DHS APD/AAA Feedback April-May regarding Budget Note HB 5026

Best Case Scenario Program is fully funded - Caseloads grow as forecasted - Need to slowly bend the cost curve			***Alternate Case Scenario*** Program is not fully funded - Reductions below current service level - Need to rapidly bend the cost curve		
CORE VALUE	POTENTIAL OPPORTUNITY	GREATEST ANGST	CORE VALUE	POTENTIAL OPPORTUNITY	GREATEST ANGST
To respect client choice in living out their life with dignity and be safe	More jobs available to qualified providers in communities	Create more Community Based Care (ALF, RCF and AFH)	To increase integrity of programs – more home visits to verify task completed (case aide)	Multi person household with one service client	Resource limits for MAGI
Need for regional training for case manager's	Separate out IADL from ADL care (providers less fraud	More Community Based Resources including Senior Day Care	Reduce fraud. Medicaid Investigator in each office	Remove IADL's of shopping, meals, housekeeping, laundry	Bring back furlough days - even on a voluntary basis
SPL13 in Nursing Facilities? Need to look at that – look at tiered waiver	Look at Natural Supports again (need different criteria)	Develop process when family member hired as Home Care Worker	Need QA compliance specialist locally. Evaluate CAPS, and duties according to rule	Matrix of need for Nursing Facility admission – not all consumers need to receive services in nursing facilities	Out of State Residents – Taxpayers are paying for person who have never paid $1.00 Oregon taxes. Change the EA laws for recovery – make Washington pay for Washington for example
Safety, Independence, professionalism, accountably, trust	More education to Hospitals about discharges to Nursing Facilities all the time	Improve Integrity, reduce cost, reduce fraud	Improve assessment accuracy	Tiered waiver. Nursing Facility being most need. If they don't meet that need – then not eligible for Nursing Facility	Training in SPL, CAPS, Eligibility needed regionally
Prevention	Limiting Nursing Facility choice ability	Lack of training on SPL, CAPS, and eligibility	Prevention	Evaluate core work (what are the priorities?)	Discontinue SPPC
Safety	Minimize medical fraud	Lack of QA review	Safety	Training for families and support groups provided by us or CCO or AAA	Someone on OPI can't have medical
Field input	Home Care Workers Application Process – more difficult. Need consistency.	Need more clarity in IADL rules (difference between warming up a meal, or cooking one as an example)	Field input	Modify CBC rules, allow more flexible models	AFH rates too low – not much incentive for providers
Choice	Structure communication APD/OLRO	Lack in Care Planning	Choice	Increased Adult Day Services	Safety at risk
Transparency	Teach our staff how to work with conflict – should manage facilities better and address service reductions in a supported way	Time spent on QA results – but what are the results telling us?	Transparency	Expand room and board facilities program	Due process issues – staff time, it doesn't pan out
Person centered	CCO/ Private funded APD	Safety focus	Person centered	Expand PACE (including agencies other than Providence)	Levels of stress – increased time off
Service Equity (how do policies effect different groups)	Hospital social workers doing eligibility or State workers in every hospital	Lack of guardians	Service Equity (how do policies effect different groups)	Combine DD, MH, services (mix $)	Do things more quickly without thinking things through and costing more (e.g. MAGI, Vouchers)
Allows for caseload coverage to meet need	Mixed funded Case Managers, people who can see the big picture (Medicaid, CCO, AAA)	Lack of facility/AFH Living situations	Opportunity to test the core values	Increase OPI hours	Increased APS due to closing people who need supports
Allows for staffing to do prevention allowing for increase in safety	Encourage cross funded on-site child care (CW) with day services or nursing homes (APD)	Staffing	Program integrity	Better use of technology for clients (vs provided by a person)	Not enough field input in process

