Bree Collaborative | Complex Discharge
April 20th, 2023| 3:00 – 4:30 a.m.
Virtual

MEMBERS PRESENT

Darcy Jaffe, Washington State Hospital Association (chair)
Maralyssa Bann
Gloria Brigham, EdD, MN, RN, Washington State Nursing Association
Shelley Bogart, DSHS-DDA
Rodas Demssie, MSN, RN, ACM, MultiCare
Glory Dole, RN, MA, WA HCA
Kelli Emans, DSHS
Jeff Foti, MD, Seattle Children's
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
Amber May, MD, Kaiser Permanente
Kellie Meserve, MN, RN, Virginia Mason Franciscan Health
Keri Nasenbery, MHA, BSN, Harborview Medical Center
Sheridan Rieger, MD, Concerto Health
Zosia Stanely, JD, MHA, Washington State Hospital Association
Cyndi Stilson, RN, BSN, Community Health Plan of Washington
Janice Tufte, PCORI 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.

Action: Adopt March minutes.

DISCUSS: COMMON DISCHARGE BARRIERS

Mr. Locke shared a draft of common discharge barriers for discussion, based on the workgroup's previous conversations on common definitions for complex discharge. The goal is to develop common categories to target resources for discharge pathways. Workgroup members discussed the barriers.

- Members agreed that generic categories are useful for organizing, but they are still too broad to target resources. For example, just knowing someone has a behavioral health care need does not tell much about why they might experience difficulty being placed in post-acute care (more specifics might include – psychosis, risk of harm to self and others, lack of SUD treatment options, eligibility requirement barriers.
- Some additional categories discussed include:
    - Bariatric care, private duty nursing, staffing/provider needs, patient and family/caregiver acceptability of discharge options, prior authorization/process barriers, and barriers to infrastructure development such as funding, license regulations, regulatory requirements.
- There appear to be two different types of barriers described – infrastructure/process barriers like staffing, eligibility, and access/availability to post-acute care facilities and complex patient

characteristics such as medical need, behavioral needs, or social needs. Many patients may experience multiple barriers or a complex interaction between barriers.

DISCUSSION: METRICS AND ALIGNMENT

Mr. Locke invited presenters from the Health Care Authority and DSHS's ALTSA Home Care Services to describe how they use metrics for discharge.

- Glory Dole, WA Health Care Authority, shared how the HCA started to collect weekly data about discharges during the COVID-19 pandemic. Currently the HCA collects data from MCOs on the number of patients who are complex discharges using a drop-down list of discharge barriers to categorize the patients. MCOs are meeting monthly to address high-priority barriers such as behavioral health concerns, or housing concerns.
    - Q: How is "complex discharge" defined?
    - A: each MCO uses a slightly different definition that boils down to patients who no longer have medical necessity to stay in the hospital.
- Kelli Emans, ALTAS Home Care Services, shared how they collect data on patients referred to HCS. HCS collects data on referrals from all acute care hospitals, tracking the length of stay from referral to placement, and tracking some barriers, including financial documents, guardianship issues, etc. The biggest discharge outcomes are referrals to SNFs or return home.
- Following the two data presentations, other members, especially from health delivery systems, shared how they collect discharge data.
    - Kaiser Permanente collects discharge data using the intended outcome to stratify data – looking at the number of patients waiting for discharge to SNFs vs. discharge to nursing homes for example.
    - Virginia Mason tracks avoidable delays and categories of delays, mostly related to the process reason for the delay (payer-related delays and placement delays for example).

Mr. Locke summarized the opportunities for data alignment.

- Alignment on definition of medical necessity to help all stakeholders track Length of Stay the same way.
- Alignment on how we track barriers (could be based on our common discharge categories chart) – track barriers based on patient characteristics, discharge destination, and process delay characteristics.
- Alignment on how we agree to report on discharge data.

PUBLIC COMMENT AND GOOD OF THE ORDER

Mr. Locke invited final comments or public comments, then thanked all for attending. At the next meeting the workgroup will review the data barrier categories, as well as brainstorm needed evidence on improving the discharge process. The workgroup's next meeting will be on May 18th from 3:00 – 4:30 PM.