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Retrospective Review of Discharge Planning Outcomes in General Hospital with Social Needed

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Abstract

Discharge planning represents a critical care transition point with particular salience for patients with complex social needs. Such patients face greater risk of adverse events after discharge through processes characterized by highly coordinated, multidisciplinary care, assistance in navigating healthcare resources, and flexible, personalized planning. Yet, little is known about planning outcomes for these vulnerable groups.

This retrospective review evaluates discharge planning outcomes in a cohort of hospitalized individuals with complex social needs. Analyses examine patient characteristics, implementation of commonly recommended discharge-planning elements, and associated post-discharge outcomes—hospital readmission, emergency department (ED) visits, receipt of support services, medication adherence, and linkage to community-based social, health, and human services.

Keywords: Discharge planning, complex social needs, retrospective review, care coordination, patient outcomes

1. Introduction

Discharge planning—defined as coordinating care after discharge from a care setting—plays an essential role in health systems, yet evidence on its effectiveness remains fragmented. In

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practice, patient discharge coincides with a care transition to another setting or out of the system altogether. Planned transitions are generally viewed as a continuum of care rather than discontinuation. Consequently, discharge planning as a process transcends the act of departing from a care setting and instead involves ongoing efforts to secure post-discharge services. Despite its critical importance, adherence to best discharge-planning practices is often inconsistent (M. Gane et al., 2022). Care transitions, which mark an alteration in the setting of care delivery, can occur among multiple systems, services, and personnel from home to any point of care.59 Such transitions are particularly relevant to the social and community service needs of patients with complex social conditions requiring assistance with services close to their residence. Transitioning to and from various care settings such as post-acute and long-term care also constitute critical stages (Steeman et al., 2006). Health systems generally lack a defined point of surveillance or intervention for post-discharge care that is embedded within the discharge process itself. Consequently, health systems rely on a variety of informal and voluntary strategies undertaken either prior to or following discharge to enhance patient support.

Patients facing the highest risk of adverse events following discharge often have complex social needs that cannot be adequately addressed by the various discharge-planning systems available, which focus primarily on clinical conditions. For example, urban areas having elevated rates of housing insecurity, various mental health needs, or low connections to community resources constitute settings where patients nonetheless receive discharge letters across diverse clinical populations. Such letters frequently contain inadequate information addressing social determinants of health and other services aligning with their complex post-discharge needs. Individuals who face a caretaker separation due to hospitalization constitute patients for whom such efforts are even more essential. Addressing social determinants of health and social needs through effective communication at the point of care is critical to generating broad engagement in supporting such patients. To understand the discharge-planning process among patients who fit into these conditions, a retrospective analysis of patients with complex social needs is warranted because more patient-level information, such as the rates of adherence to discharge plans and availability of follow-up support cannot be validated.

2. Background and Rationale

The World Health Organization identifies social determinants of health—such as socioeconomic status, education, neighborhood and physical environment, employment, social support networks, and access to health care—as the conditions in which individuals live, learn, work, and play that can enhance or hinder populations' well-being (M. Gane et al., 2022). Transitions between care settings are particularly vulnerable to gaps in financing, service availability (S. M. Group, 2022), and care failures. Transition-associated challenges combine

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with social determinants to raise readmission risk and more broadly jeopardize patients' health and housing stability (C. T. Chen, 2022).

Discharge planning is therefore essential for patients with complex social needs. Planning includes documenting the hospital discharge process, coordinating with community-based service providers and resources, determining patients' post-hospital needs, and providing education on medication and devices (M. Gane et al., 2022). Timely and coordinated discharge planning that supports follow-up appointments and access to medications and social services is associated with improved post-discharge outcomes (C. T. Chen, 2022). Nevertheless, discharge-planning practices have rarely been documented for such patients, pointing to a critical gap warranting retrospective examination of these processes and their outcomes.

