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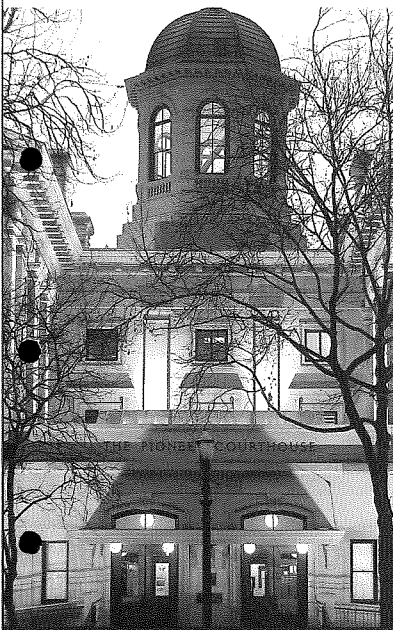
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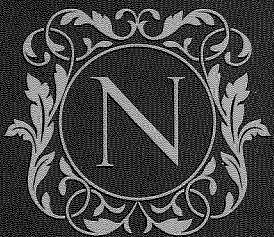


**ORIGINAL**

**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**



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## 1 ENCOMPASS MEDICAL

## 2 CERTIFICATE OF NEED APPLICATION #679

## 3 OREGON HEALTH AUTHORITY

## 4 PUBLIC MEETING

5 TUESDAY, OCTOBER 15, 2019

6 1:32 P.M.

7  
8 MR. GILMAN: Good afternoon, everybody.

9 Welcome to the OHA public meeting. My name is Matt  
10 Gilman. I'm the Certificate of Need Program Manager  
11 with the Oregon Health Authority. I wanted to  
12 welcome you all here.

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

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

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

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

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

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



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

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

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

15 **MS. O'FALLON:** Shannon O'Fallon with the  
16 Oregon Department of Justice, and I advise the  
17 State's Public Health Division, including the CM  
18 programs.

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

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

1 --

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

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

9 **MR. STOLOFF:** Okay. Thank you. So good  
10 afternoon.

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

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

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

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

13 **MR. HEATH:** Can you hear me well enough?

14 **MS. O'FALLON:** I think so.

15 **MR. HEATH:** Okay. So again, I'm Bill  
16 Heath. I'm vice president of business development  
17 for Encompass Health. And I want to take a minute  
18 to tell you who Encompass Health is. So we're one  
19 of the largest providers of post acute care in the  
20 country. We are the largest provider of inpatient  
21 rehab in the country. As of June 30, we had 131  
22 rehab hospitals around the country. SSince June  
23 30th, we've opened two more, one in Texas and one in  
24 Idaho. And before the end of the year, we will be  
25 opening two more, another one in Texas in the

1 Houston market, and one in Southern California.

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

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

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

1 level of care to be able to get back home.

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

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

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

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

3           And then one more thing I wanted to talk  
4 about here is it's not just patient care. We're  
5 also an advocate in the industry. We work with lots  
6 of other associations and this is just one example  
7 where we've partnered with the American Stroke  
8 Association on their "Together to End Stroke"  
9 program. This is a national program to promote  
10 stroke awareness and recovery. And I mentioned our  
11 hospitals are highly specialized. Across all of our  
12 hospitals we have -- most of them have a disease-  
13 specific certification from the Joint Commission.  
14 117 of those hospitals have a stroke certification,  
15 so that's why this is important to us and the Stroke  
16 Association partnership. We will also have a Stroke  
17 Association -- I mean, a stroke certification here  
18 in this market. But in addition to stroke, there's  
19 several other ones that I think Dr. Stillo may talk  
20 about in a few minutes, but we hold 289 disease-  
21 specific certifications at our hospitals across the  
22 country. Dr. Stillo.

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

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

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

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

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

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

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



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

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

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

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

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

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

1 and the Medicare rules. Okay. So we have that.  
2 And the treatment program, the rehabilitation  
3 program first of all is approved by rehabilitation  
4 physicians, such as myself. Right. The plan of  
5 care is approved. Team -- it's very, very much a  
6 team-oriented process. So in terms of rehab  
7 intensity services, our patients have to have a  
8 minimum of three hours per day, five days a week or  
9 15 hours over seven days of rehabilitation,  
10 including physical therapy, occupational therapy,  
11 speech therapy, etcetera. Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15           Myself, I have been at this for about 35  
16 years. I founded a small company or part of a small  
17 company 35 years ago. That merged into Dixon Hughes  
18 12 years ago. I've built and led practices and  
19 strategy and analytics and alternative payments.  
20 Planned dozens -- in 35 years you get to do a lot.  
21 Planned dozens of hospitals, including rehab  
22 hospitals and other specialty hospitals. Many that  
23 are open and successful, so we know what works.

