



# REPORT TO LAW & LEGISLATION COMMITTEE City of Sacramento

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915 I Street, Sacramento, CA 95814-2671

STAFF REPORT  
January 7, 2010

**Honorable Members of the  
Law and Legislation Committee**

**Subject:** Proposed Ordinance Related to Post-Hospital Transport of Homeless Patients

**Location/Council District:** Citywide

**Recommendation:** Discussion and direction to staff of a proposed ordinance related to post-hospital transport of homeless patients.

**Contact:** Mark Prestwich, Special Projects Manager, 808-5380  
Jeffrey Heeren, Senior Deputy City Attorney, 808-5346

**Presenter:** Mark Prestwich, Special Projects Manager

**Department:** City Manager's Office

**Division:** Government Affairs

**Organization No:** 0310

**Description/Analysis**

**Issue:**

The post-hospital transport of homeless patients to the streets of Sacramento has received attention over the past few years. At the request of Councilmember Kevin McCarty, staff has prepared for Committee discussion a draft ordinance prohibiting such practices without written patient consent.

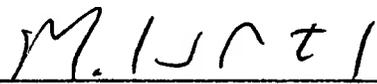
The draft ordinance has been narrowly crafted and subjects violators to a misdemeanor, the maximum criminal sanction Sacramento is empowered to employ. While there is a reasonable legal argument the draft ordinance could survive legal challenge, staff cautions that such an ordinance has not been tested before the courts and no data has been collected to evaluate the prevalence of this practice, if any. Also, the ordinance presents several practical problems including 1) How to deal with situations where homeless patients refuse consent, and 2) The possibility that little improvement in the post-hospital transition of the homeless will occur even if the draft ordinance is adopted.

**Environmental Considerations:** None

**Rationale for Recommendation:** Discussion and direction only.

**Financial Considerations:** None

**Emerging Small Business Development (ESBD):** None

Respectfully Submitted by:   
Mark T. Prestwich  
Special Projects Manager

Recommendation Approved:

  
RAY KERRIDGE  
City Manager

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**Attachment 1**

**BACKGROUND**

The post-hospital transport of homeless patients to the streets of Sacramento and Los Angeles has received attention over the past few years. At the request of Councilmember Kevin McCarty, staff has researched the possibility of Sacramento crafting an ordinance similar to a Los Angeles ordinance criminalizing the transport of homeless patients to the streets. The following report includes background information on pertinent federal and state laws, a summary of the Los Angeles ordinance, and a draft ordinance for Committee discussion prohibiting such practices without written patient consent.

**Federal Law**

Congress enacted the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986 to respond to the problem of hospital emergency rooms refusing to treat patients who were uninsured. In such situations, emergency rooms would decline treatment or transfer patients in an unstable condition to other hospitals, jeopardizing patient health.

Under the EMTALA, Medicare-participating hospitals are prohibited from delaying a medical screening exam and stabilizing treatment in order to inquire about the person's method of payment or insurance status. If the hospital is unable to stabilize the patient, the hospital must provide for an appropriate transfer to another medical facility. Besides EMTALA, other federal law requirements for hospitals participating in the Medicare program require adoption of written discharge policies for all inpatients.

**State Law**

California Health and Safety Code sections 1262.4 and 1262.5 and the uncodified provision of Chapter 794 were enacted to begin to address the needs of discharged patients and service providers affected by the transport of homeless individuals to their doorsteps. Health and Safety Code section 1262.4 expressly prohibits a health facility from transferring homeless patients from one county to another county to receive supportive services from a social service agency, health care service provider, or non-profit social service agency, without prior notice and authorization.

Health and Safety Code Section 1262.5, without specifically addressing the homeless, requires a discharge policy for all patients. Section 1262.5 also requires hospitals to make appropriate post-hospital care arrangements for patients likely to suffer "adverse health consequences" if not provided with a discharge plan. Post-hospital care includes, but is not limited to, home care, placement in a skilled nursing or intermediate care facility, or hospice care. Arrangements for post-hospital care are supposed to be made prior to release, and counseling provided for the patient, family members, or interested persons to prepare for post-hospital care.

The uncodified provisions of Chapter 794 directed regional hospital associations to host planning meetings to identify "community-based best practices" for post-hospital

transfer of homeless patients and publish recommendations by January 1, 2008. Accordingly, the Hospital Council of Northern and Central California held 25 meetings with 898 participants in 2007 and published its findings in December 2007 (see Attachment 2).

