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Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 "…to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State." The Bree Collaborative was named in memory of Dr. Robert Bree, a leader in the imaging field and a key member of previous health care quality improvement collaborative projects.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying health care services annually with substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice, evidence-based approaches that build upon existing efforts and quality improvement activities to decrease variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State's largest health care purchasers, Medicaid, and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

Bree Collaborative members identified complex patient discharge as a priority improvement area and convened a workgroup to develop evidence-informed standards. The workgroup met from January 2022 to January 2023.

See **Appendix B** for the workgroup charter and a list of members.

Background

Discharge from a hospital or inpatient setting marks the end of a person's acute clinical care. When a person requires post-acute care in a lower acuity clinical setting (i.e., cannot be safely discharged to home), the transition can be challenging as coordination between the multiple systems needed in discharge planning is complex. Further this is a vulnerable time for the person being discharged as they navigate new routines, more so if they have ongoing health or social needs. These complexities lead to longer or more difficult transitions due to a lack of appropriate post-acute care settings (adequate staffing and resources).[i] A person may be medically ready for transfer from an acute care setting but lack an appropriate and acceptable next care setting.

This situation has become increasingly urgent nationally and in Washinton Sate. In August 2021, hospitals in Washington state reported more than 900 patients who were ready for discharge but remained in a hospital setting across various payer sources.[ii] In one widely reported 2022 example, Harborview Medical Center only accepted patients in urgent need of specialized care, as more than 100 medically stable patients were in need of long-term post-acute care but unable to be discharged.[iii] While COVID-19 is a contributing factor to hospital capacity concerns, the primary issue is access to appropriate post-acute care services.[3]

Previous Collaborative Efforts in Washington State

Substitute Senate Bill 5883 (SSB 5883), Chapter 1, Laws of 2017, 3rd Special Session, Section 213 (1) (ii) directed the Health Care Authority and the Department of Social and Health Services to convene a Skilled Nursing and Acute Care Hospital Work Group to identify barriers preventing skilled nursing facilities from accepting and admitting clients from acute care hospitals in a timely and appropriate manner, solutions to those barriers, and to consider resources needed to allow for faster transfers including those with complex needs. HCA estimates that Medicaid delayed discharge patients account for 0.7% of total inpatient hospital admissions.[iv] Findings from the report informed these guidelines and are summarized in **Appendix X**. Other collaborative efforts have been led by the Department of Health, Department of Social and Health Services, the Health Care Authority, and the Washington State Hospital Association to find focused solutions for bed capacity and admission problems during flu season, respond to hospitals' concerns around length of inpatient stays and inability to discharge when health conditions indicate client is ok to discharge, and development of universal discharge protocols to identify complex clients early and begin coordination.

Complex hospital discharge was selected as a high priority Bree Collaborative topic in September 2022 and a workgroup met to fill identified gaps from previous work from January 2023 to January 2024. Key action items not addressed in the previous efforts are:[v]

- Adoption of a universal definition for patients in an acute care bed without an acute care need, allowing for differences in calculating avoidable days, length of stay, and medical necessity.
- Collecting standard patient characteristic data during the discharge planning process to understand and proactively address potential discharge barriers and communicating across sites.
- Recording all discharge barriers for all patients (delivery sites) or members (health plans).

- Coordination and communication between acute settings, post-acute settings, public agencies, and health plans

Definitions

To ensure consistency in efforts to address complex patient discharges across the state, the workgroup decided to establish a common definition for complex patient discharge that will be transferrable across settings and supports alignment of efforts to prevent and address complex patient discharges across sectors.

Complex Patient Discharge: patients who are medically ready to be transferred outside of an acute care setting but are unable to do so due to discharge barriers.

Health systems, health plans, and public agencies should collect **standard** patient characteristic data during the discharge planning process to understand and proactively address potential discharge barriers including: demographic data, geographic data, primary payer/insurer, planned discharge site, healthcare decision maker/power of attorney, and information about potential barriers (such as social need, behavioral health need, legal need, etc.)

Discharge Barriers:

Collect information about the barriers facing the patient as early as possible in the discharge planning process. Many will have multiple barriers to discharge. For conditions, social circumstances, processes, or systemic barriers that may indicate or contribute to a barrier to discharge see **Appendix X**

Guideline Checklists

Healthcare Delivery Systems

- ☐ **Adopt the universal definition** for complex patient discharge: patients who are medically ready to be transferred outside of an acute care setting but are unable to do so due to discharge barriers.
- ☐ Collect standard patient characteristic data, identify patient potential discharge barriers, and begin comprehensive discharge planning:
  - ☐ Prior to admission for elective admissions
  - ☐ Within 24 hours of admission, including on weekends and holidays, for emergency admissions.
- ☐ Begin a bilateral process for complete and timely **communication and coordination** of patient information within the facility, with the post-acute care facility, and with appropriate state agencies and health plans **at the beginning of the discharge planning process** and maintain throughout the stay.
  - ☐ This includes information about durable medical equipment, medications, and other necessary resources, especially those requiring prior authorization.
- ☐ Develop or adapt a **complex discharge tool** to facilitate discharge of patients to an appropriate care setting.
  - ☐ Adapt tool to hospital workflow and train staff on workflow.
  - ☐ Embed the adapted discharge planning tool into hospital electronic documentation systems. Ensure all members of the care team have access to this documentation.
  - ☐ Discharge planning tools that could be adapted include:
    - ☐ HHS' Continuity Assessment Record and Evaluation (CARE) and B-CARE tools
    - ☐ Sample private hospital tools from the American Hospital Association
    - ☐ AHRQ's Re-Engineered Discharge (RED) Toolkit provides evidence-based training for staff as well as processes to improve the discharge process
- ☐ Include a **data element** that identifies patients as a complex discharge patient in hospital registries.
- ☐ Educate all members of the care team on **patient needs and practices that could delay discharge to post-acute facilitie**s, such as restraint orders, psychoactive medications or medications requiring prior authorization.
- ☐ **Universally screen for the Social Determinants of Health** using a validated tool (e.g. PRAPARE). Follow the Bree Social Needs Screening guidelines and Social Needs Intervention guidelines for delivery organizations to implement social determinants of health screening and referral systems.
- ☐ Identify post-acute partners who accept patients on weekends and holidays and make this updated information available to weekend providers.
- ☐ Establish and/or follow complex transition coordination protocols in partnership with key players like HCS, DSHS and MCOs

