

February 2001

**NATIONAL
HEALTH
POLICY
FORUM**

Caring for the Elderly: Oregon's Pioneers

November 13–15, 2000
Portland, Oregon

The
George
Washington
University
WASHINGTON DC



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NHPF is a nonpartisan education and information exchange for federal health policymakers.

Acknowledgments

“Caring for the Elderly: Oregon’s Pioneers” was made possible by the generosity of the John A. Hartford and the Robert Wood Johnson Foundations.

The Forum thanks Roger Auerbach and his staff in the Senior and Disabled Services Division of the Oregon Department of Human Services for their constant support and assistance in the course of planning and conducting the site visit. Special thanks also go to Jim McConnell and his staff in Multnomah County’s Aging and Disability Services Division, who were kind enough to arrange for site visitors to see various care settings and talk with residents and managers in each.

Many people gave generously of their time and expertise in putting the site visit together. The Forum is grateful to all the speakers and behind-the-scenes advisors who helped make this site visit a success. Elizabeth Kutza and Richard Ladd furnished particularly helpful background information. For their hospitality in hosting site visitors, the Forum thanks especially Eugene Scanzera of Kaiser Permanente Northwest Region and Ken Brummel-Smith and Lynette Neal of Providence ElderPlace.

Caring for the Elderly: Oregon's Pioneers

OVERVIEW

With funding from the John A. Hartford and Robert Wood Johnson Foundations, the National Health Policy Forum (NHPF) was asked to develop a site visit to explore continuum-of-care issues and the evolution of services to seniors during a period of rapid and fundamental change. Among potential sites, Oregon stood out as the number one choice for several reasons.

First, Oregon is a clear leader in the development of home- and community-based services for its elderly and disabled residents. It was the first state to secure a waiver under Medicaid's home- and community-based services waiver program—Section 1915 (c) and (d)—and was the only state to actively relocate older nursing home residents into community-based care. Oregon will spend \$455 million (55 percent) of its 1999-2001 long-term care budget on community-based care and \$379 million (45 percent) on nursing home care. More than three-quarters of Oregon's Medicaid clients now receive care in home- and community-based care settings, and the proportion continues to increase. In the wake of the Supreme Court's *Olmstead* decision, which affirms the rights of persons with disabilities to live in the community, Oregon offered an opportunity to study the characteristics of successful home- and community-based services programs, the challenges of implementing them, and the costs to the federal and state governments.

Second, the state offered numerous examples of innovative ways to deliver care to senior citizens. From its wide array of state-funded care setting alternatives to its Medicare Social Health Maintenance Organization to five sites of the Medicare/Medicaid Program of All-inclusive Care for the Elderly (PACE), Oregon had a host of options to examine. It also provided another opportunity to continue NHPF's exploration of the impact of the Balanced Budget Act of 1997, especially as it relates to hospital-based systems and their ability to integrate care across delivery sites and forge new relationships with physicians, skilled nursing facilities, home health agencies, and other parts of the health care delivery system.

Finally, with more than half of Portland's Medicare beneficiaries enrolled in managed care, Oregon provided an interesting perspective on Medicare+Choice. In Port-

land, the Medicare health maintenance organization (HMO) market is mature and penetration is high, but the federal payment rates are low and some plans have been experiencing financial difficulties. For these reasons and more, Oregon provided a tremendous opportunity to understand continuum-of-care issues, especially as they relate to the elderly.

LONG-TERM CARE IN OREGON¹

The state of Oregon often is looked to as a national model for its long-term care (LTC) system, which is widely regarded as the most progressive in the country. Key features contributing to its success include a philosophy emphasizing home- and community-based care that is not only set in statute but also operationalized statewide, as well as full integration of all LTC services under one state agency. Oregon also leads the nation in the development of community residential alternatives to nursing homes, such as adult foster homes, residential care facilities, and assisted living facilities. Factors contributing to the success of Oregon's model include a unique political environment, state enabling legislation, and a consumer-driven delivery system.

History

In November 1980, the Governor's Commission on Senior Services appointed an ad hoc committee with a core group of persons representing seniors, providers, Area Agencies on Aging (AAAs), and the state Department of Human Resources to develop a structure for the delivery of LTC services. This committee put together a proposal for the legislature that consolidated funding for and decentralized the administration of LTC services. This legislation was passed, as Senate Bill 955, with the help of intense

¹Much of the following summary information was taken directly from two sources given to NHPF for the purpose of providing background on Oregon's long-term care system: "Long-Term Care in Oregon," by Elizabeth A. Kutza, Ph.D., Institute on Aging, Portland State University (1994), and "Oregon's LTC System: A Case Study by the National LTC Mentoring Program," by Richard C. Ladd (1996). The Forum is grateful for permission to reproduce these papers in part. Recent data were provided by Oregon's Senior and Disabled Services Division.

lobbying efforts by a well-organized senior lobby, before the legislative session concluded in June 1981. The reorganization that followed the bill's passage brought into a single administrative unit both federally and state-financed programs, including the following:

- Title XX (Social Service) dollars that had been administered by the Adult and Family Service Division.
- Title XIX (Medicaid) dollars that had been used for long-term care services.
- Title III monies under the Older Americans Act.
- Oregon Project Independence (OPI) dollars. OPI is a state-financed program of case management for older adults who are in need of in-home services but who are not eligible for Medicaid.

In 1989, the Oregon legislature additionally transferred responsibility for food stamps and for medical and cash assistance for virtually all seniors and people with disabilities to the Senior Service Division, renamed the Senior and Disabled Services Division (SDSD).

Who Is Served in Oregon's System?

Currently, 23,480 clients—nearly 50 percent of whom are over the age of 75—receive long-term care services under the state's Medicaid waiver. Eligibility for services under the Medicaid waiver is based on an assessment of a client's disability and frailty level, as well as on an income standard that is set at three times the federal guarantee under the Supplemental Security Income program. After income eligibility is determined, clients are assessed according to their ability to perform activities of daily living and the availability of any social supports.

