type that could have been managed in another setting. Lisa reviewed the list of available housing in central Oregon that would fall within the MFP parameters.

Lisa met with Matthew the following week. She explained “On the Move” in more detail and explained that, in order to qualify, Matthew would have to live in his own home, in a leased apartment or in a group setting of four or fewer individuals. She told Matthew that, because of his past history, she wanted to make sure that they could work together to find a living situation in which he could be successful. Lisa explained that there were few suitable housing options in the area, but that there was a small apartment complex set up to provide specialized living services for people who had suffered traumatic brain injuries. There were currently two other persons with traumatic brain injuries living there. She suggested that she take Matthew there to check it out. Matthew agreed.

Lisa called the resident manager, Muriel, to arrange a time for a visit. Muriel has an apartment on site and manages the property. She also provides care and is available 24 hours per day for emergencies. There is two other staff that each work 8-hour shifts. Muriel and the other staff have experience working with the mental health system and received training specific to acquired brain injuries before being hired for their current positions.

When Lisa and Matthew arrived, Muriel showed them the vacant apartment. The apartment is completely wheelchair-accessible. The apartment has a locking front door, and there are “call buttons” in each room and in case of emergency, staff can enter the apartment. In addition, if Matthew were to live there, he would receive the same personal care services he received in the nursing facility. His meals would be prepared by one of the staff, as there is no central dining room like in the nursing home. However, Matthew would receive skills training from staff, or from the local Independent Living Center, which could allow him to be more independent than in the past. Matthew would also receive assistance from a behavioral therapist who would develop a plan to work on his impulsiveness and anger outbursts. Transportation is available via a wheelchair van that services the area. Medical and non-medical transportation is covered under the 1915(c) Medicaid waiver.

Matthew was ready to move in that day. When they returned to Glen Forest, Lisa and Matthew had a discussion about the things that would need to be done before he could move. Lisa arranged a meeting with the nursing home administration regarding developing a plan for addressing Matthew’s needs, including but not limited to, what equipment they had been providing, and what issues surrounding Matthew’s behavior would need to be considered. As the facility had five years of experience in caring for
Matt, Lisa felt they would be able to provide a great deal of insight into what he would need in a community-based setting. A meeting was scheduled for the following week with Matt, Lisa, the nursing home administrator, an RN and a social worker. At that meeting, the nursing home staff acknowledged that Matthew’s physical needs could be taken care of in a less restrictive environment. They administer his medications and assist with bathing and dressing; however, they felt that Matthew was physically capable of doing more for himself than he is presently doing. A good deal of discussion ensued over the barriers Matthew encounters by way of aggressive and self-defeating behaviors as well as by his physical limitations. Suggestions were made, to which Matthew agreed, regarding areas where it was thought behavioral therapy could improve Matt’s abilities. In addition to Matthew’s behavioral needs, it would also be necessary to purchase a new wheelchair. He had gotten a wheelchair when his injury first occurred; however, it had worn out, and since moving to Glen Forest, the nursing home had provided a wheelchair. If he moved, he would need a wheelchair. Lisa would contact Matthew’s physician for a new prescription and then contact a DME provider for acquisition. She would also contact the resident manager to make sure the appropriate equipment (bath/transfer bench, grab bars, etc.) was installed in Matthew’s apartment.

Once the necessary equipment was ordered, Lisa worked on other needs Matthew will have. She located a primary care physician in the local community who was accepting new patients and made an appointment for Matthew to be seen prior to moving. She also located a pharmacy in the area that would deliver medications in the event Matthew could not pick them up. She and Matthew went shopping for some furniture and personal items he would need in his own apartment. She developed a “community map” that provided Matthew with a list of services and community resources in the area. She and Matthew set a tentative move date. Matthew met again with Muriel to sign a lease agreement and arranged a time when he would receive the keys to his apartment. Lisa notified the nursing facility in writing of the tentative move date. She met again with Matt to review the transition plan and to talk about some of the things that she would be available to help him with after the move, such as assistance in paying his bills for the first few times. She arranged to have cable TV and phone service installed. She and Matt went to a local bank so that he could open a new checking account.

During the first month after Matt’s move, Lisa visited every week. Matthew loved his new independence but was impatient at the “slowness” with which his skill training was progressing. Lisa talked to Muriel, who shared that Matthew’s impatience has led to several angry outbursts at the staff involved in the skills training. As a result, Muriel has recommended to Matt that he use the Independent Living Resource Center for skills training and he agreed. Lisa offered to facilitate that option with the ILR, and also to work with the behavioral therapist to develop some focused behavior interventions.

Over the next few months, Matt’s life bloomed. He liked the staff at the ILR, and the skills training progressed quickly. He expressed an interest in part-time employment. The ILR contacted Lisa who was able to use “On the Move” funds to help purchase Matt a personal computer. Lisa arranged to have Internet service installed in Matt’s apartment. They hooked Matt up with an agency named “Circles of Care” that employs people with disabilities to “virtually” check in on frail seniors living independently using computers and cell phones. Matt worked about ten hours a week for “Circles” and was
paid Oregon’s minimum wage of about nine dollars an hour. Even though Medicaid required Matt to contribute much of his earnings towards the cost of his care, he was much happier. For the first time since the summer before his junior year of college, he was able to pay his own way – at least partially.

In the ninth month of Matt’s participation in the Move project, Lisa contacted the local Area Agency on Aging office that manages the long-term care programs for people with physical disabilities in Deschutes County under contract with Oregon DHS. Lisa and Amy, the AAA case manager, arranged to meet with Matt together several times over the next few weeks. Matt was asked to complete an application to determine if she remains financially eligible for Medicaid. In addition, Amy reviewed the services and benefits Matt has received during the MFP year. As long as Matt remains financially eligible for Medicaid, he will continue to receive the same services and benefits. Amy will conduct a new CA/PS assessment every 12 months, or more often if there are changes in Matt’s condition. His care plan will be modified any time a change is warranted. Matt understood that his Medicaid benefits – both financial and acute and long-term care, would continue after the project in Oregon’s 1915(c) Home and Community-Based Services Waiver for Seniors and People with Physical Disabilities. Most important to Matt was that his employment could continue as well under Oregon’s Employed Persons with Disabilities program.

3. Adults with Developmental Disabilities

James is a 56-year-old man who has lived in an institutional setting since he was three years old. James’ records indicate that a developmental disability was present at birth. James was diagnosed as being profoundly mentally retarded and also has a diagnosis of Down’s syndrome. In 1955, his parents relinquished custody and placed him at Fairview Training Center in Salem (an ICF/MR) where he lived until 1993. James’ parents and his three siblings were encouraged to disassociate and move on with their lives.

During the 1990s, Fairview began to place most of its remaining institutionalized population into community-based programs. James’ support needs were such that community placement was not deemed appropriate for him, and he moved into the last state-run institution, Eastern Oregon Training Center (EOTC), on the other side of Oregon. For his first few years at Eastern, James moved to different residences on the campus, as the staff tried to identify a structure and roommates with whom he would be most comfortable. Eventually, the right roommates and structure were identified, and James has lived in his current residence for several years. The staff reports that he is happy most of the time, though he has the occasional outburst that results in some property destruction; most of his aggressiveness centers on food issues. Additionally, as he has aged, his vision has decreased to the point that he uses a cane to help him identify obstacles in his path.

James’ father died in 1979. His mother passed away about five years ago, and the location of his siblings is unknown. Despite these family losses, James has developed some relationships over the years. Through the efforts of the EOTC staff, he has developed a meaningful relationship with a couple that lives in the local community of
Pendleton. James goes to dinner with them each month, and he occasionally visits their home.

James has a job at Blue Mountain Community College in town where he shreds paper a few hours a day, five days a week. James enjoys his job, but has had his options limited because of his blindness. As his support team has looked at jobs that would best suit James, they identified jobs that include physical movement and allow him the ability to socialize with others.

Roger, a current EOTC employee, has been interested in the MFP Project ever since he heard last June that Oregon was awarded a grant. Roger has worked at the Training Center for 20 years and was employed in various positions over that time period. His intimate knowledge of nearly all forty residents who lived there uniquely qualified him to play a role as a project Transition Coordinator for the Training Center. Armed with the knowledge he acquired attending the On the Move in Oregon Transition Coordinator training for 5 days, Roger tackled his first task of identifying which people would have the most interest and success moving. James was one of the first people that Roger identified as a candidate for community transition.

Though James did not have contact with his natural family, he had developed relationships with people that lived in the local community over the years. Fred and Julie Howell had both worked at the Training Center years ago when James moved from Fairview. James won over their hearts with his smile and playful nature, and they began having him over to their home for holidays. Four years later, Fred moved to another job, and Julie followed suit soon after. To maintain their relationship with James, they scheduled monthly activities with him.

The other important relationship in James' life was the one he had with his housemate, Mike. Mike and James had been living in the same home for the past five years. Mike was younger and smaller than James. James was a protective “big brother”, and Mike loved the attention he received from James. They both liked to sit on the couch, eat popcorn, and watch wrestling on T.V. They both enjoyed eating at a restaurant called The Roundup and going to movies. James also liked to put his arms around Mike, press his lips against the top of the head, and blow; this always made Mike giggle.

Because James has limited verbal skills, those most acquainted with him were asked to provide some insight regarding his wants, needs, and desires at a person-centered planning meeting. As Roger worked closely with James, and his support team (Fred and Julie Howell, 2 long-term care workers that knew James best, and the facility behavior support specialist) to consider placement options for James, there were a couple absolutes! First, it must be close enough for Fred and Julie to be able to visit regularly, and second, he must live with Mike! While this limited some of the options, it did not eliminate a variety of choices. James and his team identified several people, places, and activities that were important to him. Among them was being able to go out to dinner with Fred and Julie, being able to eat whatever he wanted, working and making money, and being “the boss.” James did not say that living with Mike was important to him, though all agreed the difference in his behavior when Mike was and wasn't around indicated otherwise.
Once an initial list of *Important to James* had been drafted, James and his support team proceeded to identify those things that were *Important for James*. Regarding those things that were most important for him, there was a conflict between his desire to be able to eat without restrictions and the type of diet and monitoring that was needed to maintain his health. The team made note of this and determined they would need to work with the new service provider to ensure James’ desires could be accommodated to the extent that it would not jeopardize his health.

In this same time period, a similar process was occurring with Mike and his support team. Variations in the process were made to support Mike’s unique personal characteristics, interests, needs, and desires, but he also clearly enjoyed living with James, and his support team strongly advocated for a placement that would allow both to continue living together.

Within three weeks, Roger had three different opportunities to present to James. The first was a provider in the Portland Metro area, 200 miles away. In many ways, this agency was able to provide an ideal environment for James. They had a stellar reputation providing the type of supports needed for James, and they were also able to meet Mike’s support needs. It would, however, be difficult for Fred and Julie to stay actively involved. The second option was a small local agency in Pendleton that supported 11 people in three homes, but the provider was only able to serve James, not Mike. The third option came from another Pendleton agency. This company, larger than the other local agency, had the ability to support to both James and Mike. However, all of the supports provided by the third agency were in settings of more than four people. Since this last setting did not meet the housing eligibility for On the Move in Oregon, James’ support team rejected it.

With two viable options, the support team reconvened to talk through the pros and cons of each community placement. At that meeting, the group talked to James about those things that were most important to him. It was difficult to assess and prioritize the options because he would smile, make a type of excited vocalization and clap when options were presented to him that involved Mike or Fred and Julie. The support team, therefore, was in the position of making a difficult decision about what would be best for James—living with Mike, or having the natural support relationship offered by Fred and Julie. As James and his team evaluated the person-centered information that had been provided, the housing option in the Portland area was immediately eliminated from consideration, as it would conflict with one of the items James had identified as important to him.

This created a dilemma for the group. The only real viable option appeared to be the second option, which would mean James and Mike would be separated from one another. Reluctantly, and with the support team’s recommendation, Roger initiated the process of submitting information to the local Community Developmental Disabilities Program (CDDP).
Two days before the referral was to be submitted, Roger received a visit from a current EOTC staff person, Mary Tucker. Mary had known both James and Mike for many years. While Mary had not provided direct support to either James or Mike, she was very familiar and friendly with both and they seemed to like her. When she heard that James and Mike might be separated by the move, she investigated the possibility of certifying her home for foster care. Mary understood that she would have to resign her position at EOTC, but was committed to providing support to both men. Roger was relieved but not entirely surprised. Roger remembered how many employees chose to open foster homes to support people during the years that Fairview Training Center was closing. This proved to be a successful model as it created new provider capacity and helped to diversify support structures being provided within the provider network. Because she had been considering this option for some time, she had already gone through the initial process of certifying as a foster home provider. As a result, the only thing that remained was for a state licenser to do a home inspection—something that usually happens within 30 days of the request.

After Mary left, Roger immediately got on the phone and contacted Fred and Julie to schedule a meeting with James and the rest of the support team to discuss this new community placement option. He then sat back in his chair and breathed a deep sigh of relief. Had Mary not stepped forward, it was likely James and Mike would not have been able to live together, as the provider options in rural and frontier Oregon are extremely limited.

At the meeting to discuss the additional option, the team re-evaluated James’ person-centered plan, and determined that Mary’s foster home would be ideal. James would not have an individual lease in Mary’s home, since it was licensed as a foster home to support no more than four unrelated people, but the foster home option would allow James to keep his current job, which he enjoyed doing each day. As James was asked how he felt about being able to live close to Fred and Julie, live with Mike, and continue to work at the community college, he smiled broadly.

Once consensus had been reached, Roger proceeded to work with James and his team to identify what would need to be included in a benefits package in order to provide James the greatest chance for a successful, long-term community placement. The process did not take a great deal of time, as they were able to use the information collected in the Important to/Important for document as a foundation for the development of a benefits package. It was also clear home modifications would need to occur (grab bars in the bathroom by the toilet and bath, and a ramp with a very gradual grade), but Roger felt these could be accomplished through funds provided through the OTM Demonstration Project. Additionally, behavior support services were scheduled for 4 hours a month to allow a licensed behavior specialist to write a behavior support plan; train Mary on the plan, review on-going behavior data, and provide on-going assessment and consultation. Because James did not have a specialized diet, no nutrition services were requested. A similar process was initiated with Mike and his support system.

Soon after, Roger met with James and his team to develop a transition timeline that included a training schedule for the new foster provider and the establishment of
professional services (doctors, pharmacy, physical therapists, etc.) that would be in place the day the move occurred. He worked with the MFP housing specialist to assess needed household modifications. He worked with the local social security office to make sure James’ support check would be received without interruption of services, and he was able to find a vocational provider that would work with the community college so that James could keep his current job. Additionally, he started to develop a person-centered plan that would be given to Mary when James moved into the foster home. Prior to the move, Mary and the staff she employed, had been trained in compliance with OAR 411-360-0120, and would receive additional training to meet James’ needs as described in that plan.

Roger and Mary worked closely with James over the next several weeks to make sure he was well informed and comfortable with the move. They asked James if he would like to visit Mary’s home prior to the move, to which he said, “Yes.” Two visits were arranged. The first visit was a tour of the house to see how James felt after visiting. When all went well, a second visit was arranged, at which James and a support staff stayed for dinner. In that it had been a couple years since Mary had provided support to James, these visits also allowed her the opportunity to ask questions of the current staff and observe James interacting with a staff person in her home. Additionally, the EOTC site manager was able to rearrange Mary’s work schedule to allow her to shadow and work with James’ current staff at the institution.

The day of the move passed without incident, and James appeared very happy moving into Mary’s house. The schedule was designed so that James and Mike were able to maintain important routines with little variation. For his part, Roger made a commitment to James and Mary that he would check in at least weekly for the first month to answer any questions or address any problems that may arise. The first few weeks, the visits were brief, as the transition seemed to be flawless. In the fourth week, however, James seemed agitated when Roger arrived. When Roger queried Mary about the change in James, she reported that he had been more agitated, especially around mealtimes, and would knock chairs over as he walked into the kitchen. Mary was fearful that this trend might lead to more property destruction and questioned if she was capable of supporting James. This was behavior that had occurred at the institution for several years. Somehow, it had not been addressed in the person-centered plan. Roger contacted the behavior specialist, and together, they worked with Mary to put communication strategies into the plan that had been used by direct support workers at EOTC for several years, but had been omitted from any plan, as it had become second nature to them. Mary began implementing the communication strategies as mealtimes would approach, and James’ agitation subsided. For his part, Roger checked in with Mary daily over the next week and a half to make sure the issue was under control. After some reasonable assurance that the problem had abated, Roger discussed scaling back the visits to monthly. Mary felt confident the plan was working and did not foresee the need to continue the more intensive contact. They, therefore, arranged a schedule for monthly check-ins. Roger made sure to reemphasize his commitment to visit more often if the need arose.

Over the next several months, Roger continued to visit James and Mary. Occasionally, an issue would need to be addressed (i.e., what James was communicating with certain
gestures, or vocalizations), but Roger was available to review the person-centered plan and make adjustments to the plan that improved communication. On another occasion, the grab bar next to the bathtub broke, and Mary contacted Roger, who had a physical therapist out that week to assess and recommend a more durable grab bar—Roger had it replaced a few days later. In the meantime, the physical therapist showed Mary how to offer James support in and out of the tub in a manner that kept them both safe.

At the beginning of James’ ninth month under MFP, Roger met with the case manager to begin the process for transition into an on-going community-based waiver. Prior to his move, Roger had reviewed James' eligibility to determine if James would be eligible for waiver services at the conclusion of the MFP year. It was clear from the records that James had been diagnosed with mental retardation prior to the age of 18. Since he was now an adult, and because his care needs met the institutional level of care criteria, he would be eligible for Oregon’s 24-hr comprehensive waiver for developmental disabilities. Though it was obvious that James qualified for waivered services, Oregon’s Administrative Rules require the CDDP case manager to conduct eligibility determination (see OAR 411-320-0080 and 411-320-0170 for procedure for determining eligibility for people with Developmental Disabilities). The case manager, therefore, completed the eligibility process and determined that James was eligible for services. Finally, Roger met with James and his support team to conform and update the individual service package. He also confirmed that all the ongoing services James received during the MFP year would continue.

James and Mike celebrated the anniversary of their move into the community with Mary, Fred, and Julie over a nice meal at The Roundup. From James’ perspective, life had gone on as it had before, for the most part. Those that were important to him were still a part of his life. Roger did not attend the celebration, but as Roger reflected on the past year, he celebrated the fact that this day had come and gone and James had not detected that it was any different from any other.

4. Seniors

Norma, age 74, has been living at Three Fountains Nursing Home for the past two and a half years. Three Fountains is located in a small town in eastern Oregon. Norma was a schoolteacher there until she retired at the age of 62 and began drawing her Social Security retirement benefits and school pension. Norma has a son, Brian, who lives in Chicago. Norma lived with her boyfriend for several years. At age 68, Norma was diagnosed with breast cancer and underwent chemotherapy, radiation therapy and surgery. A year later she suffered a stroke. She recovered from the stroke with only slight residual deficits in memory and with left-sided weakness. Shortly after the stroke, her relationship with her boyfriend ended. After that, Norma lived alone in her house and found that she needed some assistance with activities of daily living. She paid a caregiver privately for that help. Because of the stroke, Norma gave Brian durable power of attorney so that he could manage her affairs should something else happen.

In 2005, Norma suffered another more severe stroke while at home and was taken to the hospital via ambulance. After several days, her doctor ordered her to be admitted to Three Fountains, a skilled nursing facility, for rehabilitation and recovery. Her recovery
was slower than projected, and after several months had passed, Norma was resigned to the fact that she was not going to be able to return home. Norma discussed with Brian the fact that it looked like she was going to be in the nursing home long-term and asked him to assist with clearing out and selling the house and her possessions, except for a few small items which he saved and brought to the nursing home. Norma appointed Brian as her legal guardian. Brian took over management of Norma’s assets from the sale of her home, paid the nursing facility every month and made sure her assets were invested soundly. Norma was basically happy with the care she received at the nursing home. She got along well with the staff and felt that most of her needs were met. She missed the independence she had when living in her own home, but since she was no longer able to drive, and needed substantial assistance with most activities of daily living, felt this was the best place for her under the circumstances. The things she missed most were visiting with her neighbors, playing pinochle with former teacher/friends, and being able to go shopping. However, she had given up on thinking that she could ever engage in these activities again, considering the state of her physical health. She now used a wheelchair or walker to get around the nursing home. Norma also had more difficulty with her memory and would occasionally be short-tempered with nursing home staff. Her doctor diagnosed her as having CVA-related dementia.

Norma had retired as a teacher feeling that her financial affairs were in order. She had a savings account, as well as enough monthly income from Social Security and her pension to live comfortably. However, she had not anticipated living in a nursing home on a long-term basis. Consequently, after two and a half years at Three Fountains, Norma’s bank account was depleted. Her monthly income was not near enough to cover the monthly payment to the nursing home. A social worker at Three Fountains suggested Norma contact the local DHS office to apply for Medicaid. Brian, as guardian, applied for Medicaid on behalf of his mother. Based on a financial eligibility determination and an assessment of her needs with regard to activities of daily living, Norma was found to be eligible for medical benefits and long-term care services. Norma paid her excess income each month to the nursing facility, and DHS paid the remainder.

The MFP project team identified Norma from MDS data as a potential participant in its new “On the Move in Oregon” project. Norma’s name was referred to the MFP Transition Coordinator (TC) in her area. The TC, Beverly, visited Norma one day at the nursing home and offered a brochure describing “On the Move” and gave her a brief overview of the program. She told Norma that if she was interested in considering alternatives to living at the nursing home she could call her. Norma read the brochure and called Brian to tell him about “On the Move.” Brian suggested that he contact the TC to discuss the program in more detail and to see if this is something that could benefit his mother. Beverly and Brian discussed the “On the Move” program, including some of the options that aren’t normally available to Medicaid clients. Brian thought that it would be a good idea for Beverly to meet with Norma and have her explain the program in more detail. Beverly made an appointment for the following week to meet Norma at the nursing home.

When Beverly met with Norma, she had reviewed Norma’s file and was prepared to discuss the options currently available to Norma. Two apartments in a senior complex in
town were available, and there was also space in a new congregate care setting for persons with dementia. She suggested that a visit to the various settings might make it easier for Norma to decide if any appealed to her. Norma said she would be interested in seeing these places and asked Beverly to set up the tour. Brian arranged to fly out from Chicago to accompany his mother.

The following week, Beverly, Brian and Norma visited the senior complex. It is a one-story building with 10 one-bedroom apartments. The doors open to the outside with walkways connecting the units and to the sidewalk in front of the building. The complex is located on a dead-end street. Although there is no mass transportation in the area, a small community bus picks up seniors weekly and takes them to local businesses as needed. The “Community Connections” bus service is provided to seniors and people with disabilities in the local area at no charge and is funded through grants and local donations to the local Area Agency on Aging. The complex has a laundry center and a small gathering room that residents can use to socialize or entertain guests. In this living situation, Norma would receive in-home services from a local provider in order to live independently and be safe.

The next visit was to Zumwalt Village, a congregate care setting specializing in caring for persons with dementia and Alzheimer’s disease. Zumwalt Village is set up to provide care to individuals who live in clusters of four individual apartments with a congregate dining room and 24/7 services provided to residents. Zumwalt Village is a new model of care for this area so that persons who are suffering from low to mid level dementia can live independently with the supports they need to remain healthy and safe. Norma was shown one of the vacant apartments and given a tour of the dining/activity room. Residents wear a badge, which identifies them to staff and allows staff to monitor their activities through infrared sensors, whether they are inside their apartments or in the communal areas. The badge also allows Norma the ability to contact staff at any time, just by pressing a button on the badge. Norma can use it to call in an emergency, or simply if she needs some assistance getting around the apartment. Staff is on site 24 hours a day.

