Memorandum

PREPARED FOR: Joint Task Force on Hospital Discharge Challenges
DATE: October 10, 2023
BY: LPRO Staff
RE: Summary of Needs Assessment Responses

LPRO
LEGISLATIVE POLICY AND RESEARCH OFFICE

The Joint Task Force on Hospital Discharge Challenges (Task Force) was established by House Bill 3396 (2023) to develop recommendations to the Legislative Assembly. To begin its work, the Task Force participated in a needs assessment. This document summarizes responses collected from members. LPRO is providing this information as reported by members and has not verified the contents of this document against external information sources.

Contents:

Part I. Vision

Members were asked to identify challenges for the Task Force to address and how success might look. This section is a summary of these perspectives; individual members may not support every idea expressed.

Challenges To Be Addressed

Members described challenges facing patients, hospitals, agency workers, and post-acute care providers; as well as the need to understand the entire system of admission, hospital stay, discharge, post-acute care, and readmission. Many complicating factors were noted, including a lack of shared definitions. The Task Force will need to prioritize key problems to address, including:

- **Delays in discharge.** At hospitals, challenges include wait times in emergency rooms, a shortage of beds for people who need them, and census levels that are unmanageable for staff. This contributes to staffing challenges and burnout and creates financial challenges.
- **Screening and referral**. Rules and regulations are not responsive to the needs of medically and behaviorally complex patients. Providers and staff navigate the requirements and limitations of different payers. More resources for guardianship are needed, particularly for elderly patients who need memory care.

- **Care for complex needs**. Patients need specialized care, including care for behavioral health needs and care that is accessible to patients who are chronically homeless.
- **Misaligned incentives**. Reimbursement models should provide adequate funding for facilities and staff to serve individuals with chronic health issues, behavioral health needs, developmental disabilities, and/or history of homelessness.

What Success Looks Like

Members described the need to consider both short- and long-term solutions. Short-term administrative changes could include streamlining processes for placement and care coordination. Long-term solutions could include federal partnership. Because hospital discharge is a long-term issue, solutions will need to be sustainable and adaptive over time. The Task Force should avoid "passing the buck" by delegating challenges to another group without providing direction on needed changes.

For members, success includes:

- **Patient-centered solutions**. People with complex medical and behavioral health needs require professional, trauma-informed care. Patients who are chronically homeless require specific supports in short- and long-term placements, including private rooms in facilities with small bed counts, on-site mental health care, and access to substance use treatment. Solutions may look different for patients in different parts of Oregon.
- **Reducing delays and improving the flow of patients.** This may include protocols for coordination between hospitals, counties, agencies, and post-acute care settings. It may include specialized services in long term care settings to meet the diverse needs of patients, with reimbursements that match acuity.
- **Resources for staff and training.** Solutions require more health care workers across sectors with enhanced education and ongoing training.

Members noted that the Task Force's recommendations should include specific, measurable outcomes. They should address concrete issues and be actionable within a clear time frame. Members identified potential metrics to measure improvement in the hospital discharge system, including:

- data from hospitals to show delays;
- wait times for eligibility determinations and assessment;
- availability of post-acute care beds;
- beds for behaviorally complex patients; and
- utilization of home- and community-based services by people discharged from hospitals.

Part II. Needs and Opportunities

Members were asked to share initial thoughts about needs and opportunities in six policy areas:

1) nursing training, education, licensure and certification;
2) improving discharge from acute to post-acute care;
3) increasing community-based placements for post-acute care;
4) innovative care and payment models;
5) coverage and reimbursement; and
6) federal partnership opportunities.

The subsequent sections summarize member input in these areas.

2.A) Nurse training, education, licensure, and certification

Members shared initial ideas related to *"streamlining and reducing barriers to training, education, licensure and certification for all classifications of nurses and nursing assistants for work in post-acute care settings while maintaining the quality of the workforce."*

Members raised questions about how the group should scope this conversation, noting other groups such as Future Ready Oregon are also doing work in this area. One member suggested the Task Force focus on administrative processes for this reason. Another member noted legislative committees on health care will look to the task force's recommendations when taking up workforce issues in 2024.

Members identified needs and policy opportunities across several nursing topics:

1) recruiting existing care providers from outside Oregon;
2) developing new care providers in Oregon;
3) licensure and certification changes; and
4) continuing education for existing care providers.

