Submitter: Jill Summers

On Behalf Of:

Committee: Senate Committee On Health Care

Measure: SB1076

My name is Jill Summers. I am a licensed clinical social worker at Salem Hospital. I am not representing nor speaking for my employer, but the experience I've gained in my workplace directly speaks to the intended outcomes of SB 1076, should it come to pass. At it's core, SB 1076 would turn basic human decency into law. Our unsheltered neighbors have many barriers to following up after a hospital visit, including not having a phone to make appointments, lack of transportation, no electricity for oxygen concentrators, and lack of clean, running water for wound care and handwashing, to name a few.

My job as a social work care manager is to not only identify barriers, but also help the patients overcome them. It's not as simple or easy a task as this bill makes it out to be. I've spent seven years doing this work, and I am still encountering situations where there are no good answers, or where a discharge plan takes days to put together. Why? Because the community resources are not available. This bill does not address the root causes of poor medical outcomes for unhoused patients, it merely shifts the burden onto hospitals.

Many of the discharge requirements outlined in this bill are things we are already doing at Salem Health. Every shift, I offer food, weather-appropriate clothing, rides, and shelter information. But I don't always have on hand what my patients need. Sometimes insurance companies won't pay for medication refills. After 5 pm and on weekends, most doctors offices and community services aren't open. Unhoused patients also sometimes act in ways that result in getting banned from shelters or fired by their PCP. Last night, one young man destroyed property and assaulted hospital staff in an effort to spend the night, despite staff taking every effort outlined in this bill, because there was no shelter to offer him. Should the ER then keep people like this indefinitely?

Smaller hospitals than ours will face an even greater challenge, as they must do more with fewer resources. Their nurses will be asked to become experts not only in medical care, but in social work. Hospitals may choose to hire a discharge planner if they do not already have one, but the cost then gets passed on to patients, insurance companies, and the State. Even if this bill looks cost-neutral, the longer the unhoused patients's hospital stay goes, the higher the cost to the Oregon Health Plan, into which we all pay. An identical bill was passed in California in 2019. Positive outcomes included an increase in staff awareness, streamlined discharge planning, and improvement in inter-professional accountability. But there was no clear effect on unhoused patients' long-term needs or care, and hospitals were hindered by the

same things I noted above - lack of staffing and funding for rural hospitals, and limited community supports.

To be clear, I strongly believe every patient, regardless of their housing status, should have access to someone who will help them understand what to do after they discharge. But I also see clearly that if you mandate this, there must be financial support to hospitals for hiring, training, and supplies so we can do it right. There must be concurrent bills and funding for community resources for shelter, including medically monitored step-down units for people too sick to go to shelters, but who don't qualify for other levels of care, so we have somewhere to send people. There must be mandates for county or state level data collection so we can see if this bill actually accomplishes the goal of better outcomes for unhoused patients. If SB 1076 is intended to demonstrate our State's prioritization of the needs of the homeless, then the State needs to do so in a way that is effective, not just pointing fingers.

Ultimately, while I support this bill, I do so with reservations, knowing how incredibly complicated good discharge planning can be, let alone the issue of homelessness.