



Themes:

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

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

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

- **Community engagement**
 - Grow programs that support community engagement such as gatekeepers, senior companions, employment and volunteer programs
 - Leverage networking, coordination and partnership opportunities to build communities and community connections

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

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

- **Entitlement**
 - Reactions to the idea and/or concept of changing the entitlement of Long Term Care Services from nursing facilities to Home and Community Based Care

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

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

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

During the LTC 3.0 tour throughout Oregon communities, a total of 516 comments were captured during the community presentation conversations. These comments do not include comments that were captured on the surveys. Each header captures the total number of comments related to that topic compared to the overall comments.

Prevention Planning and Early Intervention and Support for + 95% of population without Medicaid 164/516=32%
More focus on early prevention and in-home – NOT \$\$\$ that could be saved
Few medications for treatments – other options? (I)
Makes sense to prevent (W)
Reallocate savings into prevention (I)
Concern that legislation will restrict prevention programs
How do we balance resources and services?
Focus on prevention – plan b for individuals at all levels
Need more prevention to prevent waste, save dollars – example of number of TBI admits to the state hospital (I)
Supplement preventative supports/assistance (I)
What are specifics and details to ensure prevention services aren't cut in the future? Ex OPI
How to move support to investment in preventative programs? ex: OPI
Education of LTSS should start early in life (I)
Education and outreach
Childhood education on issues related to money, planning and LTC
Workshops re- living with chronic conditions
Get information into schools
Need it in writing – info
Education is key – education for family, not just those in need
Lots of different doors to find services
Bring all pieces into one (no wrong door) (I)
Make information easier to access (I)
ADRC – accessible info (I)
One telephone number – no wrong door (I)
Resources – ADRC (I)
Hours for ADRC are limited – afterhours??? (I)
Douglas development of ADRC (W)
More education for staff, development of ADRC (I)
AAA does a lot of ADRC work – options counseling to formalized training and more structure. Philosophy already here for OC concept (I)
Create hubs for services (I)
Drop in center for information – no appointments needed (I)
Surprised to know what is out there – might access other services earlier if known
Senior centers preserving independence and health (exercise resource) (W)
Need more affordable transportation (esp. in rural areas)
Nutrition/health educators (I)

Prevention Planning and Early Intervention and Support for + 95% of population without Medicaid 164/516=32%
Housing needed – income, access, and capacity have been issues (I)
Economies of scale and efficiency (W)
Housing – section 8 accessibility (I)
Lack of housing resources results in more NF placements
Transportation with provider potentially (I)
Transportation as it relates to attracting services (people)
Transportation (I)
Van that travels for transportation (W)
Transportation needed for medical and grocery shopping
Medication Management – need preventative piece
Unexpected needs (dentures – multiple replacement) – flexible??
Teach nutrition/ weight loss early in life
Do another radio program for more widespread info sharing
Rapport with hospitals, facilities (W)
Prevention – early
Intervention
Better preventative planning and transition for people with financial risk of spend down (I)
Don't extend programs without resources to meet, sustain the needs
Consumer outreach – CCO's – ID barriers, cost savings – save more (esp in rural areas)
Money to invest in money management
More effective methods of outreach
Help people to stay active
Save \$\$\$ but increase in-home Medicaid services??? How will this look?
Family caregiver – stress and medical issues
Family Caregivers need respite and day care options
Generational expectations (I)
Respite care – family caregivers (I)
Expand family caregiver support
Need respite for caregivers
Need to increase resources for respite (lifespan) (I)
Lifespan respite (W)
Our supports and services nicked and dined
Family caregivers – keep families together, - lowers cost (ex. Medicaid divorce)
Revisit spousal pay program
How to navigate continuation of provider (providers, consumers, families and agencies)