Client choice	CCO funding preventative services to delay LTC Services need	Silo's between APD and Mental Health	Person centered	More objective assessment tool	Homelessness – if we close services, where do they go?
Person centered plan	Not paying family members/parents/natural supports	Quality of homecare workers and provider availability	Client choice	MH personal support workers step it up (SPPC)	Mass changes effecting people un-equitability (for example non-English speakers who rely on family members for care)
Program integrity	Medical training for Case Managers	Regulation of Home Care Workers	Quality of care	Cut paying family members (keep cultural issues in mind)	Increase in number of hearings
Safe by meeting need	Mixing social and medical models	Continued patching vs fixing: focus not on stop gap measures but viable long-term solutions	Client safety	Increase APS fines (look at other states)	Clients learn how to defraud the system to remain eligible
Timely intakes for services	Helping people off of services (work options?)/Expectation of a conversation of how to become self-sufficient with people who have potential or desire to work – intake specific training around this expectations	Crisis response not invested in prevention	Getting services started	Give LTC to CCO's	Emotionally hard on clients and staff with cutting of services
All cases are reviewed for accuracy i.e. hours eligibility	Better coordination with community resources (reduce duplicate services)/Stronger connections with ADRC	We don't address issues with regulations with CBC and how to manage them – need an overhaul of the foster home system	Integrity, independence	Increased family training	Waivered services becoming part of CCO global budget
Frequent client contact	Increased expectations of AAAs to be working to prevent Medicaid rather than referring OPI eligible people because they have wait lists	Safety for in-home clients – ombudsman or advocate needed	Choice & autonomy	Cut/stall provider rates (NF, ALF)	Impact on staffing
Integrity, Safety, Transparency (especially in licensing)	Access to electronic medical records	How do we address loss of role associated with aging or increasing disability – address isolation?	Honesty and transparency	Working better with housing advocate (Advocate for $ to go to housing specifically to assist our clients)	Unmet needs, reassessments, lack of housing, higher acuity when they are eligible increasing costs
Transparency vs integrity	Doctor referral (CCO's) and better education of PCP's on LTC system	Current support for a slow change gets cut quickly when a new Governor or Legislator come in (more conservative)	Will need to discuss values	Home Care Workers expectations as professionals (i.e. work references, purchase own supplies, etc.)	The Hearings Process – workload impact (repeat assessments, etc)
Service, quality, choice, independence, health	More objective assessment tool	CBC Medicaid rates remain flat (specifically AFHs)	Values would not change	Creative with other resources and community partners	Compromise customer safety
Integrity, Independence, choice, autonomy	More stringent requirements for re-assessment if client and Home Care Worker does not agree with original assessment. This would prevent client from "learning' what to say to get the hours they want.	DD, MH, APD, Housing, AAA and support in all programs, need to reduce duplication in already slim resources	Are values our barriers?	Tiered SPL system with no exceptions	Keeping customers on correct services
Honesty and Empathy	More OPI for preventative /Better management of OPI dollars	We are fall back agency when MH and DD says no. Also when OHA won't do something – we pick it up	Taking away clients choice for independence	Opportunity to revamp Long Term Care community nursing program to increase program integrity	Lack of Case Management follow up due to large caseloads resulting in rework
Stewardship – training quality, timely training	Recruitment/outreach (providers/resources)	Staff hiring and trained	Prevention, safety protection	Expand SPPC	Wage freeze
More classes available on learning center	Provider development and training	Limited trainers		Eliminate Home Care Workers and move to all agency – Agency with choice	Increased APS Calls
More trainers	Due process needs to be more timely – conditions where we can close a facility for example	Exception process		Family member wants to provide care needs to go through agency	Reduced outreach
Training in field	Apply an equity lens to our programs	Automate Elder Place payments		Relative Adult Foster Home was more cost effective than Natural Support	Not planned or well thought out prior to staff action

Skype-up and running	Eliminate income CAP trusts – full cost share	The cost of the Home Care Worker/In-Home Program/Live-in Program		Stop paying Natural Support	Staff moral
Mental health of consumers	MAGI cost share	Lack of payment options		No exceptions, add-ons, tiered system – similar to ALF	Loss of staff
Person-centered plans for all eligible clients	Change eligibility criteria	No time for person centered case management		Time study related to performing tasks (ADL)	How are we going to meet client needs?
	Change the waiver – Nursing Facility no longer a guaranteed option	Blurring of the line between our program and mental health		On MAGI cases start counting resources and have a liability $	Reductions to current Service Levels without rule adjustment will displace people from CBC facilities without alternate housing options
	Automate and upgrade systems (dump legacy systems, new assessment tool, etc.)	Minimum wage change		Local Case Management Training – Saves time, money	Program change will no longer allow our services to be in line with APD vision and goals and DHS core values
	Increase client contact	Caseload size		Eliminate State paid MOW's	In-Home Program is going to run dry – eliminate $500 extra (pay in @$733)
	Increase safety	Staffing		Motel rewards for state travel only	In-home will be gutted
	One for all programs	Approval of unqualified caregivers – crims only needed		Start counting resource on QMB/SMB cases EAU claim	Community partners having to pick up more services
	Relook at RAFH again	Natural supports should not get paid full hours		Eliminate natural supports	Reduce SPL to 10
	Reach population that need services	How much value is there in Direct/in-direct verses time Case Management spent?		Resource assessment – cap on resource limit	Resource assessments to attorney's over $50,000
	Preventative services	State car availability		Open supply services/ goods to lowest price	Directs and Indirect 's
	Ombudsmen program for safety of consumers	Limited Foster Homes paid at commercial rate		Privatize state car management rentals	Staffing and funding for non-profits
	Increase direct contact	Already limited mental health services		Home Care Workers voucher pay online, could help prevent fraud	Few housing resources for difficult clients – can't move them
	Close gap in services	Clarification of the Rules to promote safety within our Provider Homes – OAR's licensing		Accurate assessments along with hours needed	Don't drop income cap trusts. We sometimes have individuals with very high care needs (think someone with quadriplegia) who are over 300% but could not remotely afford to pay out of pocket for the care they need to remain safe and even alive.
	Local case manager training resource	Sustainability		Eliminate capitation fee on mental health fee for services	Many individuals will be temporality ineligible.
	Efficient training and retraining for all case managers i.e. SPL and CAPS tool, eligibility, OAR's/waivered services	Nursing Facility savings how look small compared to In-home		"Family plans" [phone service] for Districts – I phones	Some clients' cognition drops very rapidly, and our CAPS already has too high a bar for individuals with cognitive deficits without physical ADL needs
	Local QA/compliance person (s) for each district to evaluate CM CAPS assessments and duties to ensure that they are being completed according to rule	APS pot of money to pay for petition for guardianship		EDMS to cloud service	Cutting clients as a cost-cutting tool or a temporary fix. Most clients who have long term needs (vs. short term recovery from injury, surgery, etc.) will again be eligible due to increasing disability.
	Matrix of need for nursing home admission. Not all customers need to receive services in NF	Single database for AFS		APS not being investigated - Resident to Resident, Emotional Abuse	For many of our clients, their HCW is their only contact due to lack of family or friends. Their HCW provides a source of support and socialization that they may not get otherwise, and is often the only person they are in contact with on a regular basis. Cutting off that source