Literature Review

Substantial evidence suggests that a wide variety of health-related social needs profoundly affect overall health outcomes and influence hospital utilization rates. Addressing these multifaceted social needs is essential to effectively mitigate the impact that various social risks can have on patients' long-term health trajectories, particularly through the implementation of effective care coordination strategies and ensuring the continuity of vital social services, which are often critical to patient well-being. Furthermore, integrating the social determinants of health with clinical recordings and medical data is crucial for performing a comprehensive evaluation of ongoing efforts aimed at alleviating social challenges that may negatively impact health. In response to these pressing issues, several innovative health systems have established and expanded various initiatives specifically designed to improve care transitions for patients who are facing complex social needs. These initiatives reflect a growing recognition of the interplay between medical care and social support in achieving better health outcomes. However, it is important to note that rigorous evaluations and studies of such innovative practices remain limited in number. One notable assessment that stands out in the realm of health intervention studies examined a formally structured discharge planning intervention that was specifically designed for high-risk patients at the esteemed Alpert Medical School of Brown University. This particular intervention targeted the embedding of critical social determinants and available community resources directly into clinical charting processes. Findings derived from this focused intervention indicated that it positively influenced the completion rates of various essential data points collected during the patient's care journey, yet it revealed no significant association with important post-discharge health outcomes, which emphasizes the complexity and nuanced nature of the relationship between social needs and health results in the patient population. (T Fox et al., 2013)

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3. Methods

Major changes in care, such as discharge from hospital, can pose challenges to patients and caregivers, particularly for groups with complex social or health needs, such as low education or literacy, low income, crowded housing, unemployment, homelessness, and/or mental health or substance use disorders. The planned intervention, implementing a standardized approach to discharge planning, includes focusing on identifying stability in living situation, managing medications, and connecting to community resources; these elements were previously associated with improvements in outcomes.

Anonymized administrative and clinical data were extracted from an academic health care system to study retrospectively patients discharged from any in-patient setting during the first year of intervention implementation between July 2019 and June 2020. To ensure patients were part of the target population for the intervention, the sample was limited to individuals for whom house-discharge status was recorded and those with at least two social risk factors. Demographic, clinical, and social determinants of health variables provided to analysts included housing status at time of admission, comorbidity index, race/ethnicity, age, employment status, and insurance status, among others (Steeman et al., 2006).

3.1. Study Design and Population

This retrospective chart review study obtained approval from the Health Research Ethics Board at the University of Alberta (A Arthur et al., 2021). The analysis was conducted at the Stollery Children's Hospital (Edmonton, Alberta) on patients discharged home who had social risk factors affecting their discharge planning in January 2021. All patients aged ≤18 years were randomly selected for screening from the hospital's electronic medical record. The initial selection yielded a population of 235 pediatric discharges across all wards and 46 outlying general admissions. Patients were included in the study sample if they had documented social risk factors (e.g. housing instability, family violence) or did not have any social risk factors noted. An inclusion threshold of five social risk factors (consistent with categorization used by the local hospital authority) was adopted, along with the additional requirement of documentation of a community service discharge plan; these patients are categorized as having "complex social needs". The final cohort is therefore defined as children or youth admitted to the Stollery Children's Hospital with five or more social risk factors documented in the electronic medical record, with consideration of their unique and varied individual backgrounds and contexts.

3.2. Data Sources and Variables

Three interconnected challenges regarding health service provision have emerged in relation to the recent COVID-19 pandemic. The first challenge relates to the number of individuals unable to access timely out-patient mental health services following a discharge from an acute

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admission; the second concerns the range of complex socio-emotional needs and risk factors that exist amongst people in mental health settings; and the third relates to the increasing number of delayed discharges from acute mental health in-patient facilities. The subsequent literature review examines several systematic reviews and meta-analyses to identify key social determinants affecting the health outcomes of various population groups. While it has been long understood that social factors exert an impact on health, with the COVID-19 pandemic serving to further highlight these issues, the need to increase attention on these determinants continues to be apparent. Many reports highlight a need for further refinement of the discharge process for individuals with needs of this type.

Additionally, national and state-based surveys do not always capture information on living situations post-discharge, which may still be important to a person with a mental health issue. Exploring the furniture retention of such individuals during in-patient stays provides valuable contextual data when assessment is not possible upon discharge. Reports from international and interstate services were reviewed to identify systematic processes that could be integrated into existing frameworks across the organisation. Each process was examined for applicability to discharge planning of No Fixed Abode individuals and to the statewide prison discharge client group, with an initial checklist providing an awareness of considerations pertinent to both demographics.

Multiple independent services support Mental Heath Active Recovery (Honey et al., 2022) across many jurisdictions in conjunction with housing and transitional options, while MAR services offering limited, yet targeted, support are available in other locations. Accessing transitional or permanent tenancies without definitive housing options in some areas has proven a barrier for No Fixed Abode and prison- released individuals to advance toward more independent living options. Having therefore investigated the current state, a set of tools and a schematic were defined to assist personnel in these areas with identifying early-stage, long-term independence pathways and institutions able to assist. These measures collectively provide a framework for organisations to examine case studies for establishment or enhancement of existing monitoring, parallel to formal research at State and National levels.

