

## Background

A person's discharge from a hospital setting is the point when inpatient clinical care is transferred to another lower acuity clinical setting or to a community setting such as the person's home.<sup>i</sup> Coordination between the multiple people and systems needed in discharge planning is complex and can be a vulnerable time for the person, more so if they have ongoing health, psychological, or social needs or there is a lack of appropriate post-discharge care sites, if needed.<sup>ii</sup> These complex hospital discharges occur when a patient is medically ready to be transferred outside of an acute care setting but is unable to due to transition barriers.

In a survey from August of 2021, hospitals in Washington state reported that more than 900 patients who were ready to be discharged remained in a hospital setting.<sup>iii</sup> In one widely reported example, Harborview Medical Center announced in summer 2022 only accepting patients in urgent need of specialized care, as more than 100 medically stable patients were need of long-term post-acute care but unable to be discharged.<sup>iv</sup> While COVID-19 is a contributing factor to hospital capacity concerns, the primary issue appears to be access to appropriate post-acute care facilities.<sup>3</sup>

### Improvement work 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 0.7% of total inpatient hospital admissions.<sup>v</sup> Findings from this report were used to inform the Bree Collaborative guidelines in this document and are summarized in **Appendix X**.

Other improvement efforts in Washington state include:

- Department of Health Hospital Capacity Work Group: Hospital Capacity Work Group convened to address bed capacity and admission problems that hospitals experienced during flu season
- HCA Difficult to Discharge Client Review Program: Respond to hospitals' concerns around length of inpatient stays & inability to discharge when health conditions indicate client is ok to discharge
- HCS complex discharge pilot: Outcome of HCS hospital statewide hospital summits where we identified communication and coordination as a primary barrier to transition and Developed protocols in partnership with hospitals, MCOs, HCS over a series of in-person meetings and implemented process to identify complex clients early and begin coordination

### Bree Collaborative Workgroup

Selected as a high-priority topic September 2022, workgroup met from January to September 2023. Key takeaways are:

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- All healthcare sites should align on a definition for patients in an acute care bed without an acute care need, even if different parties calculate avoidable days, length of stay, and medical necessity differently.
- Collect standard patient characteristic data during the discharge process to understand and proactively address potential discharge barriers.
- Patients may experience multiple different or overlapping discharge barriers and all should be recorded for a single patient.
- Different facilities may have their own internal process for discharge barrier collection, but each site should develop a standard process for collecting discharge barrier categories for all their patients.

## Definitions

- Current consensus definition: Patients who are medically ready to be transferred outside of an acute care setting but are unable to due to ~~external~~ **transition** barriers.

### Collecting Patient Information:

Collect standard patient characteristic data during the discharge process to understand and proactively address potential discharge barriers.

- Patient characteristic information could include: 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:

If a patient is determined to have a delayed discharge or avoidable delay, collect information about the discharge barriers facing the patient **aligned with the following categories, many will have multiple barriers to transition.** ~~considering barriers related to the following list:~~

- Medical:
  - Alzheimer's/dementia/traumatic brain injury **with behaviors**
  - Bariatric status
  - High Care Needs
  - Hemodialysis/Dialysis Availability
  - Wound Care
- Behavioral:
  - Complex behavioral need
  - Substance use disorder (Current or history)
  - Lack of psych support/services
  - **Aggressive or inappropriate behavior**
  - **Legal involvement**
- Social Needs:
  - **Transportation**
  - Housing/homelessness
  - Undocumented
  - Lack of family support/cooperation
- Legal:
  - Guardianship/Conservatorship
  - CPS/APS
  - Prior conviction (esp. sex offender/arson/violence)
- Payment:
  - Delayed insurance authorization/prior authorization
  - DME coverage
  - COPES
  - Uninsured/Lack of coverage
- Process:
  - ~~DDA Delays~~ **assessment timeframe**
  - ~~Delays from~~ **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

