Advancing an Oregon Escalation Protocol to Support Timely and Appropriate Hospital Discharges

Presented to the Joint Task Force on Hospital Discharge Challenges July 30th, 2024

ATI Advisory

AGENDA

- Brief Refresher on Task Force Conversations To-Date Regarding the Escalation Protocol
- Next Steps: Envisioning a Region-Based Escalation Protocol Approach for Oregon
  - Key Questions to Consider as this Concept Advances
- Appendix for Additional Background

Refresher on Task Force Conversations To-Date Regarding the Escalation Protocol

TODAY'S DISCUSSION WILL FEATURE AN APPROACH FOR WHAT AN ESCALATION PROTOCOL COULD LOOK LIKE IN OREGON

- In May, ATI convened a small roundtable discussion on the concept of an escalation protocol. This topic was subsequently discussed in the May Task Force meeting.
- ATI heard from Task Force members that there is interest in a more detailed discussion on how an escalation protocol might further be developed to meet Oregon's needs.
- Today's meeting seeks key stakeholder input and discussion on:
  - An early construct of a regional approach to convening key stakeholders across the care continuum to identify, triage, and appropriately place individuals languishing in hospitals without appropriate care due to critical process-related delays.

An escalation protocol is a formalized process for communication and case management utilized when certain discharge barriers are identified.

- Escalation protocols seek to improve patient flow and enhance coordination among acute, post-acute, and community providers along with state agencies during the hospital discharge process.

REFRESHER: SAMPLE ESCALATION PROTOCOL PROCESS

- An escalation protocol requires clearly defined roles, processes, and modes of communication in order to be successful.
- Here, we refer to the group facilitating the protocol as the “regional discharge coalition.”

1. Escalation trigger identified by hospital or SNF case manager

2. Case manager adds patient to list of escalated cases for monitoring by the regional discharge coalition

3. Coalition member entities monitor list of escalated cases; convener determines appropriate attendance for regular meeting

4. Coalition has regular meeting to discuss cases, with attendees based on needs of patients currently on list

5. Establishment of follow-up actions, responsible parties, timelines

Ad hoc interactions between coalition members

REFRESHER: AN ESCALATION PROTOCOL REQUIRES CLARITY ON INFRASTRUCTURE AND PROCESS

Infrastructure		**Process**	
Convener and Stakeholder Participation (Non-Exhaustive)	*Financial and Communication Resources*	*Triggers for Use*	*Components*
→ Hospitals → State and local health and human services agencies (ODHS, APD, AAAs, OHA, county behavioral health) → Oregon Eligibility Partnership (OEP) → CCOs → Post-acute and long-term care providers → Social service providers, including housing → Oregon Public Guardian and Conservator Program (OPG)	→ Funding to support the convener of the escalation protocol and regional coalition leads → Mechanism for sharing information on escalated cases, including necessary data privacy protections	→ Patient meets one or more identified discharge barriers → Barrier examples: requires guardianship, eligibility assessment delay, has been waiting for a hospital discharge for a defined number of days	→ Single designated contact within each stakeholder organization → Regular case conference/convening with hospital, state agencies and relevant stakeholders → Opportunities for ad hoc escalation → Accountability for follow-up by each relevant stakeholder

REFRESHER: ESCALATION PROTOCOLS MAY SUPPORT PROCESS IMPROVEMENT, BUT DO NOT ADDRESS CAPACITY AND ACCESS CHALLENGES THAT RESULT IN DISCHARGE DELAYS

An escalation protocol is just one of many potential policy changes Oregon may consider, and ATI has explored, to address the identified hospital discharge challenges.