- ☐ For patients identified as a complex discharge, refer them to the hospital's complex discharge team.
- ☐ Employ a **dedicated complex discharge team** to assist in complex patient discharges. The complex discharge team should include individuals who can support communication and coordination of necessary resources and information through the discharge process. Responsibilities below can be shared by the complex discharge team and the inpatient care team.
    - ☐ Hold regular discharge planning meetings with members of the care team and with others whom the hospital relies on to assist with complex transitions.
    - ☐ Identify patient medication that needs prior authorization as soon as possible in the stay and initiate the prior authorization process.
    - ☐ Utilize the hospital adapted discharge tool for complex patient discharges. Ensure complete and timely documentation of discharge barriers.
    - ☐ Identify and engage outside entities providing support or case management such as: payer's case manager, long term care/Developmental Disabilities Administration case manager, or Health Home to help the patient navigate and sustain support services.
    - ☐ Consider patient's circumstances and use medical practices and care plans in the hospital settings that can be continued in the community settings.
    - ☐ When referring to HCS, clearly indicate on the HCS referral where the client will be at time of assessment. If patient will not be in the hospital at the time of assessment, indicate the correct location (e.g., 'home')
    - ☐ Develop a person-centered written discharge plan with patient or decision-maker:
        - ☐ Share a printed version with the patient or decision-maker.
        - ☐ Share a copy with involved case managers, including payer case manager, at discharge.
        - ☐ Ensure the written discharge information is written in patient-friendly terminology and tailored to the patient's needs, including their health literacy and language preferences. Include who to contact with questions after discharge (payer case manager, post-acute providers, etc)
        - ☐ Use a patient education strategy (e.g., teach back) to ensure patient and/or decision-makers understand the discharge plan; Include medication education and a medication plan.
        - ☐ Proactively identify and address factors that may impact a patient's ability to use the discharge and medication plan such as: **patient-related factors** (health literacy, cognitive function), **medication-related factors** (adverse effects, polypharmacy), **logistical factors** (transportation, social needs) and others; discuss strategies to address these factors with the patient and/or decision-maker.
        - ☐ Reconcile medications at each transition and check for the accuracy of medication lists and dosages as well as any contraindications before discharge.

- ☐ Provide patients and/or decision-makers the opportunity for medications to be filled prior to discharge from the hospital.
- ☐ Prior to discharge, schedule a follow-up with post-acute care for patients who are discharged to post-acute care settings within seven days of discharge. Longer follow-up times can be acceptable but not preferred.
    - ☐ Schedule follow-up visits with BH and/or SUD providers, as appropriate
    - ☐ May include care consultation via phone or telehealth services to reinforce education.
    - ☐ Provide telehealth follow-up visits for patients and/or decision-makers as determined appropriate by the care team.
- ☐ Send discharge summaries to outpatient providers, including behavioral health and/or substance use disorder providers within 3 business days.

☐ Acute facilities to maintain adequate staffing of the dedicated complex discharge team on weekends.

Health Plans

- ☐ **Adopt the universal definition** for complex patient discharge: patients who are medically ready to be transferred outside of an acute care setting but are unable to do so due to discharge barriers.
- ☐ Develop process of receiving standard, documented discharge barrier information from the acute care setting as outlined in **Appendix X: Standard Discharge Barrier Checklist** and communicate to the dedicated complex discharge team.
- ☐ Use bilateral processes for **complete and timely communication** of patient information to acute and post-acute care settings, including Home and Community Services, Developmental Disabilities Administration, Area Agencies on Aging, and post-acute care settings.
- ☐ Identify and track members that qualify as a complex patient discharge.
- ☐ Prioritize complex discharges to facilitate the prior authorization process when appropriate.
- ☐ Implement **standardized post-acute coverage setting criteria** and **standard medication prior authorization criteria.**
    - Coordinate with both acute care settings and post-acute settings on prior authorization for post-acute coverage processes and medication needs during discharge planning processes.
- ☐ Provide a dedicated team and process for assisting with discharge planning and discharge disposition when a member is identified as a complex discharge.
    - Coordinate discharge care plans with delivery sites, post-acute sites, and external organizations as necessary
    - Elective: Reach out to acute care team on day of admission for patients that have documented discharge barriers.
    - Emergent: Reach out to acute care team upon notification of patient's admission for patients that have documented discharge barriers.
- ☐ Track rates of **SDOH screening and referral** for admitted patients and stratify by REaL data and payer status to identify disparities.
- ☐ Consider investments in technologies that would improve **closed loop referrals** (CIEs or SSRLs) or in social service capacity at within-network hospitals.
- ☐ Maintain **adequate network of post-acute providers** for every hospital referral region based on historic need for post-acute bed placement.
    - Regularly verify network is adequate by analyzing utilization numbers.
    - Identify post-acute providers that can accept acute care discharges on weekends and holidays and communicate this information to discharge planning teams.
- ☐ Participate in statewide efforts to reduce complex patient discharges and identify solutions to streamline transition of care processes.
- ☐ Work with acute care facility to create secondary discharge plan when appropriate if discharging to short term rehab or other post-acute care setting.

Department of Social and Health Services

- ☐ All agencies: **Adopt the universal definition** for complex patient discharge: patients who are medically ready to be transferred outside of an acute care setting but are unable to do so due to discharge barriers.
- ☐ All agencies: use bilateral processes for complete and timely communication of information across key partners, including social service agencies, public health agencies, delivery systems and post-acute settings.
- ☐ Identify barriers within organizational processes that delay discharge from hospitals.
    - Streamline assessment processes from DSHS.
    - ☐ Home and Community Services
        - ☐ Flag clients that are experiencing complex discharge for prioritization by the case management team
        - ☐ Ensure intake case management team communicates to hospital discharge team when there is a case transfer to another HCS case manager (in home or residential)
        - ☐ Follow HCS protocols including contacting client within 2 working days of receipt of referral.
        - ☐ Develop a care plan in collaboration with hospital discharge team, health plan/payer case manager and patient or guardian as soon as possible when a client is identified as experiencing a complex discharge.
    - ☐ Developmental Disabilities Administration

Post-Acute Facilities

(e.g., skilled nursing facility, acute rehabilitation center)

