Complex Discharge Guideline Checklist

Hospital
Level 2

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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

- [ ] 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 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.
- [ ] Consider patient's circumstances and use medical practices and care plans in the hospital settings that can be continued in the community settings, and identify proactive transition plans.
- [ ] When referring to or working with HCS/DDA: Establish agreement with HCS/DDA for access as appropriate to patient electronic medical records (EHR) to utilize in assessment process.
- [ ] When referring to or working with HCS/DDA: Establish regular meetings to prioritize assessments and to discuss cases – include HCS/DDA and payer case manager to jointly address barriers.
- [ ] Discuss strategies to address these factors that may impact a patient's ability to use the discharge and medication plan 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.

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Information Exchange

- [ ] Identify post-acute partners who accept patients on weekends and holidays, update this information regularly and make it available to weekend providers.
- [ ] Collect standard patient characteristic data, identify potential patient discharge barriers, and begin comprehensive discharge planning prior to admission for elective admissions
- [ ] 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.
- [ ] 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).

Workflows

- [ ] 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
- [ ] 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

Patient/Family Coordination & Resources

- [ ] Provide patients and/or decision-makers the opportunity for medications to be filled prior to discharge from the hospital.
- [ ] 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.

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