## Guidelines

### Hospitals

- Ensure complete and timely communication of information across key partners (**bilateral**)
  - Ensure clinicians in the hospital send discharge summaries to outpatient providers when possible.
  - Ensure open communication between care settings and among multidisciplinary teams within each setting.
  - Ensure the hospital discharge planning team begins **bidirectional** coordination with applicable payors, state agencies, or post-acute care agencies early in the discharge planning process **and maintain communication throughout the stay.**
  - **Ensure hospital dc team, payer and agencies to timely communicate with each other on necessary DME, medications, etc. to ensure a safe discharge.**
- Practice **timely, early**, comprehensive discharge planning.
  - Employ a full-time discharge coordinator and hold regular discharge planning meetings with members of the care team.
  - Train staff on safe and effective discharge practices.
  - Prior to discharge, organize follow-up services and address patient's financial and psychosocial barriers to care.
  - Care coordinators and case managers may provide support services to decrease length of stay and readmissions. **Engage payer's case manager to help the patient navigate and sustain support services to reduce readmission.**
  - **Start prior to admission, at least within 24 hrs.**
- Consider using or developing a discharge tool to facilitate the discharge of patients to the right care setting. Discharge planning tools include:
  - HHS' [Continuity Assessment Record and Evaluation \(CARE\)](#) and B-CARE tools
  - Sample private hospital tools from the [American Hospital Association](#)
- Consider using a discharge tool or checklist to monitor the discharge plan and patient understanding. Discharge process checklists and tools include:
  - AHRQ's [Re-Engineered Discharge \(RED\) Toolkit](#) provides evidence-based training for staff as well as processes to improve the discharge process.
- Ensure the discharge plan is communicated to the patient or **decision-maker**.
  - Develop a written discharge plan and share a printed version with the patient/caregiver.
  - 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.
  - Practice patient-centered care and work to establish trust between providers and patients.
  - ~~Consider~~ **Use** a patient education strategy (e.g., teach back) to ensure patient/decision-makers understand the discharge plan.
  - Proactively identify and address factors that may impact a patient's adherence to the discharge and medication plan and could lead to readmission.
    - Discuss patient-related factors (health literacy, cognitive function), drug-related factors (adverse effects, polypharmacy), and logistical factors (transportation, social needs) with the patient and decision maker

- Communicate to payer?
- Conduct a medication review before each care transition.
  - Reconcile medications at each transition and check for the accuracy of medication lists and dosages as well as any contraindications.
  - **Provide** medication education and incorporate a medication plan into the discharge plan.
- Prompt follow-up visits prior to discharge.
  - *A follow-up visit in an outpatient setting within seven days of discharge is best practice.* **Prior to discharge, schedule a** follow-up with post-acute care for patients who are discharged to post-acute care settings.
  - 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.

## Health Plans

- Ensure complete and timely communication of information across key partners (**bilateral**)

## 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 $\leq 48$ 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, Parsons Leigh J, Stelfox HT, Fiest KM. Patient discharge from intensive care: an updated	We included 314 articles from 11,461 unique citations. Two-hundred and fifty-eight (82.2%) articles were primary research articles, mostly cohort (118/314, 37.6%) or qualitative (51/314, 16.2%) studies. Common discharge themes across all articles included adverse events,

	scoping review to identify tools and practices to inform high-quality care. Crit Care. 2021 Dec 17;25(1):438.	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.
<b>Discharge Planning/Communication</b>	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. <i>J Hosp Med.</i> 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. <i>Postgrad Med J.</i> 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. <i>Prof Case Manag.</i> 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 review and narrative synthesis on the risks of	In total, 29 studies were included in this review. The major identified risk factors are the delayed sending of the discharge letter to doctors for further treatments, unintelligible (not patient-centered) medical discharge letters, low quality of the discharge letter, and lack of



	<p>medical discharge letters for patients' safety. BMC Health Serv Res. 2019 Mar 12;19(1):158.</p>	<p>information as well as absence of training in writing medical discharge letters during medical education.</p> <p>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.</p>
	<p>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.</p>	<p>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.</p>
	<p>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.</p>	<p>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.</p>

	<p>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.</p>	<p>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], <math>p &lt; .001</math>). Patients who were discharged on Saturday or Sunday (OR, 4.8 [95% CI, 1.7-14.6], <math>p &lt; .001</math>) and patients who were waiting for physicians' consult (OR, 4.5 [95% CI, 1.6-14.4], <math>p = .007</math>) 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.</p>
	<p>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. <a href="https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/hospital-length-stay-technical-brief.pdf">https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/hospital-length-stay-technical-brief.pdf</a></p>	<p>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).</p>

	<p>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.</p>	<p>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)</p>
	<p>American Hospital Association. Private Sector Hospital Discharge Tools. January 2015. Accessed June 20, 2023. <a href="https://www.aha.org/system/files/content/15/15dischargetools.pdf">https://www.aha.org/system/files/content/15/15dischargetools.pdf</a></p>	<p>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 tool<sup>1</sup>. 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.</p>
	<p>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. <a href="https://psnet.ahrq.gov/primer/discharge-planning-and-transitions-care">https://psnet.ahrq.gov/primer/discharge-planning-and-transitions-care</a></p>	<p>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 challenging as patients and families become responsible for care coordination. Hospital discharges are complicated and often lack</p>

		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. <a href="https://www.chrt.org/wp-content/uploads/2019/10/CHRT-Care-Transitions-Best-Practices-and-Evidence-based-Programs-.pdf">https://www.chrt.org/wp-content/uploads/2019/10/CHRT-Care-Transitions-Best-Practices-and-Evidence-based-Programs-.pdf</a>	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 Transitional Care Strategies on Outcomes After Discharge – Trust Matters, Too. Joint Commission	In concert with care coordination activities that bridge the transition from hospital to home, hospitals' clear communication and fostering of trust with patients were associated with better patient-reported outcomes and reduced health care utilization.

