# Meeting Summary

Joint Task Force on Hospital Discharge Challenges
Meeting #4
Link to Task Force on OLIS

LPRO
LEGISLATIVE POLICY AND RESEARCH OFFICE

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| Date/Time | December 12, 9-12 am (link to recording) |
| Attendees | Chair Jimmy Jones<br>Vice-Chair Elizabeth Burns<br>Sen. Deb Patterson<br>Rep. Christine Goodwin<br>Phil Bentley<br>Rachel Currans Henry<br>Daniel Davis<br>Jeff Davis<br>Eve Gray<br>Jonathan Eames<br>Trilby de Jung<br>Jesse Kennedy<br>Kathleen LeVee<br>Alice Longley-Miller<br>Leah Mitchell<br>Raymond Moreno<br>Joe Ness<br>Sarah Ray<br>Jonathan Weedman<br>Jane-ellen Weidanz<br>Dawn Wipf<br>Excused: Felisa Hagins |
| Vice Chair Elizabeth Burns and LPRO staff (link to slides) | Vice Chair Burns facilitated a member discussion about the draft memorandum to the Legislative Assembly prepared by LPRO on behalf of the Task Force. The memo provides a status update on Task Force efforts to date as well as anticipated upcoming work. The memo does not include recommendations or a complete list of policy concepts that have been identified by members. A revisions log (link) recorded staff changes made to the final draft in response to Task Force feedback on a first draft.<br><br>Key points discussed included a policy concept to develop an escalation protocol that hospitals could follow when encountering challenges placing patients in post-acute care. Key points included:<br><br>• The escalation protocol, as initially described, would include a standard process for hospitals to follow if a patient cannot be placed. The process may include a designated contact who would convene a case conference of relevant partners and have access to resources or a toolkit to support the group coordinating next steps for a patient.<br>• Some members requested that the memo indicate that OHA and/or ODHS would play the lead role in facilitating the escalation process. Other members noted this raised questions about the role that industry, such as commercial insurers, should play in this process (for example, when consumers are not Medicaid-enrolled). |

Others noted there have been many conversations about escalation, particularly during COVID-19, with some efforts more successful and others not. There is interest in learning what other states have tried related to escalation and where there may be additional opportunities for the state and industry to partner on these processes. The first draft of the memo did not note that hospitals already play a lead role in the escalation process and engage their local partners, but that these processes currently do not involve state agencies.

- Members noted a root cause analysis would be helpful to understand situations where OHA or ODHS do not agree which agency holds payer responsibility for a Medicaid-eligible patient based on their primary condition. Understanding what drives these situations could inform planning on the escalation protocol and roles.

Phil Bentley moved that the draft memorandum as discussed in the meeting be submitted to the interim committees of the Legislative Assembly related to health and human services. Dr. Ray Moreno seconded the motion. **Motion passed unanimously.** Staff subsequently submitted the adopted memo (link) and a cover letter from the Chair and Vice Chair (link).

Staff provided an update on consulting support and preview of upcoming workplan discussion and analyses:

- HB 3396 directs LPRO to produce analyses to inform the Task Force in its deliberations, authorizes contracting with third parties and provides funding to support this work. The bill provides direction for analyses related to 1) post-acute workforce, 2) post-acute capacity for complex care, 3) hospital discharge processes and outcomes, and 4) post-acute coverage, rates, and payments. These analyses were refined based on the Task Force needs assessment and discussions, availability of data, and timing of other analyses requested by the legislature.
- A consultant will be engaged by January 2024 to present analyses during the spring meetings, provide additional consultation on federal waivers and initiatives, and prepare a report of findings for the Task Force later in 2024.
- The January Task Force meeting will be an opportunity to meet the consultants, discuss the 2024 workplan, and revisit priority goals for Phase II. Members were invited to submit any additional feedback on a draft 2024 workplan (link).

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Chris Rosin

Dawn Wipf

(link to slides)

Chris Rosin from the Office of the Public Guardian presented an overview of the office and its role in hospital discharge assistance. Key points from the presentation included:

- Guardianship is a legal process by which a court removes an individual's right to make their own decisions and grants that authority to a guardian. The Oregon Public Guardian is a public office providing guardianship services for people for whom there is no less restrictive alternative for decision making, no one willing to serve as the person's guardian, and no financial resources to hire

private guardianship services. OPG assists individuals in applying for and receiving Medicaid long-term services and supports and behavioral health services. OPG also assists individuals discharging from the Oregon State Hospital and those who have been detained by law enforcement but are temporarily or permanently unable to "aid and assist" in their own defense.