### **Los Angeles Ordinance**

Los Angeles passed an ordinance in 2008 (see Attachment 3) making a health facility's post-discharge transport of a patient to a location other than the patient's residence, without written consent, a misdemeanor. The ordinance does not apply to appropriate transfer to another health facility. The ordinance defines residence to include any public or private place a homeless person may give as a residence, even if not designed for human sleeping. The penalty is a fine up to \$1,000 or probation up to three years, or both.

Los Angeles has not yet charged any health facility for violation of its ordinance. Los Angeles continues to use California's civil unfair competition law available to city attorney's of cities with populations exceeding 750,000—which presently includes only Los Angeles, San Diego, San Jose and San Francisco. Unlike a criminal misdemeanor prosecution, the civil unfair competition law has a lower burden of proof, and allows civil monetary penalties well in excess of a misdemeanor fine, and injunctions. The unfair competition law does allow cities with less population to sue, but only if the city has a full-time city prosecutor and consent from the District Attorney. The District Attorney has previously denied Sacramento permission to use the unfair competition law in other contexts, namely code enforcement.

### **Draft Ordinance**

Because California Health and Safety Code section 1262.4 already prohibits transfer of homeless patients from one county to another county for receiving supportive services from a social service agency, health care service provider, or non-profit social service agency, without prior notice and authorization, no need exists for a Sacramento ordinance to touch on this issue. Likewise, because both state and federal law require discharge policies and prescribe what the policies need to cover, it is not necessary for a Sacramento ordinance to address this issue.

Rather, Sacramento's specific problem appears to be placing discharged, or post-stabilized patients perceived to be homeless, on the streets without their consent. As such, the draft ordinance (see Attachment 4) is specifically written to prohibit health facilities from transporting or causing to transport a patient (including a homeless patient) to a location other than the patient's residence without written consent. The draft ordinance does provide an exception when the patient is transferred to another health facility following procedures in accordance with state/federal law or in the custody of law enforcement.

Even with the narrowly crafted ordinance, there may be practical problems associated with it. Requiring the written consent from a patient may prove unworkable in some situations. For example, patients that have psychiatric issues may refuse consent. This

is often seen in "5150" cases where a person committed to a psychiatric facility for 72 hours refuses consent to discharge. Psychiatric facilities document this by noting that the patient refused to sign the discharge papers. Similarly, health facilities may have situations where a medical patient will refuse consent to a transport of the type at issue here. They may refuse to declare a residence even if there is in fact a homeless camp or area where they otherwise routinely reside and which they may have even disclosed in the medical screening process.

A violation of the ordinance would be a misdemeanor punishable as provided in Chapter 1.28 of the Sacramento City Code. A person convicted of such an offense would be subject to a fine up to \$1,000, imprisonment in the county jail for up to six months, or both and administrative penalties under Section 1.28.010(c).



**Hospital Council**  
of Northern & Central California

*Excellence Through Leadership & Collaboration*

**CARING FOR THE HOMELESS IN OUR COMMUNITIES:  
POST-HOSPITAL TRANSITION OF HOMELESS PATIENTS**

*A Summary of Regional Meetings Convened by the  
Hospital Council of Northern and Central California  
In Fulfillment of AB 2745 (Jones) of the California Legislature  
December 2007*

**BACKGROUND**

In an effort to encourage community dialogue regarding the post-hospital transition of homeless patients, AB 2745 (Jones) was introduced in 2006 and subsequently signed into law by Governor Schwarzenegger. The legislation called for the California's regional hospital associations to convene local meetings of key stakeholders to identify 'best practices' and opportunities for improvement surrounding the hospital discharge of homeless patients. Twenty-five meetings with 898 participants were held throughout 2007 covering nearly every county served by the Hospital Council of Northern and Central California. The meetings were held in hospitals, Veteran's Halls, community rooms, and County Health Departments...some in collaboration with existing community groups already well-engaged with the homeless population and others in places with little local 'infrastructure' to deal with the needs of the homeless. Hospital Council staff also attended two meetings of the Northern California Homeless Roundtable (in Sacramento and in Redding) to extend the discussions further into the communities we serve.

