Southern California Continuum of Care Alliance of CoC Leaders

Survey Results Regarding SB 1152: Hospital Patient Discharge Process (prepared by Urban Initiatives)

A survey was created that included questions to see help determine how closely Southern California Continuums of Care (CoCs) were working with local hospitals to develop and implement a discharge planning policy and process in accordance with SB 1152 Hospital Patient Discharge Process: Homeless Patients, which amended Section 1262.5 of the Health and Safety Code to ensure that each hospital has a written discharge planning policy and process to prevent patients who are likely to suffer adverse health consequences upon discharge into homelessness.

The legislation requires a hospital to

- "develop a written plan for coordinating services and referrals for homeless patients with the county behavioral health agency, health care and social services agencies in the region, health care providers, and nonprofit social services providers, as available, to assist with ensuring appropriate homeless patient discharge. The plan shall be updated annually (Sec 2. Section 1262.5 (p))

Results of the survey questions are noted in the table below. Findings concerning the 13 Southern California CoCs include:

- 13 or all are aware of SB 1152;
- 11 are providing hospitals with available community resources, treatment, shelter, and other supportive services;
- 10 are meeting with local hospitals to ensure that hospitals have a written discharge planning policy and process for post-hospital care of homeless patients;
- 8 are ensuring that hospitals have access to your coordinated entry system;
- 3 are working with your County Health Information Exchange secure electronic sharing of patient health information;
- 2 are providing potential receiving agencies and providers written or electronic information written about the homeless patient's known post-hospital health and behavioral health care needs and the documentation of the name of the person at the agency or provider who agreed to accept the homeless patient;
- 2 are tracking homeless patients after discharge within their continuum of care;
- 0 are using their County Health Information Exchange to track homeless patients after discharge within their continuum of care.

Table 1. Survey questions and answers (Y=yes N=no)

		Glendale City	Imperial County	Kern County	Long Beach City	Los Angeles County	Orange County	Pasadena City	Riverside County	San Bernardino County	San Diego County	San Luis Obispo County	Santa Barbara County	Ventura County
1	Is your CoC aware of SB 1152 Hospital Patient Discharge Process: Homeless Patients?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2	Is your CoC meeting with local hospitals to ensure that hospitals have a written discharge planning policy and process for post-hospital care of homeless patients?	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y
3	Is your CoC providing hospitals with available community resources, treatment, shelter, and other supportive services?	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y
4	Is your CoC working with hospitals to ensure that hospitals provide potential receiving agencies and providers written or electronic information about the homeless patient's known post-hospital health and behavioral health care needs and the documentation of the name of the person at the agency or provider who agreed to accept the homeless patient?	Y	N	N	N	N	Y	N	N	Y	N	N	N	N
5	Is your CoC ensuring that hospitals have access to your coordinated entry system?	Y	Y	N	Y	Y	N	N	N	Y	N	Y	Y	Y
6	Has your CoC been able to track homeless patients after discharge within your continuum of care?	Y	N	N	Y	N	N	N	N	N	N	N	N	N
7	Is your CoC working with your County Health Information Exchange secure electronic sharing of patient health information?	N	N	N	Y	N	Y	N	N	Y	Y	N	N	N
8	Is you CoC using your County Health Information Exchange to track homeless patients after discharge within your continuum of care?	N	N	N	N	N	N	N	N	N	N	N	N	N

Summary of Requirements

Discharge planning policy and process requirements include:

- Providing each patient who has been admitted to the hospital as an inpatient with an opportunity to identify one family caregiver who may assist in posthospital care, and shall record this information in the patient's medical chart;

- Requiring that the patient's designated family caregiver be notified of the patient's discharge or transfer to another facility as soon as possible and, in any event, upon issuance of a discharge order by the patient's attending physician.
- Require that the patient and family caregiver be informed of the continuing health care requirements following discharge from the hospital.
- A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility or to the distinct part-skilled nursing or intermediate care service unit of the hospital. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, pain treatment and management, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan, and shall be signed by the physician.
- A hospital shall establish and implement a written policy to ensure that each patient receives, at the time of discharge, information regarding each medication dispensed
- A hospital shall provide every patient anticipated to be in need of long-term care at the time of discharge with contact information for at least one public or nonprofit agency or organization dedicated to providing information or referral services relating to community-based long-term care options in the patient's county of residence and appropriate to the needs and characteristics of the patient.
- Discharge planning policies adopted by a hospital in accordance with this section shall ensure that planning is appropriate to the condition of the patient being discharged from the hospital and to the discharge destination and meets the needs and acuity of patients.
- Hospital shall document the destination indicated by the homeless patient or his or her representative.
- Policy shall require that information regarding discharge or transfer be provided to the homeless patient in a culturally competent manner and in a language that is understood by the homeless patient.
- hospital shall document all of the following prior to discharging a homeless patient:
- Treating physician has determined the homeless patient's clinical stability for discharge, including, but not limited to, an assessment as to whether the patient is alert and oriented to person, place, and time, and the physician or designee has communicated post-discharge medical needs to the homeless patient.
- The homeless patient has been offered a meal, unless medically indicated otherwise.
- If the homeless patient's clothing is inadequate, the hospital shall offer the homeless patient weather-appropriate clothing.
- The homeless patient has been referred to a source of follow-up care, if medically necessary.
- The homeless patient has been provided with a prescription, if needed, and, for a hospital with an onsite pharmacy licensed and staffed to dispense outpatient medication, an appropriate supply of all necessary medication, if available.
- The homeless patient has been offered or referred to screening for infectious disease common to the region, as determined by the local health department.
- (7) The homeless patient has been offered vaccinations appropriate to the homeless patient's presenting medical condition.

- (8) The treating physician has provided a medical screening examination and evaluation. If the treating physician determines that the results of the medical screening examination and evaluation indicate that follow-up behavioral health care is needed, the homeless patient shall be treated or referred to an appropriate provider. The hospital shall make a good faith effort to contact one of the following, if applicable:
- (A) The homeless patient's health plan, if the homeless patient is enrolled in a health plan.
- (B) The homeless patient's primary care provider, if the patient has identified one.
- (C) Another appropriate provider, including, but not limited to, the coordinated entry system.
- (9) The homeless patient has been screened for, and provided assistance to enroll in, any affordable health insurance coverage for which he or she is eligible.
- (10) The hospital has offered the homeless patient transportation after discharge to the destination identified in paragraph (4) of subdivision (n), if that destination is within a maximum travel time of 30 minutes or a maximum travel distance of 30 miles of the hospital. This requirement shall not be construed to prevent a hospital from offering transportation to a more distant destination.
- A hospital shall develop a written plan for coordinating services and referrals for homeless patients with the county behavioral health agency, health care and social services agencies in the region, health care providers, and nonprofit social services providers, as available, to assist with ensuring appropriate homeless patient discharge. The plan shall be updated annually and shall include all of the following:
- (1) A list of local homeless shelters, including their hours of operation, admission procedures and requirements, client population served, and general scope of medical and behavioral health services available.
- (2) The hospital's procedures for homeless patient discharge referrals to shelter, medical care, and behavioral health care.
- (3) The contact information for the homeless shelter's intake coordinator.
- (4) Training protocols for discharge planning staff.
- (q) Each hospital shall maintain a log of homeless patients discharged and the destinations to which they were released after discharge pursuant to paragraph (10) of subdivision (o), if any. The hospital shall maintain evidence of completion of the homeless patient discharge protocol in the log or in the patient's medical record.