Playbook for Complex Discharges

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About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

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Contents

2 Introduction and Background

4 Promising Practices

1. Put the patient's voice and wishes front and center
2. Understand local capacity, demand, and common pain points
3. Develop strong relationships to optimize coordination and outcomes
4. Clarify roles
5. Start care plans early, and plan beyond the next step
6. Be open to flexibility and compromise
7. Build and maintain information-sharing infrastructure for enhanced coordination

11 Patient Vignettes

12 Appendix A. Conditions Contributing to Complexity in Discharge

13 Appendix B. Additional Resources

14 Appendix C. Key Informants

16 Endnotes

Introduction and Background

Discharge planners increasingly face difficulties coordinating discharges for patients with complex needs who no longer require acute physical or behavioral health care but still need postacute or transitional care. Hospitals and nursing homes are encountering more patients with cognitive and functional impairments, along with increasing rates of homelessness, mental health conditions, and substance use disorders (SUDs).[1]

Increasing complexity of discharge needs and lack of housing with appropriate supports have contributed to California's nursing homes and hospitals caring for more patients with prolonged stays. A 2023 survey of California Hospital Association members across the state found that patients stay on average 16 days longer than needed at acute psychiatric hospitals and 14 days longer than needed at general acute hospitals.[2] This translates to one in five beds in acute psychiatry facilities and one in 16 beds in general acute hospitals being occupied by patients who are medically ready for discharge but face delays.[3]

There are numerous adverse outcomes for patients remaining at a higher level of care than they need. Prolonged stays can jeopardize patients' physical, cognitive, and emotional well-being and lead to loss of independence. Additionally, prolonged stays contribute to overall decreased system capacity from inefficient use of resources, provider burnout, financial strain on health systems, and patient safety issues as access to limited acute and postacute resources is compromised for other patients in need.[4]

This *Playbook for Complex Discharges* is a resource for leadership and frontline staff at organizations that serve people with complex discharge needs from acute hospitalizations or long-term care stays. It offers recommendations and considerations for how organizations can coordinate, collaborate, and partner effectively to serve their patients, clients, and members through collaborative planning, use of Medi-Cal benefits and services, and creative problem-solving.

This playbook is intended for people working at the following types of organizations:

- **Payers:** managed care plans (MCPs), mental health plans (MHPs) and Drug Medi-Cal (DMC) programs, or Drug Medi-Cal Organized Delivery System (DMC-ODS) programs
- **Health care providers:** hospitals, skilled nursing facilities, and recuperative care facilities

Additional people who may find this playbook useful include those working for county health and human services departments (including social services), Enhanced Care Management or Community Supports providers, Public Guardian/Public Conservator offices, Medi-Cal waiver programs, home health agencies, Permanent Supportive Housing agencies, Assertive Community Treatment (and other intensive behavioral health programs), outpatient behavioral health and addiction services, and other community-based programs and providers.

How can I use this playbook?

- To educate and increase awareness of community-based services such as ECM and Community Supports, which can help support a person's transition to the least restrictive setting
- To improve patient outcomes by implementing promising practices
- To encourage local and/or regional planning to address gaps in capacity for certain levels of care in the community

What makes a discharge complex?

Most discharges from an acute care facility or long-term care facility can be managed by staff in the facility who work with the patient and their physician to identify the best step-down placement. In a small subset of cases, however, patients with complex needs require more intensive, cross-sector coordination, necessitating creative problem-solving by a multidisciplinary team to implement the best approach and options for the patient.

The recommendations in this *Playbook for Complex Discharges* support planning for complex discharges, the subset of patient cases impacted by a combination of the needs identified in Table 1. Additional detail for each category is provided in Appendix A.

Table 1. Patient Needs That Would Qualify a Discharge as Complex, by Category

CATEGORY	PATIENT NEEDS
Physical health	Patient requires dialysis, treatment for complex wounds, injectable medications, ongoing infusions, indwelling catheters, or insulin for diabetes. Patient needs assistance with pain management, polypharmacy.
Behavioral health	Patient has serious mental illness (SMI), substance use disorder (SUD), anxiety and/or depression.
Cognitive impairment	Patient has difficulty concentrating, remembering or learning new things, or making decisions that affect everyday life. Patient has memory loss, difficulty recognizing familiar people, changes in mood or behavior, trouble exercising judgment such as what to do in an emergency, or difficulty planning and carrying out tasks. In some cases, supported decisionmaking such as conservatorship may be required.
Functional needs	Patient requires assistance with activities of daily living (ADLs; e.g., bathing, dressing) or instrumental activities of daily living (IADLs; e.g., preparing meals, taking prescriptions, using transportation, managing finances). Patient needs a wheelchair or other assistive devices for mobility.
Social needs	Patient is experiencing or at risk of homelessness, lacks Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI), is socially isolated (lacks friend or family support), or has a history of violence.

