Working together to improve health care quality, outcomes, and affordability in Washington State.

Complex Patient Discharge Report and Guidelines

January 24th, 2024

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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 E** 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 F** for the workgroup charter and a list of members.

Background

Discharge from a hospital marks the end of a person's acute clinical care. When a person requires post-acute care in another setting (i.e., cannot be safely discharged to home or to home without support), 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 health or social needs. These complexities lead to longer or more difficult transitions due to a lack of appropriate post-acute care options (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 State. In August 2021, hospitals in Washington state reported more than 900 patients who were ready for discharge but remained in a hospital setting.[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 issue of complex and delayed discharge predates the pandemic. The primary issue is access to appropriate post-acute care services, including sufficient staffing and the ability to provide specialized care and with appropriate reimbursement to meet the complex needs of people transitioning from the acute care setting.[iv]

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. At that time, the HCA estimated that Medicaid delayed discharge patients account for 0.7% of total inpatient hospital admissions.[v] While the HCA specifically reported on individuals with Medicaid coverage, individuals from any payer source can experience delays in discharge. Findings from the report informed these guidelines and are summarized in **Appendix C**. 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. These efforts have focused on identifying solutions for bed capacity and admission problems during flu season, responding to hospitals' concerns around length of inpatient stays and inability to discharge when health conditions indicate client is ready 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. The workgroup identified opportunities to address the **key action items below**:[vi]

- Adoption of a common definition for patients in an acute care bed without an acute care need. Lack of a common definition has led to 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

Complex Patient Discharge Definition

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 including previous home location, primary payer/insurer, planned discharge site, healthcare decision maker/power of attorney, and information about potential discharge barriers (such as social, behavioral health, medical and legal needs, etc.)

For individuals with complex needs, many people 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 B Standard Discharge Barrier List.**

Guidelines

Hospitals

- ☐ Adopt the common 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.
    - ☐ Have a system to identify patients as complex discharge in registries/records using this definition as a minimum.
    - ☐ Collect data on both patients who meet complex patient discharge definition and have avoidable days.
- ☐ Collect standard patient characteristic data, identify potential patient 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.
- ☐ Determine decisional capacity and necessary supports early in admission and reassess as needed.
- ☐ Hospital team should discuss goals of care/palliative care prior to admission for elective admissions or as early as possible in the stay.
- ☐ Ensure patients are mobilized as early as possible in the stay as clinically appropriate and safe.
- ☐ Use complete and timely two-way communication and coordination of patient information within the facility and with appropriate post-acute care facilities or setting, state agencies, health plans and other relevant entities at the beginning of the discharge planning process and maintain throughout the stay.
    - ☐ Consider barriers as outlined in **Appendix B:** Standard Discharge Barrier List
    - ☐ 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, for example:
        - ☐ 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
- ☐ Develop a way to share complex discharge barriers information across teams in the hospital, such as including a data element to identify a patient as experiencing a complex discharge on hospital admissions or census registries.

- ☐ Educate all members of the care team on patient needs and practices that could delay discharge to post-acute settings, such as use of restraints, psychoactive medications, or lengthy prior authorization processes for medications or durable medical equipment.
- ☐ Universally screen for the Social Determinants of Health (SDOH) and social needs using a validated tool (e.g. PRAPARE, other tools that meet federal guidelines). Follow the Foundation for Health Care Quality's 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, update this information regularly and make it available to weekend providers.
- ☐ For patients identified as a complex discharge, refer them to the hospital's complex discharge team, or identified leads for assisting in patient discharge.
- ☐ Identify a dedicated complex discharge team or complex discharge lead 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 or high-cost medications as soon as possible in the stay and initiate the prior authorization process, and work with health plan and post-acute settings to address high-cost related barriers.
    - ☐ 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 or transition of care team (medical and behavioral health), DSHS Home and Community Service or 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 and working with Home and Community Services (HCS)
        - ☐ clearly indicate on the HCS referral where the client will be at the time of assessment. If patient will not be in the hospital at the time of assessment, indicate the correct location (e.g., 'home')
        - ☐ Establish agreement with HCS for access as appropriate to patient electronic medical records (EHR) to utilize in assessment process.
        - ☐ Establish regular meetings to prioritize assessments and to discuss cases – include HCS and payer case manager to jointly address barriers.
        - ☐ Understand services offered and assessment process. Review HCS assessment resource (**appendix F**)
        - ☐ Provide HCS with hospital contact and escalation contact. If hospital escalates an HCS issue internally, escalate the issue with HCS escalation contact as well.

