DRAFT

Recommendations on the Future of Long-Term Care in Oregon

May 2006

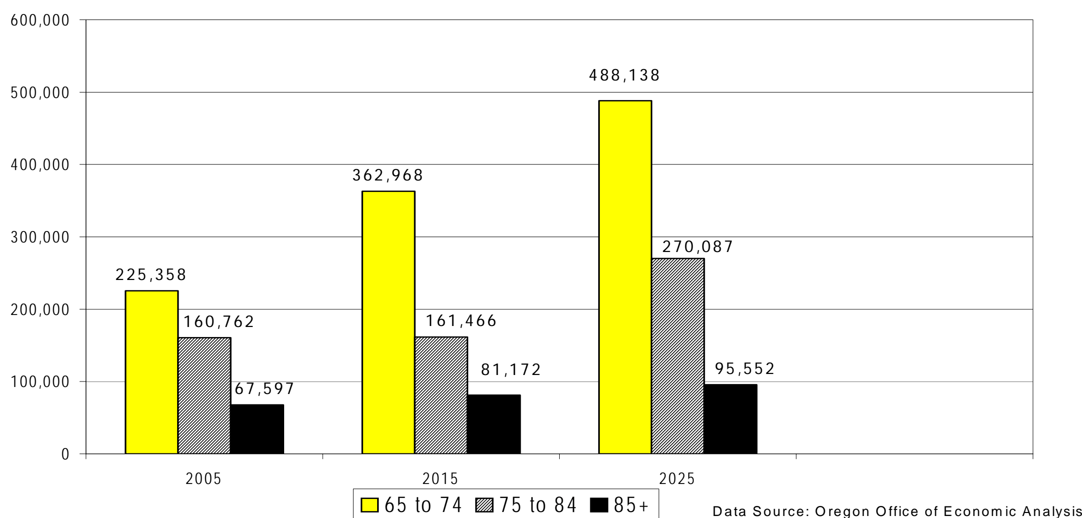
Department of Human Services
Seniors and People with Disabilities

Introduction

The number of people in the United States over age 65 is projected to nearly double in the next quarter century, growing to more than 71 million people by 2030. Oregon will closely follow this national pattern. In 2005 about 1 in every 8 Oregonians was 65 or older. By 2030 it will be 1 in 5. While Oregon's median age[1] today is 37.1[2], it is projected to increase to 39.6 years by 2025. By 2035, half the state will be over age 41.

These changes are due, in part, to Oregonians living longer and healthier lives than ever before. A boy born in 2003 is expected to live 74.8 years, a girl 80.1 years.

In Oregon, people 85 years of age or older make up a small but quickly growing group within the total older population. In 2005, about 68,000 Oregonians reached age 85. By 2025, the number is expected to exceed 95,000, an increase of almost 40 percent. (Figure 1)



Many of the aging baby boomers reaching retirement age in the next decade can be expected to live independently for many years. However, the sheer numbers of these retirees coupled with the fast growing contingent of those aged 85 and older will place an unprecedented demand on long-term care services, and the revenues needed to sustain the growth of such services.

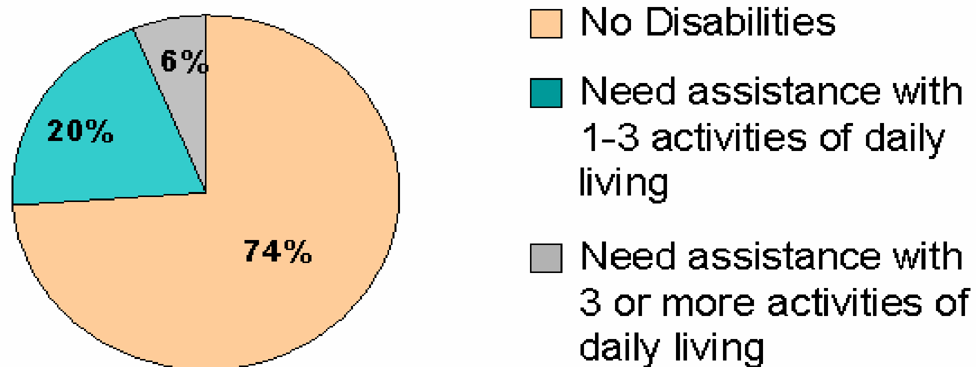
Long-term care refers to the services and supports that people need when their ability to care for themselves has been diminished due to a chronic illness or disability. The need for

[1] Median Age divides the population of Oregon in two groups, half younger and half older

[2] Median age is currently 37.1 in 2005

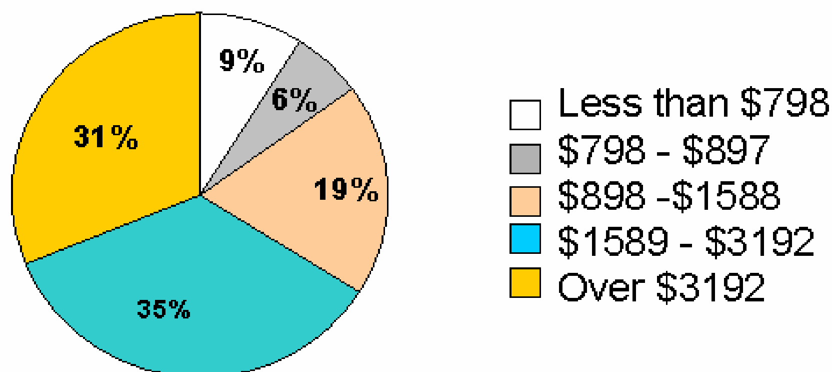
long-term care is often measured by how much assistance a person needs with “activities of daily living” (ADLs) such as bathing, eating or toileting, or “instrumental activities of daily living” (IADLs) such as shopping, cleaning and accessing community services. People who have limitations and need assistance or supervision with any ADLs or IADLs are said to have long-term care needs. About 6 million people over age 65 need long-term care in the United States.[3] (Figure 2)

National % of Seniors Needing Assistance Due to Disability



Source: Joshua M. Weiner, 2002 National Health and Retirement Study

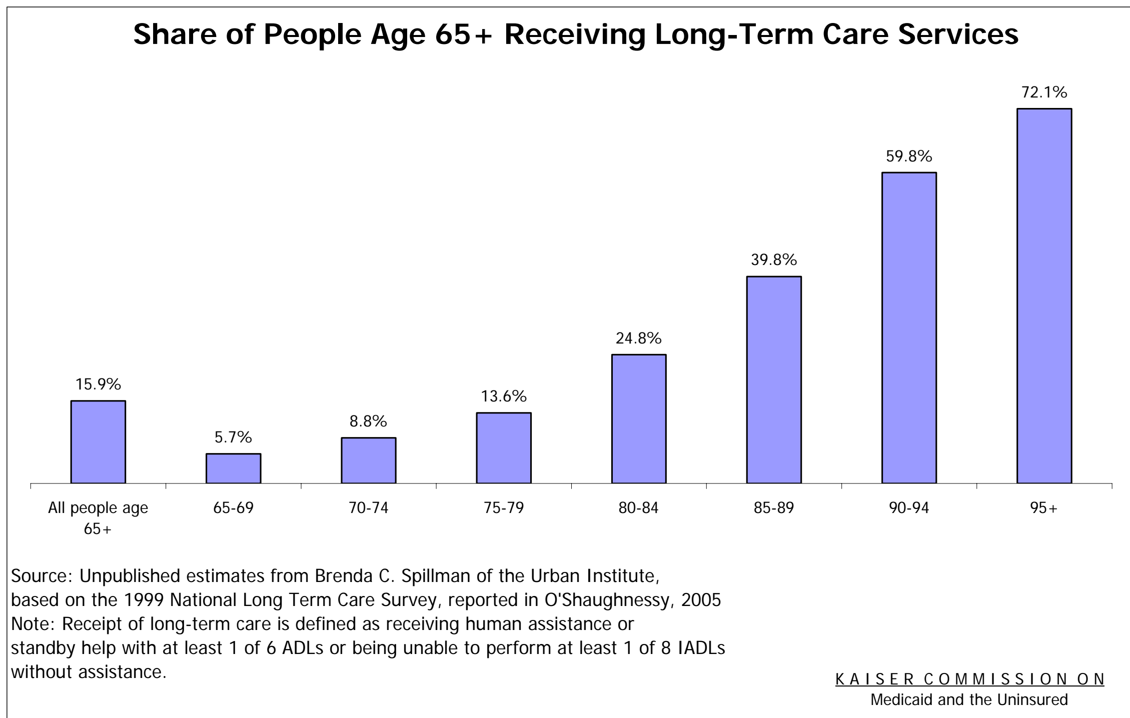
National % of Seniors and Federal Poverty Level (Monthly Income)



Source: Joshua M. Weiner, 2002 National Health and Retirement Study

[3] A Profile of Frail Older Americans and Their Caregivers, Richard W. Johnson and Joshua M. Weiner, The Urban Institute, February 2006

Long-term care needs are often a consequence of aging, most often affecting those age 85 and older, about half of whom have some long-term care needs. Nationally, about 6 percent of people age 65 to 69 received some long-term care services in 1999, escalating for age 85 and beyond . Nearly three quarters of people age 95 and older received some long-term care services in 1999. *(Figure 3)*



People who need long-term care live in a variety of settings in Oregon: in their own homes; in adult foster homes, in assisted living facilities and other congregate care settings; and in nursing homes. Most people who need long-term care live at home and in their communities, often with the help of family and friends. Providing help often poses special challenges for caregivers. Much of the responsibility for married older people with disabilities falls on spouses, who are generally old themselves and perhaps coping with their own health issues. Adult children – usually daughters – often help their frail parents, but many are raising children of their own, and are employed outside the home, forcing them to juggle work and family demands. Family caregivers can feel isolated and overwhelmed, leading to high degrees of burnout and less than optimum care for the senior in need of support. Less than 10 percent of the elderly living in the community rely exclusively on support from formal (paid) caregivers, and about a quarter rely on a mix of paid and unpaid care[4].