Sources: Author analysis of informant interviews conducted in 2024; and *Cognitive Impairment: A Call for Action, Now!* (PDF), Centers for Disease Control and Prevention (CDC), February 2011.

Why is this important now?

New services are available through Medi-Cal managed care plans: Under CalAIM (California Advancing and Innovating Medi-Cal), MCPs have new tools and incentives to support a comprehensive set of discharge options, especially for members without housing and those needing significant services and supports, such as help with activities of daily living (ADLs) or on-site medical services. Some key programs include the following:

- **Enhanced Care Management (ECM):** high-touch, person-centered care coordination for people with complex clinical and social needs. A member's ECM Lead Care Manager provides intense coordination across all delivery systems, ensuring alignment with the member's care plan and goals.[5]
- **Community Supports:** 14 community or home-based services, including housing navigation, tenancy and sustaining services, recuperative care, medically tailored meals, and others. Although

MCPs are not required to offer Community Supports, they can opt in to provide any of the services for eligible members.[6]

MCPs statewide now also bear financial risk for institutional long-term care and, as a result, have increased incentives to support people who wish to live in the community as opposed to an institution. For example, MCPs can use Community Supports to support member transitions to less restrictive settings such as licensed assisted living settings, helping to relieve skilled nursing facility (SNF) bottlenecks while delivering more cost-effective health care services.[7] MCPs are also required to provide Transitional Care Services to support members transferring from one level of care to another — e.g., hospital (general acute and psychiatric) or SNF.[8] Other programs such as the Housing and Homelessness Incentive Program (HHIP) incentivize MCPs to address homelessness in their local communities and encourage MCPs to make investments in the development of infrastructure and capacity, especially those that can resolve key gaps in care.

Increasing patient complexity and limited supply: The aging population, a surge in methamphetamine and fentanyl use over the past decade, and the increasing prevalence of homelessness are contributing to the increased demand for treatment beds and supportive services for people with complex needs. At the same time, facilities are closing (e.g., mental health facilities and board and care homes), and there are dramatic shortages of health care workers and available affordable housing, especially for people and families with low incomes.

As a result of these factors, hospitals are experiencing increases in average length of stay compared with prepandemic levels. At general acute hospitals, average length of stay has increased 6.3% from 2019 to 2023. The increase is even larger at acute psychiatric hospitals, 28.6% over the same period.[9]

Hospital staff report the following barriers in expediting discharge plans for complex patients[10]:

- The postacute facility denies admission due to patient complexity or inadequate reimbursement.
- The patient's postdischarge needs exceed provider capabilities.
- Patient's insurance does not cover the requested service.
- The health plan's provider network lacks facilities with available placements.
- The health plan delays or denies authorization.
- Patient consent issues are complex and challenging (e.g., conservatorship, family agreement and involvement, etc.).

Investments in treatment beds and housing outside MCPs: In the face of dramatic shortages in housing, billions of dollars are newly available for building infrastructure and capacity for people with complex needs. These new funding resources include Behavioral Health Transformation (Proposition 1), BH-CONNECT (Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment), Behavioral Health Continuum Infrastructure Program (BHCIP), and others.[11]

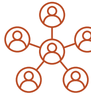
Promising Practices

In the management of complex discharges, several promising practices have emerged as effective strategies for interdisciplinary collaboration and coordination and patient-centered care. This section describes recommendations and themes collected through interviews with over 25 key informants across California, including hospital administrators, social workers, and discharge planners; representatives from regional and statewide hospital and health plan associations, MCPs,

MHPs, DMC, and DMC-ODS; and administrators and discharge planners at long-term care facilities, recuperative care facilities, In-Home Supportive Services (IHSS) programs, and other community-based programs. (For the full list of informants and their affiliations, see Appendix C.) Input from these interviews was synthesized into seven promising practices, which are applied at an individual patient level, at a systemwide level, or both, as indicated by icons beside each of the following subheads.

