
Bree Collaborative | Difficult to Discharge

February 16th, 2023 | 3:00 – 4:30 a.m.

Virtual

MEMBERS PRESENT

Darcy Jaffe, Washington State Hospital Association (chair)
Shelley Bogart, DSHS-DDA
Gloria Brigham, EdD, MN, RN, Washington State Nursing Association
Amy Cole, MBA, Multicare
Jay Cook, MD, MBA, Providence
Glory Dole, RN, MA, Washington State Health Care Authority
Billie Dickinson, Washington State Medical Association
Kelli Emans, DSHS
Jas Grewal, CareSkore
Karla Hall, RN, PeaceHealth
Carol Hiner, MSN, Kaiser Permanente
Linda Keenan, PhD, MPA, RN-BC, United Healthcare
Jen Koon, MD, Premera Blue Cross

Danica Koos, MPH, Community Health Plan of Washington
Cathy MacInroe, MSW, Providence
Elena Madrid, RN, Washington Health Care Association
Kellie Meserve, MN, RN, Virginia Mason Franciscan Health
Keri Nasenbeny, MHA, BSN Harborview Medical Center
Kim Petram, BSN, Valley Medical Center
Sheridan Rieger, MD, Concerto Health
Zosia Stanely, JD, MHA, Washington State Hospital Association
Cyndi Stilson, RN, BSN, Community Health Plan of Washington
Ric Troyer, MD, Iora Health
Janice Tufte, PICORI West
Ambassador/Hassanah Consulting

STAFF AND MEMBERS OF THE PUBLIC

Nick Locke, MPH, Bree Collaborative
Emily Robson, RN, DNP, Foundation for Health Care Quality

WELCOME

Nick Locke, Bree Collaborative, welcomed everyone to the Bree Difficult to Discharge workgroup and highlighted new members. Those present introduced themselves in chat.

REVIEW: DIFFICULT TO DISCHARGE CHARTER

Mr. Locke shared the workgroup charter and invited comments about changes to the aim and purpose. Workgroup members discussed the charter prior to voting to adopt.

- Another opportunity for impact in the “purpose” section of the charter could be developing educational material, whether that is creating shared definitions for post-acute care facilities or materials about the best pathways for discharge.
- Other solutions have been previously put forth by the 2017 legislative report that convened a discharge collaborative. New changes may be required related to COVID-19 and increased stress on healthcare systems.
- The goal of improving “discharge protocols” could be clarified.

After a brief discussion, workgroup members voted to adopt the charter and send to the Bree Collaborative.

DISCUSSION: BRAINSTORMING OPPORTUNITIES FOR IMPACT

Mr. Locke continued the brainstorming conversation from the January meeting with a goal of determining opportunities for this workgroup to make an impact.

- Mr. Locke started with an open question about current barriers for difficult to discharge patients.
 - Darcy Jaffe clarified that although many members have been discussing these barriers for years, this is meant to facilitate brainstorming and make sure we are in alignment across organizations.
 - The 2017 legislative report may provide a strong foundation for existing barriers.
 - Additional barriers discussed include:
 - The “silver tsunami” of older patients, especially those without insurance who can’t get into long-term care (not even necessarily skilled nursing facilities)
 - Volume and complexity of difficult to discharge patients – overlapping barriers for individuals
 - Workforce concerns in LTC, primary care, and post-acute care. The need to address burnout and resilience, including among social support and caregivers.
 - Reimbursement rates for primary care and post-acute care for complex patients.
 - Lack of options for difficult populations (whether that is housing barriers, SUD concerns, complex/behavioral health concerns)
 - Bureaucracy and lack of efficiency in the process (concerns like insurance eligibility, guardianship, authorizations)
 - Specific populations, including children.
 - Patient/caregiver engagement and understanding (including patients refusing transfers to long-term care)
 - Community resources for physical/behavioral health needs.
 - Contracts, bed availability, regulations, requirements
- Next, the workgroup brainstormed existing solutions and best practices that may provide a launch point for future recommendations.
 - Money: especially during COVID, extra payments to adult family homes helped place more patients in post-acute care.
 - Engagement: engage a discharge team of hospital and plan representatives early to develop communication and partnerships.
 - Develop robust communication at intake, improve transparency and trust.
 - Low-barrier transitional care: look to the example of the transitional care center of Seattle
 - Proactive Infrastructure: develop greater capacity and availability from existing programs, use a center of excellence model.
 - Education: Develop a one-pager or more educational materials on long-term care.
 - Community Support: support community resources and caregivers, develop peer-support programs or pathways.
- Finally, the workgroup discussed potential avenues to make an impact through workgroup conversations.
 - Developing common definitions and identify a post-acute care continuum
 - Use data to identify existing barriers and target resources. We will need to have common definitions prior to being able to use quality data.
 - Identify roles and responsibilities of each healthcare stakeholder, including communication plans.

PUBLIC COMMENT AND GOOD OF THE ORDER

Mr. Locke invited final comments or public comments, then thanked all for attending. At the next workgroup meeting, the team will review common definitions for difficult to discharge and the post-acute care continuum. Between now and the March meeting, Bree staff will send out a survey asking about existing definitions and data for difficult to discharge patients. The workgroup's next meeting will be on Thursday, March 16th from 3:00 – 4:30 PM.

DRAFT