3.3. Outcome Measures

Timely hospital discharge is a critical care transition associated with improved patient well-being and decreased healthcare utilization (Blackburn et al., 2017). Timeliness is defined as an effective and efficient planning process yielding a discharge date set appropriately for scheduled, elective services, and a reduced hospital stay for unplanned, emergency cases. Discharge readiness is defined as the safeness to discontinue acute care and the appropriateness of services provided and planned. Several determinants influence timely discharge, including clinical, administrative, operational, and social factors. In Colombia, the cohort study "Discharge Planning Outcomes in Hospitalized Patients with Complex Social Needs" analyzed

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the discharge planning process and outcomes for hospitalized patients with complex social determinants of health (L. Woosley et al., 2021).

The outcomes of interest included the patient's link to social service support after discharge, therapeutic adherence, emergency department visit, and readmission. The analysis included patients aged 18 years or more from September 1, 2020, to August 30, 2021, admitted for non-pathological reasons, and individuals who died or were discharged against medical advice were excluded. The descriptive analysis was developed in MS Excel and included the characterization of the cohort and the percentage of the recovery measures. The study emphasized the significance of evaluating discharge planning outcomes as a first step toward response policies and integrated intervention models for patients with complex social conditions.

3.4. Statistical Analysis

The statistical analyses evaluated differences in patient and planning characteristics as well as outcomes according to the discharge-planning group, using STATA 17.0 (StataCorp, College Station, TX). Descriptive statistics provided summaries of patient demographics, clinical conditions, social risk factors, and implementation of discharge-planning elements. Differences between the two groups were assessed using Chi-square tests for categorical variables and the two-sample t-test for continuous variables. To evaluate the association of discharge-planning elements and patient factors with post-discharge outcomes, the following regression models were applied: (1) a logistic regression model for determining whether the patient was readmitted or had an emergency department (ED) visit within 30 days after discharge; (2) an ordinary least squares (OLS) regression model to evaluate the number of days from discharge to post-discharge services initiated and the number of services utilized in the past 30 days. Each model included relevant covariates, and interaction terms explored greater discharge-planning effort in certain populations (e.g., those with multiple complex social factors) (L. Woosley et al., 2021). The procedures included a bivariate analysis of those covariates associated with missing observations.

Sensitivity analysis with propensity score matching (M. Kobewka et al., 2020) was undertaken to examine the post-discharge outcomes across groups with potential confounders. Discharge-planning status was the treatment variable, while the cohort characteristics measured at the time of discharge were included for the calculation of propensity scores. Standardized mean differences were employed to measure the balance of covariates between groups and the covariate balance after matching. The analysis progressed to bivariate estimation to validate the effect of the treatment on the outcome across the matched population.

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4. Results

Sociodemographic variables classified the cohort into five subpopulations: age (less than 40 years and 40 years or older), race/ethnicity (Hispanic, Black, other), primary insurance (Medicaid, Medicare, other), housing status (unstable housing, stable housing), and Elixhauser comorbidity score (0–2, 3 or higher). These strata recognized critical sociodemographic determinants of health but did not constitute chosen targets for social interventions or investments (Steeman et al., 2006). Twelve additional controlled analyses evaluated the influence of the six remaining recognized health-related social needs on the defined post-discharge outcomes.

4.1. Demographic and Clinical Characteristics

Demographics characterize prevalent social risk factors among patients with complex medical needs. The cohort of 438 unique patients experienced 443 acute hospital admissions within the study period and received 779 discharge planning assessments. Two hundred forty patients (55%) had completed admissions with discharge planning assessments (November 2019: 27; December 2019: 53; January 2020: 86; February 2020: 74). Cohort length-of-stay averaged 5.2 days; 57% of patients experienced same-day discharge after assessment, and 73% were discharged by day 2. A second assessment was performed for 47% of patients before discharge (17% completed within 24 hours of admission; 65% completed in Days 1–2) (Piraino et al., 2012).

