PROVIDENCE
Health & Services

Hospital Capacity, Throughput, & Length of Stay

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Providence - Oregon

8 HOSPITALS (incl. 2 critical access hospitals)

90+ CLINICS

1 HEALTH PLAN (625K+ members)

1.5K ACUTE CARE BEDS

2.2M PRIMARY CARE VISITS

3 SUPPORTIVE HOUSING FACILITIES

56K ADMISSIONS

23K CAREGIVERS

$315M COMMUNITY BENEFIT

25K SURGERIES AND PROCEDURES

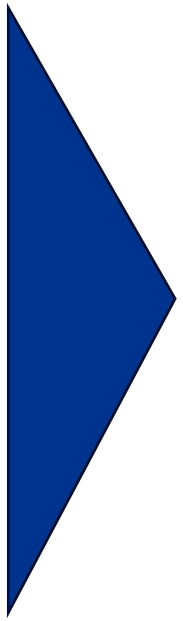
1.3K EMPLOYED PROVIDERS

$50M FOUNDATION CONTRIBUTIONS

Discussion outline

The Problem

Analysis & Findings



Recommendations

Based on the information presented, we will recommend the task force focus our work on the following:

1. Process improvement
2. Coordination and escalation
3. Investment and reimbursement
4. Other opportunities

The Problem

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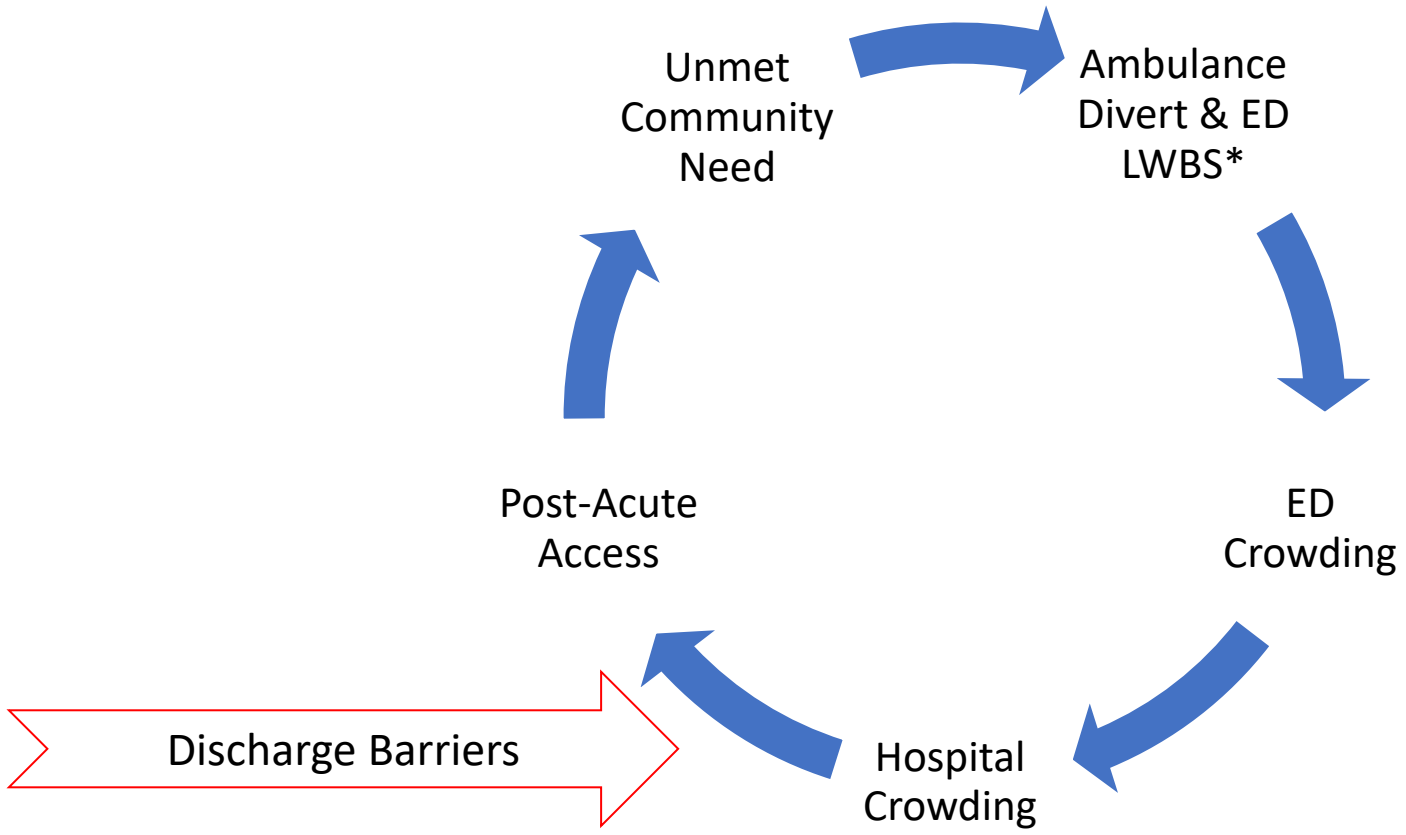
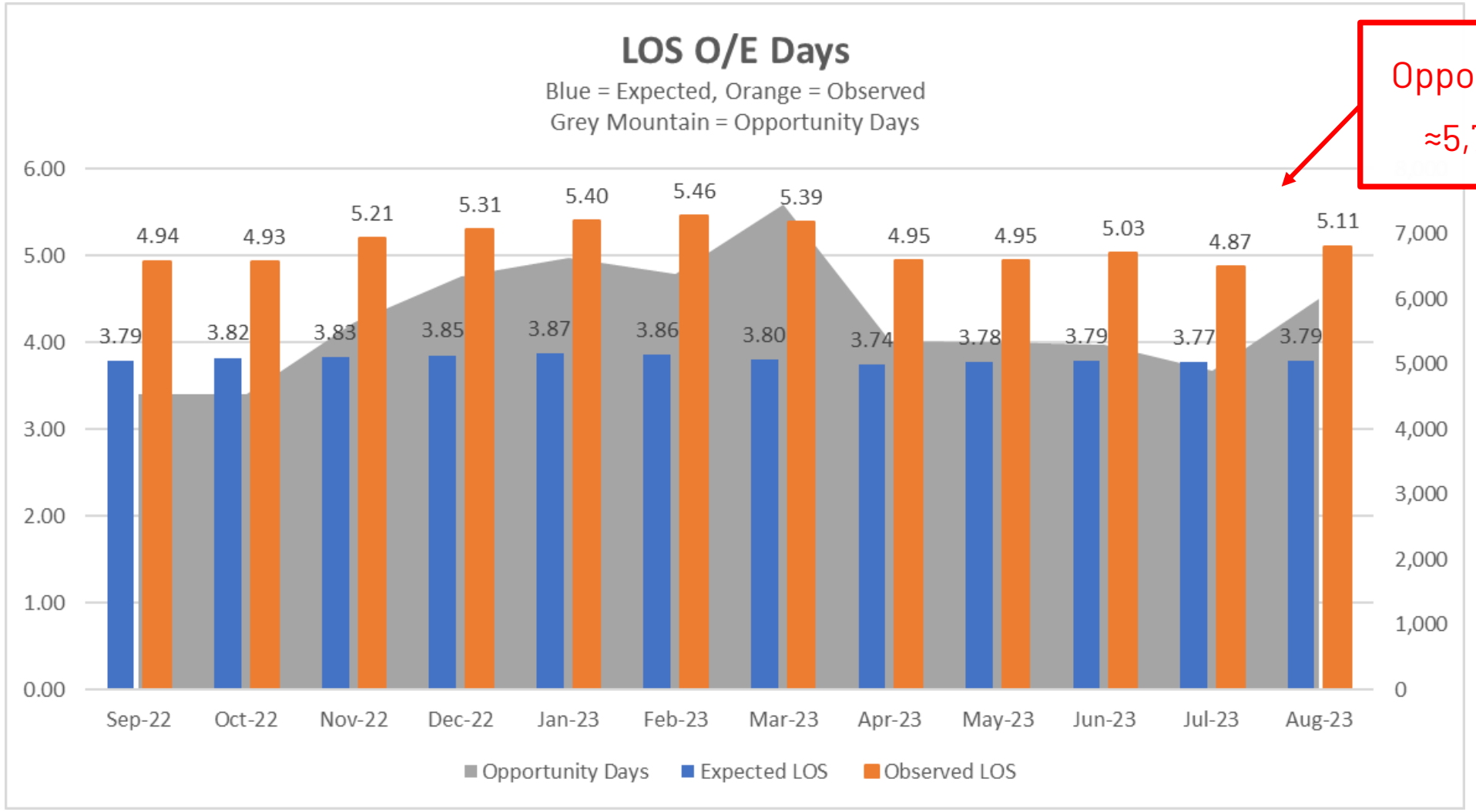
Interdependence of the health care continuum



Oregon Opportunity Days – "Grey Mountain"

Providence, Oregon - September 2022 – August 2023



Opportunity Days:
≈5,700/Month

How many more Oregonians could we care for?

