Meeting Summary

Joint Task Force on Hospital Discharge Challenges
Meeting #3
Link to Task Force on OLIS

LPRO
LEGISLATIVE POLICY AND RESEARCH OFFICE

Date/Time	November 16, 9-12 am (link to recording)
Attendees	Chair Jimmy Jones Vice-Chair Elizabeth Burns Sen. Deb Patterson Phil Bentley Rachel Currans Henry Daniel Davis Jeff Davis Jonathan Eames Trilby de Jung Eve Gray Jesse Kennedy Kathleen LeVee Alice Miller Leah Mitchell Raymond Moreno Joe Ness Sarah Ray Jane-Ellen Weidanz Dawn Wipf Jonathan Weedman Excused: Rep. Christine Goodwin; Felisa Hagins

Dr. Maria Niemuth, Northwest Human Services (link to handout)	Dr. Maria Niemuth presented to the Task Force on her perspective as a medical provider who serves homeless patients after hospital discharge. Key points included:
	• Complex patients include those needing wound care, those with memory loss, and those with opioid dependence and overdose.
	• Communities across Oregon have different challenges serving homeless patients after they are discharged from the hospital.
	• At Northwest Human Services in Salem, homeless patients keep post-discharge appointments roughly fifty percent of the time.
	• Challenges often relate to health information exchange, including:
	  ○ difficulty obtaining hospital records for homeless patients, making it hard to know how often discharged patients follow up with care. This is true even with health information exchange tools such as Point Click Care.
	  ○ difficulty communicating with hospital providers, including when the outpatient provider sends the patient to the hospital. Outpatient providers are unable to know whether patients have continued medications or filled prescriptions.
	  ○ insufficient data to track and manage complex care issues across the acute and post-acute care systems.
	  ○ labs and tests are often repeated because of lack of health information exchange and provider difficulty accessing care

records. Staffing and workload are factors limiting communication and coordination.

- Increased communication between hospitals, long-term care facilities, and primary care providers would improve care, including behavioral health care.
- Increasing access to community health workers would increase follow-up for patients after discharge.
- Increasing access to low-barrier facilities could help to temporarily house patients after discharge. Medical staff oversight needs to be part this model.
- Funding and support for more primary care capacity and outreach to patients who lack stable housing could reduce hospital visits.

Members raised the following points and questions:

- Is it possible to know the number of patients who lack stable housing who are hospitalized and waiting for discharge?
- What kinds of long-term facilities are needed for patients who lack stable housing upon discharge? [Dr. Niemuth responded that all kinds are needed. Outpatient providers have found success with adult foster care but limited availability is a barrier.]
- What legislative measures were outpatient providers referring to in their materials? [Staff note: *See* Senate Bill 1076 (2023) (did not pass); *See also* California Senate Bill 1152 (2018) (link to overview)].
- One concept that has support from Oregon's HIT Commons initiative would notify prescribers when patients are experiencing overdoses.
- Dialysis providers have identified health information exchange as a priority to serve patients following discharge.

Phil Bentley

Dr. Elizabeth Burns

Lisa Hilty

(link to slides)

A panel of presenters shared the following information on hospital discharge challenges from the long-term care provider perspective:

- "Long-term care" is a continuum of care types including help in the home with activities of daily living (ADL), residential care (including memory care and assisted living), and skilled nursing facilities (SNF), which can provide Medicare- or Medicaid-funded stays for people coming out of the hospital.
- Different facility types are subject to different state and federal regulations as well as resident rights and protections.
- Regarding skilled nursing facilities:
  - ATI Advisory studied Medicare-enrollees discharged to SNF (link to ATI Advisory analysis).
  - The average SNF stay covered by Medicare is 25 days. Presenters noted reimbursement by Medicare Advantage plans is typically lower than for Medicare.
  - Under federal law, SNF care is only covered for individuals who have qualifying care needs. Pre-Admission Screening and Resident Review (PASRR) is a tool to evaluate applicants for serious mental illness or intellectual disability.

    - SNFs must meet staffing ratios and requirements, which impact capacity.
    - Workforce levels remain below pre-pandemic levels and are limiting capacity. Nationally, it is estimated that facilities are operating at around 75 percent of capacity. In one Oregon facility, occupancy is at 65 percent of capacity.
- Regarding community-based care:
    - Community-based care (CBC) includes assisted living, residential care, memory care, and adult foster care. In Oregon, it is paid by Medicaid (via waiver).
    - CBCs use the acuity-based staffing tool (ABST) to meet Oregon requirements to determine residents' needs and appropriate staffing levels. Facilities often rely on temporary workers to meet staffing requirements.
    - Specific needs contracts are agreements between providers and ODHS to serve specific populations, including complex medical and behavioral health needs. An example setting includes 24/7 staffing and onsite LCSW and drug and alcohol counseling.
- Post-acute facilities' patient populations are experiencing more acute medical needs and more behavioral complexity over time.
    - ODHS/OHA surveyed facilities and identified top clinical and non-clinical reasons for denials of referrals (link to ODHS Presentation to Task Force, September 21, 2023).
    - Examples of complex needs resulting in patient referrals being rejected include substance use, lack of stable housing, and wound care needs.
    - Upon patient placement, challenging behaviors reported include substance use, locking oneself in one's room, having frequent visitors, and leaving the facility against medical advice.

