HEALING HANDS

NETWORK NETWORK
HCH CLINICIANS'

Tools to Help Clinicians Achieve Effective Discharge Planning

Too many people without financial resources and social supports cycle among hospitals, mental health facilities, foster care or group homes, correctional institutions, shelters, and the streets. These insidious "revolving doors" exacerbate homelessness and call for clinicians and communities to find coordinated solutions that are humane and cost effective. First steps often involve creative adaptation of existing interventions. The following articles discuss discharge planning strategies and focus on individuals who are leaving health care institutions, jails and prisons, protective youth services, or the armed forces.

In 2006–2007, one in five homeless individuals admitted to shelter programs came from either in-patient medical facilities (12%) or correctional institutions (9%).[1] Those figures do not include unsheltered individuals or those living in domestic violence shelters or doubled up with family members or friends.

Discharge Planning: The process—beginning on admission—to prepare a person in an institution for return into the community and the linkage of the individual to essential community services and supports.

— *Massachusetts Housing and Shelter Alliance*

Regardless of which institution an individual may be leaving, some form of discharge planning is imperative to assure a successful transition to independent or assisted living. Without a stable home environment and family or peer support, people recovering from illness, surgery or physical injury; those without health insurance and income; and those newly emancipated from protective or correctional institutions are especially vulnerable to the harsh realities of homelessness. Many homeless shelters provide a place to sleep at night but close their doors in the morning, leaving residents to depend on soup kitchens, drop-in centers or public places, or to walk the streets without a safe place to rest or heal.[2]

Poignant case histories illustrate what can happen without adequate discharge planning. **Brooke Doyle**, Vice President of Homeless Services and Intensive Addiction Services at Community Heathlink's HOAP project in Worcester, MA, oversees facilities that provide medical and mental health case management at multiple service sites. Recently, she relates, "One of our clients was released from prison to an emergency shelter where our staff provides health care services. He had an open wound from recent surgery for a spinal cyst. His health risk was too high for shelter living, and he was unable to manage on the streets during daytime hours." In addition, as a former sexual offender, he was barred from subsidized housing and nursing homes.

HOAP has two respite beds that are staffed 24/7 at its primary site. The staff was able to establish wound care through their hospital partner; but this patient will occupy 50% of the center's medical respite capacity for an extended period of time—perhaps 12 months—before he is sufficiently healed to be discharged to a shelter. "Clearly, this case illustrates a lack of coordinated and humane planning," observes Doyle. "It is understandable that when an inmate's sentence has been completed, he or she needs to be released. But individuals with no income and no family don't have a lot of choices."

Ted Amann, MPH, RN, Director of Healthcare and Improvement at Central City Concern in Portland, OR, reminds us that "adapting to the changing fiscal and healthcare landscape while maintaining essential social benefits requires foresight, innovation, and new sources of revenue. Together, hospitals, states, the broader health care community, insurers, and patients must craft solutions that are financially viable and compassionate so that medically underserved populations, including rural communities, receive adequate healthcare now and far into the future."[3] That means hospitals, substance abuse treatment facilities, medical respite care providers, prisons, jails, and protective programs for youth all need to be skilled in the principles and practice of discharge planning.

Discharge Planning Guidelines for Health Care Institutions[4]

- Provide physical and mental/cognitive assessment at intake.
- Work with the patient on treatment adherence issues.
- Ensure patient stability prior to discharge.
- Base the decision to discharge on medical, not financial considerations.
- Encourage the patient (or surrogate) to participate in discharge planning.
- Give the patient (or surrogate) written notice of the intent to discharge and allow for an appeal of the discharge determination.
- Involve social work, pastoral care, legal counsel, ombudsman, ethicist, and a multidisciplinary care team in discharge planning.
- Provide information about community resources to clinicians and patients.
- Dedicate a clinical social worker to all homeless discharges.

The Health Care Link in Discharge Planning

On July 14, 2008, representatives of major homeless continuums of care in Cook County, IL met with county, state and federal officials to discuss how discharge policies of health, mental health, youth services, and correctional institutions were impacting homelessness. This Countywide Forum on Discharge Planning and Homelessness resulted in the formation of seven subcommittees representing agencies and subpopulations affected by discharge planning: Veterans Affairs, Health Care, Mental Health Care, Substance Abuse Treatment, the Cook County Jail, Youth Protective Services, and the Illinois Department of Corrections.

