Bree Collaborative | Complex Hospital Discharge
September 21st, 2023| 3:00 – 4:30 pm
Virtual

MEMBERS PRESENT

Darcy Jaffe (chair) ARNP, WSHA
Shelley Bogart, DSHS-DDA
Amy Cole - Director Care Management Multicare Yakima
Rodas Demssie Associate VP, Case Management, MultiCare Health Services
Karla Hall, RN, Peace Health
Carol Hiner, MSN, Kaiser Permanente
Betsy Jones, Managing Principal, Health Management Associates
Linda Keenan, PhD, MPA, RN-BC, United Healthcare
Elena Madrid, Executive VP for Regulatory Affairs, Washington Health Care Association
Sheridan Rieger, MD, Concerto Health
Zosia Stanley, Washington State Hospital Association
Cyndi Stilson, RN, BSN, Community Health Plan of Washington
Billie Dickinson, Associate Policy Director, WSMA
Dorothy Sivansh, Molina
Kellie Meserve, MN, RN, Virginia Mason Franciscan Health
Jas Grewal, Washington State HCA
Glory Dole, RN, MA, Washington State HCA
Elizabeth Carnesi, Executive Director at Washington, HOSA
Catherine McInroe, MSW, Providence
Kathleen Heim, MSN, RN, Nursing Director, PeaceHealth
Janice Tufte, PICORI West Ambassador/ Consulting
Jen Koon, MD, Associate Medical Director, Premera BC

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN Foundation for Health Care Quality
Ginny Weir, MPH, Foundation for Health Care Quality CEO
Karie Nicholas, MA, GC, Foundation for Health Care Quality

WELCOME

Beth Bojkov, FHCQ, welcomed members to the workgroup. Those present introduced themselves in chat and adopted the August minutes.

Action: Adopt August minutes.
Result: Unanimous approval

Review: Draft Report

Beth Bojkov reviewed the draft report beginning at the Definitions section of the report. The reviewed section and discussed what the current consensus definition is defining. The group decided to change the verbiage from “transition” barriers to “discharge” barriers for consistency. A group member advocated for keeping the definition to reference only those who have avoidable days per utilization review for ease of comparing across settings. A group member advocated for removing detailed discharge barriers as it might be limiting in terms of what qualifies as a complex discharge but also concluded that removing the detailed lists makes the information less useful. Another member stated they are not sure if the discharge barriers listed here are able to identify individuals with complex

discharges. The group wanted it to remain clear that the discharge barriers are not indicators of complex discharge. Another member had the concern that if we focus on preventing complex discharge, we might have scope creep. The definition and barriers should be associated with patients that are already delayed.

Group reviewed current list of discharge barriers to discuss, make additions and further edits. Under the medical section a group member raised that particularly patients with Alzheimer's/dementia/traumatic brain injury with behaviors often show instability in utilization in healthcare services, but other patients may have this as well. A member raised that we want to focus on patients without resources.

When discussing the dot points under complex behaviors, the group did not want to narrow it down. The group decided to move High Clinical Care needs and change Complex behavioral need to 'other complex behavioral need'. A group member suggested adding self-harm or harm to others under the behavioral category. A point was raised that some of the barriers indicated are patient-level factors and some are systemic issues, such as payment reform – the group will circle back to the organization of these various categories.

Discussion: Broad Discharge Recommendations & Guidelines

Beth continued the conversation to review the recommendations in the standard discharge best practices document. Between August and September meeting some group members provided edits and additional guidelines. The group reviewed the drafted guidelines together and members discussed:

Changed "Develop practices" to "consider practices" and care plans in the hospital settings for hospital care teams to change their behavior. A member of the group stated it would be helpful for care teams, patients and families to get a one-pager of barriers that post-acute facilities. The recommendation "Educate entire care team on practices that could delay discharge to post-acute facilities"

A group member asked how weekends and holidays factor into when discharge planning needs to be documented as beginning in the record. Another group member advocated for calling out weekend staffing of discharge planning teams. Another group member identified that preferentially partnering with post-acute facilities that will be able to accommodate patient admissions on weekends could be helpful. A group member highlighted that elective admission should have discharge planning prepped prior to admission which would reduce bottlenecking – that was called out as a recommendation, however not as doable if the patient is likely to need a rehab stay afterwards because the pre-authorization process cannot be started before admission.

Beth asked the group for an action item for the statement on Health Homes. A group member suggested "identify and engage outside entities providing support or case management such as:…" which includes all entities listed. Beth asked again for examples of discharge planning toolkits or resources.

Beth asked the group for feedback about the phrase "follow up may include care consultation via phone or other telehealth services to reinforce education and post-acute care provider access to contact information for inpatient clinicians." The group suggested to add ensuring that the written discharge has a statement for patients or caregivers to contact once they leave, and the payer case manager could help with care coordination so their information should be included on the discharge plan.

Beth then concluded the group with requesting members send their recommendations for other audience members to the Bree email or her email. One group member had provided a list of their standard processes for their organization. Beth discussed the timeline regarding wrapping up of the report, and Darcy closed with a statement requesting if they can that workgroup members send in their audience member section recommendations as soon as possible.

Action Items for next meeting:

- Revisit further with group if consensus definition for complex patient discharge connects with delayed discharge or avoidable day.
- Review health plan recommendations in more detail
- Review and provide further examples for discharge planning tools.
- Workgroup members review guidelines an add additional guidelines and recommendations that would have to happen for a complex patient to be successfully discharged for the audience they represent within the healthcare ecosystem (e.g., clinicians, health delivery system, purchasers, plans, public health, patient, etc.)