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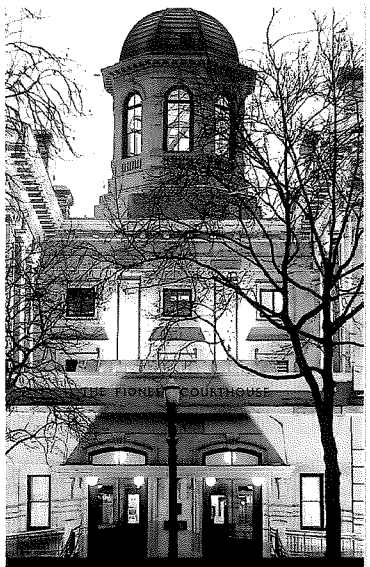

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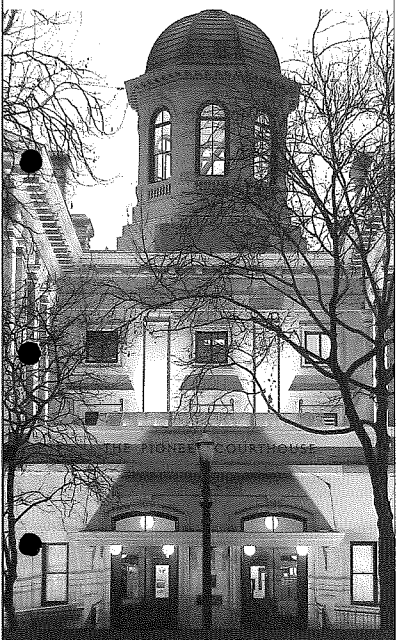

ORIGINAL

ENCOMPASS MEDICAL
CERTIFICATE OF NEED APPLICATION #679

OREGON HEALTH AUTHORITY
PUBLIC MEETING
TUESDAY, OCTOBER 15, 2019
1:32 P.M.

2850 NORTHEAST BROOKWOOD PARKWAY
HILLSBORO, OREGON 97124

ENCOMPASS MEDICAL

CERTIFICATE OF NEED APPLICATION #679

OREGON HEALTH AUTHORITY

PUBLIC MEETING

TUESDAY, OCTOBER 15, 2019

1:32 P.M.

MR. GILMAN: Good afternoon, everybody. Welcome to the OHA public meeting. My name is Matt Gilman. I'm the Certificate of Need Program Manager with the Oregon Health Authority. I wanted to welcome you all here.

The OHA initiated this meeting to hear public comments regarding Encompass' application for their 50-bed rehabilitation facility in Hillsboro. Just a reminder that if you missed the meeting yesterday, we're not going to be taking any testimony, recommendations, or decisions will be made in this meeting, and any questions will be directed to OHA staff. Therefore, the meeting is not subject to the Administrative Procedures Act or Public Meeting law.

We will have -- I know that we have -- we'll have numerous digital recordings available as long as -- as well as the transcript after the

meeting is over, which we can make available to the folks here. Hopefully, in the back you saw the sign-up sheet and you signed up on at least one sheet. One is one is for attendance. If you would like to submit public comment or give public comment, there was a sign-up sheet for that as well. We do ask that if you do want to make public comment that you sign up on that sheet.

We've got an agenda. You should have all gotten that when you walked in. The Applicant should have about 30 minutes to provide their summary of the application, and then we can open the meeting to public comment. I'll call upon people, upon individuals. If you would like to co-present with somebody else, please let me know that. And then depending on how many public comments or folks we have signed up for public comment, we'll just divide that time up to fill that time.

So when I call your name, please raise your hand. Lisa, who is at the back, will be racing around with the microphone. So for the recording and for our stenographer, please make sure that you wait until you got the mic until you start talking.

Finally, just to answer questions, if you want to submit written comments, you may do so at

any time during our application review process. And the public meeting record will remain open until November 4th. So you have until then to submit any written comments you might have. So with that, I think what I'd like to do is kind of let folks introduce themselves from both Department of Justice, OHA and then from Encompass.

MS. KRECKLOW: Hi, I'm Pam Krecklow with the Oregon Health Authority. I'm the part-time Certificate of Need Coordinator.

MS. SELOVER: Dana Selover, I am the Section Manager for Health Care Regulation Quality Improvement. That's where all these programs are. And I'm with the Oregon Health Authority.

MS. O'FALLON: Shannon OFallon with the Oregon Department of Justice, and I advise the State's Public Health Division, including the CM programs.

MS. SELOVER: And in absentia, I'm going to introduce Steve Robison he's on his way. He is our technical bed need analyst at the Public Health division.

MR. STOLOFF: Can I ask, when do you think Steve might arrive? Because we have some people dealing with need and I thought maybe we could shift

--

MS. SELOVER: I'm going to talk to the one who is in direct contact.

MR. GILMAN: Yeah. He will be here as soon as he's able to be here. We do have recordings so we can make sure that he gets both the minutes and the recordings in the case he doesn't get here in time.

MR. STOLOFF: Okay. Thank you. So good afternoon.

MS. O'FALLON: Can you do introductions --

MR. STOLOFF: I will. So good afternoon. My name is Peter Stoloff and I represent Encompass Health Rehabilitation Hospital of Oregon, in the certificate of need application for 50-bed specialty, acute inpatient rehabilitation hospital in Hillsboro. And in addition to my opening remarks, I'd like to introduce Bill Heath, who is a vice president of Encompass in business development. And then to Mr. Heath's right is Joseph Stillo, MD, who is an Encompass vice president of medical services. Dr. Stillo is physiatrist, which is a physical medicine and rehabilitation physician. He has extensive experience with the kinds of acute inpatient rehabilitation hospital services which are

being proposed by Encompass Health. To his right is Edward Stall. Mr. Stall is a nationally-recognized expert on the need for specialty, acute inpatient rehabilitation hospitals. To his right is Rodney Gilchrist, who is a senior project manager for Encompass Health in the design and construction division. And to his right is Carey McCrae, who is Associate General Counsel, who has nationwide responsibility at Encompass for certificates of need and project development.

So I'd like to start out with Bill Heath. Thank you.

MR. HEATH: Can you hear me well enough?

MS. O'FALLON: I think so.

MR. HEATH: Okay. So again, I'm Bill Heath. I'm vice president of business development for Encompass Health. And I want to take a minute to tell you who Encompass Health is. So we're one of the largest providers of post acute care in the country. We are the largest provider of inpatient rehab in the country. As of June 30, we had 131 rehab hospitals around the country. SSince June 30th, we've opened two more, one in Texas and one in Idaho. And before the end of the year, we will be opening two more, another one in Texas in the

Houston market, and one in Southern California.

So as you can see, we're very active in business development and adding new hospitals in markets across the country where we see a need for more inpatient rehab, which is why we're here today. We see a need in Oregon in general, and specifically in the Portland and the three-county area.

So what is inpatient rehab? At a high level, most specifically this is a highly specialized, acute hospital. It's not just a facility where rehab is done. It is an acute hospital level of care. These are complex patients that are being taken care of. It is being done by a team of clinicians. You can see a list here of what those are. A lot of therapy going on there as you can see. This is done under close supervision of a physician with 24-hour nursing care.

So what type much patients are going to inpatient rehab? So I mentioned before, it's a very complex patient. On the left side of the screen you can see a few of those categories. Stroke, brain dysfunction, neurological issues. 90 percent of patients, they have been in an acute care hospital. They are ready to be discharged and are not able to go home. And so they continue to need a hospital

level of care to be able to get back home.

And you see they're elderly. Typically our patients are in their 70s. On the right-hand side it shows you a little bit about how Encompass does. You can see we meet or exceed national benchmarks for quality outcomes.

Okay. Here, leading position and cost effectiveness, there's a lot of information here and I won't spend a whole lot of time, but what I want to show you -- you see on the top line Encompass Health, during this period of measurement, this is publicly available medicare data, we had a 126 hospitals in operation at that time. So in the third -- middle column there you see case mix index. That is a measure of how sick our patients or how complex our patients are. You see at 1.28, higher means more complex. So we're higher than the other freestanding hospitals, or the other hospital-based units across the country. And this is all inpatient rehab providers.

But of note, if you look at the next column, our cost per discharge is actually lower than other providers in the industry. So if you think back to the previous slide, we are meeting an exceeding the national benchmark despite the fact

that we have a higher case mix index and we're doing it at a lower cost.

And then one more thing I wanted to talk about here is it's not just patient care. We're also an advocate in the industry. We work with lots of other associations and this is just one example where we've partnered with the American Stroke Association on their "Together to End Stroke" program. This is a national program to promote stroke awareness and recovery. And I mentioned our hospitals are highly specialized. Across all of our hospitals we have -- most of them have a disease-specific certification from the Joint Commission. 117 of those hospitals have a stroke certification, so that's why this is important to us and the Stroke Association partnership. We will also have a Stroke Association -- I mean, a stroke certification here in this market. But in addition to stroke, there's several other ones that I think Dr. Stillo may talk about in a few minutes, but we hold 289 disease-specific certifications at our hospitals across the country. Dr. Stillo.