- ☐ When referring to and working with Developmental Disabilities Administration (DDA):
  - ☐ Clearly indicate on the DDA referral where the client will be at the time of assessment. If patient will not be in the hospital at the time of assessment, indicate the correct location (e.g., 'home')
  - ☐ Establish regular meetings to prioritize assessments and to discuss cases – include DDA and payer case manager to jointly address barriers.
  - ☐ Establish agreement with DDA for access as appropriate to patient electronic medical records (EHR) to utilize in assessment process.
  - ☐ Provide DDA with hospital contact and escalation contact. If hospital escalates an DDA issue internally, escalate the issue with DDA escalation contact as well.
  - ☐ Understand services offered and assessment process.
- ☐ Develop a person-centered written discharge plan with patient or decision-maker and when applicable caregiver:
  - ☐ Share a printed version with the patient or decision-maker.
  - ☐ Share a copy with involved case managers and/or care coordinators, 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, high-cost medications), logistical factors (transportation, social needs) and others; discuss strategies to address these factors with the patient and/or decision-maker.
  - ☐ Work with the patient or decision-maker, health plan and post-acute settings to create secondary discharge plan when appropriate.
  - ☐ 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 within seven days of discharge. Longer follow-up times can be acceptable but not preferred.
    - ☐ Schedule follow-up visits with behavioral health and/or SUD providers, as appropriate
    - ☐ Provide telehealth follow-up visits for patients and/or decision-makers as determined appropriate by the care team. May include care consultation via phone or telehealth services to reinforce education.

- ☐ 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 and/or lead on weekends.

Health Plans

- ☐ Adopt the common 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 B:** Standard Discharge Barrier List and communicate to the dedicated complex discharge team or lead.
- ☐ Use complete and timely two-way communication and coordination of patient information across key partners including but not limited to acute and post-acute care providers, and relevant social service and public health agencies including Home and Community Services, Developmental Disabilities Administration, and Area Agencies on Aging.
- ☐ Have a system to identify and track members that qualify as a complex patient discharge. Consider developing a system to proactively identify when a patient previously experienced a complex discharge. Notify complex discharge team and/or lead when this occurs.
- ☐ 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 providers on prior authorization for post-acute coverage processes, medication needs and durable medical equipment 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 acute care settings, post-acute settings, and other relevant organizations as necessary
    - Elective admissions: Reach out to acute care team on day of admission for patients that have documented discharge barriers.
    - Emergent admissions: Reach out to acute care team upon notification of patient's admission for patients that have documented discharge barriers.
- ☐ Screen for and track rates of Social Determinants of Health (SDOH) screening and referral for members, and stratify by Race, Ethnicity and Language (REaL) data to identify disparities. Develop pathways to address identified disparities. Follow Foundation for Health Care Quality Recommendations on Social Needs Screening and Social Needs Intervention to prioritize screening for social needs.
- ☐ 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.
- ☐ Work with the patient or decision-maker, acute care facility and post-acute facility to create secondary discharge plan when appropriate.
- ☐ Participate in regular length of stay meetings with hospitals and Home and Community Services.