- As of December 2023, 53% of clients referred to OPG were in hospital but unable to safely discharge at the time of referral; 54% of clients were homeless; and 27% had been abused or neglected. Most cases require a large amount of assessment work during the intake process and this process can take several months.
- OPG employs 13 positions including one deputy guardian position temporarily funded by a grant from Asante Health Network. The office has caseload capacity for up to 180 clients with a current waitlist of 65 clients. A volunteer program launched in 2022 supports 11 clients through ten certified volunteer public guardians.
- Mr. Rosen estimated more than 500 individuals in the community may have unmet needs for guardianship and many more may need less restrictive forms of supported decision making. He estimated that 18 additional FTE would be needed to increase OPG caseload capacity to 400-500, at an estimated cost of $6.3 million per biennium.
- The office is statutorily limited to guardianship or conservator services. The office could be statutorily expanded to offer other services such as supported decision-making or representative payee.
- OPG can request 30-day emergency guardianship for people who become stuck in hospitals, having established through court proceedings that individuals are at risk of medical decompensation in these situations. This emergency status can be initiated to begin hospital discharge coordination while also working on indefinite guardianship (which takes longer).

Dawn Wipf, a member of the Task Force representing Asante Health Network in southern Oregon, provided additional details on their partnership with the OPG:

- The Asante network serves a large proportion of Medicaid and Medicare enrollees. They began tracking discharge delays in 2020. They have seen an increase over time in patients needing guardianship services to begin the application for Medicaid LTSS and be placed in memory care. These patients often become stuck for 90-100 days when they no longer need hospital care.
- Asante has paid private guardians to assist patients with this process. They obtained legislative approval to fund an additional OPG deputy guardian for their region. Eleven cases have been referred to OPG under the grant. Four have been assigned a guardian by the court; four cases are in progress; and the remaining cases are in the assessment phase.

Questions from members included:

- What is the average length of time to complete an assessment from beginning to end? What is the benchmark amount of time?

Once a case is assigned to a deputy, Mr. Rosin noted the timeline for a non-emergency assessment is 30 days. If an emergency case, it is a 7-day timeline. The office recently implemented a change in process where individuals stuck in hospitals are always considered emergency cases.

- Of the cases reviewed for guardianship, what percent are denied? Is there an opportunity to better understand the reasons for denial so that organizations can avoid sending patients down this path when it is not appropriate?

A small percent of referrals are denied after assessment. An initial screening process is completed prior to assessment to avoid initiating the full assessment process when it is not appropriate.

- What are the tools and technology the office uses when working across systems? Are there opportunities for new tools or technologies that could simplify or automate some of this process?
- What lessons have been learned from working with Asante, and how would those apply to other parts of the state?

The OPG model is staffing rather than technology centric. Many staff have prior work experience as case managers in APD, developmental or another human services context. He noted the complexity is in the eligibility and care delivery systems rather than the assessment processes.

- How do costs for private guardianship compare to public guardianship? How did that inform Asante's decision?

Dawn Wipf noted that hospital costs are not only the attorney fees for guardianship but also the uncompensated cost of care while a patient is stuck. Asante had 4-5 patients waiting for OPG services and 17 individuals needing private-pay guardianship services. One patient had been waiting in the hospital for more than 500 days for memory care at a cost of approximately $1,000 per day despite no longer needing hospital services; the hospital is not reimbursed for these days. The OPG partnership was perceived to be a better use of resources than private guardianship services as an ongoing model.

- Has Asante been able to effectively partner with memory care providers and other post-acute providers?

Asante has an agreement with a memory care facility to accept patients while they are waiting for Medicaid eligibility determination, with up-front costs of care covered by Asante. The facility later reimburses Asante when Medicaid eligibility has been established. This has helped with placing memory care patients while eligibility is pending.

- How can this conversation stay connected to other conversations happening around the state, such as the judicial system's Commitment to Change workgroup. How can this group keep those efforts in mind as the group considers recommendations related to hospital discharge.

There were no immediate responses to this question. *[Staff have noted this question and will attempt to provide information on overlapping conversations where this information is known and available]*

- Has OPG explored contracting out for services rather than in-house staff to address need for additional services?

Mr. Rosin noted that the office has relied on contract services in the past but generally has not been able to engage contractors who are willing to take complex cases. Since the office now relies on volunteer deputies for non-complex cases, remaining complex cases are handled by staff. There were also quality, cost, and oversight concerns raised when using outside contractors.