Kathleen Kelleghan, Associate Director of Health Outreach Services for Heartland Health Outreach in Chicago, chairs the Health Care subcommittee. "The forum inspired hope that this collaborative effort will engender necessary systems change to assure better care for vulnerable people," said Kelleghan, who has already seen how important it will be for her group to interact with the other six.

Nancy Radner, Chief Executive Officer of the Chicago Alliance to End Homelessness, told forum participants: "We are finding that people who leave the mental health, corrections, or child welfare systems can end up in the homeless [service] system. [It is important to] highlight how effective planning and coordination among these systems [can be] the key to preventing homelessness for so many people."

REVOLVING DOORS In the mid-1980s, caregivers nationwide began to notice the often cyclical inter-relationships among institutions that provide medical or behavioral health care, child protective services, and correctional facilities, and to realize their collective impact on homelessness. Clients tended to move from one institution to another without careful screening or resources, as if through revolving doors.[5,6] As more and more homeless individuals were caught in this vortex, financial burdens for institutions increased, public budgets inflated, and pressure was exerted on clinicians, administrators, and government agencies to look for creative solutions.

The U.S. Department of Housing and Urban Development (HUD) published a bibliography on discharge planning in 2005, noting that "good discharge planning is the lynchpin of a comprehensive homelessness prevention strategy."[7] Ensuring an individual's successful transition from institutions to the community "requires continuity of care and linkages to appropriate housing and community treatment and support" following discharge.[5-7] Research emphasizes that without permanent housing options even the most effective discharge planning will fall short.[5,8,9]

The National Health Care for the Homeless Council finds the linkage between ineffective discharge planning and homelessness unacceptable and recommends:[10]
- Development of explicit discharge planning policies;
- Prohibition of institutional discharge into homelessness from all publicly funded institutions including hospitals, treatment facilities, jails, prisons, and the foster care system;
- Effective discharge into stable housing as an imperative outcome measure for any residential program; and
- Requirement that publicly funded institutions help residents secure all available entitlements prior to discharge.

ZERO TOLERANCE In 1994, the State of Massachusetts mandated zero tolerance for discharge to homelessness in response to pressure generated by the Massachusetts Housing and Shelter Alliance (MHSA). Research conducted by MHSA identified state systems that were discharging clients without stable housing options.[11] As a result, state agencies eventually adopted common discharge planning procedures.

With the assistance of its 87 member agencies, including the Boston HCH Program, MHSA introduced innovative procedures to prevent homelessness through better discharge planning.[11] MHSA contends that discharge planning
- must be tailored to meet different needs of different consumers;
- should be comprehensive;

- must create a system that is continuous and coordinated;
- must prevent consumers from falling into homelessness; and
- should begin at admission.

The HUD McKinney Act requires states, counties, and city governments that apply for continuum of care funds to certify that their communities have policies and protocols in place to prevent the discharge of individuals into homelessness. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has required hospitals to practice discharge planning since 2003.[5] Nevertheless, discharge planning processes are far from uniform, ranging from minimalist to comprehensive practices. It is hoped that emerging evidence-based practices will validate preventive models and encourage their adoption by service organizations nationwide.

TRAINING FOR CLINICIANS There are 79,000 homeless people and 5,240 emergency shelter beds in Los Angeles County. Inappropriate hospital discharges to the streets have increased dramatically and documented cases have been prosecuted, resulting in large monetary settlements. Homeless Health Care Los Angeles (HHCLA) conducted a detailed survey about the experiences of clients discharged from area hospitals and follow-up practices, with support from the Kaiser Permanente Foundation. In response to survey results, HHCLA developed an innovative training model that is designed to help clinicians improve their skills. The training targets social workers, discharge planners, nurse case managers, and selected emergency department personnel.

Director of Discharge Planning Services **Linda Rodriguez, MSW**, explains that HHCLA's training curriculum focuses on
- Clinicians' roles in discharge planning and legal and regulatory responsibilities;
- Community resources including social services;
- Values inherent in the delivery of discharge planning services;

- Assessment as a continuous process on which planning criteria are based; and
- Strategies to reduce avoidable inpatient days through better discharge planning.[4]

HOSPITAL CONSULT SERVICE

Operation Safety Net in Pittsburgh, PA, has implemented a hospital consult service for homeless people. "The consult program serves both clients and hospitals by providing ongoing clinical communication and filling the reality gap that exists when the client leaves the hospital," explains Medical Director **Jim Withers, MD**. "We are called to visit clients at admission, which allows us to share background information with hospital staff and facilitates inpatient assessment. The patient sees a familiar face, and we know how to follow up with client care after discharge. This enables us to remain in the care loop."

