Governor's Task Force
On the Future of Services
To Seniors and People with Disabilities

Initial Report

Submitted to:

Governor John A. Kitzhaber, M.D.

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Department of Human Services
Seniors and People with Disabilities

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Executive Summary

The Graying of Oregon: A Crisis in the Making

Between now and 2030, Oregon and the country will experience an unprecedented shift in the age of our population. Currently, the state is 10th in the nation in the number of people over the age of 65 and is projected to rank fourth in 10 years.[1] Due to the aging of the "Baby Boom" generation, the number of Oregonians over the age of 65 is projected to more than double from nearly 440,000 in 2000 to 1,029,000 by 2030. Those age 65 and older will compose 20 percent of Oregon's total population. By the year 2030, the median age is expected to be 42.[2] This unparalleled increase in the elderly population presents several pressing challenges for the state including:

- A significant increase in the demand for long-term care services
- An enormous potential increase in costs to the state and individuals
- A severe shortage of a trained health and long-term care workforce, and
- The need to identify the necessary public/private resources to pay for future long-term care services

As we age, our chances of needing some form of long-term care during our lifetime increases. Individuals 65 to 74 years of age have a 17 percent chance of needing long-term care. This increases to a 28 percent chance of needing long-term care for those individuals aged 75-84 years. By the time individuals reach 85 years of age or older, their likelihood of requiring some form of long-term care increases to nearly 50 percent.[3] Such an increase in the need for long-term care is especially alarming when combined with the anticipated doubling of the 85-plus age cohort by 2030. The number of younger individuals with disabilities is also expected to increase, further swelling the ranks of individuals needing some form of long-term care.

Furthermore, the availability of long-term care workers is expected to decrease. According to the Oregon Employment Department, the pool of potential entry-level workers (women 25-44) is projected to decline by 1.4 percent during the next

[1] Barry Donenfeld, "The Economic Downturn and Its Impact on Seniors: Stretching Limited Dollars in Medicaid, Health and Senior Services," Testimony before the Senate Special Committee on Aging, March 14, 2002, 7.
[2] Margaret B. Neal, Clara C. Pratt and Edward Schafer, *Aging Oregonians: Trends & Projections, 1993*, 1-5.
[3] Source: Nat'l Center for Health Statistics, Health Interview Survey, as cited in the Senior Health Insurance Benefits Assistants (SHIBA) A Volunteer Training Program Manual, Oregon Department of Consumer and Business Services, 2002, 7.

six years, which could severely impact the availability of long-term care workers. Since women comprise over 75 percent of the health and long-term care workforce, such a decline will negatively impact the availability of care for the increasing numbers of elders and people with disabilities.[4] In Oregon, the projected job growth for registered nurses in the next ten years is 10.4 percent, or nearly 3,700. Unfortunately we expect to lose nearly 7,000 nurses due to a severe nursing shortage.[5] "Nationally, the Department of Health and Human Services expects the shortage of registered nurses to double to 12 percent by 2010 and 29 percent by 2020 because a small growth in the nursing workforce will be overwhelmed by a 40 percent growth in demand."[6]

The average cost of private-pay nursing facility care in Oregon in 2002 is $55,000 annually. Nationally it's a little less, but is expected to rise to $190,600 annually by 2030.[7] The average cost of in-home care nationally is $20,000 and is expected to rise to $68,000 by 2030.[8] In Oregon, Medicaid is the largest payer (63 percent) of nursing facility care, and also pays for community-based long-term care for low-income consumers. As a result, it is anticipated that general fund expenditures for long-term care could triple by 2020.[9] Furthermore, healthcare costs are expected to continue to climb, reaching 17 percent of our Gross Domestic Product by 2011.[10]

Oregon's Long-Term Care Medicaid Caseload by Care Setting

In-Home Care Services Clients – 14,556
Nursing Facility Clients - 5,782
Adult Foster Care Clients - 5,399
Assisted Living Facility Clients - 3,662
Residential Care Facility Clients - 1,867

(July 2002 – Source: SPD Data Sheets)

[4] Oregon Employment Department, Labor Market Information, Healthcare Occupational and Industry Demographics.
[5] Source: NWHF Report, "Projected Decline in RNs due to Retirement, Projected Growth in RN Positions, and Effect of Doubling RN Graduation Rate Beginning 2005," 2001 and the Oregon Employment Department.
[6] *Older Americans Report*, Volume 26, Number 30, August 2, 2002, 242.
[7] Lynn N. Wallis, "Long-Term Health Care Industry—In Crisis?" *Oregon Labor Trends*, Oregon Employment Department, August 2002, 2-4.
[8] The Federal Long Term Care Insurance Program Brochure, FED00048(0502).
[9] Oregon Department of Human Services, Office of Finance and Policy Analysis, "Long Range Caseload Estimates for the Medicaid Long-Term Care Program of Seniors and People with Disabilities," June 2002.
[10] Richard Bringewatt, "Be Aware of Chronic Care," *State Government News*, August 2002, 28.

Unless we can make changes now to prepare for the future, the burgeoning elder population combined with increasing health and long-term care costs and decreasing health and long-term care workforces, portends a future lacking in care and services for our most vulnerable citizens. This report is a first step in the planning and preparation for our state's future service needs for seniors and people with disabilities.

Key Issues Facing the State

The Task Force identified numerous key issues facing the State as the result of the elder age explosion. Some of those issues included:

Outcome-Based Decision Making

- Lack of empirical data and evaluation that demonstrates services and programs provide beneficial outcomes such as quality of life and cost effectiveness

Personal Responsibility

- The need for a balance between personal and state responsibility

Bounded Choice

- Choice versus cost, the need for affordable choices within certain financial and outcome boundaries tied to assessed impairments

Integration of Services and Funding

- The high cost of liability insurance for providers
- The need for increased wages and benefits for long-term and health care workers
- The need for greater coordination between various funding and service delivery mechanisms to reduce fragmentation in the system
- The increasing demands for services during severe fiscal shortfalls
- The increasing costs for long-term and acute care services, including prescription drugs, with no stable funding source
- The need for a continuum of long-term care and acute care services in an integrated system with multiple points of entry

Information and Education

- Need for proactive education, information and incentives to enhance financial literacy and personal responsibility in retirement and long-term care planning

- The lack of statewide and community-based prevention and chronic disease management programs and community environments and infrastructures that encourage healthy lifestyles

Caregiver and Workforce Support

- More support for family and unpaid caregivers is needed
- The scarcity of health and long-term care workers

Safety Net

- The necessity of preserving a safety net for those unable to pay for their long-term care and acute care
- The lack of health care and long-term care available in rural areas

System Diversity

- The lack of culturally competent services and programs
- The need for the expansion of a continuum of long-term care housing, care and service options
- The continued need to expand person-directed or consumer-directed care and independent choices

Vision

The Task Force developed an overall vision statement for the future of long-term care services in Oregon, along with a description of whom the system will serve.

We envision that Oregon will transform services and programs for elders and persons with disabilities into an integrated, seamless system that promotes and/or supports each individual's abilities to successfully respond to life changes and care needs.

Focus of the Task Force

The future retirement of the baby-boom population will create an unprecedented demand for long-term care services. This demand will necessitate a prioritization of both the populations served and the services provided in our long-term care programs.

The task force envisions that statewide long-term care programs will serve all Oregonians with information and education regarding long-term care options and costs, plus the necessary financial and retirement planning.

Additionally, Oregonians at risk of needing care and unpaid caregivers (such as family, friends or community) will receive education, screening and assessments, and support to maximize independence.

Oregon's long-term care programs must also provide direct service to certain people within the senior and people with disabilities populations. Statewide long-term care programs must prioritize finite resources to serve Oregonians with the greatest physical, psychosocial and financial needs. Individuals receiving services should receive those services within certain defined financial boundaries while acting as partners in making decisions regarding the care and services they receive.

Overarching Recommendations

The Task Force has concluded that a cultural shift is needed in Oregon in order to successfully position ourselves to meet the needs and challenges of an aging population. All Oregonians, regardless of their incomes, must begin to take personal responsibility for making healthy behavior choices and for planning and preparing for their future retirement and possible long-term care needs. Public and private collaborations and policies must assist in creating this cultural shift. The Task Force further recognizes the need for a public policy of:

- Planned and sustainable growth of the housing, care and service systems,
- Financing achieved in a public-private partnership and collaboration that emphasizes personal responsibility, and
- A commitment to educate and promote a need for personal responsibility with a balance between personal and state responsibility, independent decision-making and informed choice.

As such, the Task Force has developed a comprehensive list of goals, strategies and actions to guide the state in moving forward. A more detailed list can be found on pages 29 through 77. However, the following is a list of eight overarching recommendations identified by the Task Force members as those items that require attention and implementation within the next year to begin laying the foundation for the future.

Outcome-Based Decision Making

- **Develop measures for the different care settings to determine whether services achieve desired outcomes, promote quality of life and are cost-effective.**

First Action Steps:

1. Direct DHS to collect data and use empirically based decision-making.
   a. Conduct a comprehensive, independent evaluation of the outcome and quality assurance measurements currently used to evaluate the long-term care system.
2. Develop consumer-oriented satisfaction measures that include personal dignity, independence, autonomy, security and functional status.
3. Require outcome measures in the development of new programs and services.
4. Utilize empirical data to change regulatory requirements to focus on outcomes for consumers.

Timeline: Begin data collection November 2002

Lead: Department of Human Services, Seniors and People with Disabilities, Finance and Policy Analysis, Health Services, in conjunction with area agencies on aging, private foundations, Department of Higher Education, and service providers.

Personal Responsibility

◆ **Encourage personal responsibility by educating Oregonians on the need to engage in healthy lifestyles and planning for retirement and future long-term care needs.**

First Action Steps:

Financial and Tax Incentives

1. Evaluate effectiveness of state long-term care insurance tax credit; recommend appropriate changes.
2. Work with private and public employers and advocacy groups to help employees plan for retirement including offering long-term care insurance.
3. Educate individuals about long-term care and the likely need for insurance. Develop and distribute materials explaining the advantages and disadvantages of long-term care insurance.

4. Create and implement a professional certification for agents who sell long-term care insurance. Require that agents complete continuing professional education work related to aging issues to retain certification.
5. Develop and distribute information explaining the pros and cons of using a reverse mortgage to help finance elder years and/or long-term care.

Healthy Lifestyles and Education

1. Create a report card for elder- and disability-ready communities.
2. Develop state recognition and award programs for worksites that promote "healthy policies."
3. Educate policy makers about the demographic trends and expectations that government will deliver programs when and how the public wants them, and the difference between the costs and revenues.
4. Develop and disseminate information regarding health and wellness via state and local public health agencies. Use widespread education techniques to promote health, such as television ads, billboards, radio, signs on public vehicles, etc.

Timeline: Begin planning January 2003

Lead: Department of Human Services, Seniors and People with Disabilities and Health Services and Department of Consumer and Business Services, Insurance Division, Legislative Assembly, Governor's Office, private sector financial service providers and related associations.

Bounded Choice

◆ **Provide choices for long-term care within certain financial boundaries for those who are eligible for Medicaid.**

First Action Steps:

1. Convene a stakeholders' workgroup to report its recommendations about service packages and cost ranges to the Governor and the Legislative Assembly. The recommendation

should address any differences between packages and ranges for seniors and people with disabilities.

2. Pursue changes in federal regulations and/or waivers to allow clients to be offered services within boundaries.
3. Appoint a workgroup of long-term care providers, advocates and public sector representatives and workforce representatives that:
   a) explores issues around subsidization of the public sector by private sector;
   b) develops recommendations for criteria upon which to base rates that meet both consumer needs and provider costs;
   c) develops reimbursement strategies that include empirically measured quality outcomes; and
   d) explores regulations that inadvertently increase provider costs.
4. Complete an analysis of:
   a) the different costs of doing business in different regions of the state;
   b) cost differences in operation of facilities of different sizes and types;
   c) Develop and implement a methodology for reimbursement to long-term care facilities that factors in improvements and maintenance of physical plant and technology that relate to the integrity, accessibility and functioning of the basic structure; and
   d) current wage and benefit levels for direct-care staff across long-term care settings.
5. Develop and implement a long-term care assessment tool as the basis of the rate setting process that recognizes consumer needs based on medical acuity, activities of daily living assistance and psychosocial conditions.
6. Develop models that adjust rates in ways that recognize both different consumer needs and different cost structures, and that encourage quality outcomes.

Timeline: Begin developing November 2002

Lead: Department of Human Services, Seniors and People with Disabilities and Finance and Policy Analysis, Legislative Assembly, Governor's Office, public sector providers and workforce representatives.

Integration of Services and Funding

- **Integrate acute and long-term care services and financing streams. Provide a continuum of services, information and funding.**

  First Action Steps

  1. Work with the Congressional delegation to promote regional parity of Medicare payments.
  2. Revise the Medicare definition of homebound to ensure that access to Medicare home services is more flexible.
  3. Revise the federal and state rules concerning the use of Medicaid and Medicare funds making them more flexible so that the use of these funds is not site specific.

  Timeline: Begin planning July 2003

  Lead: Department of Human Services, Seniors and People with Disabilities, Finance and Policy Analysis, and Health Services

Information and Education

- **Provide information and education on long-term care needs, services and planning to all Oregonians.**

  First Action Steps:

  1. Conduct a public action campaign to inform the public about the serious consequences of falls, fall prevention and safety hazards in the home.
  2. Develop projections of future needs and system capacity.
  3. Expand education of consumers and families on the benefits and risks associated with various long-term care options, including the choice of living in a less restrictive environment or the risks involved in transitions.
  4. Educate people about technologies such as remote wireless and other "smart home" technology related to health and prevention to extend the time people can live safely in their own homes.

  Timeline: Begin development July 2003

  Lead: Department of Human Services, Seniors and People with

Disabilities and Department of Consumer and Business Services

Caregiver and Workforce Support

- **Increase system capacity by developing the acute and long-term care workforce and providing family and informal caregiver supports.**

  First Action Steps:

  1. Increase and expand enrollment capacity of licensed nurses at both the community college and baccalaureate levels.
  2. Medicaid reimbursement rates should be adequate to provide competitive wages and benefits for long-term care, in-home and health workers.
  3. Continue to develop and expand Older Americans Act Family Caregiver Support Programs.
  4. Encourage and provide incentives to businesses to establish flexible schedules, programs and benefits to support family care giving.

  Timeline: 2003 Legislative Session

  Lead: Department of Human Services, Seniors and People with Disabilities and Health Services, Department of Higher Education, Board of Nursing, Governor's Office, Legislative Assembly, Oregon Health Science University, community colleges, and relevant provider organizations

Safety Net

- **Maintain a safety net for those who cannot afford to pay for their care.**

  First Action Steps

  1. Encourage the Congressional delegation to support financing strategies to add prescription drugs and long-term care benefits to Medicare.
  2. Change health insurance practices to provide multi-year policies that include incentives to invest in prevention and reduce administrative costs.

3. Adopt stronger Medicaid eligibility requirements for valuation of major assets such as homes and automobiles.

Timeline: Begin July 2003

Lead: Governor's Office, Legislative Assembly, Department of Human Services and Department of Consumer and Business Services

System Diversity

◆ **The long-term and acute care systems must reflect cultural, regional, gender and disability differences.**

First Action Steps:

1. Dialogue with representatives of cultural and ethnic communities to identify discrete needs and service strategies within those communities.
2. Take the result of the needs assessment and assist those communities to establish culturally competent programs and services.
3. Develop a workforce that is culturally sensitive and responsive to age, disability, race, gender and ethnicity.
4. Develop programs to encourage diversity in recruitment of care providers.

Timeline: Begin July 2003

Lead: Department of Human Services

Introduction

The Governor's Task Force on the Future of Services to Seniors and People with Disabilities is pleased to present this initial report for consideration in the 2003-2005 budget and legislative process. This report was created under the leadership of Co-Chairs Senator Kate Brown and Terri Waldroff and reflects the desire of Governor John A. Kitzhaber, M.D. that Oregon plan and prepare for the aging of the "Baby Boom" generation and the anticipated growth in the numbers of people with significant disabilities.

Oregon has long been considered a national leader in the provision of long-term care services and options to seniors and people with disabilities. In 1981, Oregon was the first state in the country to receive a Medicaid waiver to pay for community-based care. As a result, more than 50 percent of our Medicaid clients are living in their own homes or in other community-based settings rather than in more costly and restrictive nursing facilities. Oregon is better prepared and has more infrastructure and capacity than most states. Even so, our system is neither prepared nor adequate enough to meet the aging crisis looming before us in the first half of the 21st Century. There continue to be barriers to services, lack of capacity, system and infrastructure fragmentations, and financial and program needs that must be addressed in order for the state to meet the challenges of providing services to the aging baby boomers.

The Task Force believes that the recommendations in this report will provide the foundation for an aging and disability services system that will be capable of handling the burgeoning elder and disability populations anticipated in 2030. The recommendations are based on information and data gathered, reviewed and analyzed by the Task Force members.

The Task Force regrets that, due to time constraints and under-representation of persons with disabilities, it was not able to adequately provide recommendations on a variety of issues related to younger individuals with disabilities. As a result, we recommend another Task Force be created, consisting of advocates, providers, legislators and persons with disabilities to thoroughly address the future of services for children and younger adults with disabilities. Nevertheless, the Task Force has included, where possible, people with disabilities throughout the recommendations of this report.

The Governor convened the first Task Force meeting in October 2001, consisting of representatives from the Oregon Legislative Assembly, various commissions, agencies, provider organizations, consumers, advocates, and two physicians

specializing in gerontology. The Task Force originally divided into five subcommittees to gather and analyze information and develop a set of recommendations on specific topics, including: 1) Finance, 2) Service Delivery, 3) Planning, 4) Housing and Special Supports, and 5) Health and Prevention. The subcommittees met over a six-month period.

Due to requests by various advocacy groups, the co-chairs agreed to increase membership to each of the subcommittees by a maximum of two advocates or consumers. Therefore, eight more individuals were appointed to serve on the subcommittees (Planning and Services merged into one subcommittee.) The subcommittees developed goals, strategies and actions related to their subject areas.

The recommendations from the subcommittees were first presented to the full Task Force in June 2002 for review. A subsequent Conference Committee of the Task Force combined the subcommittees' recommendations into one report for the approval of the full Task Force. The Task Force, at its August and September 2002 meetings, voted to approve the initial recommendations reflected in this document.

Background

Demographics

Between now and 2030, Oregon and the country will experience an unprecedented shift in the age of our population. According to 2000 Census data, those individuals 65 years of age and older make up nearly 13 percent (438,177) of Oregon's population. This number is projected to more than double to 1,029,230 or 20 percent of the overall population (an increase of over 50 percent) by 2030. [11] In other words, for the first time in history, our population will have more elders than youth. Such a population shift has significant implications for the future of Oregon.

With the increase in the elderly population there is also an anticipated expansion in the number of individuals with disabilities. This is due in part to advances in medical science and to the increased prevalence of disability as we age, especially for those 80 years of age and older (73.6 percent of those 80 plus have a disability).[12] It is projected that the number of individuals 85 years of age and older will more than double by 2030, an increase from 1.7 percent (57,431) to 3 percent (136,437) of Oregon's total population, or 13 percent of the 65-plus population.[13]

The number of elder individuals from various racial and ethnic minority populations is also expected to increase by 2030. The unique differences and cultural expectations, as well as a history of discrimination and general disadvantage, compels the acute and long-term care service delivery systems to become culturally competent. In Oregon, the percent of minority people age 65 and older (includes Non-Hispanic and Hispanic) is a little over five percent of the total 65-plus age cohort.[14] Poverty rates among Black and Hispanic elders are today 2.5 times more than those among Whites. When gender is added to race, the disparities become even more notable.[15] Concrete steps must be taken to improve the retirement prospects and long-term care needs of people of color. Not only are they disadvantaged by a lifetime of employment inequities, they are often at

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[11] Office of Economic Analysis, Department of Administrative Services, State of Oregon, ww.oea.das.state.or.us/demographic/longterm/or_age5.htm .

[12] Jack McNeil, "Household Economic Studies Current Population Report P70-73, Americans With Disabilities: 1997," United States Census Bureau, created March 1, 2001 http://www.census.gov/hhes/www/disable/sipp/disab97/asc97.html.

[13] Source: Census Data, http://www.census.gov/population/projections/state/stpjage.txt.

[14] Administration on Aging, http://www.aoa.gov/Census2000/minority-sumstats.html.

[15] Robert B. Hudson, "Getting Ready and Getting Credit: Populations of Color and Retirement Security," *Public Policy and Aging Report*, Volume 12, No. 3, Spring 2002, 1.

greater risk for a number of chronic diseases, including diabetes, strokes, and heart disease.[16]

Women, Family and Informal Care Providers

Women have a longer life expectancy than men, earn less than men (72 cents to the man's dollar), provide the majority of unpaid care for children and elders, and also have a higher incidence of chronic diseases that impair mobility such as arthritis and osteoporosis.[17] Therefore, women tend to be both the highest users of long-term care as well as the primary caregivers for those needing long-term care. The number of women receiving long-term care paid by Medicaid is nearly three times greater than men.[18] With the trend toward smaller and more mobile families, the availability of children to provide care to aging parents is reduced. This trend coupled with women in the workforce further reduces the availability of family and informal care providers. Even so, 80 percent of care is provided by family members, predominantly women. Therefore, public and private policies that support family caregivers are crucial to keeping the costs for long-term care down.

Workforce

Not only are there fewer family and informal care providers, there is also a shortage in health and long-term care workers. For example, it is projected that Oregon will need over 39,000 registered nurses by 2010, but will fall short of the demand by over 7,000 given the graduation rate of the year 2000. Even if the graduation rate doubles each year beginning in 2005, there will be a shortage of over 3,000 registered nurses by 2010.[19] Other health care and long-term care jobs are experiencing similar shortage issues. Several factors contribute to the scarcity of paid health and long-term care workers including:

- An increase in demand by an aging population
- Retirement of current health care workers
- Few men and minorities entering the field
- Poor working conditions such as mandatory overtime, lifting and other physical demands, and emotional stress
- Too much paperwork incurred by reimbursement

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[16] *Keeping Oregonians Healthy: An Assessment of Leading Causes of Death and Related Behaviors in Oregon*, 1999,Oregon Health Division, 60-66.