What Services Are Provided?

The SDSD provides payment for and oversees services of four types: cash assistance, long-term care services, Older Americans Act programs, and protective services such as licensing, registration, elder abuse investigation, and guardianship. A case management approach to providing services helps older adults gain access to an array of service options and to assure appropriate levels of services.

Oregon's Medicaid waiver also allows reimbursement for services provided in the home as well as in three other care settings: residential care facilities, adult foster homes, and assisted living facilities (ALFs). Home care includes house-keeping and personal care services, such as grocery shopping, meal preparation, laundry, grooming, and bathing. It can be provided either through a formal in-home provider under contract with SDSD or through a client-employed provider (CEP). Under the CEP arrangement, the individual

caregiver is hired and supervised by the client, although paid directly by the state. Currently, 94 percent of all in-home services are provided through a CEP; home health agencies provide the remaining 6 percent.

How Are Long-Term Care Services Administered in Oregon?

Service is accessed through a network encompassing local government, private agencies, and regional state offices. AAAs provide a single point of entry at the local level for recipients of government-sponsored care. Typically, AAAs serve only the elderly. Services to the disabled are generally provided by SDSD through Multi-Service Offices (MSOs) or Disability Service Offices (DSOs). Each of these agencies has active consumer input. Senior Services Advisory Councils form the backbone of consumer input and oversight for the AAAs, while Disability Services Advisory Councils do the same for the MSOs and DSOs. At the state level, the Governor's Commission on Senior Services and the Oregon Disabilities Commission represent analogous groups.

How Did Oregon's System Develop?

While Oregon provides a model of an LTC system that is client-driven and community-based, a unique confluence of factors has influenced the development of the system, some of which may be hard to replicate elsewhere. Several factors stand out:

- Legislative and executive branch support for consolidation of licensure and regulatory authority, as well as funding, in a single state agency.
 - A nurse practice act that permits delegation of some nursing tasks to lay caregivers.
 - Early and continued use of section 1915 (c) and (d) waivers from the federal government.
 - Dedicated leadership on the part of state officials.
 - Strong and well-organized senior advocacy.
 - A relatively homogeneous population.
- Over time, other factors have proved significant as well.
- A high degree of involvement and management control at the local level, specifically the area agencies on aging.
 - A commitment to provide the most appropriate services in the least restrictive settings for all when needed, with no waiting list.
 - A fundamental belief in the right of free choice in planning and managing one's own care.
 - Reliance on a case management/care coordination model to avoid institutionalization.

What Alternatives Are Available to Oregon's Elders?

Oregon offers a continuum of long-term care alternatives. Options include the following:

- Client-employed provider—in-home care provided by individuals hired by beneficiaries and paid by SDDS for their services. Care providers may be friends, relatives (other than spouses), or home care professionals. The state also contracts directly with some home care agencies to provide care to those with more specialized needs.
- Adult foster care (AFC)—facilities with five or fewer residents and a live-in manager, offering routine care and personal services tailored to residents' needs. The home manager (working with a case manager when Medicaid beneficiaries are involved) makes arrangements for needed medical services to be provided in the home or at a clinical facility.
- Assisted living—facilities with residential units meeting specific structural requirements (such as private kitchens). Services provided are not specified under law. Housekeeping and personal care services may be incorporated in a residential contract. Assisted living is predominantly a private-pay phenomenon, though Medicaid accounts for approximately 30 percent of ALF reimbursement.
- Nursing homes—facilities that serve an increasingly older and more fragile residential population, as relatively healthier elders are more likely to choose (and be suited for) a home-based alternative. Nursing homes are also used for short-term post-acute placements.
- PACE—a community-based program that is part of a national project and serves as an all-inclusive managed care program for frail seniors. A PACE site provides all items and services covered by Medicare and Medicaid, primarily through each site's own interdisciplinary team but also through contractual arrangements with other entities (such as hospital and nursing home care).

The full continuum is readily available in the Portland area, where site visit activities were concentrated. In the rest of the state, which is more rural, access to providers is a more pressing issue. Client-employed providers and home care are the prevalent forms of caregiving in rural areas.

PROGRAM

The site visit began the afternoon of November 13, 2000, with a synopsis of the history and context of Oregon's long-term care system; panelists addressed charac-

teristics of the state's demographics, political climate, and social values and described the development of a commitment to home- and community-based care. Portland-area guests joined site visitors for an evening reception.

The second day opened with an overview of Oregon's Senior and Disabled Services Division (SDDS), which manages long-term care programs in the state. A panel presentation on alternative care settings available to Oregon elders followed. Another panel discussed strategies and partnerships focused on alleviating workforce shortages endemic in much of health care, especially long-term care. One such strategy was highlighted further by representatives of SDDS and the State Board of Nursing, who described Oregon nurses' authority to delegate certain caregiving tasks to laypeople.

The director of the Multnomah County Aging and Disability Services Department (ADSD) spoke briefly about county-level activities, especially the role of AAAs (of which ADSD is one) in providing a single point of entry to the multifaceted long-term care system. ADSD staff then escorted site visitors on small-group visits to various care facilities in the county. Featured were several adult foster care homes for residents with special needs, such as those who are deaf, ventilator-dependent, or non-English-speaking.

The theme of the opening panel on November 15, consumer protection and consumer-directed care, sparked lively discussion, particularly with the long-term care ombudsman. An examination of how different parts of the long-term care continuum fit together was offered by executives of a hospital system involved in numerous segments of that continuum. The morning concluded with consideration of Medicare and Medicaid integration in terms of both funding and care delivery.

Site visitors then traveled to a health plan clinic to participate in a discussion of Medicare managed care in Oregon and to hear about the plan's social HMO program. The integration of medical and custodial needs was pursued during a visit to two PACE sites (one of which, Cully, has a housing component) where site visitors toured facilities and talked with PACE staff.

