Dartmouth Health

Political Drivers of Health Symposium

December 16, 2024

Title of breakout session: Right Care Right Time

Panelists:

- Lisabritt Solsky Stephens, CEO, Office of the Public Guardian (OPG), *Moderator*
- Bob Dunn, Director of Public Policy for the Roman Catholic Diocese of NH
- Brendan Williams, CEO, NH Healthcare Association
- Dr. Nate Goldstein MD, Geriatrician and Palliative Care physician, Chair DH Department of Medicine

Synopsis of Sessions 1 & 2

Public health importance of this issue

Currently patients often remain in a level of healthcare services that is not matched to the care they need for a variety of reasons. Health and health systems Impacts of this may include:

- Negative impacts on the patient's health, as examples:
  - Rehabilitation is indicated after an episode of acute medical treatment but cannot be received in the acute care setting. They grow weaker while waiting for rehab placement so when they finally receive rehabilitation care they may fail and cycle back into acute care.
  - Mental health care is needed for a psychiatric crisis, but the individual is monitored for safety in an emergency room without receiving the full care they need. They may further decompensate making treatment more challenging.
- Negative impacts on other prospective patient's health due to
  - Lack of availability of beds for needed acute care.
  - Receipt of sub-optimal care in settings not ideal for the needed care.
  - Need to travel long distances to access care, causing medical risks and disrupting social supports.
- Inappropriate reimbursement to provider organizations and individuals for the level of care provided,
  - Weakening the organization.
  - Risking eventual closure of facilities or reduction in available care slots,

- Further eroding access and/or quality or care.

Current status

Many factors currently contribute to current challenges to right care at the right time:

- Lack of beds due to closure of nursing facilities across the State due largely to financial and/or workforce issues.
- Limited workforce at different level of care due to:
    - Lower pay scales, shaped in part by low Medicaid reimbursement rates
    - Lack of affordable housing
    - Lack of affordable childcare
    - (Note: organizational need to pay exorbitant fees for out of state workers to maintain basic infrastructure of care further straining the system).
- Limited capacity to establish guardianship for patients who are identified as incapacitated during hospitalization and cannot responsibly participate in discharge planning, thereby delaying transfer.
- New Hampshire's status as second oldest population in the country creating high demand for care by a vulnerable, largely publicly funded population.
    - At the same time NH is a relatively wealthy State (top 5) with a relatively small Medicaid population so potential to support care is present.
- Societal attitudes that devalue human dignity and the common good.

Opportunities to address

- General
    - Hospitals, nursing home and home care systems need to work together collaboratively as part of one system, rather than competing.
    - Messaging that underscores Article 1 of the NH constitution, that is: "…all government…is instituted for the general good", could encourage legislators and others to honor the principles of human dignity and the common good.
    - Establishing a national or state long-term care policy would be helpful.
- Financial
    - Increase Medicaid funding to support different levels of care, in particular increase nursing home reimbursement rate. (Oregon currently provides $516/day compared with NH's $260/day as of January 1st.)
        - Note Medicaid Expansion trigger law (cessartion of NH's share of expansion dollars) could further challenge care if Feds lower their match in the new year.

    - Incentivize and support organizations to persevere in underserved areas (eg the north country) and in service of underserved populations.
        - For example, hospitals providing bridge payments to nursing homes for individuals whose Medicaid approval is pending.
- Implement new models of care that de-emphasize institutional care. Piloted elsewhere, some need to be adapted to rural settings, as examples:
    - Providing primary and palliative care in the home
    - In home hospital level care that can
        - Move patient from ER to home-based care instead of hospital admission.
        - Complete hospitalization at home after a short hospital admission for stabilization and establishing plan of care.
        - Home based rehabilitation.
- Support growth of the healthcare workforce
    - Increase affordable housing options
    - Increase affordable childcare
        - Encourage work-based childcare
    - Continue to improve pay
    - Increase recognition of the services/heroism of healthcare workers
- Guardianship challenges
    - DHHS has recently allocated increased funding (1.9M a year for next two years) to improve guardianship capacity.
    - A bill (number TBD) will be before the legislature this year that would encode better levels of funding support for OPG activities going forward.
    - Some hospitals pay independently to engage licensed guardians

Speaker comments

Each panelists presented a perspective on providing the right care at the right time in session 1 and session 2. These were integrated into a single set of notes for each speaker.

Bob Dunn

- Has been working in long-term care since the late 1990s and has observed that the challenges never change but they continue to grow.

- Now going through 13th State budget in a professional advocacy role.
- The Diocese operates nursing homes and has 500 nursing home beds in NH, largest non-governmental provider in the state.
- Political determinants of health and nursing homes
  - Long term care continuum is dependent on Medicaid
  - Decisions of legislature around Medicaid funding, will impact whether NH has a healthcare system that is robust, valid, active and adequately cares for the poor and supports NH businesses and families in flourishing.
  - Must advance the principles of human dignity and common good. These are not just religious or moral principles: they are at the heart of public policy and the body politic. The first article of the NH constitution indicates the government is "instituted for the general good."
  - Pope Francis talks about the "throw away" culture, meaning a culture in which people are given value only if they are of benefit to us. If none, they are disposable.
    - Poor and elderly are particularly affected under this world view
  - Hoping the legislature will honor the principles of human dignity and the common good to push back on the throw away culture.