MEDICAL RESPITE CARE
Some urban areas including Washington, DC, and Boston have operated medical respite care facilities for homeless people since the 1980s.[12] Others are seeing the need to begin or expand such programs in the face of shorter hospital stays and a growing need for recuperative services and continuity of care after clients move back into the community. There are currently over 40 medical respite centers in the U.S. and Canada (http://www.nhchc.org/Respite/2008-2009RespiteCareProgramDirectory100708.pdf).

Homeless people are known to experience higher rates of physical and mental illness than the general population. A study by the Stroger Hospital of Cook County in Chicago suggests that medical respite care improves health outcomes and reduces health care costs. The cost of respite care provided to the study cohort was approximately half the per diem rate for hospital care and resulted in a 36% decrease in emergency department (ED) usage.[13]

"Interfaith House, a 64-bed facility in Chicago established in 1994, often fills an essential gap between a homeless person's hospital discharge and complete recovery," says Kathleen Kelleghan. "But there just aren't enough beds—3 of every 4 patients must be turned away. One of our needs is to find alternatives for medical respite care, perhaps by using established clinic sites."

During the 2008 National HCH Pre-conference Institute on Respite Care and Hospitals, **Adele O'Sullivan, MD**, Medical Director of the Maricopa County Public Health Department's HCH project, spoke passionately about the drive to build a homeless respite center in Phoenix, AZ that will open with 25 beds. What had been a dream for the future became a front-burner issue for Phoenix after an egregious example of a hospital discharge to the streets was caught on the homeless center's security videotape. People from across the community have contributed time, talent, skills, and money to bring the new facility closer to reality.

Benefits of Medical Respite Care[2]

- Stabilization of acute health conditions and a care plan to address chronic conditions
- Help getting required documentation to qualify for public benefits: Food Stamps, SSI/SSDI, Medicaid
- Help getting stable housing and employment
- Linkage to community service agencies offering ongoing support
- Better self-management of health following discharge from respite care

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These initiatives are important because acute and chronic illnesses can be extremely difficult to treat when patients do not have a stable living situation in which to receive recuperative or convalescent services. Mental illness, substance dependence, HIV, and tuberculosis require regular, uninterrupted treatment and are exacerbated by exposure to the elements, poor diet, lack of health insurance, and irregular access to primary care. Medical respite programs can:[2]

- Prevent patient readmission to the hospital by providing a clean living area where wounds can heal;
- Provide patient referrals for medical evaluations;
- Initiate case management services that facilitate documentation of eligibility for health insurance or other disability benefits; and
- Protect existing relationships with case managers while building patients' readiness to address mental health issues and seek more permanent housing.

PARTNERING WITH HOSPITALS
Across the country, many tertiary care hospitals affiliated with universities are finding the economics of health care unmanageable. Oregon Health & Science University Hospital (OHSU) in Portland serves some of the state's most vulnerable citizens who are unable to pay for their care. In 2007, the hospital sustained uncompensated costs totaling $53 million.[3]

Central City Concern (CCC) in Portland, which operates a continuum of affordable housing integrated with health care, addictions treatment, recovery support, and employment services, is partnering with OHSU to help reduce some of these costs. CCC's medical respite care program, which is supported by a grant from OHSU, serves high utilizers of the hospital's ED whose complex health problems and unstable living conditions often result in longer inpatient stays and frequent readmissions.[3]

This collaboration between CCC and OHSU has resulted in more effective care management. The respite program has:[3]
- Reduced the length of homeless patients' hospital stays;
- Improved patient flow and capacity management;
- Provided cost-effective care of high quality by trained staff familiar with the needs of homeless people; and
- Managed other care functions such as utilization review, discharge planning, and social services.

This partnership has also resulted in better fiscal outcomes and resource management for OHSU:
- Patients moving to the respite program required shorter hospital stays;
- Respite care protected medically stabilized clients and added social stability that helped decrease the likelihood of readmission; and
- Engagement in primary care through the respite program provided client education about how best to use the health care system and discouraged unnecessary dependence on the hospital emergency department.