[4] Long-Term Care: Understanding Medicaid's Role for the Elderly and Disabled, The Kaiser Commission on Medicaid and the Uninsured, Publication Number 7428, November 2005

The need for long-term care services and supports can impose significant financial hardship on individuals and even lead to financial ruin. In 2005, the average daily rate charged for nursing facility care in Eugene was $163[5] a day – almost $4,900 per month or $58,680 a year. Care at home is costly, as well. In 2005, the average cost of an hour of in-home care in Eugene was $18. If a person needed four hours a day of care, five days a week, the annual cost would exceed $18,700. Most elderly lack the financial resources to afford paid long-term care for more than a few weeks or months. Only about a third of the elderly in the community have enough resources (money in checking and savings accounts, individual retirement accounts, etc.) to pay for a year of nursing facility care[6]. About a third have such limited resources (less than $5,000) that they might be able to pay for barely three months of home care.

Nevertheless, most people try to use their own resources to pay for needed long-term care services. In 2004, about 21 percent paid for their use of Oregon nursing facilities. Private insurance pays for only a small fraction of long-term care. Private health insurance plans usually cover only a limited period of home health care and nursing facility care for people who are recovering from an illness or injury. Private insurance policies that cover the costs of long-term care are currently held by only a small percentage of Oregonians and account for a small share of spending. Medicare, which provides health insurance coverage to nearly all of the nation's elderly population, makes significant payments for home health care and skilled nursing facility care. Medicare coverage of home care and nursing facility care is closely tied to the need for acute care. Medicare pays for a maximum of 100 days of nursing facility care for people who have been recently hospitalized, and pays for home care only if other skilled services – such as nursing and rehabilitative therapy – are also needed.

People with substantial long-term care needs and limited ability to pay for care often turn to Medicaid. The federal-state Medicaid program provides a long-term care safety net for seniors who are poor, or who become poor by paying for their own care. At the end of 2005, more than 18,800 Oregon seniors received long-term care services paid for through Medicaid. Another 8,440 adults with physical disabilities also received Medicaid-paid services. Just as the need for long-term care increases with age, so does the need for financial assistance through Medicaid.

Only 1 out of about every 50 Oregonians between 65 and 74 need help from Medicaid to pay for their long-term care. However, almost 1 of every 10 Oregonians over 85 need this same help to pay for long-term care. (Figure 4)

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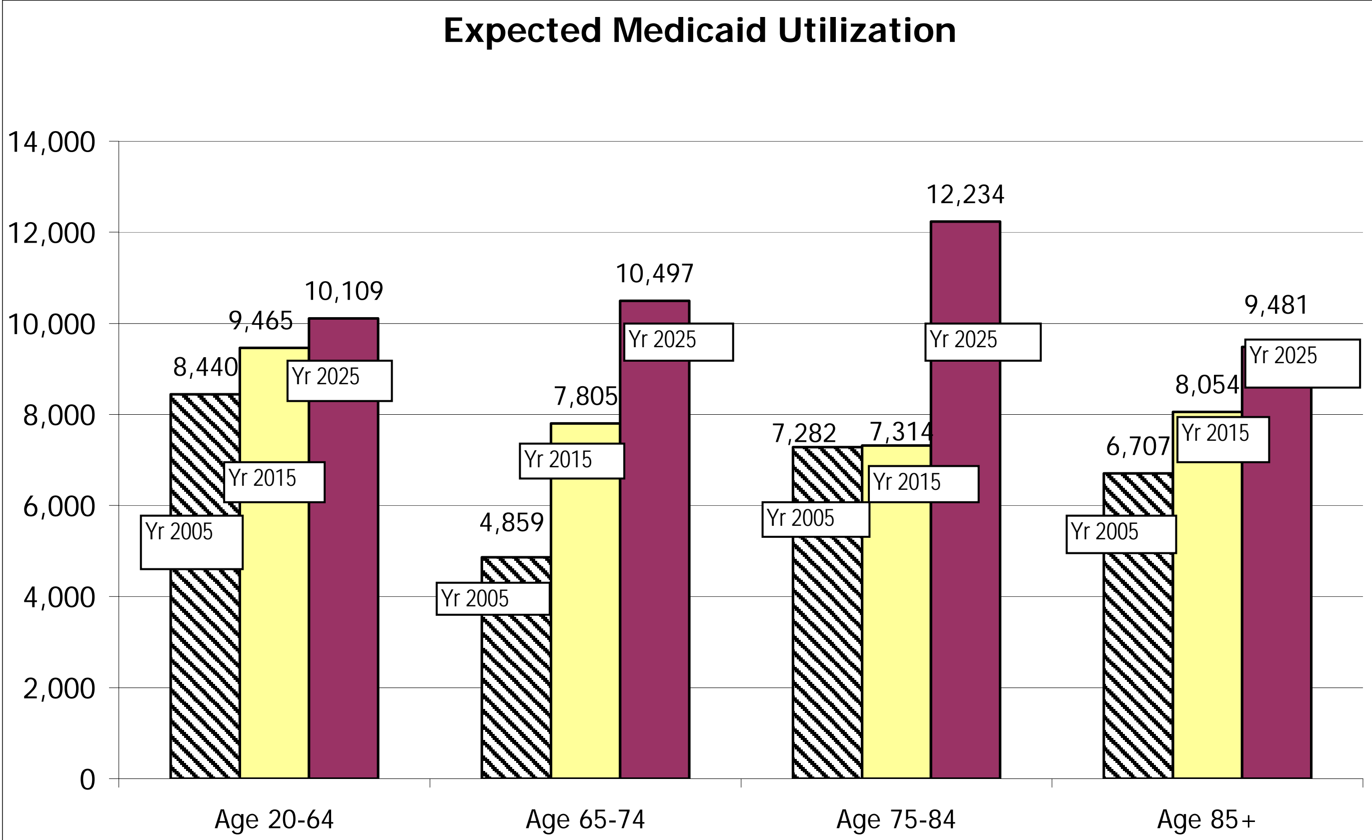
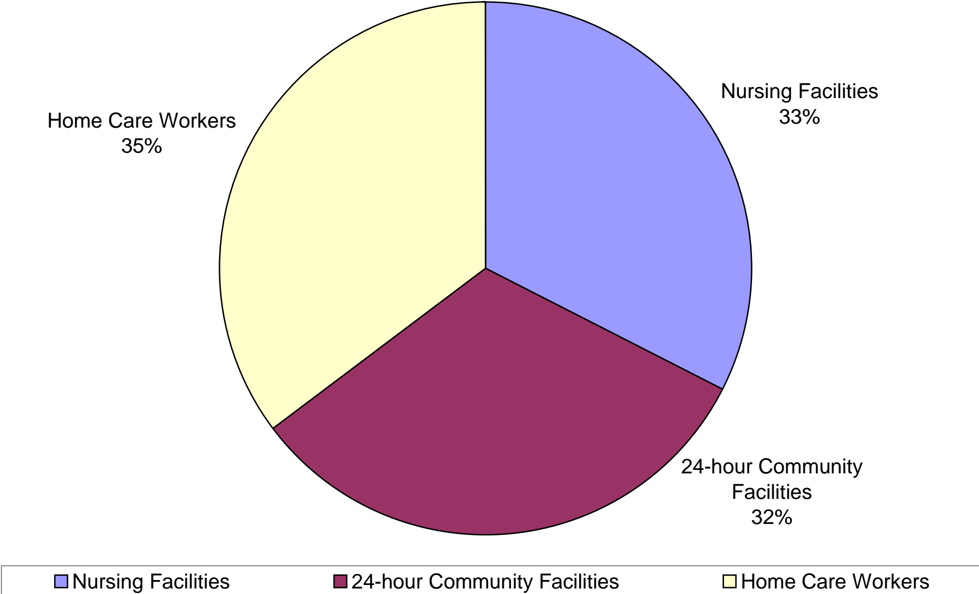
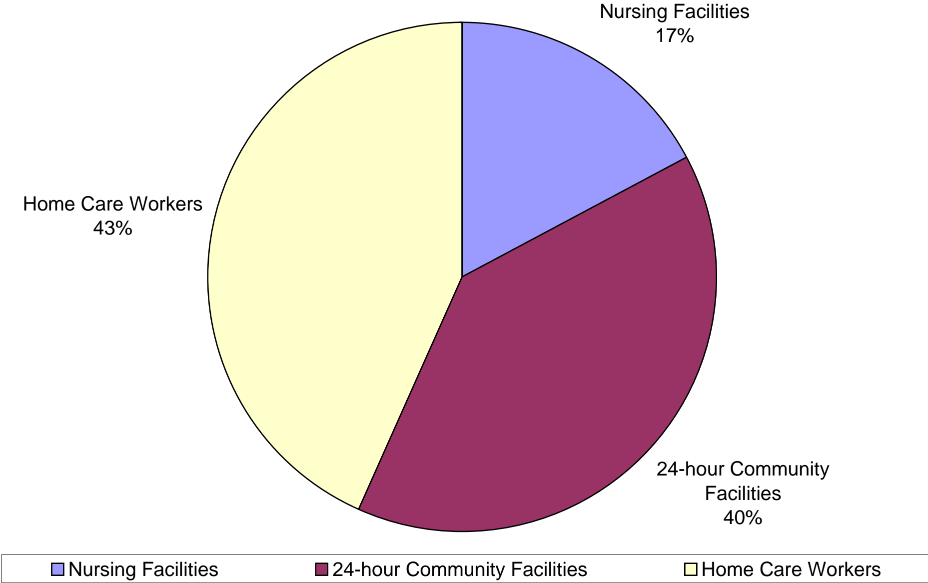
[5] The MetLife Market Survey of Nursing Home and Home Care Cost, September 2005
[6] Long-Term Care: Understanding Medicaid's Role for the Elderly and Disabled, p. 4