Recruiting existing care providers from outside Oregon

Members identified two policy concepts related to recruiting existing care providers from outside Oregon. First, five members wished to explore joining the Nurse Licensure Compact, and one member suggested individual reciprocity agreements with neighboring states. One member noted this would not increase the overall size of the nursing workforce but may address short-term staffing needs and facilitate telehealth.

Two members also wanted to identify opportunities to expedite licensing for credentialed professionals from other nations. One member noted there is a wait list for Oregon's two "re-entry" programs for foreign-educated nurses to obtain licensure.

Developing new care providers in Oregon

Members identified several opportunities to promote development of new care providers in Oregon described in Table 1 below.

Table 1. Needs and Opportunities to Develop New Care Providers

Needs	Opportunities
Support for prospective health care students	• Shadowing opportunities for high school students to learn about career opportunities in health care. • K-12 mentorship programs for aspiring health professionals. • Incentives to recruit nursing students.
Supporting and reducing barriers for current health care students	• Educational resources to help high school and post-secondary students navigate health care program prerequisites and admission processes. • Holistic admissions practices for health care students. • Student loan repayment for nurses employed in post-acute care. • Racially and ethnically concordant mentoring to health care students. • Grants, scholarships, and stipends for health care students from diverse backgrounds. • Wraparound supports for CNA students.
Support for nursing faculty	• Investments to increase nursing faculty in community colleges and other higher educational programs. • Incentives to become a nursing educator. • Address wage differences between nurses who are faculty and who practice in other settings.
Education programs	• Investments to expand class sizes. • Raise limits on the number of students per instructor. • Create additional career pathways into health care. • Evaluate whether SB 523 (2023), allowing community colleges to offer Bachelor of Science in Nursing (BSN) degrees, is increasing the workforce. • Public-private partnerships to provide initial and ongoing training for CNAs to work in post-acute care. • Hospital – Skilled Nursing Facility (SNF) partnership on developing nursing education.
Clinical rotations and placements for health care students	• Address shortages in clinical rotations for nursing students and ensure adequate clinical placements for students in post-acute care settings. • Create a centralized system for clinical placements for nursing students. • Discuss Oregon Health Authority's in-progress review of administrative rule requirements relating to students in clinical placements (anticipated in late 2023).

Needs	Opportunities
	• Extend policy changes related to clinical placements and labor management trusts from the 2023 session.

Source: Legislative Policy and Research Office

Licensure and certification changes

Members identified needs and opportunities related to nursing licensure and certification.

- **Licensure processing.** Three members identified the need to shorten the processing time for licensure applications. Suggestions included increasing staffing at the Oregon State Board of Nursing (in addition to two positions recently added); evaluating the cause of delays in licensure processing; and offering an expedited process or giving priority review to care providers already licensed in other states.
- **Background checks.** Two members also identified opportunities to address delays in background checks including exploring transitioning to Federal Bureau of Investigations Rap Back system and assessing the source of delays in processing times.
- **Licensure requirements.** Three members addressed requirements for licensure or certification in nursing professions. Suggestions included the need to shorten the timeline to licensure while retaining quality of training, pursuing cooperative licensing and a teamwork approach that avoids “gotcha” style processes, and exploring license flexibility to maintain staffing of beds when they are not in use.

Continuing education for existing care providers

Members noted needs and opportunities related to continuing education for existing workers.

- **Continuing education for discharge planners.** Suggestions including training on the Carina database to help eligible patients find caregivers, additional on-boarding support, and role clarity.
- **Continuing education for CNAs.** Suggestions included standardizing CNA trainings across settings to reduce duplication; making CNA trainings transferrable and stackable across settings; and keeping trainings simple, such as non-graded quizzes. One member noted that as the Oregon State Board of Nursing updates core competencies for CNAs to reduce barriers to entry in the profession, additional CNA training may be needed to work in post-acute care. Another member suggested offering incentives to onboard CNA students as employees while completing certification training.
- **Specialized training on post-acute care for people with complex needs.** Across professions working in post-acute care, education requirements may not

adequately prepare care providers to work with people with complex needs or high acuity. Additional specialized training is needed to address post-acute care for people with co-occurring physical and behavioral health conditions, co-occurring physical and intellectual or developmental disabilities, severe mental illness, substance use disorders, and overdose treatment. Training also needs to address changing regulations and best practices as these evolve in Oregon.