IMPRESSIONS

Site visitors left with a positive general impression of Oregon's success in making real a concept adopted 20 years ago: providing elders with a viable option to institutional care through the availability of a variety of home- and community-based care settings. Specific impressions may be summarized as follows:

■

Oregon has experimented with a variety of LTC ideas and arrangements, demonstrating a dedication to creative solutions.

State and county officials were enthusiastic about their programs, eager for site visitors to observe as much as possible, and justifiably proud of the ingenuity and commitment to ideals evident in their system.

■

Documentation of system rules and processes is not showcased.

Oregon program managers do not appear to be as data-conscious as the NHPF group that observed them. There is a sense that data collection and analysis is less important than vision. This unsystematic approach might prove difficult in the event of change in key personnel.

■

Different care settings are defined and regulated differently, but the borders between them are not always sharply defined.

For example, what is the difference, other than size and staffing requirements, between a high-care adult foster home and a nursing home? Is adult foster care a means of supplying institutional care more cheaply and with less oversight? Might not the Cully PACE site fairly be described as an uncertified nursing home? Informal culture appears to play a more important role than the formal structures and requirements of the systems.

■

Housing is a significant consideration in arranging LTC.

In part because of jurisdictional splits, this issue tends to be pushed to the background in federal policymaking. However, it is important to note that Oregon's success in addressing the question of housing (through, for example, adult foster care and residential PACE facilities) has allowed it to overcome the barrier that Section 1915 (c) presents in the form of spend-down requirements.

■

Adult foster care plays an important role, providing a home and family life to elders who might otherwise be in nursing homes.

Smaller care settings offer individual attention from familiar caregivers and other benefits that cannot be

readily measured, such as foregone iatrogenic illness. (Or, as one site visitor queried, "How do you price a hug?") Although Romanian workers/families seem to dominate this market niche in Portland, the formal aspects of this model could be replicable in other states as it mirrors small board and care homes that have existed elsewhere.

■

The links between chronic and acute care seem to be made on an individual basis, but the two care systems are very much separate. Bridging the gap between the physician and caregiver communities remains difficult.

A need to engage primary care physicians with caregivers is evident, though the appropriate nexus is not obvious. State officials have identified the integration of chronic and acute care as their next priority.

■

PACE is a program providing services tailored to a small subset of the senior population.

Providence Health System sponsors several ElderPlace PACE sites, which integrate medical and social services for the frail elderly. Institutional and staff dedication to the program is evident, but the limited funding and potentially limited interest in this model of care restricts application to small numbers of elders. Nevertheless, Providence's commitment to a residential component, currently operating at the Cully site and representing a significant departure from the classic On Lok model, may represent a new opportunity.

Consumer Orientation

■

From a management/regulatory standpoint, Oregon's approach is to favor more consumer direction and less regulation, which involves some trade-offs.

There is an obvious tension between regulation and independence. State officials believe enforcement is the least effective way to promote quality.

■

Case managers are widely viewed as key to the success of Oregon's LTC program.

Beneficiaries (or their representatives) contact AAA staff to schedule an in-home assessment by a case manager. The

case managers are able to both provide personalized service at the time of assessment and monitor a beneficiary's changing needs thereafter. Having a case manager gives Medicaid beneficiaries an advantage over private-pay clients in terms of protection. Persons without such an advocate may be better off in a regulated environment such as a nursing home than at home or in less-regulated assisted living.

■
In the reviewing of care options by the manager and the family, the degree to which steering of consumers may occur is unclear.

Are there incentives favoring home- and community-based settings? For example, are case managers encouraged to place individuals in adult foster care when remaining at home might be feasible but more costly or, conversely, when a nursing home might be more appropriate?

■
Elders in the various care setting are encouraged to contact the state ombudsman if they have complaints, although adult foster home settings have been resistant to oversight, according to the ombudsman.

All incoming complaints are reportedly addressed, without any triage mechanism, although it is unclear how they are addressed. The ombudsman tracks the volume of complaints, but the seriousness of the grievance (for example, neglect versus boring food) is difficult to determine. Participants expressed concern that fear of reprisal or ignorance of how to register complaints may reduce the complaints' effectiveness in quality assurance, particularly in adult foster homes where anonymity is problematic.

Quality

■
Care quality is addressed through the facility licensing process, via periodic inspection, and when consumer complaints are received.

Families, adult day care social workers, county licensors and some volunteers are utilized as "eyes and ears" in care settings. County workers say they know when an operator is doing an inadequate job. There appears to be little systematic collection and analysis of quality data across the system. However, state and county licensors seem to have effective informal authority, such as the ability to turn off the flow of new patients to poorly performing providers.

■
Quality assurance is a significant challenge, particularly in home-based settings.

As is the case throughout the health care system, defining and measuring quality is an imperfect process. Researchers frequently use measurements inappropriate to a long-term care context, such as functional improvement. Again, the tension between regulatory and consumer-choice approaches comes into play. Is consumer satisfaction the right quality measure for a consumer-choice model? What is the public obligation to assure safety and quality of care? What are the consequences of doing without some services?

Workforce

■
Attracting and retaining direct caregivers, a problem shared by most states, is one of Oregon's biggest challenges today.

Oregon has implemented a number of strategies, such as training lay caregivers through nurse delegation, but low pay and lack of advancement opportunities are huge deterrents to new workforce entrants. Multnomah County, in particular, has developed proactive strategies to address caregivers' expressed needs for better training, benefits, and ongoing support.

■
Nursing homes seem to be experiencing the most serious workforce crisis, compared with other health care settings.

A recent survey of long-term care facilities in Oregon found that 49 percent of workers turn over in the first 90 days of employment. LTC facilities were experiencing the greatest shortages in certified nursing assistants (48 percent), registered nurses (35 percent), noncertified nursing assistants (32 percent), licensed practicing nurses (20 percent), and certified medical assistants (20 percent).

