Oregon Association of Hospitals and Health Systems

# Discharge Planning for Patients Hospitalized for Mental Health Treatment

# Interpretative Guidelines for Oregon Hospitals

May 2016

## PURPOSE

This document is meant to offer interpretative guidance for Oregon hospitals implementing House Bill 2023 (2015)[1] related to discharge planning for inpatients hospitalized for mental health treatment. The guide offers a checklist for providers to ensure they are communicating with the patient and family to support the best outcomes following discharge from the acute care setting.

This guidance incorporates related requirements applicable to all lay caregivers from House Bill 3378 (2015)[2] as well as clarifications regarding the disclosure of protected health information from House Bill 2948 (2015).[3] Corresponding regulatory language from federal law and existing state statutes provide additional resources for providers to understand the legal requirements of implementing this new state law and aid in conducting effective hospital policies.

Discharge planning begins the moment the patient is admitted to the facility. Therefore, hospitals should be actively working through the elements outlined here throughout the patient's stay in order to support timely discharge and effective post-discharge care.

This is not legal advice. All organizations should consult with their own legal counsel in developing their discharge policies.

[1] Codified at ORS 441.196.
[2] ORS 441.198.
[3] ORS 192.567.

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# Discharge Planning Worksheet for Inpatients Receiving Mental Health Treatment

To be completed by the provider

**Patient Name:** _____ **Date:** _____

**DOB/Medical Record #:** _____

- ☐ Ask the patient if they would like to identify a family member, friend, or other support person ("lay caregiver") who will provide assistance to the patient following their discharge from the hospital. Particularly vulnerable patients, such as those hospitalized for mental illness should be encouraged to designate a support person to aid in their post-discharge care. If a lay caregiver is identified, note the designation in the patient's medical record.
  - ☐ For a patient who is younger than 14 years of age, the lay caregiver is a parent or legal guardian of the patient.
  - ☐ For a patient who is younger than 18 years of age but at least 14 years of age, the lay caregiver is the patient's parent or legal guardian unless the legal guardians refuse or there are clear clinical indications to the contrary such as sexual abuse by the guardian or evidence of emancipation. To the extent a legal guardian is not designated as the lay caregiver due to clinical indicators, those reasons should be noted in the medical record. A patient aged 14 to 18 may also designate a lay caregiver of their choice.

  **Lay Caregiver Name:** _____

  **Relationship to Patient:** _____

- ☐ If a lay caregiver is identified, encourage the patient to sign an authorization to disclose relevant protected health information. Note in the medical record if patient authorization is obtained. Information to share with the patient and lay caregiver prior to discharge should include, but need not be limited to:
  - ☐ The hospital's criteria and reasons for initiating discharge.
  - ☐ The patient's diagnosis, treatment recommendations, and outstanding safety issues.
  - ☐ Risk factors for suicide and what steps to take if danger exists, such as ridding the home of firearms/other means of self-harm and creating a plan to monitor and support the patient.
  - ☐ The patient's prescribed medications including dosage, explanation of side effects, and process for obtaining refills, as applicable.
  - ☐ Available community resources including case management, support groups, and others.
  - ☐ The circumstances under which the patient or lay caregiver should seek immediate medical attention.

- ☐ Conduct a risk assessment of the patient's risk of suicide.
  - ☐ Providers should seek input from the patient's designated lay caregiver, including interviews and patient history.
  - ☐ Providers may accept unsolicited information from family and friends not authorized for disclosure.

- Conduct a needs assessment to understand the long-term needs of the patient. The assessment should include questions regarding the patient's income, housing situation, insurance, and aftercare support, among others. The lay caregiver should be included in this conversation. At minimum, the assessment should help the provider determine:
  - The patient's capacity for self-care, including but not limited to:
    - The risk that the patient may engage in self-harm as identified in the risk assessment.
    - The patient's support network in place at the location of anticipated discharge.
    - Patient resources and ability to access prescribed medications or travel to follow-up appointments.
  - The patient's need for community-based services.
  - Appropriate post-discharge placement for the patient, including whether the patient may return to the place from which they resided prior to hospital admission or if step-down resources are needed.

- Coordinate the patient's care and transition to outpatient treatment. Providers should share the post-discharge treatment plan with the patient and lay caregiver and provide an explanation of:
  - The next level of care, how it differs from hospitalization, and what the patient should expect from outpatient treatment.
  - Contact information for the outpatient care including address and phone number of the site/provider.

- Schedule a follow-up appointment for no later than seven days after discharge.
  - If a follow-up appointment cannot be scheduled within seven days, document the applicable barriers in the patient's medical record.

- As necessary, provide instructions or training to the patient and lay caregiver prior to discharge. Instructions should address how to provide assistance to the patient and may include securing and administering medications, safety plans, name and location of follow-up appointment and community resources, or any other anticipated assistance relating to the patient's condition.