[17] Pamela Herd, "Care Credits: Race, Gender, Class, and Social Security Reform," *Public Policy and Aging Report*, Volume 12, No.3, Spring 2002, 14.

[18] Source: Oregon Department of Human Services, Seniors and People with Disabilities, 360 Assessment Data, June 2001.

[19] Source: NWHF Report, "Projected Decline in RNs due to Retirement, Projected Growth in RN Positions, and Effect of Doubling RN Graduation Rate Beginning 2005," 2001 and the Oregon Employment Department.

- Lack of training programs to promote upward career mobility for those with English as a Second Language (ESL) needs
- Shorter hospital stays that increase the need for outpatient and home health care, and
- Regulations that limit flexibility in responding to workforce shortages.[20]

With the aging of the baby boomers, the scarcity of health and long-term care workers will only increase unless action is taken now to recruit, train and retain them.

Long-Term Care Costs

Long-term care is very expensive. Nationally, the average annual cost of in-home care is $20,000 and is expected to jump to $68,000 by 2030. The average annual cost of nursing facility care is $50,000 and is expected to climb to $190,600 by 2030.[21] The average cost per person in Oregon, who receives care in a nursing facility paid by the Medicaid program is approximately $2,400 per month, or $28,800 per year. The average cost for in-home care, paid by the Medicaid Program is approximately $800 per month or $9,600 per year.[22] The average cost of care for an individual receiving services paid by Oregon Project Independence is $153.04 per month or $1,836.48 per year.[23] Those who pay privately for long-term care in Oregon pay more and often subsidize the rate paid by Medicaid. The cost of long-term care is only expected to continue to rise, making its financing a huge policy issue.

Medicaid caseload projections indicate an increase from approximately 31,000 cases in 2002 up to 75,665 by 2020 depending on the scenario used. This would mean a general fund expenditure increase from a little over $200,000,000 in 2002 to more than $600,000,000 (trended forecast) in the year 2020.[24] Neither of the forecast scenarios adjusts for inflation. In other words, general fund expenditures for Medicaid long-term care consumers could triple in less than 20 years. Such an increase in general fund expenditures will have a tremendous impact on all state-funded programs and services.

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[20] *Health Care Sector Employment Initiative: An effective course of treatment for some of Oregon's most pressing health care workforce challenges*, a project of the Oregon Workforce Investment Board, May 2002.
[21] The Federal Long Term Care Insurance Program Brochure, FED00048(0502).
[22] Source: Oregon Department of Human Services, Seniors and People with Disabilities, 360 Assessment Data, June 2001.
[23] 2001-2003 Oregon Department of Human Services, Senior and Disabled Services Division, Budget Narrative adopted by the Oregon Legislature, Long-Term Care, Oregon Project Independence, 226.
[24] Department of Human Services, Office of Finance and Policy Analysis, *Long Range Caseload Estimates for the Medicaid Long-Term Care Program of Seniors and People with Disabilities*, June 2002.

Medicaid, Medicare and Long-Term Care Insurance

Medicaid has become the default mechanism for payment of long-term care for most elderly and persons with disabilities regardless of income. While Medicaid was never intended to become the primary source of long-term care payment, it has become so, primarily because individuals who begin as middle class and paying for their long-term care privately, end up spending down their resources and impoverishing themselves, making them eligible for Medicaid. Currently, Medicaid and Medicare are the two major payment systems for acute and long-term care for seniors and people with disabilities. Medicare is a federal health insurance program, while Medicaid is a medical assistance program jointly financed by the state and federal governments for eligible low-income individuals. Medicaid provides payment for acute medical care, long-term care and prescription drugs. Medicare Part A covers inpatient hospital stays, limited skilled nursing care, home health care, and hospice services. It is funded primarily through payroll taxes paid by employees, employers and the self-employed, but also is funded by premiums paid by enrollees. Medicare Part B covers inpatient and outpatient services received from physicians, additional medical services such as outpatient and emergency hospital care, therapy services, ambulance transportation, equipment and supplies, and home health care. Part B Medicare is funded primarily through monthly premiums paid by enrollees (who must cover 25 percent of the Part B costs) and through general tax revenues.

Medicare does not pay 100 percent of all medical bills, nor does it cover prescription drugs or a variety of long-term care services provided in community-based settings. Since there are gaps in what Medicare pays, many elders and people with disabilities also purchase Medicare supplement insurance policies from private insurers, enroll in a Managed Care Organization, or purchase a tax-free savings account plan earmarked for health care expenses.

A much smaller number of seniors and younger people actually purchase long-term care insurance. According to the Health Insurance Association of America, 6.8 million long-term care policies had been sold by the end of 1999. In 1999 alone there were 750,000 long-term care insurance policies sold.[25] However, nationally, only one percent of all long-term care is paid by private long-term care insurance.[26] As a result, many individuals who require long-term care spend down their resources to pay for their care and eventually become eligible for Medicaid.

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[25] "Long-Term Care in 1998-1999: Summary of Study Findings," Health Insurance Association of America, http://www.hiaa.org/research/usefulfacts.cfm#/longtermcare .

[26] Senior Health Insurance Benefits Assistants (SHIBA) A Volunteer Training Manual, Oregon Department of Consumer and Business Services, 2002, 10.

Oregon has a long history of managed care and high enrollment of seniors in Medicare Managed Care Plans, resulting in lower medical costs. In order to keep the cost of medical care down, Medicare sets reimbursement rates for various services by region. Therefore, since Oregon has been able to keep costs down relative to the rest of the country, physicians are penalized by receiving a much lower reimbursement rate than physicians in other parts of the country (i.e., the same procedure is reimbursed at a higher rate in New York than in Oregon.) Further, the way physicians are currently reimbursed does not encourage good chronic disease assessment, management and preventive care.

State Long-Term Care Service Delivery System

The Department of Human Services' (DHS) policy unit, Seniors and People with Disabilities (SPD) is responsible for administering programs for children and adults with developmental disabilities, seniors and people with physical disabilities. The overall mission of Seniors and People with Disabilities is to assist seniors and people with disabilities of all ages to achieve well-being through opportunities for community living, employment, family support and services that promote choice, independence and dignity. The services provided by Seniors and People with Disabilities and its local partners (area agencies on aging) include: long-term care services, licensing and planning, eligibility, case management, cash assistance, and protective services. Seniors and People with Disabilities and its local partners also administer and implement the following programs: Medicaid long-term care services, Older Americans Act (OAA), Oregon Project Independence (OPI), Employment Initiative, Employed People with Disabilities, Employment for People with Developmental Disabilities, Family Support, Children's Intensive In-Home Services, 24-Hour Residential Services, and the Staley Agreement.

These programs are funded through a mix of federal and state sources. Medicaid and Oregon Project Independence require individuals to be low-income, have few resources and meet other conditions. However, eligibility for Older Americans Act Programs only mandates that individuals be 60 years of age or older, with no further requisites.

Elder Oregonians and younger persons with disabilities have a variety of long-term care options available to them in most regions of the state. These options include:

- Respite Care
- Adult Day Services
- In-home Services
- Adult Foster Homes

- ❖ Assisted Living Facilities
- ❖ Residential Care Facilities
- ❖ Continuing Care Retirement Facilities
- ❖ Other Non-Licensed/Certified Retirement Homes
- ❖ Nursing Facilities
- ❖ Program for All-inclusive Care for the Elderly (PACE) *(Multnomah Co. only)*

Chronic Disease Prevention and Management

During the 20th Century, the leading causes of death changed from infectious diseases to chronic diseases. Today, heart disease, cancer, stroke, diabetes and lung disease are the leading cause of death. Chronic diseases account for seven out of every ten deaths in Oregon. As the "Baby Boom" generation ages, the number of Oregonians affected by chronic diseases will escalate rapidly, increasing both health care costs and the burden of chronic disease. According to the Robert Wood Johnson Foundation, individuals with chronic conditions are healthcare's largest, highest-cost and fastest growing service group, accounting for 75 percent of all healthcare spending.[27] Two-thirds of Medicare spending is on behalf of the 20 percent of people who have five or more chronic conditions.[28] The more chronic conditions an individual has, the higher out-of-pocket expenditures they will incur.[29] If we are to compress morbidity (the time in which chronic disease occupies one's life span, allowing for a shorter time of disability prior to death) and subsequently decrease medical and long-term care costs, Oregonians need to modify three behaviors in particular: 1) quit smoking, 2) eat a healthy diet, and 3) exercise. Other modifiable factors include eliminating drug and alcohol abuse, infections, and environmental contaminants.[30]

While we are living longer with less disability over all, it is not certain this trend will continue for baby boomers. The prevalence of risk factors among adults approaching their later years is alarmingly high in the United States. The vast majority of the population age 51 to 61 (89 percent) have at least one modifiable risk factor, and almost one-fifth (19 percent) have three or more modifiable risk factors.[31] Over 500,000 or approximately 20 percent of Oregonians smoke.

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[27] Richard Bringewatt, "Be Aware of Chronic Care," *State Government News*, August 2002, 28.
[28] "Medicare: Cost and Prevalence of Chronic Conditions," *Partnership For Solutions*, July 2002, www.partnershipforsolutions.org .
[29] Health Policy Alternatives, Inc. in collaboration with The National Chronic Care Consortium, *A Guide to Regulatory Reform for People with Chronic Conditions*, March 2002, 3.
[30] Source: *Keeping Oregonians Healthy: An Assessment of Leading Causes of Death and Related Behaviors in Oregon*, Department of Human Services, Oregon Health Division, 1999.
[31] "At Risk: Developing Chronic Conditions Later In Life," *Challenges for the 21st Century: Chronic and Disabling Conditions*, National Academy of an Aging Society, February 2000 , 1.

Furthermore, only 27 percent of Oregonians engage in regular physical activity, contributing to an alarming trend of overweight and obesity. Over half (57 percent) of Oregon adults are considered either obese or overweight.[32] Since smoking, overweight and physical inactivity are key risk factors of chronic diseases, individuals, businesses, the state, its communities, and health and long-term care providers need to work together to increase the potential for health and decrease the incidence of chronic diseases.

Retirement Income

With the uncertainty of the continued solvency of Social Security, the dissolution and dwindling of various private and public sector pension plans and the lack of personal savings by most baby boomers, the future financial stability of many is uncertain. According to United States Senator Larry Craig (Idaho), member of the U.S. Senate Special Committee on Aging, "The personal savings rate is almost zero. Many Americans are spending more than they save." He further stressed that the average retirement savings account balance is now about $35,000 and the median is $14,000 and that 61 percent of all workers between the ages of 25 and 64 did not own a retirement savings account in 1998.[33]

As one might guess, women and minorities tend to be those most at risk of financial insecurity as they age. Single mothers who never married are especially vulnerable. Women continue to have lower labor force participation rates and earnings than men, mainly due to their disproportionate responsibility for raising children and caring for the elderly. Also, women still earn less than men.[34]

For baby boom females in Oregon, retiring at the Social Security normal retirement age, the average total, before-tax annual retirement income, ranges from just under $20,000 to approximately $24,000 annually. For Oregonian baby boom men, retiring at the Social Security normal retirement age, their annual income will range from approximately $27,000 to $33,000 (expressed in 2001 dollars).[35] While this may be enough income to meet most baby boomers' basic expenses, it ceases to be enough for many, when health and long-term care costs enter the picture.[36]

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[32] Source: Centers for Disease Control and Prevention.
[33] U.S. Department of Labor and Congressional Research Service as cited by U.S. Senator Larry Craig, Press Release, February 26, 2002.
[34] Pamela Herd, "Care Credits: Race, Gender, Class, and Social Security Reform," *Public Policy and Aging Report*, Volume 12, No. 3, Spring 2002, 13 and 14.
[35] Jack L. VanDerhei and Craig Copeland, *Oregon Future Retirement Income Assessment Project: Final Report*, Employee Benefit Research Institute, September 7, 2001.
[36] Jack L. VanDerhei and Craig Copeland, *Oregon Future Retirement Income Assessment Project: Final Report*, Employee Benefit Research Institute, September 7, 2001.

Therefore the need for Oregonians to save for future retirement and potential long-term care is most pressing. With anticipated increases in life expectancy and increases in health and long-term care costs as well as living expenses, it is doubtful that pensions and social security alone will be enough to ensure a retirement that will meet the basic needs of many aging baby boomers.

The Future

What can Oregonians expect in 2030 if the recommendations in this report are implemented?

Consumers

- To remain in their own homes longer with the assistance of technology, transportation, and family and informal caregiver support, including the increased availability of respite and adult day care services in a variety of settings.

- The continued availability of a variety of long-term care settings, including adult foster homes, residential care facilities, assisted living facilities, and nursing facilities. Other housing options will be created that provide diverse communal structures and cultural environments. Long-term care settings will be constructed for visitability and for the use of technology to assist in care needs.

- For those whose long-term care is paid by Medicaid, there will be choices within certain boundaries. Those boundaries will be determined by optimal outcomes and specific financial parameters. For example, an individual receiving in-home care may choose to remain at home, even though the optimal outcomes and financial parameters indicate a different level of care is indicated. The state would then limit the amount of payment provided to those individuals who decide to remain in their own homes rather than moving to a different care setting. This not only provides individuals with a safety net of services, within reasonable financial boundaries, it also allows them choices and enables them to direct their care.

- Many individuals will be healthier and have savings for their retirement and long-term care. They will be better able to take responsibility for their long-term care and retirement needs because they will have planned accordingly, having made needed changes in their lives 25 years earlier. They will be supported in their planning by both public and private sector funded information campaigns and incentives. Individuals will also be healthier due to lifestyle choices they make, assisted by community infrastructures that support physical activity, healthy food choices, and public transportation.

- A continuum of long-term care and medical services will be available from an integrated system with multiple points of entry. This system will not only integrate service delivery but also funding streams for services needed.

Providers

- More individuals receiving care will be paying for their care with a combination of public and private funds. Medicare and Medicaid will be integrated and provide partial or complete payment for long-term care and prescription drugs. Long-term care insurance policies will pay for what the combined Medicare and Medicaid will not pay.

- Medical providers will receive fair reimbursement for services they provide. They will receive reimbursement for conducting assessments, providing prevention and chronic disease management education to their patients in a variety of settings (office, "classroom," remote telecommunication). They will be able to effectively and efficiently communicate with the long-term care providers and their consumers.

- Long-term care providers will be reimbursed at a fair and equitable rate for their services. Such rates will enable them to pay livable wages and benefits to their employees, plus provide them with appropriate training, thereby eliminating costly turnover and problems with quality of care.

- More flexible regulations to allow for a variety of care settings and structures will be in place. Such flexibility might include the use of technology to offset the need for a specific staffing standard.

State

- An increased role in providing information and education in a variety of areas including, but not limited to: family caregiving, chronic disease prevention and management, retirement and long-term care planning.

- More help from the federal government in paying for long-term care due to the integration of Medicaid and Medicare.

- Better data will be collected to accurately set rates for the reimbursement of long-term care providers.

- Ability to offer a set of long-term care services to clients based on optimum outcomes within specified financial boundaries.

What can Oregonians expect in 2030 if we do nothing?

Consumers

- Not enough personal resources to pay for their long-term care needs, therefore requiring them to spend what resources they have to become eligible for a very limited Medicaid program.
- A Medicaid safety net with significant gaps.
- Little to no support for family and unpaid care providers.
- Inability to remain in their own homes due to a lack of transportation, technological enhancements, and long-term care providers.
- Long-term care that lacks quality and choices.

Providers

- Very low reimbursement rates for individuals receiving Medicaid, thus an inability to provide quality care, recruit and retain trained staff, and difficulty remaining solvent.
- More demand than capacity, as alternative and traditional long-term care settings will not be developed due to lack of funding.
- Litigation due to poor quality services.

State

- A system overwhelmed and unable to respond to the long-term care needs of the elders and individuals with disabilities.
- A budget overwhelmed by long-term care demands, thus severely limiting and impacting other services provided by the state including services for families, education, and state and community infrastructures.

Next Steps

Step One

Create a dialogue with Oregonians. Present these recommendations to the public for their comment and input. Once such feedback has been acquired, it will be provided to the Governor and Legislative Assembly as an addendum to this report.

Step Two

Develop legislation on key recommendations for introduction during the 2003 Legislative Session.

Step Three

Begin the process of implementing key actions and strategies that require administrative action, by working with the appropriate lead agencies.

Step Four

Establish another Task Force consisting of advocates, providers, legislators and persons with disabilities to thoroughly address the future of services for children and younger adults with disabilities.

Recommendations

Overview

In the process of developing the recommendations, distinct categories of services were identified, 1) Health, Prevention and Chronic Care, and 2) Housing, Families and Communities. Under each of these broad categories, goals and strategies were placed under subheadings, including: 1) public policy, 2) finance, 3) service provision, 4) education, 5) workforce development, 6) family and community caregiver support and development, and 7) technology. There are a total of 26 goals. Each goal has strategies and actions to assist in its implementation.

A matrix is used to present the Task Force recommendations. This matrix includes several columns that provide further information with regard to each strategy and action. On the left side of the matrix the goals, strategies and actions, are listed. On the right side of the matrix are columns with several headings. The following explains and describes those columns:

State/Fed. Policy
This column indicates if the strategy or action requires changes in state or federal government policy, and will be indicated as an "F" for federal and an "S" for state, or "F/S" for both federal and state.

State/Fed. Budget
This column indicates whether or not state or federal government funds are required to implement it with new budget resources and is similarly marked as the policy column.

State/Fed. Legislative
This column identifies whether or not state or federal legislation is required to implement the strategy or action and is marked as stated above.

Private Sector/Organizations
This column identifies whether or not the private sector needs to take the lead or at least partner with the state in implementing the strategy or action.

Lead Responsibility
This column lists the agency or branch of government that needs to take the lead in implementing the strategy or action.

Implementation Time

This column is used for estimating the implementation time of an action or strategy, whether it could be implemented in a short, intermediate or long period of time.

S = Short time to implement (1-5 years)

I = Intermediate time to implement (5-10 years)

L = Long time to implement (10+ years)

Health, Prevention, and Chronic Care

Public Policy

Goal Statement: Public policy supports self-direction and autonomy with a balance between personal and public responsibility. Eliminate the expectation of impoverishment by the person, spouse or family as a condition for receiving assistance.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Federal and state eligibility rules for Medicaid should ensure balance between individual responsibility and the public need.	S/F		F
Action 1. Seek a dialogue with federal and state policy makers, advocates and consumers to examine standards for the level of assets that can be shielded by trusts for the purpose of eligibility to Medicaid.	S/F		
Action 2. Adopt stronger Medicaid eligibility requirements for valuation of major assets such as homes and automobiles.	S/F		F
Strategy 2. Limit entry to the Medicaid long-term care system to Oregonians in need of safety net services.	S		S
Action 1. Amend Oregon Revised Statutes 108.110 to stipulate use of administrative hearings in spousal support cases.	S	S	S
Action 2. Continue to develop strategies that involve appropriate consumer cost sharing.	S/F		

Goal Statement: Medicaid consumers should be able to choose among appropriate groups of services within cost and outcome boundaries that adequately and effectively meet their needs and preferences.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategies 1. A choice of services will be available to consumers. The choices available to consumers who are Medicaid clients are limited to the package of services that meet their needs in the most effective and cost-efficient manner.	S/F	S/F	F
Action 1. Convene a stakeholders' workgroup (advocates, consumers, providers, Department of Human Services staff and other interested parties) to report its recommendations about service packages and cost ranges to the Governor and the Legislative Assembly. The recommendation should address any differences between packages and ranges for seniors and people with disabilities.	S		
Action 2. Pursue changes in federal regulations and/or waivers to allow consumers to be offered services within boundaries.	S	S/F	

Finance

Goal Statement: Oregonians must be provided with incentives to make financially responsible decisions about their future long-term care needs.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Promote the use of private alternatives to fund long-term care including long-term care insurance.	S		S
Action 1. Evaluate effectiveness of state long-term care insurance tax credit; recommend appropriate changes.	S		S
Action 2. Work with Congressional delegation for a Federal deduction for long-term care insurance.	S	F	F
Action 3. Pursue federal and state law changes to provide incentives for the use of reverse mortgages to defer Medicaid.	S/F		S/F
Action 4. Pursue state tax penalty surcharge on most retirement account withdrawals before normal retirement age; dedicate surcharge to help fund Medicaid long-term care.	S		S
Action 5. Encourage charitable contributions to long-term care.	S		
Action 6. Work with Congressional delegation to allow taxpayers who do not itemize their federal tax deductions to claim deductions for charitable giving and long-term care insurance.	S	F	F
Action 7. Create a tax refund check-off for long-term care funding for Oregon residents.	S	S	S
Action 8. Work with private and public employers and advocacy			

Goal Statement: Oregonians must be provided with incentives to make financially responsible decisions about their future long-term care needs.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
groups to help employees plan for retirement including offering long-term care insurance.	S		
Action 9. Create a tax incentive for employers to offer long-term care insurance to their employees.	S/F	S/F	S/F

Goal Statement: Stable funding sources adequate to meet documented needs and costs must be identified and developed.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Encourage the Congressional delegation to support financing strategies to add prescription drugs and long-term care benefits to Medicare.	F	F	F
Strategy 2. Begin dialogue among state and local governments to consider various local funding alternatives.	S		
Action 1. Encourage the development of local taxes and/or levies as a method to increase funding for programs and services for seniors and people with disabilities.	S		
Action 2. Recommend continuation and expansion of federal dollars for Farmers' Market coupon program for seniors and to include people with disabilities.	F	F	F
Strategy 3. Provide cost containment to improve affordability and access.	S		
Action 1. Support the continued development of methods for combining evidenced-based medical recommendations with cost considerations.	S		
Action 2. Develop methods for providing affordable pharmaceuticals and strategies to promote equitable access to useful medications.	S/F		S/F
Strategy 4. Develop mechanisms to provide health care coverage for all to diminish the incidence of chronic disease and long-term care costs.	S/F	S/F	S/F
Action 1. Support cost effective expansion of Medicaid medical coverage and other public medical programs to provide health	S/F	S/F	S/F

