Advocacy Tools

from
the
California
Office of
Patients' Rights

Discharge & Pre-Care Planning

Discharge and Pre-care planning are two of the most useful yet least utilized tools to assist clients in minimizing involuntary hospitalization. Patients in acute facilities, long-term care facilities, and nursing facilities for people with mental disabilities have discharge planning rights which can include services proved in a community setting.
These rights are based on state and federal law that can be used to shorten or avoid hospitalization and to secure a less restrictive placement during the commitment and Conservatorship process. It is important for advocates to understand these rights when advocating for clients in hearing representation, or advising clients when preparing to challenge a Conservatorship.

Empowerment Resources #12

What Does the LPS Act Require?

The LPS Act provides for referral and aftercare planning for mental health clients. This planning is to establish alternatives to hospitalization and to provide assistance in accessing services necessary after discharge.

In addition to the discharge planning requirements the LPS Act has specific Pre-care responsibilities. These are summarized in Attachment "A". Advocates should become familiar with both discharge planning and pre-care responsibilities to effectively assist their clients.

Discharge Planning

The discharge planning and referral obligations of a facility are the same regardless of whether the individual was discharged during or at the end of an involuntary hold. The mental health client and their conservator or other representative must receive an aftercare plan in writing before discharge. Welfare & Institutions Code §§ 5768.5 and 5622.

This written aftercare plan must include:

1) Nature of the illness and follow-up required.

2) Medications including the side effects and dosage schedules. If the patient was given an informed consent form with his or her medications, the form shall satisfy the requirement for information on the side effects of the medications.
3) Expected course of recovery.
4) Recommendations regarding treatment that are relevant to the patients' care.
5) Referrals to providers of medical and mental health services.
6) Other relevant information.

Health and Safety Code § 1262, Welfare and Institutions Code §§ 5622 and 5768.5

Specific Responsibilities Regarding Referrals

Section 5008(d) defines "referral" within LPS statutes and discusses pre-care and aftercare services that may prevent initial recourse to hospital treatment or aftercare services which support adjustment to community living following hospital treatment. (See attachment "B").

What are Federal Discharge Planning Requirements?

Any facility receiving Medicaid and/or Medicare funds has additional discharge planning requirements (Reference Attachment "C" for activities required under 42 CFR, § 482.43).

Voluntary Community Based Services are a Priority

Medi-Cal eligible clients in facilities have a right to request that Medi-Cal fund the rehabilitative mental health services they want in the community in a least restrictive setting. Cal. Code Regs., tit 9 §§ 1810.201-254

These include:

- **Rehabilitative Mental Health Services** ("Rehab option") funded by Medi-Cal but provided by the county.

- **Crisis Intervention** a quick response system to enable the coping of a crisis while maintaining community status.

- **Targeted Case Management** including communication, coordination, and monitoring of service delivery to ensure access.

- **EPSDT services** (Early and Periodic Screening, Diagnosis and Treatment) for children under age 21

Some clients may also qualify for:

In-Home Supportive Services (IHSS) for attendant care services such as shopping, laundry, cleaning, personal care such as bathing, etc. Welfare & Institutions Code §§12300 *et seq.* and Welfare & Institutions Code § 14132.95

It is important for advocates and clients to emphasize the above options/services when preparing to challenge an involuntary hold, whether at a Probable Cause hearing or in preparation for a conservatorship hearing. If proper pre-care and discharge planning has been completed as required, the time a client is required to be involuntarily treated may be shortened.

AFTERCARE PLAN DISCUSSION CHECKLIST.

This attached checklist can be used to assist clients in focusing on what they would need to be successful in the community. Clients can use it when speaking with staff or you can use it to facilitate the client and the staff talking about these issues. (See Attachment "D").

PASARR – PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW PROGRAM

Because so many of our client's discharge plan involves transfer to a long term care facility such as an Institute for Mental Disease (IMD), it is important for advocates to understand this screening and review program.
(See Attachment "E")

ADVOCACY ROLE

Prior to the probable cause hearing the advocate should review the medical record for the required discharge plan. At the hearing, the lack of this plan should be raised with the hearing officer. With the help of the checklist present information to show that the client could successfully remain in the community with the proper supports in place.

Familiarize yourself/review the discharge policy and procedure of your facilities. Include a review of the referral materials required by Welfare and Institutions Code 5008 which requires the facility to "maintain a current and comprehensive file of all community services, both public and private." This file should also contain "current agreements with agencies or individuals accepting referrals as well as appraisals of the results of past referrals."

A cornerstone of the PLS Act is the philosophy that a person should receive mental health treatment on a voluntary basis and in the least restrictive setting possible. Therefore, this philosophy is important for advocates and clients to emphasize when preparing to challenge an involuntary hold, whether at a Probable Cause hearing or in preparation for a conservatorship hearing. If proper pre-care and discharge planning has been completed as required, the time a client is required to be involuntarily treated may be shortened.