Escalation Protocols May Improve:

- ☑ Alignment on possible care settings based on needs
- ☑ Timeliness of Medicaid LTSS eligibility determinations
- ☑ Connections to benefits and services within Oregon's delivery system (e.g., health related services) to support community placement
- ☑ Clarity on roles and responsibilities across organizations to promote timely patient placement
- ☑ Burden on case managers and care providers currently overseeing discharges

Escalation Protocols Do Not Address:

- ☒ Lack of capacity and capabilities to meet complex care needs
- ☒ Insurance coverage limitations
- ☒ Required steps in the Medicaid LTSS eligibility process
- ☒ Lack of public guardians
- ☒ Staff shortages in post-acute or long-term care settings, or state agencies
- ☒ Need for safe discharge options to support individuals with complex care needs, when level of care needs either exceed or are not appropriate for common post-acute care providers

Next Steps: Envisioning a Region-Based Escalation Protocol Approach for Oregon

POSSIBLE CONVENERS OF A REGIONAL ESCALATION PROTOCOL PROCESS

*The convener would bring stakeholders together and serve as the administrative lead for regional coalitions. The convener would **not** take over any existing responsibilities of other entities, such as LTSS eligibility determinations. Two existing regional infrastructures Oregon could rely on for convening are: (1) a DHS APD district–based framework, and (2) a region-based CCO infrastructure.*

Convener Considerations	AAAs, APD Convener Model	CCO Convener Model*
+	→ Direct connections with the Oregon Eligibility Partnership (OEP) for cases where the Medicaid eligibility process is a challenge → Provide coverage for LTSS under the Oregon Health Plan (OHP) and strong connections with local LTSS providers → Connections to state agencies running social programs individuals may be eligible for	→ Holistic view of individuals' medical needs and history → OHP covers 31% of Oregonians with at least one hospital stay; within OHP, CCOs cover 96% of individuals with at least one hospital stay** → Builds on and refines existing CCO contractual expectations, including existing CCO/AAA MOUs; opportunity to further codify roles / responsibilities regarding individuals needing LTSS eligibility assessments → Existing CCO relationships with social services providers under ongoing HRS / HRSN / SHARE services initiatives
−	→ Significant additional state agency effort → Limited ability to intervene in cases where individual is not covered by, or potentially eligible for Medicaid → Limited connections to providers that provide services more frequently covered by CCOs, such as primary care, post-hospital extended care, etc.	→ Potential for significant additional CCO effort, pending scope of state contractual updates → Moderate incremental state agency effort to plan, develop, and oversee new contractual requirements and other guidance → Limited insight and influence over individuals being assessed for and receiving LTSS, and their associated coverage, benefits, and providers, due to LTSS being "carved out" of CCO global budgets → Limited ability to intervene in cases where individual is not covered by or potentially eligible for CCO coverage (i.e., excludes OHP FFS member and individuals are not exclusively OHP members)

*A CCO-convened approach would be similar to efforts by Health Share during the COVID-19 pandemic
**ATI Advisory analysis of Oregon All-Payer All-Claims data, 2022. Among all Oregonians with or without hospital stays, 13% of OHP individuals (18+) were in FFS: Oregon Health Authority: Medicaid Enrollment Report : Office of Health Analytics: State of Oregon.

STAKEHOLDERS WILL NEED TO DETERMINE DESIRED LEVEL OF PRESCRIPTION IN HOW CONVENERS IMPLEMENT REGIONAL HOSPITAL DISCHARGE COALITIONS

Factors	Key Questions to Advance the Regional-Based Approach
Operations	▪ How significant is the administrative burden to the identified convener? ▪ What financial or other resources are needed to support and sustain added administrative burden on the convener and participants?
Triggers for Use	▪ How will the standardized set of individual or circumstantial characteristics that elevate a case to the coalition be set?
Stakeholder Participation	▪ How will the convener support and collaborate to ensure that the right stakeholders are convened around each case and that stakeholders are accountable to follow-up actions and timelines?
Infrastructure	▪ What level of infrastructure updates will be needed for the state, providers, CCOs, and community organizations to effectively implement new requirements (e.g., billing, data sharing, referrals, etc.)?
Regulatory and Compliance	▪ What guardrails and protections will the state, CCOs, and other participating stakeholders put in place to ensure compliance with federal and state regulations (e.g., HIPAA compliance, adherence to federal Medicaid requirements if CCOs are conveners)?