Norma and Brian asked many questions of Beverly and of the apartment managers. At the end of the day, they returned to the nursing home. Beverly suggested they think about what they had seen and whether either of these options would be right for Norma. Norma thought that living in her own apartment with caregivers coming in was more appealing to her. Brian disagreed because he worried that she would be too vulnerable living alone. What if she had another fall or suffered another stroke when no one was around? Norma reminded him that she would have Lifeline and would be able to call for help if this situation arose. Norma also shared that she wasn’t sure she liked the idea of wearing a badge and being tracked. Brian still wasn’t so sure that living independently would work for his mother, and after touring Zumwalt and talking to some of the residents, he didn’t think the technology used was too invasive. In fact, he had heard of other places where similar technology was being used successfully. The residents he spoke to stated that they had had some concerns at first about the use of this technology, but acknowledged that they were not able to live alone any longer and that the atmosphere at Zumwalt was so friendly that they felt like they were living with family. The badges gave them confidence that if they did need help, someone would be there.
to respond. Brian told his mother that he liked the dementia care apartment because they arranged activities for the residents that not only promoted socialization, but also were effective in delaying the later-stage effects of dementia. If something did happen to Norma at Zumwalt, the hospital and nursing facility were close by. Brian flew back to Chicago that night and asked his mother to think about all the pros and cons of the options she had seen. Brian was unsure that he wanted his mother to move to either of the options he had seen. He felt secure in knowing that she was taken care of at Three Fountains, especially since he lived so far away and could not help in case of an emergency. He reminded Norma that she didn’t have to participate at all. But if she really wanted to give it a try, the On the Move program included a provision that if a community setting was not working out, she would have the option to return to the nursing home. Or, if Norma felt the assistive technology was too intrusive, he reminded her that Beverly had offered to look for another alternative.

Beverly waited a few days and then called Norma to find out if she had liked either the senior apartments or Zumwalt Village. Norma told her that she had liked the senior apartments but that Brian had liked Zumwalt Village and she couldn’t decide what to do. Beverly suggested that trial visits to both places might make it easier for her to decide if either place could be right for her. Norma agreed to this and Beverly arranged for Norma to spend the next two days at Zumwalt Village. Beverly contacted Brian to inform him of their plan and he agreed.

Norma’s visit at Zumwalt went well. Beverly made arrangements for Norma to stay in a vacant, but furnished apartment and for staff to administer her medications as prescribed. She received assistance with transferring and bathing as needed, and she took her meals in the dining room while she was there. She met one of the residents while having breakfast the first morning, and spent additional time with a resident who joined her in a craft project in which they made greeting cards. Because of Norma’s background as a teacher, she enjoyed this project. The next day, Norma went for a walk, using her walker. One of the staff accompanied her on the walk to make sure she was safe and to ensure she could find her way back. At the end of the second day, Beverly picked up Norma and took her back to the nursing home.

The following week, Norma spent a day at the senior apartment. She did not want to spend the night because there was not a suitable bed for her to sleep in and the apartment was only minimally furnished. However, she did spend a few hours in the apartment, and Beverly also accompanied her to the common room where several of the residents were involved in a card game, pinochle, which used to be one of Norma’s favorite pastimes. To her delight, Norma was asked to join. Unfortunately, Norma found it difficult to keep up with the rest of the players and felt discouraged. She spent the remainder of the time just observing, which was still fun, but not as much as being able to play.

Upon returning to Three Fountains, Beverly asked Norma if she had liked either of the places she had been. Norma said she preferred the senior apartment, and that she was going to call Brian and tell him about her experiences. Brian thought that the senior apartment was too risky a placement for his mother, given her impairments, and thought that she would be safer in the dementia care setting because of the 24/7 presence of...
staff. After some discussion, Norma agreed that it was important to her that she not be left alone and so she contacted Beverly to see about moving to Zumwalt Village. Although Brian reminded her that she didn’t have to move at all, Norma thought that living at Zumwalt Village was preferable to living at the nursing home.

Beverly met with Norma to discuss the services she would receive at Zumwalt Village. Her meals would be provided and she would receive assistance with medication management, personal care and housekeeping. Through “On the Move” she would be able to pay the security deposit required to move in, as well as to purchase some of the furnishings she would need. Norma will pay rent to Zumwalt Village, which includes utilities. In addition, she will make a contribution toward the cost of the services and benefits she will receive. Brian attended a care conference by telephone with the nursing home administrator, the director of nursing services and their director of social services, as well as with Beverly and Norma. They discussed the services and supports they had been providing and agreed upon those that Norma will need when she moves. The nursing home reviewed the supports they have provided surrounding dementia and agreed that Zumwalt staff was capable of supporting her needs in this area. Beverly arranged for a contract RN to provide training to Zumwalt staff for delegated nursing tasks.

Beverly arranged for Norma to move the following month. She notified the nursing home in writing of the pending move. She sent the informed consent form and a rental application to Brian for signature along with a list of the expenses Norma will incur for housing and for the services she will be receiving. She documented in Norma’s case file the relationship Brian had, as guardian, with his mother. During the month, Beverly worked on transferring Norma’s medical care to her primary physician’s office in town, and arranged with the local pharmacy for home delivery. She also requested that the doctor write prescriptions for a beginning supply of medications so that Norma wouldn’t run out shortly after the move. The Zumwalt staff will be managing Norma’s medication based on her physician’s orders. Norma will bring her wheelchair and walker with her. Zumwalt Village furnishes each apartment with assistive devices such as grab bars and bath benches. Since Norma was still having weekly physical therapy, she arranged to have the PT at the office in town and made arrangements for transportation to these appointments. She made arrangements for a telephone to be installed, as well as Internet service and cable TV. As Brian liked to communicate via email, he purchased a computer for Norma to have in her apartment, with the hope that it would be another way for them to keep in touch and at the same time stimulate her mental functioning. Norma had used a computer from time to time when she was teaching and lived in her own apartment. Since living in the nursing home, she has not had access to a computer. With changes in technology and her dementia, Norma told Beverly that she does not feel comfortable using a computer, but hesitated to tell Brian because she didn’t want to disappoint him. Beverly knew that the local high school required its students to perform community service as part of the requirements for participation in the National Honor Society, so Beverly arranged to have a student come to Norma’s home twice weekly for a computer “refresher course”. Norma was excited, but nervous, about this plan. Beverly interviewed a few students in order to ensure that Norma’s “computer coach” had a personality that would enhance the experience and allay
Norma’s fears. Beverly also arranged to meet weekly with Norma to see how she was adjusting to her new home.

Brian flew to Oregon to assist his mother with the actual move. She was given the keys to her new apartment and was welcomed by the Zumwalt on-site manager. Although the apartment was basically furnished, Brian provided some personal items, such as pictures and knick-knacks to make Norma feel more at home. Lisa had taken Norma out prior to the move to purchase some of the personal items she would need in her own apartment. Over the next two months, Beverly made weekly visits. As the weeks progressed, Beverly began to sense that Norma seemed depressed. Norma expressed dissatisfaction with Zumwalt Village, and stated that there was nothing for her to do except for some crafts from time to time. Although Beverly knew that there were other activities available for Norma at Zumwalt, she also recognized that Norma was choosing not to participate in those activities. Beverly remembered how excited Norma had been when visiting the senior apartments and attending the pinochle game, and suggested that she arrange transportation for Norma to go out for lunch and shopping with a couple of her former teacher/friends. Norma agreed. Beverly contacted Community Connections and arranged for a volunteer driver to pick up Norma on Friday. Norma was taken to a local restaurant where her friends met her. After lunch, they went to an adjacent gift shop. Although Norma couldn’t walk very far, even with her walker, she did find a few things to purchase for Brian’s upcoming birthday and was pleased about that.

In the ensuing months, Norma continued to adjust to life at Zumwalt Village and expressed to Beverly how happy she was to live there rather than in the nursing home. She was happy with the care she was receiving and felt comfortable participating in more of the activities at the Village as time went on. She continued to meet her friends for lunch every month or so. Her computer coach had taught her to use E-mail and she had learned to play solitaire on the computer. Beverly also kept in touch with Brian through email and phone calls, as arranged, and they kept each other informed of progress and problems encountered during the transition period and how issues were resolved. Brian was pleased with the communication level between them.

In the ninth month of participation in MFP, Beverly contacted the local Seniors and People with Disabilities office of DHS and arranged a time for Norma to meet the case manager, Susan, who would be taking over management of her medical benefits and service plan. Brian was also informed of Susan’s name, email address and phone number. In the 12th month, Brian was sent an application to renew Norma’s Medicaid benefits. This is required annually. Susan arranged a time to visit Norma at Zumwalt to conduct a CA/PS (Client Assessment and Planning System, the standard tool used by the Department to assess service needs with activities of daily living and instrumental activities of daily living) assessment. This assessment is required to be conducted no less than annually per Oregon Administrative Rule 411-015-0008. Brian and Norma were reassured as long as she is eligible for Medicaid and as long as her service needs continue, she will remain eligible for community-based waivered services under the 1915(c) waiver. Although Beverly would not be making monthly visits after the first 12 months, Susan would monitor Norma’s case to make sure her care needs were being met. Norma and Brian can contact Susan at any time and especially if any changes occur. Norma had been satisfied with the transition from Three Fountains to Zumwalt.
Village and felt secure that Beverly, and the local SPD case manager would ensure her continued health and safety.

5. **People with Dual Diagnoses**

**John**  
John is an 85 year old man who was civilly committed to the Oregon State Hospital (OSH) as a result of aggressive episodes that resulted in injury and unsafe smoking behaviors. John has been diagnosed with Bipolar Disorder and Dementia with Behavioral Disturbances and has a variety of complex medical problems that include coronary artery disease, renal insufficiency, chronic neck and shoulder pain, gastroesophageal reflux disease, enlarged prostrate, allergies, gout and colon cancer.

As a result of his Bipolar and Dementia diagnoses John has fixed delusions and grandiosity resulting in limited insight into and denial of his mental health and medical problems. Medications have not been able to reduce his psychosis. He makes sexual advances to staff, refuses medication and is verbally and physically aggressive whenever a routine or request does not mesh with his delusions or psychotic version of reality. In addition to requiring sophisticated person centered care, John also requires complex nursing and medical care since he is not a reliable reporter. The consequences of poor management of his health problems aggravate his behavioral problems.

John lived an independent life until the onset of dementia in his 80’s and has a history of social and business experiences that can be used in creative behavioral support programs. He retains his verbal language skills, and loves singing and music. His personal relationships have been severed by his severe behavioral problems.

When John leaves OSH, he will move to an adult foster home in Portland. Though grant parameters allow foster homes to serve as many as 4 residents, John will be placed in a home specially designed to serve people exiting the State Hospital with only 1 other resident. This will permit the use of a behavior support plan provided 24/7 that includes 1-1 staffing as needed and will allow for daily changes to John’s routines and care delivery. Daily RN assessments will provide close monitoring and there will be coordination with John’s physician on his medical problems, frequent medication changes and his use of PRN anxiety and pain medications. A psychiatrist will review John's medications weekly. Though a guardianship has been established to assist John with medical decision making, especially related to his recent cancer diagnoses, a strong coordinated team approach will be needed to balance John’s refusal of medications, his need for comfort care, the need for stabilization of his aggressive behaviors and the necessity of honoring John’s rights and preferences.

**Brenda**  
Brenda is a 44 year old woman who has lived in Oregon State Hospital since 2001. A drug overdose in 2001 left Brenda with a severe brain injury and a diagnosis of Personality Change secondary to Encephalopathy. She is incontinent at night, has pica, seizure disorder, unstable gait causing falls and expressive aphasia.
The barriers to placement in the community for Brenda are significant. Monthly episodes of aggression towards others and property damage have required locked seclusion. Brenda’s resistance to medications has resulted in legal orders to administer medications by IV or NG tube. Brenda removes her clothing so frequently that she now wears a special garment; she eats paper and towels and drinks excessive water (polydipsia) unless 1-1 staffing is available. Brenda is 5 feet tall and weighs 190 pounds. She seems to enjoy lots of physical activity. Her speech is limited to a few workhorse sentences that frequently include racial, ethnic and religious slurs.

Brenda’s family has maintained contact with her despite childhood and adolescent substance abuse and behavioral problems that resulted in her becoming a ward of the state. Brenda’s father is her guardian. He wants her to live in a community closer to home that would allow for more family visits.

In the community, Brenda will need weekly review of her medications by a psychiatrist or neurologist experienced in the management of both anticonvulsive and antipsychotic medicines. 24 hour nursing must be available to provide prn medications for her periods of escalations and to communicate with physicians. Provider staff will require sophisticated training in de-escalation methods and behavioral support to be able to manage her volatile and unpredictable behaviors. Staffing will need to be high to ensure that during stable periods Brenda is able to develop the social and recreational activities that she needs to better cope with the challenges of her physical condition and to prevent her from engaging in pica behaviors. Brenda needs a range of daily physical exercise and should be able to participate in intense physical activity. She needs to live alone or in a home with residents who do not react to frequent intrusions and her lack of personal boundaries.

**A.2. Benchmarks**

Oregon will measure five benchmarks, two of which are required by CMS and three that have been chosen by the State. Oregon DHS has identified five benchmarks and recognizes that it may be necessary to change or add to them before or during implementation and will include any changes in subsequent reports. Ongoing participant assessment and community reviews of the services provided will direct expenditures and reinvestment of funds. These decisions and their results will be reflected in state reporting to CMS.
Benchmark #1:
Projected number of eligible individuals in each target group to be assisted in transitioning

<table>
<thead>
<tr>
<th>Federal Fiscal Year</th>
<th>Children</th>
<th>Adults with Physical Disabilities</th>
<th>Adults with Developmental Disabilities</th>
<th>Seniors</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>12</td>
<td>40</td>
<td>40</td>
<td>20</td>
<td>112</td>
</tr>
<tr>
<td>2009</td>
<td>12</td>
<td>110</td>
<td>50</td>
<td>60</td>
<td>232</td>
</tr>
<tr>
<td>2010</td>
<td>12</td>
<td>150</td>
<td>55</td>
<td>80</td>
<td>297</td>
</tr>
<tr>
<td>2011</td>
<td>4</td>
<td>200</td>
<td>55</td>
<td>260</td>
<td>359</td>
</tr>
</tbody>
</table>

Oregon has increased its estimates of the numbers of people who will choose to transition from nursing facilities since its’ grant application was initially submitted in October 2006. The increased estimate is a result of extensive analysis of MDS data, data on Medicaid nursing facility residents from Oregon Client Assessment and Planning System (CA/PS) and demographic and statistical trending of changes in Oregon’s long-term care system over the past ten years. The results of this analysis, when combined with the state’s long history of community-based care, strongly suggest to Oregon that many of the adults with physical disabilities and the adults with developmental disabilities who currently reside in Oregon nursing facilities live there not because of a need for the round-the-clock supports and nursing care provided by nursing homes but instead due to a lack of appropriate community care. Oregon will create the needed community care settings using resources available through the On the Move project.

Each group, including children, will be tracked separately.

Benchmark #2:
Qualified expenditures for Home and Community-Based Services.

Oregon currently provides home and community-based services to seniors and people with physical and developmental disabilities through three different 1915(c) waivers and a section 1915(j) state plan service option\(^2\), and through the State Plan Personal Care option. Qualified home and community-based service expenditures in these 5 programs exceeded $640 million in the most recent waiver/program year, and are detailed in Appendix 13.

<table>
<thead>
<tr>
<th>Federal Fiscal Year</th>
<th>Total across Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>$682,779,885</td>
</tr>
<tr>
<td>2009</td>
<td>$730,574,477</td>
</tr>
</tbody>
</table>

\(^1\) 38 of these adults live at Eastern Oregon Training Center; the remaining 162 live in Oregon nursing facilities.

\(^2\) Before January 1, 2008, self-directed services under the 1915(j) State Plan service option were provided through Oregon’s Independent Choices program, a Section 1115 demonstration program.
### Benchmark #3

No more than 5% of all participants will revert to long-term (30 days or more) institutional care during the 12-month period of MFP participation.

<table>
<thead>
<tr>
<th>Federal Fiscal Year</th>
<th>Maximum number reverting to institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>6</td>
</tr>
<tr>
<td>2009</td>
<td>12</td>
</tr>
<tr>
<td>2010</td>
<td>15</td>
</tr>
<tr>
<td>2011</td>
<td>17</td>
</tr>
</tbody>
</table>

Oregon’s 5% target is based on experience relocating people from institutional to community-based care. Oregon’s historical experience extends to seniors, people with physical disabilities and people with developmental disabilities; since 2005, the state has also engaged in relocation activities with children in nursing facilities. Analysis of data available suggests a reversion rate of about 10%, dependent on the population and the circumstances of the relocation. Oregon aims at a reversion rate of no more than 5% in the On the Move project to demonstrate the efficacy of the increased resources available to participants in OTM, as opposed to more traditional resources available through current Home and Community-Based waivers. We also plan to demonstrate the value of Transition Coordination services and more frequent contacts with project participants then are common in the 1915(c) waivers.

Data will be updated and maintained in the OTM database. Participants will be individually tracked throughout their OTM year; a participant “succeeds” for benchmark purposes if he or she returns to the institution for no more than 30 consecutive days during the 365-day year. Data will be aggregated and reported to CMS every six months as part of the Semi-Annual Web Based Report.

Please note that the participant numbers above are for illustrative purposes only based on Oregon’s modeling assumptions of even monthly transitions during the federal fiscal year. The actual 5% benchmark will be based on actual participant transitions during the year.

### Benchmark #4

90 percent of all respondents will demonstrate an increase in their “Choice and Control” scores from the baseline survey first follow-up delivery.

<table>
<thead>
<tr>
<th>Federal Fiscal Year</th>
<th>Number demonstrating increase in “Choice and Control” cumulative scores from baseline survey to initial follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Quality of Life surveys will be administered to OTM participants three times – immediately prior to institutional discharge (baseline), about 12 months after discharge (first follow-up) and about 24 months after discharge (second follow-up). The “Choice and Control” module of the survey asks, in questions 6 through 12, about participants’ ability to make everyday choices. A cumulative score for answers to questions 6 through 12 will be calculated for each participant at baseline administration, at the first follow-up and at second follow-up. Calculation of the benchmark will be based on a predicted absolute difference between the two survey results (post 1 – pre) = change in choice in control.

Please note that the participant numbers above are for illustrative purposes only based on Oregon’s modeling assumptions of even monthly transitions during the federal fiscal year. The actual 90% benchmark will be based on actual participant transitions during the year.

**Benchmark #5**
The availability of “one-time” transition services, including housing services for OTM participants will contribute to an increase in the number of public housing units developed specific to the needs of seniors and people with disabilities.

<table>
<thead>
<tr>
<th>Federal Fiscal Year</th>
<th>Additional housing units developed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>20</td>
</tr>
<tr>
<td>2009</td>
<td>50</td>
</tr>
<tr>
<td>2010</td>
<td>75</td>
</tr>
<tr>
<td>2011</td>
<td>100</td>
</tr>
</tbody>
</table>

There are fewer than 67,000 subsidized housing units in Oregon. Over 75% of these units are located in the Portland metropolitan area and South along the I-5 corridor to Eugene. Five of the seven fastest growing counties in the state are far outside this area. Out of the total of subsidized units, less than 10% are specifically designated for seniors or people with disabilities and less than half of these units are accessible. Appropriate and affordable housing is needed throughout the state but particularly in the Eastern 2/3 of the state and South of Eugene and along the Pacific coast. “On the Move” funding will allow Oregon to work towards development of affordable and accessible housing for seniors and people with disabilities in a number of ways. This benchmark is intended to track the success of the state’s partnership and advocacy efforts to promote the development of accessible housing units as a part of projects funded with independent funding streams.

Refer to Addendum A: Benchmarks pages 95 to 98.
B. Implementation Policies and Procedures

B.1. Participant Recruitment and Enrollment

1. Transition coordinators
In discussions with issue planning groups, Oregon identified the need for dedicated MFP Project Transition Coordinators. Transition Coordinators will play a crucial role in Oregon’s MFP Project, acting as agents of change for potential participants to facilitate and monitor the move from the institution back to the community. Transition coordinators will perform the following tasks:

1. Meet with potential MFP participants and their families to explain program and concepts.
2. In conjunction with local Seniors and People with Disabilities/Area Agency on Aging management and County Developmental Disability Program managers, explain MFP program to nursing facility administrators and staff. Establish agreements for communicating timelines, should an individual choose to participate in MFP demonstration.
3. Complete all needed assessments and service plans.
   a. Verify that participant will have lived in a nursing facility for 6 months or longer at estimated transition date.
   b. Work with local eligibility staff to establish Medicaid financial eligibility.
   c. Work with local case management staff to establish/update Medicaid functional eligibility (CA/PS assessment).
   d. Work with participant, family, significant others involved with person to develop other person-centered plans, like an Essential Lifestyles Plan (ELP).
4. Set up process for communication with participant, family and/or guardian, significant others, and Nursing Facility that develops on-going timeline to transition period.
5. Develop individual housing option(s) for MFP participant.
6. Assist participant with choice of housing option and choice of roommate, if applicable.
   a. Arrange for trial visit(s) if desired.
7. Assist participant with arrangements necessary to allow the participant to move.
   a. Coordinate professional services needed for environmental needs assessment.
   b. Activity of Daily Living (ADL) related.
      i. Specialized medical equipment.
      ii. Assistive technology.
      iii. Work with local office staff to contract for needed modifications and equipment.
      iv. Authorize payment for completed work.
   c. Housing payment arrangements.
      i. Security deposits.
      ii. Utility deposits and installation fees.
      iii. Work with local office to ensure on-going housing payments.
   d. Household set-up.
      i. Arrange for cleaning as needed.
ii. Arrange for participant’s property to move from facility/other sites.
iii. Arrange for purchase of additional household goods and furnishings as needed.
iv. Arrange for basic food stocking as needed.
e. Services and supports.
   i. Use CA/PS and person centered planning tools to develop benefit package.
   ii. Work with participant, family, others and provider(s) to develop individual service package.
   iii. Coordinate professional services needed outside of service/benefit package (e.g. primary care physician).
   iv. Coordinate existing supplemental community services (e.g. on-going utility assistance).
   v. Ensure that appropriate services are in place prior to move date.
   vi. Coordinate initial transportation arrangements.

8. Help participant move.
9. Assist with transition.
   a. Check in with participant, as participant desires but not less frequently than weekly during month 1 and monthly during months 2 through 12.
   b. Evaluate services provided for appropriateness, intensity and adequacy at monthly intervals, and work with participant and families to adjust as needed.
   c. Assist participant with problem solving.
   d. Assist participant with vocational supports if desired.
   e. Assist participant with community inclusion activities if desired.
   f. Assist provider with problem solving.
   g. Assess provider needs.
10. No later than month 9 of MFP year.
   a. Begin planning process for transition to on-going home and community-based services.
      i. Work with local office (SPD/ AAA/DD) to determine appropriate waiver for transition.
      ii. Update CA/PS and person centered plan in conjunction with local staff.
      iii. Update individual service package to conform to updated needs and 1915(c) available benefit package.
      iv. Enroll participant in 1915(c) waiver as required. Enrollment must be effective no later than 366 days after enrollment in MFP.

As part of the duties above, transition coordinators will also be responsible to assess those barriers that exist that may prevent an otherwise willing and eligible participant from successfully transitioning to the community. They will report about barriers to MFP staff, and they will work with MFP staff, policy teams and/or resource developers to recommend and implement strategies to minimize the barriers.

Transition coordinators will report to local SPD/AAA managers or to the SPD Office of Developmental Disability Services and will have a “dotted line” reporting relationship with SPD’s Money Follows the Person Project Team. They are stationed throughout Oregon in local communities. In addition to the knowledge, skills and abilities expected
of state and Area Agency on Aging case managers\textsuperscript{3}, Transition Coordinators would need to demonstrate excellent communication skills and independent decision-making ability. Preference in hiring will be given to individuals already employed by the state or its partners as human services case managers.

In addition to extensive training currently available for human service case managers, the MFP Project Team will conduct a multi-day orientation for each group of transition coordinators as hired. Content is still under discussion but will likely include:

**Day 1 (Monday 1:00 p.m.- 5:00 p.m.): MFP 101**
- Introductions — getting to know you
- Define Money Follows the Person — Why MFP?
  - MFP Structure/Roles
- Defining job duties
  - Role of Transition Coordinator (review TC job description)
- Nursing Facility Structure
- Understanding population and structure differences between seniors, people with physical disabilities and people with developmental disabilities

**Day 2 (8:00 a.m.- 5:00 p.m.): Transition Planning (Assessments and Supports)**
- Informed consent
  - Working with guardians and conservators
- Facilitating effective transition plans
- Assessments
  - Overview of MDS Document
  - Understanding CA/PS assessment
    - Participant identification
    - Eligibility/Appropriateness
  - Using person-centered planning tools to aid with transition
    - Important to/Important for, ELP, Community mapping, etc.

