**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.
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.

2. 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.
3. Homeless Discharge Flowsheet Specifics.

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:

- 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
  - 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 Behavioral Health Care**
  - is needed
  - is NOT needed

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