Aftercare Checklist Post LPS Hold
(post-implementation of SB 43)

Audience	Checklist

• **Care Managers (Enhanced Care Management or otherwise)**
• **Hospital Discharge Planners (and/or Hospital Liaisons)**
• **Non-Hospital Treatment Programs**
• **Field-Based Teams Offering Linkage or Continuity Care**
	1. Assess the individual's connection to family, conservator (if conserved or in process of conservatorship), and if they are connected to a field, outreach, and/or outpatient team to assist with each of the checklist items below.
	
	2. Confirm the patient's arrival at designated placement (residential treatment or housing placement, if part of their discharge plan)
	❑ Community agency outreach to patient and to referring hospital if no-show
	  ○ If placement was refused or disrupted, reassess barriers and attempt re-engagement.
	  ○ When applicable, notify assigned outreach or field team for follow up.
	
	3. Confirm intake completion for assigned mental health (MH) and/or substance use disorder (SUD) services
	❑ Treatment agency outreach to patient and to referring hospital if no-show
	  ○ If placement was refused or disrupted, reassess barriers and attempt re-engagement.
	  ○ When applicable, notify assigned outreach or field team for follow up.
	
	4. Confirm the patient's access to prescribed treatments (including psychiatric, addiction medications, and medical)
	❑ If medication adherence is a concern, connect to pharmacy support, home visits, or outreach teams.
	❑ Schedule or verify attendance at primary care and behavioral health follow-up appointments.
	❑ Address any transportation barriers to medication pick-up or medical visits.
	
	5. Continue engagement and case management support
	❑ If a long-term case manager or care coordinator is not assigned, designate one.
	❑ Schedule weekly or biweekly check-ins based on risk level.
	❑ If under court-ordered treatment or conservatorship, ensure adherence by coordinating with legal teams and treatment providers.

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6. **Establish crisis prevention and long-term support plan**
   - ❑ Establish a crisis response plan, including a designated point of contact if the individual destabilizes.
   - ❑ If the patient disengages from care, initiate outreach team follow-up to prevent deterioration.
   - ❑ Facilitate warm handoffs to peer support groups, recovery services, or community resources, ensuring active linkage and follow-up.
   - ❑ Refer to harm reduction services and contingency management interventions when clinically appropriate.

7. **Confirm all handoffs, referrals, and interventions are completed and documented**
   - ❑ Update care plans, service engagement status, and risk assessments in the system.
   - ❑ If care gaps exist, escalate to the appropriate workgroup or leadership team for resolution.
   - ❑ Confirm/inform required parties of treatment plan (i.e., custodial parent/guardian, PG/LPS conservator, probation officer, etc.).