**Day 3 (8:00 a.m.- 5:00 p.m.): Designing MFP supports**
- Identifying and setting up services that enhance self-direction
  - Health Services
  - Social Supports
  - Transportation
  - Volunteering/Employment
  - Advocacy
  - Financial Resources
- Identifying Other Supports
  - Mental Health/Addiction
  - Roles of Families and Friends
  - Social/Faith/Recreation
  - Community Integration
- Housing
  - Qualified residences

\textsuperscript{3} State of Oregon class specifications for case managers are found in Appendix 2 of this Protocol.
Reasonable accommodation
- Finding housing
  - Different housing public programs/resources
  - How to apply and documents needed
  - Developing relationships with local housing authorities
- Utilizing one time expenses

Day 4 (8:00 a.m. - 5:00 p.m.): Living in the Community
- Designing an MFP Benefit Package
  - Provider networks
  - Services available
    - Using assistive technology
  - Billing and reimbursement
- Quality of Life Survey
- Transfer trauma
- Post transition follow up (weekly, monthly visits)
- Community integration
- Monitoring and advocacy
- Follow-up schedules and checklists
- Transition and on-going services

Day 5 (8:00 a.m. - 1:00 p.m.): Establishing methods/strategies for on-going communication

Additional mandatory training content areas will include:
- CA/PS Training
- Community Building
- Transition from MFP to waiver services
- Using DHS eligibility and case management system screens
- Using MFP specific forms and reporting systems

Communication patterns will be created to ensure that MFP project staff and Transition Coordinators stay on the “same page” in regards to participant issues and that project decisions are made consistently throughout Oregon. These will include regular weekly briefings via videoconference: monthly in-person team meetings and electronic group issue discussions.

2. Eligibility Screening

Financial Eligibility Criteria
All participants in the Money Follows the Person project must meet Oregon’s financial eligibility for Medicaid long-term care services, which is 300 percent of the SSI Federal Benefit Rate. Eligibility staff in the local office will determine financial eligibility. All participants will need to be financially eligible for at least one month prior to the date of transition.

Functional Eligibility Criteria
Functional eligibility criteria for the project will be the same as that used for other Oregon long-term care consumers. Oregon ranks persons into priority levels one (1)
through thirteen (13) based on their needs for assistance in six activities of daily living. Functional reassessments are completed not less frequently than annually. Functional eligibility will be determined by case management staff in the local office working in conjunction with Project Transition Coordinators. All participants will need to be functionally eligible for at least one month prior to the date of transition.

*Eligibility for Community-Based Care Services after MFP*

Project participants must be eligible to receive nursing facility or community-based services under the same criteria as other Oregon consumers. All adults who transition are ages 18 or older; eligible for Title XIX; must be documented as eligible for services through the Home and Community-Based Services waiver(s) or the 1915(j) State Plan service. Seniors and people with physical disabilities must meet the functional impairment level within the service priority level; people with developmental disabilities must meet eligibility requirements for Mental Retardation and other Developmental Disabilities set forth in Oregon Administrative Rule and meet the need for Title XIX Level of Care in an ICF/MR. Children are eligible if they meet the criteria required under Oregon’s Medically Involved Waiver.

*Six months residency*

Transition coordinators will examine institutional admission records to verify that the participant will have lived in an institution at least six months prior to the date of transition. Verification notes will be documented in the participant’s record.

3. **Transition tools**

Transition coordinators will utilize a variety of tools to assess a person’s appropriateness for transition.

Each coordinator will first be supplied with information about potential participants that “On the Move” staff has identified through data analysis and case management records review. They will use this information only for introductory purposes, as an initial guide to people who may be well served through the project. Residents may also be referred to the project, or may self-identify as wanting to participate in the On the Move project.

Every Medicaid nursing facility resident in Oregon has a comprehensive assessment using Oregon’s Client Assessment and Planning System (CA/PS tool). This CMS-approved tool sets the functional eligibility for nursing facility and Home and Community-Based waiver services in Oregon’s long-term care system for seniors and people with physical disabilities\(^4\). This assessment documents a person’s abilities and

\(^4\) Individuals must be assessed as meeting at least one of the following priority levels as defined in OAR 411-015-0010:

1. Requires Full Assistance in Mobility, Eating, Elimination, and Cognition.
2. Requires Full Assistance in Mobility, Eating, and Cognition.
3. Requires Full Assistance in Mobility, or Cognition, or Eating.
4. Requires Full Assistance in Elimination.
5. Requires Substantial Assistance with Mobility, Assistance with Elimination and Assistance with Eating.
6. Requires Substantial Assistance with Mobility and Assistance with Eating.
7. Requires Substantial Assistance with Mobility and Assistance with Elimination.
8. Requires Minimal Assistance with Mobility and Assistance with Eating and Elimination.
10. Requires Substantial Assistance with Mobility.
limitations in areas of activities of daily living (ADL) and instrumental activities of daily living (IADL). It also collects information about living environments, personal characteristics and preferences, treatments and general health history. Using a programmed algorithm, CA/PS then calculates an individual's priority for receiving services based upon the degree of assistance an applicant requires with specific activities of daily living. This assessment tool is used to determine eligibility that an individual meets a “nursing facility level of care”, the marker that makes a person eligible to receive home and community-based waivered services as well. Though the name “service priority levels” suggest a hierarchy of services based on a level of need, that's not the case. All individuals who are assessed to meet a “nursing facility level of care” are eligible for all services offered through the 1915(c) waiver. In other words, people assessed at service priority level 13 are eligible for the same set of services as people assessed at service priority level 1. Differences in scope, intensity and volume of authorized services are based on the individual's needs and supports. Case managers complete the initial level of care assessment and subsequent annual (at minimum) re-assessments with individuals present and participating as much as possible. The case manager uses a laptop to directly record an individual’s responses during the assessment, while being guided to collect additional information by triggers built into the system. The flexibility of the laptop computer also allows the case manager to conduct an assessment in the individual's home, solicit and record individual insights and preferences throughout the assessment, and include direct observations in the assessment information. Case managers upload the assessment and updates to the SPD central database upon return to the local office. Assessments are required to be updated at least annually. Transition coordinators will be instructed that any CA/PS assessment for a potential participant that is more than six months old must be updated; they will be allowed to exercise professional judgment as to the need to update more recent CA/PS assessments. CA/PS assessments will also be completed for “On the Move” participants who live at the Eastern Oregon Training Center. For these participants, the CA/PS will be used as a common basis to assess needs for assistance with activities of daily living, and ability to self-perform instrumental activities of daily living. Other person-centered tools, like the “Important to Important for” tool and community mapping will be used in a support team environment to help determine a fuller picture of the resident’s need for supports.

Person-centered planning tools that will be used include:

- Essential Life Style Planning tool - Essential lifestyle planning is a guided process for learning how someone wants to live and for developing a plan to help make it happen. It’s also
  - A snapshot of how someone wants to live today, serving as a blueprint for how to support someone tomorrow;
  - A way of organizing and communicating what is important to an individual in “user friendly,” plain language;

(11) Requires Minimal Assistance with Mobility and Assistance with Elimination.
(12) Requires Minimal Assistance with Mobility and Assistance with Eating.
(13) Requires Assistance with Elimination.

Adapted from an article by Michael Smull and Susan Burke Harrison
A flexible process that can be used in combination with other person centered planning techniques; and,
A way of making sure that the person is heard, regardless of the severity of his or her disability.

Essential lifestyle plans are developed through a process of asking and listening. The best essential lifestyle plans reflect the balances between competing desires, needs, choice and safety.

- Community mapping tool: Community mapping is an asset-based tool that begins with the assumption that our communities are resource rich. It takes an inside-out approach by first focusing on the gifts, talents, interests, and contributions of each individual and how those individual assets contribute to the building of communities. Community mapping is relationship-centered and develops a unique community landscape that creates interplay between the individual, citizen associations and congregations (churches, clubs, and other informally organized groups), businesses, schools, hospitals, local not-for-profits, places of gathering, and local economic drivers that are also critical to the health and safety of an individual. The purpose of the community map is two-fold: First, and most importantly, to recognize that people need an opportunity to contribute their unique gifts and talents. Identifying associations and congregations that need people with specific skills is a critical step. Second, making people aware of institutional resources that support community well-being. A community map provides the person an introduction to their community and serves as a key to community access that is a critical health determinant.

4. Participant rights and responsibilities

Transition Coordinators will meet face-to-face with the potential participant (and their guardian, if one exists) to review all aspects of the demonstration and assess interest in MFP demonstration. The following information will be included in conversation:
- Process for enrollment
- Eligibility criteria
- Process for transition planning
- Community service options
- Ongoing support beyond the first year
- Rights and responsibilities and appeals process

Written material explaining MFP and a copy of the informed consent document will be left with the potential participant and/or guardian to review. All written materials will meet DHS communication standards. They will be written in written in easily understandable (6th grade) language. Alternative formats are available on request, as are translation resources. Transition coordinators will offer to discuss any questions that arise and establish method for on-going communication (phone, email, mail, face-to-face, etc.).

People who decide to participate in the MFP project must sign the informed consent document after discussion of the terms of the document with the Transition Coordinator.

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6 In Oregon’s project, an adult is presumed legally competent unless there is a holding, as decided by a court, of functional incapacity to meet needs of daily living without which perilous physical injury or illness is likely to occur.
It is expected that every individual with mental retardation or a developmental disability participate actively and have the opportunity for program requirements to be explained to them in a manner that maximizes their comprehensive abilities. In that there is such a wide range of support needed to ensure informed consent for a person with MR/DD, it is difficult to outline a specific approach. Each person is unique and the approach will need to be person-centered. To avoid error or manipulation, On the Move in Oregon (OTM) Transition Coordinators will request participation of a third-party person with the most intimate understanding of the potential participants preferred form of communication as well as their stated interests (through verbal or non-verbal forms of communication). If able, the potential participant will identify the third-party person they wish to assist them. In the event the person is unable to identify the most appropriate third party, members of the individual’s Interdisciplinary Team (IDT) (consisting of current program staff, family, friends, and other relevant professionals). In the event the potential participant has a legal guardian, and the identified guardian meets the guardianship qualifications set forth in Oregon Revised Statute, the OTM Transition Coordinator will involve the legal guardian in all conversations and decisions regarding participation in the program.

5. Re-enrollment after institutionalization
Re-enrollment into “On the Move” will be automatic after any short-term (less than 30 calendar day) re-institutionalization in the nursing facility or ICF/MR.

In accordance with CMS instruction, participants who have been re-institutionalized in the nursing facility or ICF/MR will initially be considered as disenrolled from the “On the Move” project. Review of the disenrollment will be automatic. The former participant’s care plan that existed immediately prior to re-institutionalization will be examined by a cross-disciplinary team, including Transition Coordinators who have not previously worked with the participant, MFP Central Office Staff, subject matter experts from the Home and Community-Based Services waivers units and the SPD Medical Director. The examination will attempt to discover if the re-institutionalization resulted from a change in the participant’s health and functional status or from a deficit in a needed support under the “On the Move” project. The team will also recommend supports needed to allow the participant to succeed in “On the Move.” The Transition Coordinator assigned to the participant will offer re-enrollment based on team recommendations and the availability of the needed support. All re-enrollment review and decision processes will be documented on the participant’s record.

6. Project rollout
Rollout of Oregon’s “On the Move” project will be staged geographically, based on targeted population needs, availability of other community-based resources and local interest and support. While the initial roll-out plan looks at capacity development for people with targeted needs (i.e. adults with physical disabilities with obesity concerns), other members of the population without the targeted need set will also be eligible for transition.
The tentative rollout schedule for the second quarter 2008 through June 30, 2009, is displayed below.

<table>
<thead>
<tr>
<th>Population</th>
<th>Location</th>
<th>Number to transition</th>
<th>Start date anticipated</th>
<th>Services after MFP year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with developmental disabilities in ICF/MR</td>
<td>Rural – Umatilla County</td>
<td>17</td>
<td>4/1/2008</td>
<td>Comprehensive Services Waiver for People with Developmental Disabilities</td>
</tr>
<tr>
<td>Adults with developmental disabilities in Nursing Facilities</td>
<td>Urban – Multnomah and Lane counties</td>
<td>45</td>
<td>4/1/2008</td>
<td>Comprehensive Services Waiver for People with Developmental Disabilities</td>
</tr>
<tr>
<td>Seniors – dementia related needs</td>
<td>Frontier – Union, Baker, Wallowa, Grant, Malheur and Harney counties</td>
<td>30</td>
<td>4/1/2008</td>
<td>Home and Community-Based Services Waiver for Seniors and People with Physical Disabilities</td>
</tr>
<tr>
<td>Adults with physical needs – obesity related needs</td>
<td>Rural – Jackson, Josephine, Coos and Curry counties</td>
<td>20</td>
<td>4/1/2008</td>
<td>Home and Community-Based Services Waiver for Seniors and People with Physical Disabilities</td>
</tr>
<tr>
<td>Seniors and people with physical disabilities – brain injury related needs</td>
<td>Rural and frontier – Sherman, Wasco, Jefferson, Crook, Deschutes, Klamath and Lake counties</td>
<td>50</td>
<td>10/1/2008</td>
<td>Home and Community-Based Services Waiver for Seniors and People with Physical Disabilities</td>
</tr>
<tr>
<td>Adults with physical needs – obesity related needs</td>
<td>Urban and rural – Marion, Polk and Yamhill counties</td>
<td>20</td>
<td>10/1/2008</td>
<td>Home and Community-Based Services Waiver for Seniors and People with Physical Disabilities</td>
</tr>
<tr>
<td>Seniors and people with physical disabilities – behavioral support related needs</td>
<td>Urban and rural – Douglas, Lane, Linn, Marion, Washington, Clackamas and Multnomah counties</td>
<td>60</td>
<td>10/1/2008</td>
<td>Home and Community-Based Services Waiver for Seniors and People with Physical Disabilities</td>
</tr>
</tbody>
</table>

From July 2009 through September 2011, the project rollout will continue statewide.
7. Draft brochures
Proposed draft brochures, describing the “On the Move in Oregon” project for potential participants and for family members, are attached in Appendix 3 of this Protocol. These have been supplied as samples of written materials that will be available to potential participants, families, guardians, and other potential stakeholders. Additional materials are being developed that address each of the populations and will be supplied for CMS review prior to distribution.

Refer to Addendum A: Participation Recruitment and Enrollment pages 99 and 100.

B.2. Informed Consent and Guardianship

The informed consent procedures that will be used in the Oregon MFP Project were developed through consultation with stakeholders representing consumers and family members of seniors, people with physical disabilities and people with developmental disabilities. As described in Section B.1.4 above, Transition Coordinators will include information about participant rights and responsibilities in their first face-to-face meeting with the potential participant. An affirmative decision by a potential participant to enroll in the project will require execution of the informed consent form before actual enrollment. Prior to that execution, the Transition Coordinator will explain the meaning of each statement to the potential participant and affirm that they understand requirements and risks. The contents of the informed consent form include:

a. Information about the details of the project demonstration.
b. Benefits of participating in demonstration.
c. Information regarding long-term (waiver) options at conclusion of MFP year.
d. Potential risks of participating, including the risk that all services may not be available at conclusion of MFP year, if applicable.
e. Statement that information regarding participant will not be part of any research project.
f. Confidentiality.
g. Voluntary withdrawal from project, including an explanation of what will occur as a result of withdrawal.
h. Complaint/appeal process.
i. Consent.
j. Option to decline.

The form itself is included as Appendix 4 to this Protocol.

If a legally sufficient guardianship relationship exists\(^7\), the guardian must consent to project participation in order for a person to participate in the MFP project. The

\(^7\)For the purpose of the MFP Demonstration Project only full and in some instances limited guardianship will be considered legally sufficient. Any potential participant with a temporary guardian will not be eligible for participation while the temporary guardianship is in effect. Oregon Revised Statutes limit temporary guardianship to 30 days, but allow one additional 30-day extension. It may be used in an emergency medical or
Transition Coordinator will involve the participant as fully as possible, encouraging his/her input regarding individual preferences, needs, and provisions for transition. The Transition Coordinator will explain to the guardian that their participation in and cooperation with the transition process is essential and active participation is expected.

Transition coordinators will determine the frequency and intensity of guardianship involvement through conversations with the institution/nursing facility staff and administration: resident file review and discussions with other parties involved with the potential participant. Coordinators will document both the type of guardianship relationship that exists and the type and frequency of the guardian’s interaction with the potential participant over the past six months in the participant record. If the guardian is not maintaining the frequency and intensity of contact required under Oregon laws, a referral will be made to the appropriate regulatory body. While Oregon law does not specifically prohibit nursing facility administrators from serving as resident guardians, the Executive Director of the Board of Nursing Home Administrators states that she believes that the Board would view such a guardianship as a conflict of interest on the part of a facility administrator.

35 to 40 of the potential project participants are residents of the state’s ICF/MR – the Eastern Oregon Training Center (EOTC). Only two residents have guardians; all others are under the custody of the superintendent under Oregon Revised Statute 179.360 (attached as Appendix 5). All residents will participate in providing informed consent to the highest degree possible. When the person’s comprehension restricts their ability to fully consent to MFP participation, an individual’s person-centered planning team will meet to review any proposed placement and communicate any potential concerns to the Deputy Superintendent. The person-centered planning team will typically include the resident, people that the resident has identified as important to them, direct-care staff who know the resident well, the EOTC behavioral support specialist and the transition coordinator. Family members will also participate if they wish, even if no longer legal guardians of the resident. It is expected that residents of EOTC participate actively in this process in a manner that maximizes their comprehensive abilities. In that there is such a wide range of support needed to ensure participation, it is difficult to outline a specific approach. Each person is unique and the approach will need to be person-centered.

If the team finds the placement to be appropriate, its recommendation that the person participate in MFP is presented to the Disposition Board. The Disposition Board, required by Oregon Administrative Rule, is an “administrative, clinical, and community consumer body appointed by the Superintendent to assess the release and/or discharge plans of residents.” The Board will review the recommendation; approve or disapprove, and provide its recommendation to the superintendent. The superintendent...
will then approve or disapprove the recommendation of the Disposition Board. If MFP participation is approved, the superintendent will execute the informed consent document on the participant’s behalf and will provide the form to the Transition Coordinator. The Coordinator will work with EOTC staff to send a notice of facility discharge letter to the individual and their guardian or family as soon as MFP participation is approved. In all cases, notice will be provided at least 15 days before the proposed discharge date along with information pertinent to the MFP project. If the Disposition Board disapproves the recommendation of the person-centered planning team, and the superintendent agrees with the Board disapproval, direction will be provided to the team about mitigations that need to be made to the person-centered plan that would allow that would allow the Disposition Board to recommend its approval.

If a guardianship exists, a written communication plan between the guardian and the Transition Coordinator will be developed to outline communication processes and frequency during the transition period. As the participant moves to on-going home and community-based services after the transition year, a further extension of that plan will be developed between the case manager and the guardian.

The Oregon Department of Human Services, Seniors and People with Disabilities Division, will receive and review all critical incident reports; respond to problems concerning critical events or incidents and will investigate consumer complaints regarding violation of their rights throughout the Money Follows the Person project.

B.3 Outreach, Marketing and Education

“On the Move in Oregon” has conducted several outreach sessions during the development of this Operational Protocol and plans more sessions in the months ahead. A list of meetings to date, and currently anticipated activities follows.

Informational Meetings:

Service Providers:

| 7/19/2007 | 7/20/2007 |
| 8/13/2007 | 8/14/2007 |

Housing Providers and Agencies:

| 1/9/2008 | 1/22/2008 |
| 1/30/2008 | 2/7/2008 |
Assistive Technology:

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Transportation:

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<td>4/16/2008</td>
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<tr>
<td>6/18/2008</td>
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Advisory Councils:

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<td>1/15/2008</td>
</tr>
<tr>
<td>1/25/2008</td>
<td>2/7/2008</td>
</tr>
</tbody>
</table>

Presentation materials used by project staff through January 22, 2008 are attached in Appendix 69. Project staff plans focused outreach visits during February and March to those areas in which “On the Move” will be rolled out first. In most cases, the first point of contact will be the management of the local Seniors and People with Disabilities/Area Agency on Aging office that manages the provision of long-term care services in that area. Local managers will assist project staff with meeting local nursing facility administrators and staff, housing providers, elected officials and consumer advisory councils.

The Oregon Department of Human Services website will contain a link to a site dedicated to Oregon’s “On the Move” project. A dedicated “800” line will direct callers to “On the Move” project staff.

Detailed training plans for Transition Coordinators are described in section B.1.1. of this Protocol. Information about the program will be disseminated to SPD/AAA office staff and management in late March 2008, using DHS communication vehicles and interactive “NetLink” trainings.

**B.4. Stakeholder Involvement**

In keeping with Oregon’s history of stakeholder-driven development of services for seniors and people with disabilities, a large number of people, representing a variety of interests, have participated in the design of the Operational Protocol and will continue to collaborate with the state in the implementation of the MFP Project.

In the past six months, MFP Issue Groups have met every other week with MFP project staff to design the program that Oregon proposes to implement. The invitation to

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9 All presentation materials are updates as dates change.
participate in Issue Groups was broadly circulated to SPD partners, including advocacy groups, nursing facility and community-based services providers, worker organizations, consumers and their families, state agencies and local government agencies. Participants self-selected; no participant was refused. In some cases, SPD extended additional invitations to groups or individuals who had not self-selected to help ensure that all sides of an issue were heard at the table.

The “Participant Selection” Issue group helped MFP project staff work through decisions about identification of potential participants, project rollout, informed consent and guardianship and education and outreach. People who participated in this group represented the following:

- Community Providers Association of Oregon
- Consumers
- Consumer advocates
- Eastern Oregon Training Center
- Family members
- Garten Services
- Governor’s Commission on Senior Services
- Multnomah County Aging and Disability Services Division (an Area Agency on Aging (AAA))
- Northwest Senior and Disability Services (AAA)
- Office of the Long-Term Care Ombudsman
- Oregon Developmental Disabilities Commission
- Oregon Health Care Association
- Providence Child Center

The “Benefits and Services” Issue group helped MFP project staff work through decisions about identification of qualified residences, service packages, 24-hour backup systems and care continuity. People who participated in this group represented the following:

- Cedar Sinai Park
- Coalition for Healthy Oregon
- Community Providers Association of Oregon
- Consumers
- Consumer advocates
- Eastern Oregon Training Center
- Family members
- Garten Services
- Governor’s Commission on Senior Services
- Lane Council of Governments (AAA)
- Lane County Mental Health and Development Disability Services
- Multnomah County Aging and Disability Services Division (an Area Agency on Aging (AAA))
- Northwest Senior and Disability Services (AAA)
- Office of the Long-Term Care Ombudsman
- Oregon Cascades West Council of Governments (AAA)
Oregon Developmental Disabilities Commission
Oregon Health Care Association
Oregon Home Care Commission
Oregon Rehabilitation Association
Oregon Technical Assistance Corporation
Partnerships in Community Living, Inc.
Providence Child Center
Providence Benedictine Nursing Center
Service Employees International Union
State Independent Living Council

A “Quality” Issues group has met twice to discuss MFP quality management requirements and the quality management systems that exist under Oregon’s 1915(c) waivers. The group will continue to meet monthly at least through the 2008 calendar year. People who participated in the group represent:
- Consumers
- Consumer advocates
- Family members
- Lane County Mental Health and Development Disability Services
- Multnomah County Aging and Disability Services Division (an Area Agency on Aging (AAA))
- Northwest Senior and Disability Services (AAA)
- Office of the Long-Term Care Ombudsman
- Oregon Developmental Disabilities Commission
- Oregon Health Care Association
- Oregon Technical Assistance Corporation
- Partnerships in Community Living, Inc.