PROMISING PRACTICES	INDIVIDUAL PATIENT LEVEL	SYSTEM-LEVEL
1. Put the patient's voice and wishes front and center	✓	✓
2. Understand local capacity, demand, and common pain points		✓
3. Develop strong relationships to optimize coordination and outcomes		✓
4. Clarify roles	✓	
5. Start care plans early, and plan beyond the next step	✓	
6. Be open to flexibility and compromise	✓	
7. Build and maintain information-sharing infrastructure for enhanced coordination		✓

1. Put the patient's voice and wishes front and center



Incorporating the patient perspective through policy and practice at the provider or plan level, as well as through individualized care plan goals and discharge options, is crucial for improving health outcomes, increasing patient satisfaction, and empowering patients, especially during complex discharges.

On an individual level, centering the care plan on the patient's goals, preferences, and values can help ensure sustainability and success — plans that align with a patient's and family's goals are often more coordinated and have a higher likelihood of success. Patients empowered to define their own goals and outcomes will be more committed to meeting them than if goals are externally prescribed.[12] This approach, in turn, can lessen the stress on the care team and allow a deeper focus on creative problem-solving.

Strategies to ensure the patient voice in the care plan[13]

- Train care-planning teams in motivational interviewing and trauma-informed care.
- Incorporate patient goals, values, and preferences in assessments and documentation so they are considered up front (vs. being an afterthought).
- Include the patient and, if they wish, their family or caregiver in case conferencing.

Including patients or members on advisory boards or committees helps to ensure that the patient voice is represented. However, payers and providers should also adopt more proactive approaches for capturing the member experience to inform the development of patient-centered models and policies. Amplifying the patient voice can challenge and correct payer and provider assumptions

about patients, their preferences, how they view or choose to engage with health care, and potential solutions for system improvement. By establishing policies and practices that rely on patient input, organizations can enhance cultural competency and ensure the patient voices are integrated into decisionmaking.[14]

2. Understand local capacity, demand, and common pain points

Conducting or leveraging a needs assessment for your community can provide critical insight about where there are gaps in care or supply-demand mismatches, facilitating patient-level planning as well as community-wide planning. Developing resources listing the facilities and services in your local jurisdiction (along with their willingness to address some of the common challenges listed above) can not only directly support discharge-planning teams, but can also serve as an informal mechanism for identifying care gaps. MCPs and MHPs can support gap assessment through their own network strategy, leveraging any plans related to Medi-Cal network adequacy requirements and compliance. Another avenue to surface these issues is to create multi-entity working groups where insights and pain points can be shared and problem-solved collaboratively across impacted partners (see sidebar).

Multi-Entity Working Groups for Local Planning and Problem-Solving

Regular in-person convenings among key partners (MCPs, MHPs, DMC/DMC-ODS, hospitals, SNFs) can help to foster shared goals and shared accountability. Forums may be councils or collaboratives, with varying levels of formality and scope. Some collaboratives are led by county agencies and focus more on advocacy and policy — in San Diego, the county leads the Healthy San Diego Joint Consumer and Professional Advisory Committee, convening partners to discuss changes and opportunities for improving Medi-Cal managed care.[15] In San Mateo, the MCP leads a forum focused on problem-solving for individual patients/clients and has incorporated a formal memorandum of understanding to help define roles and participation, as well as bolster accountability. Service providers may also lead convenings — for example, in Los Angeles recuperative care providers established the Los Angeles Recuperative Care Learning Network, which brings together providers, health plans, hospitals, and other leaders on opportunities to grow capacity for medical respite services.[16] These types of forums can foster opportunities for shared problem-solving, which establishes a foundation of trust and goodwill that can continue to build over time. Regardless, it's important to create a forum where each stakeholder can articulate their own needs (e.g., SNFs asking for standard information from the hospital on a discharge), while also being responsive and accountable to each other.

