Complex Discharge Guideline Checklist

Health Plan
Level 3

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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

- [ ] Maintain adequate access to the network of post-acute providers for every hospital referral region based on historic need for post-acute bed placement.

Coordination & Communication

- [ ] 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.
- [ ] Participate in regular length of stay meetings with hospitals and Home and Community Services.

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Information Exchange

- ☐ 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 in social needs. Follow Foundation for Health Care Quality Recommendations on Social Needs Screening and Social Needs Intervention to prioritize screening and intervention for social needs.

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/