Bree Collaborative | Complex Discharge May 18th, 2023| 3:00 – 4:30 a.m. **Virtual**

MEMBERS PRESENT

Darcy Jaffe, Washington State Hospital
      Association (chair)
Shelley Bogart, DSHS-DDA
Amy Cole, MBA, Multicare
Rodas Demssie, MSN, RN, ACM, MultiCare
Billie Dickinson, Washington State Medical
      Association
Jeff Foti, MD, Seattle Children's
Jas Grewal, WA Health Care Authority
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
Catherine McInroe, MSW, Providence
Kellie Meserve, MN, RN, Virginia Mason
      Franciscan Health
Keri Nasenbery, MHA, BSN, Harborview Medical
      Center
Sheridan Rieger, MD, Concerto Health
Kim Sinclair, MS-HAIL, PeaceHealth
Cyndi Stilson, RN, BSN, Community Health Plan
      of Washington

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. Those present introduced themselves in chat and adopted April minutes.

> **Action:** Adopt April minutes.

DISCUSS: DATA ALIGNMENT

Mr. Locke invited two speakers to present on how discharge data is being used at health care organizations. Kellie Meserve, MN, RN, presented on Virginia Mason's discharge data and Carol Hiner, MSN, presented on Kaiser Permanente's discharge data.

Virginia Mason shared their data collection interface. The system relies on discharge managers to enter information about discharge barriers into Epic. Barriers are categorized into "type" and "reason." Barrier "types" are broad categories of barriers, including placement delays, medical needs, social need, or internal delays. "Reasons" give further clarity about the situation. For example, a barrier may be classified as a social need delay due to lack of housing.

- Members discussed the system. The data fields do allow for overlap (one person may experience multiple barriers), and the definitions are standard across Common Spirit.

Kaiser Permanente uses an Avoidable Delay Tool across their Washington hospitals to be specific about delays in placement and track trends of avoidable stays. The tool classifies barriers mostly by the post-acute care placement site, but can also track the number of delayed patients and the totally number of avoidable delays.

- Members discussed the next steps for Kaiser's data system, including the potential to stratify discharge data by race/ethnicity/language to better target equity initiatives.

Mr. Locke transitioned the workgroup to discuss alignment on data fields for discharge. The three categories of data to build consensus include the definition of "avoidable delays," important patient characteristics to collect, and strategies for categorizing discharge barriers.

- Avoidable Delays/Length of Stay:
  - Members discussed how the definition for avoidable delays may change by site. Specifically, payors may use a different definition for medical necessity than hospitals.
  - Additionally different sites have different cut-offs for when length of stay is considered "Long length of stay" (one hospital waits 8 days after medical necessity is not met, another waits 10 days after medical necessity is not met).
  - Members agree that collecting information on length of stay, average length of stay, and median length of stay is still important.
  - Additional, members would like to align on the same definition for "avoidable delay" even if there is an understanding that the data collection process is different.
  - The current definition for avoidable delay is "the patient does not meet medical necessity and their care needs can be met at a lower level of care."
- Patient Characteristics:
  - Members discussed what patient information is important to collect about as part of discharge planning, before barriers are identified. Characteristics include: demographic information (age, gender, race/ethnicity), primary insurer, previous care location, and intended discharge location.
  - Additionally, members recommended some measure of admission necessity (to track patients who did not meet medical necessity upon admission to the hospital)
  - Geographic data, such as the zip code and county can help discharge teams understand service availability.
  - It would be good to collect potential barrier information early, before it becomes the reason for a delay.
    - This could include social characteristics, medical diagnoses (SUD, dementia, etc.), and other mitigating legal or behavioral factors.
- Discharge Barriers:
  - Discharge barriers were categorized by broad "types" (medical, behavioral, process, legal, etc.) and then by more specific reasons. Members agreed this was a good outline for discharge barriers.
  - Additional comments included: additional medical needs such as trach or tube feeding, late payment/debt issues, access to services, and access to supplies.
  - Two new categories were discussed: Lack of Community Resources (home health, PDN staff, other services), and Supplies/Equipment (especially bariatric beds and/or lifts).
  - Members discussed how to use the list of barriers.
    - We can use the list to make specific recommendations for how to address each category of barriers.
    - We could advocate for systems-level collection of data like this, at least in these broad categories to target further funding.
    - We could further organize by short-term, long-term, and policy-level barriers to target current interventions.
  - Members agreed that organizations should be collecting discharge barrier data in a process similar to this, but did not want to enforce data collection like this across all hospitals, especially considering many hospitals already have an established process.

DISCUSSION: NEXT STEPS

Mr. Locke invited comments about how to make further recommendations on complex discharge. Mr. Locke proposed that members either begin to discuss each discharge barrier category (i.e. medical barriers, behavioral barriers, social need barriers), or begin to evaluate broad discharge interventions such as discharge planning. Members elected to focus on interventions specific to each barrier type, starting with medical barriers (dementia, bariatric status, wound care needs, etc.).

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 begin to discuss interventions to help address medical complexity. The workgroup's next meeting will be on June 15th from 3:00 – 4:30 PM.