

NOTES FROM OPI STATEWIDE FOCUS GROUPS

9/30/09 and 10/14/09

1. Core Services

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

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

PRO	<ul style="list-style-type: none"> ▪ Range of services offered is surprising and it should be standardized ▪ I support a goal of moving all AAAs toward providing core services ▪ Yes, at least CM, HC/PC (later pulled back from this after discussion) ▪ Yes, but all services should be person centered (as opposed to list centered) ▪ If Personal Care is not being provided, why not? ▪ Funding limitations are what they are: CM, PC & HC should be mandated ▪ Case Management should be mandated ▪ Case management, yes ▪ Money management, yes ▪ Case Management is our primary service (2 AAAs) - allows network of service ▪ Case Management not needed - only direct services ▪ Case Management may not be needed ▪ Options Counseling is already being used in some places; could reduce Case Management burden (LCOG) ▪ Assessment > Options Counseling: own resources for paid services
CON	<ul style="list-style-type: none"> ▪ No ▪ Mandated is probably the wrong angle to go with this ▪ Case Management should not be optional; is fundamental to program ▪ If above prevails, it might be a disincentive for others to provide services ▪ Services should be available only when not available through other resources (and that's done @ a local level)

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	<ul style="list-style-type: none"> ▪ Rural versus urban factors, services can't be mandated ▪ Same range service discounts social networks, family supports already taken into account by Case Managers ▪ NO boxes - sometimes things are not available and there are no resources ▪ Services should follow the person, not the plan ▪ No, as needed ▪ Should be person driven ▪
NEUTRAL	<ul style="list-style-type: none"> ▪ Are alternate funding sources available? ▪ 'Community Fathers' concept where services are driven by immediate need, not service plans ▪ Protective services are missing from this list ▪ Case Management \$\$ should not be utilized in lieu of service hours; many have family that can perform CM role ▪ OPI is a finite service and as such must be reserved for those with no other options ▪ Other funding sources should be used prior to OPI ▪ OPI \$\$ should be used as a last resort, when nothing else is available ▪ We should be looking into leveraging Medicaid funds for some services but maintain person centered care as primary ▪

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2. STANDARDIZATION: General

PRO	<ul style="list-style-type: none"> ■ Need to balance flexible standardization with accountability ■ Some standardization yes ■ Clarity is essential; make decision and move forward'; consumers are confused and should not be ■ AAAs love flexibility but also need accountability ■
CON	<ul style="list-style-type: none"> ■ Services should be more flexible, not less (person centered planning) ■ All aspects should be person centered, not driven by the State of Oregon
NEUTRAL	<ul style="list-style-type: none"> ■ Any standardization must be applied both to seniors and younger disabled ■ Standardization should come from a set of standards, rules, policies, not from some person

STANDARDIZATION - SPL

PRO	<ul style="list-style-type: none"> ■ All services should be uniform for fairness and portability ■ Should be standard throughout the state ■ When someone moves they should be able to count on their services in the new location; basic levels of service Urban/rural disparity; cost of doing business increases in rural Oregon ■ should be available to everyone
CON	<ul style="list-style-type: none"> ■ Fair to have uniformity but not always possible

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NEUTRAL	<ul style="list-style-type: none"> ▪ 2/3 of the AAAs serve 1-18 but some up to 12 only ▪ Need option to refer to Medicaid when OPI plan isn't adequate
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STANDARDIZATION: Service Hours

PRO	
CON	<ul style="list-style-type: none"> ▪ Service follows the person
NEUTRAL	<ul style="list-style-type: none"> ▪ Should be able to divert additional funds when additional need exists ▪ Suggestion: Brokerage system with standardized tiers (as in adult DD programs)

STANDARDIZATION : WAIT LIST

PRO	<ul style="list-style-type: none"> ▪ 1st come, 1st served should be the standard ▪ 1st come, 1st served, based on like needs ▪
CON	<ul style="list-style-type: none"> ▪ Need should trump 1st come, 1st served ▪ We don't like them ▪ Wait lists should not create false expectations; if used at all, they should be transparent with applicants knowing how they can move up

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NEUTRAL	<ul style="list-style-type: none"> ▪ Statewide Screening tool should be developed to allow uniformity but preclude the need for a full assessment, which are too time-consuming (especially in rural areas) to be practical ▪ Should be certain that most needy are getting served ▪ Should ensure income and natural supports are factored in ▪ Risk Assessment tool - statewide ▪ Whatever we use must be tempered with consideration for natural supports
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STANDARDIZATION: Expenditure Limits

PRO	<ul style="list-style-type: none"> ▪ Guidelines might be helpful ▪ This should <u>not</u> be taken off the table
CON	<ul style="list-style-type: none"> ▪ Case Management should not be limited ▪ Individual AAAs, driven by client, need and SPL ▪ Reason OPI costs less now is that there is less red tape
NEUTRAL	<ul style="list-style-type: none"> ▪ Need to accumulate data that shows how many receiving OPI would be eligible for Medicaid services but are choosing not to enroll in those services ▪ If under 14 on SPL maybe they should be required to go to Medicaid ▪ Need to look past OPI to see cost of care to state and federal government for all programs ▪ Suggestion of individual limits for OPI expenditures (consumer choice about how to spend) ▪ Use of biennial extension

