

Audience:

Inpatient and OB Nurses

- **Discharge Planning for Homeless Patients to Comply with Senate Bill 1152**

Effective 1/1/2019, SB 1152 requires hospitals to provide discharge planning for homeless patients.

- **Purpose** is to help prepare homeless patients for return to the community by connecting them with available community resources, treatment, shelter, and other supportive services.
- The law does not require hospitals to find or create service that do not exist in the community.

The following services must be offered to homeless patients before discharge:

- Physician Examination and determination of stability for discharge
- Referral for follow up care
- Referral for behavioral healthcare if it's determined that the patient requires it
- Food
- Weather appropriate clothing
- Discharge medications (prescription)
- Infectious Disease Screening
- Vaccinations appropriate to the presenting medical condition
- Transportation within 30 minutes or 30 miles of the hospital

Homeless Discharge Planning Workflow

1. **Nursing** will identify if patient is homeless during initial assessment in the Navigators.
 - An automatic consult to Social Work is initiated.

IP RN Housing Status Flowsheet in Discharge Planning of Admission Navigator

IP RN Housing Status Flowsheet in Discharge Planning of Admission Navigator

Navigators

Admission | Transfer | Discharge

Discharge Planning Review - IP Discharge Planning

Time taken: 1654 | 12/27/2018 | Show: ☐ Row Info ☐ Last Filed ☐ De

Values By | Create Note

Discharge Planning

*Prior Living Situation

<input type="checkbox"/> Alone	<input type="checkbox"/> Apartment	<input type="checkbox"/> Assisted living
<input type="checkbox"/> Caregiver	<input type="checkbox"/> Children	<input type="checkbox"/> Condominium
<input type="checkbox"/> Family members	<input type="checkbox"/> Foster Care	<input type="checkbox"/> Friends
<input type="checkbox"/> Group Home	<input checked="" type="checkbox"/> Homeless	<input type="checkbox"/> House
<input type="checkbox"/> Incarcerated	<input type="checkbox"/> Mobile home	<input type="checkbox"/> Parents/Legal G...
<input type="checkbox"/> Roommates	<input type="checkbox"/> Senior housing	<input type="checkbox"/> Shelter
<input type="checkbox"/> Single Resident ...	<input type="checkbox"/> Skilled Nursing ...	<input type="checkbox"/> Spouse/Partner
<input type="checkbox"/> Subacute/LTAC	<input type="checkbox"/> Other (Comment)	

Stairs in home ☐ Yes ☐ No

*Support Systems ☐ None ☐ Spouse/significant other

OB RN Housing Status Flowsheet in Triage Navigator

OB Navigators

Open Case C-Section Charging

Triage Admission Shift Assessment Transfer Discharge

ARRIVAL

Arrival Info

Chief Complaint

Patient Profile

Episodes

Dating

Prenatal Labs

History

Allergies

OB Providers

Prenatal Assessm...

DOCUMENTATION

Telephone Triage

Vitals and Screeni...

Enter Results

FHR

Uterine Activity

Membrane Status...

Cervical Exam

LDAs

Additional Tests

Interventions

Provider Notify

NST/AFI

Housing Status

Note

Care Handoff

Housing Status - Housing Status

Time taken: 1348 12/27/2018

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Values By Create Note

Housing Status

*Prior Living Situation

☐ Alone ☐ Apartment ☐ Assisted living

☐ Caregiver ☐ Children ☐ Condominium

☐ Family members ☐ Foster Care ☐ Friends

☐ Group Home ☒ Homeless ☐ House

☐ Incarcerated ☐ Mobile home ☐ Parents/Legal G...

☐ Roommates ☐ Senior housing ☐ Shelter

☐ Single Resident ... ☐ Skilled Nursing ... ☐ Spouse/Partner

☐ Subacute/LTAC ☐ Other (Comment)

*Type of Residence

☐ Private residence ☐ Homeless

☐ Group home ☐ Assisted living

☐ Home care staff ☐ Nursing home

☐ Other (Comment)

Restore Close Cancel Previous Next



If patient requires Social Work specific interventions to facilitate discharge and Social Work is unavailable, patient is held until appropriate linkage to community resources can be made.

- Nursing, and or Social Work and Case Management in collaboration with the patient's providers must complete Homeless Discharge Documentation which is required prior to patient discharge.

OB RN Homeless Discharge Flowsheet in Discharge Navigator

OB Navigators

Open Case C-Section Charging

Triage Admission Shift Assessment Transfer **Discharge**

DISCHARGE

BestPractice

Unresulted Labs

Outstanding Imm...

MAR Link

Running Infusions

LDA Removal

Patient Belongings

Review D/C Orders

Set Home Pharm...

Manage Orders

Progress Note

DC Checklist

DC Disposition

Homeless Dischar...

Remise

Homeless Discharge

The discharge plan is intended to help prepare the patient for return to the community by connecting him or her with available community resources, treatment, shelter, and other supportive services. The plan must be guided by the patient's best interests, physical and mental condition, and preferences for placement. The patient must be informed of placement options. The available community options for this patient are:

Discharge Destination:

Social services agencies, nonprofit social services providers, and/or government agencies

Any location the patient identifies as his/her principal dwelling place

Any other desired discharge destination indicated by patient or their representative

patient declined to state where he/she will go after discharge

Discharge Requirements

Transportation

☐ transport provided

patient declined offer of transport

transport not offered due to distance

IP RN Homeless Discharge Flowsheet in Discharge Navigator

Navigators

Admission Transfer **Discharge**

DISCHARGE
BestPractice
Review D/C Dispo
D/C Disposition
Homeless Dischar...
Outstanding Imm...
MAR Link

Homeless Discharge

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3. Homeless Discharge Flowsheet Specifics.

Homeless Discharge

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patient declined to state where he/she will go after discharge

▼ **Discharge Requirements**

Transportation ☐ transport provided

patient declined offer of transport

transport not offered due to distance

transport not offered since patient declined to state destination

Meal ☐ meal provided

meal medically contraindicated

patient declined offer of meal

Clothing ☐ patient's clothing adequate for weather

weather-appropriate clothing provided

patient declined offer of weather-appropriate clothing

Medications ☐ appropriate supply of all necessary medications provided

only prescription provided

no medications prescribed

patient declined offer of prescription and medications

▼ **Follow-up Care**

The physician or designee must communicate post-discharge medical needs to the patient. The person who communicated post-discharge medical needs to the patient was:

Physician/Designee Name:

The patient was given a medical screening exam and evaluation, and the physician has determined:

Follow-up ☐ is needed ☐ is NOT needed

Behavioral Health Care

Please contact Molly Shane, RN at Molly.Shane@ucsf.edu, with questions.

Click here the APeX Knowledge Bank- <http://myapex.ucsf.edu/>

Always Remember Your Responsibilities for Use for the Electronic Health Record

Apex is the legal electronic health record for patients at the UCSF Medical Center. All users have the following responsibilities:

- Assure that all information is entered correctly and accurately and within your scope of practice.
- Stay up to date on changes in Apex.
- Follow all UCSF Policies & Procedures on use of the electronic health record.
- Report any issues or problems to your Manager and/or IT Service Desk at (415) 514-APeX (2739)