- ☐ Adopt the **universal definition** for complex patient discharge: patients who are medically ready to be transferred outside of an acute care setting but are unable to do so due to discharge barriers.
- ☐ Use bilateral processes for complete and timely communication of information across key partners, including social service agencies, public health agencies, and healthcare delivery systems
- ☐ Maintain list of acute care facilities within the referral region.
- ☐ Develop and maintain staffing capacity to accept patients who have attributes listed on the standard discharge barrier checklist, including through the weekend
- ☐ Every Friday, notify acute care facilities if you are unable to accept discharges over the weekend.
- ☐ Prioritize acceptance of patient transfers/admissions that meet criteria for a complex patient discharge.
- ☐ Identify and work to develop solutions to barriers on an individual patient level.
- ☐ Develop standard communication channels with referring acute care facilities and ability to receive **electronic, standard, documented discharge information** from the acute care settings as outlined in **Appendix X: Standard Discharge Barrier Checklist** and communicate internally to relevant team when taking over a person's care.
    - Communicate as soon as possible to the acute care referring provider if:
        - Patient has incomplete documentation.
        - Post acute facility cannot access medical records.
    - Communicate with health plan and applicable state agencies as soon as information is received to obtain prior authorization approval for post-acute placement.
- ☐ Participate in statewide efforts in data collection and others to reduce complex patient discharges and identify solutions to streamline transition of care processes.

Adult Family Homes & Assisted Living with Memory Care who accept complex patients

- ☐ Use bilateral processes for complete and timely communication of information across key partners, including social service agencies, public health agencies, and healthcare delivery systems.

Appendix X: Evidence

Focus Area	Citation	Abstract/Findings
Background: Discharge Barriers	Meo N, Liao JM, Reddy A. Hospitalized After Medical Readiness for Discharge: A Multidisciplinary Quality Improvement Initiative to Identify Discharge Barriers in General Medicine Patients. Am J Med Qual. 2020 Jan/Feb;35(1):23-28.	Patients with prolonged hospitalization were more likely than those with extended hospitalization to have financial (P < .001) or behavioral (P < .001) barriers, homelessness (P < .05), and impairment of decision-making capacity (P < .01*). Understanding the characteristics and discharge barriers of patients who are hospitalized despite medical readiness may increase appropriateness of inpatient resources.*
	Harrison JD, Greysen RS, Jacolbia R, Nguyen A, Auerbach AD. Not ready, not set…discharge: Patient-reported barriers to discharge readiness at an academic medical center. J Hosp Med. 2016 Sep;11(9):610-4.	One hundred sixty-three patients were enrolled, and 68 patients (42%) completed an admission survey and discharge survey ≤48 hours before discharge. Patients completed on average 1.82 surveys (standard deviation, 1.10; range, 1-8). Total and mean numbers of barriers were highest on the admission survey and decreased until the fourth survey. On average, the total number of barriers to discharge decreased by 0.15 (95% confidence interval: 0.01-0.30) per day (P = 0.047). Ninety percent of patients were discharged with at least 1 issue. *The 3 most common barriers on the admission and discharge survey remained the same: pain, lack of understanding of recovery plan, and daily-living activities.*
	Flaugh RA, Shea J, Difazio RL, Berry JG, Miller PE, Lawler K, Matheney TH, Snyder BD, Shore BJ. Barriers to Discharge After Hip Reconstruction Surgery in Non-ambulatory Children With Neurological Complex Chronic Conditions. J Pediatr Orthop. 2022 Sep 1;42(8):e882-e888.	Approximately three-quarters of patients experienced delayed discharge (73%) with barriers identified for 74% of delays. Most prevalent barriers involved education (30%) and durable medical equipment (29%). Postdischarge transportation and placement accounted for 26% of barriers and 3.5 times longer delays (P <0.001). Factors associated with delayed discharge included increased medical comorbidities (P <0.05) and GMFCS V (P <0.001). Longer LOS and medical clearance times were found for female (P =0.005), older age (P <0.001), bilateral surgery (P =0.009), GMFCS V (P =0.003), and non-English-speaking patients (P <0.001).
	Plotnikoff KM, Krewulak KD, Hernández L, Spence K, Foster N, Longmore S, Straus SE, Niven DJ,	We included 314 articles from 11,461 unique citations. Two-hundred and fifty-eight (82.2%) articles were primary research articles, mostly

	Parsons Leigh J, Stelfox HT, Fiest KM. Patient discharge from intensive care: an updated scoping review to identify tools and practices to inform high-quality care. Crit Care. 2021 Dec 17;25(1):438.	cohort (118/314, 37.6%) or qualitative (51/314, 16.2%) studies. Common discharge themes across all articles included adverse events, readmission, and mortality after discharge (116/314, 36.9%) and patient and family needs and experiences during discharge (112/314, 35.7%). Common discharge facilitators were discharge education for patients and families (82, 26.1%), successful provider-provider communication (77/314, 24.5%), and organizational tools to facilitate discharge (50/314, 15.9%). Barriers to a successful discharge included patient demographic and clinical characteristics (89/314, 22.3%), healthcare provider workload (21/314, 6.7%), and the impact of current discharge practices on flow and performance (49/314, 15.6%). We identified 47 discharge tools that could be used or adapted to facilitate an ICU discharge.
	Meador R, Chen E, Schultz L, Norton A, Henderson C Jr, Pillemer K. Going home: identifying and overcoming barriers to nursing home discharge. Care Manag J. 2011;12(1):2-11.	A qualitative analysis was conducted to describe barriers to discharge and strategies intervention staff used to leverage each client's strengths and work around obstacles. Three main barriers to discharge were found: having an unstable or complex medical condition, lacking family or social support, and being unable to obtain suitable housing. Intervention staff advocated on the behalf of clients, encouraged clients to build skills toward independent living. and contributed extensive knowledge of local resources to advance client goals. Cases of successful transition suggest that a person-centered approach from intervention staff combined with a flexible organizational structure is a promising model for future interventions.
Discharge Planning/ Communication	Rush M, Herrera N, Melwani A. Discharge Communication Practices for Children With Medical Complexity: A Retrospective Chart Review. Hosp Pediatr. 2020 Aug;10(8):651-656.	Discharge communication was documented for 59% of patient encounters. Communication was less likely to occur for patients with technology dependence (P = .01), older patients (P = .02), and those who were admitted to a teaching service (P = .04). The quality of discharge summaries did not change for patients with technology dependence compared with patients without technology dependence. Communication with the PCP at discharge was less likely to be documented in children with technology dependence. Hospitalists may encounter barriers in completion of appropriate and timely discharge communication with PCPs for CMC. Consistent handoff processes