Across Providence Oregon

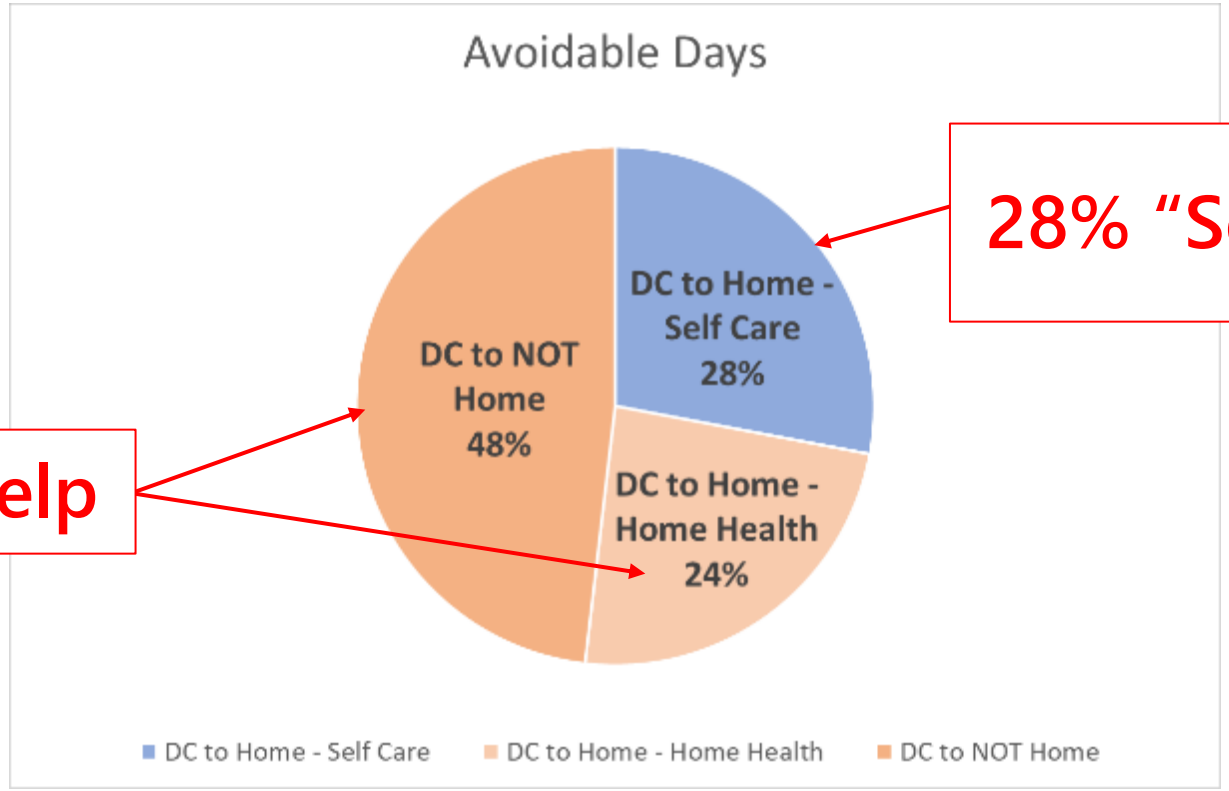
- ≈ 5,700 “Extra” Patient Days/Month

How many more patients could we take care of?

- 1,140 “Extra” Individual Patients/Month*
- 37 extra Patients/Day Across Providence Oregon

* Assuming 5-day LOS

Continuum of care needs to reflect community need



28% "Self Care"

72% Need Help

Data & Findings

Multiple data sources

To verify assumptions, we analyzed several data sets

Retrospective Data

(Providence & OHSU)

Real-time Data Snapshot

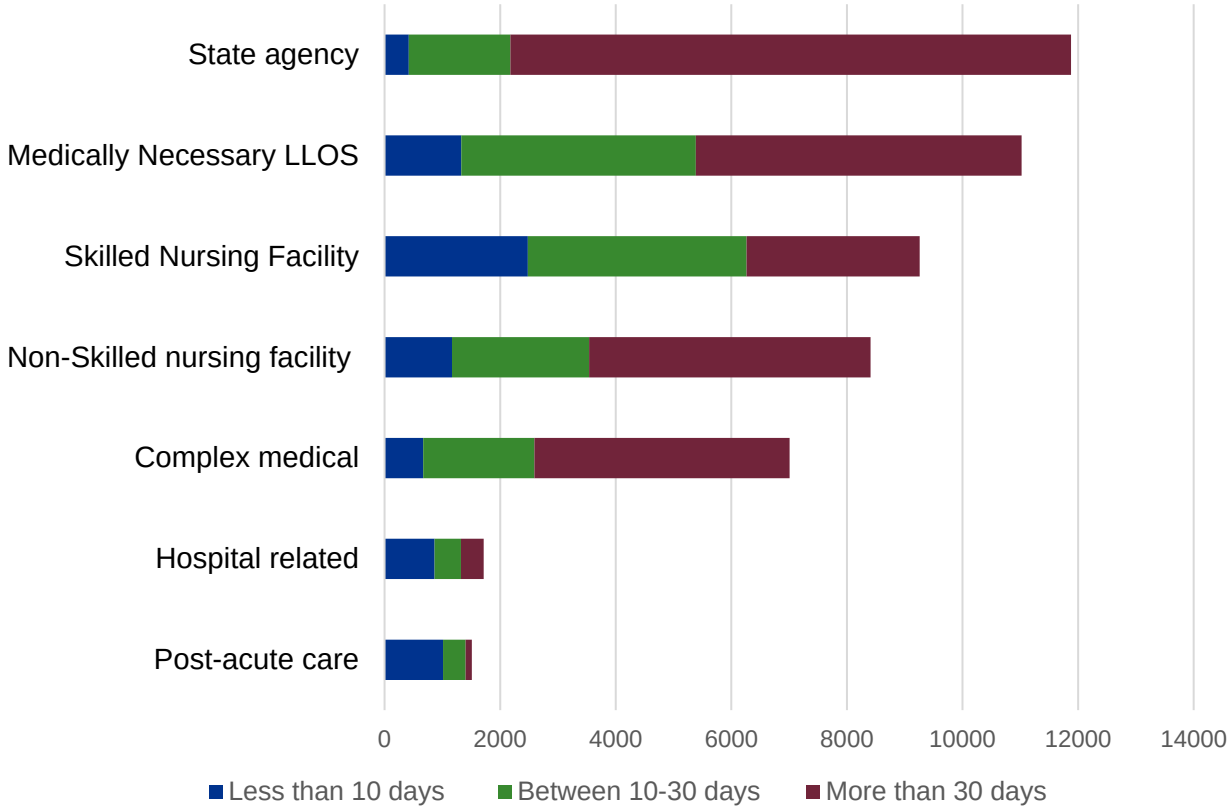
(Prov. St. Vincent, Nov. – Dec. 2022)

