Complex Discharge Guideline Checklist

Hospital
Level 1

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The current state of the issue

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.

Coordination & Communication

- [ ] 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.
- [ ] 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.
- [ ] Identify and engage outside entities providing support or case management to help the patient navigate and sustain support services.
- [ ] Ensure hospital staff understand patient circumstances and medical practices that can't be continued in the community setting, (e.g, restraints, psychoactive medications, tele-sitters).
- [ ] Collaborate with health plan to ensure patient has PCP prior to discharge.
- [ ] Establish clear roles and responsibilities between hospitals and health plans for transitions of care. Communicate with HCS/DDA to identify their role in patient care during discharge planning and after discharge.
- [ ] 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
- [ ] Send discharge summaries to outpatient providers, including behavioral health and/or substance use disorder providers within 3 business days.
- [ ] When applicable, provide HCS/DDA case managers with hospital contact and escalation contact.
- [ ] If hospital escalates an HCS/DDA issue internally, escalate the issue with HCS/DDA escalation contact as well.

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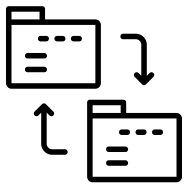
Information Exchange

- [ ] Collect standard patient characteristic data, identify potential patient discharge barriers, and begin comprehensive discharge planning within 24 hours for emergency admissions.
- [ ] The complex discharge team/lead + inpatient hospital team to ensure complete and timely documentation of discharge barriers using the complex discharge tool.
- [ ] Clearly indicate on referrals to HCS/DDA where the client will be at the time of assessment (e.g, hospital, home, etc)
- [ ] Share a copy of the discharge plan with involved case managers and/or care coordinators, including payer case manager, at discharge.



Workflows

- [ ] Educate all members of the care team on patient needs and practices that could delay discharge to post-acute settings: (restraints, psychoactive medications, or lengthy prior authorization processes for medications or durable medical equipment)
- [ ] For patients identified as a complex discharge, refer them to the hospital's complex discharge team, or identified leads for assisting in patient discharge.
- [ ] Understand HCS/DDA services offered and their assessment processes.
- [ ] Utilize the hospital adapted discharge tool for complex patient discharges.
- [ ] Ensure all members of the care team have access to the discharge planning tool.
- [ ] Reconcile medications at each transition and check for the accuracy of medication lists and dosages as well as any contraindications before discharge.
- [ ] Ensure patients are mobilized as early as possible in the stay as clinically appropriate and safe.

Patient/Family Coordination & Resources

- [ ] Determine decisional capacity of patient 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.
- [ ] Develop a person-centered written discharge plan with patient or decision-maker and when applicable 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.
- [ ] Share a printed version of the discharge plan with the patient or decision-maker.
- [ ] Include in the written discharge plan 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.

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