Prevention Planning and Early Intervention and Support for + 95% of population without Medicaid 164/516=32%
Family caregivers program funding
Tax break for family caregivers
Financial planning – state assistance for reverse mortgage planning – state could certify lenders?
Need support/resources for family support programs when families take on caregiving
Natural supports – eligible for respite
Eliminate natural supports barriers
Support for family care givers
Respite for family members and caregivers
Respite care for private pay (I)
Natural support systems need more support
Family needs respite services (I)
Educate the public
Drop in education LTC
Medical expenses
Make referrals for private pay (W)
In-home, home health offered (W)
Need for sophisticated supports (I)
Need a little bit of care -= Not Medicaid paid so that they can stay home
Exploring the alternative of sliding fee scale for private pay services
Those who lose eligibility, move out, and come back when eligible again (I)
Little higher income not eligible – no programs available
Services and CM for those just above the cut-off (I)
Continuous outreach
OPI eligibility getting tougher and means less ability to prevent crisis and more negative consequences for individuals
OPI – how many on OPI went to Medicaid?
OPI – little cost, big benefits (W)
OPI program (W)
OPI
OPI is always looked at to be cut
OPI-In-home – CBC – NF (back and forth arrows)
OPI (W)
OPI – move more funding to this program because it is cost-effective (I)
Malheur County = poorest County – costs are the same as in the Valley
Make LTC insurance affordable (I)
LTC insurance policies change from today to when you have a need in 50 years (I)

Prevention Planning and Early Intervention and Support for + 95% of population without Medicaid 164/516=32%
Wanting advice about LTC insurance
LTC insurance – help people understand the options and maybe provide a state option (I)
Medication management as a stand-alone service (I)
Telehealth support
Help for non-Medicaid – transportation, medication management and assistance, financial help for prescriptions,
APS – community in-home
Money management
\$\$ management (I)
DME loan system (I)
Better funding for legal costs for guardianship and conservators (I)
Average person doesn't know the language of LTC
Awareness of AFH system
Medicaid after spending down \$\$
Lack of services for people with assets
Transition from private pay to Medicaid is very difficult (I)
Open living well and planning classes to all (I)
Need to supplement to help families pay for care without having to spend down to Medicaid
Avoid stark choice of Medicaid or severe financial impact on families
In-home regardless of cost (I)
Wellness coaches (W)
Seniors know what previous policy/system was “living in yesteryear” and do not want to change (I)
Message to families, community, - youth and students
Guidance, choice counseling with private pay – provides list, resources (home and community based) (W)
Address LTSS in living will
Visibility and one stop – raise awareness (I)
Take away stigma of LTSS/LTC
Education/informational sessions in communities about aging, retirement and LTC
Access points are underfunded (I)
Many access points (no wrong door) (W)
Statewide services (with local focus) (I)
Go to employers
What is LTC? – other services are a secret
Lack of knowledge of LTC

Prevention Planning and Early Intervention and Support for + 95% of population without Medicaid 164/516=32%
Access to LTC too informal
Perception that public assistance (Medicare) will be there
Look at family income – to get services
Outreach to educate – TV local news
Found out about options (W)
People need to be responsible for making choices about what kind of care they need and when they receive it (I)
There needs to be culture change around awareness (I)
Acknowledgement (compensation) for costs – transportation)
Support for shared housing
Congregate housing – centered on art for example
Look at affordable housing (need housing for opportunities) (I)
Resources within HUD and new developments (I)
Need transportation solutions – a statewide solution?
Support creative housing options focused on communities of interest – artist communities, for example (I)
Improve transportation services (I)
Doctors for the elderly
Transportation
Lack of education – transportation, Medicare, Medicaid, \$ for private pay insurance
Look at transportation rates (i.e. In-home to Ironside = same as Ontario)
Villages idea
Providing choices (W)
Choices – people have responsibility – there is a limit to what the agency can do
Private pay-in for Medicaid services such as case management
How can we figure out/help people to not get on gov't /state funding
What % of aging population ends up eligible for Medicaid?

