

# CALIFORNIA'S DISCHARGE PLANNING LAW

*The following laws were in effect prior to Jan. 1, 2019:*

## **HEALTH AND SAFETY CODE SECTION 1262.4.**

- (a) No hospital, as defined in subdivisions (a), (b), and (f) of Section 1250, may cause the transfer of homeless patients from one county to another county for the purpose of receiving supportive services from a social services agency, health care service provider, or nonprofit social services provider within the other county, without prior notification to, and authorization from, the social services agency, health care service provider, or nonprofit social services provider.
- (b) For purposes of this section, “**homeless patient**” means an individual who lacks a fixed and regular nighttime residence, or who has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations, or who 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.

## **HEALTH AND SAFETY CODE SECTION 1262.5**

- (a) Each hospital shall have a written discharge planning policy and process.
- (b) The policy required by subdivision (a) shall require that appropriate arrangements for posthospital care, including, but not limited to, care at home, in a skilled nursing or intermediate care facility, or from a hospice, are made prior to discharge for those patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. If the hospital determines that the patient and family members or interested persons need to be counseled to prepare them for posthospital care, the hospital shall provide for that counseling.
- (c) As part of the discharge planning process, the hospital shall provide 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.
  - (1) In the event that the patient is unconscious or otherwise incapacitated upon admittance to the hospital, the hospital shall provide the patient or patient’s legal guardian with an opportunity to designate a caregiver within a specified time period, at the discretion of the attending physician, following the patient’s recovery of consciousness or capacity. The hospital shall promptly document the attempt in the patient’s medical record.
  - (2) In the event that the patient or legal guardian declines to designate a caregiver pursuant to this section, the hospital shall promptly document this declination in the patient’s medical record, when appropriate.
- (d) The policy required by subdivision (a) shall require 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. If the hospital is unable to contact the designated caregiver, the lack of contact shall not interfere with, delay, or otherwise affect the medical care provided to the patient or an appropriate discharge of the patient. The hospital shall promptly document the attempted notification in the patient’s medical record.

- (e) The process required by subdivision (a) shall require that the patient and family caregiver be informed of the continuing health care requirements following discharge from the hospital. The right to information regarding continuing health care requirements following discharge shall also apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient, if the patient is unable to make those decisions for himself or herself. The hospital shall provide an opportunity for the patient and his or her designated family caregiver to engage in the discharge planning process, which shall include providing information and, when appropriate, instruction regarding the posthospital care needs of the patient. This information shall include, but is not limited to, education and counseling about the patient's medications, including dosing and proper use of medication delivery devices, when applicable. The information shall be provided in a culturally competent manner and in a language that is comprehensible to the patient and caregiver, consistent with the requirements of state and federal law, and shall include an opportunity for the caregiver to ask questions about the posthospital care needs of the patient.
- (f)
- (1) 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.
  - (2) A copy of the transfer summary shall be given to the patient and the patient's legal representative, if any, prior to transfer to a skilled nursing or intermediate care facility.
- (g) 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, pursuant to Section 4074 of the Business and Professions Code.
- (h) 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. At a minimum, this information shall include contact information for the area agency on aging serving the patient's county of residence, local independent living centers, or other information appropriate to the needs and characteristics of the patient.
- (i) A contract between a general acute care hospital and a health care service plan that is issued, amended, renewed, or delivered on or after January 1, 2002, shall not contain a provision that prohibits or restricts any health care facility's compliance with the requirements of this section.
- (j) 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.
- (k) This section does not require a hospital to do any of the following:
- (1) Adopt a policy that would delay discharge or transfer of a patient.

- (2) Disclose information if the patient has not provided consent that meets the standards required by state and federal laws governing the privacy and security of protected health information.
- (3) Comply with the requirements of this section in an area of the hospital where clinical care is provided, unless medically indicated.
- (l) This section does not supersede or modify any privacy and information security requirements and protections in federal and state law regarding protected health information or personally identifiable information, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg).
- (m) For the purposes of this section, “**family caregiver**” means a relative, friend, or neighbor who provides assistance related to an underlying physical or mental disability but who is unpaid for those services.

*The following law, which is a continuation of the above law, takes effect on Jan. 1, 2019:*

- (n)
  - (1) Each hospital, as defined in subdivisions (a), (b), and (f) of Section 1250, shall include within its hospital discharge policy a written homeless patient discharge planning policy and process.
  - (2) The policy shall require a hospital to inquire about a patient's housing status during the discharge planning process. Housing status may not be used to discriminate against a patient or prevent medically necessary care or hospital admission.
  - (3) The policy shall require an individual discharge plan for a homeless patient that helps prepare the homeless patient for return to the community by connecting him or her with available community resources, treatment, shelter, and other supportive services. The discharge planning shall be guided by the best interests of the homeless patient, his or her physical and mental condition, and the homeless patient's preferences for placement. The homeless patient shall be informed of available placement options.
  - (4) Unless the homeless patient is being transferred to another licensed health facility, the policy shall require the hospital to identify a post discharge destination for the homeless patient as follows, with priority given to identifying a sheltered destination with supportive services:
    - (A) A social services agency, nonprofit social services provider, or governmental service provider that has agreed to accept the homeless patient, if he or she has agreed to the placement. Notwithstanding paragraph (2) of subdivision (k) and subdivision (l), the hospital shall provide potential receiving agencies or providers written or electronic information about the homeless patient's known posthospital health and behavioral health care needs and shall document the name of the person at the agency or provider who agreed to accept the homeless patient.
    - (B) The homeless patient's residence. In the case of a homeless patient, “residence” for the purposes of this subparagraph means the location identified to the hospital by the homeless patient as his or her principal dwelling place.

- (C) An alternative destination, as indicated by the homeless patient pursuant to the discharge planning process described in paragraph (3). The hospital shall document the destination indicated by the homeless patient or his or her representative.
- (5) The 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.
- (o) The hospital shall document all of the following prior to discharging a homeless patient:
  - (1) The 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.
  - (2) The homeless patient has been offered a meal, unless medically indicated otherwise.
  - (3) If the homeless patient's clothing is inadequate, the hospital shall offer the homeless patient weather-appropriate clothing.
  - (4) The homeless patient has been referred to a source of follow-up care, if medically necessary.
  - (5) 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.
  - (6) 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.

***The following law, which is a continuation of the above law, takes effect on July 1, 2019:***

- (p) 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.
- (r) For purposes of this section, "**homeless patient**" has the same meaning as provided in Section 1262.4. [**NOTE:** this definition is effective Jan. 1, 2019]
- (s) It is the intent of the Legislature that nothing in this section shall be construed to preempt, limit, prohibit, or otherwise affect, the adoption, implementation, or enforcement of local ordinances, codes, regulations, or orders related to the homeless patient discharge processes, except to the extent that any such provision of law is inconsistent with the provisions of this section, and then only to the extent of the inconsistency. A local ordinance, code, regulation, or order is not deemed inconsistent with this section if it affords greater protection to homeless patients than the requirements set forth in this section. Where local ordinances, codes, regulations, or orders duplicate or supplement this section, this section shall be construed as providing alternative remedies and shall not be construed to preempt the field.
- (t) Nothing in this section alters the health and social service obligations described in Section 17000 of the Welfare and Institutions Code.
- (u) Subdivisions (n) to (t), inclusive, do not apply to the state hospitals under the jurisdiction of the State Department of State Hospitals, as specified in Sections 4100 and 7200 of the Welfare and Institutions Code. [**NOTE:** This exemption is effective Jan. 1, 2019]