- Notify the designated lay caregiver in advance of patient discharge or transfer.

**Additional Notes:**

**Clinician Signature:** _____ **Date:** _____

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## Interpretive Guideline Details

## Applicability

House Bill 2023 (2015), now codified as ORS 441.196, requires hospitals to adopt and enforce policies for the discharge of "a patient who is hospitalized for mental health treatment."[4] This standard means the law applies:

1. To hospitals
2. Upon patient discharge
3. When a patient has been hospitalized for mental health treatment.

### *Hospital*

Hospital refers to all acute hospitals as well as specialty mental or psychiatric hospitals.[5] For both types of facilities this requirement is a condition of licensure by the Oregon Health Authority (OHA). As a state law, the requirement is applicable only to hospitals licensed in the state of Oregon.

### *Discharge*

The law defines "discharge" as "the release of a patient from a hospital following admission to the hospital."[6] OHA rules contained within Oregon Administrative Rules (OAR) chapter 333, divisions 500 through 535 applicable to all hospital regulation clarify that "discharge" means:

> "The release of a person who was an inpatient of a hospital and includes:
> (a) The release and transfer of a newborn to another facility, but not a transfer between acute care departments of the same facility;
> (b) The release of a person from an acute care section of a hospital for admission to a long-term care section of a facility;
> (c) Release from a long-term care section of a facility for admission to an acute care section of a facility;
> (d) A patient who has died; and
> (e) An inpatient who leaves a hospital for purposes of utilizing non-hospital owned or operated diagnostic or treatment equipment, if the person does not return as an inpatient of the same health care facility within a 24-hour period."[7]

This overarching definition confirms that the law is applicable only to patients that are receiving inpatient services from a hospital. The applicability solely to hospital inpatients is also confirmed in the written testimony of the bill's original sponsor.[8] Thus, while procedures are recommended to help individuals receiving mental health treatment transition from all levels of care, the requirements outlined in this guidance document are meant specifically for statutory requirements related to discharging inpatients.

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[4] ORS 441.196(2).
[5] OAR 333-505-0030(4)(b)(B) and 333-525-0000(9).
[6] ORS 441.196(1)(a).
[7] OAR 333-500-0010(8).
[8] NAMI Oregon, Comments on House Bill 2023, May 18, 2015. Available at https://olis.leg.state.or.us/liz/2015R1/Downloads/CommitteeMeetingDocument/74258.

### *Hospitalized for Mental Health Treatment*

OHA rules do not define "hospitalized for mental health treatment," leaving it up to the hospital to determine the scope of the requirement. The term is recommended to apply to all "patients admitted to psychiatric inpatient treatment," as that is the term appearing in testimony and appears to have been the law's intent.[9]

[9] NAMI Oregon, Comments on House Bill 2023, May 18, 2015. Available at https://olis.leg.state.or.us/liz/2015R1/Downloads/CommitteeMeetingDocument/74258.

## Additional Requirements

### *Publicly Available*

Hospital policies for discharge of patients hospitalized for mental health treatment must be in writing and made publicly available.[10] The requirement for a written policy on discharge planning exists at both the state and federal level.[11]

The requirement for public availability is specific to the inpatient psychiatric discharge policy. This may be achieved in a method left up to hospital including posting the policy on hospital units or website, providing copies of the policy, or maintaining copies of the policy to distribute to members of the public upon request. An individual does not need to be a patient of the hospital to request a copy of the facility's inpatient psychiatric discharge policy.

### *Documentation*

Discharge planning required for patients receiving mental health treatment are subject to several documentation requirements. These requirements are noted throughout this guidance, but also noted here in consolidated form to ensure compliance.

All hospitals are required to maintain a medical record for patients admitted for care.[12] The medical record of a psychiatric inpatient must include:

- Discharge planning documentation.[13]
- Signed authorization for the disclosure of protected health information.[14]
- The lay caregiver designated by the patient or legally applicable caregiver if the patient is a minor.
- If the minor is 14 or older and the provider does not to designate the legal guardian or parent as a lay caregiver due to cause, the reasons for that determination.[15]

[10] ORS 441.196(2); OAR 333-505-0030(5).
[11] 42 CFR 482.43.
[12] OAR 333-505-0050(1).
[13] OAR 333-505-0050(2)(k).
[14] 45 CFR § 164.508.
[15] ORS 109.675.

## Defining the Lay Caregiver

- *Ask the patient if they would like to identify a family member, friend, or other support person ("lay caregiver") who will provide assistance to the patient following their discharge from the hospital.*

As an initial step, hospitals must offer all patients receiving inpatient care the opportunity to designate a "lay caregiver."[16] Lay caregiver is the statutory term however hospitals may feel free to use other terms to describe the functional role of the lay caregiver such as support person. For the purpose of this guidance document the term lay caregiver encompasses the role of a support person or other organizational term of art meaning a non-medical personal associate of the patient that assists with tasks following discharge.