Finally, three members noted that additional effort is needed to ensure trainings are used and helpful when they are offered. One member noted the pressure to maximize time in patient care undermines time for professional development that could support upskilling or career advancement. Another member suggested paying care providers to participate in trainings.

2.B) Improving discharge from acute to post-acute care

Members shared initial ideas related to "*facilitating timely discharge of patients from hospitals to appropriate placements in post-acute care settings*."

Broadly, members noted the goal of discharge planning should be a seamless journey for patients from the hospital bed to an appropriate post-acute setting or in-home care. This seamless transition should involve patients in the discharge process and foster collaboration between hospitals, post-acute facilities, and agencies.

Members identified challenges and needs across several areas summarized in Table 2 below.

Table 2. Needs and Opportunities related to Discharge Delays

Needs	Opportunities
Discharge process	• Streamline the eligibility determination process for Medicaid coverage of long-term care. • Examine the amount and type of documentation needed for discharge to identify ways to reduce documentation burden. • Reduce burdens placed on case managers and care providers to improve the discharge process. • Allow primary care providers more decision-making authority to reduce unnecessary costs and use of resources. • Increase oversight of facilities refusing referrals of patients.
Funding-related discharge delays	• Shorten the length of time to secure approval of exception rate funding. • Approve rate increases concurrently with eligibility determination and referrals.
Transportation	• Addressing strict regulations on transportation.

Needs	Opportunities
	• Address inadequate air ambulance funding to reduce delays in transporting patients to higher or more specialized care settings. • Address the shortage of emergency medical technicians (EMT) and ambulances, exacerbated by stringent regulations, that hampers non-emergent basic life support ambulance transports.
Technology	• Leverage new technologies for enhanced care coordination. • Integrate hospital technology for more streamlined clinical eligibility assessment. • Allow virtual hospitalists to support the transition to placement and prevention of readmission.
Public guardians	• Increase the number of public guardians. • Immediate access to guardianship to fast-track assessments.
Staff shortages	• Increase staff in post-acute settings who can assist with placements in adult foster homes and other post-acute settings. • Explore whether hospitals seeking magnet status could be a hindrance to attracting RNs who do not have a BSN.

Source: Legislative Policy and Research Office

Members also advanced **ideas for innovation** and learning in this area, including:

- Escalation protocols that can be used to address discharge delays of medically stable patients.
- Developing a case management process tailored for patients with complex social, financial, clinical, and behavioral needs.
- Learning from what worked during the COVID-19 response.

2.C) Increasing Community-Based Placements

Members shared initial thoughts related to *"increasing available options for and access to community-based placements [for post-acute care]"* with regard to:

1) capacity of community-based facilities,
2) regulation of complex care, and
3) investments in staffing for complex care.

Capacity of community-based facilities

Multiple task force members noted a need for increased capacity in and access to placements at existing community-based facilities, including:

- adult foster homes;

- residential treatment facilities;
- home health services;
- supportive housing;
- medical respite care;
- recuperative care centers;
- inpatient psychiatric care; and
- behavioral and mental health services in post-acute settings, particularly for people with substance use disorders.

Members suggested mapping existing post-acute care facilities throughout the state to understand facilities' capacity to provide care for patients with both physical and psychiatric needs. Effective resource allocation and informed decision-making will rely on a comprehensive understanding of available facilities. Members also suggested evaluating services, staffing, and reimbursement structures in these settings.

Regulation of Complex Post-Acute Care

Members noted that appropriate post-hospital discharge sites that can manage complex patients are in high demand. Regulatory support is needed to increase access to placements and facilitate responsive care for patients with complex needs.

Members suggested that prior authorization requirements and mandated physical assessments need careful reconsideration. Coordination for quick placement will require streamlined processes and effective collaboration between various healthcare entities.

Members also identified the need to eliminate discrimination in who is accepted for placement based on factors such as mental health or substance use disorders, homelessness, or criminal history.

Investments in Staffing for Complex Care

Members noted that innovations in placement settings should include increases in staffing to serve more complex patients. Reimbursement to post-acute care providers should also account for caring for patients with higher needs, including in adult foster homes, home health, and hospice agencies. There is a need to reduce stigma for nursing care providers who work in post-acute care.

Members noted that if rate increases are tied to the Acuity-Based Staffing Tool (ABST), staffing minimums are also needed (along with access to ABST data across time). Members also noted that post-acute care wages should be comparable to hospital settings, and that more investment is needed in community-based home care workers.