		could be used to improve care for our patients with enhanced coordination needs.
	Zoucha J, Hull M, Keniston A, Mastalerz K, Quinn R, Tsai A, Berman J, Lyden J, Stella SA, Echaniz M, Scaletta N, Handoyo K, Hernandez E, Saini I, Smith A, Young A, Walsh M, Zaros M, Albert RK, Burden M. Barriers to Early Hospital Discharge: A Cross-Sectional Study at Five Academic Hospitals. J Hosp Med. 2018 Dec;13(12):816-822.	Discharge orders for patients ready for discharge are most commonly delayed because physicians are caring for other patients. Discharges of patients awaiting care completion are most commonly delayed because of imbalances between availability and demand for ancillary services. Team census, rounding style, and teaching teams affect discharge times.
	Zhao EJ, Yeluru A, Manjunath L, Zhong LR, Hsu HT, Lee CK, Wong AC, Abramian M, Manella H, Svec D, Shieh L. A long wait: barriers to discharge for long length of stay patients. Postgrad Med J. 2018 Oct;94(1116):546-550. doi: 10.1136/postgradmedj-2018-135815. Epub 2018 Oct 9. PMID: 30301835.	Discharge site coordination was the most frequent cause of delay, affecting 56% of patients and accounting for 80% of total non-medical postponement days. Goals of care issues and establishment of follow-up care were the next most frequent contributors to delay. Together with perspectives from interviewed staff, these results highlight multiple different areas of opportunity for reducing LLOS and maximizing the care capacity of inpatient hospitals.
	Jones WD, Rodts MF, Merz J. Influencing Discharge Efficiency: Addressing Interdisciplinary Communication, Transportation, and COVID-19 as Barriers. Prof Case Manag. 2022 Jul-Aug 01;27(4):169-180.	Nurses fully trained in the interdisciplinary communications program aimed to reduce DOTE had significantly lower DOTE outcomes on their discharges compared with untrained staff (i.e., average untrained = 127 min, average trained = 93 min). In addition, the fully trained nurses had 14% more of their discharges fall at or below the 90-min goal compared with untrained staff (i.e., untrained = 40%, trained = 54%). Supplemental research also suggested that the content of the communication training program was very relevant (e.g., empowering families to pick up the patients and using scheduling vs. will-call transportation strategies with patients lowered the DOTE metric). Corollary analyses showed that readmissions were also lowered, and patient satisfaction ratings increased. In addition, the interdisciplinary communications training program can benefit from being updated to include content on how COVID-19 issues adversely impact discharge times since significant relationships between various COVID-19 measures and higher discharge exit times were documented.
	Schwarz CM, Hoffmann M, Schwarz P, Kamolz LP, Brunner G, Sendlhofer G. A systematic literature	In total, 29 studies were included in this review. The major identified risk factors are the delayed sending of the discharge letter to doctors

	review and narrative synthesis on the risks of medical discharge letters for patients' safety. BMC Health Serv Res. 2019 Mar 12;19(1):158.	for further treatments, unintelligible (not patient-centered) medical discharge letters, low quality of the discharge letter, and lack of information as well as absence of training in writing medical discharge letters during medical education. Multiple risks factors are associated with the medical discharge letter. There is a need for further research to improve the quality of the medical discharge letter to minimize risks and increase patients' safety.
	Patel H, Fang MC, Mourad M, Green A, Wachter RM, Murphy RD, Harrison JD. Hospitalist and Internal Medicine Leaders' Perspectives of Early Discharge Challenges at Academic Medical Centers. J Hosp Med. 2018 Jun 1;13(6):388-391.	We received 61 responses from 115 institutions (53% response rate). Forty-seven (77%) "strongly agreed" or "agreed" that early discharge was a priority. "Discharge by noon" was the most cited goal (n = 23; 38%) followed by "no set time but overall goal for improvement" (n = 13; 21%). The majority of respondents reported early discharge as more important than obtaining translators for non-English-speaking patients and equally important as reducing 30-day readmissions and improving patient satisfaction. The most commonly reported factors delaying discharge were availability of postacute care beds (n = 48; 79%) and patient-related transport complications (n = 44; 72%). The most effective early discharge initiatives reported involved changes to the rounding process, such as preemptive identification and early preparation of discharge paperwork (n = 34; 56%) and communication with patients about anticipated discharge (n = 29; 48%). There is a strong interest in increasing early discharges in an effort to improve hospital throughput and patient flow.
	Subramony A, Schwartz T, Hametz P. Family-centered rounds and communication about discharge between families and inpatient medical teams. Clin Pediatr (Phila). 2012 Aug;51(8):730-8.	Of 118 families, 70% knew discharge goals, whereas only 41% knew discharge day and 63% knew discharge medications. English speakers were more likely to report knowing discharge goals (adjusted odds ratio [AOR] = 3.9, 95% confidence interval [CI] = 1.2-12.2) and discharge medications (AOR = 3.2, 95% CI = 1.1-9.8) compared with Spanish speakers. Non-Hispanics were more likely to report knowing discharge day compared with Hispanics (AOR = 2.7, 95% CI = 1.1-6.6). Families on teams that conduct FCRs are knowledgeable of discharge goals but less knowledgeable of discharge day and medications. Spanish-speaking and Hispanic families are less likely to report

		knowing discharge plans compared with English-speaking and non-Hispanic counterparts.
	Rohatgi N, Kane M, Winget M, Haji-Sheikhi F, Ahuja N. Factors Associated With Delayed Discharge on General Medicine Service at an Academic Medical Center. J Healthc Qual. 2018 Nov/Dec;40(6):329-335.	Patients were interviewed to identify whether they were aware of their EDD. Bedside nurses were interviewed to identify barriers to discharge. In our study, 49.8% of the patients had a delayed discharge. Patients who were aware of their EDD were less likely to have a delayed discharge (odds ratio [OR], 0.3 [95% confidence interval (CI), 0.1-0.6], p < .001). Patients who were discharged on Saturday or Sunday (OR, 4.8 [95% CI, 1.7-14.6], p < .001) and patients who were waiting for physicians' consult (OR, 4.5 [95% CI, 1.6-14.4], p = .007) were more likely to have a delayed discharge. Early identification of the EDD and communicating it with the care team and the patient/family, mobilizing resources for safe weekend discharges, and creating efficient process for consultations might decrease delayed discharges.
	Tipton K, Leas B, Mull N, Siddique S, Greysen SR, Lane-Fall M, Tsou A. Interventions to Decrease Hospital Length of Stay. AHRQ Evidence-Based Practice Centers. 2021. https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/hospital-length-stay-technical-brief.pdf	Few studies have evaluated system-level interventions focused on medically complex, high-risk, or vulnerable patient populations, including frail elderly patients and those with complex chronic illness. Strategies assessed in multiple systematic reviews include geriatric consultation services and early specialized discharge planning. • Substantial research gaps need to be addressed, including interventions for socially or economically vulnerable populations and patients with psychiatric or substance use disorders, contextual factors affecting feasibility of implementation, and the resources and potential savings associated with interventions to reduce LOS. • Hospital administrative leaders, researchers, and policymakers can work to reduce LOS by improving research practice, developing targeted health system interventions, and collaboratively addressing the social care needs of medically complex and vulnerable patient populations. • Two interventions (clinical pathways and case management) improved key outcomes for patients with heart failure. Clinical pathways reduced LOS, readmission, and mortality (low to moderate quality evidence from a single systematic review). Similarly, case management decreased LOS and readmissions (moderate quality evidence from a