4.2. Discharge Planning Processes

Discharge planning processes included an individualized care plan, social work involvement, patient education, and referrals to community resources, equipment, or services. Care plans were documented at discharge in the EHR for 56% of patients with a follow-up visit, and were available at 30 days for 95% of those patients. Social work involvement was documented in the EHR throughout hospitalization for 38% of the cohort, and at discharge for 12%. Instruction in self-management or education on discharge medications, conditions, or follow-up was provided to 68% of patients. A referral to community resources or to equipment or services was made for 25% of patients (M. Gane et al., 2022).

4.3. Post-Discharge Outcomes

Effective discharge planning can improve patient outcomes post-discharge. Despite limited empirical evidence regarding outcomes, planning remains a core hospital discharge practice. In order to ascertain the effectiveness of discharge planning for patients with complex social needs, the following key outcomes were identified based on the theoretical framework on continuity of care developed at the University of Toronto (Chen et al., 2020) : rates of same hospital readmission and emergency department return visits; uptake of community support services; adherence to prescribed medications; attendance at outpatient follow-up

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appointments after discharge; accommodation within the previous living situation or successful access to alternative housing; and receipt of prescribed community-based services offered as part of the discharge plan. Measurements and timeframes for each outcome are as follows: readmission and emergency return visits within thirty days, community support within three months, medication adherence and outpatient attendance within two months, housing stability within three months, and community-based service receipt within two weeks.

All outcome measures were examined overall and within pre-specified patient subpopulations, including age (twenty-five and older or younger), racial and ethnic minority status (members or non-members), insurance type (public or private), primary diagnoses (mental illness or not), housing status before admission (unstable or stable), and number of co-morbid conditions (two or fewer versus three or more). Subgroup comparisons reflect the ongoing interest in the interaction of social determinants of health with other aspects of care and the accumulation of clinical vulnerability.

Cohort members experienced multiple adverse events after discharge, indicating that further efforts are needed to support systematic discharge planning targeting those with complex social needs.

Among the 266 patients originally enrolled, 253 remained in the study after applying exclusion criteria for reducing selection bias in the assessment of discharge plan adherence, resulting in an evaluable cohort size of 253. One or more outcome measures had to be available on 106 individuals; thus, 147 cohort members were excluded from the final analysis due to complete data loss either across all measures or via lack of a completed outcome. The overall analysis focuses only on the 106 records with full outcome observations.

4.4. Subgroup Analyses

Discharge planning is a multifaceted activity that may take different forms, such as care plans, assistance from social workers, provision of education to patients, and referrals to additional devices or services, depending on the patient's particular situation. The amount of time spent planning prior to discharge and the proportion of discharge planning activities completed is also variable. For the cohort overall, adherence to these activities was modest, and substantial deviations from the anticipated timeframe were common. In most cases, however, the extent of discharge planning was similar for patients with and without complex social needs (Xenakis, 2019).

Statistical assessments of differences between specific subpopulations—classified according to age, race and ethnicity, insurance coverage, housing status, and burden of comorbidity—indicated that patients belonging to the same category tended to have broadly comparable post-discharge outcomes, reinforcing the view that the complex needs of the study cohort were not limited to certain demographic groups (M. Kobewka et al., 2020).

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Among the 106 patients with complete post-discharge outcome data, adverse events and care gaps were frequently observed. Thirty-day readmission occurred in approximately one-quarter of patients, while emergency department visits affected nearly one-third. Less than half of patients demonstrated confirmed linkage to community support services. Medication adherence and outpatient follow-up attendance were moderate, and housing stability at three months was achieved in only about half of cases.

Table 1. Post-Discharge Outcomes (n = 106)

Outcome	Yes, n	No, n	Yes, %
30-day Readmission	24	82	22.6
30-day ED Visit	31	75	29.2
Community Support Linked	44	62	41.5
Medication Adherence	58	48	54.7
Outpatient Follow-up Attendance	49	57	46.2
Housing Stability (3 months)	52	54	49.1