Department of Social and Health Services (DSHS)

- ☐ **All departments**: Adopt the common 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 departments**: use complete and timely two-way communication and coordination of information across key partners, including but not limited to social service agencies, public health agencies, acute care providers, post-acute providers, and health plans.
- ☐ **All departments**: Continue to identify barriers within organizational processes that delay discharge from hospitals. Communicate barriers with hospitals, health plans and post-acute facilities.
- ☐ **All departments:** Develop process of receiving standard, documented discharge barrier information from the acute care setting as outlined in **Appendix B:** Standard Discharge Barrier List and communicate to the dedicated complex discharge team or lead.
- ☐ **DSHS**: Establish and maintain an online directory with list of Washington state post-acute facility care capabilities (e.g., pulmonary and respiratory care, advanced wound care, intravenous antibiotics, etc.) that is publicly available and with reliable contact information available to verify information before patient transfers.
- ☐ Streamline assessment processes by:
    - ☐ Make regional staff contact information and escalation staff contact information easily accessible.
    - ☐ If HCS or DDA regional staff escalate hospital issues internally, escalate the issue with hospital escalation contact as well.
    - ☐ Establish agreements with hospitals for access to patient electronic medical records (EHR) to utilize in the assessment process as appropriate.
    - ☐ Establish and communicate clear expectations for assessment of clients who have a current care plan that will need to be adapted to a community setting (e.g., use of sitters, use of restraints, etc.)
- ☐ Home and Community Services (HCS)
    - ☐ 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)
    - ☐ Develop processes to minimize delays due to HCS case manager transfers.
    - ☐ 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[1] as soon as possible when a client is identified as experiencing a complex discharge.
    - ☐ Ensure patients, hospitals, and post-acute providers (as relevant) are kept up to date on timelines to complete assessments, establish rates, and any exception to the rule (ETR) review.
- ☐ Developmental Disabilities Administration

[1] The term guardian us used to refer to a court appointed decision maker, which can include a guardian, conservator, both or other protective arrangement.

- ☐ Flag clients that are experiencing complex discharge for prioritization by the case management team.
- ☐ Ensure intake case management team communicates with hospital discharge team when there is a case transfer to another case manager.
- ☐ Develop processes to limit delays due to DDA case manager transfers.
- ☐ Develop a care plan in collaboration with hospital discharge team, health plan case manager and patient and/or guardian as soon as possible when a client is identified as experiencing a complex discharge.

Post-Acute Facilities

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

- ☐ Adopt the common 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 complete and timely two-way communication and coordination of information across key partners, including but not limited to acute care facilities, social service agencies, public health agencies, and health plans.
- ☐ Maintain list of acute care facilities within the referral region.
- ☐ Develop and maintain staffing capacity and competencies to accept patients who have attributes listed on the standard discharge barrier list found in **Appendix B**., including through the weekend as resources allow.
- ☐ Every Friday, notify acute care facilities within discharge area/region if unable to accept discharges over the weekend.
- ☐ Identify and work to develop solutions to barriers to admissions in collaboration with acute care facility on an individual patient level to assist in the post-acute care facility's ability to accept an admission.
- ☐ Develop communication channels with referring acute care facilities and ability to receive electronic, documented discharge information from the acute care settings including but not limited to information in the **Appendix B:** Standard Discharge Barrier List 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.
- ☐ Communicate with acute facilities in a timely manner when staffing capabilities change ability to admit patients.
- ☐ Provide necessary information to Department of Social and Health Services (DSHS) as requested on usual care capabilities for DSHS directory.
- ☐ When applicable, work with the patient or decision-maker, acute care facility and health plan to develop a secondary discharge plan when applicable.