		single systematic review). More research is needed to confirm these findings (Figure i).
	Gonçalves-Bradley DC, Lannin NA, Clemson L, Cameron ID, Shepperd S. Discharge planning from hospital. Cochrane Database of Systematic Reviews 2022, Issue 2. Art. No.: CD000313.	Participants allocated to discharge planning and who were in hospital for a medical condition had a small reduction in the initial hospital length of stay (MD − 0.73, 95% confidence interval (CI) − 1.33 to − 0.12; 11 trials, 2113 participants; moderate-certainty evidence), and a relative reduction in readmission to hospital over an average of three months follow-up (RR 0.89, 95% CI 0.81 to 0.97; 17 trials, 5126 participants; moderate-certainty evidence). There was little or no difference in participant's health status (mortality at three- to nine-month follow-up: RR 1.05, 95% CI 0.85 to 1.29; 8 trials, 2721 participants; moderate certainty) functional status and psychological health measured by a range of measures, 12 studies, 2927 participants; low certainty evidence). There was some evidence that satisfaction might be increased for patients (7 trials), caregivers (1 trial) or healthcare professionals (2 trials) (very low certainty evidence)
	American Hospital Association. Private Sector Hospital Discharge Tools. January 2015. Accessed June 20, 2023. https://www.aha.org/system/files/content/15/15dischargetools.pdf	At this time, there is no standardized hospital discharge tool. However, the Department of Health and Human Services (HHS) has developed a standardized patient assessment tool to capture clinical and demographic characteristics of patients across post-acute care settings. This tool exists in two forms – the Continuity Assessment Record and Evaluation (CARE) Tool and the B-CARE tool1 . However, these two tools do not identify the best next setting for patients being discharged from general acute-care hospitals, and providers report both tools are burdensome and lack the ability to capture the full spectrum of a patient's medical complexity to determine post-hospital care needs. Hospital discharge planning tools differ from patient assessment tools in that hospital discharge planning tools are used only within the general acute-care hospital to inform patient transition into post-acute care.
	Bajorek, S. A., McElroy, V. 2020. Discharge Planning and Transitions of Care. Agency for Healthcare Research and Quality: Patient Safety Network. Accessed June 20, 2023.	Transitions of care refer to the movement of patients between different healthcare settings such as from an ambulance to the emergency department, an intensive care unit to a medical ward, and the hospital to home. The transition from hospital to home can be

	https://psnet.ahrq.gov/primer/discharge-planning-and-transitions-care	challenging as patients and families become responsible for care coordination. Hospital discharges are complicated and often lack standardization. Patients receive an onslaught of new information, medications and follow-up tasks such as scheduling appointments with primary care providers. **As such, discharge planning should begin as soon as possible.**
	Dreyer, T. 2014. Care Transitions: Best Practices and Evidence-Based Programs. Center for Healthcare Research & Transformation. Accessed June 20, 2023. https://www.chrt.org/wp-content/uploads/2019/10/CHRT-Care-Transitions-Best-Practices-and-Evidence-based-Programs-.pdf	This paper summarizes best practices in care transitions and describes successful programs that reduced readmissions and overall costs. The paper also includes an annotated bibliography detailing the research on care transitions (Attachment A) and describes the care transitions programs offered by the University of Michigan Health System and Blue Cross Blue Shield of Michigan (Attachment B). The program descriptions were developed through interviews with key informants in each program, providing greater detail than was available on care transitions programs at other organizations
	Mansukhani RP, Bridgeman MB, Candelario D, Eckert LJ. Exploring Transitional Care: Evidence-Based Strategies for Improving Provider Communication and Reducing Readmissions. P T. 2015 Oct;40(10):690-4. PMID: 26535025; PMCID: PMC4606859.	In summary, **more-effective handoff and improved provider communication** can have a positive effect on hospital readmissions, quality of care, and patient satisfaction, ultimately reducing overall health care costs while potentially avoiding CMS penalties for excessive rehospitalization rates. In this article, we discuss evidence-based strategies for improving provider communication and reducing readmissions
	Patient Flow Initiative Eliminates Barriers to Discharge. Hosp Case Manag. 2016 Dec;24(12):171-2. PMID: 30133204.	When Intermountain Medical Center in Murray, UT, reached capacity a few months after opening, a year-long initiative on patient flow determined that part of the holdup was taking care of last-minute details. Each unit holds a **multidisciplinary care coordination meeting every day to discuss each patient** and what they need to go to the next level of care. The team sets an anticipated discharge date during the first meeting, giving everyone on the team a target for carrying out their responsibilities. The unit charge nurse chairs the meetings and ensures team members carry out their responsibilities for moving the patient toward discharge.
	Li, J, Clouser, J, Brock, J, Adu, A, Vundi, N, and Williams, M. 2022. Effects of Different	In concert with care coordination activities that bridge the transition from hospital to home, hospitals' **clear communication and fostering**