As called out in the legislation, this report summarizes our findings, lessons learned and opportunities for continued community collaboration and fulfills the requirements as set forth in AB 2745 to provide a summary report of the regional meetings.

**METHODOLOGY**

The Hospital Council of Northern and Central California created an organizational plan to carry out the provisions of AB 2745. Each Regional Vice President implemented the plan in their respective territories, tailoring each meeting to the local needs and circumstances. Among Hospital Council staff, a common meeting agenda was drafted so that all of the discussions would generate similar input in order for us to better assess trends, gaps and future opportunities across the region.

In communities with existing local 'infrastructure' serving homeless residents, these meetings were often done in conjunction with those service providers. In communities with no real organized network of service providers, hospitals directly convened the discussion. The invitation list for each local meeting included all local hospitals and those individuals and agencies as outlined in the legislation, including but not limited to: County Board of Supervisors; law enforcement; county social service agencies; County health care service providers; continuum of care coordinators (HUD); nonprofit social service providers; and regional advocates for the homeless. The actual participation of those invited to each meeting varied but, overall, the meetings were well-attended and included a good representation of local stakeholders.

December 19, 2007

## **OVERVIEW**

There is little doubt that the regional meetings as envisioned by Assemblymember Jones and called for in this legislation provided an important opportunity for hospitals, communities, California...and, ultimately, for the homeless patients in our cities. There are several striking 'themes' that resonated in all of our local discussions:

- **There is clearly a shared belief in all communities and among all stakeholders that the current situation facing California's homeless population is a complex, long-standing, deep-rooted, under-funded problem. It is bigger than any single institution and it is one where solutions will require engagement of all sectors. Each stakeholder held a shared interest in improving the care and services for homeless residents...how each were able to contribute to that differed but there was clearly a shared commitment to that outcome.**
- **It is important to recognize that each organization or nonprofit providing services to the homeless, including hospitals, operates within a larger community context and is not an 'island' unto itself. It follows then that the solution to the homeless problems facing our cities must also be solved in that larger context and through the efforts of multiple stakeholder groups. Communication between stakeholders ...and learning how the parts of a community work together on this issue...are essential.**
- **It also follows that the problems that homeless individuals deal with also occur in a larger context and they rarely are just a single issue of health care *or* housing *or* transportation. Rather, in most cases, California's homeless deal with all of those issues and more...substance abuse, mental illness, domestic violence, limited job skills, children to care for, lack of finances...the list goes on. Their issues are not one-dimensional...nor can our solutions be one-dimensional.**
- **In the absence of a larger State or community homeless plan, it often falls to every organization or institution involved to work outside their 'highest and best' use...moving into areas where they have inadequate staff, training and/or resources...in order to meet the homeless patient's needs. For example, it is common to find hospitals involved in every aspect of caring for the homeless...clothing, transportation, meals, family, health insurance programs, and public assistance...housing agencies searching for healthcare, food, and insurance...or homeless shelters attempting to provide medical care.**
- **There are many passionate and deeply committed community members who work on the homeless issues every day...and often with very limited resources.**
- **Local infrastructure to deal with homeless issues varies greatly from place to place...and ranges from extremely well-developed to virtually none at all.**

## **PRINCIPLES DRIVING THE COMMUNITY CONVERSATIONS**

In meetings all across the Hospital Council's Northern and Central California region, a common set of principles seemed to emerge from these community conversations. Every community is committed to find the most effective strategies and solutions to serve their homeless residents driven by the following shared principles:

- **Permanent and sustainable solutions** that result in life changes vs. 'temporary fixes'
- **Collaborative work across all sectors:** healthcare, social service and other government agencies, law enforcement, nonprofit community-based organizations, faith-based groups, housing agencies, elected officials, and schools
- **A network of services for homeless residents** that is centralized, integrated, seamless and easy to access and that spans the full continuum of care
- **Reliable funding from a variety of sources** (to decrease dependence for funding from a single source) and a commitment to *expand* rather than simply *shift* resources for this population
- **Ensuring the 'highest and best use' of all community resources** in meeting the needs of this population

#### **CURRENT CHALLENGES, RESOURCES AND SERVICE GAPS**

Each regional meeting began with the identification of local resources currently available. As expected, those community resources varied from region to region and from the urban to the more rural communities. This discussion led to the identification of 'gaps' in services as viewed through the lens of each community. Those 'gaps' are summarized here.