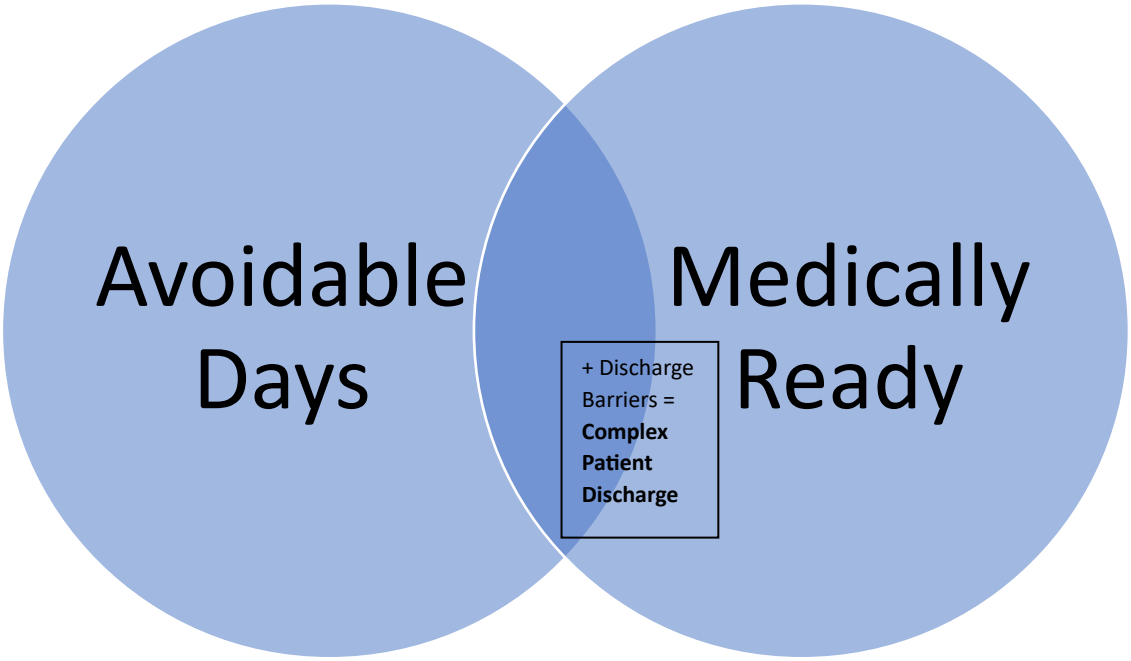
Adult Family Homes & Assisted Living Facilities (who can accept complex patients)

- ☐ Adopt the common 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 complete and timely two-way communication of information across key partners, including but not limited to acute care facilities, social service agencies, public health agencies, and health plans to facilitate discharge planning.
- ☐ Collaborate with the hospital's discharge planning team to understand the specific requirements and recommendations for the potential resident's care.

    - The nurse delegator should communicate with the hospital discharge team about discharge plan as soon as possible to address potential delays in discharge.
- ☐ When applicable, work with patients and/or decision-maker, acute care facility and health plan to develop a secondary discharge plan.
- ☐ Request a care plan from acute care facility and other relevant entities that can be replicated in this setting prior to admission.
- ☐ If denying admission, note what supports would be necessary for consideration of acceptance for admission.
- ☐ Communicate with the resident's primary care provider (PCP) and behavioral health providers at least upon admission; assist in identifying a PCP when needed.

Measuring Complex Discharge – Future Considerations

Hospitals and health plans employ various measures to identify individuals who no longer need hospitalization, such as those who meet the criteria for the complex discharge definition. Measures are designed to optimize resources, identify those in need of support, and manage costs effectively. The workgroup's goal was to decide on a common definition to facilitate identification and funneling of resources to ensure safe and timely discharge. Avoidable days are calculated by utilization review or other systems that do not always involve the inpatient medical team who are tasked with planning discharge alongside patients and families. Health plans identify patients on avoidable days, but those patients do not all qualify as a complex discharge – they may have a safe discharge plan in place and plan to discharge from the hospital in a timely manner. Medical readiness is determined by the care team and attending practitioner that assumes responsibility for each patient – when medical readiness as determined by the inpatient team and avoidable days do not align, it can create confusion between health plans and hospital care teams on who is ready to discharge and captures patients beyond those that meet the definition of complex discharge. There are other measures, such as length of stay, that hospitals use to understand who is hospitalized but should not be anymore. The workgroup determined a common definition to facilitate identification, data sharing and funneling of resources to ensure safe and timely discharge which can be achieved using measures are designed to optimize resources, identify those in need of support, and manage cost. **Future work is needed to establish, define, and operationalize process and outcome measures that can be used to understand statewide conditions for patients identified as a complex discharge and drive improvement efforts across sectors.**