	Transitional Care Strategies on Outcomes After Discharge – Trust Matters, Too. Joint Commission Journal on Quality and Patient Safety. 48(1): P40-52.	**of trust with patients** were associated with better patient-reported outcomes and reduced health care utilization.
	Burton, R. 2012. Improving Care Transitions. HealthAffairs. Web Access.	Given the current budgetary environment and the fact that Medicare is estimated to spend $12 billion per year on potentially preventable hospital readmissions, interest in improving care transitions to reduce Medicare spending is likely only to grow.
	Health Services Advisory Group. Care Coordination Best-Practices Toolkit. 2019. Quality Improvement Organizations/Health Services Advisory Group. Accessed June 20, 2023. https://www.hsag.com/globalassets/care-coordination/carecoordtoolkit032019final508.pdf	As aCMS Quality Improvement Organization (QIO), HSAG is committed to improving the quality of care delivered in each state we serve. HSAG has met with providers across this state and nationally, identifying tools that will aid you in the work of improving care transitions and coordination across the continuum. Many of these **tools have been included in this book to serve as a guide to readmission prevention**. We hope this information will help you and your organization improve care coordination efforts and result in reduced avoidable hospital readmissions.
	Stanton M, Dunkin J. A review of case management functions related to transitions of care at a rural nurse managed clinic. Prof Case Manag. 2009 Nov-Dec;14(6):321-7.	In this study, it was determined that the case managers were managing the transitions between the clinic and other outpatient services, as well as managing and ordering the patient's medications and therapies. Approximately 45%-50% of case management functions involved either **obtaining medication assistance for patients without funding or assisting patients with the ordering and procurement of essential medicines**. Another 45% of the case manager's time was spent **coordinating referrals to a wide variety of specialty clinics** for diagnostic testing, obtaining appointments with community-based family practice physicians, or coordinating examinations for specialty physicians.

Appendix X: Standard Discharge Barrier Checklist

- **Medical**
  - ☐ Neurological (e.g., dementia, traumatic brain injury) with behaviors with high healthcare utilization
  - ☐ Bariatric status
  - ☐ Hemodialysis/Dialysis Availability
  - ☐ Wound Care
  - ☐ Other high clinical care needs
- **Behavioral**
  - ☐ Substance use disorder (Current or history)
  - ☐ Lack of psych support/services
  - ☐ Aggressive or inappropriate behavior
  - ☐ Supervision Needs
  - ☐ Complex behaviors
    - Aggressive
    - Wandering
    - Inappropriate
  - ☐ High Potential for harm to self and/or others
  - ☐ Other complex behavioral need
- **Social Needs**
  - ☐ Lack of transportation to follow-up medical appointments
  - ☐ Lack of housing/homelessness
  - ☐ Undocumented
  - ☐ Lack of family support/cooperation
  - ☐ Activities of Daily Living (ADLs)
- **Legal**
  - ☐ Guardianship/Conservatorship
  - ☐ DCYF-CPS
  - ☐ DSHS-APS
  - ☐ Prior conviction (esp. sex offender/arson/violence)
  - ☐ Engagement with legal system related to behavioral health, substance use disorder.
- **Payment**
  - ☐ Insurance authorization/prior authorization timeliness
  - ☐ Insurance authorization process
  - ☐ Durable Medical Equipment (DME) coverage
  - ☐ Medicaid reimbursement rates
  - ☐ Managed Care Organization (MCO) funded rates.
  - ☐ Uninsured/Lack of coverage
- **Process**
  - ☐ Developmental Disabilities Administration (DDA) assessment timeframe
  - ☐ HCS assessment timeframe
  - ☐ DDA provider search
  - ☐ HCA provider search
  - ☐ Transfer to Eastern/Western
- **Post-Acute Placement**
  - ☐ Bed Type not available
  - ☐ Delay in response
  - ☐ Unable to transfer.

Appendix X:

Discharge Barrier Category	Discharge Barrier Sub-Category	Discharge Barrier Reason	Potential Solutions
Medical	Alzheimer's/Dementia/TBI	Post-acute care beds for memory care patients	
		Inappropriate/Aggressive patient behaviors	
	Respiratory Needs	Post-acute care beds for respiratory patients	
	Dialysis	Post-acute care chairs for dialysis patients	
		Transportation to and from dialysis centers	
		Specialized transportation in the supine position	
	Bariatric Patients	Post-acute care beds with infrastructure for bariatric patients	
		Appropriate staffing available to care for bariatric patients	
		Post-acute care infrastructure (beds/lifts) for bariatric patients	
	Wound Care	Appropriate staffing for wound dressing needs	
Behavioral	SUD/OUD	Post-acute care beds for patients with SUD/OUD	
		Appropriate staffing to provide SUD/OUD treatment	
		Lack of psych support services in post-acute care	
	Complex Behavioral Diagnosis	Lack of psych support services in post-acute care	
		Post-acute care beds for patients with mental health diagnosis	
Social	Housing/Homelessness	Lack of appropriate home for discharge	
		Lack of affordable housing options	
		Lack of family or caregiver to provide support in home setting	
		Lack of step-down transitional care or respite beds	
	Lack of Family Support	Lack of family or caregiver to provide support in home setting	
	Undocumented	Lack of insurance eligibility for post-acute care	
		Legal concerns for discharge	

Appendix X: 2017 HCA DSDS Legislative Report

Barriers	Solutions
Rates/Financial: • SNF contracted rate w/ MCOs doesn't include therapies, Rx, DME • SNFs won't accept MCO covered clients/MCO contract rate too low • Delays in authorization's • MCOs using Administrative Dat Rate (ADR) • CARE generated rates are too low • ETR requests diff and time consuming	• MCOs pay separate/tiered rates • MCOs reimburse SNFs based on acuity level, • Financial incentives in SNF contract • Provide SNFs training/tools on bene's and when/how to bill • MCOs provide SNFs w/ rate & covered services • Need more DME providers & coordination process, streamline/accelerate the process
Process: • Lack of clarity around MCO coverage criteria • Lack of standard discharge planning process • Insufficient alternatives care settings • Need early BHO involvement	• Provide more info re: billable services • Develop standard discharge process/streamline with MCOs • Provider resource development
Guardianship: • Process delays & challenges • Lack of guardians accepting high risk needs clients	• Look for opportunities within process • Involve BHO early on • Multidisciplinary team to address
Level of Care (LOC): • Functional assessment & process delays	• Look for opportunities within process
Regulatory: • SNF licensing/surveys/Star ratings prohibiting admission	• Review regulatory challenges RCS/DOH • RCS enriches consultative interactive process • Improve comms and reestablish QA nurse
Patient Issues: • Clients w/ challenging situations • Medically complex • Non-cooperative clients/families • homelessness	• Resource development: post acute facilities and memory care, ESF, ECS • Education/training • Consistent comms / provider assistance to clients/families
Insufficient available resources: • Hospitals do not understand PASSR process DDA clients • Lack of knowledge of HCS work/process • Workforce challenges	• Develop clear guidelines for working w/ HCS clients • Workforce/resource development