Brendan Williams, NH Healthcare Association

- NHHA represents a many healthcare facilities that provide facility-based nursing care. 7000 beds between all the facilities. Includes 74 nursing homes, a number of private homes and county nursing homes, continuing care retirement communities (CCRCs) and assisted living facilities.
- Notes
  - Nursing home wages have risen 47% since the pandemic. Difficult to sustain.
  - NH Medicaid rate will be $260 per day as of January first, whereas OR is $520.
    - OR is also a leader in homecare. $20+/hour for home care workers there.
    - No national long-term care policy so challenge is to the States.
  - Among states, NH has the second oldest population, second to Maine.
  - Workforce challenges: down 50,000 workers nationally despite increased wages. Lack of affordable housing and childcare are deterrents.
  - Current examples of strain.
    - Hillsborough county nursing home has waitlist of >100 with 50 beds offline.
    - Cheshire County's Maplewood has 50 beds offline.

            - Makes it difficult for Cheshire Medical Center to discharge people
        - Hudson has 100 residents but 17 are not getting paid for, so can't take discharges from St Joseph's.
    - Hospitals have benefit of private insurance income while nursing homes are almost exclusively supported by public funding.
        - Hospitals are contracting with out of State employees at exhorbitant rates, but nursing homes can't afford to do that.
    - Healthcare needs to be unsiloed.
        - Three legged stool: nursing homes, hospitals, homecare. They are all inter-related so solutions need to address them as a cohesive system.
        - Homecare has benefited from recent increases in support.
    - Outgoing governor and legislators have helped improve the situation so we are staying afloat but not thriving.
    - Have made strides in last few years, working in partnership with home and community-based care systems which are all different components of the same system: don't want to pit vulnerable constituencies against one another.
    - Has been in his role for 8+ years.
        - First four years there were just three transitions
            - NL hospital closed a nursing homes
            - Two facilities in Hanover were sold
            - Catholic charities sold Jaffrey facility
        - Since pandemic over 20 nursing homes, a third of private nursing homes, have been sold. Buyers have saved them, hoping for profit in the long term, looking at demographics of NH and betting they will make it.

Dr. Nate Goldstein

- Geriatrician and palliative care physician. Chair, Department of Medicine at DH.
- Goal should be health, but current system creates cycles of illness. People wait longer to leave hospital, they stay in bed too long and get sicker so can't rehab as easily, fail in rehab and cycle back into hospital. Etc.
- Usually think of right place right care in terms of post-acute care but there are numerous other areas where the issue is a concern.
    - Goal is to keep people healthy and functioning in their communities. Lots of models for reducing need for nursing or inpatient care:
        - Providing primary and palliative care in the home

        - Diverting patients in the ER from hospital admissions by providing supported home care.
        - Completion of hospital stays at home after initial acute care. Home based hospitalization.
        - Rehab at home
    - Not new concepts, but some need to be adapted to rural areas.
- 25% of older adults live in rural areas.
- Currently the majority of older adults will spend the end of their lives cycling in and out of hospitals and rehab.
- Need to develop models of reimbursement that work for long-term care facilities.
- How do we fund these novel programs to older adults who may not have private insurance? Develop systems of care that provide care they need it, where they need it?
- Nursing workforce is limited for many reasons
    - Doesn't' pay well and its hard work! Why would anyone do that when they can earn the same in a fast food restaurant?
    - No place to live, lack of affordable housing
    - Lack affordable childcare

Lisabritt Solsky Stephens

- Office of the Public Guardian (OPG) is a statewide not for profit.
- Services for people adjudicated incapacity.
    - Cognitive issues
    - DD/ID
    - Traumatic brain injury
    - Dementia
    - Illness
    - Lose civil rights when determined incapacitated, so burden of proof is high, beyond a reasonable doubt.
- Primary sources of funding for OPG: two contracts with DHHS (70%) and one smaller one with Dept of Corrections
- Guardians are masters prepared professionals, certified, available 24/7 and only paid $9.91 a day or $3000+/year for this work. Make decisions about the physical well-being of clients. Fiduciaries make decision about financial well-being.
- Can't grow to meet the increasing demand.
- If someone with one of those cognitive issues needs a public guardian, must be already engaged in the area agency system or MH centers to qualify when hospitalized.

- Big gap: growing number of seniors who develop an acute illness and become incapacitated, then can't participate in planning. Also a group that gradually loses incapacity and then lands in hospital and incapacity is recognized. So they cannot assist in their DC planning.
    - Lack of a guardian is the third most common reasons for not being discharges. 55 days extra time in hospital as a result.
    - Can't qualify for adult services while in the hospital
    - Sometimes friends or family can support decision making, but many can't, won't or shouldn't for diverse reasons.
    - DHHS has asked for 1.9M in both years of the biennium to support public guardian services.
    - Waiting list already and this will grow because of
        - Aging of NH population.
        - First generation of people with DD/ID living in the community who need guardians as their parents age or die.
    - Grateful to DHHS for recognizing and planning support.