DR. STILLO: Thank you everybody. It's my pleasure to address this group today. Thank you so much.

Since my training in physical medicine and rehabilitation at the Rusk Institute of Rehabilitation Medicine at NYU Medical Center years ago, I've had the honor and the privilege of serving the disabled population for over 30 years. I've been with Encompass Health for over 20 years. I should also mention that our chief medical officer who I answer to directly, Dr. Lisa Charbonneau, can say the same about her training as well as her tenure with Encompass Health over the years.

So Dr. Charbonneau and myself, along with the physician advisory board, comprise the medical leadership pf this company. I'm not going to read my slides except to use them as reference material, but I would like to address you in three distinct areas; access, programming, and quality outcome.

So as you can see here, I would point you to the first bullet slide that, you know, we consider the acute care clinicians our partners, the case managers, the therapists, the primary care physicians, the consultants, etcetera, the discharge planners as our partners. Why? Because we want to come together and try to identify the best post acute venue for rehabilitation after a patient has suffered a disabling injury or trauma or a medical

illness. So we try to come together and say what is the best way we can use this individual's Medicare, if it's a medicare patient, etcetera, what's the best way we can put this patient through this system. Why? In order to best achieve the patient and family's goals. Okay.

And part of that is to try to keep the patient from bouncing back into the hospital, both during the course of rehabilitation, as well as after the patient has completed their course of rehabilitation. I can tell you that I and we have been poised to advocate, because this really is an advocacy position that I'm describing. We've been poised to advocate for patients in need of access to rehab services. We try to partner with the regulatory agencies and payers, who sometimes don't seem like we're on the same page in terms of interpreting the medical necessity criteria for admission. So we try to partner with them.

I'll give you an example. A few years ago I was with -- I was on the local coverage determination committee from Cahaba, Alabama. At the time, they were one of the big Medicare administrator contracts, or physical and media, essentially. But we tried to get together, tried to

see what exactly is the inpatient rehabilitation rule saying. Dr. Charbonneau and I were recently in touch with one of our Medicare Advantage or managed Medicare partners. I use the word "partner," again, to try to synchronize our understanding as to the best level post acute venue for a particular patient.

So I think that we really see -- we don't see adversaries, enemies. We feel that everybody can be a partner. Why? Because if we keep the patient first, we really all are partners in a positive manner. I will mention, also, that patients' rehab needs don't vary from state to state. What does vary is perhaps services and accessibility, availability of inpatient rehabilitation and post acute venues. Okay. So that really what does -- can vary from state to state.

I'm not going to read the slide to you unless you really want me to. Okay. I didn't think so. But there is a substantial difference between the inpatient rehabilitation facility or IRF, as we call it, versus the skilled nursing facility world. Okay. We operate on different playing fields, regulatory playing fields, but I can assure you this

is not a game. If we look at the left side of the slide in blue, you'll see the requirements for some inpatient rehabilitation hospitals. Okay.

First of all, we are hospitals, we are designated as acute care hospitals. We have hospital licensure. And with that we are poised to take care of what we call intensity of service. Intensity of services in regard to medical care. Remember, patients -- people come in, they have a disabling illness or injury or trauma, right? So they wind up, let's say, a stroke or spinal cord injury, amputation, brain injury, etcetera. Okay. Other neurological, neuromuscular diseases. Right. Well, that's their rehab diagnosis which needs to be treated and that will have special comorbidities associated with it. Spacticity, loss of sensation, pain, etcetera.

But remember that patients -- people will continue having their comorbid conditions. Diabetes, hypertension, COPD, congestive heart failure, gout, on and on and on. Renal disease, right, chronic kidney disease. All right. So all of those require the level of medical oversight that we have in our hospitals. Indeed, we're demanded to have according to the conditions of participation

and the Medicare rules. Okay. So we have that. And the treatment program, the rehabilitation program first of all is approved by rehabilitation physicians, such as myself. Right. The plan of care is approved. Team -- it's very, very much a team-oriented process. So in terms of rehab intensity services, our patients have to have a minimum of three hours per day, five days a week or 15 hours over seven days of rehabilitation, including physical therapy, occupational therapy, speech therapy, etcetera. Okay.

And we are work together with our very skilled pharmacists and nurses who can be rehabilitation nurses, certified rehabilitation. Why? Because patients can have things associated with their condition. Such as neurogenic bladder, neurogenic bowel, pain issues, wound issues, and on and on and on. So we're very, very much different in terms of what is required. You won't see -- on the right-hand slide, you will not see similar requirements for the skilled nursing facility industry. Okay. It's just not there.

As Mr. Heath was referring to, we -- well, even before I say that, let me just talk about programming. So talk about access a little bit

generally. Let's talk about programming. First of all, in a system the size of our system, 133 hospitals currently, two more by the end of the year, you know we are able to leverage economies of scale. What do I mean by that?

Well, when we want to develop, we can develop and share evidence-based best practice protocols for decision support, for program development. Mr. Heath mentioned that we have 289 disease-specific, Joint Commission certified programs across our company, an average of two to two and a half per hospital. In my former hospital in Toms River New Jersey, we had five. We had stroke, brain injury, cardiac, pulmonary, diabetes. And I think now they have a wound -- so these programs are developed. The advantages that these programs are developed based upon community need. We also have hip fracture, Parkinson's, etcetera.

All right. But one thing that Encompass Health does is support our clinicians in such an outstanding way, in terms of educational programs for further development of their skills and expertise. We fund over 50 research projects within Encompass Health. And the AHA -- American Heart Association, American Stroke Association guidelines

concluded that inpatient rehab facilities are a better rehab option for stroke patients than a skilled nursing facilities. This is the guidelines that came out in 2016.

Yes, we have a lot of technology that I can offer. You we have a whole program of people to evaluate the efficacy and the applicability of all these different technologies that are out there. We have more than this besides the Vector Gait and Bioness and the VitalStim, body weight supported treadmill training, treadmill testing, which we developed on our own, which has great safety features. You know, Bioness, SaeboFlex interactive Metromed, etcetera, etcetera. So we have all the technology that patients could possibly need.

We also have patient-centered technology -- again, busy slide but just a couple things. We do have a proprietary electronic medical record. You should understand that rehabilitation hospitals are not required to participate in electronic medical record program. However, Encompass Health, about 10 years ago, decided to spend $200 million to have our Cerner-based -- Cerner is the company that we use, a Cerner-based electronic medical record. Why? Because now we're able to get in there and leverage

all the data. Last year in 2018 we had 178,000 discharges from our hospitals. Okay. So you can imagine what a spreadsheet might look like. That's a lot of data. But we can manage. Why?

So that we can develop programs such as this. I'll just point to one here which is called the React Program which we partnered with Cerna. This will actually tell us the risk. If you're having rehabilitation in our hospitals -- in one of our hospitals, this React algorithm will run in the background and alert all clinicians that this patient is at risk for bouncing back to the emergency room, to go back to the acute care hospital. Okay. Then we can act on that develop support. We have shared this nationally at the American Medical Rehab Providers Association, so we really want to share this technology and understand that there are ways to triage patients if they wind up at risk.

We're also working on one now for readmissions after patients are -- so this looks busy, but I'll just tell you right now, this is from the Med Pack report to Congress in March of this year, March of 2019. And even though Mr. Heath showed you how Encompass Health fairs against other

rehabilitation hospital benchmarks, according to the Uniform Data System medical rehab data. What this is showing you is how the IRF industry compares to the SNF industry on three different parameters. Two of them are up here. One is in terms of discharge back home, discharge back to the community, that IRFs do that successfully twice as much as skilled nursing facilities. All right.

On the right-hand side it will show that in terms of during the course of -- during the inpatient course, how often do patients go back to the acute care hospital before they are even done with their rehab is four times higher in skilled nursing facilities. Or I should say is four times lower in inpatient rehab hospitals. The graph that is not on this slide is that once patients are discharged either from SNF or from the inpatient rehab hospital, patients wind up going back to the hospital for readmission within 30 days, 30 percent higher when they come from SNFs. Or I should say 30 percent lower when they discharge from IRFs.

So I talked to you briefly about access, about programming, about quality outcome data, and now I'd like to give it over to Mr. Ed Stall. Thank you.

MR. STALL: Thank you. And my task is to talk a little bit, or quickly, about the bed need methodology and those kinds of things. So quickly I'm Edward Stall, a partner with DHG Healthcare. Quickly about DHG Healthcare, we're one of the 10 largest privately-held healthcare advisory practices in the country. We have over 20 advisory professionals spending all day every day advising and learning about healthcare providers and the issues that we're dealing with. We work in all 50 states, several foreign countries. Our expertise is in things like reimbursement, strategy, demand, analytics, clinical alignment, alternative payment models, all of these things that are emerging.