Statewide

Case Studies

Retrospective data (2022-2023)

Reason for discharge delay*

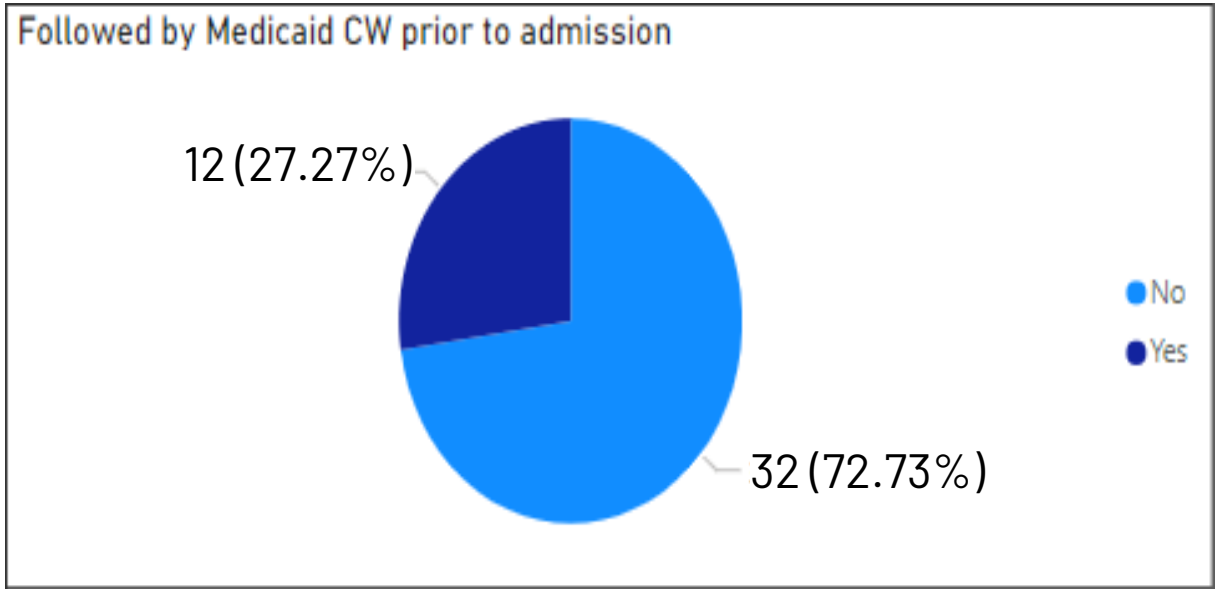


State agency delay	Waiting for Medicaid daily rate/assessment/exemption; Challenge finding provider for current rate; Developmental disability; Adult/Child protective
Medically Necessary LLOS	Patient appropriate for hospital-level of care
SNF delay	SNF Refusal - Bed Not Available/DC Plan of Concern; SNF Refusal - No Accepting Facility; SNF Refusal - Refusing to Accept Patient Back
Non-SNF delay	Non-SNF Refusal - Bed Not Available/DC Plan of Concern; Non-SNF Refusal - No Accepting Facility; Non-SNF Refusal - Refusing to Accept Patient Back
Complex medical delay	Patient needs rates higher than base rate - Antipsychotic medication; Bariatric; Delay DME; Dialysis, RX Costs; Significant wound care; Trach/vent
Hospital related delay	Delay in service – OR/MD/Equipment; Outpatient services, PPT/OT/ST; Radiology/imaging; Weekend delay
Post-acute care delay	Home health not available, hospice not available, transfer back delay, transportation, weekend delay

