
Bree Collaborative | Complex Discharge

March 16th, 2023 | 3:00 – 4:30 a.m.

Virtual

MEMBERS PRESENT

Shelley Bogart, DSHS-DDA
Amy Cole, MBA, Multicare
Billie Dickinson, Washington State Medical Association
Kelli Emans, DSHS
Jas Grewal, WA Health Care Authority
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
Elena Madrid, RN, Washington Health Care Association
Zosia Stanely, JD, MHA, Washington State Hospital Association
Cyndi Stilson, RN, BSN, Community Health Plan of Washington
Eric Troyer, MD, Iora Health
Janice Tufte, PICORI West
Ambassador/Hassanah Consulting
Sara Williams, MSN, RN, PeaceHealth

STAFF AND MEMBERS OF THE PUBLIC

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

WELCOME

Nick Locke, Bree Collaborative, welcomed everyone to the Bree Difficult to Discharge workgroup and highlighted new members. Darcy Jaffe, the workgroup chair, was absent for the meeting. Zosia Stanely, JD, MHA, stepped in to help facilitate. Those present introduced themselves in chat.

DISCUSS: COMMON DEFINITIONS

Mr. Locke briefly debriefed the workgroup's survey about common definitions and measures. Members began by discussing a common definition for "difficult to discharge" based on survey results and accepted definitions in literature.

- First, members discussed transitioning from the phrase "difficult to discharge" which places the burden of difficulty on patients to "complex discharge" which highlights the existing barriers to discharge/transition, and places the onus on interdepartmental care teams. Workgroup members agreed to highlight the phrase "complex discharge" in workgroup material.
- Additionally, members agreed that the "complex discharge" definition should focus on the barriers to discharge such as physical health needs, behavioral health needs, or social needs.
 - Separate, but related to complex discharge is "avoidable days: days when a patient is medically appropriate for discharge but remains in the hospital. This idea of avoidable days ties into length of stay and is important to measure for cost and value purposes.
- The important element of complex discharge is the barrier more than length of stay
 - Length of stay may become a barrier, but not the focus
 - Other broad barriers could include inadequate caregiver support, chronically active complex medical history, social need (especially housing or food), a specific medication need, complex care process needs (infusion), legal/guardianship needs, and other non-medical needs (such as psychosis or behavioral health needs).

- At the next workgroup meeting the group will try to add a list of common/similar barriers for complex discharge patients as a first step for developing specific pathways for discharge.
- The important concepts are “safe, timely, and appropriate” discharge.

DISCUSSION: METRICS AND ALIGNMENT

Mr. Locke continued the conversation on alignment by sharing data survey responses. Current data being collected focuses on payers. A few organizations collect aggregate discharge data, but there aren't accepted definitions to compare data accurately.

- Workgroup members started by discussing how organizations collect data.
 - Payer is the most common and most important data field for coverage and discharge options.
 - Some other hospitals collect barriers to discharge data, but usually only on an internal excel spreadsheet.
 - Other essential data include discharge position (where the patient ended up), discharge priority (where the patient wanted to go), length of stay/utilization, readmission/health system utilization (ER visits, readmissions), zip codes/risk codes (as an indicator of social need)
 - Much of these data still needs to be standardized and categorized
- Workgroup members also discussed how data is currently aggregated or shared
 - Many organizations collect data for regulatory purposes, but far fewer share data publicly or for population monitoring purposes
 - The HCA, WSHA, DSHS, and MCOs all collect high-level discharge data, but many have their own purposes. (WSHA collects hospital level data, DSHS collects data on referrals received from hospitals, MCOs/HCA generally collect Medicaid-specific data related to length of stay).
 - We need to level-set on what the data means and how to better create alignment.
- Additional questions for data include:
 - Is data collection feasible/worth the effort?
 - Can we use data for funding purposes/to target specific programs to the greatest need?
 - The first priority is understanding the payer mix and clients who have complex discharge
- The workgroup's goals for future data use include:
 - Actionable data that is understandable and shareable to target short and long-term solutions.
 - Common definitions that allow us to look back and forward
 - Addressing barriers to data alignment – ensure common data collection capacity is feasible and practical.

PUBLIC COMMENT AND GOOD OF THE ORDER

Mr. Locke invited final comments or public comments, then thanked all for attending. Members expressed interest in ensuring that discharge solutions are included, as well as data. At the next meeting the workgroup will review data definitions and discuss data alignment solutions, as well as brainstorm ways to turn alignment into action. The workgroup's next meeting will be on Thursday, April 20th from 3:00 – 4:30 PM.