**Guidelines for the Discharge of Homeless Patients**

**November 2013**

**Policy Statement**

It is the policy of Maine hospitals to manage the care of homeless patients with the same dignity and compassion that all patients should expect to receive at any Maine hospital. Prior to discharge, an appropriate discharge plan for post-hospital medical care will be completed and clearly documented in the patient’s medical record. To improve continuity of care and better address the particular health care needs of the homeless patient population, Maine hospitals are committed to the following guidelines when treating, admitting, and discharging homeless patients.

The following Guidelines have three distinct parts with each part playing an important and complementing role:

1. Hospital Guidelines
2. Discharge Planner Education and Training Guidelines
3. Community Resource Guidelines

**Hospital Guidelines**

1. **Understanding and Developing Community Resources**

Hospitals should establish and build relationships with community service providers to assure accurate and updated contact information, acceptance criteria for community services, and to maximize resources available for homeless patients.

1. **Arrival at the Hospital**
2. Identify patients who are homeless or at risk of being homeless.
3. Attempt to notify the appropriate community resources and document accordingly.
4. Secure patient’s belongings.
5. **Admission to the Hospital**
6. Identify various benefits that the patient may be eligible for.
7. Discuss the benefits with the appropriate community resources and document accordingly.
8. **Discharge Planning**
9. Discharge planning should begin as soon as possible after admission. Homeless patients face particular barriers to ongoing care including medical and social service needs.
10. As the patient is approaching discharge, the hospital should collaborate with the appropriate community resources to ensure that resources are in place at the time of discharge and document the effort accordingly.
11. The hospital should work toward a timely release of information to community resources. Examples include: Discharge Instructions, Discharge Summary and Medication Instructions.
12. The discharge plan for transition into the community should be developed with patient participation or the participation of an appropriate surrogate.
13. The patient should be transferred with all appropriate supplies and medications.
14. The hospital should make final contact with the community resource prior to the actual discharge of the patient and document accordingly.
15. The patient should be discharged with safe transportation and weather appropriate clothing.

**Discharge Planning Education and Training Guidelines**

**A. Discharge Planning Approach**

Discharge planning for homeless individuals transitioning from a hospital should be done utilizing an integrated discharge planning team approach.

**B. Recommended Training Components for Discharge Planning Education**

1. Understanding the composition of the different homeless populations.

2. Learning about the best practices in the field of homelessness.

3. Knowledge of the housing and other residential resources available for homeless

 youth, adults and families in the community/catchment area.

4. Knowledge of the different resources and support available for homeless youth,

 adults, and families in the community/catchment area.

5. An understanding of General Assistance and what services are available to homeless

 youth, adults and families in their home communities.

6. A knowledge of the “211” call number and its potential for use in discharge planning.

7. A visit to the local shelter and transitional program that includes a review of the

 facilities’ policies and referral procedures.

8. An understanding of the different risk assessment tools available for the different

 homeless populations.

**Guidelines for Community Resources**

**(Hospitals cannot commit to these Community Resources)**

1. **Community Discharge Location**
2. Prepare for the arrival of the patient being discharged after receiving communication from sending hospital.
3. Notify sending hospital of the patient’s status upon arrival and confirm medication supply status, etc.
4. **Ongoing Activities**
5. Provide case management where appropriate.
6. Provide follow up with benefits and services needed to maintain appropriate level of care.
7. Document continuing collaboration with hospital.
8. **Accountability**

Each community discharge location will be responsible for designating an appropriate member of its Management Team to be responsible and accountable for assuring compliance with these guidelines.