Decisions reached through the Issue Group process have been shared with the overall Project Planning Committee. The Project Planning Committee provides broad oversight and guidance to the MFP Project. The Planning Committee meets once a quarter, and will continue to meet on that schedule throughout the life of the Project. People who serve on the Planning Committee represent:
- AARP
- Brain Injury Association of Oregon
- Cedar Sinai Park
- Chehalem Youth and Family Services
- Clackamas County Social Services Department (AAA)
- Coalition for Healthy Oregon
- Community Providers Association of Oregon
- Consumers
- Consumer advocates
- Douglas County, Oregon
- Eastern Oregon Training Center
- Family members
- Garten Services
Appendix 12 explains the organizational structure of the grant and also shows the number of consumers and family members who participate.

SPD intends that consumer involvement remain a strong component of its “On the Move” project. We anticipate that consumers will be involved not only with the project decision-making process, but also in working with participants in a “peer support” model. Oregon intends to include peer counseling and facilitation services as a supplemental OTM service. Services, to be provided by consumers, deliver counseling, assistance, facilitation and other support services to Medicaid eligible adults with physical or developmental disabilities. Peer counseling and facilitation services assist Medicaid-eligible individuals with acquisition of and improvement in self-management and adaptive skills required to live with a serious disability. Peer services are provided through Centers for Independent Living (CILs) or like organizations that focus on developmental disabilities, such as Self Advocates as Leaders (SAAL). Peer providers are people with serious, long-term physical disabilities who have acquired the skills and abilities necessary to maintain their lives in the least restrictive setting possible. Peer providers assist Money Follows the Person project participants to gain independence.
after extended residence in Oregon nursing facilities, or in Eastern Oregon Training Center, Oregon’s ICF/MR.

Peer counseling and facilitation services are coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. Oregon uses a person-centered planning process to empower the MFP participant in leading and directing the design of the service plan. Peer counseling and facilitation services include, but are not limited to:

- Working with family members and other support networks.
- Supporting the individual as he advocates for himself.
- Assisting with community inclusion activities.
- Assisting with employment/volunteering activities.
- Peer mentoring.
- Problem solving.

During the process of design, SPD Assistant Director James Toews, MFP Project Director Julia Huddleston and other SPD management staff met with Oregon Housing and Community Services (OHCS) Department leadership, including the OHCS Deputy Director, Housing Division Administrator and Housing Finance manager. Collaboration is ongoing around a variety of issues, including development of a legislative proposal funding a new model of housing with long-term services for Oregon’s frail elderly and people with disabilities. The two agencies are also collaborating around development of inclusionary housing models for people with disabilities who are at risk of homelessness. Agency leadership, including project director Huddleston, meet every several weeks to further discuss development of multi-dimensional mission-focused housing. Ideally, these will be multi-generational mixed-use housing projects, affording seniors and people with disabilities the means to live in integrated, rather than needs-based, communities while still receiving the supports that they need in a safe and respectful way. Next steps in this process include development of local demographics of need and capacity to inform a brainstorming process. Housing and service providers will be invited to share in this initial brainstorming to be scheduled during April 2008. Additional participants, including consumers and their advocates, will be invited to participate in design of a pilot model during the summer and early fall, 2008.

MFP project staff has invited a variety of stakeholders to several informational sessions concerning development of housing and assistive technology in the Oregon MFP Project. Agencies and organizations invited to participate include:

- ACCESS, Inc.
- Alvord-Taylor Independent Living Services
- Ashland Department of Planning
- Beaverton Office of Economic Development
- Bend Urban Renewal Department
- CAPECO
- CareWheels Corporation
- CASA
- Cascadia
- Catholic Charities
Center for Human Development, Inc.
Central Oregon Resources for Independent Living
City of Portland
Clackamas County Community Development
Clackamas County Housing Authority
Clatsop County Housing Authority
Community Action Organization
Community Action Team, Inc.
Community Connection of Northeast Oregon
Community Connections of Wallowa County
Community Development Corporation of Lincoln County
Community Partners in Affordable Housing
Community Services Consortium
Consumer advocates
Coos and Curry North Bend Housing Authority
Corvallis Housing Department
Corvallis Neighborhood Housing Services
Douglas County, Oregon
Eastern Oregon Center for Independent Living
Elders in Action
Elite Care Corporation
Eugene Planning and Development Department
Eugene Research Institute
Family members
Gresham Community and Economic Development Department
Harney-Malheur County Community Action Agency
HASL Independent Abilities Center
Hillsboro Office of Community Development
Hillsboro Planning Department
HOPE
Housing and Community Services of Lane County
Housing Authority of Douglas County
Housing Authority of Jackson County
Housing Authority of Lincoln County
Housing Authority of Malheur County
Housing Authority of Portland
Housing Authority of Salem
Housing Authority of the County of Umatilla
Housing Authority of Washington County
Housing Authority of Yamhill County
Housing Works
Independent Living Resources, Inc.
Innovative Housing, Inc.
Intel Corporation
Josephine County Housing and Community Development Council
• Klamath Housing Authority
• Klamath/Lake Community Action Services
• Lane Independent Living Alliance
• Lifeways
• Linn County Affordable Housing
• Linn-Benton Housing Authority
• Mainstream Housing, Inc.
• Marion County Housing Authority
• Medford Housing and Community Development
• Medford Office of the City Manager
• Metropolitan Affordable Housing Corporation
• Mid-Columbia CAC
• Mid-Columbia housing Authority
• Mid-Columbia Housing Resource Center
• NeighborImpact
• New Day Enterprises, Inc.
• Northeast Oregon Housing Authority
• Northwest Housing Alternatives
• Northwest Oregon Housing Authority
• Northwest Senior and Disability Services
• Office of the Long-Term Care Ombudsman
• Opportunity Foundation of Central Oregon
• Oregon Alliance of Senior and Housing Services
• Oregon Cascades West Council of Governments
• Oregon Center for Aging and Technology
• Oregon Coast Community Action
• Oregon Health Care Association
• Oregon Health Science University
• Oregon Housing and Associated Services
• Oregon Rehabilitation Housing Association
• Polk Community Development Corporation
• Portland Office of Schools and Community Partnerships
• Progressive Options
• Progressive Options, Inc.
• REACH Housing and Community Development
• Regency South, Inc.
• Rogue Valley Community Development Corporation
• Salem Community Development Division
• South Coast Independent Living Services
• Specialized Housing, Inc.
• SPOKES Unlimited
• Springfield Department of Development Services
• SPRY Learning
• State Independent Living Centers
• Step Forward Activities, Inc.
The ARC of Oregon
Umpqua Community Action Network
Umpqua Community Development Corporation
Umpqua Valley disAbilities Network
Washington County Aging and Disability Services
West Valley Housing Authority
Yamhill Community Action Partnership

The 2007 Legislative Assembly directed the Oregon Department of Human Services, Seniors and People with Disabilities Division to work collaboratively with the Oregon Department of Transportation to identify current and projected transportation needs of seniors and people with disabilities in Oregon. Members of the MFP project staff participate in staffing the workgroup developing these projections.

Participation costs for consumers are paid by SPD in accordance with DHS Policy Transmittal 06-043 and Oregon Accounting Manual Policy 40.10.00. Consumers and family members are eligible for reimbursement for costs of participation as non-state employees. Both are attached in Appendix 7.

Refer to Addendum A: Stakeholder Involvement page 101.

B.5. Benefits and Services

“On the Move in Oregon”, the state MFP program, will be operated by and through the Seniors and People with Disabilities (SPD) Division of the Oregon Department of Human Services. DHS is Oregon’s single state Medicaid agency, responsible for administering and overseeing services throughout the state. Seniors and People with Disabilities (SPD) is the administrative unit within DHS assigned to provide leadership, regulate services, provide protective services, manage resources, and carry out DHS responsibilities related to Medicaid program participation in long-term care for individuals who are elderly or who are adults with physical disabilities, and for adults and children with developmental disabilities.

Area agencies on aging are responsible for administrative functions for programs for seniors and people with physical disabilities at the local or regional level. An interagency agreement or memorandum of understanding between the Oregon DHS and each local/regional Area Agency sets forth the responsibilities and performance requirements of the AAA. The interagency agreement is available upon request. Area Agencies on Aging (AAAs) meet the definition of an area agency on aging under the Older Americans Act and Oregon Revised Statute 410, and are administered by a unit or combination of units of general purpose local government. AAAs administer the Medicaid, financial and adult protective services, and regulatory programs of elderly or adults with physical disabilities. Oregon DHS assesses the performance of the AAAs in conducting waiver operational and administrative functions through a biennial Performance Review function, and through an annual random sample of 1% of waivered participants using a standard survey form (the Quality Assurance Home and...
Community Based Care Case Review Checklist). This checklist records review of financial and service eligibility, participant preferences, risk monitoring, participant goals, contingency plans, signed plan of care and participant choice form. The local office managers are responsible for reviewing each case, documenting corrective actions and signing off on the review. The local office returns a finished survey form for each case reviewed to SPD for review, database entry, tracking and analysis. SPD staff compile this information into reports at least annually and more frequently as needed. In accordance with 42 CFR §431.10, when Oregon DHS does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

County governments are responsible for administrative functions for programs that serve adults and children with developmental disabilities at the local or regional level. An interagency agreement or memorandum of understanding between the Oregon DHS and each county government sets forth the responsibilities and performance requirements of the county. The interagency agreement is available upon request.

Counties administer the Medicaid, protective services, and regulatory programs of children and adults with developmental disabilities. Oregon DHS assesses the performance of the counties in conducting waiver operational and administrative functions through a biennial Performance Review function, and through an annual random sample of 1% of waivered participants using a standard survey form (the Quality Assurance Home and Community Based Care Case Review Checklist). This checklist records review of financial and service eligibility, participant preferences, risk monitoring, participant goals, contingency plans, signed plan of care and participant choice form. The local office managers are responsible for reviewing each case, documenting corrective actions and signing off on the review. The local office returns a finished survey form for each case reviewed to SPD for review, database entry, tracking and analysis. SPD staff compiles this information into reports at least annually and more frequently as needed. In accordance with 42 CFR §431.10, when Oregon DHS does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

For seniors and people with physical disabilities, local case management entities are entry points for all services and perform standardized functions such as level of care assessment/reassessment, plan development, service authorization, service monitoring, and offer of choice between nursing home and community-based care. These local entities are either SPD field offices or Area Agencies on Aging (AAA’s) performing according to OAR 411-002-0100 through 0175 and written agreements with SPD. SPD contracts with qualified providers for the provision of waiver services.

SPD delegates responsibility for case management programs for people with developmental disabilities to counties or regions. Local oversight responsibilities include planning and resource development, negotiation and monitoring of contracts and subcontracts, and documentation of service delivery to comply with state and federal requirements. Counties also are responsible for case management services, evaluation and coordination of services, and quality assurance services. Quality assurance activities are aimed at improving the quality of services and ensuring that services comply with state and federal requirements and adult protective services laws. SPD contracts with qualified providers for the provision of waiver services.
Service delivery mechanism: Fee for Service.

Target Population: Target populations are Oregon residents who live in institutional care facilities for a period of 6 months or more and who are Medicaid eligible for at least the 30 days that immediately precede transition from the institution. These include seniors, people ages 18 to 64 with physical disabilities, people ages 22 to 64 with developmental disabilities and children ages 21 and under with physical and/or developmental disabilities. Effective January 1, 2010, the definition of institutional care facility will also include the Oregon State Hospital, which is the state institution for mental diseases for people who are dually diagnosed with mental illness and physical or developmental disability.

The rollout plan anticipated for State Fiscal Years 2008 and 2009 contemplates start-up activities targeted to certain areas of the state. The rollout plan will target services to all populations described above. Beginning July 1, 2009, SPD contemplates that the MFP Project will be available statewide.

Participants will leave the institution and participate in the “On the Move” program for 365 days. Effective day 366, participants will transition from the project into a variety of home and community-based waivers and State Plan services. These include:

- Home and Community-Based Services Waiver for Seniors and People with Physical Disabilities, number 0185.90.R2. This waiver does not have a waiting list and is not near maximum capacity. If the waiver approached maximum capacity, SPD guarantees that it would request to add additional waiver “slots”.
- Developmental Disability Services Comprehensive Services for Children and Adults Waiver, number 0117.90.R3. This waiver is near maximum capacity and there is a wait list. The approved waiver assumes the creation of 50 additional “slots” each year. People leaving nursing facilities and other institutions are given priority for placement over the wait list. SPD believes that sufficient capacity will exist for On the Move participants.
- Medically Involved Waiver for Children with a Nursing Facility Level of Care Need. This model waiver was submitted to CMS in December 2007 to be effective January 1, 2008. SPD was informed by CMS in late February 2008 that the waiver was approved. The transition of the number of children who will transition from the MFP Project will not cause the waiver to reach maximum capacity.
- Self-Directed Personal Assistance Services, State Plan Amendment transmittal 07-14, approved effective February 1, 2008.

SPD does not contemplate that it will need to amend an existing waiver or propose a new waiver to ensure that MFP participants retain Medicaid eligibility as they move to the community. SPD will request to amend waiver 0185.90.R2 for HCBS services to Seniors and People with Physical Disabilities to add behavioral support services. Waiver amendment submission will occur not later than March 31, 2010 with a requested effective date of January 1, 2010. All other qualified services are currently
available to the population through the existing waivers and self-directed state plan services.

Community-based long-term care programs into which MFP participants will enroll are available on a statewide basis. MFP participants will not be enrolled into managed long-term care.

**Service Package:** The MFP service package will vary by individual need. All MFP participants will be eligible for services contained within the package; Transition Coordinators will work with participants, support networks and providers to assess the scope, intensity and duration of the participant need. Services may be offered as either “Qualified Home and Community Based Services” or as “Home and Community Based Demonstration Services” based on their inclusion in the 1915(c) waiver or State Plan option in which the participant will enroll after MFP\(^{10}\).

<table>
<thead>
<tr>
<th>Seniors and People with Physical Disabilities</th>
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<tbody>
<tr>
<td>Specialized Living Services(^{11})</td>
<td>Qualified</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>Qualified</td>
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<tr>
<td>Home Modifications</td>
<td>Qualified</td>
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<tr>
<td>Adult Day Services</td>
<td>Qualified</td>
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<tr>
<td>Chore Services</td>
<td>Qualified</td>
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<tr>
<td>Personal Care</td>
<td>Qualified</td>
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<tr>
<td>Personal Emergency Response System</td>
<td>Qualified</td>
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<tr>
<td>Respite Care</td>
<td>Qualified</td>
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<tr>
<td>Transportation Services</td>
<td>Qualified</td>
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<tr>
<td>Adult Foster Home Services</td>
<td>Qualified</td>
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<tr>
<td>Assisted Living Facility Services</td>
<td>Qualified</td>
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<tr>
<td>In-Home Services</td>
<td>Qualified</td>
</tr>
<tr>
<td>Community Transition Services(^{12})</td>
<td>Qualified</td>
</tr>
<tr>
<td>Case management</td>
<td>Demonstration</td>
</tr>
<tr>
<td>Behavioral Support Services</td>
<td>Demonstration</td>
</tr>
<tr>
<td>Employment Services</td>
<td>Demonstration</td>
</tr>
</tbody>
</table>

\(^{10}\) The continuation of services in the 1915(c) waivers will be explained to the participant as part of the “Informed Consent” process.

\(^{11}\) Specialized Living Services are support and assistance with activities of daily living and instrumental activities of daily living, provided to individuals who cannot live independently or be served in other community-based facilities. Services are provided through a shared-attendant model to individuals living in private residences located in apartment complexes or otherwise in close proximity to each other. Specialized Living Services are directed to helping service recipients toward more independent living.

\(^{12}\) Community Transition Services assist eligible individuals to return to their own homes or apartments from nursing facilities or from inpatient acute hospital stays. Assistance is in the form of payments for moving expenses such as: security deposits required to obtain a lease on an apartment or home; essential furnishings to establish basic living arrangements (e.g. bed, table, chairs, window blinds, eating utensils, and food preparation items); set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); and health and safety measures such as pest eradication, allergen control or cleaning prior to occupancy. This is a one-time service. Payment is authorized only for the minimum amount necessary to establish the participant’s basic living arrangement.
<table>
<thead>
<tr>
<th>Service</th>
<th>Type</th>
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<tbody>
<tr>
<td>Independent Living Skills</td>
<td>Demonstration</td>
</tr>
<tr>
<td>Crisis management services</td>
<td>Demonstration</td>
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<tr>
<td>Habilitation</td>
<td>Demonstration</td>
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<tr>
<td>Specialized Medical Equipment and Supplies</td>
<td>Demonstration</td>
</tr>
<tr>
<td>Family Training</td>
<td>Demonstration</td>
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<tr>
<td>Consultative Services</td>
<td>Demonstration</td>
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</table>

**Children and Adults with Developmental Disabilities**

<table>
<thead>
<tr>
<th>Service</th>
<th>Type</th>
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</thead>
<tbody>
<tr>
<td>Case management</td>
<td>Qualified</td>
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<tr>
<td>Residential facilities</td>
<td>Qualified</td>
</tr>
<tr>
<td>Foster Care</td>
<td>Qualified</td>
</tr>
<tr>
<td>Supported Living</td>
<td>Qualified</td>
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<tr>
<td>Employment Services</td>
<td>Qualified</td>
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<tr>
<td>Proctor care</td>
<td>Qualified</td>
</tr>
<tr>
<td>Behavioral support services</td>
<td>Qualified</td>
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<tr>
<td>Independent Living Skills</td>
<td>Qualified</td>
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<tr>
<td>Home Modifications</td>
<td>Qualified</td>
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<tr>
<td>Chore Services</td>
<td>Qualified</td>
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<tr>
<td>Crisis management services</td>
<td>Qualified</td>
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<tr>
<td>Habilitation</td>
<td>Qualified</td>
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<tr>
<td>Personal Care</td>
<td>Qualified</td>
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<tr>
<td>Respite Care</td>
<td>Qualified</td>
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<tr>
<td>Personal Emergency Response System</td>
<td>Qualified</td>
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<tr>
<td>Transportation Services</td>
<td>Qualified</td>
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<tr>
<td>Community Transition Services</td>
<td>Qualified</td>
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<tr>
<td>Specialized Medical Equipment and Supplies</td>
<td>Qualified</td>
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<tr>
<td>Family Training</td>
<td>Qualified</td>
</tr>
<tr>
<td>Consultative Services</td>
<td>Qualified</td>
</tr>
<tr>
<td>Non-Medical Transportation Services</td>
<td>Qualified</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>Demonstration</td>
</tr>
<tr>
<td>Adult Day Services</td>
<td>Demonstration</td>
</tr>
</tbody>
</table>

13 Consultative services are **supports** for the purpose of providing treatment, training, consultation or other unique services necessary to achieve outcomes in the plan of care that are not available through State Plan services or other waiver services. For example: behavior consultation consisting of assessment of the individual, the needs of the family and the environmental factors that affect behavior; development of a positive behavior support plan, training and implementation of a positive behavior support plan with the family and providers, and revision and monitoring of the plan as needed to prevent injury to the individual or others. Social sexual consultation to assess the individual and the environmental factors that affect the behavior; develop a support plan with the individual, family and providers; implement, train, monitor and revise the plan as needed to meet the identified outcomes of the plan. Licensed nurse services to assess the individual develop a support plan with the individual, family and providers; implement, train, monitor, and revise the plan as needed to meet the identified outcomes of the plan.

14 Home Delivered Meals and Adult Day Services are not provided through approved waivers for Children and Adults with Developmental Disabilities. During the year that the participant is a part of the “On the Move” project, both may be offered to these populations as demonstration services. Adult Day Services will be limited to people ages 18 and over.

15 Home Delivered Meals and Adult Day Services are not provided through approved waivers for Children and Adults with Developmental Disabilities. During the year that the participant is a part of the “On the Move” project, both may be offered to these populations as demonstration services. Adult Day Services will be limited to people ages 18 and over. Oregon ensures that if either service is utilized by participants who will transition to approved waivers...
Full Home and Community-Based Services waivers definitions of “specialized living” and “consultative services” are found in the footnotes to this Protocol.)

All participants will be eligible for the following demonstration services:

- Peer support services
- Products for the maintenance of health and hygiene
- Medication management
- Community Transition Services that exceed waivered limits
- Service animals
- Vehicle modifications
- Benefit planning services
- Specialized Diets

In addition, all MFP participants will be eligible for the following “Supplemental Demonstration Services:

- Housing coordination
- Trial visits
- Rent deposits
- Security deposits
- Home modifications
- Household goods
- Household set-up
- Moving expenses
- Housecleaning
- Food stocking
- Housing cost subsidy
- Housing location services
- Roommate location services
- Substance abuse treatment services
- Care-giver training
- Nutrition services
- Problem solving services
- Mental health services
- Vehicle repair
- Utility deposits
- Payoff of existing debt (HUD public housing; utility companies)
- Storage charges
- Lock and key replacement
- Legal Services
- Fitness memberships and supplies
- Transit passes
- Care Coordination Services
- Workforce Training

Waivers for Children and Adults with Developmental Disabilities, the state will propose timely amendments to add those services to the appropriate 1915(c) waiver.
- Specialized Consultative Services related to mental illness
- Telemedicine
- Therapeutic recreational services and activities
- Therapy animals
- Assistive technology assessment
- Assistive technology purchase
- Technology installation
- Technology training
- Technology maintenance
- Internet installation
- Peer counseling and facilitation services
  Employment site modification

Oregon believes that many of the supplemental services will not be needed beyond the On the Move year. For other, on-going needs – for example, nutrition services, mental health services and problem solving – we intend to actively explore mechanisms to add on-going access for all the populations served through the Seniors and People with Disabilities Division to the home and community-based infrastructure.

The Home and Community-Based Services Waiver for Seniors and People with Disabilities, 0185.90.R2, will be amended to add Behavioral Support Services. These services will provide treatment, training, consultation or other unique services necessary to achieve outcomes in the plan of care that are not available through State Plan services or other waiver services. Examples could include behavior consultation, development of a behavioral plan of care and behavioral issues training for families and caregivers.

The amendment will be submitted not later than March 31, 2010, to be effective January 1, 2010. Oregon anticipates that no other amendments will be needed.

Approved rate setting methodologies are found in Appendix 8.

Refer to Addendum A: Benefits and Services pages 102 to 104.

**B.6. Consumer Supports**

*Transition Coordinators*

In discussions with issue planning groups, Oregon identified the need for dedicated MFP Project Transition Coordinators. Transition Coordinators play a crucial role in Oregon’s MFP Project, acting as agents of change for potential participants to facilitate and monitor the move from the institution back to the community.

During the initial 15 to 18 months of the MFP project, transition coordinators will be State of Oregon employees, reporting directly to SPD’s Money Follows the Person Project Team. They will be stationed throughout Oregon in local communities. SPD has agreed to evaluate this strategy mid-year 2009, and may, at that time, change the
reporting structure to allow Transition Coordinators to be employees of Area Agencies on Aging in those Oregon counties in which the Area Agency manages the Medicaid long-term services program. SPD requests amendment of this Operational Protocol effective January 1, 2010 to implement the modified reporting structure. In addition to the knowledge, skills and abilities expected of case managers, Transition Coordinators will need to demonstrate excellent communication skills and independent decision-making ability. Preference in hiring will be given to individuals already employed by the state or its partners as human services case managers. We expect a transition coordinator to MFP participant ratio of 1 to 15 during the MFP year. That ratio will be evaluated in the 4th quarter 2008, and may be adjusted downwards if needed. The recommendation to adjust ratios will be made by the project director, based on input from transition coordinators and the Quality Issues group, to SPD Assistant Director Toews as well as the project Planning Committee.

**24-hour Emergency Backup Systems**

SPD currently requires Developmental Disability (DD) provider agencies to provide people receiving services through the Supported Living rule access to on-call personnel that are available by telephone at all times.

Many people with a developmental disability who are supported by a provider live in their own home or apartment through a certified program called Supported Living. People generally receive less than 24-hour a day supports, so most are alone at night. Each person receives training about the type of incidents that may require backup assistance, where to locate on-call numbers, how to contact on-call personnel, and what to do if there is no response to the call. In cases of a medical emergency, people receiving support and/or the staff providing supports are instructed to contact qualified emergency personnel (9-1-1).