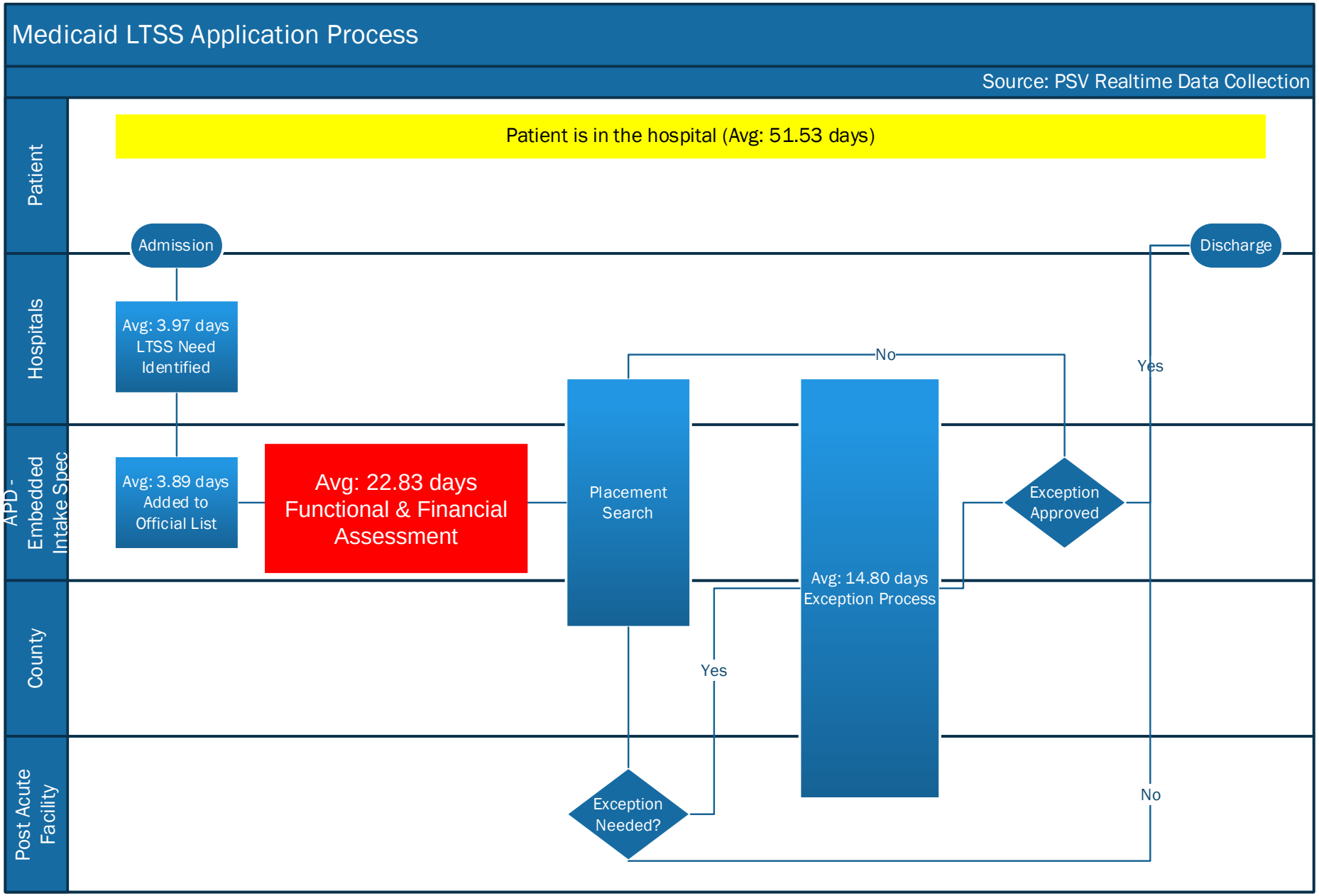
*2022 and 2023 (through Sept.)

Real-time data snapshot (PSVMC)

- **Data collection period:** Nov. 14 to Dec. 31, 2022
- **Location:** Providence St. Vincent Hospital
- **Target Group:** Patients currently on Medicaid or are Medicaid eligible
- **Number of patients:** 43 total, 32 patients were new to Medicaid



