Meeting Summary

Joint Task Force on Hospital Discharge Challenges
Meeting #7
Link to Task Force on OLIS

LPRO
LEGISLATIVE POLICY AND RESEARCH OFFICE

Date/Time	April 25, 2024, 9-1pm (link to recording)
Attendees	Chair Jimmy Jones Vice-Chair Elizabeth Burns Sen. Deb Patterson Rep. Christine Goodwin Phil Bentley Rachel Currans-Henry Jeff Davis Jonathan Eames Eve Gray Felisa Hagins Trilby de Jung Kathleen LeVee Alice Longley-Miller Leah Mitchell Raymond Moreno Jesse Kennedy Sarah Ray Jonathan Weedman Jane-ellen Weidanz Excused: Daniel Davis Joe Ness
Opening Remarks and Meeting Overview (staff slides)	Today's meeting is a focused conversation on the post-acute care system including: 1) A presentation of survey findings and policy opportunities from ATI Advisory 2) Member discussion time 3) Follow-up on member questions about background checks and post-acute worker pipelines from the March meeting. The March Task Force meeting focused on the post-acute worker pipeline. Upcoming meetings include a focused conversation on hospital discharge and eligibility determinations in May, and coverage and reimbursement in June. These focused conversations will provide opportunities for members to note which policy concepts are most of interest, as well as noting which concepts do not seem workable. Meetings from July to September will focus on integrating takeaways across topics and developing recommendations. Meetings in October and November will focus on finalizing the Task Force's report to the legislature.
Understanding and Addressing Key	ATI Advisory presented key findings from their post-acute provider and workforce analyses. This work included a provider survey, analysis of

Oregon Provider and Workforce Capacity Challenges (slides and data appendix)

ATI Advisory

- Cleo Kordomenos
- Kristen Lunde
- Johanna Barraza-Cannon

agency workforce data, key informant interviews, and additional desktop research and literature reviews. More detailed findings are available in a data appendix.

ATI recommended three ways Oregon can bolster post-acute system capacity, and presented policy opportunities and examples from other states for each area:

1) Investing in and cultivating a post-acute workforce with the specialized training and skills necessary to confidently and competently meet complex care needs.
2) Supporting existing post-acute providers through policy, programming, and payment flexibilities that enable innovative and specialized care delivery models that support complex care needs (as appropriate to the individual's needs).
3) Expanding the types of providers and supports available post-hospitalization to continue providing recuperative care to individuals and as alternatives to common post-acute care provider types.

Members asked brief clarifying questions during the presentation as follows:

Question from Sen. Patterson: Has ATI looked at Oregon's caseloads and how those compare to other states? Extremely high caseloads were a theme at the recent Area Agencies on Aging conference.

> ATI: There is not a comparative analysis planned with other states at this time, but ATI will be presenting data on Oregon's caseloads and caseworker staffing at the May meeting.
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> ODHS noted that during the 2024 legislative session, there were additional funds appropriated to AAAs for case workers but not to APD. There will begin to be a discrepancy in case loads between AAAs and APDs.
>
> OHCA noted that in addition to eligibility determination delays, providers are increasingly reporting delays in payments that are also putting additional strain on providers.

Question from Sen. Patterson: How should members interpret the finding that workers were more or less likely to accept Medicaid in certain regions?

> ATI: The Healthcare Workforce Reporting Program notes whether a person works in a setting that accepts Medicaid. Unclear if this is at the facility or bed level. ATI can follow up on this question.
>
> ODHS noted that providers choose 1) whether to accept Medicaid, and 2) the number of people they will accept with Medicaid within their overall case mix (unless an individual in the facility who was previously private-pay becomes eligible for Medicaid, in which case

the facility must accept their Medicaid coverage for long term services and supports).

Kathy Levee noted skilled nursing facilities that hold Medicaid contracts cannot designate beds as Medicaid or non-Medicaid beds. In assisted living and memory care facilities, allocations and designations are allowed.

Question from Vice Chair Burns: Does “accepts Medicaid” include people who are pending a Medicaid determination, or only those who are already eligible?

Question from ODHS: Does “Medicaid” mean medical coverage or LTSS coverage? Anecdotally, there are reports of concerns on both sides.

ATI: The HWRP data is a survey of licensed workers rather than provider entities so relates more to the setting in which a person works. ATI will see if additional detail can be provided on how this question is asked at the point of data collection.

Question from Jeffrey Davis: Is data available on licensed facilities and bed counts by region over time? Anecdotally there are reports of adult foster homes closing.

ATI: This analysis is not part of ATI’s work but ODHS has this information available [ODHS confirmed this can be provided]. Qualitatively, this issue has been noted in ATI’s interviews.

Comment from Eve Gray: It is important to look at parity in reimbursement of different types of foster homes. Lane County trains new providers for behavioral health adult foster homes but they switch to become developmental disability foster homes because the reimbursement is so much higher.

