Meeting Summary

Joint Task Force on Hospital Discharge Challenges
Meeting #8
Link to Task Force on OLIS

LPRO
LEGISLATIVE POLICY AND RESEARCH OFFICE

Date/Time	May 23, 2024, 9-1pm (link to recording)
Attendees	Chair Jimmy Jones Vice Chair Elizabeth Burns Sen. Deb Patterson Daniel Davis Jeff Davis Trilby de Jung Eve Gray Felisa Hagins Alice Longley Miller Leah Mitchell Raymond Moreno Rachel Currans Henry Jonathan Weedman Jane-ellen Weidanz Phil Bentley Excused: Representative Christine Goodwin Jonathan Eames Jesse Kennedy Kathy Levee Joe Ness Sarah Ray
Opening Remarks and Meeting Overview (slides)	Today's meeting is a focused conversation on hospital discharge processes and challenges, including: • A presentation from ATI Advisory assessing Oregon's hospital discharge processes and experiences; • ATI recommendations on opportunities to promote more timely hospital discharges; • An overview of the Oregon Capacity System from APPRISE Health Insights; and • Presentations from ODHS licensing and facility oversight staff responding to ATI's post-acute facility survey findings. An upcoming meeting in June will focus on coverage of post-acute care and provider reimbursements. 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.
Assessing Oregon's Hospital Discharge Processes and	ATI Advisory presented key findings from their assessment of Oregon's hospital discharge processes and experiences. This work included analyzing trends in average hospital length of stay and complex care

Experiences (slides 1-17 and appendix)

ATI Advisory

- Cleo Kordomenos
- Laura Benzing

diagnostic cohorts from Oregon's All-Payer All-Claims data, an analysis of APD and Area Agency on Aging case manager workforce wage and employment trends, key informant interviews, and additional desktop research. More detailed findings are available in a data appendix.

Key findings

- Nationally, Oregon has the 2nd lowest hospital beds per capita among states.
- Total patient days are increasing (+20% from 2017-2022);
- Hospital bed staffing capacity remains below licensed hospital bed capacity (78%).
- Process barriers impede timely and appropriate hospital discharges to post-acute care, including LTSS eligibility process, lack of coordination between hospitals and state agencies during discharge, and increasing complexity of clients placing more demand on case workers and post-discharge providers.
- The percent of case managers leaving their jobs at APD and AAA is increasing over time, and the average years of experience of the case managers who leave is increasing.
- Vacant case manager positions are trending upward and wages have fallen behind inflation.
- Case load metrics are undercounts that do not capture 1) the increasing complexity of clients, and 2) clients without a paid caregiver.

Policy opportunities and recommendations related to these findings were presented separately (see next section).

Questions and Answers

Facilitated by Chair Jimmy Jones

Members asked questions following the presentation.

Question from Phil Bentley: can the asset testing portion of eligibility screening be simplified? Given the complexity of the federal coverage pathways, is there anything within our system that could be changed at the state level to simplify these processes?

- Jane-ellen noted that there are different financial eligibility thresholds for LTSS depending on how one qualifies for Medicaid. Traditional Medicaid ("OSIP-M") has an asset threshold of $2,000. Since Medicaid was originally established, Congress has created additional categories of people who may be covered. Populations that are covered through a waiver or other state plan option may have different thresholds.
- ATI noted that outside of federal waivers that may be time consuming for the state to pursue or slow for CMS to approve, there are opportunities to improve existing processes. ATI's presentation later in the meeting will review these (see below).
- ODHS noted all financial eligibility processes across APD and AAAs are done through the ONE system under an umbrella partnership called the Oregon Eligibility Partnership. Anyone involved in the process can work in that system. This can be good for access but challenging if

case managers only infrequently conduct these screenings and lack familiarity. ODHS is working with OEP to establish dedicated expert teams who focus on these cases. ODHS will present on this work at an upcoming meeting specifically related to people with mental illness and LTSS needs.

Question from Leah Mitchell: do we know how long it is taking to do financial eligibility assessments in the ONE system or how this compares to other states?

- ODHS can provide the processing time for the financial eligibility process as a discrete step. The ONE system doesn't track processing time for functional need assessment. They are working on a dashboard to measure how well Oregon is doing relative to the federal requirement to complete these assessments within 45 days.

Question from Vice Chair Burns: regarding data ATI presented on hospital bed staffed capacity being below licensed capacity, are there additional details on the reasons for the gap?

