Facilitate effective discharge planning

Overview of this strategy

Discharge planning is the process of identifying and preparing for a patient's anticipated health care needs after they leave the hospital. “Discharge planning identifies and organizes services a person with mental illness, substance abuse, and other vulnerabilities needs when leaving an institutional or custodial setting and returning to the community (Backer et. al, 2007).”

Jenkins et al. (2020) lists several challenges to traditional discharge planning processes: “Most hospital discharge policies and best practice guidelines are not tailored to patients with no fixed address, contributing to inappropriate discharges and health inequities for people experiencing homelessness…. Although people experiencing homelessness are frequently discharged to emergency shelters, this discharge pathway does not provide a fixed or long-term solution and puts a strain on emergency housing facilities.” During the Healthcare X Homelessness Pilot, we found there are often no warm hand off processes built between the hospital and the homeless response system (including shelters) for clients with complex medical needs.

A system-wide discharge planning effort includes a dual emphasis on assessing needs and aligning resources. Health systems strive to ‘begin discharge planning on day 1’, meaning that initial patient assessment includes social determinants of health, allowing the care team as much time as possible to align resources to a person’s unmet needs. Additionally, discharge planning requires a detailed view of existing community resources; updated asset maps with specificity around eligibility and prioritization for care in various settings are instrumental. Periodic training of health system staff on homeless response system resources supports the uptake of effective referral processes to the most appropriate settings; health systems in the Healthcare x Homelessness pilot leveraged the expertise of their homeless response partners to learn about the spectrum of housing resources and eligibility and prioritization for various housing types. Health system and homelessness response providers collaborate to develop regional approaches to discharge, streamlining referral processes, particularly around specific subpopulations needing specialized support.

Facilitating effective discharge planning includes:

- Creation of person-first processes for subpopulations experiencing or at risk of homelessness, such as leveraging care coordinators or dedicated housing navigators who are trained in empathetic communication and partnering with patients, to support discharge planning and execution of discharge plans.
- Effectively utilizing the individual’s personal supports to divert pressure on the homeless response system

- Collaborating across sectors to find the most appropriate discharge setting and effectively utilizing available community resources, such as respite, recuperative care or complex care shelters or integration of home health care in the homeless response system.
- Processes and guidelines that are simple enough to be reliably followed, including ensuring referrals are accepted and complete
- Mechanisms for continual monitoring & reducing gaps in care delivery, such as monitoring readmissions, case conferencing, and developing a humanitarian and business case for other system investments

Impact of this Strategy:

Discharge planning is likely to boost outcomes in these areas:

- Individual health outcomes - improved recovery rates and engagement in preventive health care, reduced hospital readmissions, reduced emergency room visits, increased ability to engage in self-management and health-promoting behaviors including post-discharge instructions
- Population level outcomes - reduced hospital readmissions, reduced emergency room visits, reduced inflow to the shelter system through diversion to safe placements
- Degree of system coordination - improved coordination of entry to the homeless response system, which may have a secondary effect of reducing 'moral injury' which may occur when clinicians to feel like they have no option other than discharging people back to an unsafe environment
- Using resources effectively- decreased unnecessary hospital utilization, including decreased length of stay in inpatient care

Resources and tools for implementing this strategy

https://nhchc.org/clinical-practice/homeless-services/discharge-planning/

Practical advice from the field

Discharge from hospital or other health care settings offers opportunities to connect patients to respite and recuperative care, preventive healthcare providers (primary care, behavioral health, specialty care) and the homeless response system. Teams explored ways to facilitate effective discharge from the healthcare system to a variety of needed supports.

In Sacramento, health systems piloted or expanded on existing hospital-based patient navigation services to directly support people experiencing homelessness. In Sacramento, four health systems coordinated efforts to provide hospital-based patient navigators to connect patients to the homeless response system's coordinated entry, make referrals to Medicaid-funded community supports and case management services, establish follow-up primary care appointments and connections to other needed community supports. Teams strengthened existing partnerships with local respite care programs, supporting respite care

providers to connect people with housing placement support with the goal of discharge into PSH.

Sustaining effective discharge planning in the long-term is likely to be somewhat challenging. Teams listed enabling conditions that could support a community to get started with effective discharge.

- An evident enabling condition is the existence of a range of safe discharge options: from respite and recuperative care to transitional and permanent supportive housing. An array of willing partners need to be engaged alongside the hospital; respite and recuperative care are often separate from the hospital's network of care providers.
- Availability of respite, recuperative care and short-term shelter options that can accept patients with medical complexity by providing or leveraging care.
- Within healthcare, while community benefit leaders can broker partnerships with other organizations, case management directors need to be involved in the day-to-day work to ensure effective collaboration among service providers. Each safe discharge option will have its own inclusion and exclusion criteria, length of stay, and service array, and hospital discharge planners need to navigate the spectrum of care options to find appropriate placement.
- Funding for innovative pilots can support the launch of this work, but community-wide investment is needed to provide long-term funding responsibility for a range of safe discharge options.

Tactics & Change Ideas:

- Identify pathways for discharge for specific subpopulations (ex, people who are homeless who are receiving cancer treatment (chemo); people needing palliative care)
- Develop options for discharge to medical respite care, to support people as they get get their feet under them and move into permanent supportive housing
- Develop partnerships with home health care agencies and consider providing this support in the homeless response system
- Use time in respite care to identify and support people moving into permanent supportive housing

Bright spots, tools & examples from the field:

- Better Care Playbook: Person-Centered Transitional Care for Individuals with Complex Needs

References:

Backer, T.E., Howard, E.A. & Moran, G.E. The Role of Effective Discharge Planning in Preventing Homelessness. *J Primary Prevent* **28**, 229–243 (2007). https://doi.org/10.1007/s10935-007-0095-7

Jenkinson J, Wheeler A, Wong C, Pires LM. Hospital Discharge Planning for People Experiencing Homelessness Leaving Acute Care: A Neglected Issue. Healthc Policy. 2020 Aug;16(1):14-21. doi: 10.12927/hcpol.2020.26294. PMID: 32813636; PMCID: PMC7435079.