While the law only requires providers to offer patients the opportunity to designate a lay caregiver, particularly vulnerable patients, such as those hospitalized for mental illness, should be encouraged to designate a support person to aid in their post-discharge care.

The caregiver may be any individual who, at the patient's request, agrees to be involved in the discharge process and aid the patient as necessary following discharge. For a psychiatric patient, the lay caregiver is defined with more precision when the patient is also a minor. Below, relevant considerations for identifying the lay caregiver are provided for both adult and minor patients.

The patient must always be central to the identification and involvement of a lay caregiver. While patients have the right to designate a caregiver of their choosing to be involved in their care plan, hospitals should consider the mental and physical functioning of the lay caregiver relative to the patient. To the extent that a caregiver may create issues in caring for the patient hospital staff should be thoughtful in how the caregiver is involved. Similarly, for patients lacking a designated caregiver but for whom there is a viable option, staff should make efforts to involve a potential caregiver as much as allowable under state and federal law.

The lay caregiver and their relationship to the patient should be noted in the patient's medical record. Designation of the lay caregiver should be noted such that other health care professionals in the hospital are aware of the designation and the subsequent obligation to notify the caregiver of steps in the discharge planning process.

### *Adult Patients*

For an adult patient the lay caregiver must be explicitly designated by the patient unless a guardianship or other legal arrangement exists. All patients have the right to designate a family member or representative of his or her choice and have that person notified of their admission and discharge to the hospital.[17] The lay caregiver should also be counseled on relevant patient information to prepare them for post-hospital care.[18]

[16] ORS 441.198(2)(b).
[17] 42 CFR § 482.13.
[18] 42 CFR § 482.43(5).

### *Minor Patients*

In Oregon, individuals are deemed to have arrived at majority at the age of 18 years.[19] Individuals under the age of 18 are therefore minors and subject to additional clarification with respect to designating their caregiver following psychiatric discharge.

- *For a patient who is younger than 14 years of age, the lay caregiver is a parent or legal guardian of the patient.*

For a patient who is younger than 14 years of age, a parent or legal guardian of the patient should be automatically designated as the lay caregiver.[20] In the absence of a parent or legal guardian, Oregon recognizes the right of a "relative caregiver" to intervene.[21] The relative caregiver is a competent adult related to the minor patient by blood, marriage or adoption who represents via affidavit that the minor child lives with the adult and that the adult is responsible for the care of the minor child.[22]

- *For a patient who is younger than 18 years of age but at least 14 years of age, the lay caregiver is the patient's parent or legal guardian unless the legal guardians refuse or there are clear clinical indications to the contrary such as sexual abuse by the guardian or evidence of emancipation. To the extent a legal guardian is not designated as the lay caregiver due to clinical indicators, those reasons should be noted in the medical record. A patient aged 14 to 18 may also designate a lay caregiver of their choice.*

For a patient who is at least 14 years of age, the lay caregiver may be an individual designated by the patient.[23] The parent or legal guardian will also be automatically designated as the lay caregiver unless the conditions of ORS 109.640 or ORS 109.675 are met. Such situations include when a minor has been sexually abused by the guardian or in the case on an emancipated minor.[24] An emancipated minor may include legal emancipation under the provisions of ORS 109.510 and 109.520 or 419B.550 to 419B.558 or a minor that may be deemed emancipated by virtue of having lived apart from the parents or legal guardian while being self-sustaining for a period of 90 days prior to obtaining treatment.[25]

Note that a minor aged 14 years or older may obtain treatment for a mental or emotional disorder or a chemical dependency, excluding methadone maintenance, without parental consent.[26] However, the parents of the minor should be involved prior to discharge and the end of treatment unless the conditions of sexual abuse or emancipation described above apply.[27]

[19] ORS 109.510.
[20] ORS 441.196(1)(b)(A); OAR 333-505-0030(1)(b)(A).
[21] ORS 109.575(1).
[22] ORS 109.572.
[23] ORS 441.196(1)(b)(B); OAR 333-505-0030(1)(b)(B).
[24] ORS 109.675(2).
[25] ORS 109.675(2).
[26] ORS 109.675(1).
[27] ORS 109.675(2).

## Patient Authorization to Disclose Protected Health Information

- *If a lay caregiver is identified, encourage the patient to sign an authorization to disclose relevant protected health information. Note in the medical record if patient authorization is obtained.*

In order to facilitate the discharge process and ensure communication with a designated lay caregiver, hospital should encourage patients to sign an authorization to allow the disclosure of relevant health information with the lay caregiver.[28] Providers should explain that only the minimum necessary information will be shared and the benefits disclosing health information will have on the ability of a patient to see positive outcomes. Note that this section outlines relevant state and federal regulations as they pertain to patients that do not have a legal guardian (i.e. adults). More specific discussion of allowable disclosures for other categories of patients is available below.