In addition to the need for long-term care services becoming more frequent as people age from the "youngest elderly" through the "oldest old", the intensity of services provided becomes more pronounced.

Since 1981, Oregon has led the nation in the development of lower cost alternatives to institutional care (nursing facility care). Home and community-based alternatives to nursing facility care emphasize independence, dignity and choice. They offer needed care and supports at lower cost than medical models. Though state Medicaid funding in Oregon for 2005 is almost equally split between nursing facilities, community facilities and home care, more than 80 percent of clients receive services in their own homes or in their communities.



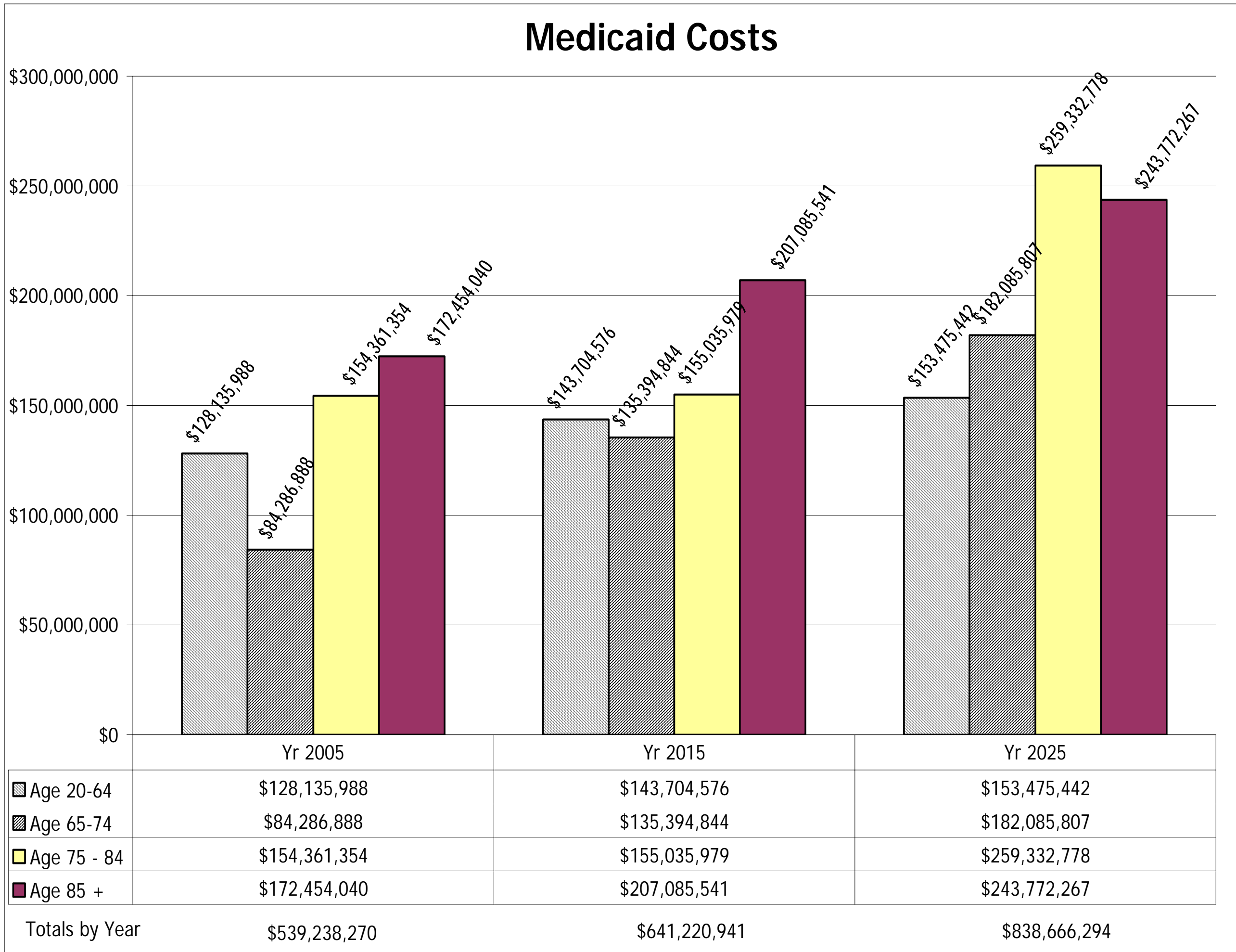


Even in lower cost home and community-based settings, services for the oldest old tend to cost more than those for younger elderly, primarily due to the extent of services needed. The oldest old are more likely to need care on a 24-hour a day basis, rather than a few hours of help during the day. In December 2005, the average monthly Medicaid payment

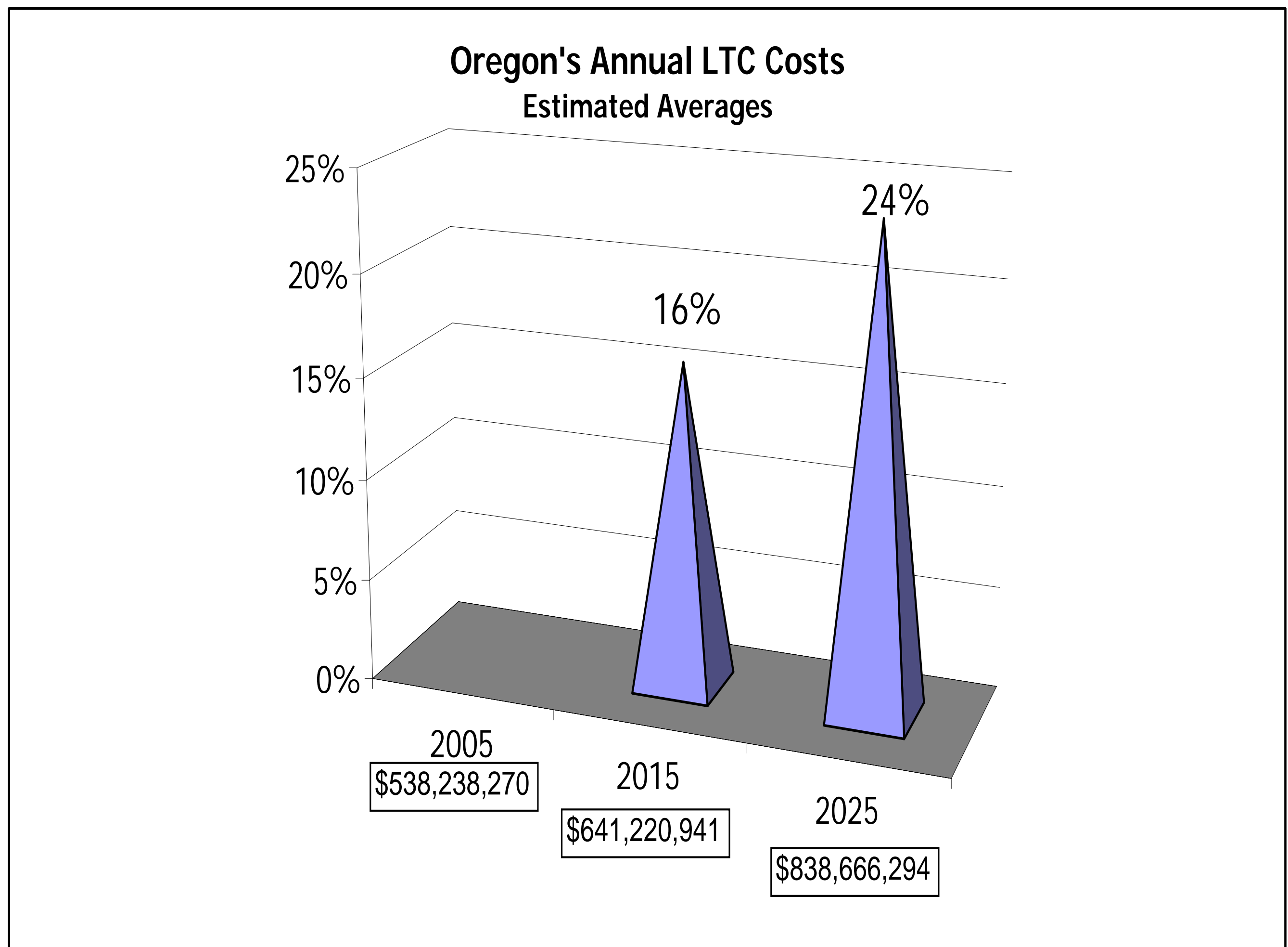
for long-term care for a person between 65 and 74 was $1,445; for a person 85 or older, this amount increased to $2,143 a month.

