Meeting Summary

Joint Task Force on Hospital Discharge Challenges
Meeting #10
Link to Task Force on OLIS

LPRO
LEGISLATIVE POLICY AND RESEARCH OFFICE

Date/Time	July 30, 2024, 9-11am (link to recording)
Attendees	Senator Deb Patterson Representative Christine Goodwin Chair Jimmy Jones Vice Chair Elizabeth Burns Daniel Davis Jeff Davis Jonathan Eames Eve Gray Kathy Levee Alice Longley Miller Jesse Kennedy Leah Mitchell Raymond Moreno Joe Ness Sarah Ray Rachel Currans Henry Nikki Olson Jonathan Weedman Jane-ellen Weidanz Excused: Phil Bentley Felisa Hagins
Opening Remarks and Meeting Overview (slides 1-9)	Acknowledgment of the passing of Senate President Peter Courtney. Several members are excused to attend Sen. Courtney's service. Nikki Olson is appointed as the Oregon Health Authority representative to the Task Force. This abbreviated meeting focused on: 1) Medical respite care; 2) Discussion of policy concepts. In addition to ATI's presentation on medical respite care, the purpose of this meeting is for members to discuss policy concepts, flagging priority concepts as well as concepts that should not move forward. Staff will work with the chair, vice chair, and ATI Advisory consultants to prepare a first draft of recommendations from member input. Draft recommendations will be shared for discussion and iteration at the September meeting. Staff will update draft recommendations following the September meeting and prepare a draft report for Task Force review at the October meeting. Staff will incorporate further member feedback on the final recommendations and report

	that will be presented for task Force approval at the November meeting. Separate from the Task Force Report, ATI will produce a report with its analysis. Members are encouraged to reach out to the chair, vice chair, or staff, with any questions or feedback between meetings. Due to abbreviation of meeting, several presentations are postponed: • 1915i Overview (OHA/DHS slides) • Revisiting Escalation Protocol (ATI slides) • ATI Report Preview (ATI slides)
Deliberation Process Chair Jimmy Jones (slides 10-15)	The Chair provided an overview and reflections on the decision-making process of the Task Force over the next few meetings. The Task Force was formed due to challenges in the discharge process: delays in discharge, financial challenges, and workforce shortages. Populations of people with high levels of need are growing—including people who are aging, who have complex care needs, and who are homeless. If the Task Force does not act now, another group may need to take up these same issues in the following interim, when the challenges facing the state have worsened. Members can achieve solutions that will work for everyone even if they may not be able to achieve the best of all outcomes for all parties. The Task Force should be guided by the criteria for success identified when it began its work; recommendations should be: • Relevant to reducing discharge delays. • Patient-centered (including for homeless patients). • Specific enough to be actionable. In the words of Trilby de Jung: the Task Force should avoid passing the buck.
Providing Medicaid Coverage & Reimbursement for Medical Respite in Oregon (slides) ATI Advisory • Jonathan Amos	ATI Advisory provided a snapshot of medical respite policies and programs as an alternative model of care to support individuals experiencing homelessness or complex care needs. Task Force members expressed interest in ATI further discussing medical respite opportunities. • Medical respite programs provide acute and post-acute care for individuals experiencing homelessness who are too ill or frail to recover on their own from a physical illness or injury, but not ill enough to be in a hospital. • Medical respite closes the gaps between hospitals and homeless shelters that lack the capacity and licensing to provide medical support needed for recuperation. • Medical respite typically falls into the following categories defined by states and CMS: ○ **Short-term post-hospitalization housing**. Short-term housing for individuals who do not have a residence to continue recovery from physical, psychiatric, or substance use conditions. Care typically includes wraparound services and case management and may include ongoing physical and behavioral health services.

    - **Recuperative care**. Short-term residential care with ongoing medical care, such as medication monitoring, wound care, monitoring vital signs, supporting nutrition and diet, and other physical and behavioral health services.
- Research on medical respite shows these programs reduce hospital admissions, ED visits, and length of stay while improving individuals' housing status.

A small number of medical respite care programs in Oregon are currently funded through three key pathways:

1. State general fund grants and investments
    a. Project Turnkey 2.0 grant funding enabled new medical respite beds at non-profit shelters.
    b. ODHS' Office of Resilience and Emergency Management used general fund dollars during COVID to provide housing to those needing safe places to recover following hospitalization.
2. CCO approaches
    a. OHA's SHARE Initiative requires a portion of CCO profits to be spent on housing related services—some of which are invested in medical respite facilities.
    b. CCOs use flexibility within global budgets to provide health related services, which may include temporary housing.
    c. CCO wrap-around services include care navigation and transitions between services.
3. Other grants, partnerships, and non-profit efforts
    a. Private philanthropic grants from Bezos Day One Fund, for example, helped Mid-Willamette Valley Community Action expand shelter bed capacity.
    b. Other nonprofit medical respite providers report receiving grants from CCOs, hospitals, and private donors.