Person-centered services 51/516=10%
Case worker caseloads are too high to be a useful resource to people
Non-service caseload
Check-in calls
Consistent relationship with service (doesn't have to repeat story, trust)
STEPS program – teaches people how to be employers for their home care workers (W)

Person-centered services
51/516=10%
Customer service – person centered (W)
Resolutions/standards vs. person centeredness (I)
Relocation/transition – rehab modification need a triangle (W)
Full spectrum of services
Increase health services going into individual’s homes (I)
When applying for services – must talk about medical needs
In home rehab – 3 different people to aid in recovery – maybe one would be better \$\$
Stop working together (I)
Think through all consequences – rehabilitation example
Customer Service – info – better staffing (I)
List of resources – community based (W)
Help needed to navigate system (I)
Triangles in physical disabilities (I)
POA has too much power – should be mandated to visit NF/take part in care
#30 too low for Medicaid personal incidental fund
Independent personalities and fear of consequences – docs prevent people from asking for help
Social norms – society values youth, health – but (de)valuing individuals who are older and with disabilities
Perception of incapacitated individual
Stubbornness to be independent
Perceptions of family to be in NF
Personal planning (ex – housing modifications) (I)
Interpreting documentation not to support of consumer (I)
Advocacy – transportation for the blind for example(I)
Market empowerment of seniors
“LTC MART” – needs to be person to person
Rethink/reform pay-in (how can you maintain household)
Social isolation – remove the barrier
Families/doctors vs. consumer pretenses
Services for social isolation (I)
Increase access and variety (I)
Fear factor, denial and pride
Family persuades client into ALF – then family knows they are safe
Aging friendly
Quality increased
Look at eligibility guidelines and assessments- re-define who is eligible and take risks and falls into account

Person-centered services 51/516=10%
Connect to holistic and person centered care
Concern about state imposition vs. consumer rights to make choices
Maximum flexibility to deal with different situations
Keep services for individual
Need more flexibility in service planning
Support menus and choices in services
Support in home clients with arranging care plans, schedules, etc (I)
Give CM more control over appropriate choice and risk (I)
Empower CMs- give more time for upfront time in care planning (I)
Flexible – menu of services (I)
Diversion programs –conversation about choice, guardian and conservators, entitlement for those who need it

Independence enhancing technology 18/516=3%
Technology built for impaired
Eligibility – broader re-prioritization; work on assessment tool (I)
Education and training (technology, computers) (I)
Improvements on technology – ADRC and care tools (W)
Better info available on-line for both consumers and organizations (W)
Need portal to ADRCs and SHIBA
How can we draw industry, such as builders to support aging? Encourage building that is environmentally friendly to older adults – get others involved beyond the agency and what it can do
Technology with awareness that not all consumers have (or want) technology
Assistance with changing technology –want stability (I)
Need for mobile delivery of services
Building design considerations – such as needs for individuals with visual impairments
Exchange/ share DME's
Technology – need to approach with knowing there is a learning curve (I)
Cell phones instead of emergency response to save money (I)
Person needs socialization, too, which technology cannot alone bring to the person (I)
Finding the right services at the cost available to be reached
Skype doctor visits
Decisions around technology – how are things fairly distributed?)

Community engagement
56/516=11%
Companionship program – intergenerational
High school students monitoring seniors
Use high school volunteers (I)
Intergenerational programs (teens and seniors) (W)
Match up volunteer website to find people in your community (I)
Support creative options for older adults to contribute to communities (Baby boomers, etc) (I)
Support gatekeeper programs for early ID of concerns before crisis
Connect neighborhood watch programs with gatekeepers
Rural – Rural parts of the state – gate keeper with sheriff, LE, Postal service, community members, connections
Create volunteer program to have seniors and individuals with disabilities maintain parks – give lottery funds instead to senior services (I)
Volunteer rides
Senior companion – RSVP
State-wide senior companionship program
Need to focus on volunteer programs and resources
Volunteer time bank for people to trade services (I)
Employment eg. EPD and home businesses (I)
Employment status – disability status?
Collaboration with CCO's and LTC for a range of services (employment, living, health) (I)
Want care givers who are allowed to support clients at work
Get word out – more volunteers and others to help
Need more access to activities
Activities needed (hold more accountable for existing rules – create new opportunities) (I)
Fire department responses to fall (W)
Education and awareness for physicians and hospitals
Coordinate with medical side
Coordination with other agencies, esp. in rural areas (transportation, corrections, feds, local non-profit)
Don't get to see savings – work with legislators and advocates
Need to get information out to communities
Community connections (W)