Based on costs from December 2005, Oregon currently spends more than $411 million each year (combined state and federal funds) to provide services to people 65 or older, who receive Medicaid-funded long-term care and $128 million for people with disabilities under age 65. If 2005 costs remain static, and if the Medicaid caseload increases in proportion to the aging of the population and the growing population of people with disabilities, Oregon's 2005 annual cost of $539 million will increase to more than $640 million in 2015, and will exceed $838 million each year by 2025.

To arrive at these projections, average 2005 costs where people are currently served (both people with disabilities under age 65 and the age cohorts of 65-74, 75-84, and 85+) were trended forward based on expected population increases. The future costs were trended using 2005 dollars. They do not reflect otherwise expected price increases and inflation.



	Yr 2005	Yr 2015	Yr 2025
Age 20-64	$128,135,988	$143,704,576	$153,475,442
Age 65-74	$84,286,888	$135,394,844	$182,085,807
Age 75 - 84	$154,361,354	$155,035,979	$259,332,778
Age 85 +	$172,454,040	$207,085,541	$243,772,267
Totals by Year	$539,238,270	$641,220,941	$838,666,294



Oregon's Long-Range Planning Process

Keeping in place Oregon's model long-term care system, and trending it forward with expected rates of aging and population growth, will require a huge increased investment of state, federal and private resources. Of greater concern is whether the aging demographic that is unfolding today will simply overwhelm Oregon's capacity to develop the needed expanded service capacity and find the additional revenues to support such an expansion.

In his 2005 budget message, Governor Ted Kulongoski directed the Department of Human Services to begin a long-range planning process to address the future of Oregon's long-term care system. "Of paramount concern is Oregon's ability to provide compassionate and effective care to its expanding population of seniors and people with disabilities, while recognizing that such growth must be sustainable within projected revenues," said the Governor.

The 2005 Oregon Legislature echoed these same concern*s*. The report, "2005-07 Budget Highlights," published by the Oregon Legislative Fiscal Office in October 2005, includes the following statement:

> "Despite solid support for the SPD budget, future legislators will need to confront the challenge of the long-term sustainability of Medicaid long-term care. …The General Fund portion of the 2005-2007 legislatively adopted budget is 17 percent higher than the 2003-05 legislatively approved budget. …The bulk of this increase is the result of higher service costs and a growing caseload. Biennial double-digit increases in General Fund spending in the SPD budget can be maintained, but only at the expense of other state funding priorities".

Beginning in August 2005, the Department of Human Services (DHS) convened a Workgroup on the Future of Long-Term Care in Oregon (see appendix A). DHS gave this charge to the Workgroup:

> As the aging demographics unfold, the financing of Oregon's nationally recognized long-term care system will become a major challenge. Even with a reasonable rate of growth in future Oregon revenues, the burgeoning number of seniors and people with disabilities needing long-term care support could overwhelm and outstrip Oregon's capacity to pay for needed services.
>
> It is imperative that Oregon plan now for the future of its long-term care system. The plan should preserve the key values of independence and choice and Oregon's noted paradigm of home and community supports. But the plan must squarely face the inevitable squeeze in future resources. It must propose strategies to keep people independent and healthy for as long as possible. And it must recommend how both long-term care and acute care services can be better aligned for those persons with extended or chronic care needs.

In addition, DHS asked the Workgroup to answer the following seven questions:

1. What specific research or data about senior and disability population trends are needed to guide the development of the long-range plan?

2. What evidence-based practices can be taken to scale which will promote healthy aging and prevent or mitigate the chronic conditions or diseases that frequently trigger a person's need for long-term care?

3. What broad and effective public and private sector strategies can be developed to encourage Oregonians to plan for their retirement and long-term care needs using

appropriate financial and retirement tools? Examples should include LTC insurance, estate planning, reverse mortgages, living wills, choice counseling, etc.

4. What models of elder and disability-friendly communities could Oregon replicate that would help keep seniors and people with disabilities healthy and safe in their home neighborhoods and communities?

5. What non-entitlement based set of safety net services might be offered to seniors and people with disabilities for whom a little help would delay their need for comprehensive long-term care supports?

6. With a concern that future revenues may not stretch to pay for a vastly expanded population using the current mix of service choices, what changes in the array of services should be considered? How might the concept of "bounded choice" (from the previous Governor's task force) be incorporated?

7. What cost-effective and quality-based combinations of acute care and long-term care could Oregon develop to serve certain individuals with chronic conditions and diseases?

Subcommittees of stakeholders and DHS staff have deliberated on these seven questions over the past nine months.

What follows are the preliminary findings and recommendations of each group.

1. What specific research or data about senior and disability population trends are needed to guide the development of the long-range plan?

The purpose of this workgroup was to review and develop research and data questions needed to develop a long range plan for long-term care in the State of Oregon. Assembling the data is important to identify the information necessary for people to plan for their own long-term care needs, for communities to plan for the long-term care needs of members of the community that will need these services, and to better define the role of government in ensuring that long-term care services are available and accessible to all.

As part of the process, the Department will begin a thorough review of the current long-term care system. This review will be focused on outcomes, and identify gaps that currently exist. The review will require collaboration between DHS and stakeholders, including Area Agencies on Aging (AAA), industry groups, consumers of long-term care services, caregivers, and other stakeholders.

In addition, funding and resources will be sought to thoroughly research the following questions:

1. Demographics- Projected: What will Oregon look like demographically over the next 20 years? How will people be distributed by:
   - Age
   - Gender
   - Race and Ethnicity
   - Income and Resources
   - Geographically (urban, rural, frontier)
   - Health Status/chronic conditions

2. Economics
   - How will Oregon's economy change over the next 20 years – both on a statewide basis and regionally?
   - What will be the income distribution of the coming senior age wage?
   - What will be the cost of acute and long-term care

3. What is the current system- What services and supports are currently available?
   - Formal
   - Informal
   - Technology
   - Community Design

- How is the current system working?
  - ➢ What predicts quality of care?
    - Provider Training/Education
  - ➢ Who is using the public system versus the private system?
  - ➢ What problems currently exist?

4. What types of services will people need?
   - What factors cause people to need services?
     - ➢ Which chronic conditions?

   - How can the support be provided?
     - ➢ Informally
       - What factors predict the availability of informal services?
         - ⇒ Family Composition
         - ⇒ Willingness/availability

     - ➢ Formally
       - What factors predict the need for formal support?
         - ⇒ Lack/exhaustion of informal support
       - What factors cause families to seek formal support?
         - ⇒ Magnitude of disability

     - ➢ Community Design
       - What designs support people's ability to live independently?

     - ➢ Technology
       - What will be available for people who need assistance?

5. What types of services will people want?
   - What psychosocial characteristics and values distinguish the coming generations?
   - How will the coming generations define "quality of care?"
   - Would integrating acute and long-term care service systems contribute to better outcomes and consumer satisfaction?

6. How do these needs and service preferences match what is currently available and what is feasible for the state?
   - What might be gained (system efficiency, improved consumer outcomes and satisfaction) by integrating service delivery (acute and long-term care)?

2. *What evidence-based practices can be taken to scale which will promote healthy aging and prevent or mitigate the chronic conditions or diseases that frequently trigger a person's need for long-term care?*

This subcommittee reviewed data and research relating to healthy aging, including modifiable risk factors.

Modifiable Risk Factors in the Older Adult Population, Oregon 2001

	Age 55-64	Age 65-74	Age 75+
Meets physical activity guidelines of moderate physical activity 30 minutes at least 5 days per week	38%	36%	32%
Eats 5+ servings of fruits/vegetables a day	24%	27%	37%
Overweight	39%	46%	36%
Obese	29%	19%	17%

After reviewing existing data, the group concluded that the promotion of physical activity and healthy eating practices in Oregonians 50 years and over would reduce future utilization of long-term care, reduce the incidence and disability from chronic diseases, and increase the numbers of persons who can experience a "healthy old age."