In the current delivery system, medical respite is provided on a limited basis that varies by region. When an individual is ready for discharge, hospital planners may refer an individual to a non-profit shelter, with or without recuperative care, if available in the region. In certain instances, short-term housing support may be available, along with wrap-round services including case management between transitions.

Oregon could expand access to medical respite without first needing to obtain additional federal approvals. State pathways to promote medical respite care using existing Medicaid managed care flexibilities include:

- CCO Opportunities
    - Using the CCO procurement process to require that new CCO contracts address post-discharge needs for homeless individuals.
    - Strengthening requirements in existing CCOs' contracts to include medical respite providers.

    - Strengthening SHARE Initiative guidance that CCO reinvestments should include medical respite care.
- Provider Opportunities
    - FQHCs can operate medical respite programs and receive reimbursement from CCOs (including through alternative payment models for non-traditional services).
    - Other medical respite providers may also form relationships with CCOs to provide care (including by working with CCOs to meet benchmark goals).

States may also reimburse medical respite care as a Medicaid-covered service. These approaches have varying requirements for federal approval and offer varying levels of federal matching funds:

- Medicaid State Plan Amendment (see MN)
- Managed care "In Lieu of Services" (ILOS) (see IL)
- Section 1115 Medicaid demonstration waiver (5 states currently, 7 pending)
    - Five states currently operate medical respite programs under an 1115 waiver with another 7 states requesting to do so pending CMS approval
    - Examples include:
        - California: Up to six months of short-term post-hospital housing
        - Kentucky: Up to 45 days of recuperative care
        - Hawaii: Post-hospital housing for people who are homeless

ATI noted that in the short term, Oregon could pursue approaches that center on CCO procurement. In the longer term, Oregon may secure a state plan amendment, using general funds, or an 1115 waiver, with federal match for medical respite.

Jonathan Weedman expressed support for medical respite services, emphasizing that the 1115 waiver approach—making medical respite part of the state's OHP benefit— would support consistent medical respite services across the state and reimbursement to providers.

Eve Gray noted that ShelterCare, highlighted in the presentation, serves a small proportion of all potential clients. It does not address the whole scope of the problem. Since requesting approval of an 1115 waiver may take longer than other approaches reviewed, is it possible to use existing CCO resources for nursing staff on site at shelters?

Chair Jones operates shelter care beds in Marion County with medical providers on site. This model meets people's needs when they need a place to get better but do not need hospital-level care. It will not solve the larger problems facing this population but will address this sliver of the problem. More funding to enhance these models across the state would relieve the burden on hospitals and post-acute care providers. The model also provides individuals with social services.

Jane-Ellen Weidanz asked whether shelters may serve individuals with ADL needs.

- Chair Jones answered that shelters may be able to take more complex individuals, but that shelters may only take clients during the day, which is a barrier to discharging clients at night with additional needs.
- Jeff Davis described the Franklin Shelter in Bend, which provides part-time nursing services, allowing the shelter to serve people with higher levels of need.

Rep. Goodwin noted that a sense of urgency is needed. Federal waivers are long-term solutions. Short-term concepts for legislative action should be innovative, including at the regional level—partnerships that include CCOs and other stakeholders. Oregon should also explore regulations for long-term care providers. Finally, the state should leverage the money agencies are spending currently—including for workforce programs—to direct funds where they are most needed.

Chair Jones noted that Oregon Housing and Community Services has been historically underfunded and does not have full understanding of shelter needs across the state, including behavioral health, medical, and care needs. It might make sense for ODHS to have a larger role in the shelter system.

Sarah Ray noted that adult foster homes, including mental health, developmental disabilities, and APD foster homes, are cost-effective placements for clients with complex needs, but that homes face increased regulatory burden, including assessments, that may lead to closures of more homes in the future.

Policy Concept Tracker (policy tracker document)

LPRO Staff

Chair Jones

LPRO created a document tracking concepts offered to date by Task Force members. The tracker document does not rank or prioritize concepts. Concepts are arranged according to the framework in HB 3396 (2023). Members are encouraged to identify missing or incomplete concepts, to give feedback both in meetings and by email to the chairs. Public input on concepts is encouraged. Members may evaluate concepts through the lens of their agreed-upon criteria to identify priorities and concepts that need more refinement.

Leah Mitchell noted several priorities:

- Presumptive eligibility for Medicaid patients. Many patients waiting to discharge from the hospital are waiting for LTSS eligibility determinations. The complexity of the process is a barrier. It is important to look for solutions that do not require a federal waiver to make changes.
- The PHEC benefit should move from the current 20-daylimit to a 60-100 day benefit. This could help discharge patients who, for example, need IV antibiotic treatment.
- Some sort of escalation pathway and protocol would help get everyone on the same page to help place patients quickly.