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



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

5           So Oregon bed need methodology in a  
6 certificate of need, basically we start with this  
7 sort of an idea that we've met the standard of the  
8 590, the general bed need. And then regulation 645  
9 comes into play which talks about specialty  
10 services. So basically a quick summary of that kind  
11 of thing, what we've got to deal with is the rehab  
12 need using seven beds per thousands standard.  
13 Address specialty rehabilitation, special needs,  
14 sizes of populations, rates of historic utilization,  
15 accessibility, quality, those kinds of things.

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

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

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

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

13           One thing I will point out is the bed need  
14 ratio or bed need is per hundred thousand total  
15 population. Health care planning has evolved over  
16 the years and now focuses on a specific population.  
17 And the population for complex rehab is an elderly  
18 population. This little pie chart to the right --  
19 to the left shows 72 percent of patients are 65 and  
20 older. Medicare also clearly focuses the rehab  
21 provider on the complex patient. It's called CMS  
22 13, and it's 60 percent rule. 60 percent of your  
23 patients have to come from these conditions. And  
24 you saw them in an earlier slide, stroke, brain  
25 injury, those kinds of things. But the impact is the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 **MR. STOLOFF:** Thank you, Mr. Stillo.

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

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



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

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

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

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

9           There's also a number of other rules that  
10 OHA has distinguishing this. In fact, the  
11 certificate of need rules for skilled nursing  
12 facilities in 333-610-001019 provides that SNFs are  
13 licensed to provide care for persons who require the  
14 availability of an RN 24 hours a day, but do not  
15 require the levels of nursing, physician and  
16 specialized services available in a hospital. So  
17 this goes to the line of demarcation. The Medicare  
18 regulations similarly say the same thing in 42 CFR  
19 424.20, which state that SNFs provide skilled  
20 nursing care, that as a practical matter, can only  
21 be provided in a SNF to be distinguished from an  
22 inpatient rehabilitation facility. Thank you.

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

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

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

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

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

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

22 **MR. STOLOFF:** Is that for Edward Stall or  
23 --

24 **MS. O'FALLON:** Yeah. Whoever.

25 **MR. STALL:** Yeah. Let me just point us

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

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

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

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

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

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

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

6 **MS. O'FALLON:** Thank you.

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

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

15 **MR. GILMAN:** Okay.

16 **MR. STOLOFF:** I made a mistake.

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

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

4 **MS. SELOVER:** And not applicable is also  
5 acceptable.

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

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

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



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

7 **MR. GILMAN:** Deanna Palm.

8 **MS. PALM:** Good afternoon. I'm Deanna  
9 Palm, President of the Hillsboro Chamber of  
10 Commerce. We represent more than 800 businesses and  
11 50,000 employees in the greater Hillsboro area. I'm  
12 here today to speak in favor of the Encompass Health  
13 Rehabilitation Hospital of Oregon's application to  
14 build an inpatient rehabilitation hospital in  
15 Hillsboro to serve our fast-growing Washington  
16 County.

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

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

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

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

25 For all of these reasons, we urge you to

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

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

9 **MS. PALM:** I will.

10 **MR. GILMAN:** Sherry Stock.

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

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

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

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

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

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

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

18           **MR. GILMAN:** Gwen Dayton.

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

25           I'm going to submit written testimony and

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

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

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

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

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

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

25           It is not surprising that there are low

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

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

25           So we have made a concerted effort to



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

10           We have the second lowest rate in the  
11 nation, Arizona is the lowest, of stays over a  
12 hundred days. Most of our stays are short stay.  
13 Seven out of ten days, I want to make sure that is  
14 exactly right, are short stay days. And a short  
15 stay, they get five days a week of physical therapy.  
16 82 percent of short stays get five days a week of  
17 physical therapy, and 77 percent of that group get  
18 occupational therapy services. So we do provide  
19 therapy services. And that's why we haven't had an  
20 influx of rehab beds into these communities because  
21 these patients, by and large, we would never say  
22 there's not perhaps a slice of really acute care  
23 patients that maybe they're staying in the hospital  
24 now. I can't say.