Background

See Appendix B for highlights of articles and research reviewed by the subgroup and which support the decision to focus on physical activity and healthy eating.

A review of the data identifying triggers to long-term care and morbidity/mortality among older adults indicated that over two-thirds of older adults 65 and older have at least one chronic condition, with the prevalence of those with multiple chronic conditions rising with age: 62 percent of those 65 or older, and 70 percent of those 80 or older, had two or more chronic conditions. These numbers are expected to grow given the increasing number of younger adults with chronic conditions.

Physical activity and nutrition are critical mitigating factors in the onset and severity of chronic conditions such as diabetes and arthritis. Increased physical activity contributes to the ability to live independently and decreases the incidence of depression and anxiety. Physical activity and good nutrition reduce the incidence and severity of fall-related injuries, decrease the incidence and complications from heart disease or stroke, and can prevent or delay the onset of conditions such as high blood pressure, colon cancer, and diabetes. Recent research shows that those who are physically active may also delay the onset of Alzheimer's disease.

The subcommittee agreed that any recommendations to increase physical activity and good nutrition should promote evidence-based strategies using a socio-ecological framework of culture and individual behavior change. Sustainable change also requires that all recommendations adhere to the following principles of successful program implementation:

- **Avoid victim blaming**. Strategies should address multiple levels of intervention and support including individual, interpersonal, community, organizational, environmental, and policy.
- **Build on existing Oregon resources and partnerships**. Incentives should be built into strategies that promote successful Oregon programs in both public and private sectors.
- **Ensure that interventions are culturally and linguistically appropriate**. Interventions must be adaptable and effective in a variety of settings and with different ethnic or cultural groups.
- **Enlist family and peer support**. Successful behavior change is maximized when the intervention or program includes a family and/or peer support component.
- **Support varying levels of physical ability**. Interventions need to be acceptable and accessible to all Oregonians in the targeted age groups regardless of current health status or physical ability. Health promotion strategies need to be designed for persons who already have disabilities or severe chronic disease.
- **Recognize co-morbidity issues**. As noted above, the majority of older adults have more than one chronic medical condition. And while 7 percent of all adults in Oregon report experiencing depression within the past year; the number increases to 30 percent for adults with a chronic disease. Effectively managing disease and attention to the issue of social isolation must be included in strategies to ensure full participation of target populations in developing programs.

Recommendations

The following recommendations are proposed.

1. Create an Oregon Healthy Aging Coalition.

Rationale: A coalition will raise awareness of need for support of healthy aging in older adults. A coalition would provide oversight of media campaign, support development of statewide strategies and funding to promote healthy aging, and development of a needs assessment and evaluation process.

Implementation considerations: Participation in such a coalition should include both public and private representatives, including concerned citizens, aging network, health care systems, business community, local and state government.

Funding: Funding should be included for statewide organizational meetings and outreach for the coalition. Current or in-kind funding could include staff work for the coalition to be provided by SPD's health promotion/disease prevention coordinator. Possible grant funding might be obtained through the National Association of Chronic Disease Director's Healthy Aging Council or Northwest Health Foundation.

2. Develop marketing campaigns to promote healthy aging.

Rationale: Research indicates that statewide campaigns, when linked with specific community-level interventions and target population messages, increase public awareness of health issues, and help change social norms and community standards.

Implementation considerations: AARP has researched key messages to increase physical activity in adults. Kaiser Permanente has developed an effective community campaign to encourage healthy lifestyles. DHS should join with AARP and Kaiser Permanente and other interested groups to adapt/develop existing materials to use in a mass media campaign to promote physical activity in older adults. Strategy should include both a state-level media campaign as well as community-level media kits that can be tailored to community needs and resources.

Funding: While forging partnerships with healthcare organizations and AARP, DHS should pursue funding for a statewide media campaign and tool kits.

3. Sponsor legislation to tax soft drinks.

Rationale: The economic cost of diet-related diseases is conservatively estimated to be at least $71 billion annually. A small tax on soda might be politically feasible and would generate significant revenue to support a range of public health efforts related to Oregon's obesity epidemic.

Implementation considerations: The recommendation is to levy a tax of 3 cents for each unit (bottle, can, or 12-ounce serving) of soft drink manufactured or imported by the bottler or importer of soft drinks.

Funding: While projected Oregon revenue is not currently available, examples from two other states are included by way of comparison: Washington had a tax of $0.01 per 12-oz can from 1989 to 1994, resulting in $14 million in annual revenue; West Virginia has a tax enacted in 1951 and still in effect of $0.01 per half-liter plus $0.80 per gallon of syrup, resulting in $12.5 million in annual revenue.

4. Fund training and technical assistance.

Rationale: In order to promote evidence-based practice across a broad population, critical stakeholders need timely access and training in curricula and program models. A centralized approach would assure dissemination of successful practices and early identification of problems. The existing local networks within public health and the aging network would need support in developing this expertise.

Implementation considerations: Training and technical assistance focusing on evidence-based practices to support healthy aging, should be provided to the aging and public health networks. Training should address evidence-based models, Oregon programs and resources, and the benefits of partnerships between public health, aging services, healthcare providers and the business community.

Funding: Funding would be needed for events and materials.

5. Fund projects that implement selected evidence-based interventions.

Rationale: DHS should utilize the mechanism of challenge grants to assist communities across Oregon to develop partnerships with business and local leaders in order to expand access to the kinds of programs that have proven to improve the health of older persons. An inventory of these projects is included in Attachment C.

Implementation considerations: Grants should be available to counties or cities who demonstrate readiness to promote healthy aging through use of the community media kits and ability to provide matching funds or essential support services needed to implement and sustain selected evidence-based programs noted in Attachment C. Projects would focus on developing and enhancing community resources, and systems that support healthy aging and will include appropriate data collection and evaluation.

Funding: Most effective would be to fund a minimum of one project in every county, along with statewide staff to support this network.

6. Expand availability of the chronic disease self-management programs.

Rationale: Self-management programs are designed to help people gain self-confidence in their ability to control the symptoms that arise from a range of chronic diseases and how their health problems affect their lives. Research shows that participants in evidence-based self-management programs manage their symptoms better, are less limited by their illness, and may spend less time at the doctor or in the hospital. Currently DHS efforts have supported the development of self-management efforts in approximately 14 counties.

Implementation considerations: Additional funds and resource commitment from DHS is needed to expand the model to hard-to-reach target groups such as dual eligibles, non-English speakers, and persons with depression, and to encourage more support of the model by health insurers.

7. Explore health care insurance-related discounts/incentives for those who meet specific health behavior and/or preventive screening criteria.

Implementation considerations & funding information to be developed.

8. Increase the number of worksites that offer effective health promotion programs and policies at worksites.

Implementation considerations & funding information to be developed.

#3 What broad and effective public and private sector strategies can be developed to encourage Oregonians to plan for their retirement and long-term care needs using appropriate financial and retirement tools? Examples should include LTC insurance, estate planning, reverse mortgages, living wills, choice counseling, etc.

The need for long-term care services and supports can impose significant financial hardship on individuals and even lead to financial ruin. In 2005, the average daily rate charged for nursing facility care in Eugene was $163[7] a day or $58,680 a year. Care at home is costly, as well. In 2005, the average cost of an hour of in-home care in Eugene was $18. Based on four hours a day of care five days a week, the annual cost would exceed $18,700. These costs are in 2005 dollars. In 20 to 30 years, when many middle-age Oregonians of today may need long-term care, these costs may well have doubled or tripled as a result of inflation.

Like their counterparts throughout the country, Oregonians are unfamiliar with how likely it is that they will need long-term care, how that need increases with longevity, and how much long-term care costs. Over 40 percent[8] of Americans mistakenly believe that long-term care is an entitlement that all Americans are eligible for at retirement.

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[7] The MetLife Market Survey of Nursing Home and Home Care Cost, September 2004
[8] The MetLife Long-Term Car IQ Test

Oregon needs to develop an effective strategy that provides easily accessible information, tools and resources, geared to a variety of audiences that discuss the big questions around long-term care:

- What is it?
- Who needs it?
- Why should I plan for it?
- Who will pay for it?