Once needs are identified and community partners have convened and agree on priorities, a critical step in addressing gaps is identifying opportunities to pool and coordinate resources to co-fund and codesign programs and solutions. County agencies and health plans are eligible to receive state funding to develop and increase the capacity of treatment beds and housing; funding programs include the Behavioral Health Continuum Infrastructure Program (BHCIP), the Behavioral Health Bridge Housing (BHBH) Program, the Housing and Homelessness Incentive Program (HHIP), Homekey, and the Community Care Expansion (CCE) Program, among others. Although each program or initiative has its own unique programmatic requirements, there are overlaps and opportunities for awardees to optimize outcomes by coordinating across programs and agencies. For example, a community that has identified gaps in its care continuum related to interim housing could coordinate and pool together funding across BHBH and HHIP to

fund the start-up and development of new recuperative care or short-term posthospitalization housing options.

3. Develop strong relationships to optimize coordination and outcomes

Wide-ranging expertise and creative problem-solving are needed to identify discharge options for patients with complex physical, behavioral, and social health needs. While subject matter experts exist in each system, it is unrealistic for inpatient discharge planners to know all the resources across all payers and delivery systems. Developing a reliable network of partnerships helps to ensure the availability and consistent support of a multidisciplinary team with cross-cutting expertise to support a hospital or SNF's most complex cases.[17]

Although strong relationships can manifest on the ground within care teams and coordinators, they are most sustainable and effective when fostered through shared goals at all levels of leadership. Hospitals, long-term care facilities, managed care plans, and county behavioral health agencies must have strong relationships at all levels — from the C-suite to the director to frontline teams working on the ground — to request, approve, and execute authorizations and care transitions.

Discharges for complex patients often get stalled because of programmatic barriers — eligibility rules or restrictive policies that may be tied to funding limitations, regulatory guardrails, and lack of shared stakeholder knowledge/alignment. Strong relationships with county agencies and programs can help streamline processes and address systemic issues to better serve patients. The following are some ways in which county partnerships can help address barriers for complex discharges:

- Identify process improvements that support completion of an In-Home Supportive Services (IHSS) evaluation prior to discharge.

- Optimize referral processes for local programs such as the Community Living Fund (CLF) or the Aging and Disability Resource Connection (ADRC), which provide wraparound community supports to at-risk patients (see the Additional Resources section for links to non-MCP resources).

Strategies for building the relationships needed for complex discharges

- **Put in the time and prioritize people.** The relationships you need with people outside of your organization take an investment of time and effort — and are best when fostered through high-touch, consistent, and in-person interactions. This means being present and engaged at meetings, picking up the phone when needed, and making sure you know who people are and who does what at partner organizations. And when contacts transition out and new people come in, it also means you start again building new relationships.

- **Assign a single point of contact at your organization for your partners.** When discharge planners get stuck, they need to be able to reliably reach the health plan or county partners for assistance. This can be a one-to-one relationship where one health plan lead is assigned to a particular hospital or long-term care facility, or an interdisciplinary regional team that acts as the dedicated point of contact for a group of facilities. For MCPs, this could be the assigned long-term services and supports (LTSS) liaison position required by the California Department of Health Care Services (DHCS).[18]

- **Be available and reliable.** Discharges can happen any time of day or night, including weekends. If you are a payer organization, make sure your teams and/or contracted providers are available and responsive to discharge planners outside of

normal business hours. This goes beyond timely approval of authorizations and includes being available to help facilitate connections with community providers as part of care planning and discharge planning.

- **Visit the facility and get face time with partners.** It's hard to know how things work if you haven't seen them for yourself. As a payer and provider, visiting a skilled nursing facility, adult residential facility, or permanent supportive housing unit (for example) helps bring greater awareness of the setting — the strengths and capabilities of the facility — as well as trust and rapport needed for challenging placements. This awareness can also help foster a more patient-centered approach, where care planners have firsthand experience with placement options and can address patient-specific needs and concerns more directly.

4. Clarify roles

Decide who is the "quarterback"

The care team handling a complex discharge must have at least one "quarterback," or lead, that drives the coordination and advocates on the patient's behalf. It works best when the quarterback is aligned with the patient's primary needs or diagnoses (e.g., a SUD navigator when the patient's primary needs are SUD) but ultimately should be someone who is trusted by the patient, is proactive in reaching out to facilities for placements, and can effectively communicate across the multidisciplinary team.

For complex discharges, it's likely there will be an inpatient quarterback, who will ultimately hand things off to an outpatient quarterback. During discharge planning, these two quarterbacks will likely collaborate to surface available resources and options and will need to be in alignment with what success looks like for that patient. Both the inpatient and community-based teams need to be flexible and trust that everyone wants what is best for the patient.

