Office of the Long-Term Care Ombudsman – Policy Concept Feedback 8-5-24

(Long-Term Care Ombudsman, Oregon Public Guardian & Residential Facilities Ombudsman)

Domain 1: Discharge from Hospitals to Post-Acute Care
LTSS
Eligibility

1.1 The legislature should 1) allocate funding for ODHS caseworker positions using a methodology that accounts for individuals who do not have a paid provider and accounts for varying complexity of cases, 2) direct agencies to establish dedicated teams of case workers (APD, AAA, and OHA-BH) who specialize in eligibility assessments for complex cases, and 3) increase AAA/APD caseworker staffing to improve wait times for LTSS determinations.

Specialized teams for complex case assessments sounds reasonable and more staff doing the work should help with wait times.

1.2 ODHS and OHA should take necessary steps to enable LTSS financial eligibility determinations to be based on self-attestation of assets for people who are homeless, including seeking any necessary legislative changes or federal approvals.

This sounds good. We have seen the process around proving a lack of assets for LTC eligibility be a barrier for homeless individuals. It is likely a rare situation where a homeless person is hiding a bunch of assets.

1.3 The legislature should direct OHA and ODHS to study options to adopt LTSS presumptive eligibility and waive or streamline asset testing, including studying financial and equity impacts, for the next waiver cycle beginning 2028.

Agree

1.4 ODHS and OHA should provide guidance to local case workers on how to intervene when a delay occurs in LTSS **financial** assessment.

Agree

1.5 ODHS and OHA should 1) develop an integrated process to streamline **functional** assessments across programs, 2) publish caseworker expectations for: assessment scheduling, communication with hospitals, and expected response times, and 3) provide training to case workers and hospital discharge staff to align expectations.

We support any efforts to streamline and bring parity to the way these assessments are done across the different systems.

Guardianship

1.6 The legislature should 1) continue funding for five limited duration positions in the Office of the Public Guardian, 2) fund (six) additional OPG positions, and 3) provide funding to local networks of pro bono and nonprofit guardians.

We are very supportive of 1 and 2. Also supportive of 3; the need for guardianship services for indigent individuals with complex needs is very high, there will always be room for other providers beyond OPG.

1.7 The interim legislative work group on guardianship should make recommendations to the legislature on formal guidance for providers and the public supported decision making in non-guardianship cases.
We believe this would move the needle forward slightly for the development of supported decision making in Oregon and are in favor.

Escalation Protocol and Care Coordination

1.8 OHA and ODHS should 1) create a centralized database of post-acute facilities with real-time numbers and types of placement openings, and 2) train hospital discharge planners on use of the system. OHA should explore whether the APPRISE Health System could add this functionality to the Oregon Capacity System, including tracking of facilities with specialized needs contracts.

The creation of this type of statewide database of placement options would be great for hospitals. If it does get created, we'd advocate for OPG to have access.

1.9 *[Staff note: ATI will present a more detailed straw proposal for this concept at the July meeting]* [Lead entity TBD] should convene regional meetings to coordinate/escalate complex discharges. The lead entity should develop a process to obtain consent from patients, share protected health information within the group as necessary, and engage paid caregivers in care planning. The legislative assembly should require and fund participation from Oregon Eligibility Partnership staff in each region's convening. If appropriate, the lead entity should collaborate with homeless services' coordinated entry meetings in each region. OHA and ODHS should consider connection points with approval processes for enhanced Medicaid rates for hard-to-place patients (e.g., see #3.8). Where Medicaid is not the primary payer, the lead entity should establish a process to ensure payer participation (e.g., see #1.10).
We do not fully understand this but are interested in learning more when the proposal becomes available.

1.10 OHA and ODHS should leverage existing managed care authorities to 1) require CCOs and D-SNPs to provide more targeted care coordination and case management at the point of hospital discharge; 2) strengthen integration between hospital discharge planning and new HRSN supports; and 3) strengthen CCO utilization of new required Traditional Health Worker networks for care transition support.

In our experience, CCO's are already pretty involved in these complex discharge cases, but more encouragement to coordinate is always a good thing.

1.11 OHA and ODHS should provide guidance and training to hospital discharge planners, case managers, and post-acute facilities to align expectations on which care settings are appropriate for patients with certain complex needs.

Agree with this. At our Agency we have run into many cases where it does not seem like the hospital discharge planners understand the landscape of care options out there. In one case this resulted in a bad outcome where a hospital discharged an OPG client to homelessness because they did not believe there were any facilities in the state that could handle the client's needs. The client wasn't particularly difficult, but it was very difficult to set up a plan once they were homeless. We did eventually succeed, and the client has been doing well ever since in an enhanced needs care facility.

Domain 2: Innovative Care and Payment Models
Medical respite

2.1 *[Staff note: ATI will present additional information on this concept at the July meeting]* The legislature should 1) expand medical respite programs statewide for people experiencing homelessness; 2) make medical respite a covered OHP benefit or provide other sustained funding; 3) direct OHA to coordinate delivery of medical respite and Medicaid-paid housing benefits, and 4) direct OHA and ODHS to establish options for provision of home health and in-home care services in shelters.

