

Bree Difficult to Discharge Workgroup: Data and Definitions Survey Results

March 16th, 2023

1) How to define “difficult to discharge”

Patients who are in acute care beds who no longer meet medical necessity and are ready to be discharge. We use this term as a synonym for "avoidable days"

An individual for whom acute hospital level of care is no longer medically necessary but their medical/behavioral health profile is not stable or predictable such that community providers or family are unable to support them.

Patient who has barriers to discharge and has exceeded their days of medical necessity for continued hospitalization.

We define difficult to discharge individuals based on care needs, characteristics and/or dynamics that will impede a safe discharge to the community with LTSS support. Regardless of LOS in the inpatient setting as these are the individuals who will most likely result in LOS past medical stability.

A difficult to discharge patient is one that has barriers to a safe discharge, either for reasons of safe placement (AFH, SNF etc), for specific elements such as hemodialysis, wounds, behaviors, SUD and bariatric nuances to include equipment. It is often a combination of SDOH, physical health and BH concerns and often accompanying non decisional status leading to the need for guardianship.

A difficult to discharge patient is a patient that is inpatient at an acute care hospital, that is facing barrier(s) to discharge

Inpatient persons who are medically stable or ready for discharge > 5 days.

Observation status persons >3 days who are medically ready for discharge >1 day.

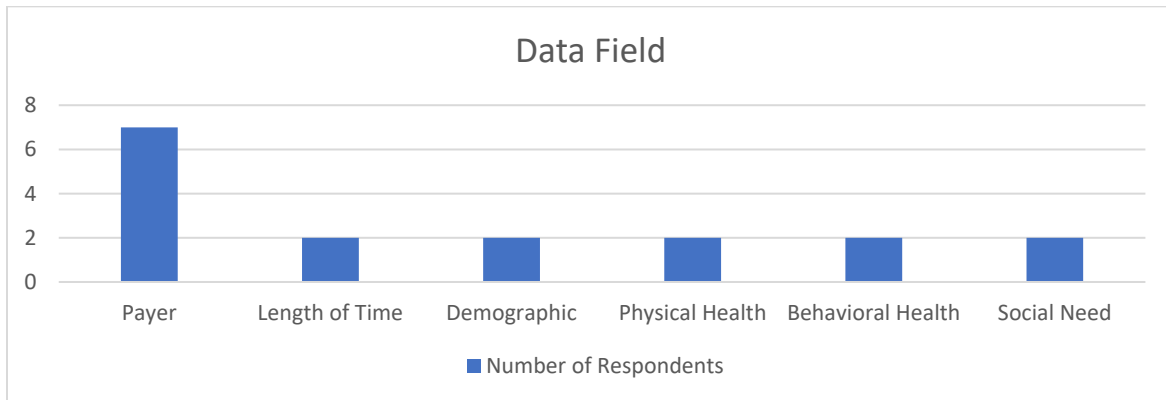
"Difficult to discharge" is derogatory, non-patient-centered language. We prefer not to use this language at our site because it puts the onus on the individual patient and is deficit-based. Strongly recommend a more appropriate, equity-based way to discuss the issue. That being said, we do capture when patients become "medically ready for discharge" (which is driven by clinician determination of when the patient is clinically appropriate for lower level of care) and "avoidable days" (when utilization management metrics deem the patient does not meet inpatient criteria).

Key Points:

- Is there a phrase other than “difficult to discharge” to use about barriers to safe discharge? (One commenter suggests the term is synonymous with “avoidable delays”)
- Is the definition based on length of stay, barriers to discharge, or both?

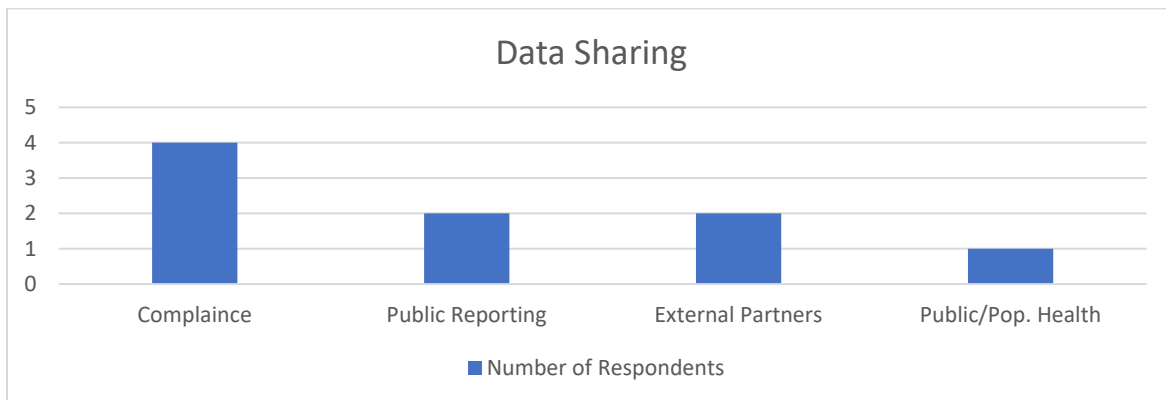
2) What data does your organization collect on difficult to discharge patients?

- **Payer (88%)**
- Length of Time in Hospital (25%)
- Patient Age and Demographics (25%)
- Physical Health Needs (25%)
- Behavioral Health Needs (25%)
- Health Related Social Needs (25%)
- Other (Please Describe)
 - Barrier to discharge
 - Number of days medical necessity not met
 - Length of time since referral



3) Who does your organization share data with?

- **Compliance/Regulatory Agencies (50%)**
- Public Reporting for Transparency (25%)
- External Discharge Partners (25%)
- Public Health/Pop Health Monitoring (12%)
- Other (Please Describe)
 - WSHA
 - MCOs



4) What are areas for improvement for discharge data?

- Consistency of definitions; timing of collection; collection that is doable ("the juice is worth the squeeze")
- Community residential providers who are willing to serve a challenging population and invest in additional training for their staff on how to meet the needs of clients with complex medical and behavioral health profiles. Support from agencies (state and community) to offer and fund additional trainings for community residential providers and their staff.
- Difference in definition and data collection leads to disagreement about the data, hard to share when we all speak a different language and measure success differently. Would love to come to common ground so we can tackle the biggest issues and all be aligned in our understanding of the scope and size of the various barriers.
- Understanding the barriers that SNF and AFH have to acceptance of complex members and remediating such to track and trend appropriately.
- Being made aware of patient in long stays of observation status so we can be of assistance in DC planning earlier in the episode and capturing OBS data.
- An opportunity to share formally and informally the data that affects hospital and MCO and agencies so all can work on solutions.
- Have a set definition for difficult to discharge and a uniform way to collect data, data sources, etc.
- I separately highlighted and visible at the state level how many people are abandoned in the ED for placement. If there is to be reform on this issue, it needs to be brought to light, monitored/tracked, and scrutinized.
- A summary of state wide cases showing the average loss per case on our hospitals - in dollars and in FTEs of nursing and provider time. We not only have a financial crisis, we have a staffing crisis and filling beds with these patients contributes to burn out and care fatigue (concern over not enough staff or beds for the sick coming in). If the state has to hire X number case managers or care givers to replace the measurable burden on the hospital, I'm sure they can figure out a lower cost option.