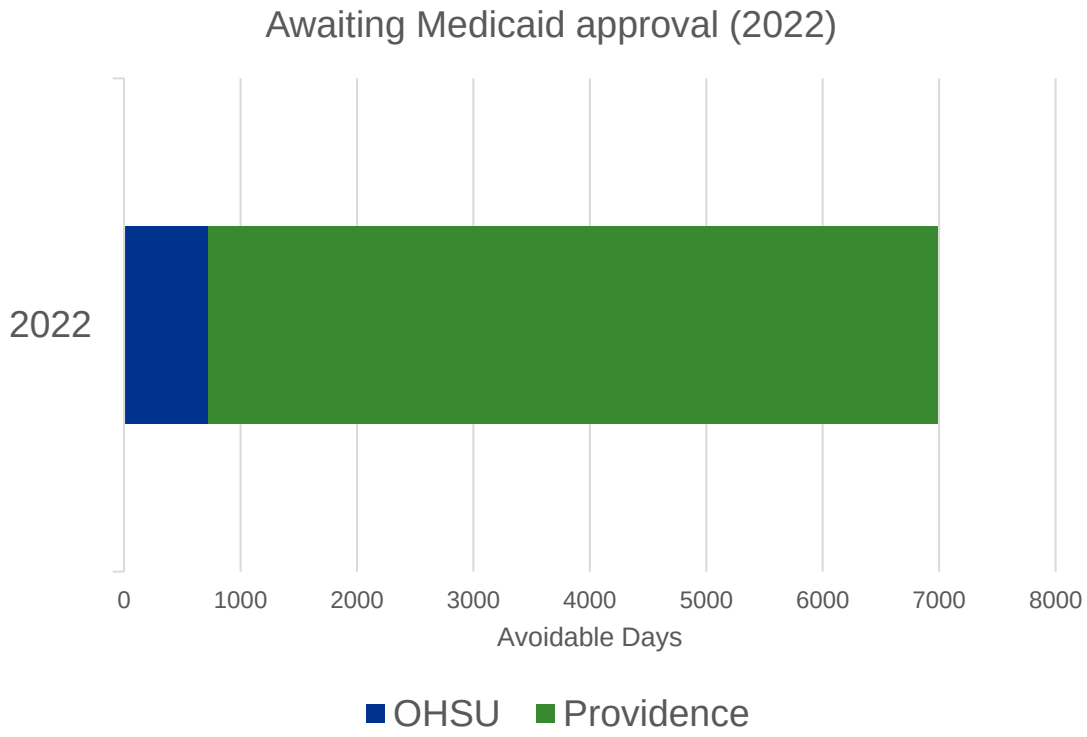
Process barriers: Medicaid assessment



Process barriers: Medicaid assessment

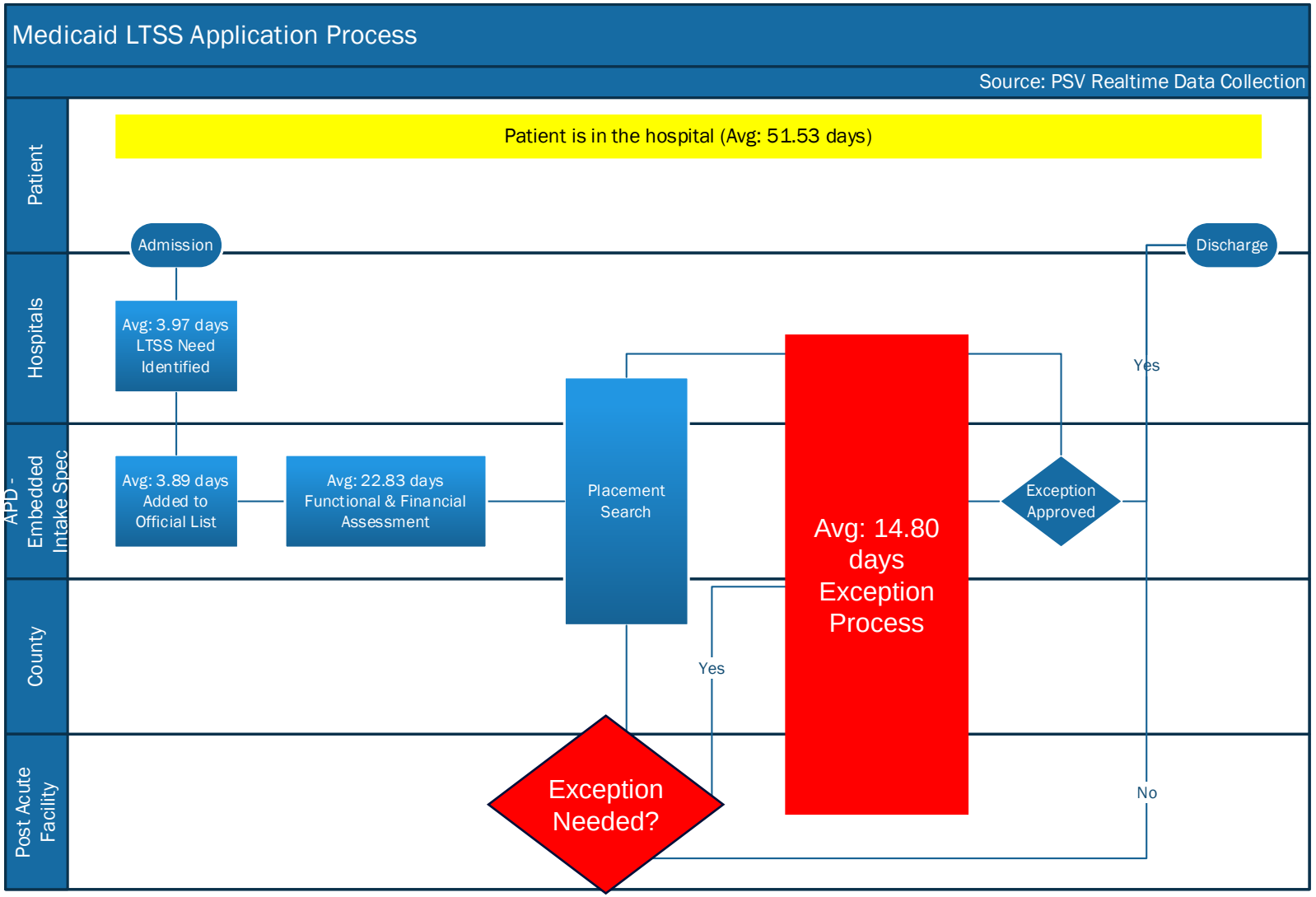
Functional and financial assessments

45+ days to process and approve long term care Medicaid funding for patients needing financial support



