Sample Language for Homeless Patient Discharge Planning Policy

Hospitals may wish to consider including some or all of the following language to their current discharge planning policy as a part of the process of complying with California's homeless patient discharge planning law. This language does not constitute a comprehensive hospital discharge planning policy — it is meant to assist hospitals in supplementing their current policy. Hospitals should work with their legal counsel to develop a comprehensive, compliant policy.

1. The purpose of this policy is to help prepare the homeless patient for return to the community by connecting him or her with available community resources, treatment, shelter, and other supportive services.
2. Nondiscrimination policy: Housing status will not be used to discriminate against a patient or prevent medically necessary care or hospital admission.
3. This policy applies to patients discharged from an inpatient unit, emergency department, ____ _____ *[add ambulatory surgery centers or other locations where this policy applies]*.
4. The *[hospital to determine: nurse, discharge planner, social worker, other]* assigned to the patient will ask each patient if he or she is homeless. A homeless patient is an individual who:
    - Lacks a fixed and regular nighttime residence, or
    - Has a primary nighttime residence that is a supervised publicly- or privately-operated shelter designed to provide temporary living accommodations, or
    - Is residing in a public or private place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.

The hospital may wish to use CHA's "Questionnaire to Determine Whether a Patient is Homeless as Defined in State Law" (DP Form 1-B) to assist.

5. The *[hospital to determine: nurse, discharge planner, social worker, other]* will document the patient's answer or refusal to state by _____ *[entering into specified field in electronic health record, filling out a form, or other method; hospital to determine]*.
6. All information about discharge will be provided to the homeless patient in a culturally competent manner.
7. The *[hospital to determine: discharge planner, case manager, social worker, other]* will prepare an individual discharge plan for each homeless patient. Discharge planning will be guided by the best interests of the homeless patient, his or her physical and mental condition, and his or her preferences for placement.
8. A post-discharge destination will be identified for each patient, which may be:
    a. A social services agency, nonprofit social services provider, or governmental services

provider that has agreed to accept the patient. The *[hospital to determine: discharge planner, case manager, social worker, other]* must document the name of person at the receiving agency or shelter who agreed to accept the patient. The *[hospital to determine: discharge planner, case manager, social worker, other]* must send the receiving entity written or electronic information about the patient's post-discharge health and behavioral health needs. *[If the hospital already uses a form to document the patient's post-discharge needs, the hospital may specify that a copy of that form will be emailed or sent in another way to the receiving agency.]*

b. The homeless patient's **"residence,"** which is defined as "the location identified to the hospital by the patient as his or her principal dwelling place."

c. An alternative destination, as indicated by the homeless patient.

The hospital will not "cause the transfer" of a homeless patient to another county for the purpose of receiving supportive services from a social services agency, health care service provider, or nonprofit social services provider in the other county, unless the hospital has received prior authorization from the receiving entity to accept the specific patient.

9. Each homeless patient will be offered the following services prior to discharge:

   a. The patient will be offered a physical exam and the physician will determine the patient's stability for discharge.

   b. The patient will be given referrals for any needed follow-up care, both medical and behavioral, as determined by the treating physician. Referrals will include: *[hospital to determine: the provider's name, address and phone number to make an appointment, other information]*. If follow-up behavioral health care is recommended, the *[hospital to determine: nurse, discharge planner, social worker, other]* will contact the patient's health plan or primary care provider or other provider (including entry into coordinated entry system), if applicable. *[**NOTE:** If the hospital has a standard policy about notifying the primary care physician of each encounter, refer to that policy, as appropriate. If the hospital is located in an area with a coordinated entry system, put details about how to enter patients into the system here.]*

   c. The patient will be offered a meal. *[Hospital to add details about whether this will be an inpatient tray or "to-go," how to coordinate with dietary department, etc.]*

   d. If the patient's clothing is not weather-appropriate, the patient will be offered weather-appropriate clothing. *[Hospital to add any details about how clinical staff or discharge planning staff obtains clothing, documents clothing requisition, etc.]*

   e. The patient will be provided discharge medications as determined by the treating physician. *[Hospital to add details about how this will be coordinated.]*

   f. The hospital will *[offer homeless patients or refer homeless patients for]* infectious disease screening. *[Hospital to add details about which diseases (if any) the local health department has determined are common to the region; if the hospital will screen homeless patents for these diseases, and if so by whom; or if patients will be referred for screening, and if so, the referral location and contact information.]*

g. The patient will be offered vaccinations appropriate to his or her presenting medical condition, as determined by the treating physician.

h. The patient will be offered transportation to his or her chosen discharge destination, if that destination is within 30 miles or 30 minutes of the hospital. *[Hospital to add details about how this will be coordinated.]*

i. The patient will be screened for, and helped to enroll in, any affordable health insurance coverage for which he or she is eligible. *[Hospital to add details about how this will be coordinated.]*

j. Hospital to add information here about documentation requirements. The hospital may wish to use CHA's "Homeless Patient Discharge Planning Worksheet" (DP Form 1-A) to assist.

10. The *[hospital to determine: nurse, discharge planner, social worker, other]* will add each homeless patient to the homeless patient log. *[Add details about the log – electronic, paper, etc.]*

11. The hospital coordinates services and referrals for homeless patients with:

    [List, as applicable:

    - County behavioral health agency
    - Health care and social services agencies in the region
    - Other health care providers
    - Nonprofit social services providers]

[The plan must include referral procedures and a list of local homeless shelters and their:

- Hours of operation
- Admission procedures/requirements
- Population served
- General scope of medical and behavioral health services available
- Contact information for intake coordinator]

12. Training. *[Hospital to describe training protocols for discharge planning staff.]*