Members raised the following points and questions during discussion:

- Beginning in 2012, facilities began to accept more complex individuals who were no longer being admitted to the state hospital. Facilities stepped up to meet needs of complex individuals. It is critical to have staff trained to meet complex needs.
- The cost of private guardianship is relatively expensive.
- Access to public guardianship is backlogged and individuals remain in hospitals waiting for guardian appointment. One solution is a volunteer advocacy program for retired attorneys to pair with patients.
- ODHS does not have statutory authority to participate in delivery of guardianship services. The Task Force should consider non-guardianship concepts, such as supported decision-making.
- A centralized database listing facilities around the state (including those with specific needs contracts) and the number of placement openings would help hospitals with the discharge process. The ODHS website does list providers but not vacancies, which are more difficult to track. It will be important to study not just the

	number of specific needs placements but also the types that are available.
Michelle Hankes (link to slides)	Michelle Hankes of ShelterCare presented on a model for medical recuperation services that is currently offered in Lane County: • ShelterCare operates a medical recuperation program among other services, including transitional housing. • Medical recuperation is offered in a motel setting with suites, each with two or three individual rooms. Meals are provided on site but medical services are not. • Individuals must be homeless and recovering from a medical issue to qualify. The hospital and Coordinated Care Organization team initiate referrals. Patient stays range from 30-120 days, determined by the CCO. • Exit outcomes can include transitioning to permanent housing, to institutional care settings, to transitional housing, to shelter, or returning to streets.
Information Gathering and Discussion of Next Steps Staff Presentation of Information Gathered (link to slides 9-41)	LPRO staff presented information gathered about concepts for near-term consideration (see link, slides 14-37). These concepts were identified by members in Meeting #2 (link to Meeting #2 summary). In lieu of making formal recommendations in advance of the December 15 deadline—as the Nov. 9 drafting deadline for legislative concepts has passed—members discussed submitting to the Legislative Assembly a memorandum summarizing Task Force work and discussion to date. Staff will draft a memorandum on behalf of the Task Force, to be provided for member review beginning November 27. Members will submit any feedback by December 1. The draft report will be posted on December 7 for public consideration in advance of the Task Force meeting on December 12. A vote to approve the memorandum would signify that the memo reflects Task Force work to date (but does not signify endorsement of any concept). Member discussion of next steps included the following points and questions: • What will happen with concepts discussed in Meeting #3 that had not been raised previously? [Staff noted that meeting #3 discussion will be noted in the meeting summary, shared out with members, and incorporated into work plans for future meetings.] • It will be important to consider raising rates across different kinds of placement settings, not just for adult foster care or facility beds. • The executive branch will review proposed next steps to offer feedback, emphasizing long-term, sustainable changes, including concepts to increase capacity. • Adult foster home placements are decreasing due to reimbursement rates, which providers report are insufficient to provide care. Adult foster homes take some of the most complex patients. • The Office of Aging and People with Disabilities noted that exception rates are intended to apply to no more than ten percent

	of placements. Currently, over fifty percent of adult foster homes in Oregon have exceptions. Ongoing efforts to study wages and rates are intended to support reevaluation of rates broadly. APD's internal evaluation suggested that discharge incentives did not speed up placements. • Discharge incentives and exceptions could be considered together as part of an overall conversation about rates. Increasing reimbursement may support an overall increase in capacity. • LTC providers are interested in the Task Force further exploring Medicaid eligibility requirements, guardianship, the regulatory environment for post-acute settings, and the nurse education pipeline. • What role should the task force play regarding Medicaid reimbursement? It could be to discuss base rates vs. special needs rates, and how to serve folks with high needs. • Workforce challenges apply across professions, including all kinds of workers in addition to nurses. • The Task Force's chair and vice-chair proposed that a small group of members should convene to talk more about an escalation process. More information will follow. • The needs of people who lack stable housing are different, may require different solutions, and will need specific focus. • Discussions about workforce barriers should consider direct care workers, including both certified nursing assistants and people who are uncertified. • Discussion of guardianship should include surrogate decision-making. • Discussion of discharge incentives and exceptions could be included in a larger conversation about rates. • Discharge escalation concepts could include an urgent criteria pathway for people who are unhoused and hospitalized to prioritize getting APD benefits.
Public Comment	• The Hospital Association of Oregon commented following Meeting #2. The comment was posted as materials for this meeting (link to comment). • One member of the public provided verbal testimony, offering an example of an individual who remained hospitalized after being ready for discharge, suggesting that the state maintain a centralized source of placement options. • A Task Force member commented that placement companies take a percentage of the placement rate (for example, a fee equal to 120 percent of the rate for a one-month stay).

Meeting Materials	• Meeting Overview & Roadmap
	  ○ Link to staff presentation (slides 3-5)
	  ○ Link to Meeting #2 Summary
	• Provider Perspectives: Post Acute Care and Long Term Care
	  ○ Northwest Human Services materials
	  ▪ Link to handout (Dr. Maria Niemuth)

        - Link to Stephen Goins letter; Link to Kevin Holloway letter
    - Link to Long Term Care presentation (Phil Bentley, Dr. Elizabeth Burns, Lisa Hilty)
    - Link to ShelterCare Medical Recuperation (Michelle Hankes)
- Information Gathered and Discussion of Next Steps
    - Link to staff presentation (slides 9-41)
    - Supplementary ODHS materials
        - Link to midterm report
        - Link to efficacy analysis