Myself, I have been at this for about 35 years. I founded a small company or part of a small company 35 years ago. That merged into Dixon Hughes 12 years ago. I've built and led practices and strategy and analytics and alternative payments. Planned dozens -- in 35 years you get to do a lot. Planned dozens of hospitals, including rehab hospitals and other specialty hospitals. Many that are open and successful, so we know what works.

I've been an expert witness for state health planning and worked with the state health

planning bed need models. I have significant experience in Medicare data analytics, which is increasingly important, particularly to a service like rehab, which is mostly a Medicare patient base.

So Oregon bed need methodology in a certificate of need, basically we start with this sort of an idea that we've met the standard of the 590, the general bed need. And then regulation 645 comes into play which talks about specialty services. So basically a quick summary of that kind of thing, what we've got to deal with is the rehab need using seven beds per thousands standard. Address specialty rehabilitation, special needs, sizes of populations, rates of historic utilization, accessibility, quality, those kinds of things.

In the next few slides, I hope I'm going to hit many of these for you. They're all in the CON, but I hope I'm going to give you at least a little highlight tour of what those are.

You've heard that Oregon, in general, has a low access to care or beds per thousand of care. This is actually a chart that shows beds per thousand, per hundred thousands by state. What matters here is look to the far right, the little bars in red, one of them is Oregon, which is the

lowest -- the second lowest state. Only Alaska has fewer beds per hundred thousand. This is three-county area is right there in that same -- really low. And our home location of Washington County where we are here has no beds. So a very significant population with no beds.

You see that seven bed her thousand standard, which is the Oregon standard in the health plan. We're going to use that in our bed need methodology, but that isn't even half the ratio of beds per thousand that are in service today in the country. It's a very conservative bed need ratio.

One thing I will point out is the bed need ratio or bed need is per hundred thousand total population. Health care planning has evolved over the years and now focuses on a specific population. And the population for complex rehab is an elderly population. This little pie chart to the right -- to the left shows 72 percent of patients are 65 and older. Medicare also clearly focuses the rehab provider on the complex patient. It's called CMS 13, and it's 60 percent rule. 60 percent of your patients have to come from these conditions. And you saw them in an earlier slide, stroke, brain injury, those kinds of things. But the impact is the

rehab hospital has to serve the elderly and has to serve the complex patient. We don't get paid for things that aren't complex. It's very important to understand that, and that's the need that we're trying to demonstrate.

When I say population segmentation, here's why it matters. We all heard that the age wave on one of those, right, may have been here a little longer, and the age wave drives demand. Here's the population growth of this three-county area that's used in our certificate of need. Notice in Washington County, the 65-and-older population is growing by almost 23 percent. That's in the next five years. And the other two counties in the service area has also grown 22 percent. The impact of this is growth rates of this age group drive demand. Growth rates for this age group will outstrip supply very quickly and we've seen this happen in markets all over the country. So the age wave is coming and the appropriate measures to use is around this 65-and-older population.

The growth rate is not in one place. You know, the age wave happens everywhere. At least here in this market it's happening everywhere. These ZIP Codes shown in red have grown 20 percent

or more. Notice they're not all in Washington County. They're across the metro area. They're across the three-county area, which means all providers. SNFs serving the elderly, rehab providers serving the elderly will be impacted by this group.

So we turn this into a little slightly, maybe more specific measure, which would be patient beds per thousand for the 65-and-older population. Please notice here the same thing happens. Oregon and the three-county area, Washington County would be the lowest in the country. Which simply says is there enough capacity -- enough access to care. U.S. rate of .74 per thousand is almost four times that of the Oregon rate or the service area rate. And it simply says is there an issue with capacity and beds.

Let's put it in a map. Let's talk about this a little more specifically. And this takes that same data and puts in a picture. The dark green are those with high ratios of beds per thousand. The white, you'll see Oregon, is the lowest and that point is also low, over there on the far right. But notice what happens over here in the West, we talk about -- we've heard comments that

we're different. Oregon is different. The West is different. Medicare Advantage impacts all of this. Recent data from CMS, which is September data, they report Medicare Advantage penetration or rates, Oregon was 40 percent, 41.8 percent. California, your neighbor to the south was 40.6 percent. So similar Medicare Advantage rates, but California has twice the number of beds per thousand.

You see Pennsylvania over here on the East. I only point that out because they also have a 40 percent Medicare Advantage rate. Encompass Health has nine hospitals in Pennsylvania and succeeds in these Medicare Advantage markets. So there you go. Medicare Advantage doesn't drive care now. You know what's different is Medicare Advantage requires preapproved. Medicare pays for a patient after the fact. Medicare Advantage you have to go and basically get that patient approved. Encompass has become very good at that for the patients that need that care and they have to tell their value proposition.

There is one other common measurement, and this one I really like because it's not about bed per thousand or how do we stack up. This is how many Medicare patients actually received free

Medicare. Now we're talking about patients. Now we're talking about real people. How many people get the care that they deserve in this market. And the same picture points out the service area, three-county area, the state, all of the above. And the same measure is consistent across the market. This is a map by ZIP Codes. The blue ones are really low. But you'll see Washington County basically one percent versus the state at one, versus the U.S. at almost four. A fourth of the rate. So it's across the market.

Even one other measure which is how existing hospitals discharge their patients. This uses a thing called rehab-appropriate patients. You see on the far right your two providers that have rehab units. They discharge patients at 2.6 to 4 percent. That's higher than most in the market, but it's half of that of the U.S. So again, they're run to serve more.

And finally I want to leave you with a couple of closing thoughts. Don't know if you know this but when you talk about access to care, distance matters. Families don't want to travel long distances to see a patient that's in the hospital or a rehab hospital for 14 days. The

further the distance, the less likely they are to access rehab. So we're finding that putting rehab where the people are really matters. Particularly in these large metro areas.

So Washington County is the second largest county in the country without a rehab bed. Second. That's out of 4,500 or 5,000 counties. Clackamas ninth. So it continues to point to that same thing. Let's bring it home to one final thought which is it matters to the patient. Dr. Stillo has talked about quality and outcomes. Talked about a family member. Talked about a family member that lives here in Hillsboro near the library. It's hard to get to the downtown locations. If that patient has a stroke, do they get access to this high level of care. To the high level of care that Medicare dictate. And then finally there's a value proposition. There's this myth that rehab a very expensive. What you find when you actually study the complex patient -- now this doesn't mean every patient, but the complex patient that acute rehab targets is the costs don't actually go down. I'm not going to go through all the details here, but if you look at what happens here, as patients move from IRF to SNF, readmissions go up for this most complex -- this is cardiac

valve, a really sick patient. Readmission go up. And actually for the very sick population, cost of care can go up. So let me leave it there with you. I'm going to let Peter take us home for the last couple of minutes. I appreciate your time.

MR. STOLOFF: Thank you, Mr. Stillo.

So Encompass filed its certificate of need application on November 2, 2018. And it clearly shows in appendix A in that application, and in the January 7, 2019 response to the screening questions that there is a need for at least 91 specialty, acute inpatient rehabilitation beds in the service area as defined under OHA's rules in OAR 333, division 590-0040 and 0050. And then taking into account the inflow into the service area, which is specifically provided for in OHA rules in 645-0030 A and B, and 590-0450 sub 6, there is a need for more than the 91 acute inpatient beds.

I'm going to speak briefly to the issue of competition. You heard a lot yesterday from the skilled nursing facilities in the area. And I'd like to at least make it clear that the certificate of need process is not intended to eliminate competition or limit access to needed services such a inpatient rehabilitation facilities. The Oregon

Court of Appeals, in fact, held in 1993 in Mercy Medical Center versus Oregon Health Policy that the certificate of need laws do not create an entitlement to a government-sanctioned monopoly.

With respect to the issue of distinction and the line of demarcation in between inpatient rehabilitation facilities and SNFs, and this goes to the question of Dr. Selover yesterday. In fact, the inpatient rehabilitation facilities with respect to exclusionary criteria, there are specific exclusionary criteria. Whereas with skilled nursing facilities, you heard the testimony yesterday and I'll let it speak for itself. But with respect to the inpatient rehabilitation facilities, the exclusionary criteria are that there must be a physician's order. The patient must have an acute medical condition to be distinguished from a chronic or long-term care medical condition, and at least 60 percent of the inpatient population of the inpatient rehabilitation facility requires intensive rehabilitation services for treatment in one or more of the 13 conditions. So that's the line of demarcation there.

I want to point out, also, to the Oregon Health Authority persons here today that the rules

are specific. They clearly establish this line of demarcation in the 645 rules in rehabilitation, which state that the inpatient rehabilitation rules are not intended to apply to beds in long-term care facilities. This is also in OAR 333-590-0010 subsection 1, that defines acute inpatient care as specifically excluding care provided in long-term care facilities.