25           You know, I hear the comments about brain

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

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

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

1 84 percent of the payment in the sample size that  
2 were made were unnecessary and unreasonable.

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

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

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

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

25 **MR. GREENMAN:** I think Ms. Kilmurray also

1 signed up.

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

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

7           **MR. GILMAN:** Okay. So Joe.

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

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

1 is articulated in division 580, section 0050.

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

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

22           Even though it has been noted that there  
23 are some demographic issues coming in the next 10,  
24 15 years that might continue to increase the level  
25 of need for these services, the mitigating factor on

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

12 In the Encompass application, it's also  
13 notable that while they do address the fact that you  
14 do need to take account of inpatient need in  
15 division 590, they really moved quickly from that  
16 issue. And that is because the 590 evaluation  
17 component would indicate a maximum of far fewer than  
18 91 beds in the service area. And as a result of  
19 that, there's even some discussion about whether the  
20 590 standard is applicable or rational -- a rational  
21 methodology to impose upon the application.

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

1 subspecialty standard that's found in division 645.  
2 And this application is no different in that regard.  
3           There have been some comments today also  
4 about the convenience factor of the location here in  
5 Hillsboro. While we're sympathetic to the fact that  
6 it would be good to have medical services in close  
7 proximity to people's homes, the Encompass  
8 application did select the tri-county, Clackamas,  
9 Washington, Multnomah County as the service area. So  
10 the individual Hillsboro-based location has to be  
11 factored in with the fact that these Portland  
12 services are already available.

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

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

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

6 **MR. GILMAN:** Thank you. Pamela Kilmurray.

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



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

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

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

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

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

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

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

19 We -- and I think -- you can correct me if  
20 I'm wrong, but Encompass also estimated to provide  
21 75 percent less Medicaid and charity care than RIO.  
22 In RIO 2019 -- fiscal year 2019, the percent of  
23 RIO's Medicaid and charity care was 47.85 percent.  
24 And the next highest was Medicare and then the rest  
25 is commercial payers. And a lot of patients, even

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

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

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

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

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

8           **MR. GILMAN:** Okay. Arden Olson.

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

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

1 facilities build as PAM viewed the evidence.

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

8 MR. GILMAN: Mary Brown.

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

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

14 MS. BROWN: Oh, okay. Sorry.

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

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

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

1 were transferred to Legacy Good Samaritan Rehab  
2 Institute of Oregon. He was discharged on June  
3 20th. And I will have to just tell you I'm a  
4 registered nurse by profession. I worked for Humana  
5 Insurance Company. I've worked for the U.S. Army.  
6 I've worked for Community Hospital of Hillsboro, so  
7 I've got a wide range of experience. The first  
8 thing I would have to say is that if there was  
9 anything about the quality of care that we received  
10 at RIO, I wouldn't be writing this letter. I think  
11 it's all about location, location, location. I will  
12 go into that further.

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

14           **MR. GILMAN:** John White.

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

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

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

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

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

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

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

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

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

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

19           **MR. GILMAN:** Tom Hughes.

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

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

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

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

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

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

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

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

4 **MR. GILMAN:** Dick Stensen.

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

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

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

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



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

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

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

1 country and our use of those beds. But fourth, and  
2 this is some new information for you this afternoon,  
3 you will find in my -- I think it's page 6 of that  
4 binder I gave you, despite the anxiety of the  
5 existing skilled nursing facilities, and I'm very  
6 highly aware of the services they provide, an  
7 analysis of ten different geographic markets, SNF  
8 utilization before and after opening an acute care  
9 inpatient rehab facility showed virtually no impact  
10 on utilization. And that graph is in there on page  
11 6 take a look at that.

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

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

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

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

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

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

20 I thank you for hearing my comments.

21 Based on my experience, I think this is long  
22 overdue. Thank you.

23 **MR. GILMAN:** Bob Terry.

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

10 **MR. GILMAN:** Thank you.

11 **MS. STOCK:** Yeah, after today.

12 **MR. GILMAN:** Yes.

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

20 **MR. GILMAN:** Okay.

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

23 **MR. STENSEN:** No. He just left.

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

1 just speaking for himself? Does anybody know?

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

4 **MR. GILMAN:** It says retired.

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

7 **MS. O'FALLON:** And Mr. Stensen?

8 **MR. STENSEN:** Yes.

9 **MS. O'FALLON:** Representing yourself or --

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

12 **MS. O'FALLON:** Okay. Thanks.

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

15 **(Whereupon, meeting concluded.)**

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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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