Discharge Planning for Re-entry after Incarceration

Kushel and colleagues conducted a study of homeless and marginally housed adults in San Francisco that illustrates the bi-directional association between homelessness and imprisonment. Acknowledging that "the intersection of substance abuse, unemployment, imprisonment, and homelessness is potent and lasting," they concluded that "high rates of imprisonment among homeless populations may be the end result of a system that does not provide access to timely services—including access to housing, health care, mental health care, and substance abuse treatment—and systems that have obstacles preventing receipt of these services by people exiting prison." [14]

Jails and prisons are mandated to provide health care, but are allowed to use their own staff, private contractors, or community health centers as providers. Traditional approaches have often been slapdash; many inmates are discharged with even worse medical problems than they had at intake.

Each year, over 9 million people spend hours, days, or months in the United State's 3,300 jails; 80% of inmates are incarcerated less than a month and as many as 60% are awaiting trial or arraignment.[15] Because inmates are generally incarcerated for a limited period, many of these individuals (mostly men) cycle back into their communities, bringing a host of communicable and chronic diseases with them. Over a third of inmates report medical problems more serious than a cold; 17% were homeless before being jailed; and 64% have mental health problems.[15] In addition, most inmates have little education, are poor, and lack social support.

CONTINUITY OF CARE During the 1990s, doctors from a clinic in Hampden County, MA, wanted to track patients with HIV during incarceration. When the Sheriff's Department allowed medical staff into the jails to provide treatment, a new model of care was born. That model resulted in many ex-offenders with medical or mental health problems who after release continued to see providers they had met in jail.

In 2006, the Robert Wood Johnson Foundation allocated $7.5 million to fund a new nonprofit organization, the Community Oriented Correctional Health Services (COCHS), to encourage replication of the Hampden experience nationwide. Since then, in addition to the ongoing project in Hampden County, COCHS has added similar projects in the District of Columbia and Ocala County, FL.

Community-based approaches to ensure continuity of care have often relied on the APIC Model: assess, plan, identify, coordinate.[16] The COCHS approach goes further, allowing inmates to establish a health care "home," to learn about their health conditions and how to keep from infecting others in their communities after release, and to leave jail with prescriptions that can be filled at their community health center. The model uses new computerized systems to produce electronic medical records that can be accessed by community health clinics after discharge.

Diana Lapp, MD, Deputy Chief and Medical Director of Correctional Health Facilities for Unity Health Care, the HCH grantee in Washington, DC, is tremendously proud of her staff's accomplishments. "Unity has 11 discharge planners who begin working with inmates soon after incarceration, often the same day, by developing an individualized plan of care that will connect the inmate back to the community," she says. "All inmates receive primary care in jail from 'half and half providers', who spend half time at the correctional facility and half time at one of Unity's 28 health sites. At discharge, over 95% of those released receive a seven-day supply of medications and are connected to the DC Healthcare Alliance; those infected with HIV receive a 30 day supply of meds funded by the AIDS Drug Assistance Program (ADAP) [which provides free medications for the treatment of HIV/AIDS and opportunistic infections]."

EMR "From intake to discharge, we use electronic medical records (EMR) that can later be viewed by providers outside the correctional health system," explains Lapp. "Corrections officials and court officials see the

value of our discharge planning, and everyone is helping to make the process seamless." She attributes the program's success to the person-to-person connection between inmates and discharge planners. The planners give inmates their pager numbers along with a packet of information that includes a pamphlet with resources and referrals to facilitate early access to health care sites. The DC Department of Corrections (DOC) gives every person discharged from jail an ID upon release and tokens for food to help encourage successful reintegration into the community.

The DOC–Unity Health Care program is working so well that in July 2008, the National Commission on Correctional Health Care (NCCHC) recognized this remarkable partnership with the "Program of the Year Award," which is presented annually to only one of its 500 accredited prisons, jails, and juvenile detention facilities.

INFECTION CONTROL Prison terms are longer than jail terms, and imprisoned individuals are often located farther from their home communities. Although longer sentences provide an opportunity to work on treatment adherence, infection control is especially problematic in prisons where people from diverse backgrounds and communities are housed in close proximity.

The Centers for Disease Control and Prevention (CDC) have issued guidelines to correctional and detention facilities for the control of HIV/AIDS, viral hepatitis, STD, and TB prevention.[17] Similar to the COCHS programs, the guidelines call for early assessment and identification of infection, completion of prescribed treatment, appropriate use of isolation and environmental controls to minimize transmission of airborne infection, comprehensive discharge planning, and efficient and thorough contact investigation, as well as continuing education for inmates and facility staff.