■
There seems to be a gap in training requirements for nursing home personnel versus AFC operators.

AFC operators are required to have some relevant experience and are given some training, but they are not required to be medically trained even to the level of a certified nursing assistant. In other states, both the nursing society and the nursing home industry would oppose this lenience. Some AFC operators are registered nurses, though, and may be purposefully associated with higher-acuity patients.

Institutional versus Community-Based Care

■
Oregon has taken getting people out of nursing homes as an article of faith.

Oregon's bias against nursing homes raises questions about bed supply for the future. Access to a range of long-term care options is an explicit goal of state leaders. Yet the number of nursing home beds has decreased from 14,778 in 1993 to 13,884 in 2000. Meanwhile, the number of elderly Oregonians continues to increase. Is it possible that the beds available will not meet demand in the future? Supply or budget constraints may hinder patients and their families from truly exercising their choices.

■
The nursing home industry does not seem to be as politically powerful in Oregon as it is in most other states.

It is unclear why the industry is less adversarial. Nonetheless, this factor has contributed to Oregon's widespread acceptance of home and community-based care as an acceptable—indeed preferred—alternative to nursing home care.

Managed Care

■
Portland's Medicare managed care market has maintained an equilibrium.

Portland was one of the first markets to implement a Medicare managed care program, with Kaiser beginning its Medicare HMO in 1978 and all four of Portland's current Medicare risk contractors serving the Medicare population by the late 1980s. The market has fluctuated very little over the past ten years, even after the passage of the Balanced Budget Act of 1997.

■
In response to a low federal payment rate, health plans seemed to have carved up the market in a way in which all HMOs benefit.

While managed care penetration is high, only one Medicare+Choice plan offers drug coverage and none now offer zero premium options. High penetration seems to be tied to a strong managed care orientation in the community, with the majority of Medicare beneficiaries aging into the Medicare+Choice program.

■
State officials acknowledge that Oregon's efforts to better identify and serve dually eligible beneficiaries are still in their infancy.

However, as part of a newly funded Medicare/Medicaid integration project funded by the Robert Wood Johnson Foundation, Oregon plans to establish an integrated database to better profile dual eligibles, develop and implement chronic care intervention strategies, and design and develop new delivery models.

■
Kaiser's Medicare Social Health Maintenance Organization (SHMO) has a good track record of integrating acute and long-term care, but it is really based on an insurance model, not a social services model.

Long-term care services seem to be an add-on to the standard benefit package. Site visitors questioned the wide-scale marketability of such a product.

SELECTED COMMENTS FROM SITE VISITORS

- “If these alternative forms of institutional care [such as adult foster care] work so well, what does that suggest about all of the regulatory standards we impose on other institutions?”
- “Analysts should exercise caution in portraying an overly positive point of view. We only saw their best face; many questions remain.”
- “Let us not forget: there is a system here. Oregon deserves credit for creative solutions.”
- “The Oregon model has enjoyed a long honeymoon. We're so happy that the emphasis is being shifted from nursing homes to home- and community-based care that we haven't evaluated whether it's better or even adequate.”
- “Federal policymakers aren't comfortable with a program that seems to be thriving. Their instinct is that, if problems aren't visible, it means more digging needs to be done.”
- “When I get old, I want to live in Oregon.”

CONCLUSION

Whether Oregon's long-term care model might work in other areas is hard to discern, given that its success is

dependent on a set of interlocking checks and balances that has grown over time. Since Oregon was the first state to get a home- and community-based Medicaid waiver, it has had considerable time to refine its approach. In Oregon today, the number and variety of care arrangements available make it easier for government to weed out bad actors and move recipients to other sites. Other markets with fewer resources or with a history of fraud and abuse might not be able to perform as well without much greater oversight and regulatory intervention.

Agenda

Monday, November 13, 2000

4:00 pm Welcome [*Westin Hotel, Alder Ballroom*]

Judith Miller Jones, *Director*, National Health Policy Forum

LONG-TERM CARE IN OREGON: HISTORY AND CONTEXT

Elizabeth Ann Kutza, Ph.D., *Director*, Institute on Aging, Portland State University

Richard Ladd, former *Director*, Senior and Disabled Services Division, Oregon Department of Human Services

- What are the demographics of Oregon's long-term care population? How is the population distributed among the various care settings, and how has this changed over time?
- What features of Oregon's political and social character have enabled its progressive approach to long-term care?
- How was the home- and community-based Medicaid waiver implemented? What was learned in the process that might be helpful to other states?
- What initiatives has the current administration undertaken to serve the health care and social services needs of Oregon's elders?

5:30 pm Reception [*Westin Hotel, Park Room*]

Tuesday, November 14, 2000

8:00 am Breakfast available [*Alder Ballroom*]

8:30 am MANAGING HOME- AND COMMUNITY-BASED CARE:
SENIOR AND DISABLED SERVICES

Roger Auerbach, *Administrator*, Senior and Disabled Services Division, Oregon Department of Human Services

- How is the Senior and Disabled Services Division currently organized to provide services?
- Who is served by Oregon's long-term care system? What services are provided? How are services delivered? What have been the trends in types of services provided?
- What has been the cost experience by type of service?
- How are the programs funded and how is this funding coordinated?
- What features of Oregon's long-term care system have been critical to its success and viability? What are the key challenges that confront it?
- Which parts of the system are "exportable" to other parts of the country? Which are unique to Oregon?

9:30 am CARE SETTING ALTERNATIVES

James A. Carlson, *Executive Director*, Oregon Health Care Association

Nancy Gorshe, *Senior Vice President*, Community Relations, Assisted Living Concepts, Inc.