Hospital providers are subject at all times to the Health Information Portability and Accountability Act (HIPAA). This law was designed to protect the privacy and confidentiality of protected health information. Hospitals should check that they are interpreting HIPAA in such a way as to facilitate reasonable and necessary sharing of patient information, particularly for mentally ill patients that may be at risk of self-harm in the period following their release from the hospital. Providers are always required to follow federal law and should consult state law only where the state law for disclosure is more protective of patient privacy.

At the state level, House Bill 2948 (2015)[29] codifies into Oregon law when a provider may disclose protected health information without explicit patient authorization. The state law mirrors HIPAA regulations almost exactly with the addition of standards for patients being treated for mental illness. H.B. 2948 specifies certain elements of protected health information for inpatient psychiatric patients which should be considered appropriate for disclosure if the caregiver meets one of the categories for allowable disclosure. Those elements are contained at the end of this section, which describes the type of health information providers should offer lay caregivers.

### *Personal Representatives: When No Authorization Is Required*

In limited circumstances, a specific authorization to share protect health information may not be necessary for the hospital to make a health care disclosure. This occurs when the patient has a legally appointed personal representative. Note that the disclosure may only be made to the legal guardian or personal representative in these circumstances, which may or may not include the designated lay caregiver. The personal representative designation is narrower than the lay caregiver, so hospitals should not assume a lay caregiver is also a patient's personal representative unless there is evidence to the contrary.

For an adult or emancipated minor, a personal representative is any person with authority to act on behalf of an individual and make health care decisions such as an individual designated to hold power of attorney or in a declaration for mental health treatment.[30]

Hospitals, and other covered entities under HIPAA, must always treat a personal representative similarly to the individual with respect to privacy of health information.[31] Thus, the personal

[28] OAR 333-505-0030(4)(b)(B)(i).
[29] Now ORS 192.567.
[30] 45 CFR 164.502(g)(2).

representative of a patient may request access to the patient's health information without a specific authorization for that disclosure. Typically, disclosure of protected health information is subject to a "minimum necessary" standard.[32] However, the minimum necessary requirement does not apply in situations in which a hospital has specific authorization from the patient for the disclosure, meaning it also does not apply when a personal representative has requested information.[33]

Hospital personnel always retain discretion to not recognize the patient's personal representative in the event that the hospital has a reasonable belief the patient has been or may be subjected to domestic violence, abuse, or neglect by the personal representative or the disclosure could endanger the patient; and in the exercise of professional judgment the disclosure would not be in the best interest of the patient.[34] Note that both prongs must be meant to withhold the information. Providers should document the evidence and belief of abuse and endangerment if not disclosing under this protection.

### *Disclosure of Information for Un-Emancipated Minor Patients*

Un-emancipated minors are individuals under 18 years of age still residing with a legal guardian that have not initiated separation procedures. A parent, guardian, or other person authorized under law to act *in loco parentis* to make health care decisions for an un-emancipated minor must be generally treated as the patient's personal representative.[35] In the event a parent is acting as a minor patient's personal representative, the standards outlined in the Personal Representative subsection apply and no specific authorization is required for disclosure of protected health information.

However, minors have authority to act as an individual without the legal guardian operating as a personal representative when the minor may consent to treatment without parental consent under state law.[36] Oregon law does specifically allow minors aged 14 and older to consent to mental health treatment without parental consent,[37] thus providers should confirm whether such patients wish to have a parent or other legal guardian treated as a personal representative. In the case of a minor patient under the age of 14, providers should treat the parent as a personal representative unless there are indications of abuse or endangerment as described below.

Hospital personnel always retain discretion to not treat a guardian as a minor patient's personal representative in the event that the hospital has a reasonable belief the patient has been or may be subjected to domestic violence, abuse, or neglect by the personal representative or the disclosure could endanger the patient; and in the exercise of professional judgment the disclosure would not be in the best interest of the patient.[38] Note that both prongs must be meant to withhold the information. Providers should document the evidence and belief of abuse and endangerment if not disclosing under this protection. For emancipated minors or minors for which the provider has concerns regarding abuse, the same standards that apply to adult patients should be used in determining whether disclosure of protected health information is allowable.

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[31] 45 CFR 164.502(g)(1).
[32] 45 CFR 164.502(b).
[33] 45 CFR 164.502(b)(2)(iii).
[34] 45 CFR 164.502(g)(5).
[35] 45 CFR 164.502(g)(3).
[36] 45 CFR 164.502(g)(3).
[37] ORS 109.675.
[38] 45 CFR 164.502(g)(5).