Goal Statement: Stable funding sources adequate to meet documented needs and costs must be identified and developed.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
insurance to Oregonians at lower income levels.			
Action 2. Expand public medical assistance programs to provide health insurance to all where the insurance premium is excessive in proportion to after-tax household income.	S/F	S/F	S/F
Action 3. Change health insurance practices to provide multi-year policies that include incentives to invest in prevention and reduce administrative costs.	S		S
Action 4. Develop reimbursement incentives to provide optimal care in all settings, including medical offices, homes, and long-term care facilities.	S/F	S/F	S/F
Action 5. Develop incentives for comprehensive and complicated care of seniors and people with disabilities including appropriate reimbursement for: a) Health assessment, consultation and counseling b) Delivery models that do not require in-person visits, and c) Working with families and caregivers.	S/F	S/F	S/F

Goal Statement: Medicare and Medicaid program rules, coverage and expenditures need to coordinate and jointly provide seniors and people with disabilities with required services. Required services include acute and long-term care, pharmaceuticals, mental health and chemical dependency services.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Develop and implement various models of joint state and federal financing of all care services.	S/F	S/F	S/F
Action 1. Actively pursue Federal waivers to allow Oregon to integrate Medicare and Medicaid funding streams.	S/F	S/F	S
Action 2. Work with the Congressional delegation to promote regional parity of Medicare payments.	F	F	F
Action 3. Revise the federal and state rules concerning the use of Medicaid and Medicare funds making them more flexible so that the use of these funds is not site specific.	S/F	S/F	
Action 4. Revise the Medicare definition of homebound to ensure that access to Medicare home services is more flexible.	F	F	F
Action 5. Expand Oregon's current Program of All-Inclusive Care for the Elderly (PACE) demonstration to a non-urban provider and location to test its effectiveness in rural parts of the state.	S/F	S/F	
Action 6. Actively pursue grant funding for demonstration projects that will allow Oregon to grow the infrastructure needed for acute and long-term care integration.	S	S	

Goal Statement: Medicaid reimbursement for long-term care needs to compensate providers based on both consumer needs and provider costs.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Reimbursement across the long-term care continuum should reflect market-based costs that meet stipulated consumer need in various settings.	S	S/F	
Action 1. Appoint a workgroup of long-term care providers, advocates and public sector representatives and workforce representatives that: a) explores issues around subsidization of the public sector by private sector b) explores levels of adequacy in contingency reserves, profits and planned giving; c) develops recommendations for criteria upon which to base rates; d) develops reimbursement strategies that reward empirically measured quality outcomes; and e) explores regulations that inadvertently increase provider costs.	S		
Action 2. Complete an analysis of: 1. the different costs of doing business in different regions of the state; 2. cost differences in operation of facilities of different sizes; 3. costs that are driven by aging facility infrastructure; and 4. current wage and benefit levels for direct-care staff across long-term care settings.	S	S	
Action 3. Regularly collect, analyze and maintain the cost data of			

Goal Statement: Medicaid reimbursement for long-term care needs to compensate providers based on both consumer needs and provider costs.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
providing community-based care	S	S	
Action 4. Develop and implement a long-term care assessment tool as the basis of the rate setting process that recognizes consumer needs based on medical acuity, activities of daily living assistance and psychosocial conditions.	S	S	
Action 5. Change regulatory structure to reflect that need for long-term care services is driven by consumer's medical and psychosocial conditions as well as their need for assistance with activities of daily living.	S/F	S/F	
Action 6. Develop models that adjust rates in ways that recognize both different consumer needs and different cost structures, and that motivate quality outcomes.	S/F	S/F	F

Service Provision

Goal Statement: All Oregonians have access to health care.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Develop health systems that are a continuum supporting all people when they need care, where they need care, and how they need care. The continuum includes: 1. Prevention/Health Promotion 2. Illness recovery 3. Chronic disease management 4. Rehabilitation and functional support and long term care support 5. End of life Care 6. Mental Health Services 7. Pharmacy Management *8.* Substance abuse services	S/F	S/F	S
Action 1. Develop unified approach to the current fragmented system.	S/F	S/F	S
Action 2. Within the parameters of state and federal confidentiality laws, provide access to records and information sharing across agencies and providers with prior consumer consent.	S		
Strategy 2. Improve methods for screening, prevention and management of chronic conditions.	S	S/F	
Action 1. Expand use of screening and assessment methodologies to identify modifiable or reversible conditions causing excessive disability.	S	S/F	

Goal Statement: All Oregonians have access to health care.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Action 2. Identify, evaluate and replicate effective programs in the following areas: fall prevention, proper nutrition; physical activity; smoking cessation; screenings and immunizations; medication management; and chronic disease management.	S	S	
Action 3. Identify and focus preventive activities with specific communities shown to have a higher prevalence for certain chronic diseases.	S	S	
Action 4. Establish or expand programs to train volunteers to conduct evaluations of homes for hazards that lead to falls and injuries.	S	S	
Action 5. Increase the use of evidence-based management tools for health and chronic conditions.	S	S	
Action 6. Encourage the incorporation and support of individual goal setting for chronic disease management by providers and health educators.	S		
Action 7. Establish, develop, and fund chronic disease self-management.	S	S/F	
Strategy 3. Promote health care systems that encourage consumer-centered service coordination.	S/F		
Action 1. Provide professional liability and regulatory protection to care providers when a consumer makes a capable choice that involves risk.	S/F	S/F	S/F
Action 2. Assure individuals have complete access and ownership of the information in their medical/social records.	S/F		

Goal Statement: All Oregonians have access to health care.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Action 3. Provide access to communication devices for consumers with high need and who cannot afford them, to assist in communication with health care providers.	S/F	S/F	S/F

Goal Statement: Identify, develop and support cost-effective services, programs and products that proactively promote the individual⊨s ability to successfully respond to life changes and care needs.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Develop effective methods to identify and intervene early with those individuals who are at risk of needing long-term care.	S	S	
Action 1: Expand the gatekeeper-type programs.	S	S	
Strategy 2. Anticipating a significant growth of demand and need, ensure a stable supply of viable long-term care options that are desirable to the consumer.	S	S	
Action 1: Develop projections of future needs and system capacity.	S		
Action 2: Assess various levels of services and utilization to help identify what it takes to stabilize availability of long-term care options and services.	S		
Action 3: For those areas that cannot provide or support viable/stable long term care options (rural areas, ethnic communities), the state should provide subsidies and flexibility regarding program models.	S	S	
Strategy 3. Provide statewide services to promote independence and choice.	S		
Action 1: Expand access to consumer-directed care options.	S		
Strategy 4. Coordinate, wherever possible, planning for seniors and people with disabilities with planning for all children, families and communities. Work towards collaborative planning that encompasses the continuum of services and supports for family members of all ages.	S		

Goal Statement: Identify, develop and support cost-effective services, programs and products that proactively promote the individual=s ability to successfully respond to life changes and care needs.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Action 1. Partner with state and local agencies/commissions, schools and private organizations to mutually promote intergenerational activities, public awareness campaigns and collaborative planning.	S		
Strategy 5. Foster the development of quality insurance products and rate them to facilitate consumer choice and comparability.	S		
Strategy 6. Explore strategies that address the issues of availability, access and affordability of liability insurance for nursing homes and community-based care facilities.	S		S/F
Action 1. State of Oregon should create a self-funded liability insurance program available to facilities.	S	S	S

Goal Statement: To effectively assist at-risk Oregonians and establish consistent statewide solutions to issues related to diminished capacity and reducing the incidents of abuse.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Evaluate and revise the Adult Protective Service function of the State.	S		
Action 1: Clarify the definition of abuse across all care settings.	S		
Action 2: Develop uniform training curriculum for adult protective services investigators, law enforcement, legal professionals, medical and long term care providers.	S	S	
Action 3: Standardize investigation procedures and timelines.	S		
Action 4: Increase staffing and allocate to local areas more realistically and equitably.	S	S	
Action 5: Provide oversight to determine if interventions are timely and appropriate, and if local triage decisions are adequate.	S		
Strategy 2. Fund, develop, and implement a continuum of services to assist people with various degrees of capacity in decision making	S	S	S
Action 1: Develop more guardianship diversion services, including bill-payer and representative payee programs.	S	S	S
Action 2: Increase the number of qualified guardians and conservators, especially for indigent persons.	S	S	S
Action 3: Evaluate the need to create a registration and certification system for guardians and conservators. Based on the result of the evaluation, develop such a system.	S	S	
Action 4: Encourage the completion of advance directives for health care.	S		
Action 5. Develop tools for assessing decision-making capability,			

Goal Statement: To effectively assist at-risk Oregonians and establish consistent statewide solutions to issues related to diminished capacity and reducing the incidents of abuse.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
especially for people with multiple disabilities.	S		
Strategy 3. Develop model programs to improve fraud, abuse and exploitation prevention programs.	S	S	
Action 1: Develop and distribute a user-friendly universal screening tool for abuse to be used by community gatekeepers.	S	S	

Goal Statement: Identify, support and develop cost effective services and products that effectively address special needs populations that require services related to aging, long-term care, or physical disability.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Plan and implement a strategy to integrate services for individuals with mental health needs, substance abuse treatment needs, or persons with developmental disabilities who also need long-term care into the acute and long-term care systems.	S	S	S/F
Action 1: Convene planning processes involving consumers and representatives of the mental health, substance abuse treatment, developmental disabilities services, and representatives of long-term care and acute care systems to develop methods of serving these populations seamlessly.	S		
Action 2: Develop a process for identifying elders and people with disabilities who have clinical mental health needs, substance abuse treatment needs, and developmental disabilities.	S	S	
Action 3. Work with providers of mental health, substance abuse prevention and treatment, and developmental disabilities services to identify individuals who are anticipated to be in need of services regarding aging or disability.	S	S	
Action 4. Develop and provide integrated funding sources sufficient to meet identified needs.	S	S	S/F
Action 5: Implement, monitor and evaluate the results of the planning process.	S	S	S

Goal Statement: Identify, support and develop culturally competent services and products that proactively and effectively serve individuals and cultural and ethnic communities that require services related to aging, long-term care, or physical disability.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Dialogue with representatives of cultural and ethnic communities to identify discrete needs and service strategies within those communities.	S		
Action 1: Take the result of the needs assessment and assist those communities to establish culturally competent programs and services.	S	S	
Action 2: Take the results of the needs assessment and assist all providers in Oregon with providing culturally competent services.	S	S	
Action.3: Develop and provide integrated funding sources sufficient to meet identified needs.	S/F	S/F	S/F
Action 4: Implement, monitor and evaluate the results of the planning process.	S	S	

Education

Goal Statement: Educate all health care providers about aging and disability.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Increase training options where consumers and their representatives are viewed as capable and autonomous and managers of their care.	S	S	
Action 1. Support educational institutions in developing curricula that trains the providers to facilitate consumer driven decisions.	S	S	
Strategy 2. Increase educational capacity by increasing enrollment in health, long-term care and social services, availability of qualified instructors, clinical capacity, funding and awareness of health and long-term care careers.	S	S	S
Action 1. Offer community-based caregiver training opportunities from secondary schools and colleges.	S	S	
Action 2. Establish a program of scholarship, tax credits and tax expenditures to promote and increase geriatric training in professional schools.	S/F	S/F	S/F
Action 3: Make training programs specific to geriatric, physical and mental disabilities and developmental disabilities a priority within the federal and state medical residency funding streams.	S/F	S/F	S/F
Strategy 3. Enhance health and long-term care students' educational experience by providing them with incentives, improving competencies, increasing flexibility, options and support systems and developing optimal mobility through career pathways.	S/F	S/F	S/F

Goal Statement: Educate all health care providers about aging and disability.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Action 1: Develop statewide mandatory curriculum requirements in geriatrics, disability, and diversity-related issues for all levels of education.	S	S	S

Workforce Development

Goal Statement: Develop and maintain a health and long-term care trained, responsible and appropriate workforce sufficient to meet statutory mandates and provide quality care to all Oregonians.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Develop and provide incentives to attract and retain individuals to the health and long-term care workforce.	S	S	S
Action 1: Increase and expand enrollment capacity of licensed nurses at both the community college and university levels.	S	S	
Action 2. Establish programs of scholarship, tax credits, tax expenditures and other financial incentives to promote nursing as a career and to increase the number of nurses.	S/F	S/F	S/F
Action 3: Assure that facility staffing standards are tied to realistic workload expectations (in order to provide necessary quality of care).	S		
Action 4: Explore the potential of utilizing the federal immigration policies to attract qualified health and long-term care workers.	F		
Action 5: Medicaid reimbursement rates should be adequate to provide competitive wages and benefits for long-term care, in-home and health workers.	S/F	S/F	
Action 6: Provide ongoing training and opportunities for advancement, and increased competency and professionalization of	S	S	

Goal Statement: Develop and maintain a health and long-term care trained, responsible and appropriate workforce sufficient to meet statutory mandates and provide quality care to all Oregonians.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
providers.			
Action 7: Develop and implement recruitment outreach programs to increase professionals trained in geriatrics, psychiatry andphysiatry.	S/F	S/F	
Action 8: Support an ongoing centralized effort that facilitates health and long-term care workforce development and serves as a clearinghouse for innovative activities and best practices throughout the state.	S	S	
Action 9: Explore options for providing access to health and dental insurance for licensed Adult Foster Home providers and their employees.	S	S	S
Strategy 2. Develop a workforce that is culturally sensitive and responsive to age, disability, race, gender and ethnicity.	S		
Action 1. Develop programs to encourage diversity in recruitment of care providers.	S/F	S/F	S/F
Action. 2. Include culturally competent materials and evaluation in training, professional development, quality assurance and licensing programs.	S	S	

Technology

Goal Statement: Broad-based technology will be a tool to improve quality of life for aging Oregonians and people with disabilities. Systems should be affordable, user friendly, comply with universal design principles and respect the privacy rights of everyone.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Technology will be used to improve medical and in-home care and will include the use of remote caregiving and telemedicine.	S/F	S/F	S/F
Action 1. Disseminate telemedicine and health safety monitoring systems in homes and facilities, especially in rural areas.	S/F	S/F	S/F
Action 2. Establish a payment schedule for tele-medicine and tele-care services.	S/F	S/F	
Action 3. Evaluate the experiences of the 20 states that pay for telemedicine and remote caregiving and adopt their best practices.	S/F		
Action 4. Obtain waivers or modify the Oregon Health Plan to allow payment for medical, home care, and other Medicaid services delivered remotely.	S/F	S/F	
Action 5. Create a workgroup to explore options, conditions and costs of remote delivery of selected provider and caseworker services.	S		
Action 6. Develop and distribute personal smart cards or computer cards for management of personal medical records and easy portability.	S/F	S/F	

Goal Statement: Broad-based technology will be a tool to improve quality of life for aging Oregonians and people with disabilities. Systems should be affordable, user friendly, comply with universal design principles and respect the privacy rights of everyone.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Action 7. Ensure utilization of computer programs to store medical and social records with privacy-protected Internet access.	S/F	S/F	

Housing, Families, and Communities

Public Policy

Goal Statement: State policy for long-term care will focus on the quality of different care settings to determine whether services achieve beneficial outcomes, promote quality of life and are cost-effective.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Develop systems to measure, evaluate and incorporate continuous quality improvement programs.	S	S	
Action 1. Emphasize consumer-oriented satisfaction measures that include personal dignity, independence, autonomy, security and functional status.	S		
Action 2. Increase consumer involvement in development of programs & quality measurements.	S		
Action 3. Utilize outcome measures in the development of new programs and services.	S		
Action 4. Conduct a comprehensive, independent evaluation of the outcome and quality assurance measurements currently used to evaluate the long-term care system.	S	S	
Action 5. Ensure that a system is developed and implemented to evaluate the effectiveness of programs and services to seniors and people with disabilities using empirical data and quality of review information. Make outcome data and evaluation results easily	S	S	S

Goal Statement: State policy for long-term care will focus on the quality of different care settings to determine whether services achieve beneficial outcomes, promote quality of life and are cost-effective.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
accessible in a usable format to consumers and legislators.			
Action 6. Using empirical data, conduct ongoing evaluations of the long-term care system to identify and resolve problems and issues.	S	S	
Action 7. Utilize empirical data to change regulatory requirements to focus on outcomes for consumers.	S/F	S/F	S/F

Goal Statement: All Oregonians shall have a variety of community housing options available ranging from remaining in their own homes to living in long-term care facilities.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Provide a supply of age and disability friendly housing at a reasonable cost.	S	S	
Action 1. Create a task force to explore the development of appropriate criteria to ensure sufficient capacity of a variety of long-term care settings.	S		
Action 2. Create a certificate for " Age and Disability Friendly Homes" that can be used as part of the marketing of the housing stock.	S		
Action 3: Recognizing that nursing facilities currently provide short-term post-hospital care and safety net services, the State of Oregon and providers will work together to ensure an adequate supply of nursing facility beds, taking into account regional capacity issues.	S	S	
Action 4: Develop and implement a methodology for reimbursement to long-term care facilities that factors in improvements and maintenance of physical plant and technology that relate to the integrity, accessibility and functioning of the basic structure.	S	S	
Strategy 2. Make land use rules more age and disability friendly.	S		S
Action 1. Charge Department of Land Conservation and Development to review zoning laws to identify barriers to creating disability and senior friendly housing.	S		

Goal Statement: All Oregonians shall have a variety of community housing options available ranging from remaining in their own homes to living in long-term care facilities.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 3. Assure all elderly and disabled Oregonians have housing that meets their basic needs.	S	S/F	S/F
Action 1. Review existing programs to determine regional housing gaps and develop programs to meet identified needs.	S	S/F	
Action 2. Work with Oregon Economic and Community Development on helping define community-based enterprise zones in communities where incentives can be offered to offset from current and future tax liabilities.	S	S	
Strategy 3. Allow families to care for their aging and disabled relatives with as little disruption to family life as possible by developing strategies that allow them to live independently nearby.	S		
Action 1. Work with Oregon Economic and Community Development Department and Oregon Housing and Community Services Department to explore opportunities to use more Community Development Block Grant dollars for renovations and space accommodation.	S/F	F	
Action 2. Develop statewide criteria for special use permits for accessory housing in single family residential zones for a limited time period in which a medical need exists as certified by a licensed medical provider.	S		
Strategy 4. Waive cumbersome and unnecessary requirements for specific pilot projects that employ new and creative building practices and promote a variety of models in housing development and customize them to meet local and individual needs.	S/F		

Goal Statement: All Oregonians shall have a variety of community housing options available ranging from remaining in their own homes to living in long-term care facilities.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Action 1. Encourage the Oregon Department of Housing and Community Services, municipal housing authorities and the private sector to work together to develop accessible, affordable housing.	S		
Action 2. Create " Reinvention Labs" that allow public organizations to waive rules and procedures temporarily to experiment with new ways of meeting housing needs. (E.g. Oatfield Estates as a sample "hybrid care facility.")	S		
Action 3. Promote and support building code changes that favor "Smart Home" Technology and accessible construction.	S		S
Strategy 5. Assure that publicly supported housing meets the needs of seniors and people with disabilities.	S		
Action 1. Increase the number of "set aside" units for special needs and persons with disabilities in new public housing developments.	S/F		
Action 2. Broaden Public Housing's definition of disability to include the needs of people with Alzheimer's, autism, dementia, sensory impairment, mental illness, head injury and age related disabilities to assure that public housing meets the needs of people with these conditions.	S/F	F	F
Action 3. Create and maintain an inventory of special housing for Oregon by combining data on the current status and conditions of publicly supported housing (Oregon Housing and Community Services Department, Department of Human Services and Housing Authorities). Use this data to determine Oregon's ability to meet aging, disability and special needs.	S	S	

Goal Statement: All Oregonians shall have a variety of community housing options available ranging from remaining in their own homes to living in long-term care facilities.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Action 4. Review alternatives for utilizing existing Housing Authorities' stock to convert to assisted living facilities.	S		
Action 5. Allow Housing Authorities to provide mixed housing (both affordable and market-based).	S/F		
Action 6. Pass legislation that allows Housing Authorities the same option that Oregon Housing and Community Services Department has to finance mixed housing.	S/F		S

Goal Statement: Housing options will support personal dignity, promote privacy, autonomy, comfort and security and ensure optimal health and function.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Implement Universal Design Principles that create an "enabled" environment to meet the challenges of those who have age and non-age related disabilities.	S		
Action 1. Research, organize and distribute information about best practices for housing design and modifications that are age and disability friendly and easily adapted to changing needs.	S	S	
Action 2. Create a certification program for builders and architects that they can use to advertise their age and disability friendly qualifications.	S	S	
Action 3. Work with Building Codes Division, Oregon Building Industry and Oregon Remodel Association to develop proper tools to teach “Smart Home” Technology.	S		
Strategy 2. Provide a choice of housing environments with diverse communal structures and cultural environments.	S	S	
Action 1. Develop innovative approaches to long-term care, encouraging care through family and other informal supports as well as intergenerational residential care settings.	S		
Action 2. Provide opportunities for cultural enrichment.	S		
Action 3. Recognize the diversity of ethnic background and cultures in designing housing.	S		