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PARTICIPANT COST SHARING: Assets

PRO	<ul style="list-style-type: none"> ▪ "warm and fuzzy" has no place here; limits should be established ▪ Yes ▪ Yes, contribute some additional funds ▪ Liquid assets should be considered ▪ Liquid assets - yes, as long as they know their \$\$ will contribute to others' need
CON	<ul style="list-style-type: none"> ▪ What little bit has been saved is sometimes seen as all that's keeping some folks from proverbial 'poor farm' ▪ Some folks will go without food before spending nest egg ▪ We should not penalize folks in need when they've done the right thing all their lives
NEUTRAL	

PARTICIPANT COST SHARING: Fee Collection

PRO	<ul style="list-style-type: none"> ▪ Rule should be written (with teeth) to allow cutoff of services for non payment. ▪ Rule written to enable services to stop for non-payment ▪ Seems reasonable and should be statewide ▪ Services should end if pay-in is not paid ▪ Good Guy/ Bad Guy ... rule should allow cutoff of services
CON	<ul style="list-style-type: none"> ▪ Additional CM costs to gather information; additional admin costs to collect; sometimes it is months before they pay

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NEUTRAL	<ul style="list-style-type: none"> ▪ Rule should take into account how much gain vs. how much administrative effort ▪ Collection can be avoided by consumer paying provider directly ▪ Cost Benefit Analysis should be done; admin costs to collect may be prohibitive ▪ Cost Benefit Analysis may be difficult to make
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PARTICIPANT COST SHARING: Estate Recovery

PRO	<ul style="list-style-type: none"> ▪ Yes, within limits ▪ Should be \$ for \$ ▪ Yes (general agreement with this group) ▪ Future clients only - no retroactive ▪ All clients - effective date of law at time of assessment/re-assessment
CON	<ul style="list-style-type: none"> ▪ No (three voices) ▪ Risk is tipping the scale and pushing someone onto more costly Medicaid ▪ Estate should be protected; people should not have to give up what they've worked their whole lives for ▪ Many want to stay out of 'the system' and OPI, however small, allows them to do that ▪ Estate should be protected ▪
NEUTRAL	

PARTICIPANT COST SHARING: Fee Schedule

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PRO	<ul style="list-style-type: none"> ▪ Additional assets should be included in sliding fee scale schedule
CON	<ul style="list-style-type: none"> ▪ This is appropriate only for the areas in which distance isn't a factor; e.g., some AAAs require 3 hours travel time for a 2 hour assessment; it isn't fair to assess those clients for total time spent in a case management activity
NEUTRAL	<ul style="list-style-type: none"> ▪ No response recorded ▪ Pay in should be standard but more liberal than Medicaid

4. FOCUS OF OPI

PRO	<ul style="list-style-type: none"> ▪ All are good goals ▪ Goals still timely ▪ OPI, as a brand is still a good one, should be incorporated into larger vision though ▪
CON	<ul style="list-style-type: none"> ▪ Goals timely except "frail and vulnerable" language needs to go ▪ Should include "living in your own home" ▪ Doesn't take into account boomers with both higher demands and giving back as volunteers, expect empirical data that supports intended and unintended consequences ▪ Home and CB service model has served Oregon well but we need to refine the goals to accommodate the need for future (broader range of services) ▪ #3 might conflict with the other goals ▪ Goals are relevant and broad but are our strategies too narrow? ▪ 2 (preventive and long term care services to reduce risk of institutionalization) and 3

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	<p style="color: red;">(Provided to frail & vulnerable adults who are lacking access to other services) might be a center of dissention</p> <ul style="list-style-type: none"> <li style="color: red;">▪ As a part of a larger set of services, goal of OPI extended to 'frail and vulnerable' should not be omitted <li style="color: red;">▪
NEUTRAL	<ul style="list-style-type: none"> <li style="color: green;">▪ Cannot move on to creativity when continually fighting for the status quo (funding) <li style="color: green;">▪ Need to leverage more local services: model: Children & Families Juvenile Services with communities putting together local plans guided by the State of Oregon <li style="color: green;">▪ Should focus on and present a stronger case (to legislature) how much we are saving the state, not change the goals <li style="color: green;">▪

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FOCUS OF OPI: Incorporation into the future of Oregon's Long Range Planning Needs