Brochures and pamphlets that provide this information should be widely disseminated. Not only at traditional spots where elders gather, but also in places where "boomers" find themselves today, such as work places and athletic clubs and at times when they are helping an elderly family member deal with age-related needs, including doctors' offices, hospital waiting rooms and the like. Given boomers' familiarity with the Internet, the same sorts of information should also be made available in interactive formats on the web, through sites such as www.networkofcare.org,,

As boomers reach age 65 and beyond, the need for long-term care services will not only strain individual budgets, it could also push Oregon's Medicaid budget out of control. Besides providing necessary information and tools to help boomers understand long-term care, Oregon should take steps to make long-term care planning as much a part of the retirement planning process as the decision about where to invest 401(k) accounts. Steps to be taken should include:

1. Providing worksheets and FAQs to help people decide if they have adequate income, assets and savings to self-insure.
2. Helping people understand both the pros and cons of family caregiving.
3. Helping people understand the pros and cons of purchasing long-term care insurance by:
    a. Providing worksheets and FAQs to help people decide if purchase of a long-term care insurance policy is right for them;
    b. Passing the legislation needed to allow Oregon to implement a Long-Term Care Insurance Partnership Program[9];
    c. Implementing a continuing education program for insurance professionals in Oregon to help them educate individuals and employers on the features, advantages and benefits of Long-Term Care Insurance Partnership Program policies;

[9] The Long-Term Care Insurance Partnership Program will be available in all 50 states in 2007, as a result of the passage of the 2005 Deficit Reduction Act. The Partnership Program incentivizes purchase of long-term care insurance – if a policyholder uses up their maximum benefit and becomes Medicaid-eligible, assets up to that maximum benefit level are exempted from Medicaid asset recovery.

   d. Working with insurers, employers, unions, associations and other partners to help create a vibrant and inexpensive market for long-term care insurance among today's workers;
   e. Continuing to create and enhance the consumer protections necessary to maintain a quality product for tomorrow's seniors.
4. Helping people to understand the pros and cons of reverse mortgages and other instruments that help them leverage non-liquid worth by:
   a. Providing worksheets and FAQs to help people decide use of a reverse mortgage, or other self-leveraging, is right for them;
   b. Creating a statewide policy around use of reverse mortgages[10];
   c. Working with lenders, bankers and other partners to help create a vibrant and positive environment for sale of reverse mortgages;
   d. Continuing to create and enhance the consumer protections necessary to maintain a quality product for tomorrow's seniors.

4. What models of elder and disability-friendly communities could Oregon replicate that would help keep seniors and people with disabilities healthy and safe in their home neighborhoods and communities?

Communities across the nation are researching and implementing pilot projects to become more livable and supportive of the needs of older citizens and persons with disabilities.

The subcommittee on question #4 considered the following key factors contributing to livable communities for seniors and people with disabilities:

- Transportation:
  - Access to public transportation,
  - Innovative transportation models in areas with limited/no public transportation,
  - Mobility transition planning as people age or become disabled.

- Housing:
  - Incentives for developing accessible housing (across the lifespan).

[10] A "reverse" mortgage is a loan against your home that you do not have to pay back for as long as you live there. With a reverse mortgage, you can turn the value of your home into cash without having to move or to repay the loan each month. No matter how this loan is paid out to you, you typically don't have to pay anything back until you die, sell your home, or permanently move out of your home. To be eligible for most reverse mortgages, you must own your home and be 62 years of age or older.

  - Home maintenance & modification resources.
  - Innovative housing and support models.

- Naturally occurring retirement communities:
- Assistive technology.
- Access to health and long term care.
- Civic engagement & volunteerism.
- Community environments that are designed to be safe and promote physical activity.
- The role of employment and changing retirement patterns.
- Incentives for/promotion of healthy living and disease self-management.

The subcommittee is looking at measurable criteria developed in other states which actually benchmarks community livability against the above factors.

In addition, the subcommittee will study funding sources, grant cycles and funding structures that can seed community livability projects, and assist communities in self-evaluating their progress toward benchmarks.

5. What non-entitlement services might be offered to seniors and people with disabilities for whom a little help would delay their need for more comprehensive long-term care supports?

This workgroup began by reviewing what factors are critical to supporting a person with long term care needs in their communities regardless of their financial situation and eligibility for Medicaid. The group generated a lengthy list of what creates a safety net. Some key themes to these supports emerged. They included friends and families that create personal networks of support., access to information and resources, access to someone who can assist in navigating systems, and local resources for things such as home and safety modifications, home delivered meals, money management, and medication management. The presence of these supports act as safety nets that can be used to prevent untimely and costly out-of-home care.

Recommendations:

Strengthen the safety net of friends and families:
Many Oregon programs for long-term care focus on the individual's family and personal network as part of the individual's support system. The Medicaid program and Oregon Project Independence pay family and friends for direct care supports. The Older American Act offers training assistance to family caregivers. Yet, many of these families are learning to give care support and meet their own needs in a piece-meal fashion. Family

and friend burn out can be one of the crucial factors in someone moving to a more costly support service. The group recommends the following:

- Develop a Master Caregiver Program that provides training and peer supports to family caregivers.
- Partner with local businesses to host Master Caregiver resources as part of an EAP program
- Expand capacity in local volunteer and faith-based organizations
- Expand the number of community gatekeepers to help connect isolated individuals to support networks.

Strengthen Access to Information and Referral Services:
Like many resources, information regarding long-term care services and supports is more readily available via the internet. In 2005, the Area Agencies on Aging contracted with Trilogy Systems to develop the web site, Oregon Network of Care, that provides a very thorough directory of services by county as well as articles and information on issues related to long-term care. The work group recommends augmenting this site by efforts to train local users on its use and benefits. The group also identified gaps in Oregon where state long-term services are delivered by both State offices and by Area Agencies on Aging. The group recommends the following:

- Establish an Aging & Disability Resource Center in a rural community where there are separate AAA and SPD offices, to:
  - Establish coordinated access points for long-term care planning tools, information, resources and services for seniors and people with disabilities
  - Expand capacity in rural communities
  - Seek US Administration on Aging grant opportunity

Strengthen access to someone who can assist in navigating systems:
Having someone available to assist in identifying what a person needs and the resources available is crucial. Private case management is not available statewide and although AAA's can develop a fee-based case management for persons not eligible for Medicaid or OPI, the feasibility for doing that is unclear. The group recommends:

- Expand the capacity for local disability and aging networks to provide long-term care planning resources, information and assistance and care planning/management services.
- Establish information and assistance and care management service standards.
- Expand resources to support care management and planning services .
- OPI Modernization Act to expand care management services to persons with disabilities.

- Explore cost-sharing and sliding-fee-scale options for OAA and private care management.

Strengthen availability of local resources:
While looking at factors critical to a safety net, the group reviewed potential "tipping points" that can create the situation where a person is no longer able to stay home. What it found was that many people were managing risk in order to stay at home. Local programs such as Home Delivered Meals were often cited as both a resource that made staying home a choice, as well as an opportunity to have someone check in on a person. The group recommends:

- Expansion of nutrition services for seniors and people with disabilities as prevention/diversion model.
- Volunteer development, recruitment & support to expand capacity of local programs.
- Model training of volunteers as community gatekeepers to:
  - Identify individuals at risk for abuse or neglect.
  - Help connect individuals to supportive services.
  - Explore innovative funding mechanisms to expand revenues.
  - Cost sharing.
  - Seek increased state funding for nutrition services.

6. *With a concern that future revenues may not stretch to pay for a vastly expanded population using the current mix of service choices, what changes in the array of services should be considered? How might the concept of "bounded choice" (from the previous Governor's task force) be incorporated?*

National spending on formal long-term care is approaching $200 billion a year. In Oregon alone, 2005 spending for the nearly 19,000 Oregon seniors and nearly 9,000 persons with disabilities receiving Medicaid-funded long-term care will exceed $539 million. And yet, informal care – care provided voluntarily by families and friends – is by far the predominant sort of care received by most seniors and people with disabilities in need.

Oregon has led the country in development of home and community-based alternatives to institutional care. Now, faced with the coming age wave, the subcommittee focused on the need to develop models that will meet people's needs, preserve autonomy and share costs equitably among individuals, families and the larger society.

Oregon's current system of long-term care provides a wealth of alternatives to institutional care. Most of these alternatives, including the institutional care portion are all covered under the Medicaid program. Under current Federal law, Medicaid can pay for a full range of community alternatives only if they are directly linked to an institutional level of care. Therefore, to serve as many people as possible, from those with few needs to those requiring total care, Oregon, like many states, has set the eligibility threshold (institutional level of care) fairly low.

And at least until now, a long-term care Medicaid recipient could freely choose across the entire range of Medicaid-funded alternatives. And states could not narrow this choice by tying service duration and amounts to specific acuity levels, which otherwise would be the primary tool for containing costs.

Nationwide, 53 million people are covered by Medicaid. Twenty-five million are children and 13 million are low-income adults. The remaining 15 million are seniors and/or people with disabilities, of which seven million are also on Medicare.

These 15 million people, comprising only 30 percent of enrollments, account for over 70 percent of the expenditures. And the seven million on Medicare account for 42 percent of the expenditures, making the dual eligibles the single most expensive population in the Medicaid program.

Using the above numbers, and trending them forward based on aging demographics, the Medicaid program looms as a huge fiscal crisis for state and federal governments.

For this reason, nearly every state is now researching steps to contain Medicaid costs and to restrict access to only the most vulnerable individuals.