Appendix

Additional Escalation Protocol Background as Presented by ATI Advisory at the May Hospital Discharge Task Force Meeting

COMPONENTS OF AN ESCALATION PROTOCOL INCLUDE CLEARLY DEFINED ROLES, PROCESSES, AND COMMUNICATION ACROSS STAKEHOLDERS

Possible Protocol Characteristics

Patient Population

- Patients who will be discharged from an acute-care hospital or other facility and have a barrier to such discharge

Triggers for Use

- Patient meets one or more identified discharge barriers
- Barrier examples: requires guardianship, eligibility assessment delay, has been waiting for discharge for a defined number of days

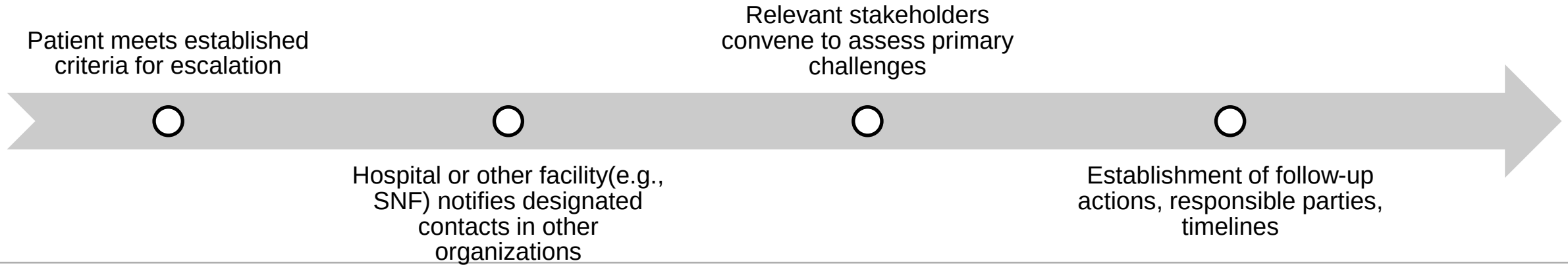
Stakeholders Engaged

- Hospitals
- State agencies
- Post-acute and long-term care providers
- Social service providers
- Residential treatment centers for adult mental health and/or substance use

Components

- Criteria for escalation
- Single designated contact within each stakeholder organization
- Case conference/convening with hospital/facility, state agencies and relevant stakeholders
- Clear roles and responsibilities of relevant stakeholders
- Process for establishing follow-up actions

Possible Protocol Steps



STATES AND STAKEHOLDERS ARE RECOMMENDING AND TESTING A RANGE OF RELATED SOLUTIONS, BUT NO CLEAR STANDARD EXISTS

	Washington[1,2]	Massachusetts[4]
Convener(s)	→ State	→ State
Action	→ Implementation	→ Implementation
Program/ Recommendation	→ Variety of supports, including case management, for discharges and placement of people who are unhoused, have mental health or substance use issues, require guardianship services, do not have access to traditional health insurance, or have specialized medical care needs	→ Discharge Support Team/Line, supporting with long-term care and housing discharge challenges → Patient criteria not defined, but focus on patients with skilled nursing needs and who are homeless or housing unstable
Process	→ Health Care Authority and Department of Social and Health Services work with hospitals and MCOs to find suitable community placements	→ State-produced guidance and resources for hospitals → "Last resort" option to contact state Discharge Support team through a standardized intake form

Oregon Local Innovation Spotlight:

→ Asante and APD representatives from two counties convened complex case team meetings twice a week to work through challenges

1. https://www.wsha.org/wp-content/uploads/Budget-Brief-Pro-Difficult-to-Discharge-FINAL-2022.pdf
2. https://www.wsha.org/wp-content/uploads/DTDLetterheadJuly292022FINAL.pdf
3. https://www.mass.gov/discharge-resources-and-guides-for-hospitals