Appendix X. Acronyms

Acronym	Meaning	Definition
AAA	Area Agencies of Aging	Public or private non-profit agencies designated by the state to address the needs and concerns of older persons in local communities[vi]
ADL	Activities of Daily Living	Basic skills needed to perform everyday tasks independently, such as eating, bathing and toileting
BH-ASO	Behavioral Health Administrative Service Organizations	Organization that contracts with the HCA to provide access to behavioral health crisis services as part of their managed care models[vii]
DCYF	Department of Children, Youth and Families	Cabinet-level agency that focuses on child care, early learning, welfare, foster care, adoption, juvenile rehabilitation etc [viii]
DDA	Developmental Disabilities Administration	Cabinet-level agency that provides support for individuals with developmental disabilities and their families; division of DSHS[ix]
DME	Durable Medical Equipment	Medical devices and supplies intended for repeated use, such as wheelchairs, oxygen tanks, hospital beds, and glucose monitors
DOH	Department of Health (WA)	State agency that oversees public health and health care services in Washington[x]
DSHS	Department of Social and Health Services	State agency that oversees social and health services in Washington, providing food, cash, medical, child care, disability support, mental health and addiction services and more[xi]
LTC	Long Term Care	Variety of services that support people with their personal care needs in different settings including home-based, facility-based or community-based.
HCA	Health Care Authority	state based agency that administers Medicaid (Apple Health), Public Employees Benefit Board (PEBB), and School Employees Benefit Board (SEBB) and behavioral health services and leads efforts to transform healthcare through developing models for value-based purchasing and health technology assessments[xii]
HCS	Home and Community Services	Division of DSHS that plans, develops and provides long-term care services for persons with disabilities and the elderly using Medicaid funds[xiii]

HHS	Department of Health and Human Services	U.S. federal agency responsible for overseeing public health and health care services for Americans[xiv]
MCO	Managed Care Organizations	Entities that provide health care services and benefits through insurance contracts; they aim to reduce costs and improve quality through different strategies[xv]
SNF	Skilled Nursing Facility	Facilities staffed with licensed nurses and other health care professionals who can perform procedures and treatments like wound care, medication management, physical and occupational therapy, and speech therapy[xvi]
SUD	Substance Use Disorder	recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home[xvii]

Appendix A: Bree Collaborative Members

Member	Title	Organization
June Altaras, MN, NEA-BC, RN	Executive Vice President, Chief Quality, Safety and Nursing Officer	Multicare Health System
Susie Dade, MS	Patient Advocate	
David Dugdale, MD, MS	Medical Director, Value Based Care	University of Washington Medicine
Patricia Egwuatu, DO	Family Medicine Physician	Kaiser Permanente
Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
Colin Fields, MD, AAHIVS	Medical Director, Government Relations & Public Policy	Kaiser Permanente
Jason Lake, MD	Chief Medical Officer	Confluence Health
Mark Haugen, MD	Family Medicine	Walla Walla Clinic
Dary Jaffe, MN, ARNP, NE-BC, FACHE	Senior Vice President Safety and Quality	Washington State Hospital Association
Sharon Eloranta, MD	Medical Director, Performance Measurement and Care Transformation	Washington Health Alliance
Norifumi Kamo, MD, MPP	Internal Medicine	Virginia Mason Franciscan Health
Angie Sparks, MD	Chief Medical Officer, Community Plan	UnitedHealthcare
Greg Marchand	Director, Benefits, Policy and Strategy	The Boeing Company
Kimberly Moore, MD	Associate Chief Medical Officer	Franciscan Health System
Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
Nicole Saint Clair, MD	Executive Medical Director	Regence BlueShield
Mary Kay O'Neill, MD, MBA	Partner	Mercer
Kevin Pieper, MD	Chief Medical Officer	Kadlac Medical Center
Susanne Quistgaard, MD	Medical Director, Provider Strategies	Premera Blue Cross
Hugh Straley, MD (Chair)	Retired	Medical Director, Group Health Cooperative; President, Group Health Physicians
Judy Zerxan-Thul, MD	Medical Director	Washington State Health Care Authority

The Bree Collaborative: Complex Patient Discharge Charter and Roster

Problem Statement

In a survey from August of 2021, hospitals in Washington state reported that more than 900 patients who were ready to be discharged were stuck in the hospital.[1] In one widely reported example, Harborview Medical Center announced in summer 2022 that they will only accept patients in urgent need of specialized care, as they have more than 100 medically stable patients in need of long-term post-acute care.[2] It can be difficult to find appropriate post-acute care for a number of reasons, including patient's complex behavioral health or social needs and a lack of appropriate post-discharge care sites.[3]While COVID-19 is a contributing factor to hospital capacity concerns, the primary issue appears to be access to appropriate post-acute care facilities.[1]

Aim

Increase evidence-informed practices for appropriately and equitably discharging people from acute care facilities in order to increase access to acute care and improve quality of life for non-acute patients

Purpose

To propose practical and evidence-informed recommendations to the full Bree Collaborative on appropriate and timely discharge of people from acute care facilities to post-acute settings, including:

- Defining topic area and scope.
- Aligning definitions and language around difficult to discharge and defining responsibilities.
- Identifying barriers to discharge.
- Identifying practices for improving the discharge process.
- Defining "appropriate" post-acute care.
- Identifying practices and partnerships to increase access to appropriate post-acute care.
- Implementation of discharge protocols
- Forming recommendations for further collaboration and investigation on complex discharges/transitions.
- Consider system transformation toward a high quality post-acute care continuum

Duties and Function

The workgroup will:

- Research evidence-informed and expert-opinion informed guidelines and best practices for screening, monitoring, and treating HCV (emerging and established).
- Identify current barriers and future opportunities for implementing interventions.
- Consult relevant professional associations and other stakeholder organizations and subject matter experts for feedback, as appropriate.
- Align with other related state-wide initiatives and Hep C Free Washington.