As a reminder, a personal representative under HIPAA is a narrower definition than the lay caregiver under state law. The personal representative designation is specific to allowable disclosure without an authorization, however a parent or legal guardian that is a lay caregiver may be entitled to disclosure based upon the patient's written authorization or permitted circumstance, described in the following subsections.

### *Disclosure with Patient Authorization*

Hospitals and their associated health care professionals may disclose protected health information only as authorized by the individual or as permitted under HIPAA. Specific authorization by the patient is the most straightforward route to sharing relevant information with a lay caregiver. Hospitals should encourage patients hospitalized for mental health treatment to sign an authorization of disclosure for their lay caregiver to aid in aftercare and positive long-term outcomes.

The disclosure of protected health information is subject to a "minimum necessary" standard necessary to accomplish the goals of the disclosure.[39] Patient authorization is always required for the disclosure of psychotherapy notes to a caregiver.[40] Patients may revoke an authorization at any time, but providers are not liable for disclosures made in reliance on that authorization.[41]

Patient authorizations must be valid and meet the requirements of HIPAA for the disclosure to be allowable.[42] A valid authorization is a written document in plain language containing the following six elements.

1. A description of the information to be used or disclosed;
2. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;
3. The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure;
4. A description of each purpose of the requested use or disclosure;
5. An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure; and
6. Signature of the individual and date.[43]

When a patient has authorized the disclosure, the description outlined as element #3 may be recorded as "at the request of the individual," if the individual does not provide a statement of the purpose.

In addition to the six elements above, a valid authorization must contain language placing the individual on notice of:

1. The right to revoke the authorization;
2. The ability or inability to condition treatment, payment, or eligibility for benefits on the authorization; and
3. The potential for disclosed information to be re-disclosed by the recipient and no longer protected. [44]

[39] 45 CFR 164.502(b).
[40] 45 CFR 164.508(a)(2).
[41] 45 CFR 164.508(b)(5).
[42] 45 CFR 164.508(b).
[43] 45 CFR 164.508(c)(1).

Upon obtaining authorization from a patient for disclosure of health information, the hospital must provide the individual with a copy of the signed authorization.[45]

### *Disclosures Permitted without Patient Authorization*

Under certain circumstances, hospitals and their associated health care professionals may disclose protected health information without a specific patient authorization. With respect to a designated lay caregiver, those unauthorized disclosures fall into three categories:

1. When the disclosure is implicitly agreed to and directly relevant to such caregiver's involvement,
2. When the individual patient lacks capacity and disclosure is in the best interest of the individual, or
3. To avert a serious threat to health or safety.

All allowable disclosures without patient authorization should occur under the first two situational categories, as hospitals should never discharge a patient if there is any immediate concern regarding the patient's health and safety or the health and safety of those near the patient. However, for the sake of completeness, legal standards relating to all situations are provided below.

#### When the disclosure is implicitly agreed to and directly relevant to such caregiver's involvement

Hospitals may use or disclose protected health information to family members and other support persons when the individual is informed in advance and had opportunity to agree, prohibit, or restrict the disclosure either implicitly or orally.[46] The protected health information must be directly relevant to such caregiver's involvement with the individual's health care.[47] For the purpose of Oregon law, this could include a caregiver designated by a patient receiving inpatient mental health treatment.

In any instance in which the patient has an opportunity to object to disclosure and the health professional reasonably infers that there is no objection, the disclosure is allowable.[48] This situation will occur most commonly when a caregiver is present with a patient at the time at which a provider is offering information. The provider may ask the patient verbally whether she/he may disclose health information when another individual or caregiver is present, and may proceed with the disclosure upon the patient's verbal agreement.[49] Alternatively, the provider may take the patient's silence or lack of objection at the presence of the other individual as implicit assent for the other individual to be a party to the protected health information. In contrast to a written authorization, this assent should be considered conditional on the particular circumstance, and not evidence that future health information should be disclosed.

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[44] 45 CFR 164.508(c)(2).
[45] 45 CFR 164.508(c)(4).
[46] 45 CFR 164.510.
[47] 45 CFR 164.510(b)(1).
[48] 45 CFR 164.510(b)(2).
[49] 45 CFR 164.510(b)(2).

When the individual patient lacks capacity and disclosure is in the best interest of the individual

If the individual is not present or there is no opportunity to agree or object to disclosure due to patient incapacity or other emergency, providers may disclose health information in limited circumstances.[50] Specifically, if a health professional believes that the disclosure is in the best interests of the patient, they may disclose protected health information that is directly relevant to the person's involvement with the patient's care or needed for notification purposes.[51] Hospitals should exercise their judgment and experience with common practice to make reasonable inferences of the individual's best interest, particularly considering the role of lay caregivers in acting on behalf of the patient to pick up prescriptions, medical supplies, or other similar forms of protected health information.[52] As much as possible, hospitals should identify the criteria for such inferences in their written policies based on the practical experience of patients with mental illness.