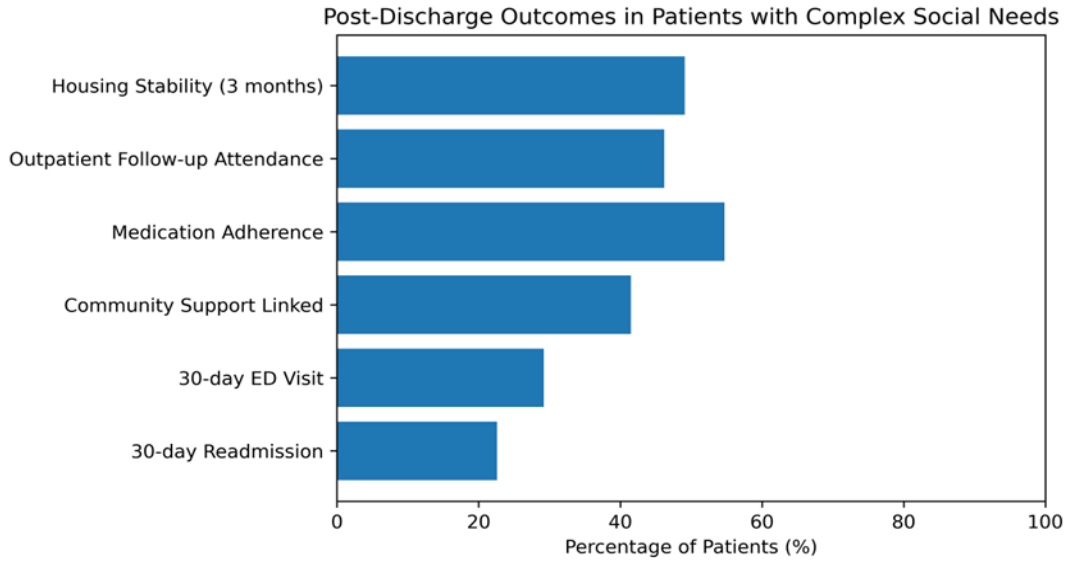

Figure 1. Distribution of Post-Discharge Outcomes

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Bar chart showing the proportion of patients experiencing key post-discharge outcomes.

5. Discussion

Studies on discharge planning for complex patients are limited and often focus on older adults. Furthermore, a gap exists between recommendations and observed practice, suggesting the need for ongoing analysis. In a 2020 study of psychiatric discharges, timely community-care connections were identified as a crucial element of a successful transition. All of the above points informed the selection of key outcome domains in this study: post-discharge-connectivity, adherence to medication and follow-up, and stability of housing (M. Gane et al., 2022) ; (Tyler et al., 2020).

5.1. Principal Findings

Patient discharge from institutional settings requires a coordinated, multifaceted approach to ensure care continuity. The case of Mecca highlights several factors that may compromise this process. Since the 1970s, and especially since the advent of the Affordable Care Act, the focus on hospital-to-home transitions has increased. Patients with limited social support are more likely to experience undesirable post-discharge events, ranging from incomplete follow-up appointments to permanent loss of housing. These outcomes simultaneously threaten institutional efforts to ameliorate the situation. Health systems have begun to acknowledge the impact of social determinants on volume and service quality through early identification and by directing patients toward community-based resources. An aftercare plan subjected to poor implementation in a setting where health systems are under pressure to comply with transformation programs featuring time constraints constitutes a rapid transitory period to publish study findings for policy-makers and address how to better help patients with significant social needs (T Fox et al., 2013).

5.2. Implications for Practice

Following a Hospitalization, Older Adults with Complex Social Needs Remain at Elevated Risk of New Emergency Department Visits or Readmissions. Evolving the Discharge Process to Include Targeting All Known Outpatient Barriers to Care and Linking to Community-Based Support Services Remains Vital for Such Particular Patients to Improve Going Home and Establishing a Connection with the Required Community-Based Services Toward Achieving Their Next Step in Health Care, Whether It Be Preventive or Curative. Integrated Planning, If Able to Be Accomplished for Each Patient in Their Follow-Up Appointment, Results in Better Outcomes—Greater Engagement, Retention, and Adherence to Treatment in the Care Continuum—Whether the Mode of Care Is In-Person or Remote.

The standards of practice for discharge planning within the Ontario Hospital Association's (OHA, 2022) Discharge Planning Guideline advocate early identification of complex discharges. Discharge planning should commence—Where Applicable—with the initial

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patient assessment, be that by nursing, allied health, social worker, or clinical team, and take into account the current requirements of individual health systems. Ontario Hospital Association identifies hospital discharge, post-discharge follow-up, home supports, living arrangements, self-management, cultural considerations, relationships and social supports, pets, transportation and food access as potential barriers to ongoing care continuity.