##### ***Inconsistency in Overall Community Plans / Infrastructure to Serve the Homeless***

- The absence of comprehensive community plans creates a lack of clarity on roles, accountability, and scope of services available leading to fragmented, duplicative or, in some cases, totally 'absent' services for this population.
- In most cases, the centralized function, if one existed at all, was carried out through a collaboration of non-profit agencies and was not 'institutionalized' in the County or City systems.

##### ***Inadequate Capacity to Serve the Needs of the Homeless Population***

- Every community reported that the local shelter capacity fell short of the daily basic needs. Compounding the problem, shelter staff reported that they are not trained or equipped to manage individuals with medical needs.

##### ***Complexity of the Problems Facing the Homeless***

- Lack of permanent, affordable housing...a 'housing first' view was shared by many participants in these community meetings.
- Services for the homeless are made more challenging due to the complexity and multi-dimensional nature of the problems they face (e.g. shelter, substance abuse, mental illness, domestic violence, and the like).
- Specifically, services for homeless residents with substance abuse issues are a huge unmet need in every community (detoxification facilities, sobering centers, or long-term recovery locations are few and far between).
- The ability to secure legal guardian status and/or conservatorships for the homeless is difficult.

### ***Healthcare Challenges***

- The single biggest gap in the health-related 'continuum of care' is the lack of medical respite care facilities. We found communities that have no respite care options or, if they did, the capacity is inadequate, under-funded, or too restrictive in its use (e.g. San Francisco has a 60-bed medical respite facility but that capacity is far below the City's needs). *This was universally reported in all regions of Northern and Central California.*
- Facility protocol for the discharge and transfer of homeless patients varies among hospitals, community service providers, shelters and others involved with this population.
- Intensive case management services for patient follow-up have proven effective in some communities but are not widely available (this links to continuing challenges with affordable pharmaceutical services, medical equipment, and the like for homeless patients).
- Underutilization of community clinics (especially for weekend care) was noted.
- All communities suffer from a severe shortage of inpatient psychiatric beds/services as well as a shortage of long-term care options for the homeless
- Overuse of emergency departments by homeless patients burdens an already over-taxed system within hospitals and does not necessarily promote the long-term health of the homeless patient.

### ***Lack of Data and Information Sharing***

- Hospitals vary in their data collection re: homeless patients, length of stay, recurrence of hospital stays, etc, making it more challenging to clearly define the scope of the problem. It is difficult to correctly collect data identifying a patient as 'homeless' upon admission or arrival in the Emergency Department, due to inaccurate reporting by the patient, data entry system limitations and other constraints.
- HIPAA regulations make the sharing of homeless patient information from hospital to hospital or from hospital to community agency more challenging.

### ***Funding and Resources***

- The inadequacy of, constraints on, and reliability for funding of homeless services in general, and homeless healthcare services specifically, is a continuing struggle.
- Not all stakeholders in a given community had a good understanding of the resources available to serve the homeless population...agency lists were outdated, not available in a centralized location or incomplete.

### ***Services for Homeless Children***

- This population presents unique challenges and there was a sense that the resources, services, and needs of homeless children elevated the problem to a higher level.

### ***Additional Challenges***

- Parolees recently released from County jails or State prisons add complexity to the local challenges as many shelters and homeless centers will not provide services to individuals with a criminal record.
- Homeless individuals with behavioral or mental health problems, especially those who have been barred from previous shelters as a result, are difficult to place.
- Some existing State legislation actually is counter-productive to serving homeless (e.g. 5150 holds).
- Not all community resources are 'at the table' in these discussions (e.g. long-term care facilities and 'board and care' residences) and must be included.
- The bureaucratic delays to qualify a homeless individual for assistance programs (SSI, Medi-Cal, etc) take months and delay funds to pay for permanent housing solutions and/or their medical needs.

- Regardless of any single community's resources, shelters, plans or services, it is the fundamental right of any competent adult to choose to accept medical care or social service assistance...or not. Every meeting included real-life stories about homeless individuals who simply declined to participate in any of the help offered.