On a Different Model	<ul style="list-style-type: none"> ▪ No stigma attached to Project 2020/ADRC model ▪ Project 2020 model: Options Counseling, Family Caregiver: In-home Supports; healthy living ▪ If 2020 is model (OAA is funding source) younger persons with disabilities will be left out of the picture ▪ Project 2020/ADRC where Options Counseling may re-direct consumers into more appropriate programs ▪ Options Counseling first ▪ Experience shows no one want to give money away without creative solutions and new ideas ▪ Outcomes, goal attainment have empirical value ▪ Rep. Cowan's bill last session was a good start, should move forward ▪ LTC Nasua Project 2020 - ADRC model ▪
Current Issues	<ul style="list-style-type: none"> ▪ Inconsistent services being delivered; message is mixed to legislators, uniformity required so we can talk about what kind of savings OPI affords ▪ Wait lists are too high, funding inadequate, need stable funding source ▪ New thinking ▪ Stable funding source
To Be Considered	<ul style="list-style-type: none"> ▪ Individual need should be considered first, how to acquire services should follow ▪ Person centered planning tools, person centered planning ▪ Update, current OPI Case Management training ▪ Federal Match ▪ Take into account Community Capacity ▪ Eliminate those who are hoarding for their kids' inheritance

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	<ul style="list-style-type: none"> ▪ Asset test needed ▪ Exactly what is NOT being delivered effectively ([incredulously] are you sure the budget note really asked this question? (from the daughter of a consumer) ▪ Community resource mapping (civic, volunteer, faith-based) ▪ Should re-visit the planning efforts of 2005 Modernization ▪ Looking at (both) short term goal (budget note) and long term
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FOCUS OF OPI: Strategies to ensure younger persons with disabilities are able to access OPI Services

<p>GENERAL OBSERVATIONS (broken out by session)</p>	<ul style="list-style-type: none"> ▪ Physical Disabilities folks should be able to stay in own homes; it should not be an all or nothing option - will save the state \$\$ ▪ Using community resources may result in more AAA to AAA disparity, not less ▪ Highly structured plan could possibly avert local disparities ▪ Unless one lives along I-5 Corridor, services are lacking ▪ Federal \$\$ = Strings attached ▪
	<ul style="list-style-type: none"> ▪ "Effective" [delivery of OPI services] requires a goal or objective that can't be established when ½ of the potential service population isn't being served ▪ Data must be gathered to find out how many would be served ▪ Plan for implementation and target a date, don't wait for money ▪ Efforts should be made for federal funding to entice legislature ▪ Who will be served and what services are needed ▪ Local involvement with local legislators ▪
	<ul style="list-style-type: none"> ▪ Whatever services offered to seniors must also be offered to the disabled population

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	▪
	<ul style="list-style-type: none">▪ Need to more clearly evidence our services with data for legislature; anecdotes are insufficient▪ Known as an unfunded mandate, OPI should be either just for seniors or for seniors and disabled▪ Explore options for co-housing opportunities where services can be centralized and residents can depend on one another (see NWDS profile book for example

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9/30/09 - AM

Attendees: Steven Guzauskis, COCOA; Scott Bond, OCWCOG; Kay Whitney, NWSDS; Lori Austin, SCBEC; Julie Bergstrom, MCADS; Eva Mabbott, CAPECO; Ruth McEwen*, NWSDS ADS Council; Phyllis Rand, NWSDSAC; Judy Cunio, DD Council; Bandana Shresha, AARP; Tina Treasure, SILC and ODC; Don Bruland, RVCOG; Sally Lawson, NWSDS; Don Bishoff, Senator Morrisette's office; David Fuks, Cedar Sinai Park; Robert Pope, ODC/ODHHS; Carol Simonds, DD Council

SPD Staff: James Toews, Cathy Cooper, Carolyn Wilson, Karen Mainzer, Max Brown, Elaine Young, Lynda Dyer

9/30/09 - PM

Attendees: Tim McQueary, GCSS; Bill Lynch, OCDD; Phyllis Rand, NWSDSAC; Ruth McEwen, NWSDS ADS Council; Carol Cookson, Easter Seals; Bill Olson, Advocacy Coalition; Mary Shortal, MCADS; Sara Wirfel, AARP

SPD Staff: Jeanette Burket; Cathy Cooper; Dawn Rustrum; Carolyn Wilson; Kelsi Eisele; Janet Dornhecker; Ryan Kibby; Carolyn Ross; Elaine Young, Lynda Dyer

10/14/09 - AM

Attendees: Rick Bennett, AARP; Tina Treasure; SILC; Joan Claypool, SILC; Jerry Cohen, AARP; Nancy Sargent-Johnson, LCOG; Cheryl Miller, OHCC; Joanna Desky, CCSS

SPD Staff: Cathy Cooper, Jeanette Burket, Carolyn Wilson, Elaine Young, Becky Murphy, Lynda Dyer

10/14/09 - PM

Attendees: Harold "Bud" Staff, MLTQCC; Dave and Rosemarie, NWSDS; Mike Volpe, Rick Bennett, AARP, Linda Lenox, Sheila Thomas, Lane Independent Living Alliance; Gretchen Jordan, LTC Omsbudsman

SPD Staff: Cathy Cooper; Elaine Young, Lynda Dyer,

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