There's also a number of other rules that OHA has distinguishing this. In fact, the certificate of need rules for skilled nursing facilities in 333-610-001019 provides that SNFs are licensed to provide care for persons who require the availability of an RN 24 hours a day, but do not require the levels of nursing, physician and specialized services available in a hospital. So this goes to the line of demarcation. The Medicare regulations similarly say the same thing in 42 CFR 424.20, which state that SNFs provide skilled nursing care, that as a practical matter, can only be provided in a SNF to be distinguished from an inpatient rehabilitation facility. Thank you.

And in conclusion, based on the testimony of Encompass individuals today and Edward Stall, there is clearly a need for a 50-bed specialty,

inpatient acute rehabilitation hospital in this particular service area as defined by Encompass in its certificate of need application, based on the evidence-based data, which we have provided in the application and appendix A, that I cited earlier, and in accordance with Oregon's certificate of need rules in divisions 590 and 645. Thank you very much.

MS. O'FALLON: Shannon O'Fallon again with the Department of Justice. I have two questions. I think I'll start with Peter, this one's for you. So your last argument, are you basically saying that in looking at bed need, long-term care facility beds sort of shouldn't be counted in the mix of what is available out there; is that what you're saying?

MR. STOLOFF: That's correct because the rules say that. The rules distinguish acute care, and I've cited the rules, but I'll get it in writing in November 4th, distinguish acute care from skilled nursing care. And the rules in 590-0060 say that in determining need under the 590 rules, the general bed need rules, you look at the facility being proposed as against other acute inpatient facilities. SNFs do not provide acute care. They cannot provide acute care. They're not licensed.

They're in a different licensure category. They're not licensed to provide acute care. They provide skilled nursing care. And that's the line of demarcation that's important that we like to make in making sure that OHA at least is cognizant of that position because it's fully evident in the rules.

MS. O'FALLON: All right. Thanks. And then my second question, and I may not sort of be seeing this right, but -- right, so we heard testimony yesterday about -- and I think -- I know most of you were there, right, that Oregon is different. There's more of an emphasis in Oregon -- these aren't my words, like, these are other people's words. I'm paraphrasing. Right, more in0home care, you know, people spending less time in facilities. So I'm trying to figure out when you say, right, we don't have very many beds in Oregon, and therefore, there's need, I mean, can you necessarily make that leap? Or are these patients just being cared for in a different way and not in inpatient facilities?

MR. STOLOFF: Is that for Edward Stall or --

MS. O'FALLON: Yeah. Whoever.

MR. STALL: Yeah. Let me just point us

back to the patients we're talking about here, because Oregon may, in fact, be different on how care is delivered, in-home care, and things like that. These -- look at the 13 CMS patients. These are brain injury patients. They're stroke patients. These are the patients that can't go home. They're very complex. And we're not trying to take care of anybody that just needs a little extra time to recover. We're talking about people that need therapy that cannot function by themselves elsewhere. So this is a very complex patient and that's our specific and specialized population.

MS. O'FALLON: I'm sorry -- I'll talk loudly -- one follow-up. So yesterday I think it was Legacy was saying that their sort of census at the -- is it the RIO facility? Am I saying that right, the RIO facility was 60 percent or something like that. Right. So not full all the time. So how do you explain that again if we have, you know, these low bed numbers?

MR. STALL: Well, I don't know their care or their patterns. I certainly presume that they're very good. What is different that we find about Encompass and its ability to qualify patients, we've talked about that 178,000 records, these clinical

pathways. They're so evidence-based and they have size and scale. So that size and scale let's them negotiate with payers for these pre-approvals. We have great success, for instance, with Kaiser in California.

So these Medicare Advantage plans don't scare Encompass Health away. In fact, they've become a patient advocate to go say why does this patient need it and then the proposition is X. They also go to the hospitals and actually prescreen these patients. When I say the hospitals, they're not an acute hospital so they got to go prescreen patients anywhere they are, doctor's office or otherwise, so they're not getting patients for themselves.

DPUs, let's get a little difference between an IRF and a DPU. DPU is the distinct part unit which is a hospital patient unit. Doing great care, no doubt about that. IRFs, as you saw in that first chart, tend to be larger because they're freestanding. And there's something about that, there's something with size and scale that let's them have depth of therapists, depth of physicians, additional physicians, a wider range of services, those kind of things. So size and depth, a little

bigger can be better in terms of all that you can offer in rehab. The distinct part units, the liaisons or people that will go out and qualify the cases. And then the clinical pathways and just the evidence-based medicine that is allowed to happen.

MS. O'FALLON: Thank you.

MR. GILMAN: If there's no more questions, we can go ahead and get started with our public comment portion. One quick question though is I have Peter, Bill, and Edward, you signed up on the public comment sheet. I'm guessing you meant to sign on the "I'm here" sheet.

MR. STOLOFF: That's correct. I'm not giving public comment.

MR. GILMAN: Okay.

MR. STOLOFF: I made a mistake.

MR. GILMAN: Great. I just wanted to -- so I think based on the amount of time we have left, and we have about 14 folks signed up for public comment, so I think that's about five or six minutes apiece. So let's go with five. And what I'll do is I'll call your name. Lisa will grab them mic. And then if you could do a couple of things for us, let us know your name and what organization or facility you're representing. And then it would also be

extremely helpful if you'd let us know if you're planning to submit written comments too, just so we know to be looking out for that. Yes. Yeah.

MS. SELOVER: And not applicable is also acceptable.

MR. GILMAN: Not applicable is also acceptable, if you're not representing a facility.

Okay. So the first person I have is Marylee Rush.

MS. RUSH: My name is Marylee and I represent Brain Injury Association of Oregon. I'm a nurse and have been for 25 years. I had an accident a few years ago that caused a brain injury and spinal cord injury. I have observed during that time and being active through BIA, two things that have been brought up here. And I just came, so please bear with me, is the scattered effect of getting better at rehab that has occurred. But the scattered effect means the end effect of us getting better has been (inaudible) different types of facilities, different types of results. And in talking to various other people in the health industry that were injured, it would be so nice to have one location knowing -- that's what I was attracted to, what you said -- and having that here

and having it in various departments in the county. But especially for the person that is getting better, that they aren't fragmented all over to different this can help, that can help and so forth. I think it would be a big asset to have you here. Thank you for coming.

MR. GILMAN: Deanna Palm.

MS. PALM: Good afternoon. I'm Deanna Palm, President of the Hillsboro Chamber of Commerce. We represent more than 800 businesses and 50,000 employees in the greater Hillsboro area. I'm here today to speak in favor of the Encompass Health Rehabilitation Hospital of Oregon's application to build an inpatient rehabilitation hospital in Hillsboro to serve our fast-growing Washington County.

As you know, there are presently no acute inpatient rehabilitation hospital services here and although skilled service -- skilled nursing facilities provide rehabilitation care to a great number of patients every year, they do not have the resources nor hospital licensure to provide the intensive inpatient rehabilitation care that numerous research studies have consistently -- sorry about that. That has consistently shown can achieve

significantly better results for patients with certain diagnoses and allow them to return to the community with a higher level of function.

I believe you are also aware that Oregon ranks last behind all states for inpatient rehabilitation beds per thousand population over the age of 65. And also last in all states for the percentage of potentially rehab-appropriate patients referred to an inpatient rehabilitation hospital. So it would seem clear that there is a general need for more of these hospital services in Oregon, especially in our high-population areas.

Our growing population and increasing traffic congestion on Highway 26 means that all services of any kind that are only available in Portland are getting further away time-wise by the year. I would say quicker than that. Intensive inpatient rehabilitation services now only available to us in Portland are no exception and an obstacle to the mostly elderly families in Washington County that need them, who often choose instead local skilled nursing care for their loved ones despite the often less-than-optimal outcomes for those complex conditions.

For all of these reasons, we urge you to

approve the Encompass Health Rehabilitation Hospital of Oregon certificate of need application for Hillsboro and Washington County. We deserve the same level of acute inpatient rehabilitation care here that is readily accessible in other counties and other states. Thank you.

MS. O'FALLON: I assume you'll submit those written comments?

MS. PALM: I will.

MR. GILMAN: Sherry Stock.

MS. STOCK: Hello, I am Sherry Stock, Executive Director of the Brain Injury Alliance of Oregon and neuro gerontologist. I have a son with a severe brain injury so this has been part of my life since he was three months old. And I sustained, four years ago, a spinal court injury so I am coming at it from lots of different angles. So I did submit written testimony, but one of the things I'd like to cover is frequently, especially with younger people with brain injury, what they're diagnosed with is they're diagnosed with mental health issues. So when they're diagnosed with mental health issues, what are they given? They're given medications.