ODHS: This is correct that adult foster home payments are highest for intellectual and developmental disabilities AFHs, lower for behavioral health AFHs, and lowest for APD foster homes. HB 2495, introduced by Rep. Nosse in the 2023 legislative session, sought to address this, but did not pass.

Question from Alice Longley Miller: Regarding Minnesota’s wage pass through, what settings are included and what percent is passed through?

ATI: Generally, it covers personal care services, but they can follow up with more specific details.

Comment from OHCA: When ATI looks into this, it is also important to look at how wages in Minnesota compare to Oregon’s wages for the same job classification.

Comment from Kathy Levee: Important to note the HWRP analysis doesn't include direct care workers and this feels like a gap.

Discussion: Insights and Policy Options

Facilitated by Chair Jimmy Jones

Chair Jones asked members to discuss the **three areas** where ATI reviewed potential policy concepts:

- Supports for post-acute workers
- Supports for existing post-acute providers
- Models to extend post-acute care, such as medical respite

Questions posed to the group included:

- Which of the concepts shared by ATI are of most interest?
- Are there specific findings from ATI's analyses that are particularly relevant to the policy concepts?

Member comments and questions are grouped by policy concept below (not necessarily in the order in which they were raised):

<u>Supports for post-acute workers</u>

Nursing student pipeline enhancements

- Vice Chair Burns asked to explore the ideas elevated in March to strengthen the nursing student pipeline, as well as nursing student loan forgiveness or incentives to enter post-acute care.
- Kathy supports Vice Chair Burns' points about expanding the nursing student pipeline and pathways into post-acute careers.
- Jesse also supports loan forgiveness for nursing students, especially as a mechanism to address nurse faculty shortages.
- Ray supports the point about needing to home grow our nursing workforce and supports CNA-to-RN advancement pathways.
- Alice is interested in CNA apprenticeship programs.

Wage enhancements

- There is interest in exploring wage increases or a Medicaid wage pass-through requirement for direct care workers (Alice, Jonathan).
- Kathy noted Oregon already has some of the highest wages for these workers among states. She agrees with ATI that the state should look at the workforce pipeline in addition to rates. It is not realistic to raise rates if reimbursements don't increase.
- When looking at proposals related to rates, workforce solutions, and addressing acuity, Felisa asked how do we apply a lens that emphasizes fairness to workers, employers, and patients?
- Ray agrees these are hard jobs that need to be supportive for the people who hold them.

Behavioral health training for existing post-acute workers

- Eve thinks it is not realistic to recruit additional BH workers to post-acute settings during a time of worker shortages and is interested in specialized behavioral health aide roles and BH trainings for existing post-acute workers.

Adequate staffing levels

- Alice noted there are minimum staffing levels in skilled nursing settings but they hear these aren't adequate to make people feel safe or supported.
- Ray agrees that staffing shortages lead to a cycle of burnout and turnover that further exacerbates the shortages.
- Kathy noted Oregon has higher staff to patient ratios than most states due to the acuity-based staffing tool. The unemployment rate is around 4% so recruiting people to fill vacancies may not be realistic. She cautioned against reducing the conversation to "the post-acute sector has capacity challenges and if they can increase staffing, they can accept these patients."

Supports for post-acute providers

Incentives and value-based payment models

- Eve is interested in facility or provider financial incentives to accept more complex individuals.
- Eve is interested in expanding the PACE program as a value-based care model; she noted ODHS recently launched an RFP to expand PACE statewide.

Piloting changes to facility requirements

- Eve asked if the Oregon Health Authority and ODHS can pilot test changes to various OARs to test if facilities are more likely to accept patients with complex care needs.
- Felisa supports looking for opportunities to pilot rule changes, particularly in managed care given CCOs are regionally focused.
- Kathy also supports focusing on the regulatory burden and monetary penalties on providers when they are found to not be providing adequate care.

Models to expand post-acute care

Specialized needs facilities

- Eve wants to be cautious about creating specialized facilities because they may still not take medically fragile individuals. Concentrating high-acuity individuals in specialized settings may burn out workers in those settings. These are some of the most complex, challenging patients who may have violence or aggression issues, and have long-term mental health conditions

that can be improved but not fully resolved through treatment. Providers leave within 1-2 years.
- Jonathan likes the concept of specialized facilities for the population of people whose needs are not well met by existing facility-based models but shares Eve's concern about concentrating high-acuity patients and risk of worker burnout. This would need to be tremendously well staffed and resourced to be successful.

Medical respite / recuperative care programs

- Chair Jones noted if people discharge to recuperative care programs but need assistance with activities of daily living (ADL), the program can't provide those.
- Eve noted California allows emergency shelters to be a setting for in-home care services. She wants to explore this.
- Jonathan also wants to explore recuperative care as a Medicaid benefit. Some CCOs already contract with recuperative care providers but patients can get stuck there if they can't transition to nursing facilities due to their homeless status.
- Chair Jones noted medical respite programs are not very well funded. It's difficult to do if there aren't housing options. Are medical respite programs in other states doing well?
- Felisa noted Boston Healthcare for the Homeless opened a medical respite center that could be a model for Oregon. There is a need to pair this with Medicaid-paid supportive housing options with to keep people from cycling back to the hospital.
- ATI highlighted that Hawaii is seeking to fund medical respite through its Medicaid waiver, paired with housing supports to ensure people transition to housing.

