Hospital Association of Oregon

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Joint Task Force on Hospital Discharge Challenges
Oregon State Legislature
900 Court Street NE
Salem, OR 97301
Delivered electronically to JTFHDC.exhibits@oregonlegislature.gov

Chair Jones, Vice-Chair Burns, and Members of the Task Force:

The Hospital Association of Oregon is a mission-driven, nonprofit association representing Oregon's 62 community hospitals. Together, hospitals are the sixth largest private employer statewide, employing more than 70,000 employees. Committed to fostering a stronger, safer Oregon with equitable access to quality health care, the Hospital Association provides services to Oregon's community hospitals ensuring all are able to deliver dependable, comprehensive health care to their communities; educates government officials and the public on the state's health landscape; and works collaboratively with policymakers, community organizations, and the health care community to build consensus on and advance health care policy benefiting the state's 4 million residents.

Hospitals are more than just buildings; they are cornerstones within the communities they serve. Our hospitals are employers, partners in community projects, and community spaces—all while providing vital health services to generation after generation of families in communities across Oregon. We know that when our hospitals are strong, our communities win.

On any given day, hundreds of patients are cared for in Oregon hospitals while waiting to be discharged to their next care setting. These individuals are not getting optimal care for their needs, and the hospital resources they require are unavailable to others who need them and cannot access them any other way. We can and must do better as a state and as a community.

While pervasive challenges with workforce, housing, and behavioral health are contributors to the problem, we have identified several opportunities to intervene that could substantially change the trajectory for these patients and the patients who struggle to access hospital-level care. The task force should focus on those opportunities with actionable solutions. We recommend the following:

1. **Speed up Medicaid eligibility assessments.** Hospital data indicate that longer discharge delays are likely to be caused by delays in this state-led process. In the analysis Dr. Raymond Moreno presented to the

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task force, the functional and financial assessments together accounted for an average of 22.83 hospital days. Several task force members expressed support for prioritizing improvements to this process as part of "Phase I."

a. Reduce time to complete the functional assessment by leveraging the patient's clinician. Explore options to reinstate waivers that were in effect during the public health emergency.
b. Reduce time to complete the financial assessment by granting presumptive approval based on basic funding need for Medicaid or low-income Medicare.
c. Establish a fast-track placement process for hospice patients. Delays in placing hospice patients result in more patients dying in the hospital rather than in a (likely preferable) hospice setting.
d. Standardize hospital requirements related to assessment processes and consistently train case workers and care managers.

2. **Improve care coordination for patients with complex needs.** While open and staffed post-acute care beds generally exist across the state, post-acute care environments vary greatly in what patient needs they can meet and in what patients they will accept. For example, hospitals experience substantial challenges when trying to place patients who are houseless or who use intravenous drugs. Dr. Lesley Ogden highlighted the increasing number of referrals her rural hospitals must routinely make before securing an appropriate placement for a patient with complex needs.
    a. Develop a formalized case management and escalation process that brings hospital, state, and post-acute stakeholders together as soon as a discharge barrier is identified. For Medicaid patients, the state should organize this. We echo Dr. Moreno's recommendation to prioritize this early in the task force's work, as it may help identify other process improvement opportunities.
    b. Create mechanisms for hospital staff to support post-acute staff through the transition of a complex patient. More support from hospital staff could enable post-acute providers to take higher-complexity patients, thus reducing a key barrier to hospital discharge, and could also contribute to the continued education and development of the post-acute care workforce.
    c. Standardize evaluation and admission criteria to post-acute care settings.
    d. Identify and address regulatory/licensing barriers to acceptance of certain patients.

3. **Improve reimbursement to support post-acute care providers.** Look to the post-acute care provider community to recommend reimbursement structures that recognize increasing levels of patient acuity and will support post-acute care for patients with complex needs.
    a. Extend Medicaid coverage for skilled nursing facility (SNF) care beyond the current 20-day limit.
    b. Provide sustainable reimbursement to adult foster homes and home health and hospice providers. Task force members noted that the hospital decompression initiative in early 2022, which offered $10,000 incentive payments to adult foster home providers, was highly successful.
    c. Simplify the exception payment structure and process. We heard at the task force meeting that over 50% of placements with adult foster homes currently require exceptions, compared to the federal regulatory target of 10%.

This task force discussion should not be the end of the conversation. Post-acute and long-term care providers have an indispensable role in ensuring that people receive the health care they need. We look forward to working with our partners to solve the systemic challenges we are all facing when trying to place patients in post-acute settings.

Thank you,

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