- ATI noted the data for this analysis comes from the Oregon Capacity System provided by OHA. *[LPRO staff note: OCS data do not capture reasons for beds being offline, including whether blocked beds are the result of staffing shortages.]*
- Vice Chair Burns noted that increasing length of stay in the hospital tracks to increasing acuity and complexity of patients there. Yet discharging them to post-acute care sooner raises the risk of readmission given higher acuity. The presentation also noted a substantial amount of SUD and mental health needs. Hospitals used to have psychiatric wings where these patients could be managed. Many hospitals have decreased this capacity or moved it off site. How much of that is driving the discharge crisis? Do hospitals feel there is opportunity to bring these beds back?
- Eve Gray noted that hospital beds close primarily due to nurse staffing, and that staffing deficits may increase length of stay due to the steps and work involved in discharge. Functional assessment should be done through a single system or process, regardless of the cause of the functional limitation, to streamline eligibility determination. This would require a system overhaul.

Eve commented that Oregon should explore medical respite facilities for the population of patients whose discharge is delayed, as some individuals may lack adequate housing for recovery.

Question from Eve Gray: Does ATI Advisory have more detailed information about the kinds of serious mental illness people experience when discharge is delayed, to understand the care needs of the population? For example, what percentage of people are experiencing psychosis?

- ATI has data about diagnoses included within its definition of serious mental illness and will follow up.

Question: Phil Bentley asked how Oregon is meeting the need for inpatient psychiatric beds.

- ATI found that the number of psychiatric beds remained consistent from 2017 to 2022, but that the data do not tell us whether, on the ground, we are meeting the needs of people with complex SMI needs.
- Ray Moreno noted that data about beds, on any given day, may not fully reflect staffing issues or available beds across different patient types.
- Phil Bentley noted that nurse staffing shortages are exacerbated by staffing requirements that apply to hospitals and soon, to nursing facilities. Nurse staffing is part of multiple challenges and should be a focal point for the Task Force.
- Leah Mitchell noted that when looking at bed and staffing data, the focus is usually on the adult population. For adults, the length of stay is typically higher. The Task Force should continue to focus on nurse staffing.
- Jeffrey Davis noted that nurse staffing may be more complex than spots for nurse education. For CNAs, creating more slots didn't result in more candidates. Attracting more people who are willing to join the profession maybe a more difficult problem to solve.

Opportunities to Promote More Timely Hospital Discharges (slides 18-29)

ATI Advisory: Kristen Lunde

ATI recommended three ways Oregon can address hospital discharge process and outcome challenges identified in their assessment, including:

1. Streamlining eligibility assessments for 1915(i) and long-term services and supports;
2. Documenting and increasing case worker capacity; and
3. Addressing post-acute and long-term care provider placement capacity (to be discussed further in June).

Streamlining eligibility assessments

ATI identified opportunities including:

- Aligning stakeholders' understanding of which post-discharge care settings are appropriate for people with certain needs;
- More responsive scheduling and contacts between hospital and LTSS eligibility assessment leads;
- Setting expectations for assessment timelines and providing updates;
- Clarifying what services are available and who is responsible for assessments and case management.

ATI reviewed results of a focus group discussion on a hospital discharge escalation protocol. The group identified the specific characteristics and steps that would need to be defined in order for Oregon to design and

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implement a protocol. A scan of other states revealed that while some, such as Washington and Massachusetts, are testing similar approaches, no state has developed a clear "off the shelf" model.

ATI identified opportunities to improve the eligibility assessment process, some of which could be advanced with existing authorities, and others which would require new federal waivers:

- **Shorter term:** 1) hospitals can begin eligibility assessment processes as soon as possible following admission and identification of need rather than waiting until ready for discharge; 2) ODHS and OHA can review recent changes to the financial eligibility assessment process and enable local case workers to intervene when delays occur.
- **Longer term:** 3) Oregon could implement systematic changes to the Medicaid eligibility assessment process, such as presumptive eligibility for LTSS and easing asset requirements for financial eligibility; 4) for individuals already enrolled in Medicaid, Oregon could leverage CCO-MOU requirements to support robust participation of CCOs in system coordination for members receiving LTSS.

Case worker capacity

ATI noted Oregon's current caseload methodology does not reflect the true volume of case work. The state could better capture the actual volume of work by 1) counting individuals who do not have a paid provider, and 2) accounting for varying complexity of cases. These changes could reduce worker burden and speed up assessment processes.

ATI highlighted an example from Lane County where the AAA created a dedicated team of case workers experienced in complex cases to alleviate burden on other case managers. Providers in this region report fewer difficulties with LTSS screening processes than other regions.