Kathy Wiseman, *Licenser*, Aging and Disability Services Department, Multnomah County

Pam Matthews, *Administrator*, HomeCare Network and Evergreen Hospice

- What are the features that distinguish the various care settings? How does each fit into a continuum of care?
- What choices are eligible elders making? What are the trends? Will nursing home occupancy continue to decline?
- What are the regulatory and oversight mechanisms for each of the care setting categories?
- What are the differences among payment methodologies and levels for alternative care arrangements?
- How is a care plan for each elder developed? Who is responsible for seeing that it is carried out?
- Are there major differences between the care settings for elders and those for disabled? If so, what are they?

10:30 am Break

10:45 am STRATEGIES AND PARTNERSHIPS THAT ADDRESS
WORKFORCE SHORTAGES [*Park Room*]

Cindy Hannum, *Assistant Administrator*, Senior and Disabled Services Division, Oregon Department of Human Services

Margaret Murphy Carley, *Deputy Director and Legal Counsel*, Oregon Health Care Association

Mary Shortall, *Deputy Director for Aging Services*, Aging and Disability Services Department, Multnomah County

- What have been the trends in workforce shortages for long-term care workers in Oregon over the past decade?
- Is it more difficult to recruit and retain workers for some care arrangements (for example, in-home care) than for others? How about for certain types of patients (for example, elderly versus disabled)? If so, why?
- What local and statewide strategies have been successful in addressing worker shortages in Oregon? For example, how does the Multnomah County Client-Employed Provider program function, and how has it been received by caregivers?

11:45 am SUPPORTING CONSUMER-DIRECTED CARE THROUGH NURSE DELEGATION

Cindy Hannum (see title above)

Mary Amdall-Thompson, *Program Executive for Professional Services*, Oregon State Board of Nursing

- What is nurse delegation? What determines who delegates what tasks to whom? In what settings? Who is then responsible for the proper execution of tasks?
- What defines the distinction between nursing care and personal care?
- How do nurses feel about delegation? Has this changed over time?

- How does nurse delegation work in support of consumer-directed care?
- How do other states' nurse practice acts compare to Oregon's?

12:45 pm Working lunch

1:00 pm A SINGLE POINT OF ENTRY: THE ROLE OF AREA AGENCIES ON AGING IN THE OREGON SYSTEM

Jim McConnell, *Director*, Aging and Disability Services Department, Multnomah County

- What are the roles and responsibilities of the Area Agencies on Aging (AAAs) in Oregon's long-term care system? How do they relate to SDSD? How does this differ from other states?
- Where do AAAs get their funding and how is it pooled to provide services to the aging?
- How does an elder who needs assistance access the long-term care system? Who helps him or her find resources to match needs? How much influence do counselors have over individuals' decisions?

1:30 pm Bus departure for Multnomah County facilities tour

Jim McConnell (see title above) and Aging and Disability Services Department staff

4:00 pm Tour debriefing [*Westin Hotel, Park Room*]

6:00 pm Bus departure for dinner [*McMenamins' Edgefield*]

Wednesday, November 15, 2000

8:00 am Breakfast available [*Alder Ballroom*]

8:30 am CONSUMER PROTECTION AND DIRECTION

Meredith Cote, *Director*, Oregon Office of the Long-Term Care Ombudsman

Liz McKinney, *Executive Director*, Oregon Trail Chapter, Alzheimer's Association

Janine DeLaunay, *Interim Director*, Oregon Disabilities Commission

- How does the ombudsman program work to assist and protect consumers? How has Oregon's ombudsman program changed over the years?
- Describe the consumer-directed program elements of Oregon's long-term care system. What is the independent choices waiver and how will it affect consumer-directed care in Oregon?
- What happens when the health of an elderly or disabled person living independently deteriorates to the point that he or she is no longer able to make rational decisions or to care properly for him/herself?

9:30 am THE CARE CONTINUUM: HOW THE PIECES FIT TOGETHER

John Lee, *Chief Executive Officer*, Providence Health System

Glenn Rodriguez, M.D., *Regional Medical Director*, Providence Health System

- What is the structure of the Providence Health System? For example, what is the level of integration and range of services provided? What is the breakdown of funding sources (Medicare, Medicaid, private, uncompensated)?

- What environmental factors affect the market for the system's services? Demographics? Location? Economic conditions? Competition? Managed care penetration? State and federal payment policies?
- Describe the system's goals for providing a continuum of care to its elderly patients. How is the system set up to integrate acute and long-term care? To what extent have reductions in reimbursements, new payment methods, and expanded administrative requirements affected providers' ability to ensure continuity of care across settings?
- Which provisions of the Balanced Budget Act of 1997 (BBA) are having, or are likely to have, a positive or negative impact on the system's operations and why? How will the BBA affect the mix of services offered and/or the population being offered services?

10:15 am MEDICARE/MEDICAID INTEGRATION

Doug Stone, *Manager*, Health and Long-Term Care Planning Unit, Senior and Disabled Services Division, Oregon Department of Human Services

Joel Young, *Director*, Health Partnerships, Division of Health, Oregon Department of Human Services

Cindy Klug, *Administrative Director*, Center on Aging Health Services Integration, Providence Health System

John Mullin, *Director*, Clackamas County Social Services

- What has been Oregon's experience with beneficiaries who are eligible for both Medicare and Medicaid?
- What have been the major disconnects in attempts to coordinate the two funding streams and the care provided?
- What is the Oregon Medicare/Medicaid Integration project and what are its objectives?
- What are some possible delivery system models that may help achieve these objectives?

11:00 am Bus departure for Kaiser Permanente

11:30 am MEDICARE+CHOICE: THE UPS AND DOWNS OF MEDICARE MANAGED CARE IN OREGON [*Kaiser Central Interstate Building, Room 2D*]

Mitch Greenlick, *Professor Emeritus*, Department of Public Health and Preventive Medicine, Oregon Health Sciences University

Eugene Scanzera, *Medicare Product Line Manager*, Kaiser Permanente Northwest Region

Annie Mockabee, *Director of Regulatory Affairs*, The Regence Group

Jack A. Friedman, *Executive Director*, Providence Health Plans/Oregon

- Describe the evolution of Medicare managed care in Oregon. What elements spurred growth? What has been the relationship between plans and providers?
- Who are the current players? How have they carved up the market? Has that changed over the years?
- What have been the trends in benefits and premiums?
- What has been the impact of changes at the federal level, especially the new payment methods enacted under the BBA?