Community engagement
56/516=11%
Educate the community – education, lifespan of LTC not crisis only (block acronymns)
LTC education for Insurance companies
DCBS partnerships – consumers –insurance agents
Focus on community resources already available
Rural – small communities get to know neighbors, network, and check on each other (W)
Depression within facilities prevents clients from getting into communities
Social activities – opportunities (W)
Isolation occurs because I choose to stay at home
Service groups to counter social isolation (W)
Socialization – reason to get up and out of house (I)
Attend meal site – get out from house/isolation (I)
Memory care in <u>same</u> community (W)
State makes new plans – community doesn't receive benefits/outcomes (I)
I choose to stay home – trips to dr and ER visits = \$\$
MDT's – connections with law enforcement (W)
Senior centers – help to refocus
Promote community supports and values (I)
Think bigger: communities, senior tax deferral
LTC = place where we put people. It should be about community
How can we support funding for community services
Companionship program – intergenerational
High school students monitoring seniors
Use high school volunteers (I)
Intergenerational programs (teens and seniors) (W)
Match up volunteer website to find people in your community (I)
Support creative options for older adults to contribute to communities (Baby boomers, etc) (I)
Public education – get interest in LTC (retirement planning, lifespan ed)

Service settings and workforce development
149/516=29%
NF's are getting higher skilled clients from hospital
NF payment levels based on need
NF's barriers currently – education, emergent care, CM's capacity is down, interstate

Service settings and workforce development
149/516=29%
(OR/WA)
NF barriers – Hospital decline at home, assisted living, out of state
NF – people moving from other states
Nursing facility (W)
Hospital – doctor – NF
LTC – NF traditionally; AFH, RCF, ALF, In-home= less
Would need exceptions for NF
Keep NFs for those who need it
Support NFs as a place for respite
Remove SNF barriers
Nurses go to Boise because there are better wages – high turn over
Don't lose protections of current NF eligibility if change in standards
Nursing homes have lobbyists
Skilled rehab for NFs is critical
Skilled NF – are the right people in skilled NF?
Families may choose NFs because of proximity, familiarity with staff, confidence and desire in 24 hour care
NF respite is good model
Want more LTC ombudsmen – more oversight in NF
Smaller NF's = -institutional small rooms that feel like cells -low food -cement doors and linoleum floors
NFs feel like jail cells (I)
Smaller NF's =bad
Perception of being jailed (isolation) (I)
NF – security due to RN, medical staff
NF- only option for LTC
LTC – just help me in the home – not NF
Prevent readmissions and inappropriate discharge planning
Third party discharge planning
NFs – no motivation now to get better – all about maintenance until death. Transforming to wellness model addresses this
NFs for people with no other resort (W)

Service settings and workforce development
149/516=29%
Could NF services be part of CBC
NF barriers – residency issues – in state
Good idea – Need time to plan – check back with stakeholders and consumers – surprised 18% what NF
Need a graphic to show low need of services to high need, NF services
Education NF – skilled care
Concerns of safety – need for facilities
Streamline paper work and regulations (esp NFs)
Rehab is working well (W)
Good transitions (W)
Need quality care in facilities
Licensing standards for AFH, RCF, in home – standards need to be raised to operate facilities
Can we work with private sector to set higher standards?
Can we financially incentivize improvements to that CBCs can provide for higher levels of care?
Need to transform the HCW program through better training and skills needed for high-needs consumers
Incentive for more skills/ training
Profit motive for providers
Need more agency services and training for client employers
Educated / skilled providers (HCW)
Training and professionalization of HCWs and providers (I)
Need training for HCWs – professionalization, criminal background checks
Mixture, leveraging if resources (CEU, training ex)
Provider rates need to entice providers to stay in the business in Oregon
Qualified providers if wanting to stay home/CBC
Adjust provider rates
Reimbursement – staffing (I)
Equity in reimbursement among settings (ALF, AFH) (I)
Need to grow provider capacity – more AFH, more private pay @ lower costs
Partnerships with providers-open communication (W)
Providers (HCW's) – living wages, increase skills, increase local economy (training and classes)