This is a good recommendation. We have seen medical respite options help people get back on their feet when available. And when not available we have seen people repeatedly wind up back in the hospital, because they are never able to fully recover once back to homelessness.

Specialized facilities
2.2 [Lead entity TBD] should study what regulatory framework and level of staffing would be minimally necessary and appropriate for a step-down facility serving a group of higher acuity patients. Consider what reimbursement level would be appropriate to support recruitment and retention of staff under this model.

This could be a positive option but framing it as "what regulatory framework and level of staffing would be minimally necessary," doesn't feel resident-centered. This group of residents will need flexible staffing to meet ever-changing needs based upon acuity. We'd prefer to use language like, "study what regulatory framework and staffing are needed to ensure resident rights are in place and that high-quality staffing is in place to meet the high-acuity residents' needs."

More options for high-acuity patients, including step-down options are positive and needed.

2.3 The legislature should direct ODHS to expand the state's existing Enhanced Care Services program or other specialized care delivery model.

Expanding ECS options is needed. OPG has had a lot of clients see success when in ECS program.

Domain 3: Coverage and Reimbursement
HCBS Rates

3.1 The legislature should 1) increase base rates for adult foster homes (AFH), 2) adopt an acuity-based reimbursement model, and 3) address rate parity across AFH types (see HB 2495). The acuity-based rate methodology should employ a standard assessment process and rate tiers to improve transparency and predictability in reimbursements while minimizing reliance on rate exceptions. ODHS should immediately offer a higher base rate while developing new rate methodologies.

Foster home rates certainly need to be adjusted up; however, to our knowledge, the rate structure is already acuity-based.
http://www.dhs.state.or.us/spd/tools/program/osip/rateschedule.pdf

It's our understanding that most individuals are assessed at base plus 3 for AFH, and that the provider also receives the Room and Board payment on top of that rate.

3.2 The legislature should adopt acuity-based payment methodologies for home and community-based providers who are required to use acuity-based staffing tools.

This recommendation is confusing because:

First, it is our understanding that ALF/RCF Medicaid rates are already acuity-based – there are levels or base+ amounts and the payment is based on the acuity of the resident. See rates sheet here:
http://www.dhs.state.or.us/spd/tools/program/osip/rateschedule.pdf

It's also our understanding that most individuals are already at levels 4 or 5 for ALF and base plus 3 for RCF, and you add the Room and Board payment on top of that dollar figure. (This would need to be verified by DHS – we suggest getting this breakdown from DHS to show where the current Medicaid LTC population falls on the rate schedule for each setting type.)

Second, acuity-based staffing tools are the way a provider determines how many staff are needed for their particular population of residents. For decades, facilities have been required to staff for the planned an unplanned needs of residents (acuity) at all times. The expectation has always been that this is based on the acuity, and the ever-changing acuity, of a resident population. Regulation of acuity-

based staffing tools (either the provider's proprietary tool or the DHS provided tool) showing that the facility is actually staffing to that level is more recent, but the underlying requirement to staff based upon acuity has not.

3.3 The legislature should direct ODHS and OHCS to study opportunities to offset the cost of creating new adult foster homes. Such approaches might include county-level microlending programs or use of land trusts.

Sounds creative and like a great way to increase this option.

Wages

3.4 The legislature should establish a minimum wage for direct care workers.

This sounds positive, so long as the unintended result isn't the elimination of other needed workers for a particular facility. Having less turnover and enough staff to meet the needs of residents is of the utmost importance.

3.5 The legislature should establish a Medicaid rate pass-through for direct care workers.

Yes, we agree – with each rate increase, currently there is no assurance that taxpayer money goes to the caregivers and the direct operations of the facility – which, in turn, impacts residents' day-to-day experience and overall wellbeing. Instead, to our staff and volunteers it seems that the taxpayer money goes to profit (to owners and/or shareholders) instead of where it's truly needed, at the resident direct-care level.

Nursing facility rates and coverage

3.6 The legislature should extend the OHP post-hospital extended care (PHEC) benefit to 60 or 100 days (Medicaid-only enrollees).

Agree.

3.7 The legislature should direct ODHS and OHA to create a "hard to place" rate for nursing facilities to be administered by CCOs, OHA, and ODHS through standard processes (e.g., criteria might include homeless, SUD, challenging behaviors, plus LOS 7+ days and rejection from all NFs within 20 miles of hospital).

Higher funding for placements, even SNF placements is usually the only way to get a truly difficult client placed, however, there needs to be a review of current exceptional rates to ensure that the money is truly going to improve the care and outcomes to the resident/patient. Current exceptional rates already exist for the following types of individuals: Bariatric: $28,429.04/month; Complex:

$21,335.56/month; Enhanced: $21,335.56/month; Pediatric: $39,239.29/month; Ventilator: $36,310.65/month.

With Specific Needs Contracts – additional creative placements can be achieved, but there is little accountability for where the dollars are spent and our agency has seen non-compliance with the contract repeatedly, resulting in negative outcomes to residents. The contracts or negotiated rates are critical and we support them, but only with true accountability measures in place by ODHS and OHA.