In the hearing preparation explore with your client the use of IHHS services or other support services to avoid the need for hospitalization, make sure the hearing officer is presented with this information during the Probable Cause hearing. You may also wish to propose the use of these services to the hospital staff responsible for treatment and discharge planning. (See In Home Support Services Information Letter, Oct 2001)

Set up a focused monitoring of your facilities for discharge plans. This could include not only your acute facilities but IMDs or other nursing facilities. Possible areas to monitor would be whether there is an aftercare plan in the chart, when was the planning begun? Does it include all the things required by Welfare & Institutions Code? Has a PASARR review happened? Did the client and his family participate?

Have your clients use the attached Aftercare Plan Discussion Checklist as a tool to prepare for hearings. This should help guide them to the questions they should be asking the hospital to plan for discharge. Remember – this is a tool for your clients, you as an advocate are not a case manager responsible for discharge planning.

The checklist information could also be important in conservatorship hearings. It is possible that with an appropriate discharge/aftercare plan, the conservatorship may not be necessary. This information should be given to the client's public defender.

Review the status of PASARR evaluations within your county. Assist your clients in filing an appeal if they do not receive an evaluation before they are placed in an IMD.

Attachment A

"PRE-CARE" SERVICES

It may be possible to avoid involuntary hospitalization by insuring that hospital staff fulfills their "pre-care" responsibilities. Before an individual can be involuntary committed, the physician must certify that the individual is not able to accept voluntary treatment. This necessarily implies that voluntary services, appropriate to the individual's needs, have been made available.

The requirement to consider community alternatives to an involuntary detention are found in Welfare & Institutions Code Section 5151 and 5008(d).

> [P]rior to admitting a person to the facility for 72-hour treatment and evaluation pursuant to Section 5150, the professional person in charge of the facility or his or her designee shall assess the individual in person to determine the appropriateness of the involuntary detention. If in the judgment of the professional person in charge of the facility providing evaluation and treatment, or his or her designee, **the person can be properly served without being detained, he or she shall be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis**… (Emphasis added***)***
> California Welfare & Institutions Code § 5151

This read with the "referral" language in Section 5008, "All persons shall be advised of available pre-care services which prevent initial recourse to hospital treatment or aftercare services which support adjustment to community living following hospital treatment" make the preference for community treatment supported by services put in place by facility staff and county mental health.

Also, it is important to note, that included on the 14-day certification form, that the evaluator is required to sign when placing someone on this involuntary hold is a statement certifying to the fact that referral services were refused by the patient. The certification form states:

The above-named person has been informed of this evaluation and has been advised of the need for, but has not been willing to accept treatment on a

voluntary basis, or to accept referral to, the following services:

____

(the form includes 5 blank lines for services to be listed)

Attachment B

Welfare & Institutions Code, Section 5008(d):

"Referral" is referral of persons by each agency or facility providing intensive treatment or evaluation services to other agencies or individuals. The purpose of referral shall be to provide for continuity of care, and may include, but need not be limited to, informing the person of available services, making appointments on the person's behalf, discussing the person's problem with the agency or individual to which the person has been referred, appraising the outcome of referrals, and arranging for personal escort and transportation when necessary. Referral shall be considered complete when the agency or individual to whom the person has been referred accepts responsibility for providing the necessary services. All persons shall be advised of available pre-care services which prevent initial recourse to hospital treatment or aftercare services which support adjustment to community living following hospital treatment. These services may be provided through county welfare departments, State Department of Mental Health, Short-Doyle programs or other local agencies. Each agency or facility providing evaluation services shall maintain a current and comprehensive file of all community services, both public and private. These files shall contain current agreements with agencies or individuals accepting referrals, as well as appraisals of the results of past referrals.

Attachment C

FEDERAL DISCHARGE PLANNING REQUIREMENTS

1. Early, Ongoing, Documented Discharge Evaluation

The facility 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 planning" 42 C.F.R. § 482.43(a)

An evaluation must be completed on all those who are at risk, e.g. health problems, or homelessness or re-hospitalization, etc. without proper discharge planning, and for individuals where a discharge plan has been requested. 42 C.F.R. § 482.43(b)(1)

A registered nurse, social worker or other qualified person must develop or supervise the development of the evaluation. 42 C.F.R. § 482.43(b)(2)

The evaluation must include:

- Consideration of the need for and the availability of post-hospital services. 42 C.F.R. § 482.43(b)(3)
- Consideration of the patient's capacity for self care and of the possibility of the patient being cared for in the environment from which he or she entered the hospital. 42 C.F.R. § 482.43(b)(4)

The evaluation or discharge plan must be completed in a timely basis so that appropriate post-hospital arrangements can be made and to avoid unnecessary delays in discharge.
42 C.F.R. § 482.43(b)(5)

The evaluation or discharge plan must be included in the patient's hospital record and it must be discussed with the patient or the patient's representative. 42 C.F.R. § 482.43(b)(6)