2.D) Innovative Models for Complex Care

Members shared initial ideas related to *"supporting innovative care models and innovative payment models to increase access to placements in post-acute care settings by patients with complex health needs or who lack stable housing."*

Responses addressed the following, described further in Table 3 below:

1) new settings and care types.
2) new incentives and funding models.
3) expanding home and community-based service models.
4) post-acute care in shelters.

Table 3. Ideas for Innovative Models for Complex Post Acute Care

Needs	Opportunities
New settings and care types	Members suggested new kinds of post-discharge settings and specialized programming to serve patients with behavioral health diagnoses and those who lack of stable housing. • Short-term respite facilities to stabilize chronically homeless patients prior to adult foster home placement. • A "gap" placement option for medically stable patients who are waiting for approval of the Long-Term Care Benefit (LTCB). In the gap concept, state funds would purchase a home near the hospital to be modified to meet Americans with Disabilities Act standards and staffed by nurses and nursing assistants. • Nursing facilities with individual rooms staffed by trained healthcare professionals who can provide care to patients with complex needs.
New incentives and funding models	Members suggested new incentives and increased funding for placement settings to meet the needs of complex patients, including: • Rates based on level of care and acuity of patient with a statewide fee schedule and benefits aligned across products. • Dedicated funding for nurses and social workers to support transitions between settings. • Increased payment for specialized settings and placements that serve patients with complex care needs. • Incentives to take back patients served prior to hospitalization who are discharged with higher post-acute care needs. • Incentives for post-acute providers to engage with patients while in the hospital to develop a community-based care plan to reduce readmission. • Expanding use of Special Needs Contracts for unique populations to align reimbursement with the cost of care.

Needs	Opportunities
	• Incentives to create more capacity for placement by transitioning patients to home care prior to the end of their full benefit. • Incentives for AFH (adult foster homes) to keep patients stable and housed. • Value-based payment models, including reimbursement for traditional health workers and non-professional staff.
Strengthening home and community-based service models (HCBS)	Members suggested several innovations to strengthen delivery of HCBS: • Evaluating services, staffing, and reimbursement for home health and hospice agencies that serve patients with complex medical and behavioral health needs. • Post-acute alternatives like Recuperative Care Programs and the Program for All-inclusive Care of the Elderly (PACE). • Innovative models like C-TRAIN (OHSU) to bundle payment for nurses or social workers to support homeless patients with chronic conditions. • Improving access for patients to get care in the community for chronic conditions, like dialysis. • Including home health agencies in planning when patients leave skilled nursing. • Stable funding for supportive housing with integrated health services.
Post-acute care in shelters	Members identified the need for options to provide post-acute care and services to people residing in shelters, such as: • Funding, including dedicated billing codes, for outreach teams to support patients in shelters and supportive housing. • Increasing the number of shelters and improving their quality and health services available. • Training existing shelters to provide specialized care, emphasizing the importance of training and expertise. • Ensuring care is provided by licensed and certified professionals rather than noncredentialled shelter staff who are typically not trained or licensed to provide care such as medication assistance or mental health treatment.

Source: Legislative Policy and Research Office

Members suggested exploring innovations in care delivery through partnerships with the federal government, including integrated care and value-based care models to serve patients with complex health needs (see Section 2.F).

2.E) Coverage and Reimbursement

Members shared initial ideas related to "*modifying medical assistance and commercial health benefit plan coverage and reimbursement to facilitate appropriate post-acute care setting placements*."

Members identified opportunities across Oregon Health Plan (Medicaid), Medicare/Medicare Advantage, and commercial coverage, described in Table 4.

