Complex Discharge Guideline Checklist

Health Plan
Level 1

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The current state of the issue

In a survey from August of 2021, hospitals in Washington state reported that more than 900 patients who were ready for discharge remained in a hospital setting.[1] A person's discharge from a hospital setting is the point when inpatient acute clinical care is completed. When a person requires post-acute inpatient care in a lower acuity clinical setting the transition is often challenging. Coordination between the multiple people and systems in discharge planning is complex and is a vulnerable time for the patient, more so if they have ongoing health and social needs, or there is a lack of appropriate post-acute care sites. These complex hospital discharges often result in patients being medically ready for transfer from an acute care setting but without an appropriate accepting care setting, and limit the hospitals' ability to care for their community. To help address Complex Discharges, the governor's office has appointed a statewide Complex Discharge Task Force established during the 2023 legislative session.[2]

Coordination & Communication

- [ ] 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.
- [ ] 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.
- [ ] Coordinate discharge care plans with acute care settings, post-acute settings, and other relevant organizations as necessary.
- [ ] For elective admissions reach out to acute care team on day of admission for patients that have documented discharge barriers.
- [ ] For emergent admissions reach out to acute care team upon notification of patient's admission for patients that have documented discharge barriers.
- [ ] Prioritize complex discharges to facilitate the prior authorization process when appropriate.

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Care Team

- [ ] Identify post-acute providers that can accept acute care discharges on weekends and holidays and communicate this information to discharge planning teams.
- [ ] Provide a dedicated team and process for assisting with discharge planning and discharge disposition when a member is identified as a complex discharge

Resources

- The Bree Report on Complex Discharge is meant to supplement these resources.
- Full Bree Report on Complex Discharge Health: https://www.qualityhealth.org/bree/wp-content/uploads/sites/8/2024/01/Bree-Complex-Discharge-Recommendations-FINAL-0124.pdf
- AHA Private-Sector Hospital Discharge Tools: https://www.aha.org/system/files/content/15/15dischargetools.pdf
- AHRQ Re-Engineered Discharge (RED) Toolkit: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
- CARE Tool Discharge: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Supplemental-Discharge-CARE-Tool.pdf

Read the full Bree Report on Complex Discharge online by scanning the QR code:

Connect with the Bree Collaborative at bree@qualityhealth.org

References: Strong, A & McComb, L. 2022. Budge Brief – Increase Patient Access to Appropriate Post-Acute Care Settings. Washington State Hospital Association. Accessed November 2023. Available: https://www.wsha.org/wp-content/uploads/Budget-Brief-Pro-Difficult-to-Discharge-FINAL-2022.pdf 2. Governor complex/difficult-to-discharge taskforce – workgroup opportunities and pilot program Washington State Hospital Association. Accessed November 2023. Available: https://www.wsha.org/articles/governor-complex-difficult-to-discharge-taskforce-workgroup-opportunities-and-pilot-program/