Appendix A: Evidence Table

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%). Post-discharge 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 post-acute 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 B: Standard Discharge Barrier List

- **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.
  - ☐ Lack of payment options
  - ☐ Delays in Medicaid determinations
- **Process**
  - ☐ Developmental Disabilities Administration (DDA) assessment timeframe
  - ☐ HCS assessment timeframe
  - ☐ DDA provider search
  - ☐ HCS provider search
  - ☐ Transfer to Eastern/Western, or State Hospital
  - ☐ Medicaid financial eligibility timeframe.
- **Post-Acute Placement**
  - ☐ Bed Type not available
  - ☐ Delay in response or communication
  - ☐ Workforce shortages
  - ☐ Inadequate transportation for transfer

Appendix C: 2017 HCA DSDS Legislative Report

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	

Bree Collaborative | Complex Hospital Discharge
Adopted January 24th, 2024

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, Conservatorship & Other Protective Arrangements: • Process delays & challenges • Lack of guardians accepting high-risk needs clients	• Look for opportunities within the process. • Involve BHO early on. • Multidisciplinary team to address.
Level of Care (LOC): • Functional assessment & process delays	• Look for opportunities within the process.
Regulatory: • SNF licensing/surveys/Star ratings prohibiting admission	• Review regulatory challenges RCS/DOH • RCS enriches consultative interactive process. • Improve communications and expand the role of the QIP nurse to include protocols related to admissions and discharge requirements.
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 for DDA and behavioral health clients. • Lack of knowledge of HCS work/process • Workforce challenges	• Develop clear guidelines for working w/ HCS clients. • Workforce/resource development

Appendix D. 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[vii]
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[viii]
DCYF	Department of Children, Youth and Families	Cabinet-level agency that focuses on childcare, early learning, welfare, foster care, adoption, juvenile rehabilitation etc. [ix]
DDA	Developmental Disabilities Administration	Cabinet-level agency that provides support for individuals with developmental disabilities and their families; division of DSHS[x]
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[xi]
DSHS	Department of Social and Health Services	State agency that oversees social and health services in Washington, providing food, cash, medical, childcare, disability support, mental health and addiction services and more[xii]
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[xiii]
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[xiv]

HHS	Department of Health and Human Services	U.S. federal agency responsible for overseeing public health and health care services for Americans[xv]
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[xvi]
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[xvii]
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[xviii]

Appendix E. Ongoing Efforts to Address Complex Discharge

The Washington Governor's Complex Discharge Taskforce (established by the legislature in the 2023 state budget) is currently undertaking work to establish a two-year pilot for enhanced care management services for the Medicaid and dual eligible population. The Taskforce is focusing on the following areas:

- Funding mechanisms
- Post-acute care and administrative day rates
- Managed care contracting
- Legal, regulatory, and administrative barriers to discharge.
- Pilot program implementation and evaluation

The taskforce identified barriers to discharge including identifying the most common: behavioral health and substance use disorders, behaviors/restraints, DSHS eligibility and authorization of services, high care needs and lack of housing. The pilot will prioritize development of resources specific to these most common barriers. Initial recommendations include expansion of guardianship capacity, expansion of post-acute care access to individuals who do not qualify for Medicaid due to immigration status.