Clarify the role of the managed care plan(s)

Clarifying payer responsibility between the MCP and other payers such as MHPs and Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS) is key to determining who should be the outpatient quarterback and what resources need to be coordinated. This is especially important for patients with multiple payers — people who are dually eligible for Medi-Cal and Medicare, and patients with co-occurring mental health, SUD, and physical health needs.[19]

How managed care plans (MCPs, MHPs, DMC/DMC-ODS) can support care teams with complex discharges

- Be more than a gatekeeper. Participate in care planning by offering options and solutions as well as explaining payer rules.
- Support member placements and enhanced services for patients who have both behavioral and physical health issues by considering cost sharing (e.g., MHP and MCP).
- Both MCPs and MHPs should expand their contracted networks to optimize access to services beyond minimum network adequacy requirements. When a letter of agreement is required (due to a separately negotiated reimbursement rate or because the facility is not contracted with the health plan), it should be expedited to allow for timely discharge.
- For MCPs: Align eligibility and operational processes for Community Supports with other MCPs in your service area to ease confusion and administrative burden for providers. For example, standardize authorization periods and reauthorization processes for housing navigation and tenancy and sustaining services, and offer streamlined and expedited authorization for

recuperative care so that patients aren't held up in the hospital if they are ready to be discharged.

- Update and share contracted provider networks with partners regularly — this ensures they have updated resources when developing care plans for patients — and provide guidance on authorization rules and processes, to ensure care planning and discharges can happen smoothly and expeditiously. For MCPs with delegated partners, overseeing utilization management (authorization rules and processes) will ensure delegated partners' compliance and alignment with the MCP's expectations, and is key to maintaining relationships and fostering flexibility and creative problem-solving.
- Ensure MHP and MCP staff, their contracted facilities, and providers are trained on benefits and services available — especially new programs available through Medi-Cal such as Enhanced Care Management (ECM), complex case management, and Transitional Care Services.

5. Start care plans early, and plan beyond the next step

Starting application processes for benefits like Medi-Cal, CalFresh, CalWORKs, Supplemental Security Income (SSI), or Social Security Disability Insurance (SSDI) as soon as possible after patient admission is imperative for optimizing options when the patient is ready to be discharged. Similarly, initiating assessments or evaluations for housing through Coordinated Entry, caretaker resources through In-Home Supportive Services (IHSS), or other waiver programs can help ensure services are available when needed. Inpatient teams can refer Medi-Cal patients for ECM in advance of discharge planning, helping to increase the likelihood an ECM Lead Care Manager can be assigned prior to discharge.

For many complex cases, it's not just about setting up services for the patient's discharge from A to B (e.g., hospital to medical respite), but making sure there are options identified and plans in place for the next step once the patient is ready to transition from B to C (e.g., medical respite to home or a residential care facility for the elderly). Multistep planning can strengthen relationships and increase the willingness of a postacute facility to accept a patient as partners are able to demonstrate their commitment to serving a patient across the care continuum.

Strategies for ensuring well-informed care plans

- **Be proactive.** As partners on the care team, managed care plans, mental health plans, and DMC/DMC-ODS plans can begin care planning as soon as they are notified of a patient's admission for an acute general hospital or acute psychiatric hospital stay. Health care plans are required to receive admission, discharge, and transfer (ADT) notifications to alert them of members admitted for inpatient or long-term care stays. Establishing standard processes for triaging ADT alerts can allow health plan staff to support the inpatient care team by initiating coordination with other clinical partners and providers, identifying potential discharge options based on contracted providers, and enrolling the patient in Community Supports or other wraparound support services.
- **Implement standardized screening tools to identify social drivers of health and inform care planning.** The Centers for Medicare & Medicaid Services (CMS) endorses the use of the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to inform care plans and make referrals to community services. Another nationally recognized tool is the PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) tool, which is used by health

centers and community partners, mostly in outpatient settings, to assess social risk factors. Implementing standardized, patient-centered screening and assessments can help identify and connect a patient to community-based services, but it is also imperative that providers optimize visibility to the assessments in order to reduce redundancy and burden on the patient being asked by multiple providers to respond to the same sensitive questions.

