Discharge and Aftercare Plans Impact Recovery

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Fundamentals

- GACH v. APH
- Medicare participating provider
- Inpatient v. outpatient
- Privacy
  - LPS v. CMIA v. Part 2, plus HIPAA
  - Adult v. minor
  - We’ll assume patient authorizes discussion

Minors Receiving MH or Substance Abuse Treatment

- Inpatient care – parental consent unless emancipated, self-sufficient, active duty, married/previously married
- Outpatient care
  - 12 or older: patient, if mature enough to participate intelligently, except psychotropic drugs, ECT, psychosurgery
  - Under 12: parental consent
Lanterman-Petris-Short Act

• Upon request of family or other person designated by patient, if patient authorizes, must tell:
  – Dx, prognosis, meds prescribed, side effects, and progress of patient
• Must notify patient this info was requested
• Other information: discretionary, need patient authorization (not required to be in writing under LPS)

HIPAA

• Can disclose to family, close personal friend, or other person identified by the patient, the medical information directly relevant to that person’s involvement with the patient’s care if patient agrees
  • Otherwise, need patient authorization (written)
Part 2 of Title 42 of Code of Federal Regulations

- Applies to federally-assisted substance abuse programs
- “Federally-assisted” = tax-exempt, operating under federal license/certification/registration or other authorization (including Medicare certification, certification to conduct opioid treatment, DEA registration), or getting federal funds

- “Program” = an individual or entity that holds itself out as providing alcohol or drug abuse dx/tx or referral for tx
- Or, if a general medical facility, it has:
  - An identified unit
  - Medical personnel whose primary function is provision of substance abuse dx/tx/referral and are identified as such providers
Part 2 of Title 42 of Code of Federal Regulations

- Need patient written authorization

Confidentiality of Medical Information Act

- Civil Code § 56 et seq.
- Everyone not covered by LPS or Part 2
- Plus HIPAA
Confidentiality of Medical Information Act

• Can disclose to family, close personal friend, or other person identified by the patient, the medical information directly relevant to that person’s involvement with the patient’s care

• If the patient is present or available prior to disclosure and has capacity to make health care decisions, the provider must:
  – Obtain the patient’s agreement.
  – Provide the patient with the opportunity to object to the disclosure, and the patient does not express an objection.
  – Reasonably infer from the circumstances, based on the exercise of professional judgment, that the patient does not object to the disclosure. This provision does not apply to a “psychotherapist” as defined in Evidence Code Section 1010

Evidence Code Section 1010

• MD who devotes a substantial portion of his or her time to the practice of psychiatry
• Psychologist, LCSW, MFT, professional clinical counselor, interns/trainees
• RN with master’s degree in psychiatric-mental health nursing who is listed as a psychiatric-mental health nurse by BRN
• Advanced practice RN certified as a clinical nurse specialist who participates in expert clinical practice in the specialty of psychiatric-mental health nursing
Discharge Planning CoP

- Applies to Medicare-participating GACH, APH (all pts, not just Medicare pts)
- Hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge plan
- Hospital must provide a discharge planning evaluation to patients identified above, AND to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician
  - Must tell pt, rep, MD of the right to obtain plan

Discharge Planning CoP

- Must evaluate likelihood of a patient needing post-hospital services
- Must evaluate patient's capacity for self-care or care in the environment from which s/he entered the hospital
- Timely evaluation so appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge
Discharge Planning CoP

- Hospital must arrange for the initial implementation of the patient's discharge plan
- As needed, the patient and family/friends must be counseled to prepare them for post-hospital care

Discharge Planning CoP

- For managed care patients, the hospital must indicate the availability of home health and post-hospital extended care services through contracted providers
State Operations Manual

- Currently, discharge planning required for inpatients only
- However, CMS states that “Given the increasing complexity of services offered in the outpatient setting, many of the same concerns for effective post-hospital care coordination arise as for inpatients.”

State Operations Manual

- Hospitals must actively involve patients/reps throughout the discharge planning process
- To assess patient’s capability for post-discharge self-care, must actively solicit information from patient/rep and family/friends/support persons
State Operations Manual

- Hospital “well-advised” to assume that every inpatient requires a discharge plan to reduce the risk of adverse health consequences post-discharge
- This does not mean that every discharge plan will be equally detailed or complex

State Operations Manual

- Must consider the patient’s likelihood of needing post-hospital services, including non-health care services which may be essential to a patient’s ongoing ability to live in the community, including, but not limited to:
  - Home and physical environment modifications;
  - Transportation services;
  - Meal services; and/or
  - Household services, such as housekeeping, shopping, etc.
State Operations Manual

- Hospitals are expected to have knowledge of community resources to assist in arranging services (to assist with financial, transportation, meal preparation, or other post-discharge needs)

- Surveyors will interview patients and their representatives. If they say they were not aware they could request a discharge planning evaluation, can the hospital provide evidence they received notice of their right? CHA Patients’ Rights form

State Operations Manual

- Provide written instructions
- Provide referrals to post-acute providers
- Provide training
- Send medical information to PCP and post-discharge care providers
What Will Surveyors Look For?

- Started process timely
- Involved the patient/reps
- Were patients/reps aware they could have a plan?