[1] 1 Strong, A & McComb, L. 2022. Budge Brief – Increase Patient Access to Appropriate Post-Acute Care Settings. Washington State Hospital Association. Accessed November 2021. Available: https://www.wsha.org/wp-content/uploads/Budget-Brief-Pro-Difficult-to-Discharge-FINAL-2022.pdf
[2] Zucco, E. 2022. Problems persist at Washington hospitals due to lack of long-term care options. King5 News. Accessed November 2021. Available: https://www.king5.com/article/news/health/long-term-care-availability-crowding-hospitals/281-a987d2b7-f5a3-494e-b7c9-464ab8f6d1df
[3] Kreiger, G, Moss B, and Perez E. 2019. Practices for Patients who are Difficult to Discharge: Report to the House Health Care & Wellness Committee on September 12, 2019. Washington State Health Care Authority. Accessed November 2021. Available: https://www.hca.wa.gov/assets/difficult-to-dischargepresentation.pdf

- Maintain an equity lens while developing recommendations.
- Meet for approximately nine months, as needed.
- Provide updates at Bree Collaborative meetings.
- Post draft report(s) on the Bree Collaborative website for public comment prior to sending report to the Bree Collaborative for approval and adoption.
- Present findings and recommendations in a report.
- Recommend data-driven and practical implementation strategies including metrics or a process for measurement.
- Create and oversee subsequent subgroups to help carry out the work, as needed.
- Revise this charter as necessary based on scope of work.

Structure

The workgroup will consist of individuals confirmed by Bree Collaborative members or appointed by the chair of the Bree Collaborative. The Bree Collaborative director and program coordinator will staff and provide management and support services for the workgroup.

Less than the full workgroup may convene to: gather and discuss information; conduct research; analyze relevant issues and facts; or draft recommendations for the deliberation of the full workgroup. A quorum shall be a simple majority and shall be required to accept and approve recommendations to send to the Bree Collaborative

Meetings

The workgroup will hold meetings as necessary. Bree Collaborative staff will conduct meetings, arrange for the recording of each meeting, and distribute meeting agendas and other materials prior to each meeting. Additional workgroup members may be added at the discretion of the Bree Collaborative director.

Roster

Name	Title	Organization
Darcy Jaffe (chair)	Senior Vice President, Safety and Quality	Washington State Hospital Association
Shelley Bogart	Benefits Integration & Community Hospital Program Manager	DSHS-DDA
Gloria Brigham, EdD, MN, RN	Director of Nursing Practice	Washington State Nursing Association
Amy Cole, MBA	Healthcare Executive	MultiCare
Jay Cook, MD, MBA	Chief Medical Officer	Providence
Billie Dickinson	Associate Director, Policy	Washington State Medical Association
Kelli Emans	Integration Unit Manager	DSHS
Jeff Foti, MD	Medical Director, Inpatient Care Coordination	Seattle Children's
Jas Grewal		Washington State Health Care Authority

Karla Hall, RN	Palliative Care Program Coordinator	PeaceHealth
Kathleen Heim, MSN, RN	Nursing Director	PeaceHealth
Carol Hiner, MSN	Regional Director of Network Hospital Operations	Kaiser Permanente
Linda Keenan, PhD, MPA, BSN, RN-BC	Chief Nursing Officer	UnitedHealthcare
Jen Koon, MD	Associate Medical Director	Premera Blue Cross
Danica Koos, MPH	Program Manager, Care Improvement	Community Health Plan of Washington
Cathy MacEnraw, MSW	Director of Social Work	Providence
Elena Madrid, RN	Executive Vice President of Regulatory Affairs	WA HCA
Colin Maloney, MPH	Community Health Strategies for Homelessness Manager	WA DOH
Amber May, MD	Pediatrician	Kaiser Permanente
Liz McCully, MSW	Social Work Case Manager	Swedish
Jason McGill, JD	Assistant Director,	WA HCA
Kellie Meserve, MN, RN	Division Director, Care Coordination	Virginia Mason Franciscan Health
Tracey Mullian, MSW	Manager, Case Management	Swedish
Kim Petram, BSN	Director, Case Management	Valley Medical Center
Lou Reyes		Swedish
Sheridan Rieger, MD	Market Medical Director	Concerto Health
Odilliah Sangali	Community Health Strategies for Homelessness	WA DOH
Zosia Stanely, JD, MHA	Vice President and Associate General Counsel	Washington State Hospital Association
Cyndi Stilson, RN, BSN	Manager, Transitions of Care	Community Health Plan of Washington
Ric Troyer, MD	Care Team Medical Director	Iora Health
Janice Tufte	Family Advisor	PICORI West Ambassador/Hassanah Consulting

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[i] Kreiger, G, Moss B, and Perez E. 2019. Practices for Patients who are Difficult to Discharge: Report to the House Health Care & Wellness Committee on September 12, 2019. Washington State Health Care Authority. Accessed November 2021. Available: https://www.hca.wa.gov/assets/difficult-to-discharge-presentation.pdf
[ii] Strong, A & McComb, L. 2022. Budge Brief – Increase Patient Access to Appropriate Post-Acute Care Settings. Washington State Hospital Association. Accessed November 2021. Available: https://www.wsha.org/wp-content/uploads/Budget-Brief-Pro-Difficult-to-Discharge-FINAL-2022.pdf
[iii] Zucco, E. 2022. Problems persist at Washington hospitals due to lack of long-term care options. King5 News. Accessed November 2021. Available: https://www.king5.com/article/news/health/long-term-care-availability-crowding-hospitals/281-a987d2b7-f5a3-494e-b7c9-464ab8f6d1df
[iv] Presentation to bree workgroup July 2023
[v] Forshay CM, Mellett J, Worley MM, Carnes CA, Fernandes A, Jordan TA. Implementation and Evaluation of a Prior Authorization Workflow for New-Start Inpatient Medications in Preparation for Discharge. Hosp Pharm. 2023 Apr;58(2):188-193. doi: 10.1177/00185787221127610. Epub 2022 Oct 2. PMID: 36890956; PMCID: PMC9986573.
[vi] Washington Association of Area Agencies on Aging (W4A) (agingwashington.org)
[vii] Behavioral health administrative service organization fact sheet (wa.gov)
[viii] DCYF | Washington State Department of Children, Youth, and Families
[ix] Developmental Disabilities Administration (DDA) | DSHS (wa.gov)
[x] https://doh.wa.gov/
[xi] https://www.dshs.wa.gov/
[xii] https://hca.wa.gov/employee-retiree-benefits/contact-us
[xiii] https://www.dshs.wa.gov/altsa/home-and-community-services-information-professionals
[xiv] https://www.hhs.gov/
[xv] https://www.medicaid.gov/medicaid/managed-care/index.html
[xvi] https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care
[xvii] Mental Health and Substance Use Disorders | SAMHSA