SPD intends to make this system available to all MFP participants through extension of contracts with provider agencies. The following is an outline of the process available to people whom do not have around the clock staff support. *If an MFP participant lives in a congregate setting of 4 or fewer people, 24-hour capacity is required by state licensing rules.* People should utilize their typical support structures during traditional work hours (8:00 a.m. – 5:00 p.m.). The on-call backup should be utilized after 5:00 p.m. and before 8:00 a.m., Monday – Friday. On-call protocols are in place Friday after 5:00 p.m. until Monday before 8:00 a.m.

**On-Call Support**

There should be two-levels of support in an on-call system:

1st Level Support: All participant homes and apartments will be assigned to a provider agency support area. Each area has assigned management personnel that rotate an on-call pager on a weekly basis. These managers carry an on-call book with individual profiles that include information about each person’s medical/behavioral profile and emergency contacts. Each on-call manager also has backup support staff that carries a pager, in the event that staff support is required.

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16 State of Oregon class specifications for case managers are found in Appendix 2 of this Protocol.
2nd Level Support: The second level support consists of a group of administrators and department heads that serve several functions:

- Secondary backup, in the event the 1st level support cannot be reached
- Technical Assistance/problem solving/guidance
- Liaison for more complex issues involving police, hospitals, etc.

Responsibilities of On-Call Personnel

- Communicate any on-call issues to the appropriate management personnel via phone message or e-mail.
- If any on-call notes were made, make sure they are routed to the appropriate person. These notes could involve medical, behavioral, personnel, or housing issues. If any of the incidents involve possible abuse, contact local abuse hotline, and then contact the on-call administrator (2nd level support).
- Make sure a backup staff is available to provide staffing support, if necessary.
- On-call personnel must remain local (within a 25 mile radius of on-call area).
- Contact 2nd level support to inform of any incident that has a legal implication, involves an ER visit, hospitalization, alleged abuse, or vehicle accident.

On-call Responsibility when receiving a page:

- Return page/call within 15 minutes of receiving it. *
- If a medical issue arises and there is any doubt about the immediate health of an individual, contact or instruct that 9-1-1 be contacted, immediately.
  
  *Some incidents do not require Emergency Personnel response, but require immediate response from on-call personnel (i.e., unable to access critical medications). Person receiving support is trained to add a “777” at the end of the page to on-call personnel. This instructs on-call to immediately respond to call and proceed to the home where assistance is requested.

Incidents that should receive priority response

- **Any** serious incident or emergency. Serious incidents may be defined as:
  - Medical emergencies
  - Arrests
  - Abuse allegations
  - Fires
  - ER Visit/Hospitalization
  - Vehicle accident
  - Death

  *Specific procedures will be written that direct on-call personnel how to address each of these incidents.*

Possible situations and how to address

- Medical Issues:
  - If uncertain about the severity of a situation, contact 9-1-1 without hesitation.
  - Determine if a nurse/client relationship exists. If yes, contact the on-call RN to seek advice or inform of situation.
  - If necessary, go to home and review medical records/individual records.
• Staffing Issues:
  o Is backup staff needed (i.e., call out, leave early)?
    ▪ Will the absence of immediate staffing support jeopardize the person’s health and safety? If yes, utilize on-call backup staff.
    ▪ If no, identify any support needs the person may have until the next scheduled staff arrives. Arrange for identified needs to be met in the interim.
• Home Maintenance:
  o Assess whether or not the issue can wait until the next workday.
    ▪ If no, contact on-call maintenance personnel.

On-call system providers will be required to document issues and the specific action taken, as well as any additional follow-up required. Documentation will be regularly reviewed by the Quality Issues workgroup.

A flow chart illustrating this process is attached as Appendix 9.

Refer to Addendum A: Consumer Supports page 105.

B.7 Self-Direction

Oregon’s in-home programs for seniors, people with physical disabilities and people with developmental disabilities, fully utilize person-centered planning and individual budgeting. In-home services are supported by extensive use of public and private fiscal intermediary services, which enhance the principles of self-direction and the implementation of individual budgets.

About 10,000 seniors and people with disabilities receive long-term care services and supports each month through Oregon’s Home Care Worker program provided through the Aged and Physically Disabled 1915(c) Waiver, 0185.90.R2. In this program, the client is authorized to hire an employee, known as a homecare worker, to assist them with activities of daily living. The case manager assists the client with recruitment and retention, and the state pays the provider, and remits required withholdings. The client is the employer and directs the homecare worker in performance and timing of all authorized tasks.

“Independent Choices” was initially approved by CMS in 2000 as a “cash and counseling” 1115 demonstration waiver. Three hundred seniors and people with physical disabilities in this demonstration manage both the cash benefit and the provision of their home and community based services. The program was approved for conversion to a 1915(j) State Plan self-directed services model February 1, 2008. Statewide expansion is planned for as many as 1,500 people.

About 4,000 adults with developmental disabilities receive in-home services through the Support Services program, authorized by a 1915(c) Support Services Waiver. All support services must be developed through a Person-Centered Planning process that considers the strengths, capabilities, needs, and preferences of the individual. People
who make up the individual's existing circle of support (family, friends, and advocates) and representatives from public or private service organizations providing services to the individual participate in this planning process. Support services are delivered by organizations called "support service brokerages." Brokerage organizations employ staff (Personal Agents) who assist enrolled individuals by developing an individualized support plan, obtaining available resources as necessary to implement the support plan, assisting the person, if needed, in hiring people or organizations to provide specific support services, and monitoring and evaluating the outcomes of delivered services.

"On the Move in Oregon" will continue to offer the opportunity for self-direction to participants. All OTM participants will be offered self-direction through the person-centered planning processes that the project will employ. People, who move into their own homes or family homes, or into leased apartments, will be able to exercise co-Employer authority in their choice of caregiver(s). Participants may find their own candidates for employment, screen otherwise qualified candidates for ability to meet participant needs, and refer those individuals to the appropriate provider agency. Participants will establish work schedules and train employees in how they prefer to receive their services. The co-employer provider agency will issue payment to the employee and address tax and other employer-related financial requirements on behalf of the participant-employer. The participant-employer will approve a monthly voucher verifying the number of hours their employee worked, up to the maximum monthly hours authorized by the Transition Coordinator. The Transition Coordinator will provide a task list based on the service plan and will monitor the service plan, identifying risks and unmet needs and discussing options with individuals. The participant has the right to fire the worker at any time, for any reason. Transition coordinators may alter the services authorized based on reassessments of the participant’s needs. In that situation, the Coordinator sends a notice of reduction or termination of services to the participant and to the co-employer provider agency. If an OTM participant, or their representative, requests an Independent Advocate, one will be provided.

In choosing the co-Employer model described above, rather than moving immediately to full participant self-direction as is currently exercised in 1915(c) In-Home programs, issue groups and project staff considered the vulnerability of populations transitioning from institutional life, and the many issues that will pose challenges. As participants transition to their permanent 1915(c) waiver or State Plan service at the end of the OTM project, self-directed services will again be presented as a service option to all populations.

Please refer to the attached Appendix 1 for additional details.

**B.8. Quality Management System**

On day 366, "On the Move" program participants will be enrolled into one of three existing 1915(c) waivers or into the state's self-directed services state plan option. Oregon. The three 1915(c) waivers into which participants will be enrolled – 0185.90.R2 for seniors and people with physical disabilities, 0117.90.R3.01 for individuals with developmental disabilities and 0565.R00 for medically involved children have approved Appendix H quality management strategies. The state’s multi-waiver Quality
Management Strategy Appendix H is attached as Appendix 14 to this Protocol. Oregon will employ these same Quality Management strategies qualified, demonstration and supplemental services that are part of the “On the Move” project. Strategies marked “APD” will be applied for services received by OTM participants who are seniors or people with physical disabilities. Strategies marked “DD” will be applied for services received by OTM participants who are children or adults with developmental disabilities.

The approved QMS strategies for waiver 0185.90.R2 apply to more than 25,000 individuals; those for waiver 0117.90.R3.01 to more than 6,000. As a result of the scale of these waivers, sampling techniques are employed. The smaller scale of the OTM project will allow Oregon to more fully employ various quality measures. For example, all service plans developed by locally stationed transition coordinators will be reviewed by centrally stationed project management and lead staff for compliance with the six required service plan standards. Any adjustments to the approved Appendix H strategies for the OTM project will not decrease reporting frequency, sample size or the scope of the review.

24 hour emergency back-up system
The OTM 24-hour back-up system for all participants will use a system that is currently required to be in place for adults with developmental disabilities. SPD currently requires Developmental Disability (DD) provider agencies to provide people receiving services through the Supported Living rule access to on-call personnel that are available by telephone at all times.

Many people with a developmental disability who are supported by a provider live in their own home or apartment through a certified program called Supported Living. People generally receive less than 24-hour a day supports, so most are alone at night. Each person receives training about the type of incidents that may require backup assistance, where to locate on-call numbers, how to contact on-call personnel, and what to do if there is no response to the call. In cases of a medical emergency, people receiving support and/or the staff providing supports are instructed to contact qualified emergency personnel (9-1-1).

This system will be made available to all OTM participants who live in their own homes, family homes or leased apartments through extension of contracts with provider agencies. If an OTM participant lives in a congregate setting of 4 or fewer people, 24-hour capacity is required by state licensing rules. 24/7 coverage will be required.

Two levels of support will be contractually required. All participant homes and apartments will be assigned to a provider agency support area. Each area has assigned management personnel that rotate an on-call pager on a weekly basis. These managers carry an on-call book with individual profiles that include information about each person’s medical/behavioral profile and emergency contacts. Each on-call manager also has backup support staff that carries a pager, in the event that staff support is required. Second level support consists of a group of administrators and department heads that serve several functions:

- Secondary backup, in the event the 1st level support cannot be reached
- Technical Assistance/problem solving/guidance
- Liaison for more complex issues involving police, hospitals, etc.

Support will be available to address incidents including, but not limited to:
- **Any** serious incident or emergency. Serious incidents may be defined as:
  - Medical emergencies
  - Arrests
  - Abuse allegations
  - Fires
  - ER Visit/Hospitalization
  - Vehicle accident
  - Death

*Providers will be required to develop specific procedures that direct on-call personnel how to address each of these incidents. Procedures must be reviewed and approved by OTM project staff.*

- Non-serious/ non-emergent medical issues:
- Staffing issues:
- Home and equipment maintenance:
  - Assess whether or not the issue can wait until the next workday.
    - If no, contact on-call maintenance personnel.

On-call system providers will be required to document back-up access and the specific action taken, as well as any additional follow-up required. Documentation will be forwarded to Transition Coordinators weekly for inclusion in the MFP case narrative. Transition Coordinators will report adverse outcomes to the Project Director during weekly briefing meetings. The Project Director will take action if she feels that the reported outcomes warrant intervention or remediation at the provider level. Database reports will be reviewed by the Quality Issues workgroup monthly as will a narrative summary of adverse outcome reports and actions taken by the Project Director.

**Risk Assessment and Mitigation**
During initial plan of care development and subsequent reviews, the transition coordinator conducts an assessment using the CA/PS tool and other person-centered planning tools as appropriate to review risk factors for health, behavioral and mental health and other risks with the OTM participant, to offer resources and to plan appropriate safeguards. If health or medication risks are identified, a Registered Nurse under contract with SPD will be referred to conduct a nursing assessment and may authorize follow-up visits. If appropriate, the RN develops a registered nurse plan of care for the participant and provider to follow, may delegate nursing tasks to the provider, and establish a monitoring schedule. Nursing delegation consists of training and observing that the provider is able to perform the task. The registered nurse must continue to monitor the performance of these delegated tasks and such monitoring must conform to Oregon Board of Nursing Standards. If behavioral and mental health risks are identified, the Coordinator will work with contracted providers to develop a behavioral support services and may authorize mental health and/or substance abuse services.
The transition coordinator may identify other risks. In those instances where the individual has the ability to make informed choices, the coordinator will discuss alternatives, which may mitigate the risk, and may offer project resources if appropriate, or other community resources. It is expected that every individual with mental retardation or a developmental disability participate actively and have the opportunity for program requirements to be explained to them in a manner that maximizes their comprehensive abilities. We anticipate that there will be a wide range of support needed to ensure informed consent for project participants. Each person is unique and the approach will need to be person-centered. To avoid error or manipulation, Transition Coordinators will request participation of a third-party person with the most intimate understanding of the potential participants preferred form of communication as well as their stated interests (through verbal or non-verbal forms of communication). If able, the potential participant will identify the third-party person they wish to assist them. In the event the person is unable to identify the most appropriate third party, members of the individual’s Interdisciplinary Team (IDT) (consisting of current program staff, family, friends, and other relevant professionals). In the event the potential participant has a legal guardian, and the identified guardian meets the guardianship qualifications set forth in Oregon Revised Statute, the OTM Transition Coordinator will involve the legal guardian in all conversations and decisions regarding risks.

**Incident Reporting and Management System**

OTM will require reports of critical incidents for all project participants when circumstances involve observed or suspected abuse defined in Oregon Administrative Rule (OAR) 411-020-0000 through 0130. Abuse in these rules means actions or inactions including abandonment, financial exploitation, neglect, physical abuse, emotional or verbal abuse, self-neglect and sexual abuse. SPD currently requires reporting of an additional group of critical incidents defined as abuse for people who live in community-based care facilities. These additional abuse definitions are found in (OAR) 411-050-0400 (2) for Foster Care Homes, and include involuntary seclusion of a resident for convenience of staff or for discipline, corporal punishment, and inappropriate use of restraints.

The Department of Human Services, Seniors and People with Disabilities (SPD) Divisions is responsible for protective services for adults, age 65 and older, and persons with disabilities in Oregon. These responsibilities extend to individuals receiving waiver services, private pay services, or no supportive services. These responsibilities will also extend to OTM participants. General authority for adult protective services to older adults, age 65 and older, and persons with physical disabilities is in ORS 410. 020. Authority for investigations of abuse to adults, age 65 and older is provided in Oregon Revised Statutes (ORS) 124.070 and in ORS 430.735 for people age 18 and over with developmental disabilities. DHS delegates adult protective services to Seniors and People with Disabilities (SPD). SPD assigns adult protective services responsibilities to local SPD and AAA offices and to County Developmental Disability Programs (CDDPs), including taking reports of abuse (critical incidents) and providing the subsequent follow-up through screening, assessment, investigation, and provision of appropriate resources for victim safety. The SPD Office of Licensing and Quality of Care oversees Adult Protective Services (APS) and is the appropriate authority at state level for management of critical incidents for seniors and people with physical...
disabilities. The Office of Investigations and Training (OIT) conducts abuse and neglect investigations in all state-operated programs for adults with developmental disabilities. If determined necessary or appropriate, DHS, Office of Investigations and Training may conduct an investigation itself rather than allow the community program to investigate the alleged abuse or in addition to the investigation by the community program. Under such circumstances, the community program must receive authorization from the Office of Investigations and Training before conducting any separate investigation.

OTM staff, local SPD and AAA offices, CDDPs, OIT and SPD Central Office will accept reports of critical incidents in the OTM project in any communication forms from anyone who wants to report. The local offices have screeners specifically trained to take APS critical incident reports. The state office provides a statewide toll-free number to take reports. The state office and local offices offer translators, adaptive telephone technology, and alternative formats for reporting.

Any person can report suspected or observed abuse incidents to DHS in any program, including On the Move, including waiver participants, legal representatives and family. Any reporter has immunity for reports made in good faith for elder abuse. ORS 124.060 mandates certain groups of persons to report elder abuse. Abuse mandated to be reported is defined under ORS 124.050 to be physical injury, neglect of care, abandonment, willful infliction of harm, sexual abuse, and financial abuse. ORS 124.050 (4) lists and defines the mandatory reporters to include:

- Physician, naturopathic physician, osteopathic physician, chiropractor or podiatric physician and surgeon, including any intern or resident.
- Licensed practical nurse, registered nurse, nurse’s aide, home health aide or employee of an in-home health service.
- Employee of the Department of Human Services, county health department or community mental health and developmental disabilities program.
- Peace officer.
- Member of the clergy.
- Licensed clinical social worker.
- Physical, speech or occupational therapists.
- Senior center employee.
- Information and referral or outreach worker.
- Licensed professional counselor or licensed marriage and family therapist.
- Any public official who comes in contact with elderly persons in the performance of the official’s official duties.
- Firefighter or emergency medical technician.

Case managers, transition coordinators and foster care home licensors are mandatory reporters for elderly persons, age 65 or older of critical events or incidents as defined in ORS 124.050.

Refer to Addendum A: Quality Management System, pages 106 to 108.

B.9. Housing
A participant in the “On the Move in Oregon” project will transition to a qualified residence. Qualified residences may include:

- Independent housing, which means a house or apartment that is owned or rented by the participant, or by a family member or a friend of the participant.
- Specialized living, which means independent living in a subsidized private and separate apartment with the provision of support and assistance with activities of daily living and instrumental activities of daily living. Services are provided through a shared-attendant model to individuals living in private residences located in apartment complexes or otherwise in close proximity to each.
- Adult or Child Foster Care. A foster care home provides supervision and assistance 24-hours/day to support individual health, activities of daily living and instrumental activities of daily living. The personalized services are designed to: 1) help individuals develop skills to increase or maintain level of functioning and 2) encourage maximum independence and enhance quality of life. Services are provided in a licensed private home by a principal care provider who usually lives in the home. In order to participate in the “On the Move” program as a qualified residence, the licensee must agree that the total number of individuals (including people who are MFP participants) living in the home and who are unrelated to the principal care provider, cannot exceed four.

Qualified residences may include assisted living facilities licensed by the Seniors and People with Disabilities Division effective January 1, 2010. SPD is evaluating the July 2009 CMS guidance pertaining to the use of assisted living facilities as qualified residence to determine what changes to state statute, administrative law and policy need to be made to allow such use. Specialized living services, adult and child foster care homes and assisted living facilities are certified or licensed by the Seniors and People with Disabilities Division, which also regulates the services provided.

Oregon DHS, Seniors and People with Disabilities Division (SPD) will promote the availability, affordability or accessibility of qualified residences through a variety of strategies.

**Affordable, accessible housing database:** Project staff has taken the first steps needed to make a statewide registry of affordable, accessible housing available to local SPD staff, staff of the Areas Agencies on Aging, and staff of the County Developmental Disability Programs. On-going discussions between the Oregon Housing and Community Services Department, Oregon’s state housing agency, and project research and housing staff are clarifying sources of information and state agency roles in update and maintenance. Project staff has scheduled a half-day meeting with SPD, AAA and CDDP local managers to discuss information that would assist staff and consumers in locating affordable, accessible housing. The design process will be inclusive and iterative. MFP project staff continues to inventory and validate existing subsidized housing throughout the state, confirming contact information and amenities, including the location of accessible and visitable units. SPD field staff and consumers have been preliminarily surveyed to determine desirable information variables to include in the database to facilitate community placement. Elements such as proximity to medical facilities, transportation, grocery stores and other supports are being identified. Staff is also cross-referencing available community opportunities such as support services,
volunteer options, rehabilitation, education and employment. Version 1 of the database should be available by September 2008.

**Collaboration with Oregon Housing and Community Services Department:** SPD has a rich history of collaboration with the Oregon Housing Department in development of community housing for people with disabilities as alternatives to institutionalization.

The housing program for persons with developmental disabilities has been an integral part of residential service delivery since the 1980’s. It developed from the realization that safe and appropriate community homes provide a context for residential services that contributes greatly to success in community living. Fairview State Training Center was an institution for persons with developmental disabilities that closed in 1999. At its height, more than 3,000 persons lived there. When Fairview was downsized and eventually closed, the Community Housing Section of Seniors and People with Disabilities, in partnership with private non-profit housing developers constructed or remodeled 200 homes to provide housing for those residents and persons misplaced in nursing homes. It was called the Community Integration Project (CIP). The homes were funded by general obligation bonds sold by Oregon Housing and Community Service Department and incorporate many specialized features.

When the assisted living facility model was first realized in Oregon, construction was financed through the OHCS Low-Income Housing Tax Credit (LIHTC) program. Not for profit providers were encouraged to serve the Medicaid population in assisted living facilities built using the LIHTC, and responded to the challenge. Today, more than 40 of Oregon’s 200+ assisted living facilities are partially financed through the credit and agree to serve a disproportionate percentage of low-income residents.

The collaboration continues today. SPD Assistant Director James Toews, MFP Project Director Julia Huddleston and other SPD management staff have met several times with Oregon Housing and Community Services (OHCS) Department leadership, including the OHCS Deputy Director, Housing Division Administrator and Housing Finance manager. Project staff participates in the advisory group implementing legislative “seed funding” of more than $16 million in the 2007-2009 biennium to provide permanent supportive housing for people at risk of homelessness. Oregon’s “Ending Homelessness Advisory Council” (EHAC), established by executive order of Governor Ted Kulongoski, includes people at risk of de-institutionalization as one of the populations that can benefit from permanent supportive housing. As projects present themselves for funding, project staff looks at opportunities for inclusionary housing for MFP participants. The two agencies are engaged in development of a legislative proposal funding a new model of housing with long-term services for Oregon’s frail elderly and people with disabilities. The development process also includes representatives of Oregon’s long-term care not-for-profit sector. Agency leadership, including project director Huddleston, meet every several weeks to further discuss development of multi-dimensional mission-focused housing. Ideally, these will be multi-generational mixed-use housing projects, affording seniors and people with disabilities the means to live in integrated, rather than needs-based, communities while still receiving the supports that they need in a safe and respectful way. Next steps in this process include development of local demographics of need and capacity to inform a
brainstorming process. Housing and service providers will be invited to share in this initial brainstorming to be scheduled during April 2008. Additional participants, including consumers and their advocates, will be invited to participate in design of a pilot model during the summer and early fall, 2008. While discussion to date has focused on the development of a “pilot” housing with services model in one location of the state, replication in other areas of Oregon will occur during the state’s 2009-2011 biennium. Oregon acknowledges that care must be taken in development of any “housing with services” model to ensure that neither segregated models, nor next generation assisted living facilities become the “new” products. Oregon will report on activities related to development of housing with services semi-annually.

OHCS administration has asked that Ms. Huddleston and other project staff meet regularly with the Housing Department’s Regional Advisors. These Advisors provide outreach to Oregon communities in identifying and addressing critical community development activities. RADs provide assistance to communities in capacity building, financing of affordable housing developments, and advocate and provide information to local communities, governments, and decision-makers in gaining acceptance to the siting of affordable and special needs housing.

Collaboration with Local Housing Authorities and Community Action Agencies: MFP staff is making contact with local housing authorities and community action agencies to explain the “On the Move in Oregon” project and to actively seek out opportunities for collaboration and partnership.

In early January 2008, an introductory letter was sent to executive directors of more than 60 local housing authorities and community action agencies in Oregon. The text of that letter read as follows:

“Oregon Department of Human Services, Seniors and People with Disabilities Division, has received a Money Follows the Person (MFP) grant from the federal government. The MFP grant will be used to transition approximately 1,000 people who are currently living in nursing facilities into community based housing. People who are Medicaid eligible, have lived at least six months in a nursing facility and agree to move will be eligible to participate. Eligible community living settings are a house or apartment or congregate settings serving no more than four unrelated individuals. Participants will be eligible for traditional Medicaid services as well as supplemental services that will help address issues that have typically been barriers to long-term community placement.

The MFP grant is an exceptional opportunity for creative and visionary development of housing and service models that support the aged and physically or developmentally disabled. Oregon has a proud history of national leadership in the area of community integration of these populations. We believe that MFP activities will again bring Oregon to the national forefront.

Do you have plans to develop special needs housing or housing/service delivery projects? Are you currently applying for funding on projects intended to fill gaps in your community’s ability to serve seniors and people with disabilities? Do you already have residences or service programs that would work within the MFP grant?
parameters? The grant team is finishing up its development phase and is researching potential partners for future housing and service delivery demonstrations. Please contact us if you would like to explore involvement in this exciting opportunity.”

The letter was also sent to DHS staff throughout the state and to DHS partners through the Department’s normal communication channels. The project’s housing specialist, who the letter listed as the contact person, has been contacted by over 30 agencies through January 15, 2008. Agencies that make contact are referred to the “On the Move in Oregon” project website and invited to participate in information and planning sessions scheduled in March and April 2008.