12:30 pm Working lunch

THE SOCIAL HMO: KAISER PERMANENTE'S SENIOR ADVANTAGE II

Lucy Nonnenkamp, *Project Director*, Senior Advantage II, Kaiser Permanente

Mitch Greenlick (see title above)

- What are Social HMOs? Who is eligible for enrollment? How does the care management system work?
- How long has the Oregon program been operating? Are there differences between first- and second-generation social HMOs?
- What has been Senior Advantage II's experience in terms of membership, performance, reimbursement, and risk selection?
- How does this experience compare with Kaiser's standard Medicare+Choice product?

1:15 pm Bus departure for Providence ElderPlace sites

2:00 pm Tour of Cully PACE site

2:30 pm INTEGRATED CARE THROUGH THE PACE MODEL:
A DEMONSTRATION BECOMES PERMANENT [*Cully Dining Room*]

Ken Brummel-Smith, M.D., *Medical Director*, Providence ElderPlace

Lynette Neal, *Manager of Quality and Service Development*, Providence ElderPlace

Lynn Hanson, *PACE Coordinator*, Senior and Disabled Services Division,
Oregon Department of Human Services

- What has been the evolution of the PACE sites in Oregon? What lessons have been learned as PACE plans for the future?
- What are the chief advantages of the PACE model? What have been the chief barriers to enrollment?
- How does PACE fit into Oregon's home and community-based services waiver?
- Is PACE a necessary point on the continuum or is it appropriate only for certain populations?
- Now that PACE has been established as a permanent provider type under Medicare, what challenges and opportunities does that status present?

3:30 pm Bus departure for Laurelhurst PACE site

4:00 pm Tour of Laurelhurst PACE site

4:30 pm Bus departure for headquarters hotel

6:00 pm Dinner [*Typhoon*]

Federal Participants

Kathryn G. Allen

Associate Director
Health Financing and Public Health Issues
U.S. General Accounting Office

Jonathan Blum

Program Examiner
Health Division
Office of Management and Budget
Executive Office of the President

Floyd Brown

Director
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Assistant Secretary for Policy and Evaluation
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Office of Senator Smith
U.S. Senate

Janet Forlini

Professional Staff Member
Special Committee on Aging
U.S. Senate

Bruce Greenstein

Health Insurance Specialist
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Senior Research Associate

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Research Associate

Dagny Wolf

Program Coordinator

Biographical Sketches— Speakers and Panelists

Mary Amdall-Thompson has been with the Oregon State Board of Nursing, where she is program executive for professional services, since 1982. She is a member of Advocates for Child Psychiatric Nursing, Sigma Theta Tau, and the Society for Advancement in Nursing. Amdall-Thompson received her M.S. degree in child psychiatric nursing from the University of Maryland, Baltimore, and is licensed by the Oregon State Board of Nursing.

Roger Auerbach, as administrator of the Senior and Disabled Services Division (SDSD) of the Oregon Department of Human Services (DHS), is the chief executive of the state agency that purchases long-term care services for poor and frail seniors and people with disabilities. SDSD also operates adult protective service programs, licenses and monitors long-term care facilities, and contracts with local Area Agencies on Aging to provide an array of community services. Auerbach, who is also assistant director of the DHS, has served as acting director of the Oregon Employment Department and as senior policy advisor to Gov. Barbara Roberts for health, labor, and housing.

Ken Brummel-Smith, M.D., is the medical director for the Providence ElderPlace program. He is also chair of the Providence Center on Aging and professor of Family Medicine at Oregon Health Sciences University. A member of the Primary Care and Research Committees of the National PACE Association and the National Consortium for Chronic Care, Brummel-Smith also serves on the Board of Directors of the American Geriatric Society and is its current president-elect. He is board-certified in family medicine and has a Certificate of Added Qualifications in geriatrics.

Margaret Murphy Carley is deputy director and legal counsel of the Oregon Health Care Association (OHCA), which represents nursing homes, assisted living facilities, and residential care facilities. Before joining OHCA, she worked as a registered nurse at the Georgetown University and University of Virginia hospitals. She also worked at a Washington, D.C., health care law firm and two Portland law firms. Carley has represented health care providers in the areas of Medicare and Medicaid reimbursement, fraud and abuse, certificate of need, licensure, and survey certification. She received her B.S.N. from Duke University in 1980 and J.D. from the University of Virginia in 1986.

James A. Carlson has been executive director of the Oregon Health Care Association and its assisted living and residential care resource, the Oregon Center for Assisted

Living, since 1997. From 1994 to 1997, he served as OHCA's director of government relations. Carlson works closely with both state and federal policymakers and regulators on issues affecting long-term care providers, including regulatory, reimbursement, and service delivery issues. Prior to joining OHCA, Carlson served for eight years as associate director of government affairs for the Oregon Medical Association, where he was actively involved in the drafting, passage, and implementation of the Oregon Health Plan, the state's Medicaid reform project. From 1984 to 1986, he was a legislative assistant to a member of the U.S. House of Representatives. Carlson is a fourth generation Oregonian and a 1982 graduate of the University of Oregon.

Meredith Cote, J.D., has been the director of the Oregon Office of the Long-Term Care Ombudsman (OLTCO), an independent state agency, since August 1989. The OLTCO carries a federal and state mandate to monitor the long-term care system and to investigate and resolve complaints made by or on behalf of residents of long-term care facilities. Prior to becoming the Oregon ombudsman, Cote served as the New Mexico State Long-Term Care Ombudsman. She began her career in 1979 with the AARP in Washington, D.C., first as an analyst and later as a legislative representative analyzing and lobbying quality issues in health and long-term care. She earned her J.D. at Syracuse University College of Law and holds a B.A. from the University of New Hampshire.