I have one 26-year-old at 19 years old, they said she was schizophrenic. They never did an

X-ray. Never did anything. They just put her on medications. By 22, she was so bad they took her into the ER and they found -- finally did an X-ray. Found that she had a brain tumor the size of lemon. So they did surgery but it was up at OHSU, and she got MRSA in her brain. So she not only then had brain injury from the surgery, but she also then had MRSA and flesh-eating bacteria in her brian.

She took a significant fall at OHSU, knocked unconscious for four days, and so another brain injury. So what has happened to this poor young girl who is now 26 years old? She's locked up in psych hospitals on 13 different medications. And one of the nurses, the day before she quit, told her mother if you don't get her out of here, they're going to kill her with the medications.

So it's not understanding brain injury, that is the that problem we have, brain injury and stroke. But what I see is brain injury at all ages. It's the number one killer in people 65 and over. But also children 0 to 4 learning how to walk fall and hit their head. It's the number one death of children. So understanding that it's brain injury and how to work with brain injury, this is what we desperately need.

And spinal cord injury, when I was in the hospital, I know who to contact because I'm in the business. And what they wanted to do with me is teach me how to transfer from a bed to a wheelchair and how to use my wheelchair and not hurt my fingers. So what I did is I had my husband take me out every day for four or five hours to work with a professional that taught me how to walk, before my working muscle memory and working memory could die, so I could still walk. I might not feel myself from the waist down, but I'm walking.

And that's having the proper facilities for people to go to, which we don't here in Oregon. And not other here in Oregon, by the way, but also Washington. So people would be coming from Washington for this facility as well, so it's just not right here. Thank you.

MR. GILMAN: Gwen Dayton.

MS. DAYTON: Hi, my name is Gwen Dayton, and I'm general counsel for the Oregon Healthcare Association. We represent long-term care facilities across the state, and notably all of the nursing facilities that are in what we believe to be the service area under consideration.

I'm going to submit written testimony and

rather than go through it all with you today, you'll be very grateful I'm sure, what I tend to do is focus my comment on some of what you've heard today. And then also add some additional comments as well. And we also intend to supplement our written testimony submitted today with additional evidence over the course of next 15 business days.

Before I get into some of the things that we've talked about, and some of our unique points, I wanted to put a few just key questions into the record. I don't expect you to answer them today, but I do think they should be considered at least. What actual location is Encompass putting before you for consideration? We know in their original application they had a location that was submitted, but then as of last week, they submitted an amendment that proposed a different location because they hadn't yet received the right approvals for the original location that had been submitted. So which location is under consideration?

And was the application deemed complete last week when there was the amendment? Or was it complete August 21, I think, when it was deemed complete by the state? Because there has been a significant amendment submitted to the application

that changes significantly its request. And what does OHA actually consider to be the service area that we should all be looking at when we assess need? It is OHCA's sense, and we are relying a lot on Mr. Robison's analysis in this, that the service area is the tri-county area, Multnomah, Clackamas and Washington Counties.

What we were surprised to hear Mr. Stoloff say yesterday on the record that he would consider the post medical application and the Encompass application to be subject to different service areas, when they're approximately a little under 20 miles apart depending on which site is actually chosen. We don't understand why they might be in different service areas, or why different service areas might be chosen, based on the state list that applies. So we put those questions into the record.

Moving on from those, I think the core question that has been presented this morning and is the theme, I think really, of the State's consideration of both applications, including Encompass, is to the extent to which nursing facility beds could be considered when assessing the need for rehab beds.

It is not surprising that there are low

stats for the number of rehab beds available in the tri-county area. That's because people are -- all rehab patients, most of them, are being care for in nursing facilities. That's just the reality of it. By the way, a quick example, my own mom is in the hospital for knee replacement surgery. And instead being discharged to home, she was discharged to a nursing facility where she was seen for approximately a week by a nurse practitioner and by a physical therapist. And I was there and she was -- she received assisted care for approximately, I want to say, a week-ish before she was well enough to go home. That's an example of the care we're providing in nursing facilities.

Unlike national -- I saw we had a lot of national data again today, and again, it is important to understand that Oregon is different. The State referenced that a minute ago, I will repeat it now, that our legislature has made a very concentrated and determined decision to focus people into community-based care, like assisted living, before they're considered for nursing facility care. We value independence. We don't want people to be institutionalized before they need to be.

So we have made a concerted effort to

actually limit nursing facility beds in this state, rather than increase them. So we have higher acuity people in assisted living than the rest of the country, and we assuredly have higher acuity, much higher acuity in our nursing facilities than the rest of the nation. And that is reflected in some of the stats that are in the written testimony that I'll submit, and I'll just talk about a few of them today.

We have the second lowest rate in the nation, Arizona is the lowest, of stays over a hundred days. Most of our stays are short stay. Seven out of ten days, I want to make sure that is exactly right, are short stay days. And a short stay, they get five days a week of physical therapy. 82 percent of short stays get five days a week of physical therapy, and 77 percent of that group get occupational therapy services. So we do provide therapy services. And that's why we haven't had an influx of rehab beds into these communities because these patients, by and large, we would never say there's not perhaps a slice of really acute care patients that maybe they're staying in the hospital now. I can't say.

You know, I hear the comments about brain

injury, and I don't want to be disrespectful for that need. There may be some slice of super-ill people for whom a nursing facility would not be appropriate. But everybody else has been served and is being served. Remember, you have to have a physician order to be admitted into a nursing facility. We are not allowed to care for anybody that we cannot care for. We must staff appropriately for the people that we care for. So we staff up for the people that we see. We don't take people we can't care for.

We also are -- Mr. Stall referenced the rules. You also need to consider whether there's a cost-effective alternative to the services being offered. Nursing facilities are that cost-effective alternative. We note that the Med Pak report that was also referenced earlier recommends a reduction in inpatient rehabilitation rates by five percent by unanimous vote. Inpatient rehab facilities are paid more than nursing facilities are for, in our community, arguably the much the same -- much the same care.

We are also significantly concerned that the Office of the Inspector General did an audit of inpatient rehabilitation facilities and found that

84 percent of the payment in the sample size that were made were unnecessary and unreasonable.

MR. GILMAN: Gwen, if you could wrap it up in next 30 seconds.

MS. DAYTON: Yep. One more thing, in just this year, Encompass paid a settlement of $48 million dollars to settle a false claim act. The claim involved allegations that the care wasn't necessary. The claims were inappropriate.

So this is the entity that is proposing to enter our marketplace. They're only going to take three percent Medicaid. So even some of the trauma that you just heard about may not be served by them if they are Medicaid. They're entering into a managed care marketplace that already has contracts to provide care for rehab patients and nursing facility at a lower cost than the IRFs would be proposing. We don't think this will be a successful model and we urge the State to reject the proposal. Thank you. And we will submit additional evidence into the record.

MR. GILMAN: Thank you. Okay. Joe Greenman. And are you going to be teaming up with Pamela?

MR. GREENMAN: I think Ms. Kilmurray also

signed up.

MR. GILMAN: Yes. I didn't know if -- you both went together yesterday, so I was going to ask you if you wanted to go together --

MR. GREENMAN: Can you break us up? We kind of touch on different components.

MR. GILMAN: Okay. So Joe.

MR. GREENMAN: Thanks. Good afternoon, Joe Greenman, outside counsel to Legacy Health System. And I'll talk about the legal components and the rule-based rationale for Legacy's opposition to the Encompass certificate of need application. My colleague, Ms. Kilmurray, will talk about some of the utilization, the clinical issues associated with it.

First and foremost, a broad-brush topic overview. The standard under the certificate of need laws for an applicant is that an applicant will not have -- if it does not have an appropriate relationship with its service area, it will result in unnecessary duplication of services and will have a negative financial impact on other providers. That's the basis for essentially denying the application, and we think that the Encompass application does all of those things. That standard

is articulated in division 580, section 0050.

It's been discussed here, I think most notably by Mr. Stall, that there is a standard of seven beds per 100,000 in population. And, in fact, in division 645, it's not a standard, it's, in fact, a maximum. So that would be the top threshold. So Mr. Stoloff spoke of the service area indicating a need for 91 beds using the 645 rationale, that would be the maximum allocation in the service area, not some sort of standard or need that would indicate the 91 would be indicated. So that's another reason in which we disagree.

You know, when you look at the actual service area, we currently have two IRFs providing services, one with 36 beds, the other with 18. Both have an average occupancy of roughly 60 percent. That has actually been on the decline for a period of time. Those occupancies are dictated, essentially, by the CMS criteria, when you evaluate residents for admission into the inpatient rehab facilities.