Goal Statement: Oregonians live in communities that promote healthy aging.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Public policies are implemented that support people being as physically active as possible including: • Clean air • Safe and accessible sidewalks and street crossings • Open space/parks/trails with benches • Bike paths and bike racks • Accessible, reliable public transportation (special attention to needs of rural citizens) • Accessible community based opportunities for recreational activities for seniors and people with disabilities.	S/F	S/F	S/F
Action 1. Promote community and transportation designs that make Sidewalks, street crossings, bike paths and trails, and parks in communities safe and accessible for seniors and people with disabilities to encourage physical activity.	S/F		
Action 2. Subsidize individual and group memberships/partnerships for seniors and people with disabilities in fitness programs.	S	S	S
Action 3. Promote extra-curricular, extra-mural daily physical activity at K-12 levels of education for all students to promote positive life-long healthy habits.	S		
Action 4. Create a report card for evaluating elder- and disability-			

Goal Statement: Oregonians live in communities that promote healthy aging.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
ready communities.	S	S	
Strategy 2. Public policies are implemented that support access to healthy foods including: • Easily accessible neighborhood groceries with healthy foods, especially vegetables and fruits, and • Easily accessible Farmer's Markets with vegetable and fruit coupon programs for low income seniors and people with disabilities.	S		
Action 1. Promote local policies that support Farmer's Markets being in areas accessible to seniors and people with disabilities.	S		
Strategy 3. Promote worksite environments that support daily physical activity and healthy food choices including: • Bike racks, exercise rooms, showers, health promotion information and classes in chronic disease self management at the worksite and/or in partnership with fitness/health centers and with flexible work arrangements • Participation in programs promoting use of mass transit (e.g. free or low cost passes) • Access to healthy food in cafeterias and vending machines.	S		

Goal Statement: Oregonians live in communities that promote healthy aging.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Action 1. Provide worksites with model policies for promoting physical activity, healthy eating, and chronic diseaseself-management.	S	S	
Action 2. Develop state recognition and award programs for worksites that promote "Healthy Policies."	S	S	
Action 3. Provide tax incentives for worksites that meet "Healthy Policies" criteria.	S/F	S/F	S/F
Strategy 4. Public policies will support neighborhood and housing designed or retrofitted to support elders and people with disabilities including housing, worksites, schools and retail/business centers within walking, biking and easy mass transit distance. Building and recreational facilities will be built or renovated with accessible construction (visitibility), such as smart home construction communities.	S		
Action 1. Promote state and local policies that support community and neighborhood designs that accommodate the needs of individuals with disabilities and the aging population.	S		

Goal Statement: All seniors and people with disabilities will be able to move freely and safely throughout their communities and access affordable, life-long transportation to assure independent living and allow people to remain connected to one another, to stores, to services, to healthcare, to employment and to the multitude of activities that make up life.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Provide alternative transportation for elders, people with disabilities and those who cannot use existing public transportation that is economical and convenient and also assure that elders will not be car dependent beyond the years that they can drive safely.	S/F	S/F	S/F
Action 1. Explore Massachusetts model of testing and limiting or restricting time and venue of driving for those who are impaired.	S		
Action 2. Develop and implement a system for diagnosis-driven mandatory driving assessments.	S	S	S
Action 3. Expand the 55 Alive Program (American Association of Retired Persons) to assure it is available to all drivers.	S	S	
Action 4. Expand the Department of Human Services transportation programs for those with special needs.	S	S	S
Action 5. Pool resources across jurisdictional lines, e.g. use school buses to transport elders and people with disabilities during school hours.	S		
Action 6. Provide a full range of convenient and affordable mobility alternatives for those who rely on public transportation.	S/F	S/F	S/F

Goal Statement: All seniors and people with disabilities will be able to move freely and safely throughout their communities and access affordable, life-long transportation to assure independent living and allow people to remain connected to one another, to stores, to services, to healthcare, to employment and to the multitude of activities that make up life.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 2. Locate more housing for seniors and people with disabilities in public transit corridors to capture the benefit of the Americans with Disabilities Act required "curb to curb" transportation at reasonable cost.	S		
Action 1. Create cross agency teams to explore and implement plans that locate housing near fixed transportation lines and take advantage of Americans with Disabilities Act required transportation.	S		
Action 2. Encourage local government planning commissions to develop incentives for locating housing within transit overlay districts.	S		
Action 3. Offer incentives to builders to construct and remodel special needs and age friendly housing near fixed transportation lines.	S	S	S

Finance

Goal Statement: Identify and develop funding sources and incentives to meet the needs of seniors and people with disabilities.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Avoid costly displacement of elders and persons with disabilities.	S		
Action 1. Require Oregon Housing and Community Services Department and Department of Human Services to collaborate on the best way to create Oregon Housing Trusts that allow parents to place housing assets in trust for their children with disabilities.	S	S	S
Action 2. Fund Oregon Housing and Community Services Department to hire architects trained in special needs, disability and senior housing issues to act as resources to builders and architects.	S	S	S
Action 3. Expand funding for the Oregon Housing and Community Services Department to establish housing centers in every region of Oregon to provide information and advice to home owners about building techniques, financing options, approved contractors, sub-contractors, maintenance and job tradesmen. Maintain a list of "approved" builders and tradesmen and tradeswomen.	S	S	S
Action 4. Create demonstration programs with state funds dedicated to increase number of low-income elderly units that have programs to allow residents to remain independent in their communities.	S	S	S
Action 5. Support an increase in Oregon Lender Tax Credits that are used directly to reduce the cost of rents in low-income elderly units and for people with disabilities.	S	S	S
Action 6. Establish a program of low interest loans and other			

Goal Statement: Identify and develop funding sources and incentives to meet the needs of seniors and people with disabilities.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
subsidies that can be used for housing repairs, maintenance and adaptations to avoid costly displacement.	S	S	S
Action 7. Allocate federal Community Development Block Grant dollars for renovations and accommodations for existing homes owned and occupied by people with disabilities and seniors.	S		
Action 8. Track and support having a federal law change that would create a low income tax credit program for low-income homebuyers for the purchasing and/or retrofitting of homes to adapt to age and disability related needs.		F	F
Action 9. Provide tax incentives to promote the development of active community environments, home technology and accessible construction and increase funding for grants and low interest loans to finance conversions and new public units.	S/F	S/F	S/F
Action 10. Establish public housing tax exemptions for organizations that provide housing to low-incomeseniors and special needs population.	S/F	S/F	S/F
Action 11. Establish Special Needs Housing Trusts to assure a financial resource and appropriate housing and services for adult dependent children.	S/F	S/F	S/F
Action 12. Maintain and expand low income tax credits and other financial supports to provide equity in new and existing developments.	S	S	S
Action 13: Support programs like "Home of Your Own" that facilitate home ownership by people with disabilities.	S	S	S

Education

Goal Statement: Oregonians must be provided with information necessary to empower them to make knowledgeable decisions about planning for potential long-term care needs either in old age or with disabilities.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Identify and provide increased training to Oregonians in order to maximize their independence and opportunities within the community.	S	S	
Action 1 Educate policy makers about the demographic trends and expectations that government will deliver programs when and how the public wants them, and the difference between the costs and revenues.	S		
Action 2. Train the public to be able to critically evaluate information available through the Web and othersources.	S	S	
Action 3. Expand education of consumers and family members regarding their rights to make decisions about health care and housing options through the development and dissemination of materials in various formats.	S	S	
Action 4. Develop and disseminate information regarding health and wellness via state and local public health agencies. Use widespread public education techniques to promote health such as television ads, billboards, radio, signs on public vehicles, etc.	S	S/F	
Action 5: Develop and disseminate information on the types and indicators of abuse and resources and services available.	S	S	

Goal Statement: Oregonians must be provided with information necessary to empower them to make knowledgeable decisions about planning for potential long-term care needs either in old age or with disabilities.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Action 6. Create a public awareness campaign to inform the public about the threat to public safety posed by persons driving beyond the age that they are capable.	S	S	
Action 7. Develop user-friendly information for consumers to understand and navigate long-term care services facilitating evaluation, comparability and informed decision-making.	S	S	
Action 8. Create an interactive educational website, housed at Oregon Housing and Community Services Division, to provide photos, drawings and specifications describing solutions to housing problems faced by people of all ages with disabilities.	S	S	
Action 9. Fund a "Day in the Life" newspaper insert campaign to create an understanding of what it might be like as an elder, in order to broaden public awareness and encourage individual planning for future needs.	S	S	
Action 10: Develop training and user friendly information for families and individuals with disabilities to help them understand how to design, direct and evaluate the supports and services they use.	S	S	
Strategy 2. Educate Oregonians around financial issues related to elder years, aging process and chronic disabilities.	S	S	
Action 1: Educate individuals about long-term care and the likely need for insurance. Develop and distribute materials explaining the advantages and disadvantages of long-term care insurance purchase.	S	S	

Goal Statement: Oregonians must be provided with information necessary to empower them to make knowledgeable decisions about planning for potential long-term care needs either in old age or with disabilities.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Action 2. Create and implement a professional certification for agents who sell long-term care insurance. Require that agents complete continuing professional education work related to aging issues to retain certification.	S	S	S
Action 3. Develop and distribute information explaining the pros and cons of using a reverse mortgage to help finance elder years and/or long-term care.	S	S	
Action 4: Provide consumer education, counseling, and state oversight to prevent predatory lending practices.	S	S	S
Action 5. Create and implement a professional certification for brokers and others who market reverse mortgages. Require that sellers complete continuing professional education work related to aging issues to retain certification.	S	S	S
Action 6. Increase availability and access to people who are competent and skilled in benefits planning.	S		

Goal Statement: Oregonians must be provided with information necessary to empower them to make knowledgeable decisions about planning for potential long-term care needs either in old age or with disabilities.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 3. Promote health education in a culturally appropriate manner throughout schools, worksites, communities, and health systems to provide information needed to make lifestyle changes and choices related to: 1. Health promotion and disease prevention 2. Disease recognition and management (early education) 3. Chronic disease management 4. Medication management, and 5. Myths and facts about aging and disability.	S	S	S
Action 1. Mandate and fund school health, nutrition , and physical education at all levels.	S	S	S
Action 2. Expand funding for public awareness campaigns about the health benefits of good nutrition and physical activity.	S	S	S
Strategy 4. Educate Oregonians to value, support, and respect elders and people with disabilities.	S	S	
Action 1 Promulgate a strategic initiative for families highlighting the social value of extended families.	S	S	

Goal Statement: Oregonians must be provided with information necessary to empower them to make knowledgeable decisions about planning for potential long-term care needs either in old age or with disabilities.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Action 2. Promote intergenerational training, experiences and mentoring through educational, work, and recreational organizations.	S	S	S
Action 3. Document and publicize the benefits to all citizens from living in mixed neighborhoods - age, income, ethnicity and ability.	S	S	
Strategy 5. Promote a public action campaign regarding abuse of seniors and people with disabilities.	S	S	
Action 1. Promote public education and information about the risks of abuse and its consequences to the elderly and people with disabilities.	S	S	
Action 2. Increase education of district attorneys and judges regarding abuse of the elderly and people with disabilities.	S	S	

Goal Statement: Educate older Oregonians, people with disabilities and their families about issues affecting them.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Educate Seniors and People with Disabilities about the availability of health, legal, social and long-term care services.	S	S	
Action 1. Develop programs on health maintenance for seniors and people with disabilities by working with advocacy networks, health care providers and state agencies.	S	S	
Action 2. Conduct a public action campaign to inform the public about the serious consequences of falls, fall prevention and safety hazards in the home.	S	S	
Action 3. Expand education of consumers and families on the benefits and risks associated with various long-term care options.	S	S	
Action 4. Refine information currently given to Medicaid consumers to better explain the Medicaid estate recovery process.	S		
Action 5. Provide education to widowers and widows on living independently.	S	S	
Action 6. Work with education system to graduate youth with disabilities with skills to be employable.	S	S	
Strategy 2. Educate people about technologies such as remote wireless (X-10) and other "smart home" technology related to health and prevention (fall prevention aids, fall detectors, home warning systems, home physiology monitoring, pill reminders, etc) to extend the time people can live safely in their own homes.	S	S	
Strategy 3. Educate seniors and people with disabilities on strategies for staying or becoming productive and employable, if desired.	S	S	

Goal Statement: Educate older Oregonians, people with disabilities and their families about issues affecting them.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Action 1. Develop a program that teaches seniors and people with disabilities to evaluate their skills.	S	S	
Action 2. Expand information to seniors and people with disabilities on employment opportunities and other activities such as volunteerism.	S	S	
Action 3: Support policies that eliminate the barriers to employment for people with disabilities and seniors.	S		

Family and Community Caregiver Support and Development

Goal Statement: Support and strengthen the role of family and informal caregivers for seniors and people with disabilities.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Build on national research that identifies the circumstances and triggers for caregiver burnout.	S/F	S/F	S/F
Action 1: Provide extensive outreach to identify and assist caregivers in accessing services prior to burnout.	S/F	S/F	S
Action 2: Assure that caregiver services such as respite, adult day care, and support groups are available and affordable and in all parts of the state.	S	S	S
Action 3. Encourage the development of adult day care and respite services provided within long-term care settings.	S		
Action 4: Continue to develop and expand Older Americans Act Family Caregiver Programs.	S	S	
Action 5: Expand state and federal family medical leave acts to cover more workers for longer periods.	S/F		S/F
Strategy 2. Make training, information, emotional support and back-up assistance available to all family and informal caregivers.	S/F	S/F	S/F
Action 1: Expand the Oregon Cares caregiver web page.	S		
Action 2: Expand respite and other services to support family caregivers.	S	S	

Goal Statement: Support and strengthen the role of family and informal caregivers for seniors and people with disabilities.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 3. Expand and promote options (tax incentives, caregiver support) to spouses, partners, and families that encourage them to provide care.	S/F	S/F	S/F
Action 1. Encourage and provide incentives to businesses to establish flexible schedules, programs and benefits to support family care giving.	S/F	S/F	S/F
Strategy 4. Develop and maintain caregiver registries that are easily accessed by those seeking care.	S		

Technology

Goal Statement: Develop and promote broad-based technology to improve quality of life for seniors and people with disabilities. The technology should be affordable, user-friendly comply with universal design principles and respect the privacy rights of everyone.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Strategy 1. Utilize technology to support efficient, effective and safe transportation.	S/F	S/F	S/F
Action 1. Explore and support the use of technology to make cars safer, streets safer for pedestrians and promote the use of home delivery businesses to minimize risk and travel time.	S/F	S/F	S/F
Action 2. Support the use of technology for scheduling, routing, and web based transportation planning.	S	S	
Strategy 2. Provide high level of assistive and communication technologies in homes and long-term care settings.	S/F	S/F	S/F
Action 1. Develop and test a menu of best practices that increase the utilization of technology for successful aging and for living well with a disability.	S	S	
Action 2. Require homes and long-term care facilities to be "wired" to allow access to medical, telecommunications and "Smart Home" Technology at the time they are built or reconstructed to avoid costly retrofitting and to allow individuals to remain in their homes or long-term care facility of choice as long as possible.	S		S

Goal Statement: Develop and promote broad-based technology to improve quality of life for seniors and people with disabilities. The technology should be affordable, user-friendly comply with universal design principles and respect the privacy rights of everyone.	**State/Federal Policy**	**State/Federal Budget**	**State/Federal Legislative**
Action 3. Provide funding to agencies for information and technology specialists to administer and provide technical support to maintain the "Smart Home" Technology systems and train staff in their usage.	S	S	S
Action 4. Develop strategies to utilize technology as task supports so that caregivers are best utilized to promote optimal social interaction.	S		
Action 5. Establish a research institute and testing laboratory (Oregon Institute for Successful Aging and Technology) to invent, and market products and services that make computing ubiquitous and useable by frail elderly and others with disabilities.	S	S	S
Action 6. Strategies should only be implemented with full knowledge and consent of care receivers (where capacity permits), guardians, and all parties involved in the process of care giving.	S		
Action 7. Investigate with Department of Human Services and Oregon Housing and Community Services Department how to add telecommunication requirements into state and federal funded housing activity.	S		

Appendix A

EXECUTIVE ORDER NO. EO 01-10

TASK FORCE ON THE FUTURE OF SERVICES TO SENIORS AND PEOPLE WITH DISABILITIES

This Executive Order creates the Task Force on the Future of Services to Seniors and People with Disabilities. The Task Force will help Oregon prepare for the aging of the Baby Boomer Generation and the growth in the numbers of people with significant disabilities. It will review, analyze, and recommend changes as needed in the State's age and disability-related programs and policies.

The Task Force will be comprised of concerned seniors and people with disabilities, policymakers, and representatives from both private and non-profit organizations serving these populations.

The Task Force will make recommendations to the Governor and Legislative Assembly on improvements to systems serving seniors and people with disabilities in their communities

It is essential that Oregon prepare for the aging of the Baby Boomer generation and for the increasing numbers of people with severe disabilities. Failure to prepare and build systems capable of meeting the needs of these individuals will result in substantial costs and diminished quality of life for these individuals.

WHEREAS the numbers of seniors and persons with disabilities has been growing rapidly, and is expected to continue to grow rapidly over the next 25 years;

WHEREAS the ratio of seniors to available caregivers is expected to diminish over the next 25 years;

WHEREAS there is evidence that many individuals who will be retiring over the next 25 years will not have access to sufficient financial resources to allow economic self-sufficiency throughout their lives;

WHEREAS Oregon does not currently have enough accessible, affordable housing to shelter this growing senior and disabled population;

EXECUTIVE ORDER NO. EO 01-10

WHEREAS Oregon does not have enough accessible transportation to allow the senior and disabled population to fully participate in community life;

WHEREAS it takes many years to build the community-based infrastructure required to house, transport and care for growing numbers of seniors and persons with disabilities in a manner that optimizes dignity and autonomy;

THEREBY IT IS HEREBY ORDERED AND DIRECTED:

1. The Task Force on the Future of Services to Seniors and People with Disabilities is hereby created. The membership of the Task Force shall be no greater than 25, comprised as follows:

    a. Six members of the Legislative Assembly with interest and expertise in the subject of social services, long-term care or financial planning.

    b. One representative from each of the following agencies and organizations, as nominated by the executive authority of the organization or agency and appointed by the Governor:

        i. The Governor's Commission on Senior Services;
        ii. The Oregon Disabilities Commission;
        iii. Oregon Association of Area Agencies on Aging and Disability;
        iv. The Housing and Community Services Department;
        v. The Department of Human Services;
        vi. The Long Term Care Ombudsman; and
        vii. The Governor's Office.

Organizations are encouraged to nominate persons who are knowledgeable about systems serving seniors and people with disabilities and who have a specific knowledge about the priority areas that constitute the focus of the Task Force.

    c. Twelve additional members appointed by the Governor who are as follows:
        i. Three persons representing consumers and advocates for individuals with long term care needs;
        ii. Four persons from statewide organizations representing long term care providers, including two from not-for-profit providers;
        iii. One in-home care provider;
        iv. One person from an organization representing services to persons with special needs;

v. One person from the financial services industry; and
vi. Two physicians specializing in gerontology who are licensed to practice under ORS chapter 677.

2. The Governor shall appoint two members of the Task Force as co-chairs. One member shall be a member of the Legislative Assembly and one member shall be a representative from a provider or advocacy organization. The co-chairs shall establish an agenda for the Task Force, facilitate communication among members of the Task Force, and shall assign duties to Task Force members and appropriate staff.

3. The Department of Human Services shall provide support to the Task Force. The directors of other state agencies with programs that impact the dignity, quality of life, safety, health and independence of seniors and people with disabilities shall cooperate by providing information as needed and available, and by meeting with and reporting to the Task Force as requested. The Department of Human Services and the Oregon Department of Administrative Services shall share the staffing functions of the Task Force. The Legislative Fiscal Office and the Legislative Administrator may consult and work with the Task Force in the performance of its functions and may furnish such information and advice as the members of the Task Force consider necessary to perform its functions.

4. The Task Force shall carry out the following activities:

a. Develop a long range plan on the future of services to seniors and people with disabilities;
b. Consider the different types of long term care services necessary to meet the needs of Oregon's aging population;
c. Review and recommend legislative actions and levels of funding necessary to implement the long range plan;
d. Review the effectiveness of such recommendations and make an annual report to the Governor and the Legislature to detail findings and advice to appropriate agencies on any recommended changes.

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5. In carrying out these activities, the Task Force shall focus upon the following priorities:

- Evaluating and improving where needed methods of governing and managing state programs for assistance to the elderly and persons with disabilities;
- Identify methods for controlling the costs of long term care services;
- Identify cross generational issues expected as demographics shift;
- The development of long term care services sufficient to meet the needs of a rapidly aging population;
- Exploring long-term care financial planning options that reduce the potential impact on the state's General Fund;
- Identifying strategies to ensure adequate private and public funding of long term care services;
- Identifying housing needs of the senior and disabled population;
- Identifying strategies to replace, modernize or update deteriorating long term care facilities in order to meet the physical, psychological and medical needs of the long term care population;
- Managing chronic health care issues and strengthening the connection between medical providers and caregivers through the study of behaviors to reduce the incidence of chronic disease;
- Identifying the different types of long term care services that are needed in rural and urban areas of the state; and
- Coordinate strategies to assure there is an adequately trained workforce to meet the needs of the growing senior and persons with disabilities.

6. The Task Force shall meet at least monthly, and may hold additional meetings as deemed necessary by the chairs.

7. The Task Force shall make its first report to the Governor by September 1, 2002, so that its recommendations can be considered in the development of the Governor's Recommended Budget.

EXECUTIVE ORDER NO. EO 01-10

8. This Order expires September 30, 2004, unless explicitly extended by the Governor.

Done at Salem, Oregon, this 30 th day of June, 2001.