Collaboration with local communities: Housing is a barrier throughout the state of Oregon. There are fewer than 67,000 subsidized housing units in Oregon. Over 75% of these units are located in the Portland metropolitan area and South along the I-5 corridor to Eugene. Five of the seven fastest growing counties in the state are far outside this area. Out of the total of subsidized units, less than 10% are specifically designated for seniors or people with disabilities and less than half of these units are accessible. Appropriate and affordable housing is needed throughout the state but particularly in the Eastern 2/3 of the state and South of Eugene and along the Pacific coast.

Many communities in Oregon, particularly in rural Oregon, are concerned that seniors and people with disabilities must leave their communities when their care needs can’t be met. For example, the Wallowa County Commissioners contracted funds for a market study on dementia care in 2006. The study is excerpted below.

“Wallowa County is a rural, isolated county occupying the northeastern corner of Oregon, bordering Idaho to the east and Washington to the north. The population, which peaked at 10,000 in the 1920’s, has hovered around 7,000 since the depression. The county has a high number of residents over age 65 (20.8%), especially when compared with the state figure (12%) and the national figure (also about 12%). With most recent figures (2005) putting Wallowa County’s population at 7,014 residents, this estimates the 65+ group at 1473. With a population of 7,014 and a geographic area covering 2,000 square miles, the density of Wallowa County is about two people per square mile. This designates Wallowa County a “frontier” community. Most residents live in one of the four towns in the county, Joseph, Enterprise, Wallowa and Lostine, with a few scattered residents in the tiny outlying ranching communities of Flora, Troy and Imnaha.

A key reason for the county’s low and unchanging population is its isolated location. Wallowa County is bordered on three sides by wilderness: on the east by Hells Canyon – the deepest gorge in North America; on the southwest by the Eagle Cap Wilderness – the largest wilderness area in Oregon; and on the west by the Wallowa Mountains, with peaks reaching close to 10,000 feet. The county is accessed by two two-lane highways. One connects through La Grande, the county seat of adjacent Union County to the west, 65 miles away. The other connects through Lewiston, Idaho to the north, 80 miles away. Both highways require treacherous travel, winding
through canyons and up and down steep grades, and both are subject to closure several times each winter because of dangerous driving conditions. If you wish to leave the county, you simply make a u-turn and head back out; there is no through-road. Wallowa County once had a stable economy, with timber and ranching the primary industries. …In the early 90’s, when all four county mills were shut down, and lay-offs from the county’s largest employer, the US Forest Service, drastically reduced employment. At the same time, ranching was experiencing difficulties as well… The decline in these two industries created an economy bordering on depression. Wallowa County continues to have one of the highest unemployment rates in the state, and the median household income hovers around $32,000, nearly 20% below the national average of $41,994… Creating a facility within Wallowa County to house and treat Alzheimers and dementia patients who have additional behavioral issues would meet a critical need, and provide a continuum of long-term care. In addition, the project would provide a number of family wage jobs with benefits, which would be an additional benefit to the community. We anticipate approximately 18-19 FTE positions at this time. A new, state-of-the-art hospital is currently under construction in Enterprise, and is expected to be open and operational March 1, 2007 (until then, the existing hospital is open and operational). Other medical services provided locally include two family practice clinics… Although Wallowa County is a remote, rural area, health care has been made a priority by the community, and the quality of health care is very high. Because of this, most older residents want to stay in the community. Residential housing and assisted living facilities in Wallowa County are limited, and are currently not meeting demand… There is one nursing home to serve the county, the Wallowa Valley Care Center, adjacent to Wallowa Memorial Hospital. This is not a secure unit and cannot accept Alzheimers or dementia patients with behavioral issues… These patients are now forced to be moved away from family and friends to care facilities 65 miles away. This can be upsetting for an older person who may have difficulty being moved out of their community. The distance also makes it extremely difficult for an aging spouse to provide support through frequent visits.”

When the market study above was brought to the attention of MFP Project staff, staff initiated contact with Wallowa County civic leadership including the county commissioners and hospital administrator. Project Director Huddleston and staff will meet with county leadership in early February 2008 to explore project development for “On the Move” participants. Project staff will engage in similar outreach efforts in areas where communities have expressed interest in development of home and community-based resources in partnership with the “On the Move” project. As of mid-January, project staff is scheduled to meet with civic leaders in five Oregon counties in addition to Wallowa County.

Refer to Addendum A: Housing page 109.

B. 10. Continuity of Care Post Demonstration

All participants in “On the Move in Oregon” will be enrolled in a 1915(c) waiver, or in the self-directed State Plan service option, on day 366. The chart below seeks to clarify status of waivers and state plan services, and the populations that are served. While
Oregon initially contemplated using a model waiver for people with Acquired Brain Injuries (ABI), analysis has led us to believe that the needs of this, and all populations who will be served through the “On the Move” project, can be met through the existing approved 1915(c) waivers and State Plan HCBS option.

<table>
<thead>
<tr>
<th>Waiver/ State Plan services</th>
<th>Population Served</th>
<th>Approved Waiver/Service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS waiver 0185.90.R2</td>
<td>Seniors and Adults with Physical Disabilities</td>
<td>Yes</td>
</tr>
<tr>
<td>Self-directed 1915(j) State Plan services</td>
<td>Seniors and Adults with Physical Disabilities</td>
<td>Yes</td>
</tr>
<tr>
<td>HCBS waiver 0117.90.R3</td>
<td>Adults with Developmental Disabilities</td>
<td>Yes</td>
</tr>
<tr>
<td>Medically Involved Childrens Waiver</td>
<td>Children with disabilities</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The actions necessary to transition “On the Move” participants to on-going home and community-based waivered services will begin no later than the ninth month that the participant is enrolled in the MFP project.

Preliminary identification of the waiver and/or State Plan service option under which the MFP will continue to receive HCBS services was made as part of the initial transition planning, and will be documented in the case narrative. If not involved earlier, transition coordinators and local office case management staff will begin the transition process in the ninth month of MFP participation. Identification of the on-going HCBS option will be finalized. Local SPD/AAA staff will reassess the participant’s financial and functional eligibility for on-going Medicaid funded Home and Community-Based Services or for State Plan services. The transition coordinator will involve the local office staff in updating the participant’s person-centered planning tools to reflect the transition from “On the Move.” If necessary, individual service packages will be updated to conform to the person’s reassessed needs and to the specification of the benefit package available to the person. In the rare circumstance that “On the Move” participants no longer meet Medicaid financial and/or functional eligibility criteria to receive Medicaid-funded long-term services, they will be afforded the same hearings and appeals rights as other Medicaid recipients in the same circumstance. “On the Move” participants would continue to receive Medicaid “aid paid pending”, including their On the Move service package during the pendency of the hearing. If an OTM participant was ultimately found not to be eligible for HCBS services, but was at risk of re-institutionalization, the state would analyze the feasibility of continuing some or all of the OTM package for the participant at state expense.

Oregon agrees that it will submit any waiver amendments needed for the following waivers not later than September 30, 2008.

- Home and Community-Based Services Waiver for Seniors and People with Physical Disabilities, number 0185.90.R2. This waiver does not have a waiting list and is not near maximum capacity. If the waiver approached maximum capacity, SPD guarantees that it would add additional waiver “slots”. This waiver will need to be amended to add behavioral support services and their limitations.
• Developmental Disability Services Comprehensive Services for Children and Adults Waiver, number 0117.90.R3.

Refer to Addendum A: Continuity of Care Post Demonstration page 110.
C. Organization and Administration

C.1. Organizational Structure

“On the Move In Oregon,” Oregon’s Money Follows the Person Project, is housed in the Seniors and People with Disabilities (SPD) Division of the Oregon Department of Human Services. The Department is the single state agency on Medicaid. DHS is made up of five divisions: Children, Adults and Families Division, Addictions and Mental Health Division, Public Health Division, Division of Medical Assistance Programs, and Seniors and People with Disabilities Division, and they are supported by the Director’s Office, Administrative Services Division, Finance and Policy Analysis and Office of Financial Services. The Department structural chart follows. The SPD organizational chart is attached as Appendix 10 to this Protocol.
C.2. Staffing Plan

Within SPD, the Money Follows the Person Unit reports to Assistant Director James Toews and Deputy Assistant Director Cathy Cooper. Project Director Huddleston is a member of the Division’s executive team. The SPD organizational chart is attached as Appendix 10 to this Protocol.

Julia Huddleston is the full-time project director for “On the Move in Oregon.” Her resume was provided to the CMS Project Officer in June 2007; an updated copy is included in Appendix 11.

Ms. Huddleston was first employed by the Oregon Department of Human Services in June 1996 in its Senior and Disabled Services Division, predecessor organization to SPD. She was hired to manage the division’s program analysis and rate setting unit, which supervised rate setting activities in nursing facilities and community-based care and also managed 1915(c) waiver compliance activities and program evaluation. While in that position, Ms. Huddleston authored and implemented Oregon’s 1115 “Independent Choices” demonstration waiver, and co-authored Oregon’s 2001 “Real Choices Systems Change” grant. In September 2001, Ms. Huddleston was transferred to the Department’s Office of Finance and Policy Analysis (FPA) as a result of departmental reorganization. While in FPA, Ms. Huddleston oversaw departmental rate setting activities, including those for the Oregon Health Plan managed care providers, managed activities of the SPD budget unit, and implemented three provider taxes for the Department – nursing facilities, hospitals and Medicaid managed care plans. In 2005, Ms. Huddleston returned to SPD as manager of its Research, Planning and Rate Setting section. In that position, she worked with SPD executive leadership and advisory councils to co-author and present Oregon’s first “Future of Long-Term Care” report17, helped to enact legislation implementing Oregon’s Long-Term Care Partnership plans, and co-authored Oregon’s October 2006 “Money Follows the Person” grant application. Ms. Huddleston transitioned to the project director position in July 2007 as the Oregon Legislative Assembly’s 2007 session adjourned.

Brent Watkins works in the “On the Move” project as one of two lead program developers. Mr. Watkins’ area of emphasis is services for people with developmental disabilities. Mr. Watkins’ undergraduate degree is from Brigham Young University and his Master of Business Administration was awarded by George Fox University. Before joining the MFP Project, Mr. Watkins worked as the Residential Director of a non-profit

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17 The report can be found at: (http://www.oregon.gov/DHS/spwpd/ltc/fltc/index.shtml)
organization supporting adults with developmental disabilities from 1998-2007. His colleague, Caryn Whatley, works in the area of emphasis of services to seniors and people with physical disabilities. Ms. Whatley has worked for DHS since 1990. For more than eight of those years, she worked as an advocate for the younger disabled, representing clients with Social Security disability claims. She also worked for five years representing the Department at administrative hearings. Ms. Whatley brings extensive program knowledge to the project as well as extensive experience working with field staff, community partners, vocational rehabilitation, and the medical and legal communities. Both Mr. Watkins and Ms. Whatley started with the project in October 2007. As of January 1, 2010, both will be reassigned to other areas of SPD as daily TC supervision is transitioned to local management teams.

Lead research analyst Julia Brown joined the MFP project in August 2007. Ms. Brown was employed by SPD as its Long Term Care Analyst and Performance Measure and Benchmark Coordinator in June 2004. Her Master’s degree in Public Administration, with a specialization in Technology Administration, was awarded by the University of Utah. Project Housing Specialist Linda Woelke joined the team in December 2007. Ms. Woelke has extensive “on the ground” experience with an Oregon Regional Housing authority, including management of Housing, Homeownership and Family Self-Sufficiency programs as well as asset management of properties including LIHTC, HUD Public Housing and USDA Rural Development. Project Coordinator, Stephanie Tyrer, joined the project in September 2007. Ms. Tyrer’s professional experience is in the area of project management including administration, budget tracking and data analysis; she also spent two years as a project coordination specialist for DHS Addictions and Mental Health Division.

“On the Move” plans to hire one more central staff position in the next 2008. The position will serve as a liaison with Oregon’s fully capitated health plans and their partner Medicare advantage plans helping to ensure that the pressures of DRG and otherwise capitated payment don’t incentivize long-term placement that is more restrictive than needed. Transition coordinators will be hired throughout the life of the project in order to maintain an approximate 1 to 15 ratio of coordinators to participants.

Effective with the January 1, 2010 amendment of the Operational Protocol, Oregon plans to restructure its Central Office project team. The restructuring is needed to address the inclusion of the “dual diagnosis” population within Oregon’s project and to acknowledge the development of the project during 2008 and 2009. The “program developer” positions discussed above will be phased out effective December 31, 2009 as daily supervision of the transition coordinators transfers to local office management. Central office project staff will continue to report to Project Director Huddleston... In addition to the 4 positions above, SPD plans to hire the following staff in 2010:

**State Hospital MFP Project Coordinator:** This position leads a staff team in development and implementation of a State Hospital Transition program. The program will consist of residential and housing supports designed to support and stabilize a person who has behavioral or psychiatric needs that cannot be managed with existing community based care services but which do not require inpatient psychiatric treatment. Services will be developed to address the
residential and behavioral habilitation needs of persons who have reached a maximum benefit from inpatient care but who have complex psychiatric and behavioral conditions on an ongoing basis. In addition to the ongoing services, specialized services will be developed to provide intensive and time limited supports for persons who have intermittent or episodic escalations of their behavioral or psychiatric conditions. All services will be provided within the framework of all 1915(c) Home and Community Based Care waivers and MFP requirements. This position will also oversee the screening and discharge activities necessary to transition to the community existing State Hospital clients who qualify for the new program.

**Workforce Development Coordinator**: This position, as part of the State Hospital Transition team, ensures that specialized workforces are defined, trained and available to support new service models and person centered care transition plans. Duties will include oversight of the contracts, activities and development work as well as development and implementation of training and consultation to prepare and support staff in successful implementation of client specific transition plans.

**Resource Developers (2)**: These positions will work within the State Hospital Transition team and the overall MFP project be to design new service models, to identify necessary housing resources and supports to support proposed new models and to design and implement the necessary regulatory and programmatic strategies to actualize new models.

Oregon acknowledges that it must stay within the administrative cap that is one of the Terms and Conditions of this project.

Refer to Addendum A: Staffing Plan page 112.

**C.3. Billing and Reimbursement Procedures**

SPD requires providers to maintain relevant service record information for a minimum of three years, per federal regulatory requirements. Local AAA’s and service providers are required to permit authorized representatives of DHS to review these records for audit purposes. Audit staff from the Department of Human Services and the Secretary of State’s Office periodically review payment records based on their applicable state statutes and administrative rules to ensure provider-billing integrity. Staff from both agencies set audit priorities each year based upon assessed risk analysis. Audit methods include on-site review as well as independent data analysis.

To maintain a clear audit trail, SPD makes payments directly to nearly all service providers through the CMS-approved Oregon Medicaid Management Information System (MMIS). This same mechanism will be employed by the “On the Move” project. While regional transportation brokers, entities that provide Non-Medical Service Transportation under direct contract with DHS, are exceptions to MMIS payment, they are required by contract to permit State and Federal review of records to conduct audits or investigate unresolved questions of fact. If exceptions to MMIS-payment exist in the “On the Move” project, the same contractual requirements will be imposed. Billing
systems for qualified services are operational at this time. Billing systems for demonstration and supplemental services are anticipated to be operational no later than April 30, 2008, with sample claims tests occurring in that month. The first set of sample claims tests will be performed during the week of April 7, 2008. Errors discovered as a result of that test were corrected during the month of May 2008, and both demonstration and supplemental claims were correctly paid in June 2008.

DHS Audits:
Providers: Oregon Department of Human Services (DHS) auditors evaluate provider financial condition and contractual compliance, review fiscal audits performed on contractors by other agencies, provide consultation to the Secretary of State’s Division of Audits programs, and evaluate provider financial system issues for compliance with federal and state standards. Audits occur on a periodic basis. DHS usually determines the frequency of an audit. A government body, an organization or an individual can trigger an audit. DHS auditors perform both desk reviews and on-site examinations of providers’ records, facilities and operations, and other information.

Internal Programs: DHS auditors provide timely, accurate, independent and objective information about DHS operations and programs. An internal audit committee made up of representatives from each DHS administrative unit, including SPD, works closely with the Audit Unit to ensure comprehensive audit coverage. The committee approves an annual audit plan of risk-based and required cyclical audits, then meets every two months, updating the plan as needed based on special requests, investigations, legislative inquiry, or other administrative direction. Auditors have complete access to all necessary activities, records, property and employees. The auditors have no direct authority over activities being reviewed. They abide by the Institute of Internal Auditors’ Code of Ethics and practices conform to the Standards for the Professional Practice of Internal Auditing, as promulgated by the Institute of Internal Auditors, the American Institute of CPA’s (AICPA), the Federal General Accounting Office (GAO) Yellow Book, Institute of Internal Auditors (IIA), and Information Systems Audit and Control Association (ISACA).

DHS internal audits fall into two categories: classification and issue-specific. Priority for audits is set by:
- Risk analysis, assessing the extent of fiscal, legal, and/or public policy impact for each potential audit subject, with those having the highest level of risk given top priority; and
- Database analysis, which determines the quantity, magnitude, degree of aberration, and inconsistencies that exist in current application of practices.

Audit Unit staff and the audit committee use the audit process to assess functions and control systems and to make recommendations to DHS administration regarding issues such as: economical and efficient use of resources; progress meeting DHS goals and outcomes; reliability and integrity of information; consumer health and safety; compliance with laws, regulations, policies, procedures, and contact terms; safeguarding assets, adequacy of internal controls; sound fiscal practices; effective management systems; and security and controls of information systems.
Secretary of State Audits:
The Audits Division is responsible for carrying out the duties of the Secretary of State’s Office as the constitutional Auditor of Public Accounts. The Audits Division is the only independent auditing organization in the state with the authority to review programs of agencies in all three branches of state government and other organizations receiving state money. Authority for the responsibilities of the Audits Division is found in sections 297.00 through 297.990 of the Oregon Revised Statutes. Secretary of State auditors review the areas of finance, performance, information technology, and fraud and abuse. Most recently, the agency conducted a review of SPD Medicaid in-home care payments (see www.sos.state.or.us/audits/index.html). Frequency of SOS audits is based on risk assessment and on standards established by nationally recognized entities including, but not limited to, the GAO and the National Association of State Auditors. Types of audits include:

- Financial and compliance audits of all components of state government and state-aided institutions. These audits determine whether a state agency has conducted its financial operations properly and has presented its financial statements in accordance with generally accepted accounting principles;
- Examinations of internal control structures and determination whether state agencies have complied with finance-related legal requirements. At the end of each engagement, the Division prepares an opinion regarding financial statements, reports significant finds, and recommends any necessary improvements;
- Financial and compliance audits of the state’s annual financial statements. This audit, the largest audit of public funds in the state and a major engagement of the Division, complies with the Single Audit Act of 1984 (PL 92-502) which requires such an audit annually as a condition of eligibility for Federal funds;
- Performance audits of the operations and results of state programs to determine whether the programs are conducted in an efficient and economical manner;
- Special studies and investigations; and
- Requested audits or special studies for counties.

In accordance with statutory provisions and in cooperation with the State Board of Accountancy and the Oregon Society of Certified Public Accountants, the Division: develops the standards for conducting audits of all Oregon municipal corporations; prescribes, revises, and maintains minimum standards for audit reports; and reviews reports, certificates, and procedures for audits and reviews of corporations. The Division evaluates reports of audits or reviews of these municipal corporations and auditor’s work papers for compliance with the standards.

In addition to audit activities of the DHS Audit Unit and Secretary of State Audit Division:
- The SPD Research, Planning and Rate Setting Unit regularly reviews random records of waiver provider payments for accuracy and consistency with agency policy and conducts monthly reviews of Waiver services expenditures and caseload counts. These monthly reviews involve the review of expenditures in each of the care settings to ensure that payments are unduplicated and within the rate schedule. The report also details expenditures by living situation and a recipient count. SPD pulls the data using DSSURS (Decision Support Surveillance
and Utilization Review System) and reviews all cleansed, paid claims on a monthly basis. The DSSURS derives data directly from the MMIS.

- The DHS Office of Payment Accuracy and Recovery receives reports of fraud in DHS programs and investigates allegations. The Office maintains a hotline for anyone to report fraud and will investigate allegations against providers such as billing for services not rendered, intentionally billing in duplicate, billing for higher level of services than was delivered, billing for services provided by unlicensed or otherwise ineligible practitioners, and kickback schemes.

Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

The claims system contains edits that ensure recipient eligibility prior to approval for payment for any type of provider claim. The Client Maintenance System contains the individual’s Medicaid eligibility information. The Claims system reads the eligibility file to ensure eligibility prior to payment. If an individual is not eligible for services on the date the claim is processed, the claim is denied and no payment is made.

All services are prior authorized for payment based on the approved plan of care. For all MFP services, the transition coordinator authorizes the specific services to be provided in the plan of care. Providers receive a copy of the plan of care, specifying the services to be provided prior to the provision of services. The transition coordinator authorizes services for individual who live at home using a form that specifies the ADL and IADL tasks to be performed and the number of hours authorized for each task. This information is used to generate a voucher that shows the number of hours authorized. A task list is provided to each worker explaining the tasks that are to be performed. The individual reviews the task list with the worker to determine how the tasks are to be completed. Residential providers receive a plan detailing the services to be provided along with a statement showing the reimbursement rate. The provider signs and returns this statement prior to the provision of services. In-home services providers must return an invoice, signed by the client to verify the provision of services prior to claims processing.

Refer to Addendum A: Billing and Reimbursement Procedures page 113.

D. Independent State Evaluation

The State of Oregon chooses not to conduct an evaluation separate from the national evaluation.
E. Final Project Budget

Oregon assures CMS that the Department of Human Services has the capability to report qualified expenditures for On the Move participants and that it can demonstrate maintenance of effort. The attached “Money Follows the Person Worksheet for Proposed Budget” illustrates Oregon’s estimates of “On the Move” costs for calendar year 2008 and beyond.

Administrative Budget Justification and Narrative:

Personnel
MFP staff hired during the 2007 calendar year includes:
1.0 FTE Project Director
2.0 FTE Program Developers
1.0 FTE Research Analyst
1.0 FTE Housing Specialist
1.0 FTE Project Coordinator
In the first six months of 2008, we also plan to hire 2 additional half time staff members to deal with issues involving information systems and health plan coordination.

Salaries are set by the Oregon Department of Administrative Services. Collective bargaining applies to most non-management positions.

Other Payroll Expense (OPE)
OPE costs include the employer share of the FICA contribution; unemployment insurance; workers compensation assessment expenses; and mass transit tax where appropriate.

Fringe Benefits
State of Oregon fringe benefits include leave time, medical and other insurances, retirement benefits and other fringe benefits, and life insurance. Most benefit packages are managed by the Oregon Department of Administrative Services; the retirement and deferred compensation plans are managed through the Oregon Public Employees Retirement System.

Equipment
Oregon Department of Human Service Standards has been used to estimate costs.

Services and Supplies
Oregon Department of Human Services standards for supply costs have been used to estimate costs. This standard includes costs attributable to general office expenses, employee training, publicity and publications, telecommunications, office expenses and rent. Adjustments to the general standard include:

- Travel: Salem-based project staff will incur per diem and lodging costs as the project develops throughout the state. The budget assumes lodging and per diem costs are incurred by 4 employees, 5 days each month.
- Registrations and Conference Expenses: The budget assumes project staff attendance at 4 conferences per year at a cost of $1,000 per conference. Lodging and per diem is included above.
• Outreach and Education Materials: The proposed budget estimates that production of brochures and pamphlets will cost $25,000.

• Telecommunications: MFP uses a teleconference line to connect outlying stakeholders to meetings in the DHS central office. Videoconferencing is also made available to connect rural and frontier staff to central office meetings. Web-conferencing is going to be provided as a means to stay in direct contact with the transition coordinators in the field. We have included $15,000 in the administrative budget for these additional costs.

• 800 lines: Most project participants and their families will be outside the Salem calling area. Project participants are poor. The project will include an “800” number for in-Oregon use. The charge for the line will be $0.13 per minute of usage. The estimated budget assumes 120 minutes of use daily.

Contractual costs, including consultant contract
Training consultation contracts are anticipated not to exceed $50,000. MFP project staff is designing the project-specific database. Database building will be contracted at a cost not to exceed $75,000.