Kathy LeVee highlighted several priorities, noting the complexity of care needs, the range of needs at each setting, and the challenges facing staff to care for individuals with complex needs:

- Fund caseworker positions with a methodology to expedite Medicaid eligibility screening for individuals in the hospital to no more than ten days. For individuals residing in long term care, the benchmark should be no more than thirty days.
- Provide resources for tools and technology to support the post-acute sector.
- The PHEC benefit should be extended from 20 days to 100 days, in alignment with Medicare.
- Regulatory alignment, including understanding and collaboration with agencies to work on regulatory challenges placing complex residents.
- Funded initiatives to pay nurse faculty and loan forgiveness for RNs and LPNs for periods of service in long-term care settings.

Chair Jones noted that long-term care settings are now more frequently caring for individuals with substance abuse and mental health needs.

Vice-Chair Burns noted that the regulatory environment has not adapted to the changing populations. Vice-Chair Burns noted that innovation and technology—including AI and other data systems—should be the subject of a statewide council dedicated to exploring applications in human services and long term care.

Eve Gray shared feedback on concepts from her discussions with local hospitals and CCOs:

- The state should maintain a dedicated fund to expedite placement when ODHS and OHA have not determined which agency is the primary payer for a person's LTSS needs. Funds could be reconciled once a determination is made. There should be parity of payment and acuity-based payment both for physical and mental health placements.
- The Task Force should retain guardianship concepts.
- Adult Foster Homes—with expanded capacity—can help care for individuals with greater complexity. Increased investment in behavioral health capacity should not silo people with substance use disorder and mental health needs. Investments and payment structure need to match the increased complexity of care needs, not single, specific types of disability.
- Agencies that have regulatory authority should explore ways to be as non-punitive as possible with providers, especially those that serve high-acuity clients.
- Apprenticeship models are helpful but should not disqualify LPNs from transferring to RN programs.
    - Kathy LeVee responded to Eve's comment about the LPN to RN pipeline, noting that LPNs are important to long-term care settings.
- The Task Force should avoid recommending creation of a new agency. She would support MHACBO overseeing new certifications or advanced aide roles.
- She supports faculty salary and student placement concepts.

- She asked whether changes to provisions for temporary licensure have mitigated the need to join the nurse licensure compact.
- She suggested that members should weigh the potential fiscal impact of different concepts.

Jane-Ellen Wiedanz noted the need for placements for individuals who are IV drug users and need IV antibiotics. During COVID, hospitals were retaining individuals for the duration of IV treatment. She agrees with Kathy on the need to speed up both financial and functional assessment processes.

Daniel Davis noted:

- IV drug users should be covered by extending by the PHEC benefit. In Central Oregon, existing efforts to cover stays beyond 20 days have been successful. A 100 day PHEC benefit would address the six-week course of IV antibiotics.
- Expediting LTSS screening would speed up discharge for about half of those waiting at St. Charles. The average LOS for inpatient care is 4-5 days for acute care. We need to challenge systems to get determinations done within that window or the state should pursue presumptive eligibility.
- Workforce is a considerable challenge but is being addressed in different spaces—it may be beyond the scope of this Task Force.

Alice Longley Miller highlighted several priorities including:

- Minimum wages for direct care workers and wage passthroughs for any rate increases.
- Training for workers who are expected to take on higher acuity patients.
- Rate increases for Adult Foster Homes. They would support the model in HB 2495 (2023) (did not pass).
- An apprenticeship model for the direct care workforce in coordination with HECC and OSBN.

Sarah Ray supports increased reimbursement rates for Adult Foster Homes.

Chair Jones noted that the regulatory burden on the post-acute sector has been profound and long-lasting. Vice-Chair Burns noted the importance of moving from a punitive to a collaborative relationship with regulators to support the increasingly complex patient population. This is important for new kinds of placements and for adult foster homes receiving patients with complex care needs.

Jeffrey Davis noted that increased rates for patients who are hard to place could be a short-term solution. Vice-Chair Burns noted that rates may or may not address whether patients are in the right placement—that there may be other kinds of settings for patients with certain needs.

Rep. Goodwin encouraged Task Force members and members of the public to reach out to her via email to discuss solutions.

	Members were encouraged to submit additional feedback to chairs and/or via email, and to further discuss concepts with other members (consistent with quorum rules).
Public Comment	• Dr. Craig Rudy (link)
Meeting Materials	• June 27 Meeting Summary (link) • Meeting Roadmap (Staff slides) • Deliberation Process (Staff slides 10-14) • 1915i Overview (OHA slides) • Escalation Protocol (ATI Slides) • Medical Respite Care (ATI Slides) • ATI Report Preview (ATI Slides) • Concept Tracker Discussion (Concept Tracker link) (Staff slides 21-24) • Expansion of APD Adult Foster Homes – LPRO Staff (link) • Summary of Home Modification Provisions – Oregon Health Authority (link) • Elderly and Disabled Bonds Program – Oregon Housing & Community Services (link) • Public comment from Dr. Craig Rudy, OR-ACEP (link)