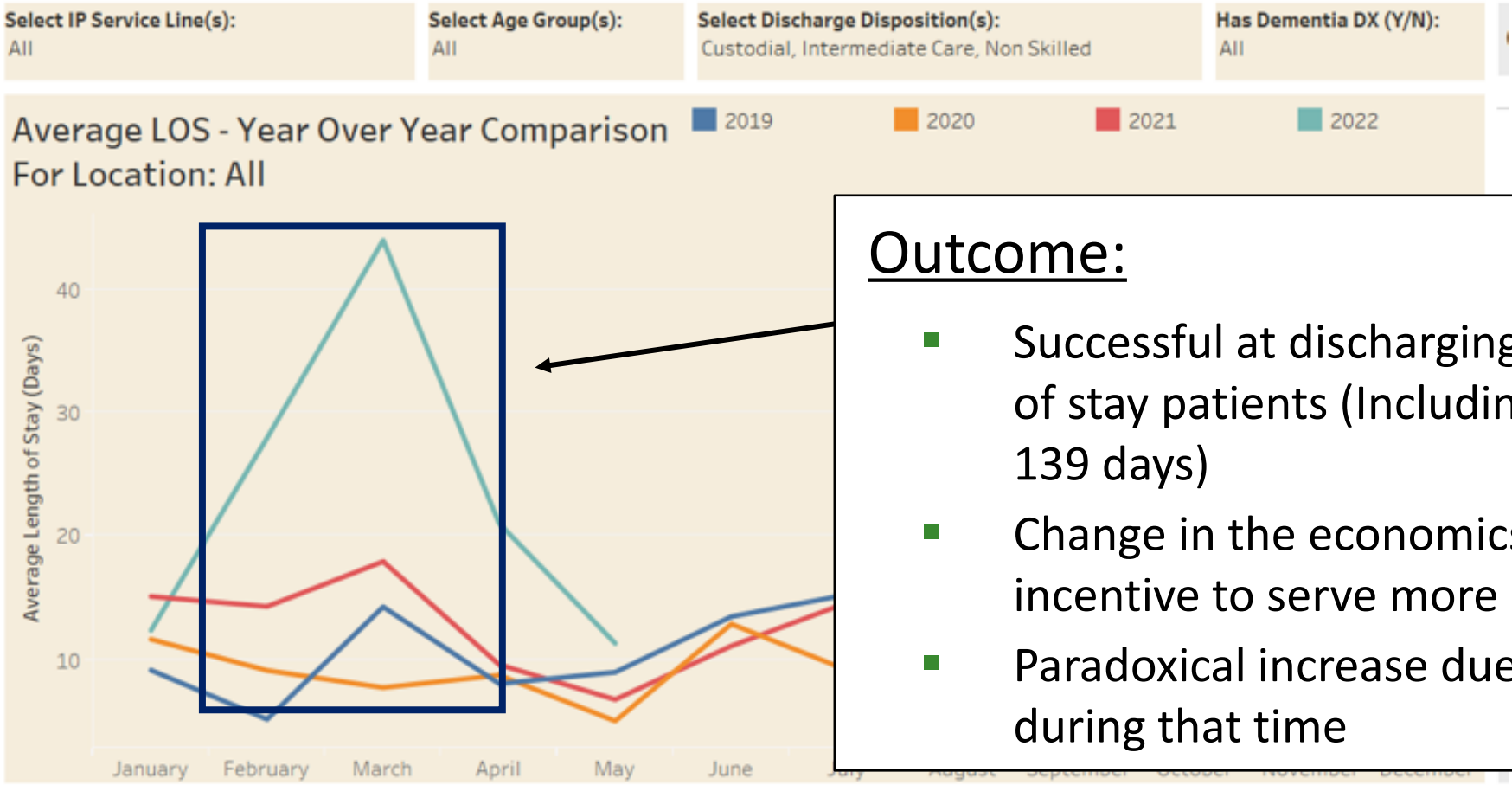
Economic barriers: Exception rate

If an exception is requested, the average time in the hospital is 93 days.