Janine DeLaunay, currently interim director for the Oregon Disabilities Commission, has worked for 20 years as an advocate for persons with disabilities. Through personal experience as a recipient of disability services, she knows firsthand the essential role that consumer choice, empowerment, and advocacy play in securing the services and supports to achieve an independent, productive life. Since 1990 Ms. DeLaunay has served as executive director of the Portland Center for Independent Living and as disability advocacy coordinator for the Senior and Disabled Services Division of the Oregon Department of Human Services. She is a past chair of the state Independent Living Council.

As executive director for Providence Health Plans in Oregon, **Jack A. Friedman** is responsible for strategic directions, management, and operations for a 320,000-member HMO and a 400,000-member PPO. After receiving his Ph.D. in anthropology from Rutgers University,

Friedman worked as a reporter for the *Business Journal*, covering health-related issues. He was then employed by Frank B. Hall Consulting Company as an employee benefits consultant. He served as executive director of the Greater Portland Business Group on Health, a multi-employer coalition. Friedman was hired as executive director of Sisters of Providence Vantage PPO and became chief development officer when Vantage PPO and Good Health Plan HMO merged in 1986 to form Sisters of Providence Health Plans. He accepted his current position in 1994.

Nancy Gorshe is currently senior vice president of community relations for Assisted Living Concepts, Inc., where she manages human relations, marketing, policy and regulations, quality improvement, and training. Previously, she was president of Franciscan ElderCare and vice president of continuum of care with Catholic Health Initiatives. She has been involved with programs for the elderly since 1975, serving as executive director of Providence ElderPlace, the first On-Lok replication site, and as assistant executive director for the National Association of Area Agencies on Aging in Washington D.C. She has extensive experience as a planner with AAAs and has held executive positions in home health care, adult day health, and hospitals. Gorshe received her bachelor of arts degree from Washington State University and her master's in social work administration and business administration from the University of Washington.

Mitch Greenlick is professor emeritus in the Department of Public Health and Preventive Medicine at Oregon Health Sciences University and director of the Oregon Health Policy Institute. He formerly served as director of the Kaiser Permanente Center for Health Research and vice president (research) of Kaiser Foundation Hospitals. Greenlick was a co-principal investigator for the Medicare prospective payment demonstration project. The principal investigator of Kaiser's Social HMO program, Senior Advantage II, Greenlick is currently a candidate for the Oregon House of Representatives.

Cindy Hannum is the assistant administrator of the Oregon Senior and Disabled Services Division, overseeing long-term care quality programs, including nursing facility, community-based care, and in-home care standards and programs. She supervises nursing facility survey and certification, state licensing for all community-based care facilities, such as adult foster homes and assisted living, and provider standards for all Medicaid nursing facility and community-based care programs. Hannum has 25 years' experience in social service and long-term care programs, having begun her career in 1974 as a case manager for the state of Oregon.

Lynn Hanson is PACE coordinator for Oregon's Senior and Disabled Services Division. Previously, she was the

Oregon Health Plan and government programs coordinator for Kaiser Permanente. Hanson has also been a private nursing home consultant.

Cindy Klug is administrative director, Center on Aging, Health Services Integration for Providence Health System. In this capacity, she conducts program development for older adult services, with special emphasis on education, and research. Recent research activities include the Millenium study, which reviewed the care and cost experiences of dual eligibles, and a study examining risk screening of Medicare managed care enrollees. Ms. Klug has been a health educator for over 20 years, developing a range of programs from older adult wellness to hospital services to services in senior housing. She holds a master's in science in teaching degree from Portland State University and she is a certified health education specialist.

Elizabeth Ann Kutza, Ph.D., is director of the Institute on Aging, Portland State University, a post she has held since 1987. She is also co-director of the Oregon Geriatric Education Center and a professor in the university's School of Urban and Public Affairs. Before coming to Oregon, Kutza served for ten years on the faculty of the University of Chicago. Her special interest is in the field of federal aging policy. Author of *The Benefits of Old Age: Social Welfare Policy for the Elderly*, Kutza also has written widely in the area of long-term care and community-based aging services. As a Robert Wood Johnson Health Policy Fellow, she spent a year as a professional staff member of the Senate Finance Committee in Washington, D.C. Kutza was recently chosen as chair-elect of one of the four sections of the Gerontological Society of America and is on the Editorial Board of *Generations*, the journal of the American Society of Aging.

Richard Ladd is president of Ladd and Associates, a health and social services consulting firm specializing in long-term care. From 1994 to 1998, he served on the faculties of both the School of Internal Medicine and the School of Public Affairs of the University of Texas. Appointment as commissioner of the Texas Health and Human Services Commission took him to Texas in 1992. Ladd had previously served as administrator of the Oregon Senior and Disabled Services Division from 1981 to 1992, where he directed implementation of the country's first Section 1915 (c) and only Section 1914 (d) home- and community-based Medicaid waivers. Ladd holds B.A. and Ed.M. degrees from Oregon State University.

Pam Matthews is administrator of HomeCare Network and Evergreen Hospice, a nonprofit, hospital-based, Medicare-certified and JCAHO-accredited agency providing skilled home health and hospice services. Previously, she was a manager with Kaiser Permanente Home Health Agency/Hospice in Portland. Earlier experience included staff

positions in home health, hospice, community health rehabilitation, and school nursing. Matthews is a member of the board of directors of the National Association for Home Care and chairs the regulatory and legislative affairs committee of the Oregon Association for Home Care. She received her B.S.N. and her R.N. certification at the University of North Carolina.