## **BEST PRACTICES AND LESSONS LEARNED**

The community meetings afforded the opportunity to learn more about successful practices and resources that were available in each region. Northern and Central California communities are resourceful, innovative and always searching for new ways to do more with less. Throughout the twenty community conversations, several 'best practice' trends emerged and are summarized with examples given below. The chance to replicate these practices throughout the region holds great promise to accelerate the region's ability to care for the homeless.

### ***Medical Respite Care***

- San Francisco's Department of Public Health operates 60 medical respite beds.
- Contra Costa County's 24-bed respite care center is expected to open in mid-2008.
- The Interim Care Project (Sacramento) is an 18-bed respite care facility operated as a collaboration between four area hospitals, Sacramento County and the Salvation Army.<sup>1</sup>
- East Oakland Community Project's 12-bed respite care center is planned to open in January 2008.
- Kern, Marin, Fresno and Santa Clara Counties are actively exploring the establishment of respite centers.
- Solano County, through the Solano Coalition for Better Health, contracts with two homeless shelters to provide respite beds.

### ***Frequent Emergency Room Users Programs***

- The *BRIDGE* program at Kaweah Delta District Hospital (Tulare County), *New Directions* (Santa Clara County), *Project Respect* (Alameda County), and *ED Action Plan* (San Francisco) have all demonstrated success in caring for homeless patients and getting them access to follow-up care outside of frequent, costly, return visits to hospital emergency rooms as well as access to other community services (e.g. interim and permanent housing options in Santa Clara County).

### ***Hospital Discharge Policies and Protocol***

- Hospital discharge planners, working in conjunction with local homeless service agencies, are developing shared discharge protocol (Contra Costa and Santa Clara Counties).

### ***Strong Community Infrastructure***

- Homeless Services Coordinating Council (San Luis Obispo County) is an example of a strong, coordinated community collaborative.
- HUD/Continuum of Care groups exist in nearly every community.

<sup>1</sup> For more information, see "No Place to Go: Addressing the Challenge of Homeless Patients in Sacramento," *California Healthcare Foundation Issue Brief, July 2006* ([www.chcf.org](http://www.chcf.org))

### ***“One Stop” Community Resources and Services***

- Several programs exist that provide a ‘one stop’ service center for homeless individuals, such as the *“Healthy Connections”* program (San Joaquin County).
- Communities with well-developed 211 systems (Alameda and Contra Costa Counties, for example) have found them to be a tremendous resource.
- Tri-City Homeless Coalition (Alameda County) is opening one-stop center and case management services for the homeless mentally ill in 2008.
- Specialized transportation systems for homeless patients leaving hospitals in San Francisco have been very helpful in connecting these patients to appropriate community resources.
- The Santa Clara Board of Supervisors has recently endorsed the development of a one-stop service center for homeless individuals.

### ***Mobile Units***

- Mobile units of service providers, mental health staff, and home health nurses reach out to the homeless populations in Tulare, Kern, Santa Clara, San Francisco, and San Mateo Counties.

### ***Substance Abuse Services***

- These ‘best practices’ are very limited in California but in other states and a few Northern California communities where they exist, they have been a valuable piece of the continuum of care for homeless individuals (examples include the San Francisco’s McMillan Sobering Center and Alameda County’s Detoxification Services Center (set to open in early 2008).

### ***Funding***

- Some communities have been successful in using Proposition 63 funds to increase services for the mentally ill homeless.