Transition Coordinators
By August 2008, SPD will hire 15 transition coordinators to work in the field with the clients that will be enrolled into MFP. Each transition coordinator will have a caseload of 12 to 15 clients and be stationed in targeted locations throughout the state. Three additional coordinators will be hired in the 2010 calendar year, allowing he project to maintain a 1 to 15 ratio throughout its life. Transition coordinators will report to the MFP project director. Communication procedures will be created that allow the coordinators receive training and project related information. Oregon requests that costs of transition coordinators be considered to be “case management services” as defined under section 1915(c) of the Social Security Act, and covered in this project as “Home and Community-Based Demonstration Services.”

Travel
Transition coordinators will be required to travel to Salem monthly. Their jobs will involve extensive local travel. Oregon counties are generally quite large, though sparsely populated. Nursing facilities in which potential participants are receiving care may be located 75 to 100 miles from their home communities. Transition coordinator travel costs include both estimated costs of assigning a state vehicle to the employee for full-time use and per diem and lodging for monthly travel.

Equipment
Oregon Department of Human Services standards for equipment costs for new field-based employees have been used in estimating costs to equip transition coordinators.

Survey costs
Oregon assumes that the Transition Coordinator will deliver the baseline survey as part of the tasks that must be performed before transition. Oregon additionally assumes that the first follow-up survey will be performed by local case managers associated with the waiver program to which the participant will transition. Based on these assumptions,
federal evaluation supports will not be needed by Oregon until the calendar year 2010 when the first 24-month follow-up surveys are administered.

In estimating costs for calendar years subsequent to 2008, several assumptions have been used:

- Participants are assumed to transition in even monthly intervals throughout the year.
- Administrative costs from 2008 have been assumed to continue. An annual growth assumption of 7.5% has been used to grow salary and fringe benefit related costs.

Costs in each of the service areas – qualified, demonstration and supplemental services – have been assumed to continue at the per capita level established for 2008. Per capita costs have been established based on Medicaid rates for institutional and community-based care in each of the populations. Informal market research has also looked at comparable private market costs in populations in which such a comparison is meaningful. Information has been aggregated across populations. Our analysis leads us to believe that initial monthly costs of $5,750 should, on average, be sufficient to provide the package of qualified services. Demonstration costs were estimated on a per participant basis since they are not currently offered as Oregon Medicaid services. Informal discussion with service providers and market analysis led us to set an initial demonstration expenditure level of $10,000 per participant. Supplemental expenses will primarily be associated with housing setup and with appropriate uses of technology to aid transition. Discussions with the state Housing and Community Services Department and public housing authorities, and with the state assistive technology advisory council housed at Oregon Health Science University was coupled with analysis of housing initiatives currently on-going through DHS for distinct populations. Based on these sources of information, we assumed an average supplemental services cost of $15,000 per transition. An annual growth assumption of 5.0% has been used to grow service costs.

F. Section Q

Summary/Abstract:
Oregon has one of the most robustly rebalanced long term care systems in the nation. Oregon’s Money Follows the Person project – “On the Move in Oregon” – continues the state’s historic rebalancing efforts using a sophisticated network of home and community-based services. “On the Move in Oregon” (OTM) is operated by the Seniors and People with Disabilities (SPD) Division of the Oregon Department of Human Services. Oregon DHS is the single state Medicaid agency. SPD is the unit within DHS that provides leadership, regulates services, provides protective services, manages resources, and administers the Medicaid long-term care program for seniors, adults with physical disabilities, and adults and children with developmental disabilities. SPD is the single State Unit on Aging, and serves as the state’s long-term care regulatory agency and Minimum Data Set (MDS) repository.

Area Agencies on Aging (AAAs) in the largest metropolitan areas of the state are on track to develop fully functioning Aging and Disability Resource Centers (ADRCs) by the end of this calendar year. The State Unit on Aging will develop the ADRC for the balance of the state. With funding from this grant, SPD and Oregon’s AAAs envision...
infrastructure development – specifically, the comprehensive, statewide resource database and contact module that provides Oregonians of all ages and income levels with easy access to information about long-term care and services and enables transition, case management and ADRC staff to offer decision support. The ADRCs, in conjunction with OTM, will play a pivotal role to help ensure that people are able to make informed choices which meet their individual needs and preferences.

**Current Status of ADRC and MFP-ADRC Partnership:**
The Lane County Council of Governments (LCOG) is the Area Agency on Aging in Lane County, and its ADRC became operational as of April 1, 2010. Four other AAAs – Northwest Senior & Disability Services (NWSDS), Oregon Cascades West Council of Governments (OCWCOG), Multnomah County Aging and Disability Services, and Washington County Department of Disability, Aging and Veterans Services – are on target to meet the requirements of a fully functioning ADRC by the end of the year. Oregon ADRCs serve people 18 and over, regardless of payer source.

Oregon’s OTM project became operational on April 8, 2008. Twenty-five locally-based transition coordinators work with long-term nursing facility residents, eligible for Medicaid, to help them transition out of facilities and back into their homes and communities. As of June 30, 2010, Oregon’s On the Move project has assisted 265 people return to the community. Transition coordinators are in and out of nursing facilities frequently. They’re often asked by residents who may not be eligible for OTM, and by their family members, what resources are available to assist them in transitioning back home.

Organizational placement of both the MFP and ADRC project directors within the SPD structure has helped to ensure complementary efforts as programs developed. With the advent of the MDS Section Q expansion, SPD envisions that coordination efforts will become more formalized. ADRCs seem ideally positioned to be designated as local contact agencies. In conjunction with OTM staff, ADRC staff can provide transition support to non-Medicaid eligible nursing home residents. In conjunction with ADRC staff, OTM transition coordinators will be trained as options counselors.

Key to these coordination efforts, and to the provision of timely and accurate services, is the development of additional tools that provide information and assistance on a comprehensive, statewide basis.

**Goals, Objectives, and Outcomes:**
Oregon’s Nursing Home Transition and Diversion Project will create access to information and data on long term service and support resources, providers, and information for consumers and their families. We believe that this project will assist with decision support and enhance Oregonians’ ability to make the most appropriate choices for their long-term service needs. Specifically, the project will:

1. Develop an interface from the ADRC contact module into the Medicaid case management system to integrate the two systems and support a single point of entry into long-term service and supports for all Oregonians. As a result, OTM, ADRC and Medicaid case management staff will be aware of an individual’s
interaction with long-term service and supports from the first identification of need.

2. Procure and implement an enhancement to the ADRC resource database that will provide real-time provider/resource information on space/bed availability. This information will be available to the general public, as well as to ADRC, OTM and case management staff. The development will include a real-time interface through which community-based long term service providers can update their profile with availability and rate information. Implementation of the enhancement will require development of:
   - Inclusion and exclusion policy for facilities;
   - Memorandums of Understanding for licensed facilities that participate in the availability and capacity implementation.
   - Protocols for update access into the system and for frequency of information update.

Oregon’s MFP efforts, focused as they must be on people who are both Medicaid eligible and who have been institutionalized for long periods of time, represent an approach to rebalancing efforts that can fairly be characterized as “getting people out the back door”. The resources to be developed in this project will assist Oregonians in better understanding long-term services early in the process, when a lower level of intervention might be all that’s needed. The resources will also assist state policy makers and analysts in a better understanding of the path that a person follows who ends up in a long term, Medicaid funded, institutionalized stay. The project can be characterized as development of a resource to “keep people from coming in the front door” of the institution.

Proposed Project:
These funds will be used to develop and deploy a resource database which will connect the ADRCs and SPD statewide. This will provide a single, transparent vehicle for any consumer – whether or not the person is Medicaid-eligible – to seek information about long term care options. This database will function as a tool for use by transition staff in any part of the state, thus enabling seamless support for clients and consumers. Finally, this tool will serve as the infrastructure to enable Oregon to support and assist residents identified by MDS 3.0, Section Q.

Project Management:
Project oversight will be provided by Sandy Hata, Interim Project Director, On the Move in Oregon (A Money Follows the Person Demonstration) and by Elaine Young, Manager, SPD State Unit on Aging and Project Director of Oregon’s Aging and Disability Resource Center project. Daily project management will be provided by Linda Lenox, ADRC Operational Analyst. Ms. Lenox will serve as the technical expert on system design and interface. We estimate that 15% of her time will be devoted to the needs of this project over its 24 month life. SPD anticipates that resource database work will be accomplished by consultant staff; specifically an information technology developer to design and implement the interface from the ADRC system to the Medicaid case management system, and an ADRC software vendor to implement the enhancement to the resource database and to real-time availability display. SPD additionally anticipates hiring a limited duration operations analyst between months 6 and 12 of the project to remain with the project through its end. The role of the analyst
will involve development of the policies and MOUs needed to implement the real time availability enhancement, and work with industry organizations. These include the **Oregon Health Care Association (OHCA)**, a private not-for-profit trade association representing the long term care industry in Oregon. OHCA’s membership includes over 620 nursing facilities, assisted living facilities, residential care facilities, senior housing, in-home care agencies, and others. **The Oregon Alliance of Senior and Health Services (OASHS)** is an association of not-for-profit, mission-directed organizations dedicated to providing quality housing, health, community and related services to the elderly and disabled. Current members include government subsidized senior housing, market rate senior housing, assisted living facilities, residential care facilities, community based services such as home care or adult day care, continuing care retirement communities, and nursing facilities. Adult foster homes are an important component of Oregon’s long-term service system. While no trade association exists similar to OHCA or the Alliance, Service Employees’ International Union Local 503 represents approximately 3500 commercial and relative adult foster home providers who provide Medicaid services in their homes to low-income seniors and people with physical, mental, and developmental disabilities.

Oregon believes that the challenges to this project are primarily technical, such as ensuring security and access for staff in the licensed facility environments and ensuring the accuracy of “real time” vacancy and rate data from providers.

**Budget Justification:**

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<th>Non-Federal Cash</th>
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<td>Federal: Project Analyst - resource database development; 1.0 FTE for 15 months at $46,836 annually.</td>
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Contract to develop interface from ADRC call module to Medicaid case management system; contract to procure and implement real-time provider information database into ADRC resource database. A detailed evaluation plan and budget will be submitted by March 31, 2011 when contract is made.

Oregon DHS does not have an indirect rate. We are currently under an approved Public Assistance Cost Allocation Plan.

Refer to Addendum A: Section Q page 114.
### Application for Federal Assistance SF-424

**Version 02**

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**5a. Federal Entity Identifier:**

**5b. Federal Award Identifier:**

**State Use Only:**

**6. Date Received by State:**

**7. State Application Identifier:**

### 8. APPLICANT INFORMATION:

**a.** Legal Name: **State of Oregon Department of Human Services, Seniors and People with Disabilities Division**

**b.** Employer/Taxpayer Identification Number (EIN/TIN): 93-0794831

**c.** Organizational DUNS: 93-355-6359

### d. Address:

- **Street 1:** 500 Summer Street NE
- **Street 2:** E-02
- **City:** Salem
- **County:** Marion
- **State:** Oregon
- **Province:**
- **Country:** USA
- **Zip / Postal Code:** 97301

### e. Organizational Unit:

- **Department Name:** Department of Human Services
- **Division Name:** Seniors and People with Disabilities

### f. Name and contact information of person to be contacted on matters involving this application:

- **Prefix:**
- **First Name:** Elaine
- **Middle Name:**
- **Last Name:** Young
- **Suffix:**

- **Title:** Manager, SPO State Unit on Aging and Project Director of Oregon's Aging and Disability Resource Center project

- **Organizational Affiliation:**

- **Telephone Number:** 503-373-1726
- **Fax Number:** 503-373-1133

- **Email:** Elaine.Young@state.or.us
**Application for Federal Assistance SF-424**

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<td>Type of Applicant 3: Select Applicant Type:</td>
<td></td>
</tr>
<tr>
<td>*Other (Specify)</td>
<td></td>
</tr>
<tr>
<td>*10 Name of Federal Agency:</td>
<td></td>
</tr>
<tr>
<td>Centers for Medicare and Medicaid Services</td>
<td></td>
</tr>
<tr>
<td>11. Catalog of Federal Domestic Assistance Number:</td>
<td></td>
</tr>
<tr>
<td>93. 779</td>
<td></td>
</tr>
<tr>
<td>CFDA Title</td>
<td></td>
</tr>
<tr>
<td>Money Follows the Person Rebalancing Demonstration</td>
<td></td>
</tr>
<tr>
<td>*12 Funding Opportunity Number:</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>*Title:</td>
<td></td>
</tr>
<tr>
<td>ADRG Nursing Home Transition and Diversion Program</td>
<td></td>
</tr>
<tr>
<td>13. Competition identification Number:</td>
<td></td>
</tr>
<tr>
<td>Title:</td>
<td></td>
</tr>
<tr>
<td>14. Areas Affected by Project (Cities, Counties, States, etc.):</td>
<td></td>
</tr>
<tr>
<td>State of Oregon</td>
<td></td>
</tr>
<tr>
<td>*15. Descriptive Title of Applicant's Project:</td>
<td></td>
</tr>
<tr>
<td>Diversion and Transition Resource Linkages</td>
<td></td>
</tr>
</tbody>
</table>
Application for Federal Assistance SF-424

16. Congressional Districts Of:
   *a. Applicant: all
   *b. Program/Project: all

17. Proposed Project:
   *a. Start Date: 10/1/2010
   *b. End Date: 9/30/2012

18. Estimated Funding ($):
   *a. Federal: 391,671
   *b. Applicant: 0
   *c. State: 0
   *d. Local: 0
   *e. Other: 0
   *f. Program Income: 0
   *g. TOTAL: 391,671

**19. Is Application Subject to Review By State Under Executive Order 12372 Process?**
   a. This application was made available to the State under the Executive Order 12372 Process for review on _____
   b. Program is subject to E.O. 12372 but has not been selected by the State for review.
   ☑ c. Program is not covered by E.O. 12372

**20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)**
   ☑ Yes     ☐ No

21. *By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U. S. Code, Title 218, Section 1001)
   ☑ ** I AGREE

   ** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions

Authorized Representative:

Prefix: ___________________________  *First Name: James
Middle Name: D.
*Last Name: Toews
Suffix: ___________________________

*Title: Assistant Director

*Telephone Number: 503 945-5858  Fax Number: 503-373-7823

*Email: James.D.Toews@state.or.us

*Signature of Authorized Representative: ___________________________  *Date Signed: 9/27/10

Authorized for Local Reproduction

Standard Form 424 (Revised 10/3/05)
Prescribed by OMB Circular A-102
<table>
<thead>
<tr>
<th>Application for Federal Assistance SF-424</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Applicant Federal Debt Delinquency Explanation</em></td>
</tr>
<tr>
<td>The following should contain an explanation if the Applicant organization is delinquent of any Federal Debt.</td>
</tr>
<tr>
<td>Item</td>
</tr>
<tr>
<td>------</td>
</tr>
</tbody>
</table>
| 1.   | Type of Submission: (Required): Select one type of submission in accordance with agency instructions.  
- New Application  
- Amended Application  
- Change/Corrected Application - If requested by the agency, check if this submission is to change or correct a previously submitted application. Unless requested by the agency, applicants may not use this to submit changes after the closing date. | 10. Name of Federal Agency: (Required): Enter the name of the Federal agency from which assistance is being requested with this application. |
| 2.   | Type of Application: (Required): Select one type of application in accordance with agency instructions.  
- New – An application that is being submitted to an agency for the first time.  
- Continuation - An extension for an additional funding/budget period for a project with a projected completion date. This can include renewals.  
- Revisions - Any change to the Federal Government’s financial obligations or contingent liability from an existing obligation. If a revision, enter the appropriate letters. More than one may be collected. If “Other” is selected, please specify in text box provided. A. Increase Award B. Decrease Award C. Increase Duration D. Decrease Duration E. Other (Specify) | 11. Catalog of Federal Domestic Assistance Number (optional): Enter the Catalog of Federal Domestic Assistance number and title of the program under which assistance is requested, as found in the program announcement, if applicable. |
| 3.   | Date Submitted: Leave this field blank. This date will be assigned by the Federal agency. | 12. Funding Opportunity Number (optional): Enter the Funding Opportunity Number and title of the opportunity under which assistance is requested, as found in the program announcement. |
| 4.   | Applicant Identifier: Enter the entity identifier assigned by the Federal agency, if any, or applicant’s control number, if applicable. | 13. Competition Identification Number (optional): Enter the Competition Identification Number and title of the competition under which assistance is requested, if applicable. |
| 5a.  | Federal Entity Identifier: Enter the number assigned to your organization by the Federal Agency, if any. | 14. Areas Affected by Project: List the areas or entities within the categories (e.g., cities, counties, states, etc.) specified in the instructions below. Use the continuation sheet to enter additional areas, if needed. |
| 5b.  | Federal Award Identifier: For new applications leave blank. For an extension or revision to an existing award, enter the previously assigned Federal award identifier number. If a change/correction application, enter the Federal identifier in accordance with agency instructions. | 15. Descriptive Title of Applicant’s Project: (Required) Enter a descriptive title of the project, if appropriate. Attach a map showing project location (e.g., construction or real property projects). For pre-applications, attach a summary description of the project. |
| 6.   | Date Received by State: Leave this field blank. This date will be assigned by the State, if applicable. | 16. Congressional District of (optional): Enter the applicant’s Congressional District, and the number of the district(s) affected by the program or project. Enter in the format: 2 characters State Abbreviation + 3 characters District Number, e.g., CA-005 for California’s 5th district, CA-012 for California’s 12th district, NC-103 for North Carolina’s 103rd district.  
- If all congressional districts in a state are affected, enter “All” for the district number, e.g., MD-all for all congressional districts in Maryland.  
- If nationwide, i.e., all districts within all states are affected, enter US-all.  
- If the program/project is outside the US, enter 00-009. |
| 7.   | State Application Identifier: Leave this field blank. This identifier will be assigned by the State, if applicable. | 17. Proposed Project Start and End Dates: (Required) Enter the proposed start date and end date of the project. |
| 8.   | Applicant Information: Enter the following in accordance with agency instructions.  
- Legal Name: (Required): Enter the legal name of applicant that will undertake the assistance activity. This is the name of the organization that has been awarded and registered with the Central Contractor Registry. Information on registrants is found on www.assist.gov. Please use the same name on all documents. If the organization is not in the US, enter 44.44,444.44.  
- Employer Taxpayer Identification Number (EIN/TIN) (Required): Enter the Employer or Taxpayer Identification Number (EIN or TIN) as assigned by the Internal Revenue Service. If your organization is not in the US, enter 44.44,444.44.  
- Organization DUNS (Required): Enter the organization’s DUNS number. DUNS number must be obtained by visiting the Grants.gov website.  
- Address: Enter the complete address as follows: Street address (Line 1 required), City (Required), County, State (Required, if country is US), Province, Country (Required), Zip/Postal Code (Required, if country is US).  
- Organization Unit: Enter the name of the primary organizational unit (and department or division, if applicable). The name of the unit will be used to determine whether the application is subject to the | 18. Estimated Funding: (Required) Enter the amount requested or to be contributed during the first funding/budget period by each contributor. Value of in-kind contributions should be included on appropriate lines, as applicable. If the action will result in a dollar change to an existing award, indicate only the amount of the change. For decreases, enclose the amounts in parentheses. |
| 19.  | Application Subject to Review by State Under Executive Order 12372 Process? Applicants should contact the State Single Point of Contact (SPOC) for Federal Executive Order 12372 to determine whether the application is subject to the |
ADDENDUM A

Revisions for Oregon Community Choices Program previously known as “On The Move.”

Introduction and Goals.................................................................Page 93
Benchmarks..................................................................................Page 95
Participation Recruitment and Enrollment.................................Page 99
Stakeholder Involvement..............................................................Page 101
Benefits and Services.................................................................Page 102
Consumer Supports.................................................................Page 105
Quality Management System....................................................Page 106
Housing......................................................................................Page 109
Continuity of Care Post Demonstration......................................Page 110
Organizational Structure............................................................Page 111
Staffing Plan..............................................................................Page 112
Billing and Reimbursement Procedures.....................................Page 113
Section Q..................................................................................Page 114
Introduction and Goals:
This addendum to the original Oregon “On The Move” Money Follows the Person program outlines the proposed changes.

Oregon’s program, previously known as On The Move, was suspended 10/1/2011. An audit of the program was conducted internally as well as externally; final results of external audit are pending.

In July 2012, Aging and People with Disabilities (APD), (previously known as Seniors and People with Disabilities (SPD)) convened stakeholders and presented a concept paper proposing Oregon reinstitute Money Follows the Person. The previous program encompassed only APD clients, the revised program will include a joint partnership between APD and Addictions and Mental Health (AMH), extending the program to qualified AMH clients.

In order to discourage any negative association with the formerly discredited version of the program the reinstituted program will be named Oregon Community Choices Program (OCCP). A Director and Deputy Director were hired and began reworking/revising the program in January 2013. These positions are currently within the Advocacy and Development Unit of APD.

A phase-in approach will be utilized to rebuild the program at a speed that is manageable.

Phase 1 will consist of identifying populations in APD/AMH that meet the service eligibility definitions for MFP and building a coding infrastructure for reporting, budgeting, and capturing appropriate match and reinvesting the federal enhancement match dollars into home and community based care. When rebalancing funds have accumulated OCCP Directors will engage Stakeholders and Steering Committee members to help determine where/what the need may or will be. An area of interest to explore includes preventative services to prevent or delay the need for higher levels of care. Some type of GAP analysis would be used to determine needs. Continued Phases will include potentially expanding the program to include other services, settings or populations based on Stakeholder recommendations and APD/AMH Steering Committee approval.
Oregon’s Historical Pattern of Nursing Facility Utilization

<table>
<thead>
<tr>
<th>State Fiscal Year End</th>
<th>Medicaid Nursing Home Residents</th>
<th>Growth/(Decline) from Previous Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2008</td>
<td>5,094</td>
<td>(2.45%)</td>
</tr>
<tr>
<td>June 2009</td>
<td>No data available</td>
<td></td>
</tr>
<tr>
<td>June 2010</td>
<td>4,681</td>
<td>(8.11%)</td>
</tr>
<tr>
<td>June 2011</td>
<td>4,727</td>
<td>1.01%</td>
</tr>
<tr>
<td>June 2012</td>
<td>4,447</td>
<td>(5.92%)</td>
</tr>
<tr>
<td>February 2013</td>
<td>4,441</td>
<td>(.13%)</td>
</tr>
</tbody>
</table>

Oregon will continue to target the following APD populations for MFP:

Nursing home populations:
- Seniors – age 65+
- Adults with physical disabilities – age 18-64
- Adults and Children with intellectual/developmental disabilities

Oregon plans to target the following AMH populations not identified previously with MFP:

Psychiatric Residential Treatment Facilities, age 21 and under
Psychiatric Hospital, age 21 and under and 65 and older

The prior Money Follows the Person Program (On The Move) relocated to community based living situations all clients who were served at Eastern Oregon Training Center, an ICF/MR. Although Oregon no longer has any designated ICF/MR facilities, there continue to be I/DD residents in nursing facilities.

Oregon has identified a gap in the ability to serve 22-64 year old clients through Money Follows the Person for individual in Secure Residential Treatment Facilities and the Oregon State Hospital and will continue to explore opportunities to serve those individuals in more person-centered community placements.
Benchmarks:

BENCHMARK #1 - Required

Meet the projected number of eligible individuals transitioned in each target group from an inpatient facility to a qualified residence during each calendar year of the demonstration.

OCCP will be a phased-in program. Initially, during Phase 1, OCCP will focus on nursing home transitions to qualified community MFP settings for the following populations.

