Thank you again for your consideration of FQHCs in the discussion of our mutual goal of improving our care delivery system. I commend the task force in the depth and breadth of the issues they are considering. I again conferred with multiple colleagues to craft this feedback, and we continue to have a strong interest in the task force's ongoing discussion and final recommendations. Any statistics I reference here have been pulled directly from presentations to the task force and I am providing feedback based on the requested outlined bullet points.

Guardianship is a massive barrier to getting many patients necessary care and placement. It is well worth funding an expansion in services and authority with a "fast track" route for those hospitalized to help with improving rapidity and safety of discharge. Need for guardianship is present prior to and during hospitalization, but naturally prioritizing those hospitalized will free up much needed hospital beds for more appropriate patients. This is applicable to those with severe mental health issues and many older unsheltered patients, but occasionally we find a care home patient who does not have an appointed POA and dementia has progressed past the point of decision making capacity. Ideally this is discovered before hospitalization or potentially terminal diagnoses, but it is not always. As guardianship is the first step in proper care for a lot of these patients, my hope is that expansion of guardianship programs would their ability to get involved earlier in the care process, thus reducing hospitalizations overall.

Post-hospitalization placement continues to be an issue compounded by low availability in regular housing and long-term care facilities. Breaking down Medicaid and Medicare barriers preventing admission to long term facilities is clearly important – the statistic that individuals with severe mental illness, SUD, obesity, or housing insecurity were the most likely to be discharged to home or self care (59+ percent) rings true. This is a terrifying and frustrating reality. Lack of availability, staff, and willingness to accept low reimbursement patients all remain seemingly insurmountable issues. Bolstering and expanding the CNA position is an excellent idea. Paying them a living wage will be essential as this is a classically underappreciated and overworked position resulting in frequent injury, burnout, and turnover. Their position and potential additional responsibilities would make them useful in a very wide range of venues.

A true respite center with medical supervision post hospitalization would be greatly beneficial to ensure appropriate transition of care between the inpatient and outpatient settings, including medication compliance, access to housing and phone services, and assurance of outpatient follow through as services become available. Having behavioral health involved at this stage would also be incredibly useful, as behavioral health is able to address mental health barriers post hospitalization and support patients with coping techniques, substance use reduction, and building healthy habits. Unfortunately without basic human needs met, behaviorists have limited capacity. Direct transfer to rehab centers when medical stabilization occurs is an integral part of medical improvement and recovery for certain individuals, but again, availability, financial, and social barriers remain an issue. We have recently had an RN working with the IPR unit case managers in Dallas to aid in coordination of care and resources at discharge, which has been greatly beneficial. No matter what the final discharge disposition is, dedicated care coordination to facilitate will be necessary and an essential investment to reduce readmission and improve patient outcomes.

Another vital thing to consider especially for those with severe mental illness or memory loss is that they are frequently cognitively incapable of compliance with outpatient follow up. Often patients already established with a primary care provider are assigned to alternate facilities post discharge because they don't recall having a PCP. If we identify this issue we work with insurance to switch them back to maintain continuity of care, but it increases the work for everyone involved, and many are missed leading to delays or even errors in care. Additionally, some patients become so terrified of leaving their care homes or going to a medical office that they refuse to attend appointments (changes in environment can be traumatizing for certain dementia patients, and poor prior interactions with the medical system spark PTSD episodes in may patients). The caregivers are appropriately not forcing these patients out of their domicile. However this leads to difficulties in comprehensive healthcare, as a lack of vital signs and physical exam findings make a medical appointment very challenging and potentially hazardous. To complicate this further, hospice and palliative care require an in-person visit within a specific timeline in order to evaluate people, so though certain patients qualify (i.e. a patient with dementia who is clearly declining but refusing visits), we are unable to provide the appropriate referral for the care they need. Currently many of these patients end up lost to follow-up and remain unevaluated until they return to the ER/hospital. Having finances devoted to traveling providers who are able to make rounds on these patients and provide treatment would be greatly beneficial. Some insurance companies are beginning to do this for discharge continuity and health maintenance evaluation, medication reconciliations, and compliance checks. This could be expanded to include providers designated as PCPs that make house calls to fill this gap in care.

This is an area of such great need that any forward progress will be appreciated. The incredibly diverse needs of this high-risk population mandates individual attention and advanced planning with extensive resources. As Oregon has the second lowest number of hospital beds per capita and the increase in inpatient needs, increasing the number of area hospitals in Salem and other high volume areas would naturally be beneficial and profitable. I would also point out that although only 3% of hospitalized patients met housing insecurity criteria, they had the highest number of ER visits. Within these visits there are obviously a lot of requests for housing, food, clothes, and other basic needs to be met or intoxication on various substances. Outpatient providers frequently find that a significant number of these patients have medical issues that would meet admission criteria either before or after their presentation to the ER. Unfortunately due to poor capacity to communicate history and overwhelmingly busy ER providers, they are not addressed. It is hard to track these "missed admissions" but they are a massive challenge for outpatient providers that I hope would improve with the implementing of any of the care coordination, guardianship, and post-hospitalization services discussed with the task force. Noteworthy that were they not "missed" they would exacerbate the main issue this task force is discussing. We continue to appreciate your efforts and consideration. This is a worthy humanitarian endeavor, and the first step in an immense systemic improvement project that we will continue to support.

Best,

Maria Niemuth, DO

Northwest Human Services

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