The hospital must reassess its discharge planning process on an ongoing basis to ensure responsiveness to patient need. 42 C.F.R. § 482.43(e)

2. Implementation of the Discharge Plan

The hospital must arrange for the initial implementation of the patient's discharge plan. 42 C.F.R. § 482.43(c)(3)

After care plans must address personal preferences, family relationships, physical and psychiatric needs, financial needs, housing needs, educational/vocational needs, social needs, accessibility to community resources, and indication of anticipated problems and how to deal with them. 42 C.F.R. §§ 482.61(e), 482(a)(4), 482.62(f)(2)

The patient and family members or interested persons must be counseled to prepare them for post-hospital care. 42 C.F.R. § 482.43(6)(c)(5) (This must be done consistent with the confidentiality provisions of Welfare & Institutions Code § 5328.)

The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care." 42 C.F.R. § 482.43(6)(d)

Attachment D

AFTERCARE PLAN DISCUSSION CHECKLIST

_____ What things caused me trouble in the community? What will help me out of trouble when I go back? (Attached is a list of different kinds of services you can talk about.)

_____ Would case management services help me? What does case management include? Should case management services be written into my aftercare plan as a recommendation?

_____ If I have a crisis in the community, will I be able to get help from a crisis house or other service instead of going to an emergency room? What kind of help do crisis homes or other crisis centers provide? Would being able to go to a crisis house or other crisis centers provide? Would being able to go to a crisis house or other service help me stay in the community and avoid coming back here? Should being able to get crisis center services be written into my aftercare plan as a recommendation?

_____ What other services might help me function the best I can in the community? Should any of these services be written into my aftercare plan as a recommendation?

_____ Will I need help in straightening out my SSI or Social Security? Who will help me?

_____ Where can I live? Are there any choices? Can I visit the places before I leave here?

_____ Is there a consumer drop-in center or self help group I can turn to for

support?

____ How often will I see and talk with my conservator?

____ I want a copy of my aftercare plan which has the answers to these questions.

Here is a list of community services to talk about as part of deciding what should go into the Aftercare Plan. These are broad categories. Don't worry about where a particular kind of help you need would fit.

____ *Case management/mental health services* to help you find a place to live, help you be as independent as possible, help you keep out of trouble, help you figure out what services will help you and help you get those services.

____ *Crisis services* -- where you can go other than to an emergency room and who can help you if you think things are getting out of control. Crisis services can include a short stay is a crisis residential treatment program.

____ *Other mental health services* to help you function the best you can by providing services that will help you achieve your goals.

____ *Adult residential treatment services*- -a board and care but with special services to help you function the best you can and to avoid getting into the kind of trouble that would put you at risk of another hold.

____ *Medication Support Services* -- Not just refilling prescriptions but also talking to you about how you are doing with your current medications and whether there are other medications that might help you feel better or function better or which may have fewer side effects.

____ *Day rehabilitation services* -- evaluation and services to restore personal independence and functioning. These are services for three hours or more each day that you would get through a specific program in the community.

____ *Day treatment intensive* -- When you need more intensive services than those available through a day rehabilitation program.

Attachment E

PASARR – PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW PROGRAM

Under the federal Nursing Home Reform Act, before a client may be admitted to a nursing facility ("NF"), he or she must have a pre-admission screening assessment as part of the PASARR. The definition of a nursing facility is very broad and includes IMDs, some PHFs, MHRFs and some units at the state hospitals are certified under federal law as nursing facilities.

PASARR pre-admission evaluation provides an opportunity to identify and document a client's potential for living in the community, rather than in an IMD/nursing facility.

There are two parts to the pre-admission assessment:

Level I – is conducted by the hospital and identifies whether the applicant to the nursing facility has a "mental illness or mental retardation." 42 C.F.R. § 483.128(a)

The person is then referred for a Level II evaluation. An independent contractor must do the evaluation. 42 C.F.R. § 483.106(e)(2)

Level II – For person with mental illness, the evaluation must be done by an independent contractor; it cannot be by DMH, the hospital, or the IMD/nursing facility. DMH contracts with evaluators around the state for these evaluations. 42 C.F.R. § 483.106(e)(2)

The purpose of this evaluation is to determine whether "the individual requires the level of services provide by a nursing facility or whether his or her needs

require either a more intensive setting or if his or her needs can instead be met in the community.   42 C.F.R. § 483.112

If the evaluator concludes that the applicant does not need nursing facility services, the applicant cannot be admitted. 42 C.F.R. §483.118(a)

The level II evaluation form asks questions about the client's potential ability to live in the community and personal care needs. It is client centered and requires client participation. The evaluation report must summarize the recommended services and this must be interpreted and explained to the individual. 42 C.F.R. §§ 483.128(c), 483,128(i), 483.128(k)

The patient has the right to appeal if he or she disagrees with the PASARR evaluation through a Medi-Cal appeal and administrative Fair Hearing process.