Service settings and workforce development
149/516=29%
Need assistance to recruit, train, need funding
Staff requirements need to be raised – goal = to attract people who are truly invested in caring for the needs of elderly and people with disabilities
Safety = key vs. luxury vs. choice
Adopt federal pay-for-performance with good, consistent measurement tools across settings – validated tool
Develop stronger direct care, worker support – help them feel good about this career
Regulatory barriers to ‘stepping up care’
Need career and pay ladder for HCWs
More provider support – such as behavioral supports (I)
Better coordination and support between CM and licensors (I)
Build capacity for settings (I)
Better reimbursement for personal care attendants – require CNA?
Increase pay for staff – better staffing levels
Why the decrease in regulations for CBC’s?
Federal/state regulations – qualified staff, certification, licensing, professional education
No more waiver to have home and CBC/staffing
Need to grow capacity for CBC
Can we use pay to have qualified providers to meet the increase in demand?
Lack of In-home agencies – rules keep them from expanding to rural areas
AFHs can be bigger
Limited market (rural areas)
Increase urgent care usage – rather than ER (I)
Physician role is important – any medical provider and medical home model should help with this
Primary care physician must be informed
Medical community – education, communication, options (Docs, discharge planner, hospital)
Home health, hospice supports, direct care, RN (W)
Making acute care settings part of the discussion
Risks of living at home – nutrition, meds, fall risk, other safety risks
LTC – in home (want to receive it)
Get rid of pay-in for in-home
Specialized provider training and education – Need this in CBC (I)

Service settings and workforce development
149/516=29%
Turnover in staff is high
AFH vs. RCF
Consider the State by Region – providers and prevention
Need local qualified providers
Voucher system to bring in
Options – post hospital (I)
Remove existing barriers
Fair reimbursement for services
Needs to build up CBC resources in community
Pay more for AFH providers
HCBS resources robust (W)
LTC = duration, acute vs chronic
ALF, AFH – all levels (W)
Shortage of beds for Medicaid service outside of metro (I)
How to promote and increase Medicaid programs – ALF, RCF (I)
Staffing resources
Few resources (I)
Eliminate vouchers (waste)
Declining LTC last 10 years
Local issue with ALF, keeping people in setting who are not appropriate for ALF
Need cheaper home care and nursing care/advice available
Home care awareness/ access needs to be increased
Developing care giver – care or advocate
Disadvantage for some types of community based care – isolation, transportation and other issues
Need CBC capacity to provide the highest levels of care
Tension, health system, LTC
System focus is needed
Funding and support for rate increases for adult day services, especially for cognitive enhancement programs
Need more time for CMs to spend with clients
IADL and home upkeep – laundry, HK, shopping, food delivery
AFH regulations (W)
Encouraging in-home (W)

Service settings and workforce development
149/516=29%
Agencies help to professionalize in home services (W)
Amount of choice (W)
Diversion transition (W)
Less in-home paperwork (I)
Increase capacity needs in rural settings (I)
People can live in their own homes (W)
Compare increase and LTC rates
Break bureaucracy – need structure (I)
Need to lower cost
Current structure (W)
Financial services for in-home (I)
Workforce numbers and training/skill
Professionalization of workforces (HEW and user path) (W)
Collaboration of LTC with ombudsmen – conflicts get resolved (W)
Need to increase focus on sophisticated day services (I)
What needs “fixing”? ALF’s and RCF’s already used appropriately
Evidence based programs have variable funding – need to expand
Medical out of state – billing is difficult due to low rate
D/C planners and clinical resource coordinators – set up meetings/workshops to educate about LTC options
Better training for DHS staff (I)
Have resource flaws (I)
LTC- emergent situation
Protective services = independent living
Keep lists (W)
Respite and back up caregivers – more supports in place (note AFH readmission rates)
Service settings and workforce development