- **Train staff on best practices for chart documentation.** Ensure discharge planning and care management teams are aware of the impacts that negative documentation and "chart lore" (carrying chart notes through a patient's medical record without intentional validation of the condition) can have on a facility's willingness to accept a patient, even when they have stabilized and progressed by the time of their discharge.

6. Be open to flexibility and compromise

Complex discharges don't have easy solutions. Or one solution. Care teams need to be open to the need for compromise, which means considering multiple options within a shared set of goals. Oftentimes, the imperfect solution may be a better option than the status quo, allowing a patient to leave the hospital on a trial basis while the care team calibrates and reassesses. But this requires a willingness across the partners to be creative and explore alternatives, especially as they align with the patient's wishes and the patient's and caregiver's goals. Some examples of compromises or flexibilities include (1) leniency on a facility's policies — for example, a recuperative care provider being willing to adopt a harm reduction approach; (2) the MCP finding a provider to deliver needed services in an alternative setting — for example, home hemodialysis or a Community-Based Adult Services (CBAS) nurse to provide wound care; or (3) acquisition of a new certification to accommodate new patients — for example, a facility getting the required certification to dispense methadone.

7. Build and maintain information-sharing infrastructure for enhanced coordination

Disparate systems and electronic medical records lead to gaps in information that could facilitate coordination, especially for a complex discharge. Integrated systems of care undoubtedly benefit from centralized medical records and visibility for a care team, but for other systems, it is possible to build infrastructure that can help support care coordination.

Strategies to support care coordination through information sharing

- Obtain consent for information sharing — understand what the patient is comfortable with being shared across the care team (broadly defined) and what, if anything, they want to keep more private (see the Additional Resources section for a link to DHCS's Authorization to Share Confidential Medi-Cal Information [ASCMI] CalAIM Pilot).
- Collect standard patient characteristic data to identify complex needs, but also streamline and expedite MCP and MHP authorizations and facility approvals.
- Develop processes for sharing screenings and assessments, to reduce patient burden and streamline collection of patient information across the care team and provider network.
- Establish processes for sharing the assigned care coordinator with providers — if the patient has a case manager or ECM Lead Care Manager, develop processes for sharing this with the patient's medical group, assigned hospital, and other specialty or ancillary providers serving that patient.

- Enhance data-sharing pathways and partnerships through health information exchange, setting up notifications and alerts to the care team when a patient is admitted, and creating visibility to who is the assigned case manager or care coordinator.
- Develop a contact list for your organization to share with care coordination partners. Ideally, this resource would list a designated contact and their direct line. For MCPs, this list should include the LTSS liaison as well as other centralized points of contact designated to the provider or facility.

Patient Vignettes

This playbook is accompanied by four patient vignettes that highlight how the promising practices can help facilitate planning and coordination for a complex discharge. The vignettes offer insight on how different settings and services can facilitate complex discharge planning, how the roles on a care team can work in reality and also change over time for multistep discharges, and how alternatives should be considered, especially as they align with the patient's goals and wishes. Read these vignettes on the CHCF website.

- **Sky's Story:** Wound Care Recovery in Recuperative Care as a Bridge to Independent Housing
- **Elliott's Story:** Transitioning Home from Skilled Nursing After a Stroke
- **Luis's Story:** Transitioning Home After a Traumatic Brain Injury with End-Stage Renal Disease
- **Jesse's Story:** Skilled Nursing Facility to Residential Treatment Facility to Board and Care After a Spinal Cord Injury

Appendix A. Conditions Contributing to Complexity in Discharge

Table A1 lists conditions that, when compounded, can lead to increasing complexity for care teams planning discharge options. If more than one of the listed conditions applies, the discharge planning should be considered "complex" and necessitate an interdisciplinary approach that can surface creative problem-solving and options for discharge.