Jim McConnell is director of the Multnomah County Aging and Disability Services Department, which is the Area Agency on Aging serving the metropolitan area of Portland. He has served as director for 18 years. Since 1997 the department has also provided programs and services to younger persons with disabilities. Prior to working for Multnomah County, McConnell spent a year in the Region X office of the Federal Community Services Administration and from 1973 to 1980 was executive director of PACT, Inc., a nonprofit community action program in Portland. He is a graduate of All Hallows College, Dublin, Ireland.

Liz McKinney is a community health educator with 18 years of experience in developing programs for individuals, families, and professionals dealing with chronic illness. Since 1991 she has served as executive director of the Alzheimer's Association, Oregon Trail Chapter, guiding the organization through a period of tremendous growth and change. Her knowledge of nonprofit management and her speaking and training skills have brought her to the table for a wide range of discussions, from infrastructure issues to state and federal policy. Her work brings her into frequent dialogue with state licensors and regulators as Oregon's systems and services respond to the needs of individuals with dementia.

As director of regulatory affairs for the Regence Group, **Annie Mockabee** is responsible for oversight of implementation of federal regulations and mandates for Regence BlueCross BlueShield of Oregon, Regence BlueShield of Washington, Regence BlueShield of Idaho, and Regence BlueCross BlueShield of Utah. Prior experience includes ten years with Regence BlueCross BlueShield of Oregon as assistant vice president of government programs. In this capacity she had responsibility for Medicare+Choice, Medicare Cost, and Medicaid programs. She was actively involved with the State of Oregon in the design, legislative strategy, and implementation of the Oregon Health Plan and was appointed by the governor to the state's Medicaid Advisory Committee, where she served for six years. Mockabee's career in the health care industry was preceded by ten years as a legislative advocate for juvenile justice system reforms and human service program development.

John Mullin has been director since 1984 of Clackamas County Social Services, a multipurpose organization providing services and opportunities for the elderly, people

with disabilities, and low-income individuals and families. He has 25 years' experience in human services.

Lynette Neal is manager of quality and service development, the internal technical assistance team for the five ElderPlace sites comprising the Providence Health System's PACE program. She is responsible for overseeing quality initiatives, regulatory compliance, participant care planning, reporting and information systems, utilization review and documentation standards, and staff development and training. Neal, who previously served as manager of one of the PACE sites, also has experience as a marketing representative.

Lucy Nonnenkamp is project director for the Kaiser Permanente Northwest's (KPNW) Social HMO site, locally marketed as Senior Advantage II. She co-chairs KPNW's Senior and Disabled Care Committee and participates in the KPNW's Medicare oversight and planning functions. She coordinated the 1996 Kaiser Permanente Interregional Geriatric Institute. Nonnenkamp joined the Social HMO team in 1983 to write the in-home support benefit and case management component of the demonstration. She developed and supervised the expanded care department, which has oversight for the home and community-based long-term care benefit, until 1990. Before being named to her current position, she was project administrator for Senior Advantage II.

Eugene Scanzera is the Medicare Product Line Manager for Kaiser Permanente Northwest (KPNW) and is responsible for managing all aspects of the region's Medicare portfolio. This includes strategic planning for Senior Advantage and Senior Advantage II (KPNW M+C plan and SHMO demonstration project, respectively) and coordinating the operational activities of the programs. Before joining Kaiser Permanente a year ago, Mr. Scanzera was with the Blue Cross and Blue Shield Association in Chicago. Earlier, Mr. Scanzera served as professional staff for health issues with the Senate Special Committee on Aging, where he drafted the original legislation enabling Medicare risk contracting with HMOs, the precursor to Medicare+Choice. He was also a staffer on the Social Security Advisory Council and served as a presidential management intern with the Health Care Financing Administration. Eugene Scanzera has master's degrees in Health Services Administration from the University of Arizona and in Social Work from the University of Alabama. He received his undergraduate degree from the University of Miami.

Mary Shortall is deputy for aging services at Multnomah County Aging and Disability Services, which provides elders with access to financial support, health care, long-term care, and protective and legal services. Before moving to Oregon, Shortall headed the Minnesota Rehabilitation

Services Division. She has worked as a medical social worker and a rehabilitation counselor, holds a masters' degree in rehabilitation and counseling and a bachelors' degree in social work and psychology, and has completed all but her thesis for a masters' degree in public administration. She was a fellow in the George Washington University Education Policy Fellowship Program, the Hubert Humphrey Reflective Leadership Program, and the Executive Leadership Program at the University of Oklahoma. In addition to her work and training, Shortall has served in many community leadership roles. She was appointed by the Ramsey County Board to lead a citizen task force to close a large residential care facility and develop a community-based model of care for persons with mental health problems. She also led a countywide effort to combine the public health services at the city and county levels.

Doug Stone is the manager of the Health and Long-Term Care Planning Unit for the Senior and Disabled Services Division. In this capacity, he is responsible for the development of Oregon's approach to the integration of acute and long-term care. Stone also works on an initiative to find ways to help persons with disabilities find and maintain employment. He has a bachelor's degree in political science from Oregon State University and has done graduate work in public administration at the University of Utah.

Kathy Wiseman, a program development specialist and licenser for Multnomah County, is currently one of four staff who license and monitor the 600 adult care homes in the county. During her eight years in this position, she has developed forms and procedures related to quality of care and licensing. Earlier, she was involved in the development and implementation of the state's original community-based assisted living program. Wiseman is a past board member of the Oregon Gerontological Association. She is a graduate of Portland State University with a B.A. in psychology.

Joel Young directs the Office of Health Partnerships for the Oregon Health Division, providing health policy leadership particularly regarding access to primary care, the safety net system, and health insurance coverage. Earlier, he worked for the state Medicaid agency for 12 years, most recently as manager of the Program and Policy Section. He managed Oregon's Physician Care Organization Program, which predated the fully capitated system and provided a model for the Oregon Health Plan. Mr. Young served as a member of the planning team for the development and implementation of Oregon's 1115 waiver. He holds a master's degree in international administration from the School for International Training in Vermont.



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