EMTALA

- *Interpretive Guidelines* require hospital to “provide a plan for appropriate follow-up care as part of the discharge instructions”
- Make reasonable efforts to assist or provide patient with necessary information
- Tell patient s/he can return to hospital if can’t find another provider to provide follow-up care
Coming Soon …

- Revised Part 2 regulations
- Revised, more comprehensive CoP for Discharge Planning
  - Every inpatient
  - Outpatients receiving anesthesia or moderate sedation
  - ED patients identified by ED practitioner
  - Others as recommended by medical staff

State Law: Aftercare Plan

- All psychiatric inpatient care providers must provide a written aftercare plan upon mental health patient’s discharge facility (GACH, APH, PHF, MHRC, SNF with special unit)
- Mental health patient = person admitted primarily for dx or tx of a mental disorder
State Law: Aftercare Plan

- Must include:
  - Nature of illness and follow-up required
  - Prescribed meds, side effects and dosage schedules
  - Patient's expected course of recovery
  - Treatment recommendations
  - Referrals to post-acute medical and mental health providers
  - Other relevant information
  - For minors released from involuntary treatment, “education or training needs, if necessary for the minor's wellbeing”

State Law: Aftercare Plan

- Give to patient and conservator, guardian or other legally authorized representative
- What is a legally authorized representative?
- Advise patient that s/he may designate another person to receive copy
State Law: Family Caregiver

• Hospitals must ask each inpatient if s/he wishes to designate one family caregiver who may assist in post-hospital care
• Caregiver = unpaid friend or relative helping with underlying disability

State Law: Family Caregiver

• Hospital must:
  – Inform patient and caregiver of continuing health care requirements after discharge
  – Include patient and caregiver in DP process
  – Provide information and instruction as appropriate regarding post hospital needs
  – Provide counseling if needed to prepare patient/caregiver for post-hospital care
State Law: Family Caregiver

• Hospital must:
  – Notify caregiver of discharge or transfer ASAP
  – However, inability to reach the caregiver need not delay care/discharge

State Law: Discharge Medication Counseling

• Prescriber, RN, or pharmacist must tell patient:
  – Dosage, use and storage of meds
  – Precautions and relevant warnings, including potential impairment of driving
  – Proper use of medication delivery devices, if any
  – Importance of compliance with directions
State Law: Discharge of Homeless Patients

- Hospital may not cause the transfer of a homeless patient to another county for supportive services without prior notification to, and authorization from, social services agency, health care provider, or nonprofit social services provider.

Los Angeles Municipal Code

- Hospitals cannot cause a patient to be transported to a location other than patient’s residence without written consent of patient, except:
  - To another health facility
  - Patients in custody
Los Angeles Municipal Code

- Homeless = lacks a fixed and regular nighttime residence, or the nighttime residence is a shelter
- Residence = fixed and regular nighttime residence or, if homeless, the location the patient gives as his/her principal dwelling

Los Angeles Municipal Code

- Written consent = knowingly, intelligently and voluntarily given, signed by patient or legal rep
- Have MD document capacity of patient
Remember

- Culturally competent
- Literacy level
- Teach back
- Document

Health Plan Obligations re: Patient Transfer

- K-K health plan or contracting medical group must, within 30 minutes of phone call, authorize post-stabilization care or inform hospital it will arrange for the prompt transfer of patient to another hospital
- Or post-stabilization care is deemed authorized and plan/group must pay
Health Plan Obligations re: Patient Transfer

• If plan/group says it will assume management of care by prompt transfer, but fails to transfer within a reasonable time, post-stabilization care is deemed authorized
• Plan/group must arrange, pay for transfer as well as immediately required medically necessary care required prior to transfer

Health Plan Obligations re: Patient Transfer

• Hospital not required to make more than one phone call as long as a hospital representative is available to take the return call
County Obligations

• County hospital is required to accept transfer of a county-responsibility patient unless it doesn’t have bed capacity, personnel, or equipment needed
• Then, must make appropriate arrangements for patient’s care
• But no particular level of service/payment mandated

Questions?
Thank you

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HOSPITALIZATION: WHAT TAKES PLACE

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Assessment

- What are we assessing for?
  - Criteria
  - Discharge Plan and Barriers
- How are patients assessed:
  - Multi-Disciplinary Team
  - Release of Information — 24 Hour Discharge Planning
  - Psychosocial Assessments
  - Treatment Team and Planning
  - Collateral Contact and Support

Discharge Planning

- Discharge planning starts within the first 24 hours
- Who is creating the plan?
- What are we looking for:
  - Housing/Food/Clothing
  - Supports
  - Services and/or Continued Treatment
  - Risk Factors
Barriers to Discharge Planning

**BARRIERS**
- Level of Functioning
- Resources
  - Services
  - Housing
  - Financial
- Insight and Judgement
- Level of Support
- Medical Necessity

**FINDING RESOLUTIONS**
- Knowledge
- Advocacy
- Investigation, Coordination, and Collaboration
- Education and Encouragement
- Creativity
- Respect and Empathy

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THANK YOU
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Discharge Planning—From the Other Side of the Door

Jessica Cruz, MPA/HS

Connections

- Individuals
- Families
- Care Providers
  - Primary Care
  - Behavioral Health Care
- Community
Follow-Up

- Who’s Responsible?
- Where Do We Go?
- Revolving Door

Solutions

- Peer Navigators
  - Mentor’s on Discharge
  - NAMI in the Lobby
- Involve Families/Caregiver from Beginning
- Connect to the Community
  - Focus Outside
Questions?

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