Post-acute provider capacity

ATI underscored that coverage and payment-related challenges are a recurring theme in their findings and engagement with stakeholders in Oregon:

- Current coverage and benefit structure creates care silos that are not well suited to individuals with complex care needs;
- Current payment rates including lack of acuity-based rates contribute to providers declining individuals with complex care needs;
- Providers are licensed to provide specific Medicaid benefits; these benefit-specific licenses contribute to the lack of providers with complex care expertise.

These topics will be explored in more detail at the June meeting.

Oregon Capacity System (slides)

APPRISE Health Insights:

- Andy Van Pelt
- Helene Anderson

Andy van Pelt and Helene Anderson from APPRISE Health Insights, the data analytics arm of the Hospital Association of Oregon, provided an overview of the Oregon Capacity System (OCS). OCS began tracking hospital bed-level discharge delays during the COVID-19 pandemic to aid system-level surge response. APPRISE has been working with participating hospitals to automate this reporting of avoidable hospital days and reasons for discharge delays. They are working to develop this system and hope it will be available to support state level monitoring and planning in the future.

Discussion

Facilitated by Chair Jimmy Jones

Vice Chair Burns facilitated a discussion among members about opportunities to improve hospital discharge processes.

Escalation Protocol

Members were asked what an ideal escalation protocol might look like.

Alice Longley Miller commented that they often hear from homecare workers that paid caregivers are often not included in the discharge process from a hospital. If there is a paid caregiver, this should be identified as part of the escalation process and they should be included in the care planning.

Phil Bentley asked whether the example from Lane County and from other states could be replicated in Oregon off the shelf? Would a governmental entity or AAA facilitate the protocol? Or is this something that could occur between providers and payers?

- ATI responded that there are not clear off the shelf models from other states or localities that could be replicated. These models provide lessons learned that could be applied to Oregon's development of a protocol, but Oregon will need to select elements from among these approaches to design something that will work at the statewide level. State agencies have been owners of these processes and provide a centralized contact at the state level. This could also be approached as a point-in-time exercise where individual stakeholders would have to be accountable to one another to follow through. Different payers will have different challenges; there would need to be meaningful involvement from the state for Medicaid-enrolled clients. If the payer is Medicare or a commercial payer, the mix of stakeholders would be different and the state may not be involved.
- Phil commented that this is an interesting concept and he sees the value proposition. This could be especially helpful in light of ATI's analysis showing the majority of people, including people with complex needs, are not discharging to facilities but to home or self-care. He would like to see examples or models to narrow down which entity would need to lead the case conference depending on coverage.

Vice Chair Burns asked if there could be standing meetings between hospital discharge planners and dedicated agency contacts? Would this help with delays in communication?

- Leah Mitchell commented that this would be very helpful. Hospitals have existing calls with various entities. It is hard to get the group of entities together at the same time. Having a regular cadence where the right mix of people could be pulled together from partner

organizations/agencies would be really helpful. This could be done in a regional consortium. For specific patients, there could perhaps be enhanced Medicaid rates if certain discharge barrier conditions were met.

- Eve Gray noted similarities to the coordinated entry system within the homeless shelter system. There are standing case management calls that occur with case managers at various agencies several times per week. They review the list of people experiencing homelessness, prioritized by vulnerability, to work together on care planning. Since all hospitals are trying to access the same services, it would be more effective to have a combined call for a single region rather than hospital-by-hospital. Having this be locally run and coordinated would be ideal. It needs to have dedicated staffing (similar to the coordinated entry system, which relies on multiple FTE per system) but they have found this model to be highly successful in the shelter space.
- Jane-ellen Weidanz noted that ODHS did this type of work during COVID surges. Considerations include how to coordinate while honoring patient preferences and privacy of health information. It could be a great idea if the system is adequately funded and staffed. The state wasn't able to maintain staffing for this after the pandemic response ended.
- Trilby de Jung seconded what Jane-ellen says about needing adequate staffing to do this well. She also agrees with Eve's comment about this working well as a local-level effort given that there is wide variation in CCO involvement in these efforts across regions.
- Ray Moreno supported the escalation protocol concept and noted the state needs to start somewhere and iterate. He agreed there is a lot of local variation and there would be value in this being a local or region-specific process. Ray underscored the importance of involvement from state agencies and the Oregon Eligibility Partnership. He supports creating a dedicated meeting on a regular cadence where the appropriate partners discuss specific patient care coordination, including protected health information. He also noted that this type of standing meeting would enable identification of recurring challenges or needs over time that may help tailor system improvements.

