Complex Discharge Guideline Checklist

Health Plan
Level 2

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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]

Care Team

- [ ] Regularly verify provider network is adequate by analyzing utilization numbers.

Coordination & Communication

- [ ] 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.
- [ ] Implement standardized post-acute coverage setting criteria and standard medication prior authorization criteria.
- [ ] Work with the patient or decision-maker, acute care facility and post-acute facility to create secondary discharge plan when appropriate.

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Information Exchange

- [ ] Develop process of receiving standard, documented discharge barrier information from the acute care setting as outlined in **Appendix B** of the report**:** Standard Discharge Barrier List and communicate to the dedicated complex discharge team or lead.

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/