/s/ *John A. Kitzhaber*
John A. Kitzhaber, M.D.
GOVERNOR

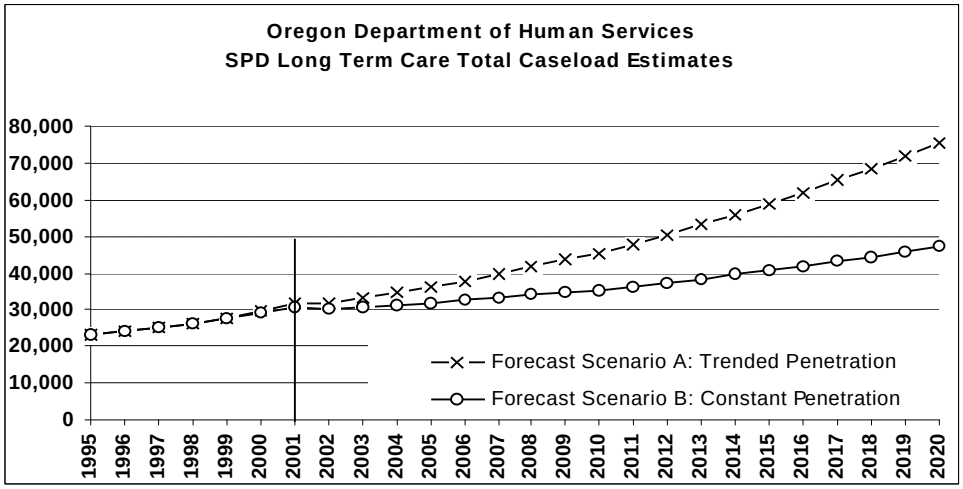
ATTEST:

/s/ Bill Bradbury
Bill Bradbury
SECRETARY OF STATE

Appendix B

Oregon Department of Human Services

Long Range Caseload Estimates For The Medicaid Long Term Care Program of Seniors and People with Disabilities



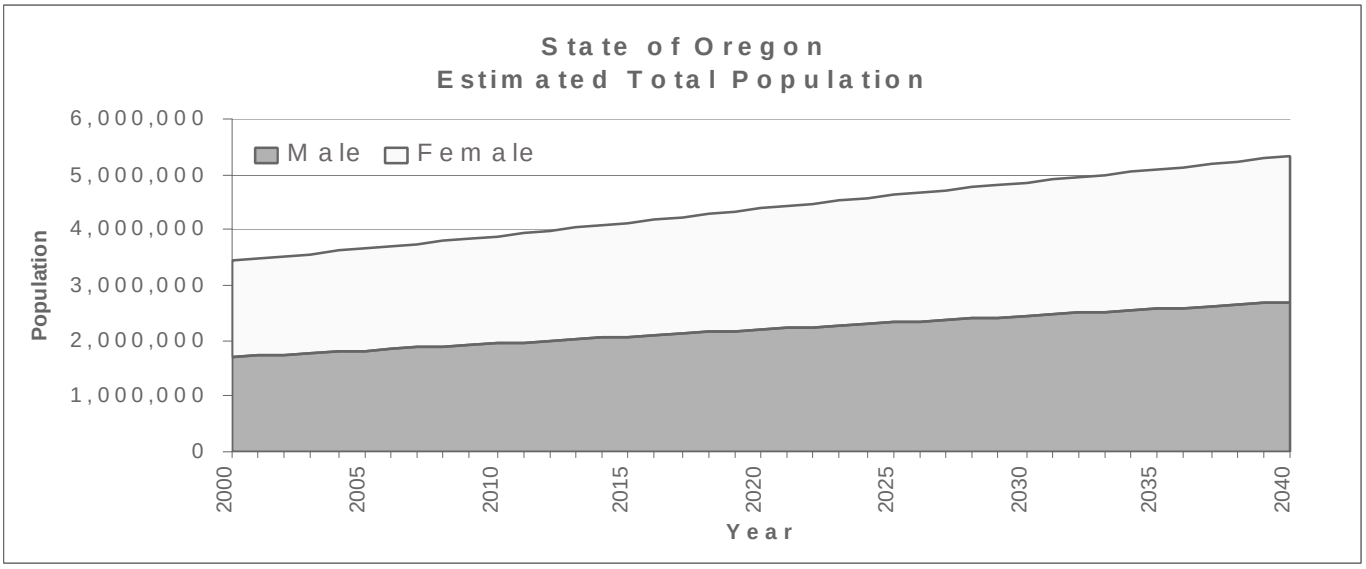
Office of Finance
and Policy Analysis

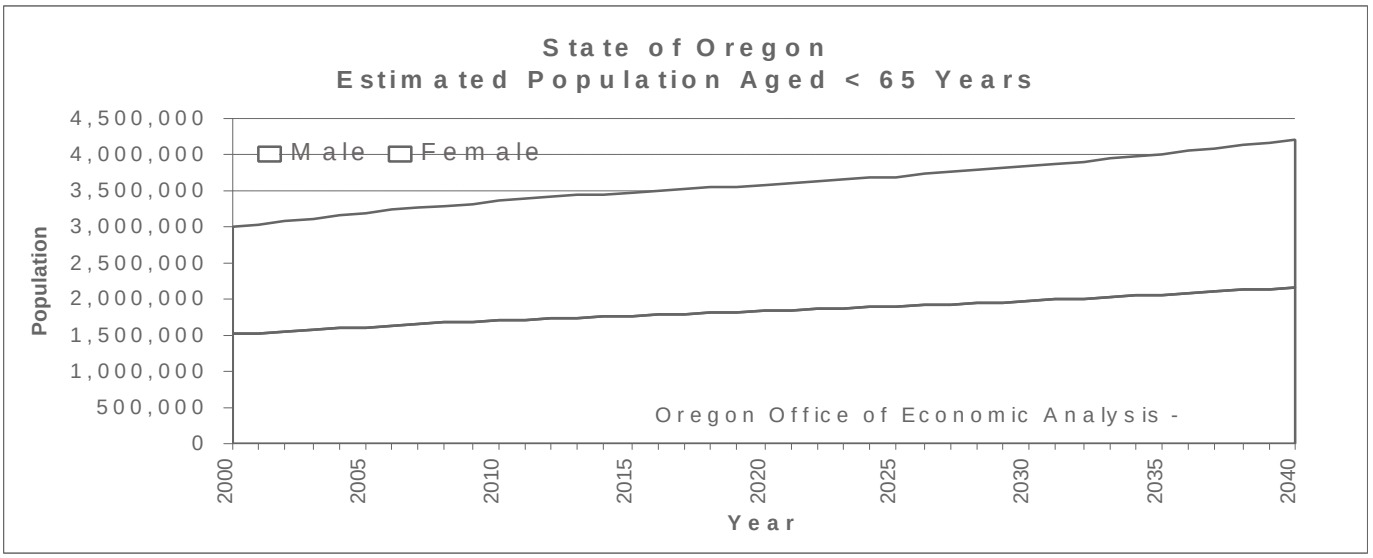
June 2002

Office of Economic Analysis Population Estimates
(DRAFT)

	2000			2005			2010			
Age	Total	M	F	Total	M	F	Total	M	F	Total
0-4	224,027	114,639	109,388	235,796	121,211	114,584	253,264	130,199	123,066	266,710
5-9	235,549	120,759	114,790	235,255	120,224	115,031	247,438	127,032	120,405	265,754
10-14	243,200	124,797	118,403	243,427	124,684	118,743	243,116	124,134	118,982	255,835
15-19	245,521	125,988	119,533	249,141	127,848	121,293	249,597	127,850	121,747	249,666
20-24	231,425	118,645	112,780	254,382	130,634	123,748	258,397	132,698	125,699	259,368
25-29	234,926	121,654	113,272	246,480	126,655	119,826	270,774	139,353	131,421	275,156
30-34	237,938	122,658	115,280	248,186	128,671	119,515	260,200	133,853	126,347	285,875
35-39	256,938	129,741	127,197	246,464	127,073	119,391	257,012	133,270	123,742	269,569
40-44	272,054	134,653	137,401	263,050	132,592	130,458	252,301	129,873	122,428	263,248
45-49	272,525	135,302	137,223	276,023	136,273	139,750	266,892	134,212	132,679	256,153
50-54	236,889	117,969	118,920	276,256	136,648	139,608	279,738	137,618	142,120	270,606
55-59	173,773	85,653	88,120	240,993	119,569	121,424	280,816	138,412	142,404	284,407
60-64	131,949	64,559	67,390	174,388	85,376	89,011	241,639	119,130	122,510	281,739
65-69	113,094	53,382	59,712	128,217	62,065	66,151	169,394	82,102	87,292	235,074
70-74	107,179	48,739	58,440	104,246	48,082	56,165	118,197	56,007	62,190	156,671
75-79	95,462	40,472	54,990	92,385	40,463	51,922	89,943	40,059	49,884	102,462
80-84	66,627	26,198	40,429	74,676	29,617	45,060	72,331	29,792	42,539	70,985
85+	57,676	17,854	39,822	66,937	22,065	44,872	76,526	26,218	50,308	81,831
Total	3,436,750	1,703,661	1,733,089	3,656,303	1,819,750	1,836,553	3,887,576	1,941,813	1,945,762	4,131,109

2015			2020			2025		
M	F	Total	M	F	Total	M	F	Total
137,126	129,584	277,672	142,779	134,892	287,631	147,915	139,715	300,189
136,465	129,289	279,965	143,808	136,157	291,543	149,798	141,745	301,987
131,251	124,583	275,008	141,145	133,863	289,926	148,870	141,056	302,053
127,504	122,161	263,240	135,102	128,137	283,466	145,560	137,905	299,252
132,981	126,387	260,078	132,981	127,097	274,827	141,240	133,587	296,448
141,624	133,532	276,463	142,091	134,372	277,439	142,219	135,220	293,283
147,304	138,571	290,676	149,820	140,856	292,188	150,401	141,786	293,249
138,718	130,850	296,405	152,810	143,595	301,585	155,549	146,036	303,271
136,314	126,934	276,349	142,043	134,306	304,090	156,626	147,465	309,563
131,582	124,571	267,514	138,270	129,244	281,071	144,235	136,836	309,480
135,644	134,962	259,890	133,118	126,772	271,594	140,014	131,580	285,498
139,456	144,951	275,210	137,544	137,666	264,386	135,067	129,320	276,334
138,043	143,696	285,557	139,240	146,316	276,491	137,490	139,001	265,727
114,819	120,255	274,544	133,338	141,206	278,726	134,801	143,925	270,219
74,427	82,244	218,079	104,521	113,559	255,538	121,908	133,629	260,218
47,015	55,447	136,512	62,902	73,610	190,975	88,965	102,010	224,916
29,857	41,128	81,427	35,425	46,003	109,379	47,940	61,439	154,172
29,091	52,740	85,395	31,271	54,125	94,753	36,179	58,574	117,809
2,069,223	2,061,886	4,379,984	2,198,208	2,181,777	4,625,606	2,324,777	2,300,829	4,863,669


State of Oregon
Estimated Total Population
6,000,000
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
0
Male
Female
Population
2000
2005
2010
2015
2020
2025
2030
2035
2040
Year


State of Oregon
Estimated Population Aged < 65 Years
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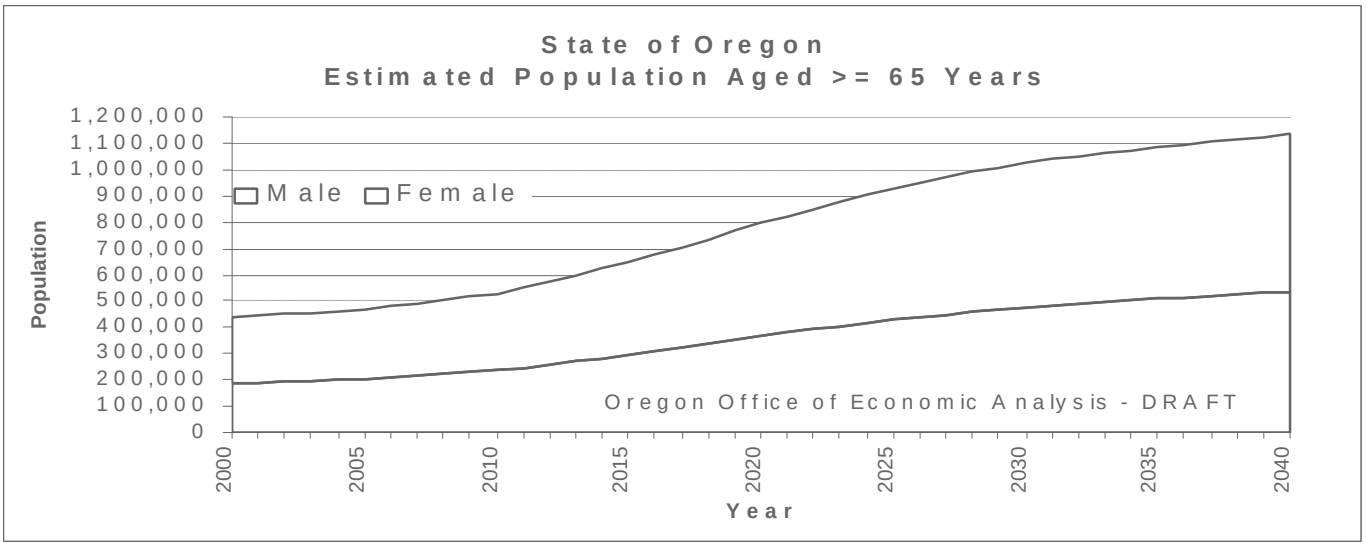
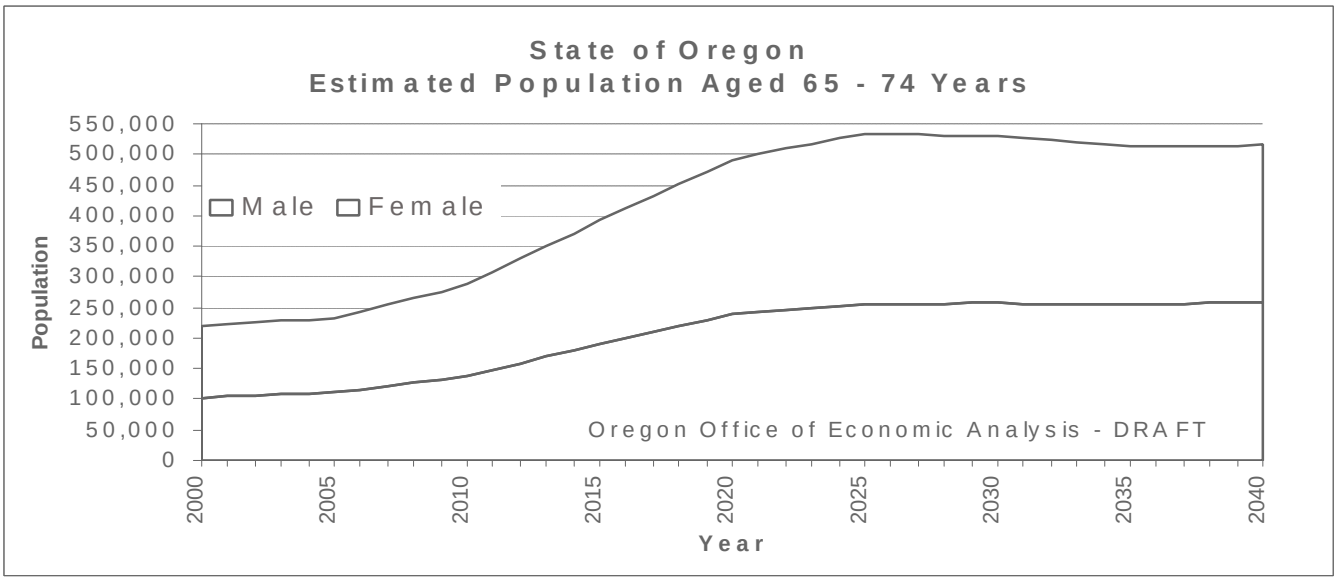
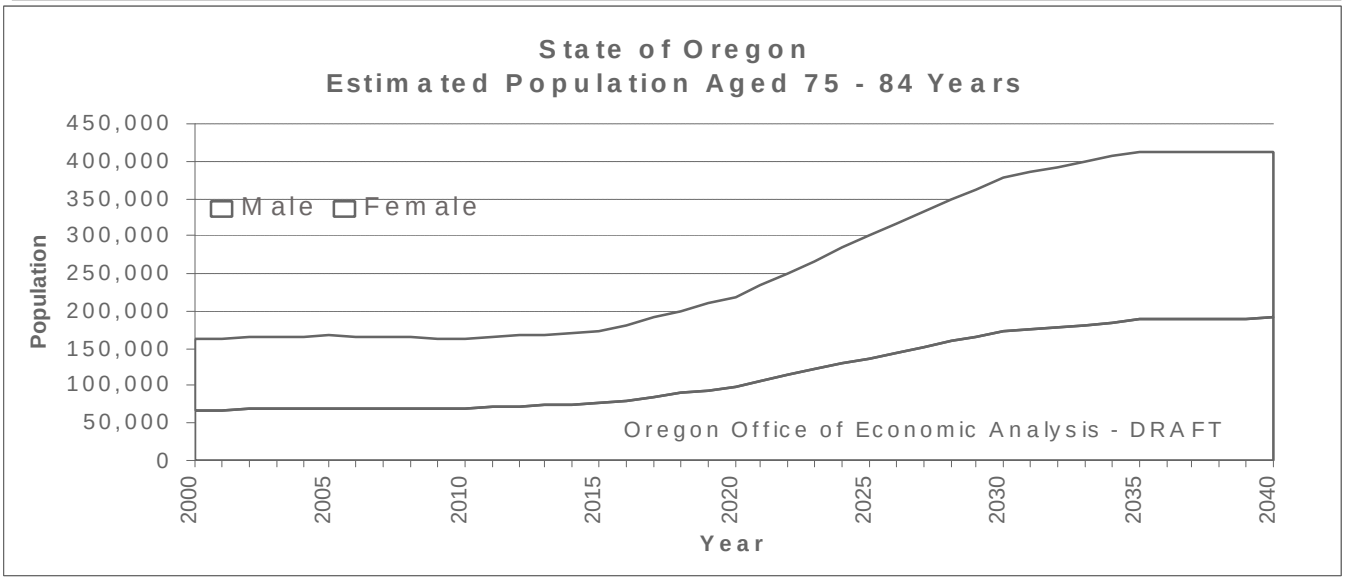
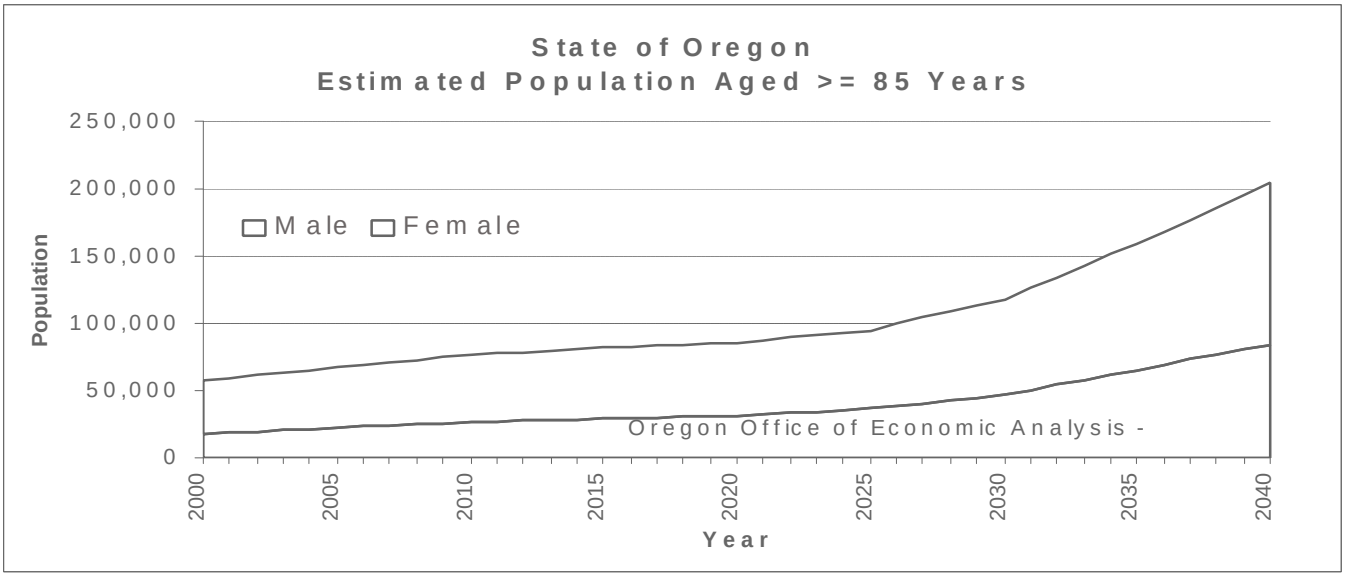
4,000,000
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
0
Male
Female
Population
Oregon Office of Economic Analysis -
2000
2005
2010
2015
2020
2025
2030
2035
2040
Year

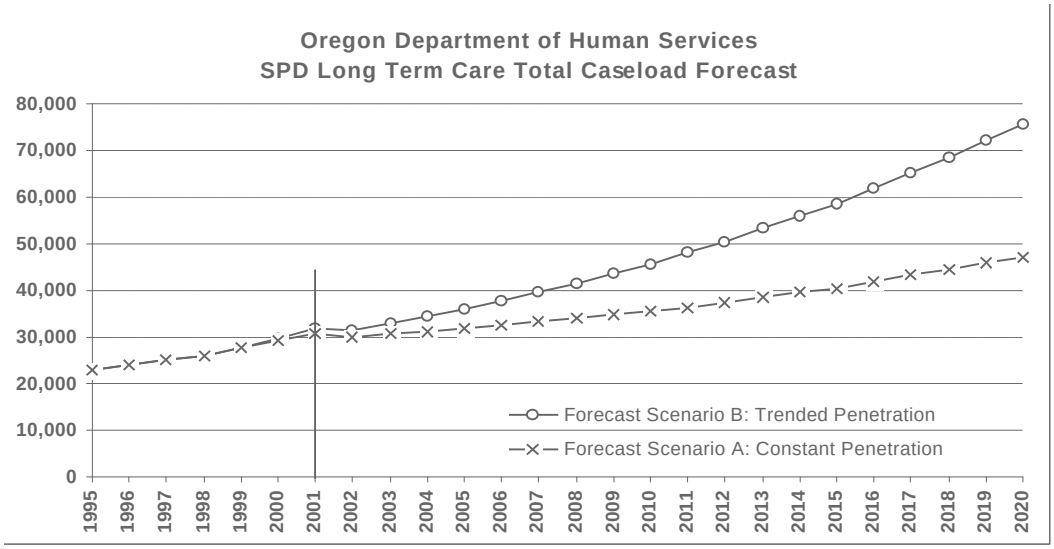

State of Oregon
Estimated Population Aged >= 65 Years
1,200,000
1,100,000
1,000,000
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
Male
Female
Population
Oregon Office of Economic Analysis - DRAFT
2000
2005
2010
2015
2020
2025
2030
2035
2040
Year