## **MOVING FORWARD: FUTURE OPPORTUNITIES**

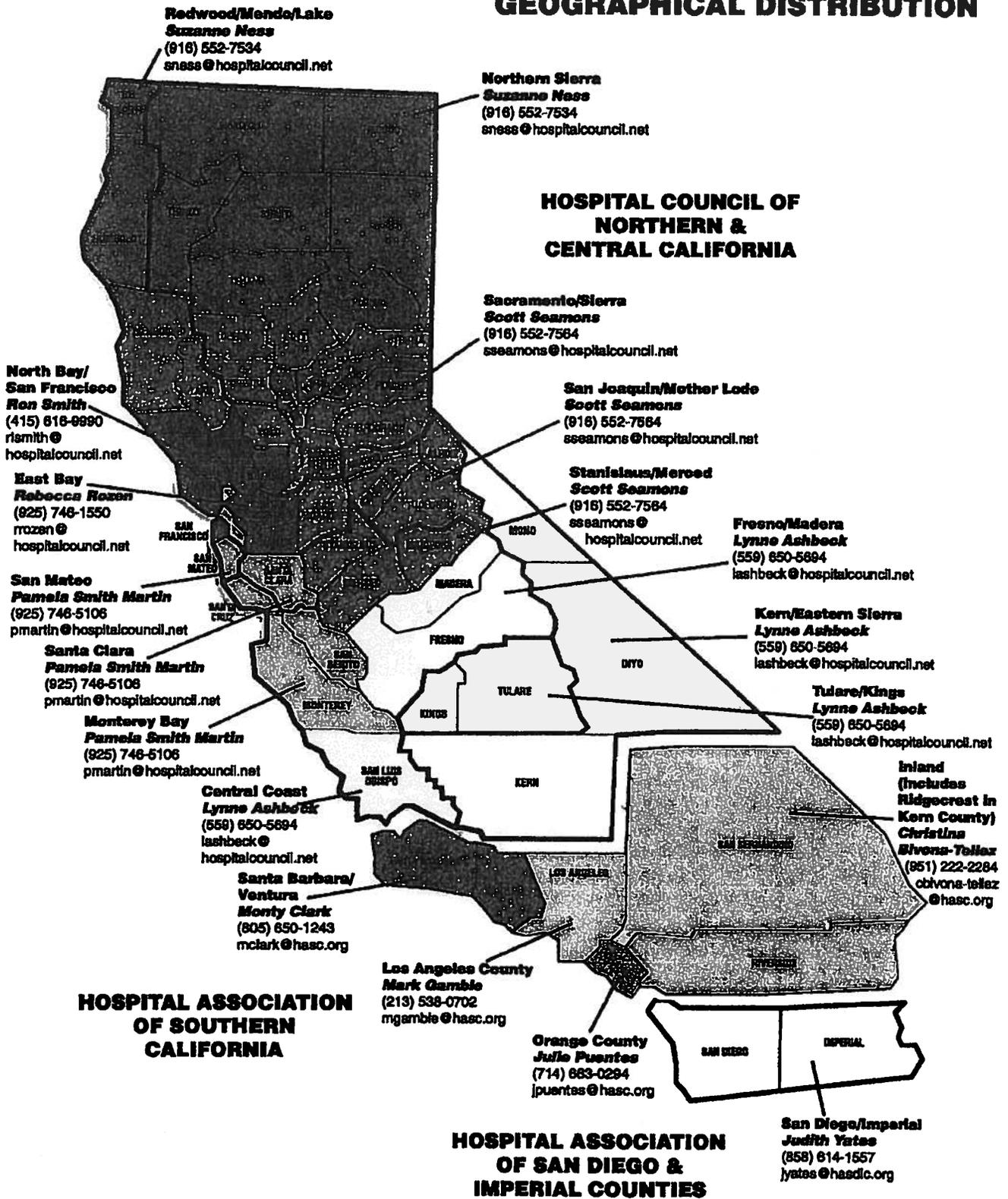
- **Medical respite care** emerged as both the most significant gap *and* the most promising opportunity to improve services for the homeless population. Continued efforts, legislation, funding and technical assistance in creating these centers throughout Northern and Central California would add great value to the healthcare needs of our homeless residents.
- In communities with **case management services for the homeless**, all reported that this ‘individualized’ care plan was highly successful. Efforts to support more case management work within each region will continue.
- **Regional and local collaboratives** are essential to advancing the larger issue of homeless services in any community. Hospitals will continue to be engaged and active participants in these local efforts to strengthen communication, coordination, referrals, and follow-up. When possible, **designation of a centralized community or County staff person/agency** to coordinate homeless services would greatly enhance local efforts.
- As one sector involved in the care of the homeless, hospitals will work together to identify, **collect and monitor relevant data** regarding hospital care of homeless patients (within the constraints of federal legislation); **shared and streamlined discharge protocol, policies, and referral processes** where applicable; and **shared resource lists** to better meet the patients needs. Hospitals will also continue with their **internal staff training** regarding their individual community’s homeless needs and practices in caring for this special patient population.