<u>Oregon Capacity System and Avoidable Days Tracking</u>

Vice Chair Burns asked members what information or data is needed to support system wide discharge planning?

- Leah Mitchell noted the data tool they are currently using for tracking avoidable days is very helpful. Hospitals were manually feeding data into this system. The new real-time tool from APPRISE that feeds out of the EHR is very helpful. Having data on post-acute bed capacity would also be very helpful.
- Trilby de Jung commented that there are many challenges related to lack of individual patient level data and quality of the data in the OCS to better analyze reasons for avoidable hospital days. For the state to consider higher rates for longer hospital stays, it would be very helpful

to have a retrospective study done with hospitals that included chart review.

Vice-chair Burns asked if APPRISE is looking further at how transportation is impacting placement of patients, not just between the hospital and a post-acute setting, but after a patient is placed in post-acute care and may need transportation assistance to other outpatient care or appointments.

- Helene Anderson noted the transportation data being captured is specific to the reasons why someone is delayed leaving the hospital. It could be someone needing transfer but lacking coverage; for example, secure transportation needed for a behavioral health patient. It is almost always non-emergent transportation. Another common challenge is that if a patient can't be transferred to a post-acute setting by a certain time of day, they are scheduled for "next available" day for transfer, which can be several days out.
- Senator Patterson asked whether there could be a second shift to coordinate these transfers later in the day? Is the issue primarily staffing cost?

Leah Mitchell asked APPRISE if they could share about their work on post-acute capacity system tracking in Hawaii?

- Andy van Pelt responded that their goal is to create capacity tracking capabilities across the broader health system. They have developed a system similar to the Oregon Capacity System that tracks post-acute beds. Hawaii is currently pilot testing that system, which includes both manual and automated data entry options for facilities who will submit updated capacity information twice-a-day. Approximately two dozen facilities are participating in the pilot phase currently; the system will open to the whole state in November 2024.
- Andy noted that in Oregon, they are working with OHSU to launch a behavioral health tile for the capacity system. They will eventually work to integrate this with the existing Oregon Capacity System.
- Daniel Davis noted there is a lot of opportunity to gain better visibility into real-time bed capacity in the post-acute system. This has been very helpful in the hospital system during COVID. Without visibility into who has capacity, hospitals send referral requests out to everyone. This creates additional work on both sides. Having visibility into post-acute system capacity, particularly for facilities with specialized needs contracts, would allow them to be much more precise in where they send referrals and more targeted in care management.

Senator Patterson asked how "people over 65 with mental illness" is being defined and whether it includes dementia?

- Jane-ellen noted that within APD when they assess individuals 65 and older, they don't look at diagnosis of cognitive impairment or dementia but functional impairment. The criteria are whether someone can manage their behaviors, communicate their needs, etc. For individuals aged 18-64, the assessment process they undergo for LTSS is determined by whether they have a primary mental health (OHA) or physical health (ODHS) diagnosis. If these individuals have a brain

injury or dementia, they are included in the APD system. Otherwise they are excluded from APD and assessed by OHA.
- ATI clarified that for the analyses they presented in this meeting, the population of people with mental illness did not include Alzheimer's disease or related dementias.

Follow Up: Aging & People with Disabilities Regulatory Overview (slides)

ODHS:

- Jack Honey
- Dave Allm
- Christy Cawa

Jack Honey from Oregon Department of Human Services provided an overview of the Safety, Oversight and Quality (SOQ) program. SOQ is responsible for facility licensing, regulatory oversight, complaint investigations, and administrative rule and policy development.

How Facilities are Regulated

Among facility types:

- **Adult foster homes** are primarily regulated at the state level through administrative rules enforced by APD local offices and Area Agencies on Aging (AAA). They are licensed annually. These rules were largely developed in the 1990s following a series of negative events.
- **Community-based care facilities** (including assisted living and residential care) are primarily regulated at the state level by SOQ and licensed every 2 years. These requirements are also largely established through state administrative rule, other than the federal Home and Community Based Care Setting requirements related to individual resident rights, which the state cannot change.
- **Nursing facilities** (including memory care) are primarily federally regulated by the Centers for Medicare and Medicaid Services. SOQ staff trained by CMS oversee annual licensing. The state has very little flexibility to make changes in this area.