Individuals who cannot make their own decisions and need a court-appointed guardian often remain in the hospital for months as a result of legal processes. The length of these legal processes is exacerbated by the Office of Guardianship & Conservatorship's and Washington State courts limited resources and capacity.

Appendix F. HCS Assessment Criteria

Washington Department of & Health Serv
Transforming live

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Acute Care Hospital Long Term Services Referral Guide: When to refer to HCS.

NOTE: guide for hospital staff to determine actions to take prior and when referring to Home and Community Services (HCS) Division for Long-term care services is appropriate for transition planning.

1. DISCHARGE PLAN

Is the client's discharge plan for SNF, LTAC, IPR or another Medical facility for rehabilitation or skilled level of care?

If **YES** –do not send a referral If **NO**—go to step 2

2. DECISION MAKER

Is the client their own decision maker?

If **YES**—go to step 3 If **NO**—Stop and review 2(a) through 2(d).

2(a)**.** Does the client have a DPOA/guardian, or can the client tell HCS if they have an alternative decision maker?

2(b). Is the Guardianship process started? If **YES**—go to 2(d). If **NO**—Stop and consult your legal counsel.

2(c). Is client eligible for the guardianship pilot criteria? If **YES**—refer client. If **NO**—Stop consult your legal counsel.

2(d). Is the court date within 14 days? If **YES**—send the referral. If **NO**—do not send the referral.

3. CLIENT CHOICE

Has the hospital social worker discussed Medicaid LTC with client/decision maker, and are the client/decision maker agreeable to Medicaid long-term care services?

If **YES**—to step 4 If **NO**—ask the client before you send the referral

4. CLIENT STABILITY

Is the client medically and psychiatrically stable for community-based level of care and near ready for discharge?

If **YES**—go to step 5 If **NO**—do not send the referral

5. APPLICATION FOR MEDICAID

Has the client or hospital filled out a Medicaid LTC application and submitted it?

If **YES**—go to step 6 If **NO**—do not send the referral. Please assist the client with filling out a LTC application

6. LOCATION FOR ASSESSMENT

Is the client going to discharge without HCS LTC services in place?

If **YES**—Please make a note on the referral form 10-570 where the client will be for assessment, that "client discharged to and would like Medicaid LTC services" so that the referral is assigned correctly.

If **NO**—the hospital will be location of the assessment, make the referral.

7. BRIEF SUMMARY

If you have gotten to this point

- Hospital Social Worker has had a conversation with the client, and they expressed that they would like Medicaid LTC services.
- The client is not on any kind of restraints in the last 72 hours or 3 days.
- The client is their own decision maker; if not, client is able to authorize an alternative decision maker or has a DPOA and /or the Guardianship Court date is within 14 days.
- The client is medically or psychiatrically stable and near ready for discharge.
- The client's discharge plan is in-home caregiver services or residential services.
- The client has completed Medicaid LTC application and it has been submitted.

YOU ARE NOW READY TO SEND THE REFERRAL TO HCS – if these steps are followed HCS will be able to assess the client timely and begin transition planning.

HCS Referral Checklist- March 2023

Appendix E: Bree Collaborative Members

Member	Title	Organization
June Altaras, MN, NEA-BC, RN	Executive Vice President, Chief Quality, Safety and Nursing Officer	MultiCare Health System
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
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
Judy Zerzan-Thul, MD	Medical Director	Washington State Health Care Authority
Colleen Daly, PhD	Director, Occupational Health, Safety and Research	Microsoft
Emily Transue, MD (chair)	Chief Clinical Officer	Comagine Health

Appendix F. 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.[2] 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.[3] 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.[4]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.
- 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.

[2] 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
[3] 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
[4] 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

- 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-HCS
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 Education and Regulatory Affairs	Washington Health Care Association (WHCA)
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
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Janice Tufte	Family Advisor	PCORI West Ambassador/Hassanah Consulting
Azmera Telahun	Associate Chief Nurse Officer , Care Management and Social Work	University of Washington

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