	Journal on Quality and Patient Safety. 48(1): P40-52.	
	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. <a href="https://www.hsag.com/globalassets/care-coordination/carecoordtoolkit032019final508.pdf">https://www.hsag.com/globalassets/care-coordination/carecoordtoolkit032019final508.pdf</a>	As a CMS 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:			
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/ODD	Post-acute care beds for patients with SUD/ODD	
		Appropriate staffing to provide SUD/ODD 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
<p><b><u>Rates/Financial:</u></b></p> <ul style="list-style-type: none"> <li>• SNF contracted rate w/ MCOs doesn't include therapies, Rx, DME</li> <li>• SNFs won't accept MCO covered clients/MCO contract rate too low</li> <li>• Delays in authorization's</li> <li>• MCOs using Administrative Dat Rate (ADR)</li> <li>• CARE generated rates are too low</li> <li>• ETR requests diff and time consuming</li> </ul>	<ul style="list-style-type: none"> <li>• MCOs pay separate/tiered rates</li> <li>• MCOs reimburse SNFs based on acuity level,</li> <li>• Financial incentives in SNF contract</li> <li>• Provide SNFs training/tools on bene's and when/how to bill</li> <li>• MCOs provide SNFs w/ rate &amp; covered services</li> <li>• Need more DME providers &amp; coordination process, streamline/accelerate the process</li> </ul>
<p><b><u>Process:</u></b></p> <ul style="list-style-type: none"> <li>• Lack of clarity around MCO coverage criteria</li> <li>• Lack of standard discharge planning process</li> <li>• Insufficient alternatives care settings</li> <li>• Need early BHO involvement</li> </ul>	<ul style="list-style-type: none"> <li>• Provide more info re: billable services</li> <li>• Develop standard discharge process/streamline with MCOs</li> <li>• Provider resource development</li> </ul>
<p><b><u>Guardianship:</u></b></p> <ul style="list-style-type: none"> <li>• Process delays &amp; challenges</li> <li>• Lack of guardians accepting high risk needs clients</li> </ul>	<ul style="list-style-type: none"> <li>• Look for opportunities within process</li> <li>• Involve BHO early on</li> <li>• Multidisciplinary team to address</li> </ul>
<p><b><u>Level of Care (LOC):</u></b></p> <ul style="list-style-type: none"> <li>• Functional assessment &amp; process delays</li> </ul>	<ul style="list-style-type: none"> <li>• Look for opportunities within process</li> </ul>
<p><b><u>Regulatory:</u></b></p> <ul style="list-style-type: none"> <li>• SNF licensing/surveys/Star ratings prohibiting admission</li> </ul>	<ul style="list-style-type: none"> <li>• Review regulatory challenges RCS/DOH</li> <li>• RCS enriches consultative interactive process</li> <li>• Improve comms and reestablish QA nurse</li> </ul>
<p><b><u>Patient Issues:</u></b></p> <ul style="list-style-type: none"> <li>• Clients w/ challenging situations</li> <li>• Medically complex</li> <li>• Non-cooperative clients/families</li> <li>• homelessness</li> </ul>	<ul style="list-style-type: none"> <li>• Resource development: post acute facilities and memory care, ESF, ECS</li> <li>• Education/training</li> <li>• Consistent comms / provider assistance to clients/families</li> </ul>
<p><b><u>Insufficient available resources:</u></b></p> <ul style="list-style-type: none"> <li>• Hospitals not clear about PASSR process DDA clients</li> <li>• Lack of knowledge of HCS work/process</li> <li>• Workforce challenges</li> </ul>	<ul style="list-style-type: none"> <li>• Develop clear guidelines for working w/ HCS clients</li> <li>• Develop guidelines working w/ HCS clients</li> <li>• Workforce/resource development</li> </ul>

## References

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<sup>iii</sup> 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>

<sup>iv</sup> 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>

<sup>v</sup> Presentation to bree workgroup July 2023