Providers may also disclose protected health information when the patient lacks capacity. In the case of the parent or legal guardian of a child patient, the disclosure is always allowable unless the provider reasonably believes the disclosure would cause harm. If the provider believes there may be harm this should be documented in the medical record. Additionally disclosure without explicit authorization is allowable if the patient lacks capacity.[53] Such disclosure must be consistent with any prior expressed preference of the patient and should be made based on the best interest of the patient. Hospital personnel should inform the individual and provide them with the opportunity to object as soon as practicable.

To avert a serious threat to health or safety

Finally, federal law also allows hospitals to disclose protected health information without authorization, written or implied, to prevent or lessen a serious threat to the health or safety of a person or the public.[54] The disclosure must be made in good faith and only to a person or persons reasonably able to prevent or lessen the threat.[55] However, this exception to patient privacy should never come into play, as any patient deemed to pose a serious threat is not appropriate inpatient discharge unless the patient is being transferred to higher level acute care.

Disclosure of information without an explicit written authorization should always be limited to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.[56]

## *Information to Include in an Authorized Caregiver Disclosure*

- *The hospital's criteria and reasons for initiating discharge.*
- *The patient's diagnosis, treatment recommendations, and outstanding safety issues.*
- *Risk factors for suicide and what steps to take if danger exists, such as ridding the home of firearms/other means of self-harm and creating a plan to monitor and support the patient.*

[50] 45 CFR 164.510(b)(3).
[51] 45 CFR 164.510(b)(3).
[52] 45 CFR 164.510(b)(3).
[53] 45 CFR 164.510(a)(3).
[54] 45 CFR 164.512(j)(1)(i).
[55] 45 CFR 164.512(j)(1)(i).
[56] 45 CFR 164.502(b).

- *The patient's prescribed medications including dosage, explanation of side effects, and process for obtaining refills, as applicable.*
- *Available community resources including case management, support groups, and others.*
- *The circumstances under which the patient or lay caregiver should seek immediate medical attention.*

The above listed criteria are recommended for hospitals to include in an allowable disclosure to the caregiver of a patient being discharged from an inpatient psychiatric unit. Oregon law specifically notes that caregiver disclosures should include the patient's prescribed medications and the circumstances under which the patient or lay caregiver should seek immediate medical attention.[57]

In addition, the Oregon health information privacy law notes a number of these factors appropriate for disclosure to a lay caregiver meeting the requirement for written authorization or one of the disclosure exceptions.[58] Those factors include:

- The patient's diagnoses and the treatment recommendations;
- Issues concerning the safety of the patient, including risk factors for suicide, steps that can be taken to make the patient's home safer, and a safety plan to monitor and support the individual;
- Information about resources that are available in the community to help the patient, such as case management and support groups; and
- The process to ensure that the patient safely transitions to a higher or lower level of care, including an interim safety plan. [59]

It is essential to remember that often the families of patients with a mental health condition are not well informed on diagnosis or hospital procedures. Hospital personnel should remember that family and other caregivers are lay persons and explain in plain language hospital processes, standards, and reasons for discharge. Designated caregivers should know the patient's diagnoses and relevant information regarding the recommended treatment and any outstanding issues or signs the patient may be decompensating.

The hospital should provide the lay caregiver with all relevant information regarding transition to the next level of treatment and supports available in the community for both the patient and family. As discussed further, hospital personnel should be particularly explicit in describing the patient's risk factors, if any, for suicide and offering suggestions regarding risk mitigation and signals for persons in the patient's support network to monitor.

Hospitals should always feel free to modify this list and include more information as is relevant to a particular patient situation. Where the patient has authorized disclosure of information to a designated caregiver, hospitals should endeavor to provide more information to ensure the lay caregiver is fully apprised of the patient's status upon discharge and prepared for any follow-up care.

[57] ORS 441.196(2)(a).
[58] ORS 192.567(3).
[59] ORS 192.567(3).

## Conducting the Risk Assessment

- *Conduct a risk assessment of the patient's risk of suicide.*

Oregon law requires that a patient hospitalized for mental health treatment receive a suicide risk assessment prior to discharge.[60] This requirement is applicable regardless of whether attempted suicide was a factor in the patient's initial admission to inpatient psychiatric care, although providers may opt to conduct more detailed assessments in cases where suicide risk is believed to be greater.

Providers must complete the suicide risk assessment in a timely manner so as not to delay discharge.[61] The assessment should be included in the patient's medical record as part of the discharge plan.[62] A patient determined to have a high risk of suicide based on the assessment should never be discharged.

- *Providers should seek input from the patient's designated lay caregiver, including interviews and patient history.*

Providers should endeavor to involve family and friends of the patient in the suicide risk assessment for the best information on the individual's state of mind and environmental risks. Patients have the right to be involved in their care planning, and this right extends to individuals designated by the patient to act in a representative capacity.[63] As such, in conducting the risk assessment, hospital staff should seek input from the patient's lay caregiver, including obtaining information about the patient's history, prior behavior, living situation, and any other relevant information.