The subcommittee, however, chose to look at solutions outside of the Medicaid program which:

- Support and extend healthy and independent aging for as long as possible.
- Rally the support of natural caregivers and community resources.
- Phase-in limited in-home supports as a pre-cursor to long-term care assistance.
- And finally, offer Medicaid-funded long-term care assistance tied to stricter acuity levels and ongoing utilization reviews.

This might be called a tiered approach to long-term care. The tiers would be:

Easily accessible consumer education resources and means and methods of distribution:

- Tools to extend use of personal assets – i.e.,long-term Care Partnership Insurance; reverse mortgages; self-insurance for need.
- Incentives – i.e., tax credit for LTC insurance purchase.
- Exploration of new alternatives – i.e pooled purchase arrangements to keep costs as low as possible.

Diversion funds should be available as a Pre-Medicaid tool:
Once a person qualifies for Medicaid long-term care, he or she is entitled to the full range of benefits including the Oregon Health Plan and nursing facility care. Limited use of state funds to help people stay out of the Medicaid safety net may be a more cost-effective use of both state and federal resources. A diversion model could include:

- Capped benefit levels for limited in-home care.
- The flexibility to address what the person needs, including housing costs.
- Assistance with Medicare or other health insurance premiums could be provided to help keep people out of Medicaid coverage.
- Exploration of a sliding fee scale.
- Exploration of dedicated revenue streams.

(Note: This model might be patterned after the highly successful Oregon Project Independence)

A Medicaid Level of Need Model should be developed:
Beginning January 1, 2007, States, under new Federal authority, can amend their State Medicaid Plans to offer home and community-based services as a State Plan optional benefit. This is a significant step, since it allows states to offer home and community-based services to people based on their needs for assistance with activities of daily living, not a need for a "nursing facility level of care".

For example, throughout 2005, slightly more than half of the people who received long-term care services in their own homes accessed 80 hours or less of paid help each month. Clearly, seniors and people with disabilities who are able to maintain their autonomy in their homes with such a limited level of paid assistance may have more limited needs than those in need of a "nursing facility level of care". Conversely, stronger informal support systems may band together to help fulfill an extensive set of needs. Adoption of a Medicaid Level of Need Model would help triage access into comprehensive services to those who cannot otherwise meet their care needs. Development of the level of need model should:

- Use the new State Plan option to develop a limited "needs-based" benefit group not tied to nursing facility level of care.

- While the maximum long-term care benefit level for people in this group would be capped, the benefit would include Oregon Health Plan coverage
- Allow families to contribute towards the costs of services not covered by the capped benefit
- Value the role that family and community plays in the life of a client by building Medicaid services as an adjunct to services provided by family and community rather than as a replacement.
- Explore premium and co-pay scenarios allowed by new Federal law.

A full range of Home and Community-based services should continue to be available for the most vulnerable:
Development of the Level of Need Model described above would allow the state to redefine and tighten those criteria that really do result in a need for nursing facility or other 24-hour care. The Full Range model should:

- Define eligibility as tied to a higher acuity need for nursing facility level or 24-hour care.
- Make the full range of facility and waivered services available to Medicaid clients.
- Actively promote the development of new models that meet people's needs, promote autonomy and share costs equitably. As an example, the development of apartment homes for which shared care attendants perform housekeeping and other tasks should be explored as an alternative to stand-alone housing with multiple shifts of care a day.
- Allow families to contribute towards the costs of services not covered by Medicaid.
- Value the role that family and community plays in the life of a client by building Medicaid services as an adjunct to services provided by family and community, rather than as a replacement. Value informal supports first; build Medicaid services assuming that services that can be provided through informal supports will be continued.

7. What cost-effective and quality-based combinations of acute care and long-term care could Oregon develop to serve certain individuals with chronic conditions and diseases?

Although Oregon has a very progressive long-term care system there remains room for refinement and improvement. Circumstances, technology, and medicine/social service capability have changed and must be incorporated into updated models to best serve consumers. Consumers who need long-term care services typically also need complex medical care from multiple providers. When fragmentation occurs between long-term care and acute care, the result is:

- Poor coordination of services among providers, leading to poorer quality of care;
- Lack of accountability for overall quality of care;
- Difficult navigation of the system; and
- Relatively high costs.

The final result is that consumers receive poorer quality services at higher than necessary total costs.

Oregon has been a leader in developing managed health plans that meet the needs of seniors and people with disabilities. Now, with the implementation of the Medicare Modernization Act many more of the Medicaid managed care plans also provide Medicare services.

In addition to innovation in health care, Oregon has had success with agencies taking responsibility for both health and long-term care services, such as the PACE program, called ElderPlace, operated by Providence Health System, and Kaiser's HMO. Unfortunately, constraints on the current programs have not allowed the flexibility to truly deliver the full range of services to the entire population of seniors and people with disabilities.

At least one pilot project is proposed that would provide integrated and coordinated care by combining the funding for Medicare, Medicaid Oregon Health Plan (OHP) services and Medicaid long-term care services into a single entity. A consumer would obtain the full range of health services (doctors, hospital, medications, equipment, etc.) and the full range of long-term care services (in-home supports, Assisted Living, nursing facility, etc.), as well as service coordination from a single entity.

The goal would be to improve the health and quality of life of the consumer, while respecting the individual's choice, self-direction and dignity, by building upon Oregon's strong community-based care system and strong presence of managed acute care. Being the single payer, the agency would have incentives to provide the most appropriate service in the place best for the consumer and at the earliest possible time. This would organize the system to focus on the consumer as a whole person (rather than as a collection of problems to be dealt with or cost shifted to someone else.) The new entity would have financial reasons to proactively work to help consumers retain health and independence to the greatest extent possible. This in turn may reduce costs over the long run while improving consumers' well-being and satisfaction.

The pilot project would target those who are in Medicare, Medicaid OHP, and qualify for Medicaid long-term care. It would require an integrated plan for all services, with care coordination to ensure that the consumer received the services when and where needed, in

a coordinated, integrated fashion with a consumer-centered approach. Inclusion of the full range of health/medical and social services is recommended. Participating entities would name the specific geographic area to be served and whether they would provide services to only those over 65 years of age and/or those under 65.

Sufficient resources need to be identified to allow the development of these new entities, while assuring delivery of quality of services. In addition, a robust quality monitoring system needs to be developed to ensure a consumer-centered system. The group was not able to reach consensus on some details, including the detailed role of the Area Agency on Aging. However, there was a strong commitment that the pilot/s should be encouraged to build on local services, including community and public partnerships.

Following is a table that describes the proposal from the Long-term Care Planning subgroup for a health long-term care pilot project in Oregon. It is assumed that DHS will issue a RFP describing program parameters, and that entities will respond in a way that more precisely specifies the program they propose offering.

Clients	Required: Triple eligible seniors and/or people with disabilities.
	Optional addition: Medicaid only clients meeting Oregon's long-term care eligibility requirements.
	Excluded groups: Certain high need/high cost groups unless the rate structure will adequately cover their needs.
Geographical Coverage	RFP responders would propose the counties or zip codes in which they will provide service.
Competition	During the pilot project, the state will contract with only one plan in each service area for any target population.
Pilot Project Size	The health/long-term care integration program may be voluntary for clients. There will be no caps on the number of clients who can choose this service option.
Services	It is a goal to include the full range of Medicare/Medicaid covered services (including Medicare Part D). The subgroup recommends that the full range of health services are included, such as Mental Health, Dental, and medical transportation.
Service Coordination Model	RFP responders must describe how they will provide service coordination across the entire population served. This must be consumer-centered and approach the person where they live.
Provider Networks	Responders must develop provider networks sufficient to provide all covered benefits, in a scope sufficient (within the natural communities of interest) to serve members throughout all parts of their service area.
Quality Assurance	Responders must have a quality improvement program in place. They must report to the state on quality and utilization measures

	the state specifies in the RFP.
Rates	Medicare Rates would be paid through a Medicare Advantage Plan (which might be, but does not necessarily have to be a SNP). As part of developing its proposal for this program, the State would petition CMS to extend the "frailty factor" to clients who enrolled in this pilot program. Medicaid rates would be based on the costs of serving a comparable set of clients in the fee for service long term care system, designed to be no more expensive than the current system over time.[11]

[11] Substantial discussion and analysis would be needed to select the characteristics that would be used with which to establish the comparability between clients in the fee for service system and in the integrated health/long-term care program. Medicaid rates should be established to provide incentives to the provider to continue the focus of Community Based Care and provide some protection to the provider of adverse selection. Rate cells of some configuration may be a solution.

Attachment A

Future of Long-Term Care
Work Group Roster

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Attachment B – Primary Resources & Research

"Depression and Chronic Disease: Double Trouble", CD Summary, November 29, 2005, Vol. 54, No. 24.

Summary of recent data collected in Oregon showing increased prevalence of depression among those with chronic conditions.

Governor's Task Force on the Future of Services to Seniors and People with Disabilities, September 2002.

Report submitted to Governor John A. Kitzhaber, including recommendations relating to health, prevention, and chronic care.

"Healthy Aging and States: Making Wellness the Rule, Not the Exception", report from the National Governor's Association, December 31, 2003.