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Adults &amp; Children with ID/DD</th>
<th>Adults with Physical Disabilities</th>
<th>Seniors</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>3</td>
<td>6</td>
<td>26</td>
<td>35</td>
</tr>
<tr>
<td>2014</td>
<td>11</td>
<td>19</td>
<td>77</td>
<td>107</td>
</tr>
<tr>
<td>2015</td>
<td>12</td>
<td>21</td>
<td>85</td>
<td>118</td>
</tr>
<tr>
<td>2016</td>
<td>14</td>
<td>24</td>
<td>98</td>
<td>136</td>
</tr>
<tr>
<td>2017</td>
<td>17</td>
<td>29</td>
<td>117</td>
<td>163</td>
</tr>
<tr>
<td>2018</td>
<td>21</td>
<td>37</td>
<td>146</td>
<td>204</td>
</tr>
<tr>
<td>2019</td>
<td>27</td>
<td>48</td>
<td>190</td>
<td>265</td>
</tr>
<tr>
<td>2020</td>
<td>36</td>
<td>64</td>
<td>257</td>
<td>357</td>
</tr>
<tr>
<td>TOTALS:</td>
<td>141</td>
<td>248</td>
<td>996</td>
<td>1385</td>
</tr>
</tbody>
</table>

Phase 2 will focus on the Addictions and Mental Health populations. A revision to the Operational Protocol (OP) will be submitted to reflect benchmarks for the AMH populations.

BENCHMARK #2 - Required

Increase Medicaid expenditures for Home and Community Based Services (HCBS) during each calendar year of the demonstration program.

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Total APD Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>$490,001,665</td>
</tr>
<tr>
<td>2013</td>
<td>$494,901,681</td>
</tr>
<tr>
<td>2014</td>
<td>$499,850,697</td>
</tr>
<tr>
<td>2015</td>
<td>$504,849,203</td>
</tr>
<tr>
<td>2016</td>
<td>$509,897,695</td>
</tr>
<tr>
<td>2017</td>
<td>$514,996,671</td>
</tr>
<tr>
<td>2018</td>
<td>$520,146,637</td>
</tr>
<tr>
<td>2019</td>
<td>$525,348,103</td>
</tr>
<tr>
<td>2020</td>
<td>$530,601,584</td>
</tr>
</tbody>
</table>

Oregon’s HCBS programs include Community Facilities, such as Adult Foster Homes, Residential Care Facilities, Assisted Living Facilities and PACE. HCBS also includes a
substantial In-Home component which includes Home Care Workers, hourly, live-in and spousal; Independent Choices, Community Transition and Specialized Living Services. Other services include Adult Day Services, In-Home Agency, Home Delivered Meals, Minor Home Adaptations, Personal Care and Non-Medical Transportation.

These numbers exclude Intellectual/Developmental Disabilities (ID/DD) at this time; Phase 2 will add I/DD expenditures. Expenditures for this population require additional research to determine and project accurate figures. The benchmark will be revised after research is complete.

Phase 2 will focus on Addictions and Mental Health populations and additional HBCS waivered services; and the benchmark will be revised to reflect the AMH population.

BENCHMARK #3

No more than 5% of all participants will revert to long-term (30 days or more) institutional care during the 12 month demonstration period of OCCP.

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Maximum number reverting to institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2</td>
</tr>
<tr>
<td>2014</td>
<td>5</td>
</tr>
<tr>
<td>2015</td>
<td>6</td>
</tr>
<tr>
<td>2016</td>
<td>7</td>
</tr>
<tr>
<td>2017</td>
<td>8</td>
</tr>
<tr>
<td>2018</td>
<td>10</td>
</tr>
<tr>
<td>2019</td>
<td>13</td>
</tr>
<tr>
<td>2020</td>
<td>18</td>
</tr>
<tr>
<td>TOTAL</td>
<td>69</td>
</tr>
</tbody>
</table>

The re-institutionalization rate will be based on actual transitions annually. The numerator will equal the number of consumers who revert to long-term institutional care for more than 30 days. The denominator will equal the number of actual transitions.

Phase 2 will focus on the Addictions and Mental Health populations. A revision to the OP will be submitted to reflect benchmarks for the AMH populations.
**BENCHMARK #4**

Increase the percentage of consumers receiving long-term care services and supports in the HCBS settings relative to the percentage of consumers living in institutions.

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>% of consumers living in institutions</th>
<th>% of consumers living in HCBS settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>16%</td>
<td>84%</td>
</tr>
<tr>
<td>2013</td>
<td>15%</td>
<td>85%</td>
</tr>
<tr>
<td>2014</td>
<td>14%</td>
<td>86%</td>
</tr>
<tr>
<td>2015</td>
<td>13%</td>
<td>87%</td>
</tr>
<tr>
<td>2016</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>2017</td>
<td>11%</td>
<td>89%</td>
</tr>
<tr>
<td>2018</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>2019</td>
<td>9%</td>
<td>91%</td>
</tr>
<tr>
<td>2020</td>
<td>8%</td>
<td>92%</td>
</tr>
</tbody>
</table>

These percentages reflect the APD populations. OCCP will focus on the Addictions and Mental Health populations during Phase 2.

**BENCHMARK #5**

Seventy-five percent of OCCP participants will demonstrate an increase in satisfaction for the Quality of Life (QoL) survey domain of Community Integration and Inclusion from the pre-transition survey to the first post-transition survey.

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Number of participants demonstrating increased satisfaction with Community Integration and Inclusion between pre-transition and post-transition QoL surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>34</td>
</tr>
<tr>
<td>2014</td>
<td>no data available</td>
</tr>
<tr>
<td>2015</td>
<td>80</td>
</tr>
<tr>
<td>2016</td>
<td>88</td>
</tr>
<tr>
<td>2017</td>
<td>102</td>
</tr>
<tr>
<td>2018</td>
<td>122</td>
</tr>
<tr>
<td>2019</td>
<td>153</td>
</tr>
<tr>
<td>2020</td>
<td>198</td>
</tr>
</tbody>
</table>

Quality of Life Model 5 questions to be used to determine increase in satisfaction in the community will include:
28. Can you get to the places you need to go, like work, shopping, or the doctor’s office?
33. I’d like to ask you a few questions about how you get around. Do you go out to do fun things in your community?
35. Do you miss things or have to change plans because you don’t have a way to get around easily?

No comparison data will be available in Calendar Year 2014. Comparison data will be available in 2015. Percentage of satisfaction will be based on actual interviews conducted.
Participation Recruitment and Enrollment:

Oregon will re-launch the new and revised OCCP in phases beginning September 1, 2013.

Phase 1 will include enrolling populations within Aging and Physical Disabilities (APD), and the Intellectual/Developmental Disabilities (I/DD) that were identified in the previous program that meet the service eligibility definitions for MFP. Prior to enrollment, the program will rebuild a coding structure for reporting, budgeting, and capturing the appropriate Medicaid match and track and reinvest the federal enhancement match dollars to be used for rebalancing Oregon’s long term care system. Participants will be identified by Oregon’s current system of Case Managers and Diversion/Transition Coordinators. Oregon has over 30 years of experience transitioning individuals to community based settings and has the necessary infrastructure in place for Phase 1. Case Managers, Diversion/Transition Coordinators will review all clients transitioning from APD and I/DD eligible institutions to identify if they are qualified candidates for MFP and if they are transitioning to eligible community based care settings. By using Oregon’s existing workforce which is experienced and talented, Oregon will be able to concentrate OCCP dollars to expand individualized services. Oregon’s previous program employed and funded through MFP, 23 Transition Coordinator positions. By not funding those dedicated positions Oregon will be able to accumulate the enhancement rate to dedicate to consumer needs, allowing Oregon to minimize the administrative claim CAP. Expanded individualized services will be determined with the input from Stakeholders and the Steering Committee. Case Managers, Diversion/Transition Coordinators will discuss with the eligible consumer and/or representative the MFP program and obtain Informed Consent if the consumer and/or representative choose to participate. If the identified consumer and/or representative choose to participate in the MFP program, identified partners will be notified of the need for a Quality of Life pre-transition survey.

Prior to enrolling APD participants in Phase 1, Case Managers, Diversion/Transition Coordinators will be trained and provided current information regarding the revised OCCP program.

Phase 1 will explore and identify Addictions and Mental Health (AMH) eligible participants. A coding structure will be developed for reporting, capturing, and budgeting, the appropriate Medicaid match and reinvesting the federal enhancement match dollars for rebalancing Oregon’s long term care system. Prior to enrolling eligible AMH participants, additional Transition Coordinators will be identified and trained on the OCCP program. Enrollment of AMH eligible participants will be anticipated during Phase 2.

Phase 2 (2014) will potentially expand the program to include other services and settings or populations, including the AMH eligible participants, based on steering committee recommendations.
Phase 3 (2015) will propose a final expansion of populations, services and settings, again, based on steering committee recommendations.

Phase 4 (2016) will do an operational assessment and move the fully functioning program out of Advocacy and Development and into the appropriate APD Unit.

Oregon plans to continue to utilize Transition Coordinators similar to the previous program during Phase 2 implementation. Previous training program will be reviewed and revised as necessary. Previous Transition Coordinators will be polled and brought together to determine needs as program is re-launched. Refresher training will be provided. New Transition Coordinators will be trained. Transition Coordinators will need to be identified for the AMH populations and trained.

Transition Coordinators will not conduct Quality of Life surveys in the revised OCCP program. To be transparent and accountable OCCP wishes to eliminate any real or perceived conflict of interest in conducting the surveys. OCCP has proposed to engage Aging and Disability Resource Connection of Oregon (ADRC) and their community partners to conduct Quality of Life surveys.

Centers for Independent Living will assist with the Quality of Life surveys in addition to the ADRCs to ensure statewide coverage.

The ADRC staff conducting Quality of Life interviews would be Options Counseling staff. The OC staff would not include staff that would be part of the transition staff. Specifics will be outlined in the contract/agency agreement.

Centers for Independent Living staff conducting Quality of Life interviews will not include any staff that would provide services to OCCP participants. Specifics will be outlined in the contract/agency agreement.

Conflict of Interest Standards as outlined in Oregon’s Community First Choice State Plan Option will be adhered to as well. Those standards include:

- No relation by blood or marriage to the individual, or to any paid caregiver of the individual
- Not financially responsible for the individual
- Not empowered to make financial or health-related decisions on behalf of the individual

Department of Human Resources Conflict of Interest Policy will ensure that any client or patient relationships are disclosed to ensure it would not be perceived to be a conflict of interest.

Staff conducting Quality of Life interviews will not have responsibility for determining financial eligibility for program.
Stakeholder Involvement:

On July 31, 2012, APD reconvened the stakeholder group originally created under the previous MFP program. Stakeholders include providers, consumers, and advocates for seniors and people with disabilities. Stakeholders indicated strong support for reconstituting MFP, and broadly agreed with the phase-in approach described under Participation Recruitment and Enrollment. They also advocated for robust stakeholder advisory participation, greater transparency and reporting structure and measurable outcomes with which MFP is to be evaluated. Finally, stakeholders agreed that any person served by MFP should have a truly person-centered plan for them to successfully make the transition from an institution into a home or community based setting. OCCP is committed to listening to stakeholder input and utilizing the input to influence program direction on behalf of OCCP consumers. OCCP values the diverse knowledge, experience and commitment of those that invest their time with this program.

Four stakeholder volunteers assisted with the selection process of the MFP Director positions.

Stakeholder meetings have begun with OCCP and will meet monthly until Phase 1 is launched. Timing and frequency of meetings after launch of Phase 1 will be determined by the stakeholders. Stakeholder membership will include representation from all targeted populations, including consumers and their families, providers, Psychiatric Hospitals, Psychiatric Residential Treatment Facilities, Centers for Independent Living, Area Agencies on Aging, State agencies, nursing home providers, self-advocacy organizations, Public Housing Authorities and others as determined by the stakeholders.

Stakeholders will advise the OCCP program through their collective wisdom, knowledge and experience.
Benefits and Services:

The participant eligibility requirements for MFP have changed since the suspension of Oregon’s program. Eligible participants will reside or have resided for a period of not less than 90 consecutive days in a qualified institution and receive Medicaid benefits for at least one day in a qualified institution.

Oregon has a long history of providing community based alternatives to nursing facilities and other institutions. Oregon’s current long term care case load includes 16% being served in nursing facilities and 84% being served in Home and Community Based Service settings. Oregon continues to strive to meet individual consumer needs that support person-centered approaches with respect to dignity, strengths, choice and autonomy. Oregon’s long term care system allows individuals to choose to receive services in their own home, a family home, an apartment or a licensed care setting with the goal to be integrated into communities.

Oregon’s home and community-based services (HCBS) waivers are being revised as the state has received approval from CMS to implement the 1915(k) waiver and Community First Choice State Plan.

HCBS waivers include:

- HCBS Waiver for Aging and People with Disabilities, number OR0185.R05.00. This waiver operates at near maximum capacity; if increased capacity is required the waiver will be amended to accommodate additional need.
- Developmental Disability Services Comprehensive Services for Children and Adults Waiver, number OR0117.R04.10. The previous waiting list for this waiver will be eliminated when the current amendment is approved. If capacity is exceeded an amendment will be requested to accommodate additional need.
- Medically Involved Waiver for Children with a Nursing Facility Level of Care Need, number OR0565.R01.02. The number of children who will transition from the OCCP Project will not cause the waiver to reach maximum capacity.
- Self-Directed Personal Assistance Services, 1915(j) option, number 07-14.
- Community First Choice Option, 1915(k), State Plan, number 12-014.
- Developmental Disability Support Services Waiver, number OR0375.R02.04.
- Developmental Disability Medically Fragile Model, number OR040193.R02.01.
- Developmental Disability Behavioral Model Waiver, number OR40194.R02.02.
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<tr>
<th>Seniors (65+) &amp; Adults (18-64) with Disabilities</th>
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<td>Adult Day Services</td>
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<td>Assisted Living Facility</td>
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<td>Behavioral Support Services</td>
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<td>Environmental Accessibility Adaptations</td>
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<td>Home Delivered Meals</td>
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<tr>
<td>In-Home Services</td>
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<td>Non-Medical Transportation</td>
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<td>Adult Foster Care (4 beds or less only)</td>
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<td>Specialized Living Services</td>
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<td>Homemaker/Housekeeper</td>
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<td>Case Management</td>
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<td>Contract RN/Community Nursing</td>
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<td>Chore Services</td>
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<td>Transition Costs</td>
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<td>Personal Emergency Response System</td>
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<td>Specialized Medical Equipment &amp; Supplies</td>
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<td>Services Recipient Training (STEPS)</td>
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<th>Children &amp; Adults with Intellectual/Development Disabilities</th>
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<td>Behavioral Support Services/Consultation</td>
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<td>Environmental Accessibility Adaptations</td>
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<td>Home Delivered Meals</td>
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<td>Adult Foster Care (4 beds or less)</td>
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<td>Child Foster Care (4 beds or less)</td>
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<td>Personal Emergency Response System</td>
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<td>Special Diets</td>
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<td>Specialized Medical Equipment &amp; Supplies</td>
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<td>Specialized Supports</td>
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<tr>
<td>Crisis/Emergent Services</td>
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<td>Community Living &amp; Inclusion Supports</td>
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<td>Respite Care</td>
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<td>Alternatives to Employment - Habilitation</td>
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<td>Family Training</td>
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<td>Supported Employment</td>
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<td>Pre-Vocational Services</td>
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<td>In Home Supports</td>
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Phase 1 implementation will not include any supplemental demonstration services. Supplemental services may be considered during Phase 2 implementation.

Phase 2 will determine eligible benefits and services for the AMH populations provided through home and community-based services waivers.
Consumer Supports:

OCCP will continue to use Transition Coordinators, as they play a critical role in the success of each MFP participant. As the program expands during Phase 2 and beyond, OCCP will add dedicated and specialized Transition Coordinators for I/DD and AMH populations.

24-Hour Emergency Backup Systems are currently required with any Home and Community Based Services waivers.

On-Call support for those participants living in their own homes will be identified and outlined in the person-centered plan of care.
Quality Management System:

OCCP participants completing their 365 days of MFP participation will continue to be enrolled in the existing home and community based services waivers as their eligibility determination allows.

Oregon will continue to utilize the previous post MFP 365 plan. That plan includes beginning to assess the participant at approximately month 9 of the 12 month eligibility to ensure continued participation in the home and community based setting. Participants require at least annual assessments to ensure eligibility and service plan updates.

If a participant was ultimately found not to be eligible for continued home and community based services, but was at risk of re-institutionalization, the state would analyze the feasibility of continuing some or the entire OCCP service package for the participant at state expense.

24 Hour Emergency Back-up System

OCCP will put into place individualized back-up plans to respond to and address any lapse in essential services and other circumstances that could have a negative effect on participant health and/or safety.

All OCCP participants will have an identified back-up systems/after hour on-call systems defined in individual service plans for all critical health and/or supportive services/providers. Critical health and/or supportive services/providers include direct services workers, transportation and equipment repair/replacement.

All OCCP APD participants enrolled in Home and Community Based Service waivers and/or the Community First Choice State Plan Amendment who reside in a licensed APD and ID/DD facilities (Foster Homes, Assisted Living Facilities, Group Homes) are required by licensing rules to have back-up systems or mechanisms to ensure continuity of services and supports.

The Community First Choice State Plan Amendment requires all enrollees to have back-up systems and mechanisms to ensure the continuity of services and supports and the safety and well-being of the individual.

Case Managers, Diversion/Transition Coordinators will ensure all 24 Hour Emergency Back-up Systems are discussed and agreed upon with the OCCP participant/representative and documented on individual service plans prior to transition to the community setting. Oregon’s Coordinated Care Organizations and the Oregon Health Plan Care Coordination program have a 24-hour Nurse Advice Line that can be utilized.

Case Managers, Diversion/Transition Coordinators are responsible for monitoring the implementation of individual service plans and assuring that OCCP participants’ health
and safety are reasonably addressed. Monitoring will include tracking responsiveness, timeliness and satisfaction of all calls related to the Emergency Back-up Systems. Reports and documentation of all calls that resulted in adverse outcomes will be forwarded to the MFP Director and Deputy Director.

**Risk Assessment and Mitigation**

All OCCP participants will have risk assessments conducted, in-person, and prior to transitioning to the community setting. A risk management plan will be developed for each participant and detailed in the individual service plan. A risk assessment tool will be used to determine the level of risk based upon multiple risk factors: power outage/natural disasters, physical functioning, mental/emotional functioning, cognitive functioning, behavioral issues, income/financial issues, safety/cleanliness of the residence, whether the individual service plan meets the needs of the OCCP participant, the adequacy and availability of natural supports, and access to services.

All OCCP participants receiving services will be contacted at least quarterly throughout the year (minimum of 1 contact every three months). Participants with three or more high risk factors must be contacted at least monthly.

Case Managers, Diversion/Transition Coordinators are responsible for the monitoring the implementation of individual service plans and assuring that OCCP participants’ assessed identified risks and mitigations are addressed. Monitoring will include contact visits with the participants to ensure risk plans are adequate and appropriate. Modifications to individual service plans will be documented as necessary.

**Incident Reporting and Management System**

All incidents of alleged, suspected and/or observed abuse, neglect and exploitation, as defined by Oregon Revised Statutes and Oregon Administrative Rules, will be reported and investigated.

In the spring of 2012, the Department of Human Services Office of Investigations and Training merged with Adult Protective Services to create the Office of Adult Abuse Prevention and Investigation. Oregonians will benefit from the sharing of dedicated staff that will be more effective and have an increased capacity for outreach and education. In addition, this joining of investigative offices will help to standardize abuse investigations for all vulnerable populations, provide for more statewide consistency and improve the ability to compile and use data for identifying trends. The new office design is focused on results, accountable and well supported programs with a focus on customer service and consumer outcomes.

Vulnerable populations include adults 65 or older, adults with physical disabilities, people with mental illness, people with intellectual/developmental disabilities and children.

All incidents involving OCCP participants will be reported to the MFP Director and Deputy Director. Incidents will be aggregated and trended for patterns and reviewed to
determine service plan revisions to mitigate risk(s) as necessary. Incidents will be reviewed to ensure timely review/investigation and assurance that the participant is protected pending completion of the review/investigation.
Housing:

OCCP has begun to explore partnerships with Oregon’s Housing Authorities. Collaboration has begun with Oregon Housing and Community Services. During Phases 3 and 4 OCCP plans to actively engage housing authorities and pursue available, affordable and accessible housing of qualified residences through a variety of strategies. By Phase 3 and 4 rebalance funds will available to consider increasing housing options for targeted populations.
Continuity of Care Post Demonstration:

All participants of OCCP will be enrolled in HCBS waivers that are available at the time. Currently Oregon is revising their waivered services. Those waivers will be updated as the waivers are finalized.
Organizational Structure:

OCCP, Oregon’s Money Follow the Person Program, is housed and administered within the Department of Human Services (DHS), Aging and People with Disabilities (APD). OCCP has partnered with the Oregon Health Authority (OHA), the single state Medicaid authority, Additions and Mental Health (AMH).

DHS and OHA are separate and distinct agencies but work closely together to ensure collaboration and integration of programs. To facilitate collaboration and integration the agencies have chartered executive level governance groups. Those groups include the Joint Policy Steering Committee, the Joint Operations Steering Committee and the Medicaid/CHIP Operations Coordinating Steering Committee. These committees are charged with oversight of policy and operations decisions that affect both agencies. In addition to the executive level committees additional committees have been formed to ensure collaboration, coordination, and implementation of services across the two agencies.

Organizational Charts (DHS/OHA), additional attachments – Pages 116 to 118.
**Staffing Plan:**

OCCP is currently staffed with two fulltime dedicated positions, Director and Deputy Director. Both Directors currently report directly to the Manager of the Advocacy and Development Unit within APD.

Additional staff may be added as the program progresses through Phases 2 through 4. The MFP Steering Committee will be consulted to determine additional staff needs. The Steering Committee includes leadership staff from APD, AMH and ID/DD divisions.

Potential staffing needs identified in the previous program including State Hospital MFP Project Coordinator, Workforce Development Coordinator and Resource Developers, will not be used initially with OCCP. These positions may be considered as the program develops.
Billing and Reimbursement Procedures:

OCCP will ensure accounting/billing/reimbursement/financial systems prevent duplication of payment for the MFP demonstration and the Medicaid program. Benefits and services will be identified and systems that include MMIS/MSIS and others as necessary will ensure appropriate coding is applied to those MFP benefits and services. Coding specific to OCCP will allow for accurate and timely data reporting to CMS and its contractors.
Section Q:

The previous program allocated funding for work with Aging and Disability Resource Connection of Oregon (ADRC). Funding allowed development and deployment of a resource database to enable statewide connections between ADRCs and Aging and People with Disabilities local offices. Oregon currently has four independently operating ADRCs. Those ADRCs serve thirteen of thirty-six more populous counties in Oregon. Several more sites are under expansion throughout the state. Statewide ADRCs are expected by federal fiscal year 2015.

The ADRCs in Oregon is designated as the Local Contact Agency (LCA) for Resident Assessment Instrument – Minimum Data Set Section Q referrals. The previous MFP program was not active at the time of the LCA designation. Preliminary discussions are underway to partner with the ADRCs and utilize the Section Q referral process to identify and refer eligible participants into the OCCP program.

The Section Q referral process that will be utilized to identify and refer eligible participants will be fully developed during Phase 2.

OCCP will continue to reach out and strengthen partnerships with the ADRCs throughout the state.
ADDENDUM B

Organizational Charts:

  Department of Human Services

  Oregon Health Authority
DHS Office of Aging and People with Disabilities (APD)
Organizational Structure

LAST UPDATED 03/31/2023

Chief Operating Officer DD/APD
Tricia Baxter

Aging and People with Disabilities Director
Vacant

APD Deputy Director
Mike McCormick

APD Field Services
Angela Mushars

Delivery Partners

District 2 – Multnomah Co. (AAA) – Peggy Brey
District 3 – WINSO (AAA) – Jeff Bohr
District 4 – Cascades West (AAA) – Scott Bond
District 5 – LOCO (AAA) – Kay Metzger

Central Delivery & Support Section

Collaborative Disability Determination
Eric Miller

Presumptive Disability Determination
Sharon Schemmel

Disability Determination Services (DDS)
Mary Gabri

Central Delivery Support
Veta Singer

MMA Buy-in and Kids Eligibility
Melissa Gannon

Provider Relations
Patti Hall

LONG-TERM CARE POLICY SECTION

Financial Eligibility & Waiver
Dale Marando

Medicaid Long Term Care Policy
Jane Ellen Russell

Long Term Services and Supports
Elaine Young

ADVOCACY & DEVELOPMENT SECTION

Homecare Commission
Cheryl Miller

Advocacy and Development
Bob Weir

PROGRAM DELIVERY

PROGRAM DESIGN