Even though it has been noted that there are some demographic issues coming in the next 10, 15 years that might continue to increase the level of need for these services, the mitigating factor on

the need is the declining lengths of stay, that again, are driven by the payer sources, either the FEFR service component of Medicare, and certainly by Medicare Advantage, and where IRFs take Medicaid, the same issues are present as well. So all different payer sources are applying criteria which is having a sustained effect of diminishing lengths of stay. So while the overall admission and discharges might overall start to see an increase, those lengths of say are going to be pushed down on the overall utilization of the service.

In the Encompass application, it's also notable that while they do address the fact that you do need to take account of inpatient need in division 590, they really moved quickly from that issue. And that is because the 590 evaluation component would indicate a maximum of far fewer than 91 beds in the service area. And as a result of that, there's even some discussion about whether the 590 standard is applicable or rational -- a rational methodology to impose upon the application.

We, of course -- the public health division's longstanding practice is that in all cases it does impose the 590 acute care bed evaluation needs standard before moving on to the

subspecialty standard that's found in division 645. And this application is no different in that regard.

There have been some comments today also about the convenience factor of the location here in Hillsboro. While we're sympathetic to the fact that it would be good to have medical services in close proximity to people's homes, the Encompass application did select the tri-county, Clackamas, Washington, Multnomah County as the service area. So the individual Hillsboro-based location has to be factored in with the fact that these Portland services are already available.

In addition to that, if you were to talk about, for instance, Legacy's Rehabilitation Institute of Oregon facility, if they were to apply to you for an expansion of their occupancy right now, there would not sufficient grounds to grant that expansion because under the division 645 rationale, there has to be sustained occupancy of 85 percent. And certainly over the past several years, RIO has not been in the neighborhood approaching 85 percent occupancy. So that would be another reason why the Encompass application is not in order at this time.

So I've got some signals here. We're

happy to note that we will submit written testimony further amplifying some of the points we make and adding some of the ones that time didn't permit to come forward today. And we thank you for providing this forum today.

MR. GILMAN: Thank you. Pamela Kilmurray.

MS. KILMURRAY: Hi. Thank you. I'm Pam Kilmurray. I'm the Director of the Rehab Institute of Oregon at Legacy Good Samaritan, which is also part of Legacy Health. And for those of you who don't know, Legacy Health operates seven hospitals in the Portland metro, northwest Washington and Willamette Valley area, along with 25-plus primary care clinics, and over 90 specialty clinics. Our hospital serves 748 patients a day. And within those hospitals includes Emanuel, which is a Level 1 trauma center, and as well as Randall Children's Hospital. Which Randall Children's Hospital is about 112 patients a day, and Emanuel has about 216 patients patient a day. RIO has 36 beds. It has a interdisciplinary team that includes nursing care, physiatrists that are available 24/7, and stroke certified staff, as well as occupational therapists, rehab therapists. We also have -- what stands us out as different is we have psychologists on our

team that work every day with our patients, as well as an internationally-known corticotherapy program.

We have all state-of-the-art equipment. We are Joint Commission accredited. All of our hospitals are Joint Commission stroke accredited, so we have access to immediate good care for stroke patients. And we are also accredited by the Commission of Accreditation for Rehab Facilities, which is CARF. And you need to be CARF accredited if you want to care for patients in Washington.

The leading diagnosis that we take care of is stroke. 50 percent of our patients is stroke, and the next following is brain injury and TBI, traumatic brain injury.

The other things that I want to call out that's different, we talked about the acuity of patients, I believe it was 1.24. RIO's case mix acuity is 1.44. The region is 1.37, and the nation is 1.38. We have a higher or case mix which suggests that RIO handles a more severe patient population than on average.

In addition our length of stay is 13.6, the region is 14.6, and the nation is 13.9. We have the lowest length stay in the region and the nation. In case I don't get to it, I'm going to say it now:

We also have the highest discharge rate back to the community compared to the region and the nation.

I think what's different, rehab here has changed. I've been with this rehab program for 17 years. And I believe 17 years ago, our length of stay was 26. About a decade ago it was 23, and now our length of stay is 13.6. And that has happened -- we have more admissions than we had a decade ago, so we are seeing more patients. The population is growing, but we have better treatment and we have better technology. So patients are improving and moving back to their community to their home. And I think that's very positive for patients and their care. I think the other important thing with Encompass' operating margin, it's a negative -- it's a negative operating margin until year four. And any over-estimation of patient stays will push negative margin beyond the five year guideline.

We -- and I think -- you can correct me if I'm wrong, but Encompass also estimated to provide 75 percent less Medicaid and charity care than RIO. In RIO 2019 -- fiscal year 2019, the percent of RIO's Medicaid and charity care was 47.85 percent. And the next highest was Medicare and then the rest is commercial payers. And a lot of patients, even

though they have insurance, they don't have an inpatient rehab benefit.

I think what I would like to close on is that RIO serves seven hospitals, all of Legacy's seven hospitals from Southwest Washington Medical Center to Silverton Hospital to east county. We also have the Kaiser contract, and we have for a couple of decades. So all Kaiser patients come to RIO, as well as OHSU, and we get a fair number of referrals right here in Hillsboro from Tuality Hospital.

So if you look at where we draw patients from -- and I hear you about wanting to be close to home, but what I know about healthcare, there is some things that you can't always get close to home, because you can't have that much patient services. What we should have close to home is outpatient rehab services so people don't have to drive.

So I would close and just say that I would -- I would say that if a another rehab center came into town and let's say you were successful in pulling all the patients from rehab, I don't know where our ventilated patients, where our burn patients would go, where those high acuity patients would receive their care.

We are an IRF. We are attached to a hospital, but we are an IRF, and we have our hospital right there to support us. So if we have a patient that has any type of stroke symptoms and we're worried about another stroke, our hospital will come over after help us. So I think that's what sets us aside with our location. Thank you.

MR. GILMAN: Okay. Arden Olson.

MR. OLSON: Hi, my name is Arden Olson. I'm counsel for Post Acute Medical. As you know, from yesterday's proceeding, we're going to submit testimony to show a series of misrepresentations that were made by persons opposed to the proposition for the need for IRF beds in our region. I'm here today simply to refer to Encompass' application that none of those misrepresentations alter PAM's view of there's a very serious need here. So I'll submit this letter, but I just want to read it.

After introducing myself, as you know from reviewing PAM's application, PAM has calculated the need in its service areas is 121 beds. Although Encompass has defined its service area as somewhat differently than PAM, it's more clear to Pam that there's amply need in this region for both projects. Indeed there will still be unmet need after both

facilities build as PAM viewed the evidence.

PAM therefore supports Encompass' assessment that there is a need for the Encompass facility at either the Hawthorn farm site or the at the alternative Andrew (inaudible) site. Thank you for having this hearing and letting me propose -- or submit this information.

MR. GILMAN: Mary Brown.

MS. BROWN: So I think you already have a letter from me. Right? Do you want me to read letter or just make comment?

MR. STENSEN: Mary, I'm going to hand it in to them in just a minute.

MS. BROWN: Oh, okay. Sorry.

MR. GILMAN: We will have the letter. Yeah.

MS. BROWN: Okay. You will have it. Okay. Well, I'll give you the essence of the letter. My husband and I support the certificate of need for a new, freestanding, acute care hospital specializing in rehabilitation in Hillsboro. Dick Stensen -- I worked for Dick Stensen and he asked me to write a letter and I was glad to do it.

On May 31st, Bernie had a stroke and we spent four days in Tuality Hospital after which we

were transferred to Legacy Good Samaritan Rehab Institute of Oregon. He was discharged on June 20th. And I will have to just tell you I'm a registered nurse by profession. I worked for Humana Insurance Company. I've worked for the U.S. Army. I've worked for Community Hospital of Hillsboro, so I've got a wide range of experience. The first thing I would have to say is that if there was anything about the quality of care that we received at RIO, I wouldn't be writing this letter. I think it's all about location, location, location. I will go into that further.

RIO has a stellar reputation and with my background and we're kind if insiders because of my being a medical professional, I would have gone anywhere to go to RIO, wherever they think would have been. And at first I thought they were over at Providence on the east side and I thought, oh, jeez, it's so far away, blah, blah, blah. We're going there anyway if we can. So it was just like, wow, they on the west side and I was really happy about that.

I work for Dick. I've already told you that. And I've already told you about my prior experiences with Humana Hospitals, where I was also

involved in the insurance division as well as being a chief executive officer for nursing and other services.

I know you're getting lots of business-oriented information, so this is all about the patient's experience and that's all it is. So I feel kind of bad because I really like RIO and I really would hate to see anything happen to that. You know, but you're going to make a good decision and I think it will be the right decision for the community.

I do want to point out that I do think that there's lots of people that are in between here and the coast. I can't imagine -- I don't know what other acute rehab facilities are available, but I can't believe that other people that are going to need acute services aren't going to seek them out, regardless of where they live if they've got the means to get there.

Hillsboro is growing by leaps and bounds and that's also half of the silicon forest so it's not getting smaller.