Participant and panelist discussion comments following speaker presentation

Session 1

- People come into the hospital every day with capacity and then lose it. They may lack relatives or friends or have ones who are not prepared to speak for them. Difficult for professionals to divine what people would want. Communities of faith may be important in providing support.
- It was noted that over one year there are about 7000 medically unnecessary days that people spent in hospitals in NH, 55 days for people lacking guardianship.
- NH Trigger law could challenge Medicaid reimbursement. Or reauthorized Medicaid adult expansion, State pays 10% while Feds 90%. If Fed participation dips below 90%, by statute NH will end participation.
- NH is tied as the State having the lowest Medicaid matching rate, locked into this. Not going to meet the needs of our State with the second oldest population. If match rate decreased, could keep Medicaid expansion but would pay more.
- Cascading effects of all this: effects care of the individual, but impacts their assistance as well, eg can impact the family who can't work due to need to care. Labor impacts. If something happened at the Federal level.

- NH match is 50-50, the lowest rate though others have it too. NH is in the top 5 wealthiest states. This is a choice. We have a stronger economy. Small Medicaid population.
- Nursing leader noted: have personally gone through this process with family members. Don't know how people get through this without knowledge of healthcare. Delays in processing applications, Waiting for Medicaid approval, workforce (clinical and administrative) limitations, bed limitations. Do you need nursing home level care. Do you meet financial need criteria? Its so complicated!
- DHHS Commissioner Weaver spoke about delays in processing applications. Cited:
  - Lack of workforce
  - Closing of beds
  - Housing shortages informing workforce,
  - Delays in eligibility determinations
  - Lack of availability of public guardians for persons who have lost capacity
- How do we get people to the table to work collaboratively for solutions?
- Troubled by the way we do our budgeting: we ask legislators to do the budgets in a span of weeks. Would love to see the budget done in the second year of the session after starting it in the first, give it time to get processed and vetted. Need to develop a way to have more discussion
- Not having common platform for delivery systems affects outcomes.
  - Finance system doesn't match the match
  - Workforces compete with each other rather than collaborating
  - Need to support people in the community who aren't reimbursed by Medicaid.
  - Not incentivized to do anything to impact SDoH.
  - Form follows finance now. Should be form following function. This value conversation happen at legislature.
- How we finance healthcare is more than talking about Medicaid. Need a council or commission. Have sat on a bunch of legislative commissions and they spin gears.
- Hard to have a discussion about right time, right care without having an isurer on the panel. And a discussion about health care financing more generally.

Session 2

- Medicaid should be absorbed into Medicare. Too easy to get cut off of Medicaid. We all pay in the end. Insurance for seniors does not cover long-term care, people must spend everything and live in poverty, then we take care of long-term care.
- I think all of us can agree that if we were designing a new healthcare system, we would not start with what we have. Rules and regs are so extraordinary. Its nuts, it's too big and complex. Nobody can navigate it. It is not the system we should have.
- We do not have a national long term care policy. Differs depending on what state you are in. State of Washington tried to define a program. It really will take some sort of Federal action. Something like Medicare that would be available to everyone. But note that most Medicare beneficiaries are obtaining benefits through private insurers, who develop algorithms to deny care.
- 80% of the people on Medicaid are parents with young people. 20% are responsible for 80% of the spending.
- Medicaid is in 50 states and several other jurisdictions and is delivered differently in each of them.
- Until someone needs care, they don't think about it. Need to plan ahead.
- People do not have the long-term resources they once did in terms of retirement supports, people are living longer, policies are closed books, locking people into spiraling upward costs to benefits for long-term care insurance.
- Where can we make headway getting people out of the hospital. Senator Avard is sponsoring a bill which Office of the Public Guardian has provided input to:
- Increase guardianship capacity for aging adults (only 70 spots now), will create a new pathway to access to guardianship while hospitalized.
- Continue the allocation provided by DHHS
- Processing time for Medicaid applications needs to be reduced. Giving providers access with consent to NH ED systems to see what is there would help. Currently if an application pending, sometimes a provisional payments is made. Some hospitals are paying the nursing home while application is pending in order to allow the nursing home to do their work. Sometimes also pay OPD to provide guardianship where needed. Critically important to everyone to get people to the next stage of care. $450 per month for OPD services, it is a relative bargain.
- Sometimes people stay in nursing homes when they could be home but they don't have a home or anyone to care for them at home.
- Note that we are talking about work arounds for a fundamentally broken system.

Notes submitted and edited by Seddon Savage

Resources:

- Barriers to Discharge Impacting Patients in New Hampshire Hospitals (PDF)
- New Hampshire Bulletin: Patients ready for discharge languish in New Hampshire hospitals, taking up needed beds