Economic barriers: Exception rate

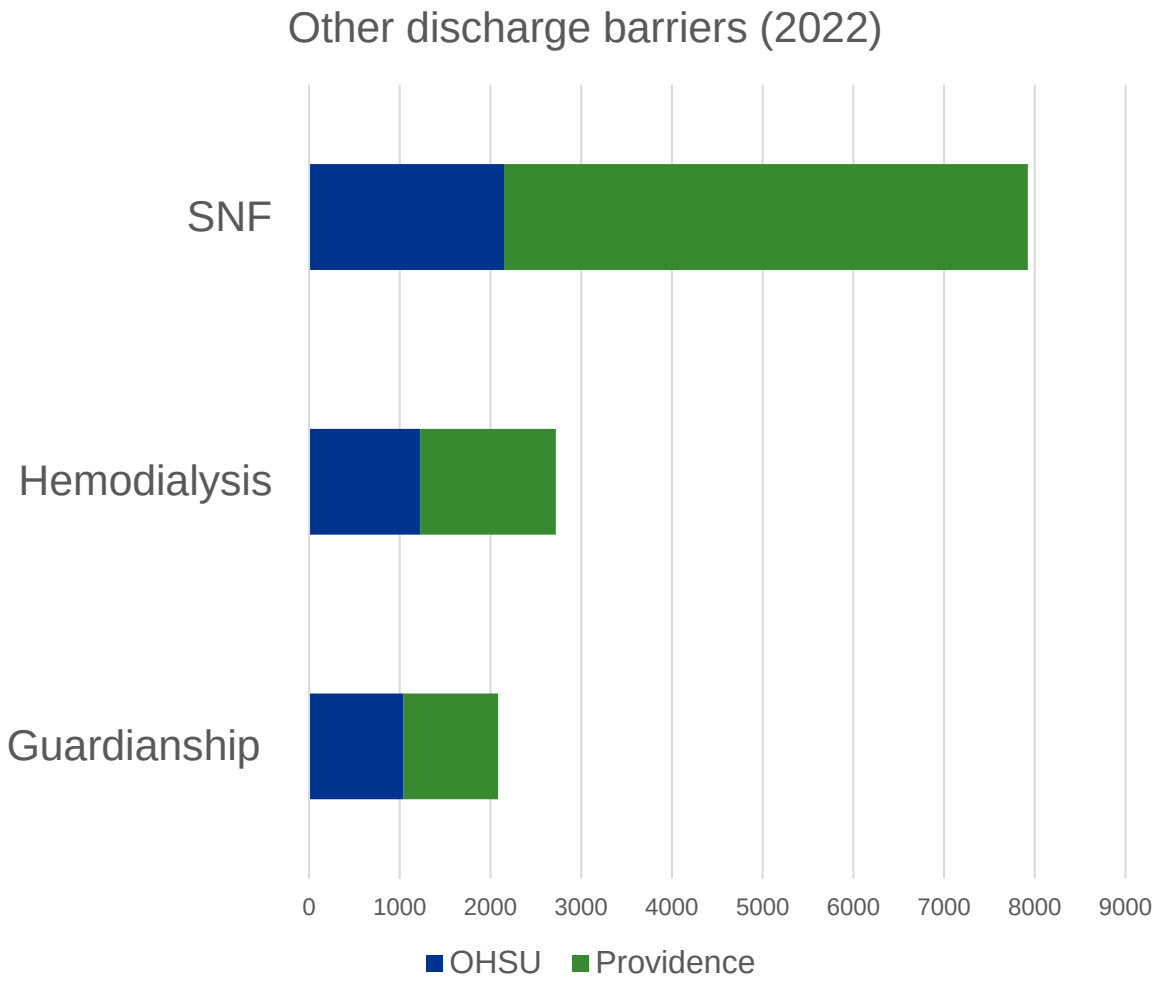
Case study: Adult Foster Home - Hospital Decompression Initiative (1/22-3/22)



Outcome:

- Successful at discharging very long length of stay patients (Including 298, 173, and 139 days)
- Change in the economics, created incentive to serve more patients
- Paradoxical increase due to cases accruing during that time

Other significant discharge barriers



- **SNF access can be difficult to obtain for several reasons:** Discharge Plan of Concern; No Accepting Facility; Refusing to Accept Patient Back; Medicaid, medically complex, needed 20+ days
- **Shortage of Hemodialysis:** Patients with chronic kidney disease present to ED and must be admitted to hospitals to manage their usually outpatient care.
- **Lack of Public Guardians:** If a patient lacks capacity (with no family/friends), the patient remains in the hospital rather than moving to a more appropriate care setting.

Recommendations for discussion

Process Improvement: Recommendations

Reduce time from hospital request to agency approval for Medicaid eligibility assessments (functional and financial)

- Develop a LTC presumptive eligibility process, mirroring existing Medicaid model
- Fast track agency approval for individuals being discharged to hospice
- Improve APD/county case worker process: Standardize hospital requirements/data sharing and consistently train case workers and care managers

Coordination and Escalation: Recommendations

Improve care coordination for patients with complex needs

- Implement a standard escalation pathway for stuck patients with accountability and timelines case (consider specific criteria around acuity, behavioral health, houseless)
- Create mechanisms for hospitals to partner more closely with post-acute care settings through the transition of a complex patient
- Standardize evaluation and admission criteria to post-acute care settings
- Identify regulatory/licensing barriers to acceptance of certain patients

Investment and Reimbursement: Recommendations

Consider reimbursement changes and investments to ensure post-acute access for high acuity patients

- Develop consistent, streamlined process for securing exemption rates
- Complete a rate review process and recommend sustainable rate increases (considerations may include acuity, behavioral health, houseless)
- Medicaid coverage - evaluate CCO SNF benefit which is currently limited to 20-days

Other opportunities

Systems or support needed to move patients to the appropriate setting more efficiently

- Information/communication: Can hospitals provide more details or information to support decisions about patient acceptance?
- Reimbursement needed: What financial assurances are needed to make settings more confident about accepting patients?
- Post-acute barriers to patient discharge: Are there specific discharge challenges that are needed to improve throughput? (example - SNF to home health)