Designated caregivers should receive a copy of suicide risk assessment(s) upon discharge as well as an explanation of how the assessment was conducted if that information was not previously shared.

While the standard should be to involve family in suicide assessment and prevention, hospital staff should always consider the particular facts of a patient situation and may opt to not include family members if staff feels that to do so would be counterproductive for that specific patient and/or situation.

- *Providers may accept unsolicited information from family and friends not authorized for disclosure.*

In some instances, a patient may object to the disclosure of protected health information to all potential caregivers. The patient's objection prevents hospital staff from offering family members any affirmative information regarding the patient's treatment. However, neither federal nor state law prohibits providers from accepting unsolicited information from friends of relatives of a patient.

When confronted with such situations, providers should not engage in conversation, but if approached, request that family members leave any information in writing. Acceptance of a written

[60] ORS 441.196(2)(b); OAR 333-505-0030(4)(b)(B)(ii).
[61] 42 CFR 482.13(b)(5).
[62] 42 CFR 482.13(b)(6).
[63] 42 CFR 482.13(b)(2).

statement does not constitute acknowledgement of any patient information and is not a violation of the patient's request for privacy.

### *Additional Requirements Related to Suicide Attempts by Minors*

Oregon law has additional requirements for hospitals treating minor patients as the result of a suicide attempt. Specifically, hospitals treating patients less than 18 years of age as a result of a suicide attempt must report statistical data regarding the attempt to OHA on a standardized form.[64] Hospitals may withhold patient name and other identifying information in the event the facility has privacy concerns with the disclosure.

The law further requires a hospital treating a minor following suicide attempt to provide the individual with information and referral to community resources, crisis intervention, or other interventions deemed appropriate by the patient's attending medical staff.[65]

[64] ORS 441.750, ORS 441.755. Form available at https://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/ASADForm.pdf.
[65] ORS 441.750.

## Conducting the Needs Assessment

- *Conduct a needs assessment to understand the long-term needs of the patient.*

A needs assessment is a particularly critical component of discharge planning for patients with mental illness. The needs assessment may be conducted as early as patient admission, but should be reassessed as necessary if there are factors that may affect continuing care needs.[66] A needs assessment should include questions regarding the patient's income, housing situation, insurance, and aftercare support, among others. The lay caregiver should be included in this conversation, with an explanation of the purpose of the needs assessment and its role in the discharge planning process.

At minimum, the assessment should help the provider determine the patient's capacity for self-care, need for community-based services, and potential appropriate post-discharge placements. This is consistent with federal rules for discharge planning which requires hospitals to assess the likelihood of needing post-hospital services, the availability of those services, and patient capacity for self-care.[67] Importantly, both state and federal law explicitly ask hospitals to assess whether the patient may be discharged to the place from which they were residing prior to admission to the hospital.[68]

The results of the needs assessment should be discussed with the patient and any designated lay caregiver.[69] A copy of the needs assessment should also be included with the patient's medical record as part of their discharge plan.[70]

Hospitals should reassess their needs assessment as part of its discharge planning reassessment, periodically to ensure it is responsive to patient and caregiver needs.[71]

[66] 42 CFR 482.43(c)(4).
[67] 42 CFR 482.43(b)(3)-(4).
[68] ORS 441.196(2)(c)(C); OAR 333-505-0030(4)(b)(B)(iii)(III); 42 CFR 482.43(b)(4).
[69] 42 CFR 482.43(b)(6).
[70] 42 CFR 482.43(b)(6).
[71] 42 CFR 482.43(e).

## Coordinating Transition to Outpatient Treatment

- *Coordinate the patient's care and transition to outpatient treatment. Providers should share the post-discharge treatment plan with the patient and lay caregiver and provide an explanation of:*
  - *The next level of care, how it differs from hospitalization, and what the patient should expect from outpatient treatment.*
  - *Contact information for the outpatient care including address and phone number of the site/provider.*

State law requires hospitals to coordinate patient care and transition to outpatient settings from an inpatient unit.[72] The transition plan may involve community-based providers, peer supports, lay caregivers, or others available the help execute a discharge plan.[73]

Federal standards similarly require hospital providers to arrange for the initial implementation of a patient's discharge plan.[74] The patient, family members, and other lay caregivers must be counseled to prepare them for the patient's post-hospital care.[75] At a minimum, this should include expectation for outpatient treatment and contact information for the outpatient site. Providers may also consider offering information on transportation options as well as steps to take or a number to call if the outpatient treatment does not work for some reason. Hospitals should generally assume that until a discharged patient has seen their next stage provider, the hospital has not fulfilled its obligation to implement a successful discharge plan.