Payment models for care coordination

- Jesse noted care coordination is often provided by RNs but is billed by the provider (an MD or NP). OHSU is testing separate billing codes for RN care coordination provided in the community. He would like to explore this.
- ATI noted it is important to differentiate whether care coordination is billed to Medicaid or Medicare. States already have flexibilities to do much of this work through Medicaid contractual authorities; it does not typically require a waiver.
- Jonathan noted CCOs do extensive care coordination but there is often not a discharge destination to coordinate to. He noted CCOs are already required to build networks and contract with traditional health workers and peer support providers. This is an untapped resource for care coordination.
- ATI noted Washington DC is offering free training to MSW students to boost its community health worker workforce.

Health Information Exchange / Community Information Exchange

- Felisa asked if there are resource lists available in electronic health record systems for providers when planning a discharge?
    - Ray noted these resource lists exist but have to be vetted to ensure that a resource is actually available before a patient is referred. Care coordination is crucial for this.
- Felisa asked if hospitals have data on the specific unmet referral needs in their own communities?
    - Rachel noted hospitals vary in use of EHRs for care coordination regardless of software capabilities. There is a need to clarify what happens in an EHR versus CIE platforms like UniteUs. She would like to see this happen through waiver implementation and those discussions are beginning now. This could be clarified through CCO contracts going forward.
    - Eve underscored that this is a significant challenge. EHRs, Homeless Management Information Systems (HMIS), CCO systems, etc., don't exchange information. It is not realistic that everyone would use the same system but there are interface opportunities. UniteUs can integrate with Epic but there is a cost to do this. This isn't a Task Force issue to solve but should be flagged for a broader list of things for the state to be working on.
    - Ray noted one bright spot is that most acute care settings use Epic and already have information exchange capabilities. This has dramatically improved over the last decade. He wants to see post-acute providers have these same supports.

Other / General Comments

- Looking ahead to recommendations, Felisa would like to see the Task Force differentiate among 1) administrative adjustments to the system that can be made quickly, and 2) longer term more foundational changes.
- Phil Bentley is concerned about the Task Force taking on too much. Some of the topics raised today are things where people have strong opinions in favor or against and have been discussed in other settings. Wants to see the group begin to narrow to the core things that it will advance.

If members have additional reactions or feedback on ATI findings or policy options presented today, please forward them to LPRO staff after the meeting.

Follow-Up: Post-Acute Workforce and Background Checks (slides)

LPRO Staff

Staff presented information gathered in response to member questions about background checks and the post-acute workforce at the last meeting. Information was gathered from:

- ODHS background check unit
- Oregon State Board of Nursing
- Oregon Longitudinal Data Collaborative
- New Hampshire Office of Professional Licensure and Certification

Members discussed next steps on these topics.

Nursing program capacity and nursing faculty

- Jane-ellen asked: Is it a good thing that out of state nursing programs can place students in Oregon? Do those students stay in Oregon after earning their degree?
    - Jesse noted many students at the OHSU nursing program in La Grande do their clinical rotations in Idaho. He did not have specific numbers but anecdotally about half stay in Idaho upon graduation.
    - Eve: Traditionally, nursing students try to use their 1:1 practicum to establish a relationship with an employer with whom they'd like to work after graduation.

Background checks

- Felisa noted background check issues appear to be about the capacity of the offices to process the applications they are receiving. It doesn't make sense to try to change the process before dealing with the capacity issue. She would like to see a Task Force recommendation to increase capacity. There may also be a need to monitor implementation of the Rap Back program as that moves forward.
- Eve is unsure whether the Task Force should make recommendations on background checks. It may not be as impactful as recommendations in other areas. The background check and appeals process are a much bigger deal for Traditional Health Workers, particularly the support provided during the appeals process. She asked whether this is something other workgroups focused in this area could take up.
- Leah Mitchell: How does Oregon compare to other states in terms of our processing times? Is it a capacity problem or an efficiency problem?
    - LPRO staff can look into this but noted that agencies may be unlikely to be able to answer this question with existing data.

Chair Jones noted that if members are interested in working further on the background check topic specifically, there may be an opportunity for a smaller group to do so. Members should reach out to him or LPRO staff if interested in pursuing this.

Public Comment

- *Oregon Association for Home Care – Holli Holland (link)*
- *Oregon Center for Nursing – Jana Bitton (link)*

Meeting Materials	• *March 2024 Meeting #6 Summary (link)* • *Staff slides (link)* • *Staff memo – Questions and Answers from the March 2024 Meeting (link)* • *ATI Advisory slides (link) and data appendix (link)*