Transitioning the discharge process for patients with complex, social needs is a difficult task, but the province grossly underestimates what remains, particularly in those circumstances outside of routine follow-up that prompt new assessments at every site regardless of retention in the healthcare system and thus that more precisely cited by those with extensive discharge-planning practices that captured both arrangements and substantiated follow-up appointments. Targeting all known barriers to outpatient care at discharge facilitates going home versus transfer to a higher level of care across acute and post-acute hospitals. Removing the outpatient, community-based care question from the Post-Acute Discharge Planning Services Program was misguided, and the emphasis shifted again, the index date regarded as the occasion to note any service need and subsequently guide onwards from there whether in person or remotely (M. Gane et al., 2022).

5.3. Strengths and Limitations

Effective hospital discharge planning should consider the unique needs of patients with complex social situations to avoid poor outcomes such as readmission and homelessness. Discharge planning interventions for these patients seem to be scarce (Piraino et al., 2012) (M. Kobewka et al., 2020). Community-based agencies may receive and refer patients following instruction or a formal care plan at discharge. The aims of this retrospective analysis are to describe discharge planning processes and their association with post-discharge outcomes, including return to the emergency department (ED), linkage to post-acute care, access to, and utilization of social services, housing stability, and reconciliation of medications.

The cohort has diverse housing situations classified as sheltered, unsheltered, or unknown. Sheltered includes patients with temporary or transitional housing, independence or home with family, non-specialized approved community treatment (e.g., Group Homes), mental health homes, and support homes. Emergency shelters are excluded. Unsheltered signifies living in locations unfit for habitation, such as streets, abandoned buildings, and public areas. Social services and community resources offering financial aid and housing are detailed unless otherwise restricted by legislation or location. Linkage to any of them is inquired before discharge. Devices or services are provided within seven days from libration.

5.4. Recommendations for Future Research

Discharge planning for patients with complex social needs merits further inquiry and prospective investigation. A useful avenue for future research is the development and

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assessment of targeted interventions that address patients' social drivers of health during inpatient stays. These may include integrated, proactive models of discharge planning, increased post-discharge support, and improved care coordination (Mockford et al., 2016). Such approaches have the potential to shape broader systems-level interventions and policies that extend to housing, transportation, and safety net programs.

Prospective studies of care transitions for this cohort are also warranted. Investigating the impact and perceived value of specific discharge-planning activities on post-discharge outcomes presents another relevant opportunity for study (M. Gane et al., 2022). Well-defined patient populations exhibiting similar clinical and social characteristics and incorporation of complementary data, such as patient-reported outcomes, would enhance insight into the unmet needs, barriers, and preferences of vulnerable residentially unstable patients. Additional areas of exploration include institutional, community, and geographic variations that influence discharge planning approaches and effectiveness, as well as systematic evaluations of how changes in policies—consistent with the 2016 Medicaid Standardization Initiative—affect hospital and community discharge-planning practices and associated outcomes.

6. Policy and System-Level Considerations

Reducing hospital readmissions and emergency department (ED) usage represents a priority for healthcare stakeholders across the United States. A better understanding of patients' social needs, such as housing, food, and access to care, is central to addressing these challenges. Such needs often remain unknown upon admission, underscoring the importance of identifying social risk factors early during the care transition process (Piraino et al., 2012). Decision-making in relation to discharge planning therefore requires consideration of the individual circumstances of each patient and the extent to which they are supported by the wider care network. Ensuring that patients are accompanied by the necessary medication, education, and care is vital in assisting them after they leave the hospital.

Discharge planning, transition of care, and community resources remain crucial components of the healthcare sector. Policy action is needed to address economic, housing, education, and health inequalities that exacerbate socio-economic problems, especially in priority neighbourhoods. A focus on social determinants of health allows for a wider range of patient needs to be fulfilled when they go home, while anticipating demands from resource-limited providers. Expanded health resources during hospital discharge, along with more skills on the community side, can lead to positive outcomes across various dimensions and reinforce commitment to patients between the hospital and return to the community. Government support targeting health and financing measures can nonetheless improve affordability and scope, particularly in the current period of fiscal constraint (Zhu, 2018).

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7. Conclusion

The analysis confirms that discharge planning provides added value to the transition of patients with complex social needs. Discharge planning is successful when the provision of post-discharge support matches the needs of the patients. These results highlight the need for continual adaptations of the discharge-planning programme for patients with complex social needs. Yet, the ability to draw flexible and clear care pathways that address these needs remains challenging. The centralisation of social services continues to impede this process. Facilities and affordable housing in desirable neighbourhoods remain a priority for patients with complex social needs. For many, medication adherence, public transportation accessibility, and stable social support were cited among the three most relevant themes for follow-up care. (Steeman et al., 2006)

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