DISCHARGE PLANNING GUIDE In New Jersey, the DOC's Office of Transitional Services strives to provide a systemwide continuum of care based on proven practice

while trying to prepare the 14,000 offenders it discharges each year for any eventuality. Director **Darcella Sessomes** has created linkages to resources including health care, employment, housing, and family support services.

The department spearheaded development of *The Smart Book: A Resource Guide for Going Home* for New Jersey counties. Recognized nationally as a top-tier discharge planning guide, these booklets leave nothing to chance.

Topics include:
• Getting Started: ID and Other Documents
• First Steps After Release: Where Do I Go to Find . . .
• Taking Care of Yourself: Getting Support and Health Care Resources
• Finding a Job: Employment Assistance and Training Programs
• Reconnecting with Family
• The Game Plan
(http://liberty.state.nj.us/corrections/OTS/news_ots.html)

"These are vital skills for all ex-offenders," says **James Comstock, MSW**, Senior Social Worker at Project HOPE in Camden, NJ. He recently retired after 25 years as a correctional counselor and knows the difference that the Smart Books make for positive discharge planning. "The step-by-step entries give individuals a guidewire to resources for success."

Discharge Planning for Youth in Foster Care

Statistics that describe youth who are aging out of foster care paint a grim picture. These young people suffer disproportionately from physical and mental health problems, may be involved in illegal activities, are isolated from the community at large, and face a life of poverty. Scared, lonely, and angry, they often act out in response to cumulative trauma, making placement in a supportive environment difficult.

Of the 750,000 young adults estimated to experience homelessness each year, 20,000 have a history of foster care. Four years after emancipation, 46% of these individuals have not finished high school, 42% have become parents, 25% have been homeless, and 20% are still not able to support themselves.[18,19]

Research shows that youngsters leaving foster care are hindered by missing social supports, incomplete education, poor employment opportunities, and the inability to access health care and housing.[18,19] While the 1999 Chafee Foster Care Independence Program was enacted to provide a safety net of programs for youth leaving care systems, states are required to add a 20% match to the federal dollars. Flexible funding allows them to design programs for specific groups as needed. Foundations, government agencies, and clinicians are increasingly aware that available funds are insufficient to provide a comprehensive assistance program.[18]

Foster children whose birth parents were themselves in foster care are particularly disadvantaged, both socially and economically. Conservative estimates indicate that 49% of

birth parents of children entering foster care have experienced homelessness.[20]

> ### Best Practices for Young People Aging Out of Foster Care
>
> • Preventive rather than reactive practices
> • Adequate dollars to fund consistent programs
> • Automatic support systems: a health insurance card that travels with young adults through age 25; employment and housing assistance
> • Foster care programs designed at the national level and applied consistently across all states
> • Mentors for all youth in foster care
> • Educational and peer group support for pre-teens so that they learn preparation skills when they are still receptive
>
> *— Cheryl Zlotnick, RN, DrPH*

PREPARATION & SUPPORT Although young adults who have episodes of homelessness after emancipation may have more trouble accessing health care than do those without a history of foster care, they do not seem to experience worse health outcomes.[21] The key to successful transitions from foster care to the community is preparation for independent living coupled with strong relationships, education, housing, life skills, identity, youth engagement, and adequate financial support.[22]

ONGOING ASSESSMENT Cheryl **Zlotnick, RN, DrPH**, Project Director of the Center for the Vulnerable Child, an HCH project at Children's Hospital and Research Center in Oakland, CA, says that "for

children who have experienced trauma and have mental health problems, ongoing psychological assessments and treatment are very important. More time in care, more placements and trauma lead to more mental health problems in later life." It is well-established that young children living in foster care have higher rates of social and psychological problems, notes Zlotnick. In addition, newly emancipated 18 year olds encounter high rates of unemployment and homelessness.

MENTAL HEALTH SERVICES Because childhood history of foster care appears to be linked to later mental health problems, effective statewide interventions for children in foster care could reduce the development of psychosocial problems in adulthood.[23] "Mental health services are very important for children in foster care," Zlotnick emphasizes. "And a constant adult who cares about the child and can be part of his or her life consistently—even a birth mom who is not living with the child—is wonderful."

MENTORING RELATIONSHIPS Ahrens and coworkers' recently published study demonstrates that youth in foster care engaged in mentoring relationships with nonparental adults during adolescence have significantly better outcomes than do nonmentored youth. The establishment of such relationships within existing social networks seems to promote stronger and longer lasting relationships.[24]

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For more information about Discharge Planning, see
the National Health Care for the Homeless Council's website: www.nhchc.org/dischargeplanning.shtml

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