Table A1. Complex Conditions and Needs of Patients by Category

CATEGORY	CONDITION OR NEED
Physical health	Wound care Insulin-dependent diabetes Dialysis Injectable medications Ongoing infusions Indwelling catheters Pain management Polypharmacy
Behavioral health	Serious mental illness (SMI) Substance use disorder (SUD) Anxiety/depression (on their own, less likely to make a discharge complex)
Cognitive impairment	Assistance with: ➤ Decision making ➤ Memory ➤ Managing emotions ➤ Planning and carrying out tasks (including some ADLs and IADLs) ➤ Conservatorship
Functional needs	Mobility impairment (e.g., wheelchair use) Assistance with ADLs: ➤ Walking ➤ Feeding ➤ Dressing ➤ Grooming ➤ Toileting ➤ Bathing ➤ Transferring (e.g., from bed to chair or walker) Assistance with IADLs: ➤ Managing finances ➤ Managing transportation ➤ Shopping and errands ➤ Laundry ➤ Housework ➤ Meal preparation and cleanup ➤ Using a telephone

CATEGORY	CONDITION OR NEED
Social needs	Younger age (<60 years old), as people with complex needs who are younger may require arrangements for 20 years or longer Housing status (instability to unhoused) Lack of SSI or SSDI Isolation (lack of friend or family support) History of incarceration (e.g., history of violence or arson)

Sources: Author analysis from informant interviews conducted in 2024. ADLs and IADLs are defined at 42 CFR § 441.505, accessed September 10, 2024; for further discussion of these terms, see 77 Fed. Reg. 26828 (May 7, 2012).

Notes: *ADLs* are activities of daily living. *IADLs* are instrumental activities of daily living. *SSDI* is Social Security Disability Insurance. *SSI* is Supplemental Security Income.

Appendix B. Additional Resources

Table B1 provides links to a variety of additional resources, organized by topic.

Table B1. Additional Resources

TOPIC	RESOURCES
Staff training and education	Trauma-informed care: ➤ Trauma Transformed — Trauma Informed Tools ➤ Coldspring Center for Social and Health Innovation ➤ Center for Learning: National Alliance to End Homelessness — Providing Trauma-Informed Care in Homeless Response ➤ NIMRC — Trauma-Informed Care in Medical Respite Cultural competence: ➤ AHRQ — The SHARE Approach—Taking Steps Toward Cultural Competence: A Fact Sheet ➤ ASAM — Words Matter: Terms to Use and Avoid When Talking About Addiction ➤ JGIM — How to Reduce Stigma and Bias in Clinical Communication: A Narrative Review ➤ JGIM — Do Words Matter? Stigmatizing Language and the Transmission of Bias in the Medical Record ➤ JAMA Network Open — Physician Use of Stigmatizing Language in Patient Medical Records Shared care plan: ➤ AHRQ: The Academy — Develop a Shared Care Plan Motivational interviewing: ➤ CWRU: Center for Evidence-Based Practices — Motivational Interviewing Resources ➤ NHCHC — CalOptima: Intro to Motivational Interviewing
Patient consent	DHCS — CalAIM ASCMI Pilot

Table B1. Additional Resources

Screening and assessments	CMS — The Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool PRAPARE — PRAPARE Screening Tool DOR — Community Living Fund Program Assessment Tool
Non-MCP programs	DHCS — Multipurpose Senior Services Program CDA — Aging & Disability Resource Connection DOR — Community Living Fund
Complex discharges in Washington State	FHCQ: Bree Collaborative — Complex Patient Discharge Report and Guidelines HCA — Practices for Patients Who Are Difficult to Discharge

Source: Author review of current literature and resources conducted in 2024.

Notes: *AHRQ* is Agency for Healthcare Research and Quality. *ASAM* is American Society of Addiction Medicine. *ASCMI* is Authorization to Share Confidential Medi-Cal Information. *CalAIM* is California Advancing and Innovating Medi-Cal. *CDA* is California Department of Aging. *CMS* is Centers for Medicare & Medicaid Services. *CWRU* is Case Western Reserve University. *DHCS* is California Department of Health Care Services. *DOR* is California Department of Rehabilitation. *FHCQ* is Foundation for Health Care Quality. *HCA* is Washington State Health Care Authority. *JGIM* is *Journal of General Internal Medicine*. *MCP* is managed care plan. *NHCHC* is National Health Care for the Homeless Council. *NIMRC* is National Institute for Medical Respite Care. *PRAPARE* is Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences.

Appendix C. Key Informants

The authors are grateful to the people listed below and others who participated in interviews or feedback sessions and contributed their time, candor, and expertise to help inform this playbook. The playbook also benefited from review and feedback during small-group sessions with managed care plan chief medical officers and members of the California Hospital Association and California Association of Public Hospitals and Health Systems.

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Endnotes

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