Adult foster home regulation by local APD/AAA staff can include complaint investigation, license renewal/monitoring, corrective action oversight, or other check-ins as needed. Regulations span the following areas:

- Facility standards
- Caregiver staffing
- Resident records
- Medication and treatment standards

Community based care facilities are regulated through surveys and site visits for licensing renewal (every 2 years), kitchen inspections (annually), and revisits if a facility is found to be out of compliance. Teams of 2-5 surveyors visit the site for 4-5 days to make observations, conduct interviews, and review resident records. CBCs with licensing violations receive a statement of deficiencies with a description of each violation. They are required to develop a correction plan. The survey team may impose civil financial penalties or other conditions depending on violations.

Nursing facilities are regulated through an annual federal survey process for licensing renewal, and for abuse and complaint investigations. A team of 3-4 surveyors from SOQ conduct on-site visits for approximately one week to observe, conduct interviews, and review resident records. Federal survey standards are outlined in the CMS State Operations Manual for Nursing

Facilities and additional state administrative rules. Facilities with license violations receive a statement of deficiencies, are required to develop a corrective action plan, and may be subject to federal and state civil penalties.

Admissions and Move-Outs

Jack Honey noted that all facilities are required to consider certain factors when admitting a new resident, including the ability to meet that resident's needs as well as how admission would impact residents already within the facility. There is no federal or state statute or rule that can compel or force a facility to admit a new resident. Facilities make their own determination about who they admit.

Facilities with specific needs contracts are subject to additional oversight and must run these admissions through their contract administrator prior to approval.

Under existing statute, facilities can issue 30-day and less-than 30-day involuntary move out notices to residents for reasons including: non-payment, failing to disclose sex crime conviction, when care or behaviors pose a danger to the resident or others, or loss or suspension of the facility's license. Involuntary move-out notices must have a safe discharge plan and location. In nursing facilities, residents who have been in a facility for 30 or more days and are discharged have the right to be readmitted for 180 days. The facility is not required to hold a bed open, but if a bed is available, the facility is required to offer it to the former resident.

Enforcement

The regulatory framework followed by SOQ is intended to be progressive, relying first on technical assistance to resolve disciplinary issues before moving to corrective action. SOQ also operates a Facility Enhanced Oversight and Supervision (FEOS) program for facilities with recurring compliance issues.

SOQ staff noted that the agency is open to discussions with industry regarding rules that may create perceived barriers to admitting residents with complex care needs. In considering rule changes, they will consider how a proposed change would impact protection of residents from harm and support providers in delivering quality care to consumers.

Chair Jones asked if there are specific administrative rules that pose challenges for delivering care to people with complex needs that could be targeted for review.

- Jack Honey indicated that this review could be done. They do not have a specific list prepared but are open to doing this work, which could help pinpoint more precisely the areas where rules may need to be revisited.
- Eve Gray noted that within the housing and homeless services sector, the harder it is to evict a resident, the more risk averse landlords will be in accepting a higher needs resident. Oregon has done substantial work to prevent evictions that focuses on 1) providing support to the landlord including risk mitigation funds where landlords can recoup costs, and 2) providing support to the person at risk of eviction,

	including assistance through the eviction process if necessary. Are these approaches relevant to long-term care? How can the regulatory environment support long-term care providers being willing to accept higher risk residents? • Jack Honey agreed this is one of the most significant factors for long-term care facilities in considering admission of a higher risk resident. Providing support in this area would require looking for other supports or resources available in the community. A second opportunity would be to increase resources and training in mental health. • Vice Chair Burns and Phil Bentley both commented that that the current regulatory environment, designed for certain types of long-term care, isn't well adapted to current post-acute care for people with complex needs and high acuity. Phil noted that it would be helpful to review the current regulatory system with consideration for the patient populations that are not currently being well served to identify areas where greater flexibility or change is needed. He is concerned that other changes designed to increase capacity in post-acute settings will not achieve the desired results if these issues of provider risk are not also addressed. • Felisa Hagins commented that there have been a variety of estimates provided from different organizations about new bed or worker capacity needed in different settings. She wants to understand what overall level of capacity is enough to serve the population of high acuity people with serious mental illness who are repeatedly cycling through these settings over time? How long should people be spending in each setting before they transition to the next one? [*Staff note: while HB 3396 does not include behavioral health settings in the scope of post-acute settings to be addressed by the Task Force, there is related analysis on this topic being conducted by Public Consulting Group. Report will be released by the Oregon Health Authority.]*
Public Comment	• Oregon Chapter – American College of Emergency Physicians – Craig Rudy (link)
Meeting Materials	• April 2024 Meeting #7 Summary (link) • Staff slides (link) • ATI Advisory slides and data appendix (link) • APPRISE Health Insights slides (link) • Aging & People with Disabilities slides (link)