						of support for clients with higher SPLs could be detrimental to
	Collaborate with stakeholders to get feedback and clarification on rules (OARs) (Licensing)	In-home program cost increases do not compare favorably to Nursing Facility costs – limits choice in contradiction with APD vision		Eliminate Live-in		
	Close ICP	Perception from Oregonians		Revert Natural Support Rules		
	Eliminate live-in	Rolling out too many programs at once which leads to inadequate training		Focus hard on making CBC settings more “home like”		
	Preventative steps: Respite, training and support for Natural Support systems	Short and long term care- MAGI		Nursing Home – SNF only		
	Natural support rules - revert	Cognition: Across the board		Move eligibility to: SNAP – SSP and Med = 5503		
	One system to record facility and community that can be viewed across state/districts	Simplifying K Plan		Change natural support definition – no longer optional		
	Close OHA bring back to local offices	Clarify lean leaders role (is it helpful?)		Eliminate live-in program		
	Work closer with housing to build intentional communities that serve our clients	Time studies spread out over time not just a snapshot		Increase service liability costs for in-home program		
	Are we looking at the right bases of ADL eligibility to meet client needs?	Re-evaluate payment schedule for CBC facilities		CM’s wear too many hats		
	Adjust SPL rules to better capture true need (e.g. one-time toileting assist wouldn’t = eligibility when there is no need	Look at creative ways to help clients and budget		More HSS3 to do eligibility		
	Move Home Care Workers to an agency	Service level determines hour allocation i.e. FA = 40 hours/week SA = 30 hours/week, etc.		Raise the age to SSA standards: 67		
	Re-evaluate payment schedule for CBC facilities	No LTSS – Who will coordinate with CC’s successfully?		Close some field offices		
	Case management coordination with CCO and BH	Resource assessments over $50,000 to attorneys		Expand SPPC as needed		
	Continue looking at options to further fund	All changes are difficult for staff and those we serve.		Fund adequate Risk or (OPI?) Positions to check in with individuals whose service were cut to see if and when they are eligible again.		
	What other services can we provide?	Recent history has shown that the change is needed before adequate rules, training, tools, etc. are in place, leaving both clients and staff in the situation of navigating the new requirements by trial and error.		Provide more opportunities for exceptions to SPPC clients		
	Open more spaces for OPI, less Medicaid	We have a number of individuals for whom English is not their first language. As the individual’s dementia increases, one of the losses is often the English they knew.				
	Expand meals program to those not in MOW Program	There are a number of cultures/languages for which we have no facilities, so we have been relying on in-home plans that grown with the client’s needs. But with the restriction of live-in and shift caregivers, we’re often facing a choice of leaving the individual, or relegate them to a facility in which NO ONE Speaks or understands their language.				
	Expand transportation for Central Oregon	Impossible to get clients under 65 served by MH even the 20 hours a month Medicaid funded				

		hours. When you ask MH about it they say we do not know anything about it.				
	HCC to take over HCW – train accordingly	Very difficult to get clients who have pets in any kink of RCF, ALF or AFC – especially if it's a cat.				
	CAPS- IADL's	No facilities for young disabled.				
	Consider more hybrid or creative plans. Examples might include Shared Attendant Plans in a particular building or neighborhood where one caregiver could easily move from one apartment home to another and even do short shifts, phone support for things like medication reminders for both in-home and SPPC clients.	We espouse keeping our elderly and disabled population as home for as long as possible for them to maintain their independence. However, with the growing costs due to the new rules for live-in and overtime pay, plans that require live-in providers or shift care are routinely being denied as they are no longer consider cost-effective. It seems unfortunate that our agency's espoused values are in conflict with the budget. I would hate to see consumers go into nursing facilities because they feel they have no choice, when they would be so much happier/healthier in their own home.				
	We must develop language- and culturally-appropriate care settings for people of different languages and cultures.					
	Educate MH staff on the 20 hours of care available to Medicaid and MAGI clients. Educate APD staff on how to make referrals to those services without having MH staff reply they don't know anything about it.					
	Recruit more providers and ALF and RCF that accepts pets.					
	Recruit more quality HCWs so that more customers can have multiple providers, reducing the need for overtime. With more available, reliable providers, some live-in plans could be converted to hourly shift care.					