Home Modifications

3.8 OHA and ODHS should use existing managed care authority to promote access to home modification services and supports that enable people to discharge from hospital to their home. OHA should use SMAC authority to direct dual-eligible special needs plans (D-SNPs) to offer these services to enrollees. OHA should direct CCOs to offer these services to OHP enrollees.

Agree. It would help make it easier to modify a home for a person who has become disabled.

Domain 4: Increasing Community-based Placements

Facility Regulations

4.1 ODHS Safety, Oversight, & Quality (SOQ) should conduct a study of administrative rules that may create barriers to facilities accepting residents with complex care needs. SOQ should 1) compare regulations for acute care hospitals, and long-term care settings that accept post-acute patients from hospitals, to identify areas where regulations could better align across acute and post-acute settings, and 2) pilot changes to these facility regulations to test whether they address perceived as barriers to complex care admission/delivery.

It is not clear to our Agency that OARs create barriers to accepting complex patients. Any weakening or removal of the existing regulations would only seem to open the door for lower quality of care. We are also not clear why it is relevant to compare regulations in acute care vs. post-acute care.

In the end, if the request is just for SOQ to study the issue for better compliance and understanding of the rules that is not a problem, but if it leads to weakening of the rules on behalf of residents and their rights, that would be hugely problematic.

4.2 The legislature should 1) allow greater flexibility for long-term care facilities to initiate involuntary move-out orders of residents to reduce perceived risk of admitting high acuity residents, 2) establish support to facilities to recoup costs of involuntary move-out orders, and 3) establish support to residents who are issued involuntary move-out orders to navigate relocation or address factors contributing to move-out order.

Enacting any part of this idea would have the opposite effect of what the task force is trying to solve. If a DHS licensed setting is allowed to more easily evict individuals, the hospital is where they will end up with no right to return to their home/facility.

The current eviction/move-out-notice for care facilities is not too onerous. If anything, our staff would like to see protections for residents strengthened so it is harder to evict them.

(3) is good, LTCO/RFO and OPG work to support constantly, but do not have the capacity to assist in every scenario. Legal aid also does what they can but doesn't always have capacity. More resources are needed for residents facing eviction.

4.3 SOQ should 1) reduce civil monetary penalties on post-acute providers with violations, and 2) provide support to facilities with residents presenting challenging behaviors due to mental health or substance use conditions. Support could include technical assistance or agency guidance in lieu of corrective actions.

The civil penalties are extremely low already and do not deter bad and/or repeated behavior. Instead, the civil penalties are looked at as a part of doing business, but with horrible human cost and harm to many vulnerable Oregonians.

More support is always needed for individuals experiencing mental health issues or substance use conditions.

4.4 The legislature should streamline licensing across foster homes serving ODDS, APD, and OHA clients.

It would be incredible if a AFH could be licensed and then immediately approved to take APD, ID/DD or mental health clients. The cross-placement options are difficult at best, currently.

4.5 The legislature should increase FTE for facility licensing functions for adult foster homes at OHA and ODHS.

This may be beneficial, but we aren't clear how many staff are currently dedicated to this work.

Background checks

4.6 The legislature should increase capacity at the Background Check Unit to address backlog and reduce processing times for pre-employment screening of DCWs.

Not sure what the wait times look like for these, but we agree that getting qualified/approved workers through this process is critical and support this.

4.7 The legislature should direct BCU to monitor background check processing times following transition to Rap Back.

Agree.

Domain 5: Worker Training, Education, Licensure & Certification – No concerns with this domain except to say that CNAs aren't required in AFH, ALF, RCF or MCC and it would be valuable to have this requirement to improve care over time in these settings and could result in higher quality.

CNAs and Direct Care Workers

5.1 The legislature should expand investments in registered apprenticeships for CNAs.
5.2 The legislature should create a registered apprenticeship for LPNs.
5.3 The OSBN should 1) develop a pathway for direct care workers to become CNAs; 2) make CNA and DCW trainings portable and stackable across employers, and 3) formalize a pathway for CNAs to become RNs.
5.4 The legislature should create an entity like MHACBO to oversee 1) advanced roles such as transition specialist or care
integration senior aide, and 2) a behavioral health certification for direct care workers

Registered Nurses

5.5 The legislature should 1) direct public higher education institutions to benchmark nurse faculty salaries to local industry
rates, and 2) match faculty compensation to industry rates.
5.6 The legislature should clarify that it is not a conflict of interest for nurses employed at Oregon State Hospital to serve as faculty and preceptors.
5.7 The legislature should 1) direct the OSBN to establish a statewide system to coordinate nursing student clinical placements, and 2) direct OSBN to monitor denial of placements over time.
5.8 OSBN should study rules for 1:1 nursing student clinical rotations and make changes to improve access to placements.
5.9 The legislature should direct OSBN to create an interstate licensure agreement between WA, CA, ID, and Oregon to allow nurses to transfer licenses in good standing without reapplication.
5.10 The legislature should forgive nursing student loans and offer other incentives for students who 1) choose careers in post-acute care, or 2) become nurse faculty.

Domain 6: Federal and State Partnerships