State of Oregon
Estimated Population Aged 65 - 74 Years
550,000
500,000
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0
Male
Female
Population
Oregon Office of Economic Analysis - DRAFT
2000
2005
2010
2015
2020
2025
2030
2035
2040
Year

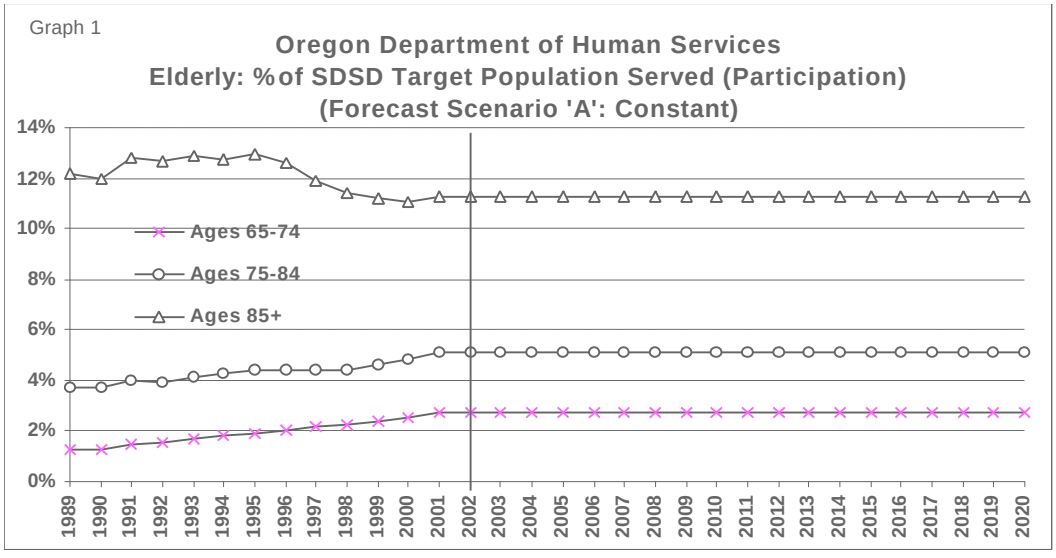

State of Oregon
Estimated Population Aged 75 - 84 Years
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0
Male
Female
Population
Oregon Office of Economic Analysis - DRAFT
2000
2005
2010
2015
2020
2025
2030
2035
2040
Year


State of Oregon
Estimated Population Aged >= 85 Years
250,000
200,000
150,000
100,000
50,000
0
Male
Female
Population
Oregon Office of Economic Analysis -
2000
2005
2010
2015
2020
2025
2030
2035
2040
Year

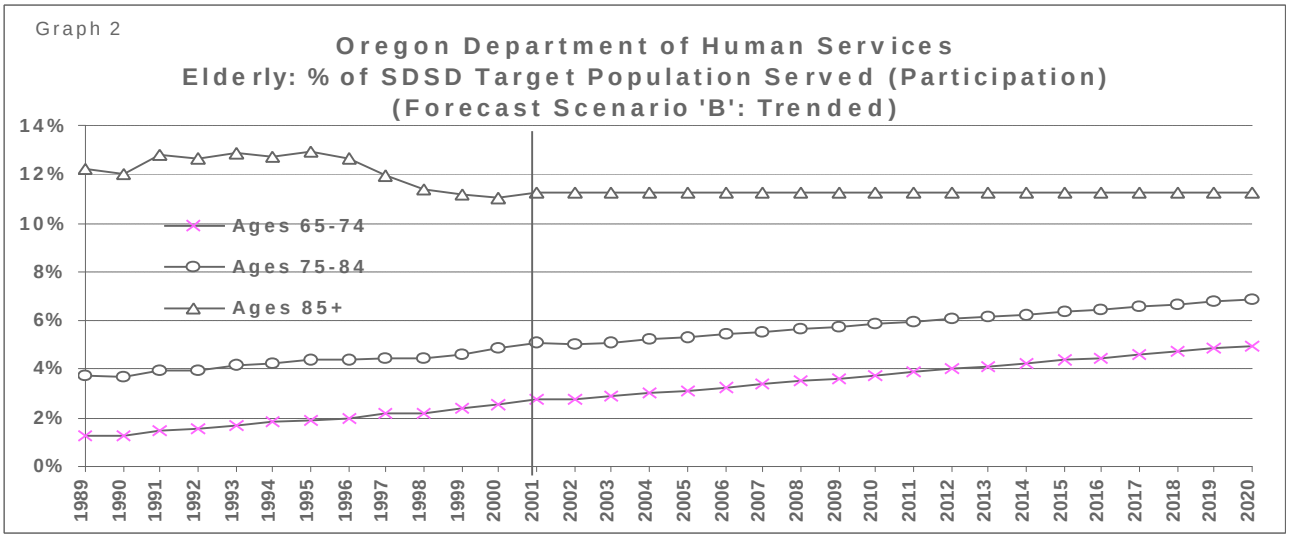
Caseload Estimates to Year 2020



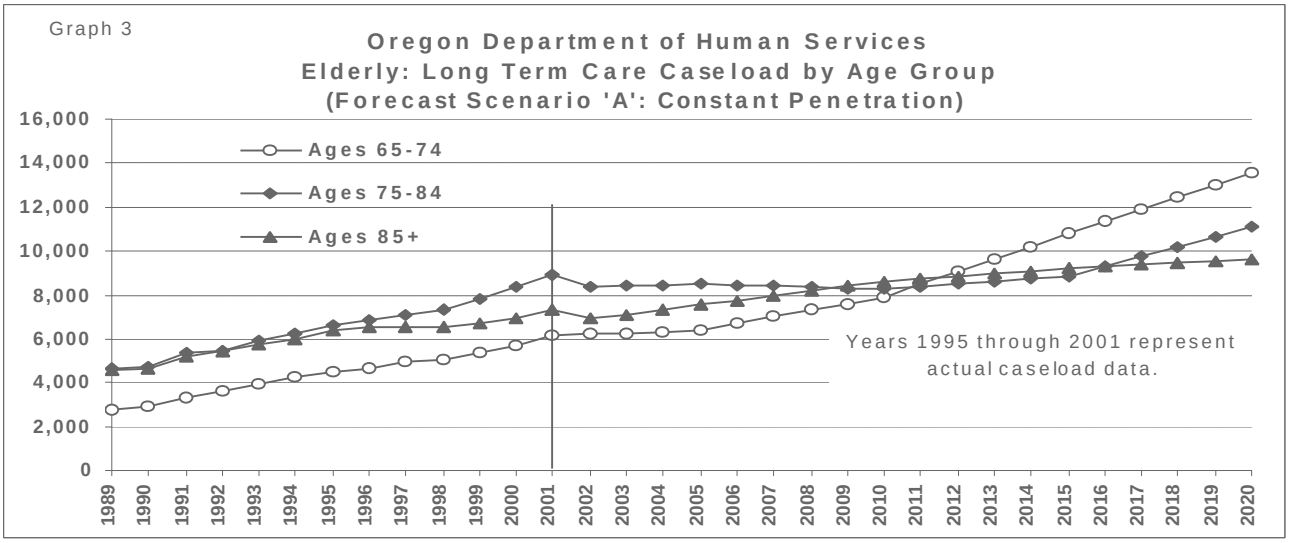
Graph 1



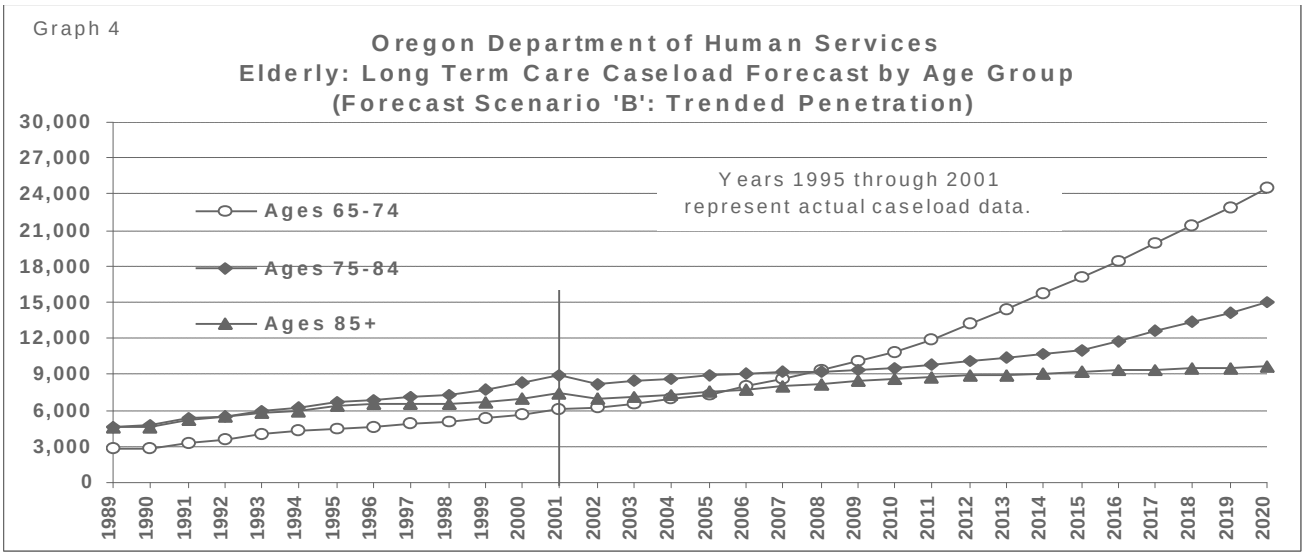
Graph 2



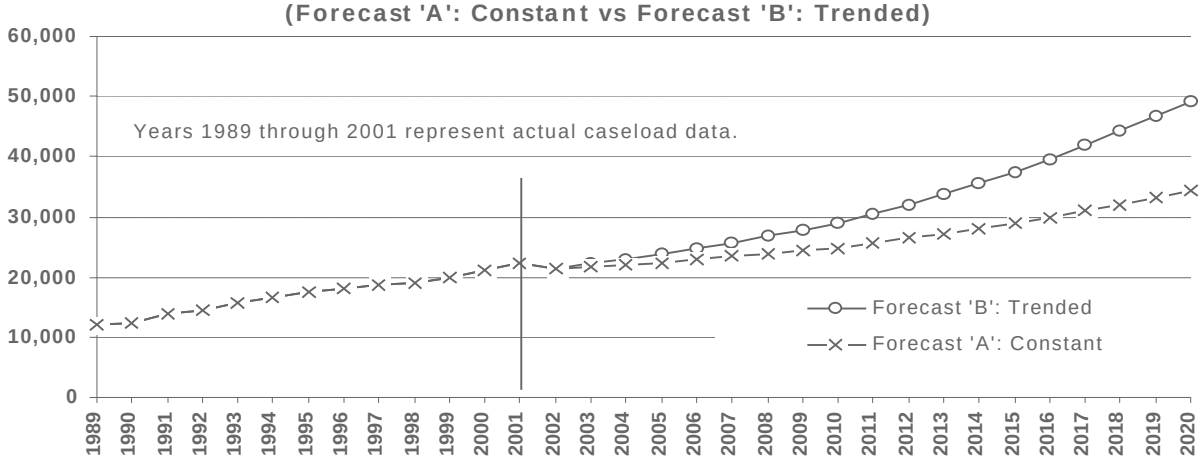
Graph 3



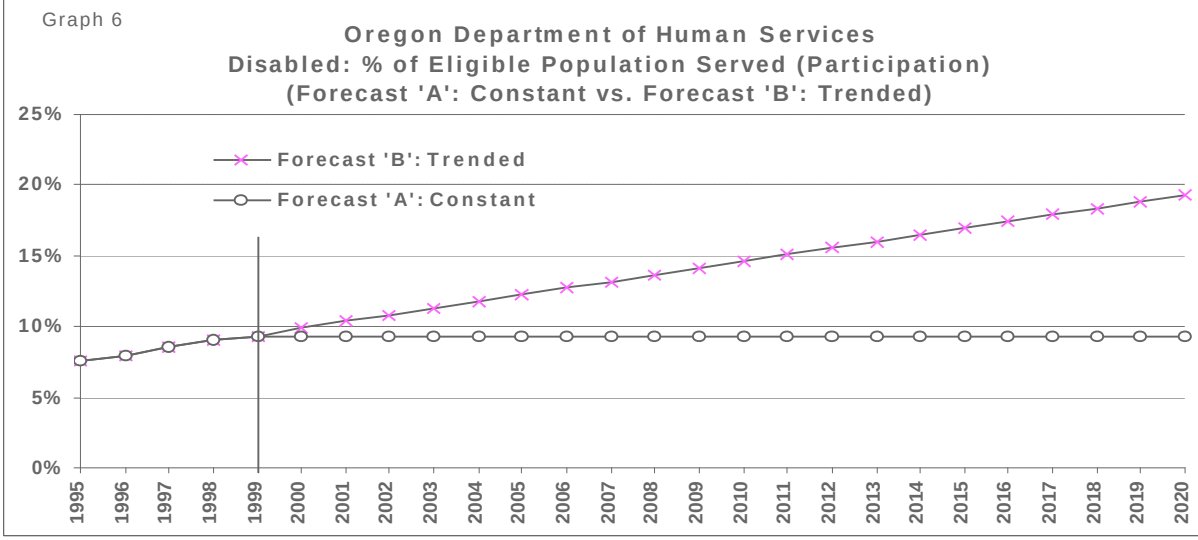
Graph 4



Graph 5



Graph 6



Graph 7

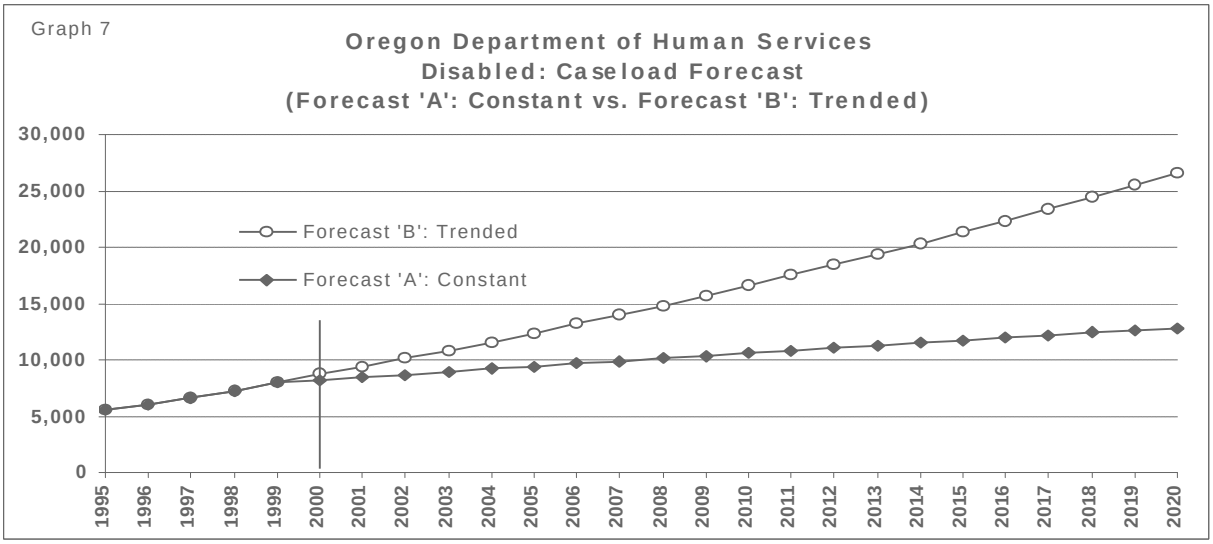


Table 1

Elderly Long Term Care Total Caseload

Year	Forecast 'A' Constant Participation	Forecast 'B' Trended Participation	Trended minus Constant
1989	12,016	12,016	0
1990	12,311	12,311	0
1991	13,904	13,904	0
1992	14,518	14,518	0
1993	15,652	15,652	0
1994	16,494	16,494	0
1995	17,496	17,496	0
1996	18,088	18,088	0
1997	18,589	18,589	0
1998	18,874	18,874	0
1999	19,882	19,882	0
2000	20,966	20,966	0
2001	22,373	22,373	0
2002	**21,451**	**21,405**	**-46**
2003	**21,778**	**22,178**	**401**
2004	**22,104**	**22,960**	**856**
2005	**22,430**	**23,749**	**1,319**
2006	**22,900**	**24,728**	**1,828**
2007	**23,370**	**25,732**	**2,361**
2008	**23,841**	**26,761**	**2,920**
2009	**24,311**	**27,814**	**3,503**
2010	**24,781**	**28,893**	**4,111**
2011	**25,587**	**30,470**	**4,882**
2012	**26,393**	**32,102**	**5,709**
2013	**27,199**	**33,790**	**6,590**
2014	**28,005**	**35,533**	**7,527**
2015	**28,811**	**37,331**	**8,520**
2016	**29,899**	**39,547**	**9,647**
2017	**30,987**	**41,830**	**10,842**
2018	**32,075**	**44,180**	**12,105**
2019	**33,163**	**46,598**	**13,435**
2020	**34,251**	**49,084**	**14,833**

Table 2

SDSD Disabled Total Caseload

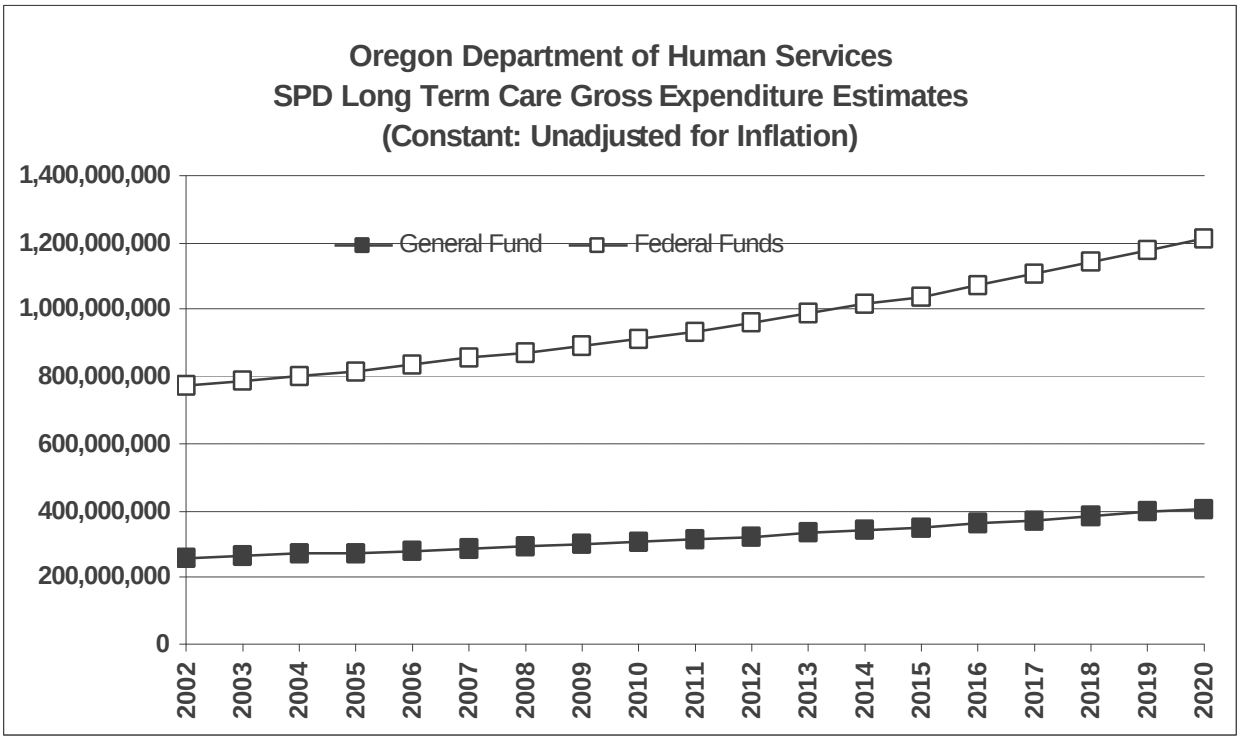
Year	Forecast 'A' Constant Participation	Forecast 'B' Trended Participation	Trended minus Constant
1995	5,547	5,547	0
1996	6,054	6,054	0
1997	6,608	6,608	0
1998	7,211	7,211	0
1999	7,980	7,980	0
2000	**8,223**	**8,708**	**485**
2001	**8,456**	**9,383**	**927**
2002	**8,692**	**10,085**	**1,393**
2003	**8,931**	**10,815**	**1,884**
2004	**9,174**	**11,574**	**2,400**
2005	**9,419**	**12,361**	**2,941**
2006	**9,655**	**13,159**	**3,504**
2007	**9,894**	**13,986**	**4,092**
2008	**10,135**	**14,841**	**4,705**
2009	**10,380**	**15,724**	**5,345**
2010	**10,627**	**16,637**	**6,010**
2011	**10,846**	**17,530**	**6,684**
2012	**11,067**	**18,448**	**7,380**
2013	**11,290**	**19,392**	**8,101**
2014	**11,516**	**20,362**	**8,846**
2015	**11,743**	**21,359**	**9,616**
2016	**11,957**	**22,353**	**10,396**
2017	**12,172**	**23,372**	**11,200**
2018	**12,389**	**24,416**	**12,027**
2019	**12,608**	**25,486**	**12,878**
2020	**12,828**	**26,581**	**13,753**