- **A focus on leveraging existing funding sources (e.g. Prop 63) and identifying additional revenue streams will continue. In addition, linkages and alignment with existing community resources will continue to be an essential element of every community plan (e.g. expanding the role of community ombudsmen to include acute care hospitals).**

#### **ATTACHMENTS**

- **Assembly Bill 2745 (Jones)**
- **List of community meetings held (location, date, number of participants)**
- **Hospital Council of Northern and Central California regional map**

# REGIONAL VICE PRESIDENT GEOGRAPHICAL DISTRIBUTION



ORDINANCE NO. 179913

An ordinance regulating the transport of discharged hospital patients.

**WHEREAS**, the problems affecting downtown Los Angeles' Skid Row area include violent crime, drugs, blight, homelessness and the infamous practice known as "homeless patient dumping";

**WHEREAS**, placing discharged patients, perceived to be homeless, on the streets of Skid Row is not only unsafe and a risk to their well-being and recovery, but a clear indication that institutions are placing concerns for financial performance above humanitarian concerns;

**WHEREAS**, the practice of patient dumping also poses a significant public health risk to the community;

**WHEREAS**, though this problem has been well documented in court proceedings and publicized extensively by the print and electronic media, some institutions persist in the practice;

**WHEREAS**, this practice was the subject of legislation last year, SB 1319 (Cedillo), which generally would have prohibited institutions from engaging in patient dumping;

**WHEREAS**, although the City supported SB 1319, the bill died in the Senate Appropriations Committee last year;

**WHEREAS**, Senator Cedillo, with the sponsorship of the City Attorney, reintroduced his legislation this year as SB 275, which would prohibit a general acute care hospital, acute psychiatric hospital, or special hospital from causing a patient to be transported to a location other than the residence of the patient without the informed written consent of the patient;

**WHEREAS**, while the City supported SB 275, and it successfully passed out of the Legislature, the Governor vetoed the bill on October 14, 2007;

**WHEREAS**, the people of the City of Los Angeles believe that we, as residents of this City and of this State, and as members of our society, must take affirmative and effective action against this inhumane treatment and the serious public health hazard the practice of patient dumping creates;

**WHEREAS**, the City Attorney has been at the negotiating table with certain hospitals for more than a year, encouraging the establishment of reasonable and uniform discharge protocols and best practices;

**WHEREAS**, the City Attorney filed civil and criminal actions against Kaiser Foundation Hospitals under existing law, which resulted in an historic settlement that included the adoption of new discharge policies designed to put an end to homeless patient dumping;

**WHEREAS**, the City Attorney filed civil actions against Hollywood Presbyterian Medical Center and Methodist Hospital of Arcadia for similar behavior, both of which actions are still pending; and

**WHEREAS**, the practice of patient dumping continues in the City in spite of these efforts,

**NOW THEREFORE,**

**THE PEOPLE OF THE CITY OF LOS ANGELES  
DO ORDAIN AS FOLLOWS:**

Section 1. A new Section 41.60 is added to the Los Angeles Municipal Code to read:

**Sec. 41.60. Hospitals; Patient Transport.**

**(a) Definitions.** As used in this section:

**(1) "Health Facility"** means any "health facility" as defined in Section 1250 of the California Health and Safety Code.

**(2) "Patient's Residence"** means the home of the patient, the fixed and regular nighttime residence or domicile of the patient, or, in the case of a patient reasonably perceived to be homeless, the location the patient gives as his or her principal place of dwelling.

**(3) "Homeless Patient"** means an individual who lacks a fixed and regular nighttime residence, or who has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations, or who is residing in a public or private place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.

**(4) "Written Consent"** means knowingly, intelligently and voluntarily given written consent, signed by the patient or the patient's legal representative.

**(b) Prohibited Activity.** A health facility may not transport or cause a patient to be transported to a location other than the patient's residence without written consent, except when the patient is transferred to another health facility following bona fide procedures in accordance with another provision of law.

**(c) Violations.** A violation of this section is a misdemeanor punishable by a fine not to exceed \$1,000, a term of probation not to exceed three years, or both.

**(d) Punishment Cumulative.** The punishment provided for in this section is cumulative to any punishment, penalty, or other relief available under any other law.