Improved outcomes for all Oregonians
46/516=9%
People with MH issues are getting older
For MH, rehab focus may not be appropriate, may need different goals

Improved outcomes for all Oregonians
46/516=9%
Need for Mental Health /LTC
MH services – County Sheriff
Need providers for elderly clients with MH
MH and disabilities – need enhancements not prioritized;
In-home MH therapy – preventative; right place-A&D services (I)
People aging with mental health needs, need to build capacity (I)
Working with the mental health system (W)
Providers – low service needs – especially MH services – criteria strict (evictions) (I)
Less than 65, primary dx, but if mental illness fall through the cracks (I)
Aging and MH treatment goals may be different than younger MH
Need to increase MH, need to better work across programs (APD, DD, A & MH) (I)
Service needs to work with all other programs – DD, APD, MH
Need trained professional caregivers skilled in working with people with cognitive declines (I)
Allow DD best practices to serve other populations (I)
How do you communicate / work this for people with cognitive issues?
Need a better business model – care facilities with medical services
Look at aging cohort – A&D services (I)
So many needs for OC training, especially people with disability apprehension (I)
Need for small non-profits with specific focus (TBI, dementia, cognitive impairments) (I)
Improvement in dementia and Alzheimer’s rates for improved access (W)
Memory care and ALF are dropping Medicaid contracts (I)
Trend toward growing number with cognitive disabilities as bio-medical systems can’t address cognition I-MH issues as well as physical health issues
Need to focus on dementia
Resources for TBI (I)
Need more RCF’s and specialized living
Define treatment goals by population
Remove barriers to becoming certified memory care providers (I)
Providers for more complex needs/ folks
Limits for people with intense support needs in AFHs (I)
Health equities and disparities need to be addressed
Lack of places to do blood pressure checks (I)
Major insurances denying benefits prior to readiness to return home (I)

Improved outcomes for all Oregonians 46/516=9%
Anyone with OHP using EK, not just seniors
Define full array – don't repeat real system change
Concern about implementing in tight budget times
Start small with pilots
Concerns that high need individuals won't have access to NF services
Must do something – good is the enemy of the best
Need to be a systems change (I)
Bureaucracy impedes applications and getting needs met, provider business
Evidence based plans – where will money come from to support services?
Alignment, shared incentives (coordinate LTSS/Medicaid)
Medicare donut hole – issue what can I afford> (R &B or food?)
Effects of recession (I)

Entitlement 8/516=2%
NFs are not the entitlement – reactions: -I like it -Easier to have conversation for divert/transition -Only way to be “safe” -Family reactions – perception of safety
NF = last resort – only if no other choices
What does NF access mean for new entitlement?
What would barriers be to NF if you changed entitlement?
Change entitlement???
Entitlement change impact of budget cuts for in-home?
Examine entitlement – responsibility and planning (I)

Miscellaneous 17/516=3%
Concern regarding revenue and the ability to fund services

Miscellaneous
17/516=3%
Proactively reinvest \$\$\$ savings to front end services and resources (I)
Outcome measure per region – resources?
Data - % uninsured in Hood River County (high/up?)
More data for causal – research (I)
Metrics for service equity
Invest \$\$ for data/metrics (I)
Need for better data to support LTC 3.0 (I)
Any data from waiting lists?
If only Medicare – how do you pay for LTC?
Metrics, outcomes and benchmarks linked with funding
Effective tracking to ‘show’ money ties with the outcomes
Measure and track unintended consequences
Total cost of care (ex: Medicare, Medicaid) – cost shifting
What is the cause of increased cost for health care?
If someone has both Medicare and Medicaid – how is LTC paid?
Would DHS consider supporting contracting with consultants? (I)
Follow up – committees to participate?