Additionally, as noted previously, for minors receiving treatment following a suicide attempt, Oregon law places additional requirements on hospitals to provide the minor patient with information and referral to community resources, crisis intervention, or other appropriate level of care following discharge.[76] Hospitals should consider applying these standards to any individual, minor or adult, receiving mental health treatment for a suicide attempt.

[72] ORS 441.196(2)(d); OAR 333-505-0030(4)(b)(B)(iv).
[73] ORS 441.196(2)(d); OAR 333-505-0030(4)(b)(B)(iv).
[74] 42 CFR 482.43(c)(3).
[75] 42 CFR 482.43(c)(5).
[76] ORS 441.750.

## Scheduling Follow-Up Appointments

- *Schedule a follow-up appointment for no later than seven days after discharge.*

Hospitals must arrange for the initial implementation of the patient's discharge plan.[77] Pursuant to Oregon's discharge law, hospitals have an affirmative obligation to schedule a follow-up appointment for a psychiatric inpatient within seven days of hospital discharge.[78] To meet this time frame, appointments should be scheduled immediately prior to or after discharge. The seven day standard aligns with metrics reporting for Medicaid patients through the Hospital Transformation Performance Program (HTPP).[79] Importantly however, Oregon law anticipates hospitals will endeavor to achieve follow-up within seven days for all psychiatric patients, regardless of payer.

In the event a patient is transferred to another inpatient setting, the follow-up appointment is not applicable as the transferee hospital takes on the obligations associated with the Oregon discharge law. Stated differently, hospitals should only schedule the follow-up appointment when the patient is being discharged to a lower level of outpatient or home-based care.

Hospitals must provide the next stage provider with all necessary medical information as needed for follow-up or ancillary care.[80]

- *If a follow-up appointment cannot be scheduled within seven days, document the applicable barriers in the patient's medical record.*

In the event that the hospital staff is unable to schedule a follow-up appointment within seven days, or if follow-up is not necessary because of discharge to another inpatient setting, this should be documented in the patient's medical record as part of the discharge plan. When the appointment cannot be made due to specific factors such as limited resources in the area or limited availability for particular services, that should be noted in the patient's medical record. Providers should be sure to ask the patient, family, and lay caregiver about the availability of non-traditional sources of care such as school-based or veteran's health care services.

It is further recommended that hospitals separately maintain a de-identified record of barriers to the seven day follow-up requirement for the purpose to identifying local gaps in step-down care.

[77] 42 CFR 482.43(c)(3).
[78] ORS 441.196(2)(e); OAR 333-505-0030(4)(b)(B)(v).
[79] Oregon Health Authority, Hospital Transformation Performance Program, http://www.oregon.gov/oha/Metrics/Pages/Hospital-Reports.aspx.
[80] 42 CFR 482.43(d).

## Providing Instructions or Training

- *As necessary, provide instructions or training to the patient and lay caregiver prior to discharge.*

H.B. 3378,[81] the other caregiver law passed in 2015, requires hospitals to adopt and maintain written discharge policies for all inpatients, including psychiatric inpatients covered under the provisions of H.B. 2023. The law applicable to general discharge policies requires hospitals to provide the patient and designated lay caregiver with instruction or training prior to discharge, as necessary for the caregiver to perform aftercare functions.[82] This is equivalent to existing federal standards which require hospitals to counsel the patient, family members, or other interested persons as necessary for post-hospital care, also applicable to all inpatients.[83]

Aftercare as defined in Oregon law specifically includes assistance with activities of daily living or instrumental activities of daily living; medical or nursing tasks such as wound care, the administration of medications and the operation of medical equipment; and other assistance provided by a caregiver to a patient, following the patient's discharge, that is related to the patient's condition at the time of discharge.[84] For patients hospitalized for mental health treatment, providers should consider additional elements such as how or where to obtain medications, patient safety plans or patient monitoring, and names and location of community and crisis resources.

Instructions should be provided at a level understandable to the patient and lay caregiver and ideally are provided both orally and in writing.

[81] Now 441.198.
[82] ORS 441.198(2)(d).
[83] 42 CFR 482.43(c)(5).
[84] ORS 441.198(1)(a).

## Notifying the Lay Caregiver of Discharge

☐ *Notify the designated lay caregiver in advance of patient discharge or transfer.*

The final requirement for discharge planning of a patient hospitalized for mental health treatment is to notify any designated lay caregiver of the patient's discharge from the hospital.[85] This notice should be provided enough in advance to allow the lay caregiver to be present if that is necessary. Notice to caregivers should never delay a patient's discharge.[86] Notice must be provided of any discharge from the facility, including transfer to another acute care setting.[87]

[85] ORS 441.198(2)(e).
[86] ORS 441.198(6)(a); OAR 333-505-0030(5)(d); 42 CFR 482.13(b)(5).
[87] ORS 441.198(2)(e).