ODHS also funds representative payee services through the Oregon Money Management program, which costs approximately $60 per month for services provided by contractors around the state. The state can access federal Medicaid match for these services.

- Why are memory care facilities requiring that guardianship services be in place when Medicaid already allows that an individual who is acting in good faith on behalf of another may assist in placement? This is not a regulatory requirement.
- Is there an opportunity for the state to formalize guidance to memory care providers clarifying what the regulations require so there is not confusion on this point?
- Is it possible this confusion stems from additional payer or agency requirements that are not in statute?

Ms. Wipf noted that there may be a perception that this is a state regulation since secure facilities will not accept patients without guardianship due to the perception that a person's rights are being taken away. Mr. Rosin noted they also hear this perception from facilities even in situations where an individual is aware they need help and willing to accept help with care planning or decision making. Facilities may understand that it is not a legal requirement to have a guardian but have internal policies requiring it.

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Lisa Bertalan

(link to slides)

Lisa Bertalan presented an overview of the Central Oregon Guardian Assistance Program (COGAP), a private non-profit that provides pro bono and sliding scale guardianship, representative payee, and other legal services in central Oregon.

- Some referrals are from St. Charles and others from circuit court for people who are detained with aid and assist orders. Most of the people they serve transition to memory care or adult foster homes.
- COGAP now contracts with St. Charles Health System to provide legal aid in guardianship petitions for patients who are hospitalized. Their intake process is similar to OPG's but overseen by a five-person advisory committee. They work closely with OPG as both entities provide services in their region.
- Their staff include a half time executive director, who also serves as their intake specialist, and a single professional guardian. Since launching in August, they have accepted a caseload of fifteen

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| | people. They are slated to receive 25 additional referrals in early 2024 and anticipate needing to establish a wait list for services.<br>• COGAP is also working with Central Oregon Community College and OSU Cascades to create a guardianship certification program. This would be based on a University of Washington 9-month certification program. This curriculum could be adapted for Oregon. COGAP intends to provide internship opportunities and mentorship to students in the certification program. Becoming a professional certified fiduciary, including the training and exam, costs roughly $10,000. COGAP also plans to provide scholarships to offset this cost though this will depend on fundraising efforts. |
| Allison Enriquez<br>(link to slides) | Allison Enriquez, manager with Oregon's Office of Developmental Disability Services (ODDS), presented on supported decision making. Key points include:<br>• Supported decision making (SDM) is one of the least restrictive forms of alternative decision making and can be considered a default option for people needing decision support, though the option is sometimes overlooked in favor of more restrictive options. SDM is an evidence-based approach that involves getting support from trusted family or friends to gather info, evaluate options, and communicate decisions. The person remains the ultimate decision maker (in contrast to guardianship, where a guardian may overrule an individual's decision).<br>• SDM is increasingly highlighted in federal and state law, including the uniform code on guardianship, to ensure it is explored before more restrictive options. Families are often unaware that SDM is an option.<br>• In statute, ORS 127.635 relating to health care representatives outlines a hierarchy of individuals who may serve as a surrogate decision maker for purposes of withdrawing life-sustaining procedures. There is not a similar Oregon statute relating to hierarchy of surrogate decision makers for LTSS. SB 1606 (2020) recognized the right to have a support person present while in the hospital as an accommodation to gain access to existing rights to health care and to ensure effective communication.<br>• Structures and frameworks for SDM exist within social service delivery systems but are not commonly recognized as an accommodation by other entities like courts, doctors, schools, banks, etc. Tools such as the LifeCourse Stoplight tool can be translated as a written SDM agreement. |
| Public Comment | • *Michael Talbert, a member of the public, submitted written comment to the Task Force. The comment was posted as materials for this meeting (link to comment).* |

Meeting Materials

- *Meeting Overview & Preview: Analysis and Consulting Support*
  - *Link to meeting #3 summary*
  - *Link to staff slides – meeting overview*
- *Review Draft of Memorandum to Legislative Assembly*
  - *Memorandum – adopted (link)*
  - *Cover letter – adopted (link)*
  - *Memorandum – redline version (link)*
  - *Memorandum – staff revisions log (link)*
- *Informational Hearing: Guardianship*
  - *Link to Chris Rosin slides*
  - *Link to Lisa Bertalan slides*
  - *Link to Allison Enriquez slides*