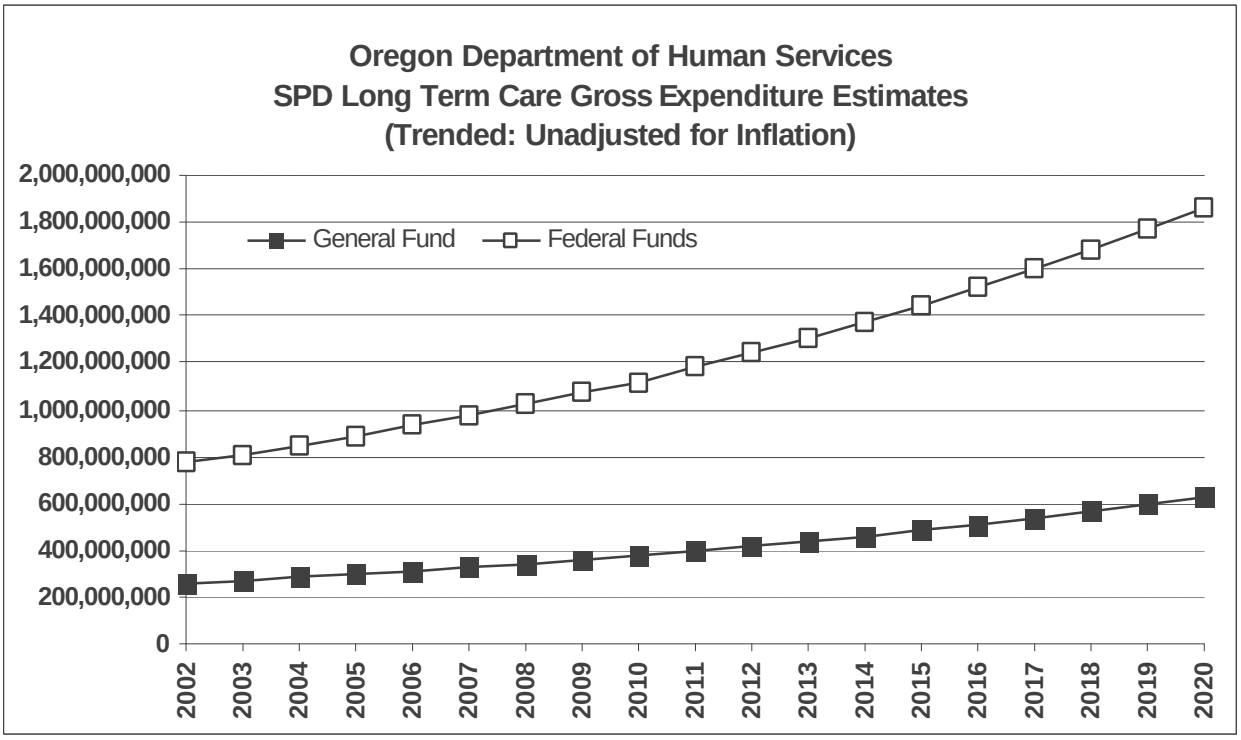
Table 3

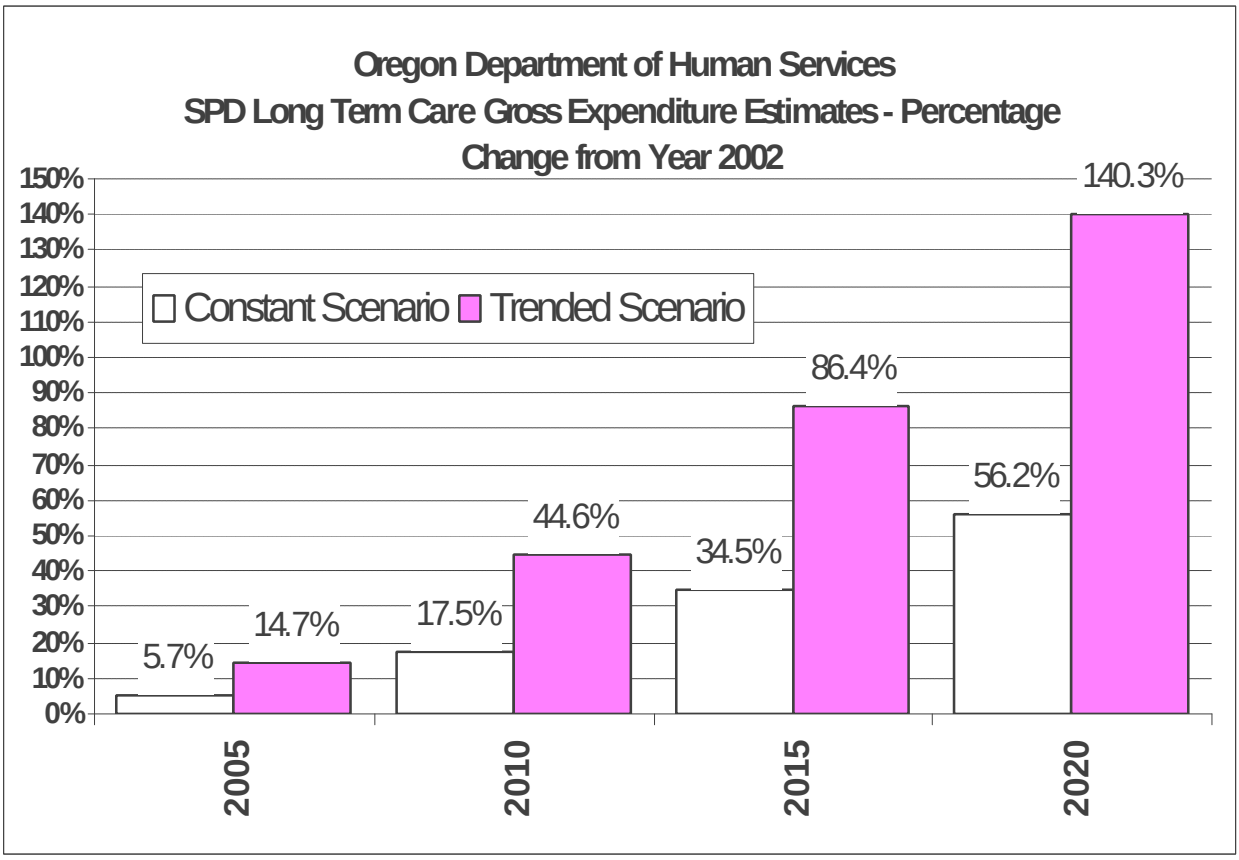
Aggregated Long Term Care Caseloads

Year	Forecast 'A' Constant Participation	Forecast 'B' Trended Participation	Trended minus Constant
1995	23,043	23,043	0
1996	24,142	24,142	0
1997	25,197	25,197	0
1998	26,085	26,085	0
1999	27,862	27,862	0
2000	**29,189**	**29,674**	**-485**
2001	**30,829**	**31,756**	**-927**
2002	**30,143**	**31,491**	**-1,347**
2003	**30,709**	**32,994**	**-2,285**
2004	**31,277**	**34,533**	**-3,256**
2005	**31,849**	**36,110**	**-4,260**
2006	**32,555**	**37,887**	**-5,332**
2007	**33,264**	**39,717**	**-6,453**
2008	**33,976**	**41,601**	**-7,625**
2009	**34,691**	**43,539**	**-8,848**
2010	**35,408**	**45,530**	**-10,122**
2011	**36,433**	**47,999**	**-11,566**
2012	**37,461**	**50,550**	**-13,089**
2013	**38,490**	**53,181**	**-14,691**
2014	**39,521**	**55,894**	**-16,373**
2015	**40,554**	**58,690**	**-18,135**
2016	**41,856**	**61,900**	**-20,043**
2017	**43,159**	**65,202**	**-22,042**
2018	**44,464**	**68,597**	**-24,132**
2019	**45,771**	**72,084**	**-26,313**
2020	**47,080**	**75,665**	**-28,586**

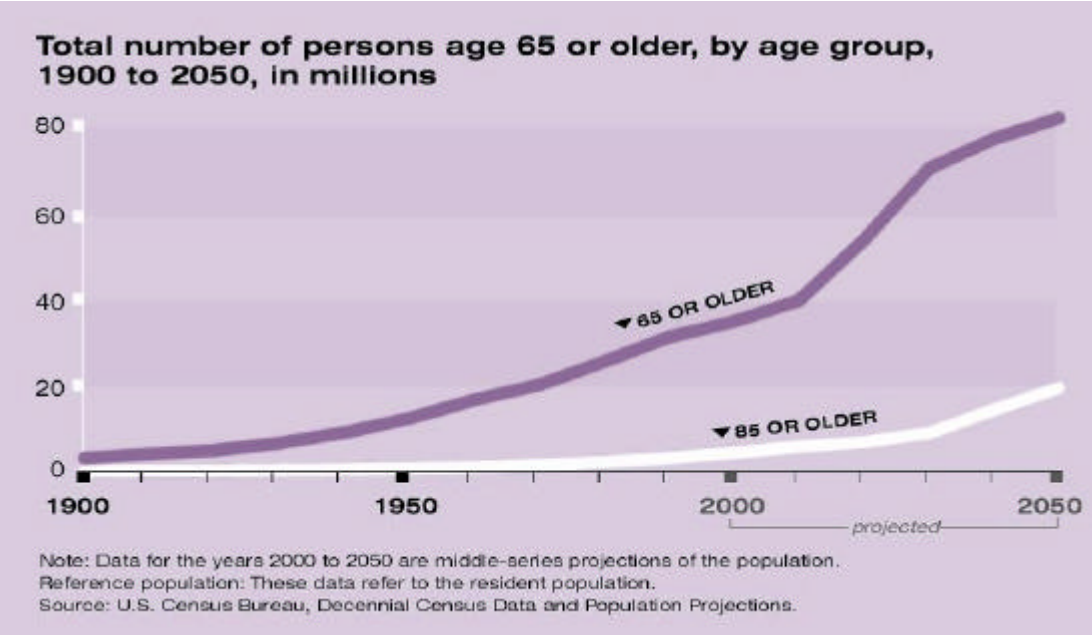
DHS Expenditure Estimations by Scenario

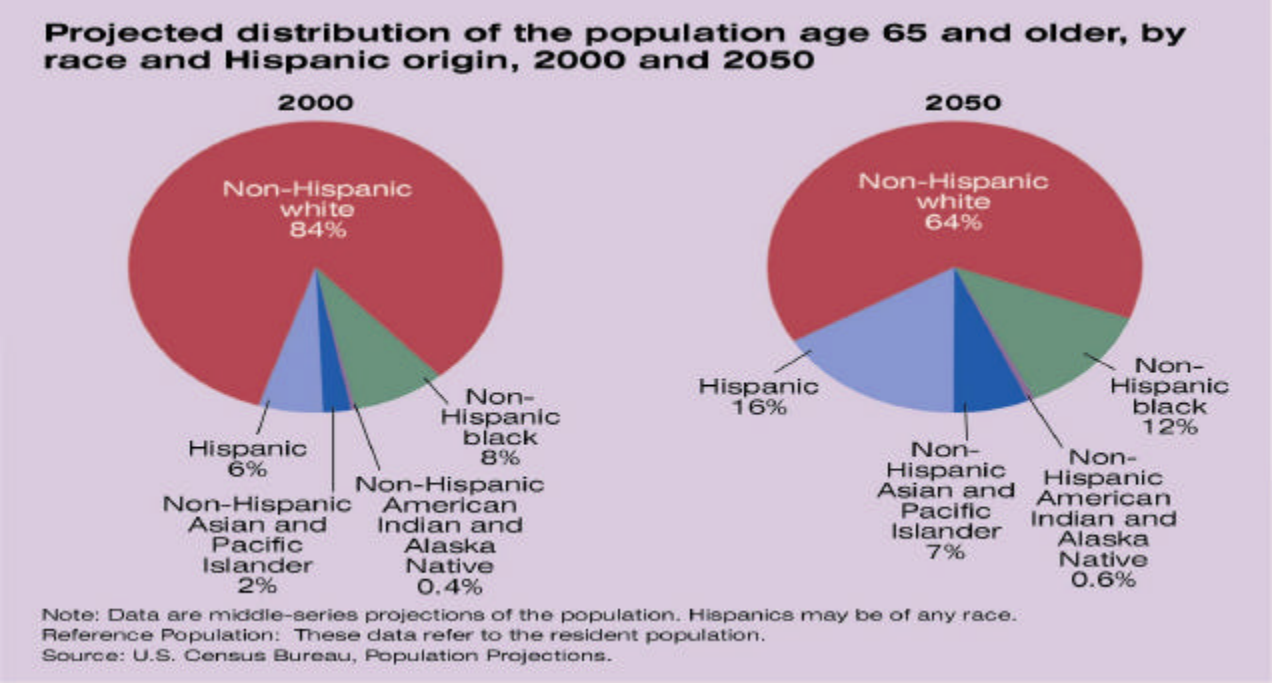

Oregon Department of Human Services
SPD Long Term Care Gross Expenditure Estimates
(Constant: Unadjusted for Inflation)
1,400,000,000
1,200,000,000
1,000,000,000
800,000,000
600,000,000
400,000,000
200,000,000
0
General Fund
Federal Funds
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020

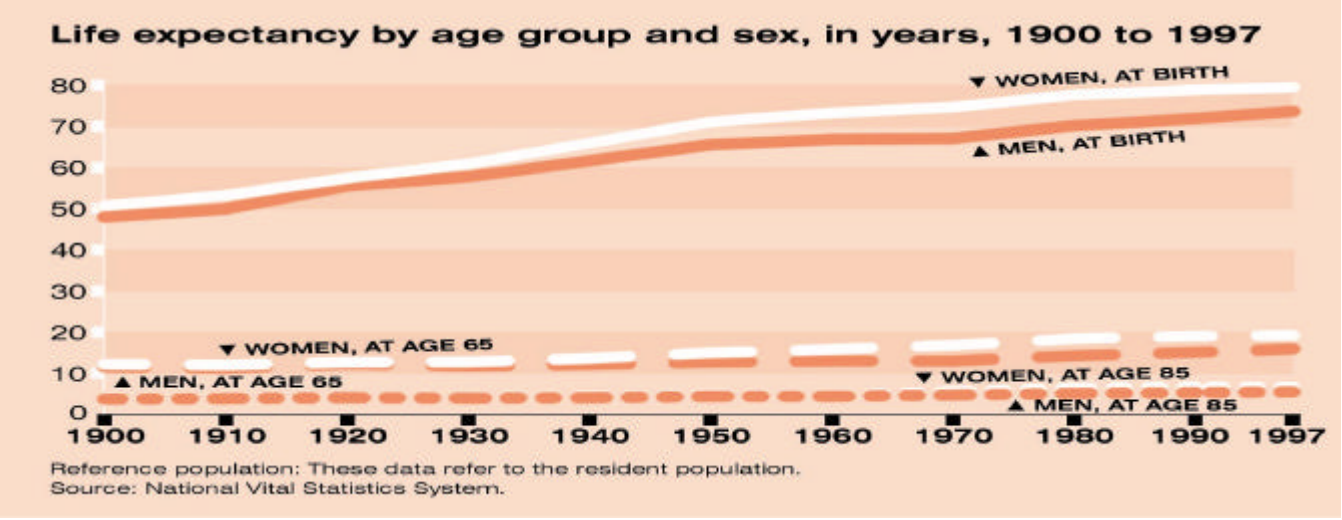

Oregon Department of Human Services
SPD Long Term Care Gross Expenditure Estimates
(Trended: Unadjusted for Inflation)
2,000,000,000
1,800,000,000
1,600,000,000
1,400,000,000
1,200,000,000
1,000,000,000
800,000,000
600,000,000
400,000,000
200,000,000
0
General Fund
Federal Funds
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020

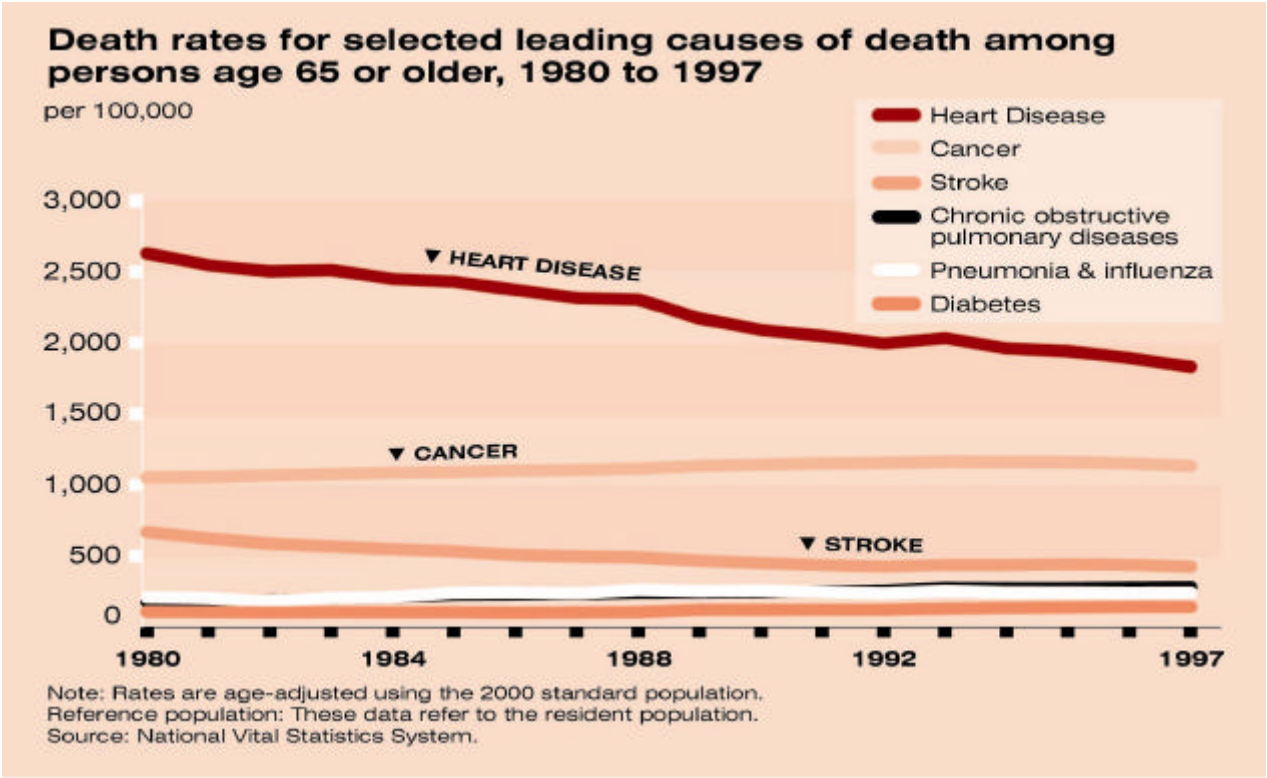

Oregon Department of Human Services
SPD Long Term Care Gross Expenditure Estimates - Percentage Change from Year 2002
150%
140%
130%
120%
110%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Constant Scenario
Trended Scenario
5.7%
14.7%
17.5%
44.6%
34.5%
86.4%
56.2%
140.3%
2005
2010
2015
2020

Appendix C

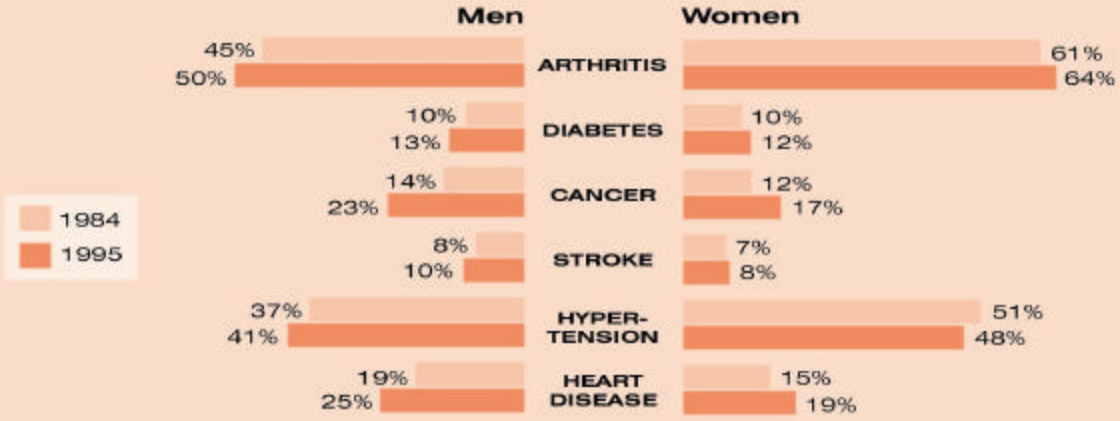

Total number of persons age 65 or older, by age group, 1900 to 2050, in millions
80
60
40
20
0
65 OR OLDER
85 OR OLDER
1900
1950
2000
2050
projected
Note: Data for the years 2000 to 2050 are middle-series projections of the population.
Reference population: These data refer to the resident population.
Source: U.S. Census Bureau, Decennial Census Data and Population Projections.


Projected distribution of the population age 65 and older, by race and Hispanic origin, 2000 and 2050
2000
Non-Hispanic white 84%
Hispanic 6%
Non-Hispanic black 8%
Non-Hispanic Asian and Pacific Islander 2%
Non-Hispanic American Indian and Alaska Native 0.4%
2050
Non-Hispanic white 64%
Hispanic 16%
Non-Hispanic black 12%
Non-Hispanic Asian and Pacific Islander 7%
Non-Hispanic American Indian and Alaska Native 0.6%
Note: Data are middle-series projections of the population. Hispanics may be of any race.
Reference Population: These data refer to the resident population.
Source: U.S. Census Bureau, Population Projections.