Table 4. Needs and Opportunities Across Coverage Types

Program	Needs and Opportunities
Oregon Health Plan (Medicaid)	Members identified specific coverage and reimbursement issues for patients with Oregon Health Plan (OHP) coverage. • Some patients need skilled nursing beyond 20-day coverage limits, including patients needing intravenous antibiotics. • OHP does not allow placement for physical rehabilitation. • Some patients with OHP may need more than 20 hours per month of personal care attendant services. • Case rate models of reimbursement and per diems could support providers to meet expectations of a specific care model focused on vulnerable populations. • Fee-for-Service (FFS) reimbursement could mitigate increased costs to providers. • Expanding emergency benefits to cover more services.
Medicare Advantage	Members identified issues for patients with Medicare Advantage coverage. This includes coverage for patients who receive a 72-hour Notice of Medicare Non-Coverage (NOMNC). • Additional transparency from Medicare Advantage plans. • Need for higher Medicare Advantage reimbursements.
Commercial coverage	Members identified issues with coverage and reimbursement for patients who have commercial plans. • Hospitals wait on authorization from commercial plans before placing patients in skilled nursing facilities (SNF). • There is a need to work with commercial insurers on authorizations and payments. • The Task Force needs to understand compliance with parity laws in the commercial sphere, and that both commercial and public plans should be required to develop more robust provider networks for behavioral health.

Source: Legislative Policy and Research Office

Members identified the need to streamline authorization for placement and payment processes across payers. One member suggested studying data on prior authorization, eligibility determination timelines, and denial rates by payer type. Members suggested developing standards or timelines for authorizations to avoid delaying discharge until funding is approved. One member suggested that a streamlined system could provide immediate payment. One member suggested broad public coverage of long-term care benefits within a model of universal health care.

2.F) Federal-State Partnership Opportunities

Members shared initial ideas related to "*opportunities for federal and state partnerships to secure federal resources and the federal approvals needed for such partnerships*."

Members were interested in learning about federal partnership opportunities, and two members suggested beginning a conversation with the Centers for Medicare and Medicaid Services (CMS) or Center for Medicare and Medicaid Innovation (CMMI). Topics of interest included current CMS/CMMI opportunities related to rates and reimbursement processes, models of care, and what CMS/CMMI are currently focused on and learning.

Members noted federal and state regulators need to work together to reduce administrative and regulatory burdens, particularly for post-acute care facilities. Regulatory and program changes are needed to ensure safe outcomes and address long processing times to determine a person's eligibility for benefits. Members identified specific needs and opportunities related to Medicaid, Medicare, and Veterans Affairs programs, summarized in Table 5 below.

Table 5. Needs and Opportunities related to Federal Programs

Program	Needs and Opportunities

Medicaid	• Explore additional state Medicaid waivers options:
	  ○ Opportunities to receive enhanced Medicaid matching rates as the Task Force considers recommending new state investments; it may be important that policy concepts drawing down additional federal match are prioritized among recommendations.
	  ○ Expand the state's 1915(i) home and community-based services waiver.
	  ○ Add "agency with choice" self-directed homecare services to Oregon's Medicaid 1915k waiver.
	• Expand access to the PACE statewide.
	• Note the importance of Medicaid rates accounting for the acuity of people receiving care.

Program	Needs and Opportunities
Medicare	• Eliminate the three-day rule for SNF care. Two members suggested exploring a federal waiver to allow Medicare reimbursement of skilled nursing facility stays without a prior three-day hospital stay. • Explore Medicare value-based programs. Two members were interested in exploring value-based payment models approved by CMS for traditional Medicare including payments supporting staff wages, training, and benefits.
Veterans Affairs	• Address limited liaison staff which challenges the coordination of placement for people with Veterans Affairs coverage.

Source: Legislative Policy and Research Office

Part III. Information and Perspectives Needed

Across policy areas, members requested to hear from others on the Task Force with specific expertise in certain areas. Members also indicated 1) perspectives they would like to hear from and 2) analyses or information that would be helpful as the group considers options. Table 6 below organizes these suggestions by policy area.

Staff will work with the Chair, Vice-Chair and members to align these requests to the Task Force meeting roadmap (see meeting materials for October 17th, 2023, for draft).

Table 6. Task Force Information Requests and Suggestions

Policy Domain	Information Requests
Nursing education, training, licensure and certification	Requested perspectives and topics: • Hearing from nursing staff, including in post-acute care and those considering or leaving the profession, to understand challenges. • Presentation from the authors of *The Future of Oregon's Nursing Workforce* report about their findings and recommendations. • Hearing from the Oregon Center for Nursing and Oregon State Board of Nursing about the nurse licensure compact and barriers to entering the nursing profession. • Input from employers, hospitals, and post-acute facilities on their experiences and ideas.
	Requested analysis or information: • Health workforce needs and vacancies in Oregon. • Information on other states' approaches to developing the nursing workforce. • Update on implementation and impact of training and workforce incentives passed in the 2023 session.

