Date: March 21, 2023
To: Sunder Deb Patterson, chair
Senator Cedric Hayden, Vice chair
Senate health care committee
From: R. Logan Jones, MD, testimony on behalf of myself
Subject: SB 1076 Hospital discharge plans for homeless patients - **opposed**

Chart Patterson, Vice chair Hayden, and members of the committee; please accept this testimonial on behalf of myself. The views here and are limited to my opinion only as an individual citizen of the state-however it is important to recognize the background I carry in this testimony. I am a practicing physician of 6 years in the state of Oregon. I completed my medical training here in Oregon, through OHSU, and continue to practice where I trained. I am a board-certified internal medicine physician. I have a faculty appointment and train students in future physicians for the state of Oregon. My practice specialty is hospital medicine, wherein I specialize in caring for hospitalized patients during their hospitalization and coordinate a safe care transition out of the hospital. In short – I'm your temporary PCP while in the hospital and specialize in discharging patients in the context of our fracture healthcare system. I also carry many different organizational positions which put me in the cross-sections of health policy. It is with this background that I offer my testimonial today to help shed light on the well intentions of SB 1076, and the potential unintended negative consequences that this bill could lead to further exacerbating healthcare access shortages in our state.

Ultimately – clarification as to whether SB 1076 would apply to patients in the emergency department for evaluation (but not yet deemed "admitted to inpatient status) is the crux of concerns with this bill. Section 1(b) utilizes the definition of Hospital under ORS 442.015. This definition is broad in its application-and defines the hospital as any physical structure with the staff and resources to provide inpatient care. Any hospital in this region, that has an attached emergency department, would then conceivably apply SB 1076 to all patients under care in the institution – Including the emergency Department.

If SB 1076 ultimately only applies to patients admitted under "inpatient status", it would push Oregon a little bit further than our current requirements with regards to discharge planning. Currently, the national standard is as set forth by title 42 CFR § 482.43. This applies to all patients admitted to inpatient status in the hospital-and in this case, participates in Medicare funding which is essentially all hospitals. These regulations are attached as an appendix for your ease of reference. As you can see, many of the standard discharge planning processes include discussion by the practicing physician and/or licensed independent practitioner, in conjunction with nursing staff and discharge planning/social services, to evaluate the medical conditions, the needs related to those medical conditions, and the patient's ability to care for themselves at the identified discharge location.

If we take SB 1076 and its application to admitted "inpatient status", the additional legislative mandates to specifically identify, aim to connect homeless patients to community resources with additional protections of not releasing them during the night during times of cold that could result in further health consequences, from my perspective are reasonable. While these additional layers of protections that come with costs, they are not insurmountable and in line with the esprit of wanting to do right by our patients. The specifics of keeping a log and tracking patients raises the questions of who and how those

systems will be stood up, and who will be expected to financially support them (including the additional human resource & technology cost), and how that further cuts into shrinking hospital operating margins. These questions are beyond my expertise to directly discuss, but I point them out nonetheless. Ultimately, as a hospitalist in Portland, I do almost all of the things contained within this bill as the ongoing standard of care in my community of practice for patients admitted to the hospital.

However, the current language of SB 1076 also seemingly encompasses emergency department care (ie- patients under evaluation but not yet deemed admitted to "inpatient status"). I have read and heard others testimony, and I agree that the spirit of this legislation - to codify humane treatment of this group of patients, expand required supports, and outline safety guidance on discharging in inclement weather. However, if the expectation is that any identified homeless person emergency department now is protected under the SB 1076, and that to release them from care (discharge) requires all of the contained steps, requirements, and additional considerations contain SB 1076 – we just don't have the human resources to accommodate (both the funding for AND that we are cannot hire and retain case managers) or physical space to stage people while waiting for these benchmarks to be met for safe discharge.