**(e) Inapplicability.** This section shall not apply to:

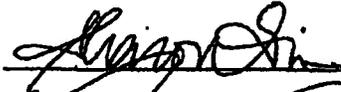
**(1) Patients in the care and custody of a California state hospital operated and administered by the State Department of Mental Health, who are civilly or criminally committed and subject to transfer to the State Department of Corrections and Rehabilitation, the Forensic Conditional Release Program, or a court for further proceedings.**

**(2) Patients who are in the custody or otherwise under the jurisdiction of the State Department of Corrections and Rehabilitation, including the Division of Juvenile Justice, the Los Angeles County Sheriff, or the Los Angeles Police Department.**

Sec. 2. The City Clerk shall certify to the passage of this ordinance and have it published in accordance with Council policy, either in a daily newspaper circulated in the City of Los Angeles or by posting for ten days in three public places in the City of Los Angeles: one copy on the bulletin board located at the Main Street entrance to the Los Angeles City Hall; one copy on the bulletin board located at the Main Street entrance to the Los Angeles City Hall East; and one copy on the bulletin board located at the Temple Street entrance to the Los Angeles County Hall of Records.

I hereby certify that this ordinance was passed by the Council of the City of Los Angeles, at its meeting of MAY 16 2008.

KAREN E. KALFAYAN, City Clerk

By  Deputy

Approved MAY 27 2008

 Mayor

Approved as to Form and Legality

ROCKARD J. DELGADILLO, City Attorney

By   
MICHAEL J. DUNDAS  
Deputy City Attorney

Date 5/16/08

File No. 06-0705-51

**ORDINANCE NO.**

Adopted by the Sacramento City Council

Date Adopted

**AN ORDINANCE ADDING CHAPTER 8.128 OF THE SACRAMENTO CITY CODE  
RELATING TO TRANSPORT OF PATIENTS UPON DISCHARGE OR RELEASE**

BE IT ENACTED BY THE COUNCIL OF THE CITY OF SACRAMENTO:

SECTION 1: Chapter 8.128 is added to the Sacramento City Code to read as follows:

**Chapter 8.128 Transport of Patients Upon Discharge or Release**

**8.128.010 Findings and Purpose**

State Law requires hospitals to develop and adopt policies and procedures that address the post-discharge needs of patients likely to experience adverse health consequences in the absence of discharge planning. Federal law likewise recognizes the importance of such planning, and requires adoption of screening and discharge policies and procedures as a condition of receiving federal funding.

Despite these requirements, the practice of transporting homeless patients to the streets occurs in the City of Sacramento. The homeless are particularly at risk of adverse consequences following discharge from health facility care. Transport of discharged or released homeless patients to the streets without their consent is unsafe and a risk to their well-being and recovery. The City of Sacramento opposes this practice and the serious public health and safety hazard that it creates. In enacting this Chapter, the City Council intends to prohibit the practice of transporting discharged or released homeless patients to the streets without their consent, enhance the likelihood of hand-to-hand or warm transfer of discharged patients to an accepting shelter or community organization or other lodging alternative, improve post-hospital transition of homeless individuals, and thereby decrease health and safety risks in the community.

**8.128.020 Definitions**

As used in this chapter:

“Health facility” means any health facility as defined in Section 1250 of the California Health and Safety Code.

“Patient’s residence” means the home of the patient, the fixed and regular nighttime residence or domicile of the patient, or, in the case of a homeless patient, the location the patient gives as his or her principal place of dwelling.

**“Homeless patient” means an individual who lacks a fixed and regular nighttime residence, or who has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations, or who is residing in a public or private place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.**

**“Written consent” means knowing, intelligent, and voluntary written consent, signed by the patient or the patient’s legal representative.**

**8.128.030 Prohibited Activity**

**A health facility may not transport or cause to be transported a patient including a homeless patient from the premises of the health facility to a location other than the patient’s residence without written consent, except when the patient is transferred to another health facility following procedures in accordance with another provision of law.**

**8.128.040 Violation**

**A violation of this chapter is a misdemeanor punishable as provided in Chapter 1.28 of the Sacramento City Code.**

**8.128.050 Exceptions**

**This chapter shall not apply to the following:**

**Patients in the care and custody of a California state hospital operated and administered by the State Department of Mental Health, who are civilly or criminally committed and subject to transfer to the State Department of Corrections and Rehabilitation, the Forensic Conditional Release Program, or a court for further proceedings.**

**Patients who are in the custody of, or otherwise under the jurisdiction of, the State Department of Corrections and Rehabilitation, including the Division of Juvenile Justice, the Sacramento County Sheriff, or the City of Sacramento Police Department.**