Summary of the need for healthy aging efforts at the state level, and some innovative programs being developed by specific states.

Keeping Oregonians Healthy: Preventing Chronic Diseases by Reducing Tobacco Use, Improving Diet, and Promoting Physical Activity and Preventive Screenings, Oregon Department of Human Services, June 2003.

Summary of chronic disease and risk factor data for Oregonians, as collected through the Behavioral Risk Factor Surveillance Systems and other data sources.

Guide to Community Preventive Services, "Promoting Physical Activity" www.thecommunityguide.org Last updated December 4, 2004.

Provides recommendations on population-based internventions to promote health and to prevent disease, injury, disability, and premature death, approvate for use by communities and healthcare systems.

Jacobson, MF, & Brownell, KD, "Small Taxes on Soft Drinks and Snack Foods to Promote Health" American Journal of Public Health, June 2000, Vol 90, No. 6, pp. 854-857.

Summary of state legislation, revenue generated, and designation of funds, in imposing taxes on soft drinks and snack foods.

National Blueprint: Increasing Physical Activity Among Adults Age 50 and Older, Robert Wood Johnson Foundation, April 2001.

Review of needs, and summary of proposals developed by six national partners (AARP, American College of Sports Medicine, American Geriatrics Society, The Centers for Disease Control and Prevention, National Institute on Aging, and The Robert Wood Johnson Foundation) to addressing planning, collaborative action, and social change relating to physical activity and aging.

A New Vision of Aging: Helping Older Adults Make Healthier Choices, Center for the Advancement of Health, Washington, DC, March 20006, Issue Briefing No. 2.

Arguing that available knowledge on how to support older adults in making ealthier choices is not being used effectively, this report provides an overview of current trends in health of older adults, and summary of research documenting both the potential impact and the barriers to helping older adults increase physical activity, improve eating habits, and make simple health changes.

"Synthesis of AARP Research in Physical Activity: 1999-2003", AARP, January 2004.

Summary of research done by AARP in partnership with The Robert Wood Johnson Foundation to assess health knowledge, attitudes, and behaviors of people age 50 and over

Attachment C - Evidence-Based & Model National Programs

Criteria Key/Definitions

1. **OR –** Whether or not the program is already in use in Oregon
2. **Target Pop –** Age; Individual vs. Group
3. **Acceptability Issues–** geography, gender, ethnicity, or language considerations
4. **Setting –** i.e. community, clinical, or home
5. **Leader** - Who runs program

Program	OR	Target Pop.	Accept-ability	Setting	Leader
1. Arthritis Foundation Exercise Program [formerly People with Arthritis Can Exercise (PACE)] - exercise program designed specifically for people with arthritis that uses gentle activities to help increase joint flexibility and range of motion and to help maintain muscle strength and increase overall stamina. *(Arthritis Foundation)*	✓ approx. 28 sites	45+ Group		Comm.	Fitness, senior & volunteer groups
2. Arthritis Foundation Aquatic Program (AFAP) – Water exercise program for people with arthritis and related conditions. *(Arthritis Foundation)*	✓ approx. 14 sites	45+ Group	Need warm-water pool	Comm..	Fitness, senior & volunteer groups
3. Body & Soul: A Celebration of Healthy Eating and Living – wellness program developed for African American churches with a focus on empowering participants to eat 5-9 servings of fruits and vegetables a day. Program combines pastoral leadership, educational activities, peer counseling, and the use of the church environment to support healthy eating. *(National Cancer Institute/American Cancer Society, NIH, CDC)*		45+ Group		Church	Congregation members
4. Disease Management – Commercial and Medicaid programs use population-based disease management programs that utilize evidence-based standards of care supported through telephonic intervention, nurse triage support, in-home counseling visits, provider coordination and written educational materials. Targeted diseases vary, but can include diabetes, congestive heart failure, asthma, etc. OMAP currently has programs for diabetes, COPD, asthma, heart failure, and coronary artery disease, but not targeted at older adults.	✓ commercial & Medicaid managed care	45+ Individual		Health/ insurance systems	RN?
5. Eat Better & Move More: A Guidebook for Community Programs – 12-week program developed for seniors participating in congregate meal programs, and is geared to participants of varying needs and abilities. Interactive weekly 30 minute sessions provide basic educational information and encourage participants to be physically active and eat a more healthy diet. Now part of the national *You Can! Steps to Healthier Aging* campaign promoted by US Dept. of Health and Human Services. *(National Resource Center on Nutrition, Physical Activity & Aging at Florida International University)*	4 state, 9 AAA, 17 community 'partners'	65+ Group	Used in rural & urban settings	Comm.	Fitness or nutrition professional

6. EnhanceFitness (formerly Lifetime Fitness Program) evidence-based exercise program focusing on stretching, flexibility, balance, low impact aerobics, and strength-training. Fitness instructors at senior centers or community recreation programs receive training and a manual to allow them to lead 3 one-hour classes per week. Oregon sites: Ambleside Meal Center, Gresham; Fook Lok Meal Center, Portland; Tigard Meal Center, Tigard *(Project Wellness of Senior Services of Seattle/King County)*	✓ Portland area senior meal sites	65+ Group	Used with Hmong, Spanish, Vietnamese, African-American & other gps	Comm.	Fitness instruct-ors
7. Healthy Changes: A Community-Based Diabetes Education & Support Program Healthy Changes, uses trained volunteer group leaders and a defined curriculum, has been designed to assist older adults in the day-to-day self-management of Type 2 diabetes by focusing on diet and physical activity during weekly group meetings. Healthy Changes does not replace formal diabetes education, but provides a powerful complement to the typical educational process. Healthy Changes was developed in collaboration with NCOA under the leadership of the Providence Center on Aging, Portland, OR. The Healthy Changes toolkit has been developed to assist local organizations to implement this program. *(Nat'l Council on Aging Healthy Aging Program)*	✓ Providence; Elders in Action	45+ Group	Used nationally with various ethnic groups; translated into Spanish, Russian, & other languages	Comm.	Lay leader
8. Healthy Moves for Aging Well Program utilizes care managers from community-based care management agencies to teach evidence-based exercises to home-bound, frail, (dually-eligible) low-income elderly clients. *(Nat'l Council on Aging Healthy Aging Program)*		frail elderly Individual		Home	Care manager
9. Improving Mood Through Accessing Collaborative Treatment (IMPACT) involves a depression care manager (RN, SW, or psychologist) working with primary care providers to intervene with older adults with depressive symptoms. The managers collaborate with the individuals' regular physicians for up to 12 months to educate and support the individuals, track symptoms and side effects, assist with changes in antidepressant treatment and provide counseling. The IMPACT care model was significantly more effective than usual care for depression at participating sites.		60+ Individual		Clinical	RN, SW, or psych.
10. Living Well with Chronic Conditions (Stanford's Chronic Disease Self-Management Program) 6-week program for people with any kind of chronic condition. Led by trained lay leaders, with interactive approach to providing basic health information, and helping individuals set short-term realistic goals to manage their conditions and improve quality of life. *(Stanford University School of Medicine Patient Education Resource Center)*	✓ 14 counties have Master Trainers	45+ Group	Spanish-language, Russian, Vietnamese	Comm.	Lay leaders

11. A Matter of Balance Designed to reduce the fear of falling, stop the fear of falling cycle, and improve the activity levels among community-dwelling adults, this program is for small groups of older adults living independently in community settings or senior housing. Coping strategies that are taught include changing attitudes and self-efficacy, as well as exercising to improve balance and strength. Uses volunteer lay leaders as facilitators. *(Nat'l Council on Aging Healthy Aging Program)*		65+ Group		Comm.	Lay leaders
12. Meals Made Easy for Diabetes 4-class meal-planning program, based on Idaho Plate method, for groups of individuals with diabetes. In Oregon, Extension faculty and diabetes health care professionals facilitate sessions. *(DHS)*	✓ Tillamook, Coos, Washington, others?	45+ Group	Spanish & English	Comm.	RD or CDE preferred
13. The StrongWomen Program – evidence-based program that trains community leaders to offer strength-training exercise program and nutrition information for older adults. Benefits of strength training for women include increased muscle mass, bone density, reduced risk for diabetes/heart disease/arthritis/depression/obesity, and improved self-confidence. *(Tufts University)*	✓ OSU Extension – Grants Pass & Tillamook	45+ Group	Women only – but popular with women	Comm.	Lay leaders
14. TeleHelp-TeleCheck Service – provides twice-weekly telephone support and emergency response for older adults who are referred to the program by health or social services. Outcomes showed lower suicide rates, lower depression scores, and decreased hospital admissions.		65+ in study Individual	Studied in Italy; more women participated	Home	Trained/ paid staff
15. Worksite Health Promotion - Worksite health promotion programs including changing worksite policies, health screening and identification of risk factors, disease management, and physical activity/nutrition programs. Focus on environmental change	✓ Pilot public employee program; 6 counties with small grants to do worksite projects	45+ Individual & group		worksites	Worksite coordinator