I have been practicing in my current institution for six years including my residency training. Since that time, with historically had overflow areas with up to three or four patients occupied in a hallway at any given time during I stressful times. In the last year, there are times where I had to go to the unit secretary to ask, "where is hallway bed W?" [Implying that there are 23 patients in the emergency department being cared for outside of an actual designated care room]. It is not hyperbole to say that we are literally converting previous storage closets to patient care spots. In the last year, I've had to care for ICU-level patients in the waiting room of the emergency department because I had nowhere to put them. The reasons are a multitude of why this scenario has come to fruition, and could take pages and pages of additional testimony, and would be much more eloquently stated and supported by data from external organizations; all to say that I have concerns that SB 1076 would be the proverbial straw that breaks the camel's back and cripple our ability to move patients in and out of the emergency department for safe care. Thus, I implore legislative members, including the members of this committee, **that if SB 1076 is to be advanced in earnest, it must be accompanied with reasonable additional supports for my emergency medicine colleagues and paraprofessionals to actually meet the charge outlined in SB 1076.**

I would like to also in addition to the general concerns of SB 1076 (while acknowledging and agreeing with the very positive intent of trying to find ways to link our homeless populations to care), share my perspective on some of the specific language of the bill for legislators to consider if clarifications and/or amendments are in order.

Section 2(b) B - I think the language written here is appropriate, and allows clinicians and responsible parties to discharge patients back to homeless status after good faith effort in identifying potential placement options. I do however share concern anytime when patient's preferences on domicile are mandated into discharge planning, it can raise a duality of conflicting interests. Namely, while attempting to *reasonably* accommodate a patient's medical & care needs, if patients do not have reasonable expectations of what should be accommodated, it can lead to failure to launch. I have many

stories last several years for patients relied on subterfuge to seek secondary gain in delaying their discharge to remain in the hospital longer by manipulating their preferences to prolonged hospitalization exponentially beyond their medical appropriateness.

Section 2 (d) - emergency departments are required by EMTALA to provide a screening medical examination. Once this has been accomplished, my interpretations is then that all patients under the care of the emergency department are there and protected by regulations under SB 1076. I then question how this clause in particular will be applied. Will this be a carte blanche for any person experiencing homelessness to go to the emergency department and be permitted to remain in the emergency apartment overnight, every night? Will emergency departments now become shelters? In my practice, once patients are already under my care, I do consider the external environment in my discharge timing, but I think the ability for anyone to walk into emergency department and fall under potential protections of this clause, should be further considered and how this functionally manifests.

Section 6 (a): I would point out that under medical standards of care, having a person be fully oriented to person place and time is not a requisite to consideration of clinically stable for discharge. Many of our homeless patients have cognitive impairment or underlying psychiatric conditions that result in chronic disorientation – however are very reasonable to discharge to their personal care. Moreover, unless they are not unfit care of themselves and under current Oregon holdable against their will and/or needing guardianship, having this particular clause about documenting orientation is unclear to me the particular utility. Requiring clinicians to put this language in their clinical documentation may be an uphill battle, but if the legislature has good reason for this and evidence to mandate its needs to require a profession to alter its own practices, the medical community can adapt.

Section 6 (f) B : medically appropriate has a wide application. I appreciate the broad legislative language here to not be overly prescriptive and leave the judgment of what medically appropriate medications are required discharge (ex - providing five days' worth of antibiotics to complete treatment for an infection, patient may have underlying mild elevated blood pressure, and providing blood pressure medications discharge is not "necessary" may actually be harmful)

I appreciate your time consideration of my testimony on SB 1076, and the work you do for Oregonians.

Humbly,

R. Logan Jones MD

SE Portland, OR

42 CFR § 482.43 - Condition of participation: Discharge planning.

§ 482.43 Condition of participation: Discharge planning.

The hospital must have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to preventable hospital readmissions.

(a) ***Standard: Discharge planning process.*** The hospital's discharge planning process must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and must provide a discharge planning evaluation for those patients so identified as well as for other patients upon the request of the patient, patient's representative, or patient's physician.

(1) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

(2) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services, including, but not limited to, hospice care services, post-hospital extended care services, home health services, and non-health care services and community based care providers, and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.

(3) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

(4) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

(5) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel.

(6) The hospital's discharge planning process must require regular re-evaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.

(7) The hospital must assess its discharge planning process on a regular basis. The assessment must include ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to ensure that the plans are responsive to patient post-discharge needs.

(8) The hospital must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The hospital must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

Source: https://www.law.cornell.edu/cfr/text/42/482.43 . Accessed 3-21-23