Okay, responses. Reasons to have another acute care facility, location, location, location. I'll just tell you that the commute is brutal. I

know -- I use Google Maps, I still use it I don't go anywhere in Portland anymore without Google Maps. I know every way to get to Legacy Hospital. I know some neighborhoods I would've never seen. I would never want to go back there again. But it took me a different way almost every time we went there. And if I had a 9:00 meeting I had to decide if I was going to try and leave, you know, at 5:30 so I wouldn't have to spend two or three hours in traffic. No, you know, I generally could make it in less than an hour.

So I would will just say that, you know, one of the greatest things we had when were in the hospital, because we were in Tuality Hospital there for four nights, it was, like, where are we going to have to get our rehab. Are we going to have to go someplace we don't want. Because, you know, they want to get you out right away, as soon as they can. Where are they going to send you?

And quite frankly, being an acute care oriented person, I was really not that skilled in understanding the extended care nursing home care and all of that. I can tell you that, you know, my brother had a stroke and he's younger than my husband. He lived in Minnesota. He was in a

skilled nursing unit and I can tell you that the main problem for him is that he didn't get therapy every day. And he was bored and depressed, and now that's Minnesota. It was a rural community. Maybe they didn't have really great services, but Minnesota is a pretty sophisticated medical environment. So, you know, I don't know what was going on there. It's just sort of an observation.

And then the access to our post outpatient care, we have Kaiser insurance, therefore, we had to use their network of services. So when we first got discharged -- by the way, I guess I should back up and say Bernie was a complex patient. He was on cardiac monitoring the entire time that he was in the acute hospital, both hospitals, RIO as well as Tuality. He went home on a cardiac event monitor. They couldn't figure out why he had a stroke. It turned out he had atrial fibrillation, which had been treated in the past, but, you know, I guess it just sneaks in on you what you're not looking.

He also went home with catheter. So we had to use Kaiser facilities for outpatient service and we all over because, like I said, because you go to the first available appointment, not the distance. But eventually all the care is now

provided by west side, with the exception of some complex patient issues, ophthalmology, neuro -- anyway. He's driving again. Before three months we're up, he's driving, but that's not necessarily a good thing, but he is driving.

So in conclusion, we support acute care rehabilitation closer and more accessible to west side patients. I think we -- like I said, I think as insiders we're a little bit more savvy about where you should go and may want to go. A lot people wouldn't have that insider knowledge and understand the importance of it, but we did. Thank you.

MR. GILMAN: John White.

MR. WHITE: Yes, I'm John White and I'm a professor of occupational therapy at Pacific University. And I speak in favor of additional rehabilitation services in Washington County. I've worked as an educator, researcher, and a practitioner over the last 40 years, mostly in the metro area. I've worked at rehabilitation facilities around the country and internationally. And I worked for some very happy years at RIO before it became a part of Legacy. And I've worked for their competition at Emanuel before they became

bonded in Legacy and RIO. And I can attest to the excellence of their services.

And part of why I think it would be good to have an intensive rehab facility in Washington County is because of the kind excellence they're able to provide to a different population, or a more accessible population I should say.

And so in supporting this, I wanted to look at research, convince what was an intuitive feeling about my experiences as to working in rehabilitation intensive and skilled nursing facilities. And that is that the outcomes are better almost across the board in terms of the different types of conditions and certainly for complex rehabilitation patients. That does come at an additional cost. Almost all research studies indicated there was additional cost. And I was not able to find a study that spoke to the long-term outcome cost. I assume there's studies out there that speak to that. I couldn't find them.

But my belief, based on working with a lot of people who had strokes and TBI, in their long-term recovery, that is sometimes 20-year recovery, is that quick intensive intervention makes a difference over the long run in terms quality of

life, in terms of functional ability, and in terms of a caregiver burden for that person. And so my feeling is that -- and again, it's more of an intuitive feeling, but my feeling is that the initial additional cost over skilled nursing in an intensive nursing facility, it paid off over the long term in terms of not having as much rehospitalization and so forth.

Another opportunity that I believe an additional facility would give, certainly healthcare professional students, is additional training opportunities. In terms of our own results of our own graduates from the Pacific University program, when students receive quality clinical education in the area, the chance of them staying in the area to continue practicing is higher. And for the most part, we've had shortages in most of the rehabilitation-related professions that could receive clinical training at a new facility. I know our student love those positions at RIO as opportunities, and I think that they would appreciate additional opportunities at a closer campus.

I think, also, there would be -- again, an intuitive feeling and I didn't hear statistics to

really support this today but Washington County is a more diverse county than Multnomah County as far as I know. And we need healthcare educators that -- or we need healthcare professionals who are able to learn about being more effective care providers of those people across a diverse population. And it seems that that would be true in an additional facility in Washington County.

And finally, one of my roles is working with people who have aphasia, that's a communication disorder related to brain injury -- thank you, I'll wrap it up. And they not only need comprehensive care so that they will have these better outcomes, but their care providers will get better training, and that they'll have additional outpatient services available to them over the often 20-year period that they will live with that condition. So I speak in favor. Thank you.

MR. GILMAN: Tom Hughes.

MR. HUGHES: Hi, I'm Tom Hughes and welcome to Hillsboro, first of all. I am here to speak in favor of this certificate of need for Encompass' hospital. I'm a little hesitant to be here today because the last time I weighed in on an issue about a certificate of need for a medical

facility was in '03, when I was mayor of Hillsboro. And during the process of the discussion, I wound up having a heart attack. So I'm hoping that that was a lightning-strike experience and not something that is cause and effect.

But one of the things that that heart attack taught me, and one of the reasons that I'm here today is that I had to have my stent placed at St. Vincent's. I had no trouble getting there. I had this white thing with a red light on top that took me right straight there. My wife who doesn't drive had a terrible time getting there and getting home, and was pretty much stuck hanging around for as long as I was there. Had that been a prolonged stay, it would have been almost unsupportable. And that was at St. Vincent's, which is relative close as opposed to Emanuel or Good Sam, which are both a little bit harder away. For somebody who doesn't drive, that becomes fairly difficult.

As somebody -- I would speak as somebody not -- I don't speak for the competitors. I don't speak for the healthcare practices in general. I speak mostly as a potential customer. You know, when they went over the list of conditions that they treat for in these hospitals, it was like they had

opened up my medicine chest and looked at all the drugs that I had currently prescribed for all of those kinds of conditions that lead to those kinds of problems.

I'm 76 years old and I think I represent a fair number of the growing population of Washington County, which is growing faster and older than most other parts of the metropolitan area. I think that if things are different in Oregon, we hear that things are different in Oregon on a number of levels. I was surprised to hear it in this discussion. Things are different in Oregon partly because we don't have this facility here. And so skilled nursing facilities have been replacing the treatment that other places people get through these kinds of hospital beds. And as somebody who is a potential customer of those, I would rather be in a facility that gets me out quicker with a higher level of success than the statistics show that the SNFs have on down the road.

So for those reasons, speaking on behalf of the -- I've been used to speaking for this community for eight years as mayor and eight years as president of the metro regional government. So I understand the needs in this part of the region in

particular, but I think that they are general throughout the Portland metropolitan area. So for that I'm speaking in favor. Thank you.

MR. GILMAN: Dick Stensen.

MR. STENSEN: Thank you. My name is Dick Stensen. What I'm here doing is I've been helping gather letters of support for the Encompass project and I'll tell you a little bit about why I did that -- and which includes some of those you have here and others, I think, I'll hand them in.

I was president and CEO of Tuality Healthcare for 22 years, and prior to that I was an associate and then administrator of the Straub Clinic and Hospital in Honolulu for 17 years. Prior to that I was in New Orleans and San Francisco working for healthcare organizations.

While I was in Hawaii, I was appointed to the state health planning and development agency certificate of need panel to review the capital projects, so I have an appreciation for the struggle you have in weighing the benefits across and making the important decisions for the community health services.

I have been impressed with the information about the Encompass project. In fact, I visited an

Encompass hospital when I was at a family gathering in Kansas City, the Mid America Rehabilitation Hospital in Overland Park. And I was very impressed with the quality of service, the intense service provided to patients. And I've been impressed with the organization as far ar everything I've learned about it.

What you have here and you'll see in the packet that I gave you, pages 3 and 4 is a list of all the letters of support that are in there. I would say before I touch on a couple of those for individuals who are not able to be here, that I came to believe this is something we really need in this community. The first time I worked -- I've been living here for the last 27 years. But also to touch on some of the things that Dr. Stillo pointed out that the CMS has noted the difference in outcomes of -- and return to community for both versus SNF. And he also pointed out the American Stroke Association guidelines for patients with stroke, that if they can get to an inpatient rehab facility, they should do rather than a skilled nursing facility. So it's very clear.