Life expectancy by age group and sex, in years, 1900 to 1997
80
70
60
50
40
30
20
10
0
▼ WOMEN, AT BIRTH
▲ MEN, AT BIRTH
▼ WOMEN, AT AGE 65
▲ MEN, AT AGE 65
▼ WOMEN, AT AGE 85
▲ MEN, AT AGE 85
1900
1910
1920
1930
1940
1950
1960
1970
1980
1990
1997
Reference population: These data refer to the resident population.
Source: National Vital Statistics System.

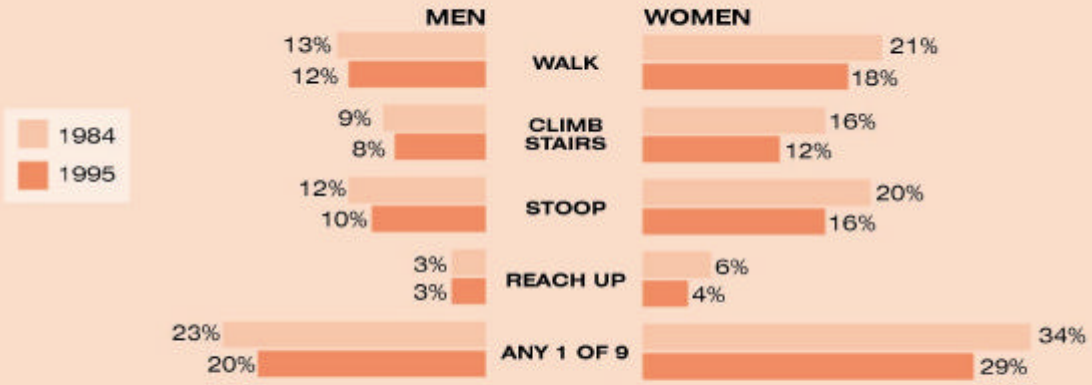

Death rates for selected leading causes of death among persons age 65 or older, 1980 to 1997
per 100,000
Heart Disease
Cancer
Stroke
Chronic obstructive pulmonary diseases
Pneumonia & influenza
Diabetes
3,000
2,500
2,000
1,500
1,000
500
0
▼ HEART DISEASE
▼ CANCER
▼ STROKE
1980
1984
1988
1992
1997
Note: Rates are age-adjusted using the 2000 standard population.
Reference population: These data refer to the resident population.
Source: National Vital Statistics System.

Percentage of persons age 70 or older who reported having selected chronic conditions, by sex, 1984 and 1995



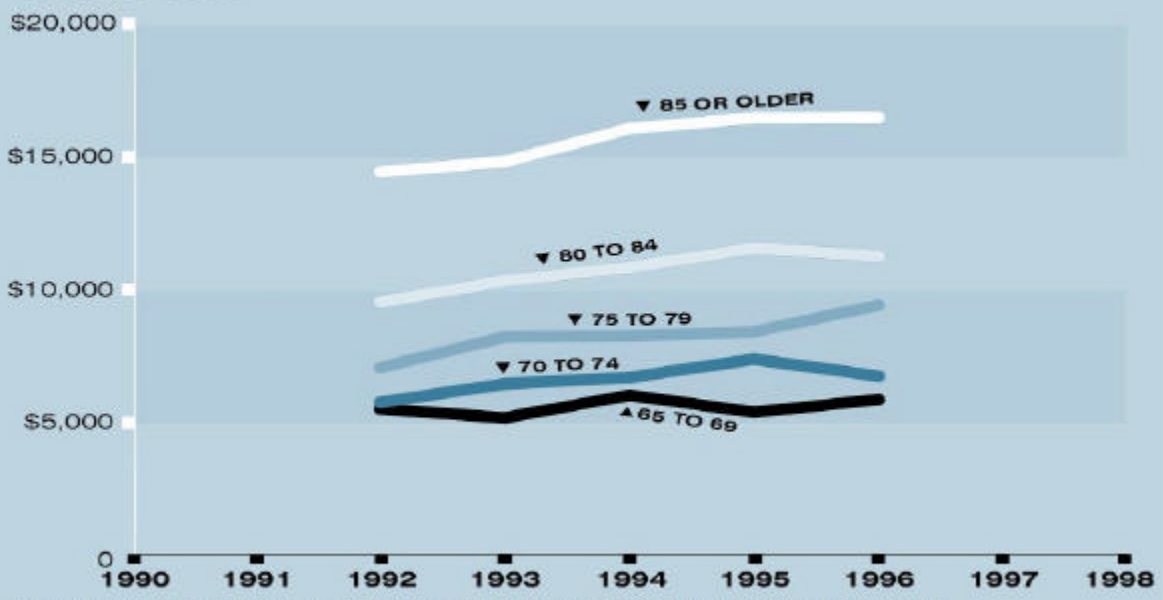
Note: 1984 percentages are age-adjusted to the 1995 population.
Reference population: These data refer to the civilian noninstitutional population.
Source: Supplement on Aging and Second Supplement on Aging.

Percentage of persons age 70 or older who are unable to perform certain physical functions, by sex, 1984 and 1995



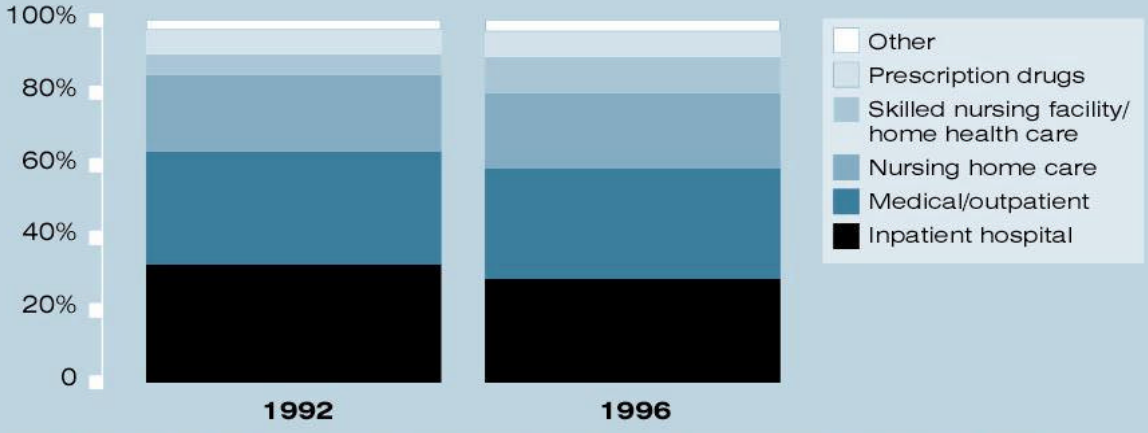
Note: The nine physical functioning activities are: walking a quarter mile; walking up ten steps without resting; standing or being on your feet for about two hours; sitting for about two hours; stooping, crouching or kneeling; reaching up over your head; reaching out as if to shake someone's hand; using your fingers to grasp or handle; lifting or carrying something as heavy as ten pounds. A person is considered disabled if he or she is unable to perform an activity alone and without aids. Rates for 1984 are age-adjusted to the 1995 population.
Reference population: These data refer to the civilian noninstitutional population.
Source: Supplement on Aging and Second Supplement on Aging.

Average health care expenditures among Medicare beneficiaries age 65 or older, in 1996 dollars, by age group, 1992 to 1996



Note: Data include both out-of-pocket expenditures and expenditures covered by insurance.
Reference population: These data refer to Medicare beneficiaries.
Source: Medicare Current Beneficiary Survey.

Major components of health care expenditures among Medicare beneficiaries age 65 or older, 1992 and 1996



Note: Data include both out-of-pocket expenditures and expenditures covered by insurance. "Other" expenditures consist of dental and hospice expenses.
Reference population: These data refer to Medicare beneficiaries.
Source: Medicare Current Beneficiary Survey.

Glossary of Terms

Activities of Daily Living (ADLs) - are activities such as bathing, dressing, toileting/continence, eating, mobility/transferring, and behavior.

Adult Day Care/Services – is a service that can help people with physical and cognitive impairments remain independent. They are offered in a variety of centers around Oregon. People with chronic or progressive health problems can be served by adult day services. Adult day programs typically provide socialization, reminiscing, recreational exercise, counseling, support groups, information, nutritious meals and snacks, health monitoring, and art/music therapy. Some day centers also offer nursing, physical therapy, and personal care.

Adult Foster Homes – are private residences licensed to provide care to five or fewer residents. They offer room and board, personal care from a caregiver in the home 24 hours a day. Planned activities and medication management are available, and some provide transportation services, private rooms, or nursing services. The type of care provided in an adult foster home varies greatly depending on the consumer's needs and the skills, abilities, and training of the provider. They are licensed, monitored and inspected by the state or local area agencies on aging.

Adult Protective Services - is a program that provides protection and intervention on behalf of those adults (aged, blind or disabled individuals 18 yrs. of age or older) who are unable to protect themselves from harm or neglect.

Americans with Disabilities Act (ADA) –Congress passed the American with Disabilities Act in 1990. It prohibits discrimination on the basis of disability in employment, state and local government, public accommodations, commercial facilities, transportation, and telecommunications.

Area Agencies on Aging (AAA) – are mandated by the federal government to function as state-based planning and service agencies for the administration of Older Americans Act Programs. In Oregon there are 18 area agencies on aging, individually operated by counties, council of governments, and private non-profit agencies.

O.R.S Chapter 410 allows area agencies on aging to optionally choose to administer state social, health, and independent living services for seniors and people with disabilities. As a result, the following options exist:

> Type A - This agency model provides programs and services funded by the Older Americans Act and the state-funded Oregon Project Independence program. It serves only persons 60 years of age and older, and does not administer any Medicaid, Food

Stamp, or Adult Protective Service programs. In Type A areas, the state also operates local multi-service offices that administer the Medicaid, General Assistance, Food Stamps, and Adult Protective Services programs to both seniors and people with disabilities.

Type B1 - This agency model must be sponsored by a governmental entity, which can be counties, councils of governments, or a consortium of counties. It administers Older Americans Act and Oregon Project Independence to seniors over 60, and Medicaid, Food Stamp, and Adult Protective Service programs and services to seniors over 65. It does not serve people with disabilities who are under the age of 65. In local areas operating as Type B1 agencies, the state also operates a disability services office, which provides Medicaid, General Assistance, Adult Protective Services, and Food Stamp programs to people with disabilities.

Type B2 - As the above, this agency model must be sponsored by a governmental entity. It administers all the programs that Type B1 agencies administer plus providing services to people with disabilities under the age of 65. In Type B2 areas there are no state operated offices for seniors or people with disabilities.

Assisted Living Facilities – are facilities with six or more private apartments. They are fully wheelchair accessible and offer full dining room services, housekeeping and call systems for emergency help when needed. Registered nurse consultation is available. Physical care and additional health care supervision and assistance can be provided in the consumer's own apartment. Organized activities and transportation are available. They are licensed, inspected and monitored by the state.

Baby Boom Generation – is the generation of individuals born post World War II from 1946 through 1964.

Caregiver – as used in this document, is either a paid or unpaid individual who provides hands-on services for either an elderly individual or for a younger individual with disabilities. While this term is being used in this document, there is concern that using the term "care" is demeaning and implies that recipients of care are passive and dependent. This term is being used by the Task Force because it is universally understood and can be used throughout the document for various individuals who provide services to others. It is not intended to be demeaning.

Cohort – is a group of individuals having a statistical factor in common in a demographic study *(Webster's New Collegiate Dictionary)*

Community-Based Care – is care provided in a home or facility that is not a nursing facility. In Oregon community-based care includes care provided in an individual's home, in a residential care facility, assisted living facility or an adult foster home.

Community Development Block Grants (CDBG) – are federal grants to communities designed to provide decent housing, a suitable living environment, and expand economic opportunities, principally for persons of low and moderate income. Community development block grants are issued through the Department of Housing and Urban Development to the Oregon Economic and Community Development Department (OECDD). These funds are allocated to communities for use in addressing housing needs for safety and health or structural soundness (e.g. replace failing septic systems, sewer connections, roof repairs, adding wheelchair ramps, etc.)

Consumer – as used in this document, refers to the individual receiving services, often referred to as a client. Consumer was the term chosen to reflect a more active involvement by many individuals in directing and evaluating the services they use.

Continuing Care Retirement Communities – are any provider that agrees to either directly furnish or indirectly make available, upon payment of an entrance fee and under a residency agreement, housing and health related services, including nursing or assistance with activities of daily living, for a period greater than one year.

Department of Human Services (DHS)– is an agency for the State of Oregon that includes the following policy and program groups: Seniors and People with Disabilities, Health Services, and Children, Adults, and Families. The Director of the Department of Human Services reports directly to the Governor.

Elders – for most purposes in this document, especially with regard to the demographic data, individuals 65 years of age and older are considered senior citizens or elders. However, for purposes of eligibility for Oregon Project Independence and Older Americans Act Programs, those individuals 60 years of age and older are considered seniors.

Family Caregiver Support Program – is a program established by the enactment of the Older Americans Act Amendments of 2000. The program calls for all states working in partnership with area agencies on aging and local community-service providers to provide five basic services for family caregivers, including: a) Information to caregivers about available services; b) Assistance to caregivers in gaining access to supportive services; c) Individual counseling, organization of support groups, and caregiver training; d) Respite care to enable caregivers to be temporarily relieved from their care giving responsibilities; and e) Supplemental services, on a limited basis, to complement the care provided by caregivers.

Fifty Five (55) Alive Program – a classroom driver improvement course developed and implemented by AARP specially designed for motorists age 50 and older. It is intended to improve their skills while teaching them to avoid accidents and traffic violations.

Home of Your Own Program – is a statewide project formed in 1996 for the purpose of promoting the use of affordable housing options and community supports by Oregonians with developmental disabilities. The program primarily focuses on assisting people who are not receiving formal services. The program is administered by The Arc of Lane County with major funding provided by the Oregon Council on Developmental Disabilities and the Office of Developmental Disability Services. The Oregon State Department of Housing and Community Services and the Federal Home Loan Bank have provided grants and loans to assist individuals in becoming homeowners through the HOYO Program.

Housing Authorities – The 22 Housing Authorities in Oregon are public and non-profit corporations created under law by a city, county or counties working together. Each authority has a defined service area and a mission that reflects the affordable housing needs of its local community and administers federal, state, and local programs in accordance with their respective missions. Administration for Housing Authorities is funded through the Department of Housing and Urban Development that also approves their five-year program plans.

In-home Services – are services provided in a person's home. Those services include help with personal or health care needs and housekeeping. More specifically they include: meal preparation, shopping and transportation, home health services, assistance with medication, housekeeping and laundry, medication management, money management, assistance with medical equipment, and dressing and personal hygiene.

Long-Term Care – is care provided in an individual's home or in a facility (either nursing or community-based care facility) to individuals, both young and old, on a daily basis, usually involving assistance with activities of daily living or instrumental activities of daily living. The need for long-term care is usually precipitated by a chronic disease or disability.

Long Term Care Insurance - is insurance coverage which provides at least 24 months of coverage on an expense incurred, indemnity, prepaid or other basis; for one or more functionally necessary or medically necessary services, including but not limited to nursing, diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital.

Medicaid – (Title XIX of the Social Security Act) - is a medical assistance program jointly financed by the state and federal governments for eligible low-income individuals. Medicaid covers health care and long term care expenses for all recipients of Temporary Assistance to Needy Families (TANF), and most states also cover the needy elderly, blind and disabled who receive cash assistance under the Supplemental Security Income (SSI) program. Coverage also is extended to certain infants and low-income pregnant women and, at the option of the state, other low-income individuals with medical bills who qualify as categorically or medically needy.

Medical Provider – is a trained and licensed individual who provides health care to others and includes, but is not limited to: physicians, nurses, midwives, physician assistants, nurse practitioners, physical therapists, etc.

Medicare – (Title XVIII of the Social Security Act) is a federal health insurance program established in 1965 for people aged 65 or older. It now also covers people of any age with permanent kidney failure, and certain disabled people. It is administered by the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services. Local Social Security Administration Offices take applications for Medicare benefits and provide information about the program. Medicare pays only for care that it determines is medically necessary.

Medicare Part A - covers the following: inpatient care in a hospital , skilled care in a nursing facility, care from a home health agency or hospice. Part A is financed mainly from a portion of the Social Security payroll tax (FICA) deduction.

Medicare Part B - helps pay for physician services, outpatient hospital care, clinical lab tests, and various other medical services and supplies, including durable medical equipment. Part B is financed by monthly premiums paid by enrollees and from federal general revenues. Medicare pays 80 percent of the Medicare-approved amount for Part B claims. If a physician accepts assignment, it means s/he will not charge over the Medicare-approved amount. The enrollee must pay the other 20 percent and more, if the physician does not accept assignment.

Nursing Facilities – are long-term care facilities that provide nursing care on a 24-hour basis in a more institutional environment. They provide skilled care, rehabilitation, and end-of-life care. They are inspected, licensed, and monitored by the state, in compliance with both state and federal regulations.

Older Americans Act - was enacted in 1965 to provide assistance in the development of...programs to help older persons through grants to the States for community planning and services... The objectives of the Act are to secure for older people of our nation: 1) adequate income in retirement; 2) best possible physical and mental health w/o regard to economic status; and 3) suitable housing...at affordable costs; 4) a comprehensive array of community-based long-term care services...to sustain people in their communities and homes, including support to family members providing voluntary care; 5) opportunity for employment without age discrimination; 6) retirement in health, honor and dignity; and 7) participating in and contributing to meaningful activity within the widest range of civic, cultural, educational, training and recreational opportunities. (See ML-1 — 7/1/93 — III-B& III-C for more detailed info.)

Oregon Economic and Community Development Department (OECDD) – is a cabinet-level agency, reporting directly to the governor. The department is funded by the Oregon Lottery, federal funds and other funds. The agency's mission is to assist Oregon businesses and

governments to create economic opportunities and build quality communities throughout Oregon. The department helps Oregon companies succeed and expand and encourages national and international companies to invest in Oregon communities. The department further assists communities to assess their business and community development capacity and to identify next steps in achieving their development goals.

Oregon Housing and Community Services Department (OHCSD) – Oregon Housing and Community Services is the state housing finance agency, providing financial and program support to create and preserve opportunities for quality, affordable housing for lower income Oregonians; and it administers federal and state antipoverty, homeless and energy assistance community service programs.

Oregon Project Independence – funds a variety of in-home services to persons aged 60 or over and persons under 60 year of age who have a diagnosis of Alzheimer's or related disorder.

People with Disabilities – as referred in this document are individuals under the age of 65 who have either a mental or physical impairment. The Americans with Disabilities Act of 1990 defines disability as a "physical or mental impairment that substantially limits one or more of the major life activities."

Program of All-Inclusive Care for the Elderly (PACE) – is an optional benefit under Medicaid and Medicare that focuses entirely on older people who are frail enough to meet their state's standards for nursing home care. The program brings together all the medical and social services needed for someone who otherwise might be in a nursing facility.

Provider – as used in this document, is either a supplier of long-term care or health care, such as an adult foster home provider or a physician. A provider does not necessarily provide direct care to consumers.

Reinvention Lab – are programs that allow public organizations to waive rules and procedures temporarily to experiment with new ways of meeting housing needs.

Residential Care Facilities – are facilities that serve six or more residents. They offer room and board with 24-hour supervision, assistance with physical care needs, medication monitoring, planned activities, and often transportation services. They are licensed, inspected and monitored by the state.

Respite Care – is a service given to families and other care givers temporarily to relieve them from providing care for frail adults. Companionship. Light assistance, recreational activities, and security are provided in a consumer's home, out of home in a group setting, or overnight in a residential setting. Respite care fosters a healthier quality of life for both the caregiver and the care receiver.

Seniors and People with Disabilities (SPD) – is a policy and program group of the Department of Human Services (DHS) that provides services to elderly and individuals with disabilities of all ages. The mission of Seniors and People with Disabilities is "assisting seniors and people of all ages with disabilities to achieve well-being through opportunities for community living, employment, family support and services that promote choice, independence and dignity." This office's main program areas are:

- Community-based care licensing and quality assurance
- Community- based care nursing and health
- Nursing facilities licensing and corrective action
- Developmental disabilities county relations
- Federal waiver and resource development
- Community and family supports
- In-home supports
- State operated group homes
- Employment services, and
- Financial supports

Smart Cards – are cards that look like credit cards and contain a microchip that holds data germane to the cardholder. They assure security and can be programmed for an authorization number, providing efficient ways to retrieve information. They allow quick access to client/patient/consumer information and enhance portability and ease of data transmission.

Smart Home Technology -is the term commonly used to define a residence that uses a home controller to integrate the residence's various home automation systems. Integration of the home systems allows them to communicate with one another through the home controller, thereby enabling single button and voice control of the various home systems simultaneously, in pre-programmed scenarios or operating modes.

Smart Homes can be used for older people and those with disabilities, providing safe and secure environments. The Smart Home allows the user to control many features or automate these features. The user can also be monitored by the Smart Home system to ensure their safety, and alert people should the user be in difficulty.

Universal Design Principles – are design principles that incorporate products and environments that are usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.

Visitability – refers to the design and construction of dwellings that enables easy access by individuals with a mobility impairment. Visitability construction typically includes items such as wider halls for wheelchairs, having at least one entrance without steps, lowering light

switches to levels that can be reached from a wheelchair, and having accessible bathrooms on main floors when feasible.

X-10 – is a power line carrier protocol that allows compatible devices throughout the home to communicate with each other via the existing 110V wiring in the house. Using X10 makes it possible to control lights and virtually any other electrical device from anywhere in the house with no additional wiring.