Policy Domain	Information Requests
	• Assessment of CNA training programs, including number, capacity, enrollment, and factors affecting enrollment.
Improving discharge from acute to post-acute care	Requested perspectives and topics: • Hearing from workers in "front line" and management positions about discharge processes and delays. • Hearing from hospital representatives about challenges trying to find placements for patients. • A conversation about specific discharge challenges and possible solutions for people with complex health needs and/or who lack stable housing. • A conversation on opportunities for collaboration to improve the discharge process. • A liaison from the Task Force to legislative committees and workgroups evaluating Measure 110 implementation. • Learning from other states about their processes and funding models for discharge planning and eligibility determination.
	Requested analysis or information: • Information about the population experiencing discharge delays, their placement challenges and post-acute care needs, and what would help keep them stable or able to reside at home. • Information from hospitals on reasons for delayed discharge (if possible, linked to information on referral outcomes) including the proportion of patients for whom pending Medicaid eligibility determination is the only reason for delay and how social determinants of health relate to barriers to placement. • Information about the process used by the Office of Aging and People with Disabilities (APD) when making eligibility determinations for Medicaid. • Identify federal regulatory barriers or guidelines that are affecting patient eligibility for post-acute placement, discharge processes, and any regulatory flexibilities or waiver opportunities. • Whether coordinating medical respite care after a skilled nursing stay would address denial of a SNF referral for lack of discharge plan. • Information about past or present models that have been successful in other industries and how they could be adapted to this situation.
Expanding community-based placements	Requested perspectives and topics: • Hearing from care providers and management on their experience trying to accommodate referrals from hospitals and what is needed. • A conversation with stakeholders and experts to identify options to increase community-based placements.

Policy Domain	Information Requests
	Requested analysis or information: • Transparent, integrated data on current post-acute care options, capacity, Medicaid-specific capacity, assisted living and adult foster home capacity, and occupancy rates. • Data on facility capability and capacity care for patients with complex needs, mental health and/or substance use treatment needs. • Information about current challenges with community-based placements and any changes agencies can make to address the post-acute bed crisis. • Analysis to understand if hospital discharge challenges are being driven by a shortage of post-acute beds or staffing for beds, which could inform decisions about solutions. • Information about the impact of real estate investment trusts on property market for [post-acute] facilities.
Innovative care and payment models	Requested perspectives and topics: • Hearing from the C-TRAIN program at Oregon Health and Science University about bundled payment models for care transitions for people with complex care needs.
	Requested analysis or information: • Information about models of medical respite care. • Information on models of care that embed or integrate support within post-acute settings for patients with complex or challenging behaviors. • Data from Oregon Health Authority and Oregon Department of Human Services showing where investments have and have not been working.
Coverage and reimbursement	Requested analysis or information: • Data on the coverage types of patients or payer mix in post-acute settings, by facility type and by region. • Information on Medicare value-based payment models, performance, and quality. • Data on the State of Oregon's progress with redetermination of Medicaid eligibility for all people covered during the public health emergency.
Federal partnership opportunities	Requested perspectives and topics: • Hearing from front line workers and consumers as experts on what should be prioritized in state-federal partnerships. • Inviting staff from the Centers for Medicare and Medicaid Services (CMS) and Center for Medicare and Medicaid Innovation (CMMI) to

Policy Domain	Information Requests
	share information about current interests, opportunities to change rates and reimbursement processes, and new care and payment model opportunities. • A conversation among stakeholders about state and federal processes or requirements that create barriers to discharge and how to ensure new federal partnerships are aligned with state goals.

Source: Legislative Policy and Research Office

About this memo

This memo was prepared by staff at the Legislative Policy & Research Office (LPRO). LPRO provides centralized, nonpartisan research and issue analysis for Oregon's legislative branch. LPRO does not provide legal advice. LPRO publications contain general information that is current as of the date of publication. Subsequent action by the legislative, executive, or judicial branches may affect accuracy.

Members of the Joint Task Force on Hospital Discharge Challenges were invited in September 2023 to participate in a needs assessment to inform Task Force planning and deliberations. Sixteen out of twenty-two members completed a questionnaire. LPRO compiled member responses, organizing information on needs and opportunities by topic. Information provided by members is reported "as is" and has not been verified for accuracy or completeness. Information is summarized for planning purposes but does not constitute a consensus view of all or a majority of members. Members hold varied views on topics within this document and not all members share all views reported here.