Mr. Stall also pointed out, of course, the dearth of beds compared to other states in the

country and our use of those beds. But fourth, and this is some new information for you this afternoon, you will find in my -- I think it's page 6 of that binder I gave you, despite the anxiety of the existing skilled nursing facilities, and I'm very highly aware of the services they provide, an analysis of ten different geographic markets, SNF utilization before and after opening an acute care inpatient rehab facility showed virtually no impact on utilization. And that graph is in there on page 6 take a look at that.

I mentioned my letter includes the names of the one or two dozen individuals who are in support of this project, but I want to touch on three of them briefly and then close my remarks. And those are physiatrists in the community, physical medicine and rehab specialists, board certified. And their specific comments are in the letters that you have there. First I will mention Dr. Bomalaski, to quote, "I am currently responsible for a 17-bed IRF in Eugene which cares for patients with a mix of stroke, traumatic brain injury, spinal cord injury, polytrauma, amputees, and other disabling injuries and diseases. This type of environment maximizes the functional recovery and

chances of returning to home, with greater independence and as compared with other environments, such as skilled nursing facilities. Since moving to Portland in 2018, I have been surprised and disappointed at the lack of inpatient rehab beds available. In comparison to other similar-sized metro areas, Portland lags far behind in providing access to these crucial services."

This is a physiatrist who has worked in several different communities across the country. And wants to stay in this year but wishes he had more resources to work with.

Then from Dr. Ensrud, a physical medicine rehab physician at OHSU, "Oregonians who cannot access acute rehab level services are getting inadequate rehab care that result in excessive disability." I think we've heard that from several different people today. "This does not allow these persons to fully participate in Oregon to the greatest extent of their potential."

And last I will quote Dr. Pagal, who is a resident of Hillsboro, but more importantly is a physiatrist. He is the Medical Director of the VA inpatient rehab facility in Vancouver, just across the river. Quote, "Throughout my years practicing

here, I have concluded that in general Portland should take pride in the high quality of medical services available. However, I have been impressed by the lack of high intensity inpatient rehabilitation in the metropolitan area. The inpatient rehabilitation units in the Portland area do a fine job with the patients they care for." And I think we've heard that today. "These units are all centrally located and the number of beds available for admission are limited. For these reasons, physicians and families routinely choose to place patients who would benefit from high intensity rehabilitation in skilled nursing facilities where only high intensity rehabilitation is available. A new acute inpatient rehabilitation facility on the west side of metropolitan Portland would greatly benefit the residents of Washington County who sustain catastrophic neurological or musculoskeletal injury."

I thank you for hearing my comments. Based on my experience, I think this is long overdue. Thank you.

MR. GILMAN: Bob Terry.

MR. TERRY: Thank you, Dr. Selover and ladies and gentlemen for being here. I encourage

you to approve this great deal for Encompass and our community. I'm a former Washington County Commissioner here and have worked in our county for over 26 years. I sat on our board for 24 years running the -- as chair or co-chair of the budget for this county. I'm also proud to tell you that I support our county and our health and human services division to the -- one of the few accredited -- nationally-accredited health and human services divisions in the state -- or in the country rather. So we are very proud of that and we are still an accredited health and human services.

I have here with me also a letter from our assistant administrator in our health and human services that I want to read, and then I have my own presentation to give to you. First of all, this is to Dr. Selover, and this is from Marie Santell, who as I said is the Assistant Administrator and the Division Manager for our Health and Human Services here in Washington County. "Dear Dr. Selover, Washington County Disability Aging and Veteran Services, DAVS, is supportive of Encompass Health's application to build an inpatient -- inpatient -- very important -- inpatient rehabilitation hospital in Washington County. As a local area agency in

aging, DAVS mission to strive to create -- very small print for my old eyes, I can tell you that. I'm sorry. Options that maintain the quality of life in older adults, veterans, and people with physical disabilities. DAVS serves a diverse population of individuals across urban, suburban, and rural areas in Washington County, Oregon. We believe that it is important for older adults and people with disabilities to have choices when it comes to their healthcare, including their post acute rehabilitation options," as this lady indicated over here. "Rehabilitation hospital can provide better outcomes, lower costs, and help older adults and people with disabilities live independently as possible. I hope that you will consider approving Encompass Health application for an inpatient rehabilitation hospital in Washington County. A regional, freestanding, inpatient rehabilitation hospital will provide the much needed services to older adults and people with disabilities, as well as in the larger community."

I also wanted to make some notes that was talked about transportation in Washington County and getting to downtown Portland or over to Multnomah County in general. I can tell you from firsthand

experience on many occasions, you don't do it very quickly no matter when it is, unless you're out there at 3:00 or 4:00 in the morning. It takes time. And it's not something that somebody needing these types of services that our other facilities do not provide inservice and outpatient as Encompass does, from what I have been able to learn.

And for myself, I am a veteran, as well as being a County Commissioner here, and for my personal endorsement, I have always worked very close to support Washington County Health and Human Services. As a veteran, it is imperative that we provide or have available to our citizens the services that Encompass can provide It is forecast that in a short six to eight years, Washington County will be our largest county in the state of Oregon. It is not practical to be running to Portland or Multnomah County for many of our services, but rather work in conjunction on a local level in support of our community service as we do now.

Washington County has always been a county that was always proud to support itself, support its local services such as Lifeworks and many others here in the local community, both with financial and

with supportive aid. Our walk-in clinic that we just opened is run actually by nonprofit organizations that we support here in the county as part of our county budget. The county has continued to upgrade many of our human resource services in all areas such as supporting Tuality Community Hospital, working with Oregon Health Science University, OHSU, to provide more current services in our community and our county walk-in clinic at Hawthorn Farms.

As I note, I have been on the Tuality Community Hospital Foundation board or at least 17 years. Encompass will make a great needed improvement to medical services not currently readily available to our community. Even though I have not -- in the workup of Encompass, I have not heard any dissent or negative comment as far as the needed services. I think that this would be called hopefully good competition. And I've hear some people here today, I don't agree with them, the services that I know they provide are not the same thing as Encompass and Encompass' type of people do provide, which is needed here locally, not just because of transportation reasons, but because we are the largest county -- will be the largest county

in the state, but we are also the most diverse county both in numbers of people and in the different types of diversity that we have in this county as was stated by Mr. White.

So I personally, as well as this county, encourages you to approve this and do it quickly. Thank you very much. I appreciate your support and your time and hearing us today. Thank you.

MR. GILMAN: All right. That is -- those are all commenters we have signed up and we do have time left if there are additional folks who have not given public comment, they would like to.

MS. STOCK: Sherry Stock again. I had another -- Carol Alleman (ph) that was here, and Carol had to leave. Today is her 80th birthday. Well, no, let me rephrase that. It's her 41st anniversary of being 39. But she -- she has both a traumatic brain injury home and everybody in her home -- it's a five-bedroom home, and everybody has brain and spinal cord injury. And she also has a day program that she works with Pacific University, actually, with students there and professors. So it's great programs that she's got but she only has a five-bedroom home, and she gets eight to ten calls a day for people that are in nursing homes looking

to get into the community to get into a home and to get into her day program. So the problem is there's not enough services here for the people that need them, which is what we're hoping -- what this will be bringing.

MR. GILMAN: Do you know if she's going to be submitting those comments in writing?

MS. STOCK: I can ask her to put that together.

MR. GILMAN: Thank you.

MS. STOCK: Yeah, after today.

MR. GILMAN: Yes.

MR. WHITE: Yes. I failed to cite one systematic review study that concluded that -- kind of emphasizing the point that to the extent IRFs often discharge to SNFs and so as a combination services often serve the community ideally. So again, it's providing the services that they do best. John White.

MR. GILMAN: Okay.

MS. O'FALLON: Can I -- Mr. Hughes, is he still here?

MR. STENSEN: No. He just left.

MS. O'FALLON: Oh, he just left. Do you know if he was representing anybody in particular or

just speaking for himself? Does anybody know?

MR. STENSEN: I think he was speaking for himself. He's retired.

MR. GILMAN: It says retired.

MR. STENSEN: He's a retired mayor of Hillsboro.

MS. O'FALLON: And Mr. Stensen?

MR. STENSEN: Yes.

MS. O'FALLON: Representing yourself or --

MR. STENSEN: I'm retired but I have been assisting Encompass in gathering information.

MS. O'FALLON: Okay. Thanks.

MR. GILMAN: We'll conclude our public meeting. Thank you all for joining us again.

(Whereupon, meeting concluded.)

CERTIFICATE

I, Cheyne Lee, do hereby certify that I reported all proceedings adduced in the foregoing matter and that the foregoing transcript pages constitutes a full, true, and accurate record of said proceedings to the best of my ability.

I further certify that I am neither related to counsel or any part to the proceedings nor have any interest in the outcome of the proceedings.

IN WITNESS HEREOF, I have hereunto set my hand this 28th day of October, 2019.

/S/ Cheyne Lee

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