Overview

Over the last few years, the Executive Office of Housing and Livable Communities (HLC) has been working closely with the Department of Public Health (DPH), the Department of Mental Health (DMH), and MassHealth to better align expectations for acute care hospitals, behavioral health facilities, and individual shelters in order to decrease the number of individuals who are discharged from these facilities directly to homeless shelters. As part of this effort, we have jointly developed a Discharge Planning Toolkit – a series of guidance documents and technical assistance products – to help achieve this goal. The information below provides an overview of these tools. This memo is a key piece of the toolkit and serves to outline HLC's expectations for HLC-funded individual shelter providers with regards to collaborating and communicating with hospitals and behavioral health facilities.

Discharge Planning to Support Individuals Experiencing or at Risk of Homelessness - Toolkit

HLC, DPH, DMH, and MassHealth have developed tools and guidance for discharging facilities and shelters. All of these materials can be accessed online at *Helping Patients who are Homeless or Housing Unstable*. This website includes resources, information and a support line to assist hospital staff in placing individuals who are experiencing homelessness or housing instability.

For Individual Emergency Shelter Providers

• *Reporting Form for Inappropriate Discharge to Adult Individual Shelter* To develop more robust information related to discharges from hospitals into shelters, HLC, in consultation with DPH, DPH, and MassHealth, have developed a reporting form for shelters to complete any time an individual may have been inappropriately discharged from a hospital to an emergency shelter. While this form will not be used to troubleshoot specific cases, the information collected will help guide future policy discussions.

• List of Acute Inpatient Hospitals and Freestanding Psychiatric Hospitals

A list of those hospitals participating in MassHealth, to which the updated Bulletins described below, apply.

For Discharge Staff

• MassHealth Bulletins

These three new Bulletins outline MassHealth's expectations and requirements Acute Inpatient Hospitals, Psychiatric Inpatient Hospitals, and Managed Care Entities facilities with regards to helping patients who are experiencing homeless or are housing unstable, including discharge planning that starts early and includes communicating with local housing agencies and shelters.

• Online Housing Tool for Housing Discharge Staff

This online decision tree can help guide hospital discharge staff when working with an individual experiencing homelessness or at risk of homelessness by providing specific action steps tailored to the individual's unique situation. A short companion video provides instructions for using the Housing Tool.

• ***How to Obtain Identification Documents***

A useful fact sheet that hospital discharge staff can refer to in assisting patients in accessing key identification documents.

• ***Finding Alternatives to Shelter: A Discussion Guide for Hospital Discharge Staff***

This document provides examples of specific prompts and questions to help facilitate an in-depth iterative conversation between hospital discharge staff and individuals about possible housing options post discharge.

• ***Shelter Realities***

This document provides clear information about things for an individual to consider before choosing to discharge to shelter, including space configurations (e.g., beds, privacy, storage), and operations (e.g., rules around daytime hours, time limits).

• ***Homeless Support Line for Discharge Staff***

An EOHHS Homeless Support Line for Discharge Staff for hospitals to call when they have exhausted all potential placement options, including speaking with a local shelter. Support Line staff aid with trouble-shooting benefits issues, connecting with resources not known to the facility, and coordinating with state government partners to address the individual's needs.

• ***EOHHS Long Term Care Discharge Support Line***

An EOHHS *Long Term Care Discharge Support Line* to assist hospital discharge staff who are working with individuals in need of facility-based long-term care post discharge.

Discharge Protocols

To help hospitals and shelters better coordinate care for a homeless or housing unstable individual, HLC and MassHealth have developed the general protocols, all of which are reflected in the tools listed above.

- Patients who were homeless prior to hospital stay and whose stay is 14 days or less
  - Hospital discharge staff have been directed to contact the emergency shelter from whence they came or, if none, the local emergency shelter about whether the individual could return after the hospitalization.
- Patients who were homeless, or housing unstable prior to hospital stay, and whose stay is longer than 14 days:
  - Hospital discharge staff have been directed to have discussions with the individual about any family, friends, and other persons that may have resources and/or willingness to help provide a housing option. This would include contacting any involved case managers and helping the individual apply for available resources for which they may be eligible.
- Patients who need assistance with activities of daily living, have skilled care needs, or have behavioral health issues that would be dangerous in shelter:
  - Hospital discharge staff have been directed to not discharge these individuals to shelter and instead seek placement in more appropriate facilities, which may include DMH facilities, respite facilities, or skilled nursing facilities.
- For all Patients Enrolled in a MassHealth Managed Care Plan
  - Discharge planning must include outreach from the provider hospital to the managed care plan to determine if the plan may be able to provide resources or help identify solutions to assist with housing.

- For Patients with serious mental illness
    - The hospital should contact the local Department of Mental Health (DMH) Area Office to determine if the patient is a DMH consumer and to identify potential housing and/or respite resources. If the patient is not already a DMH consumer, they should consult with the local DMH Area office to determine if a DMH application for services is appropriate.
- For Patients with developmental or intellectual disabilities
    - The provider hospital should contact the local Department of Developmental Services (DDS) Area Office to determine if the patient is a DDS consumer and to identify potential housing and/or respite resources. If the patient is not already a DDS consumer, they should consult with the local DDS Area office about completing and submitting a DDS application for services.
- For Patients with traumatic or acquired brain injuries
    - The hospital should contact the MassAbility (formerly Massachusetts Rehabilitation Commission) to determine if the patient is a MassAbility consumer and to identify potential housing and/or respite resources. If the Enrollee is not already a MassAbility consumer, consult with the MassAbility office about applying for MassAbility community-based services.

In addition, hospital discharge staff are directed to communicate actively with local shelters and work collaboratively to find alternative solutions.

Finally, if a discharge to shelter is to occur, hospital discharge staff have been directed to:

- Notify the shelter at least 24 hours ahead of time
- Provide the individual with copies of their prescriptions, insurance information, and at least a week's worth of medication
- Provide the individual with a meal prior to discharge
- Ensure that the individual is wearing appropriate clothing and footwear, and has transportation set up, if applicable
- Discharge the individual during daytime hours

Note: MassHealth guidance allows that in the event that a shelter bed is unavailable on the planned discharge date, but a bed will be available soon, the hospital should delay discharge until a bed is available.

HLC Expectations for Shelter providers

Shelters are vital partners in reducing discharges into homelessness and for ensuring that vulnerable individuals with no alternatives have a safe place to sleep at night - regardless of where they once called home or the challenges they may face.

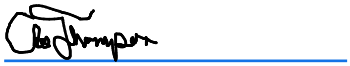
Specifically, HLC-funded shelters:

- **May not place geographic/community of origin restrictions** on access; however shelters may help individuals return to a shelter or housing in their home community
- **May not refuse entry to individuals taking prescribed medication,** including, but not limited to, opiates, oxygen, and benzodiazepines.
- **Should be prepared to receive and be receptive to inquiries** from hospitals who may have an individual who previously resided in shelter. In these situations, the shelter should:
    - **Share information** about the individual's housing history and any other support systems they may have (family, friends, case managers, housing leads, etc.)

- **Coordinate placement from the discharging facility into shelter** if space is available in the shelter, the person does not require higher levels of care, and no other safe alternative placements exist.
- **Be prepared to receive and be receptive to inquiries** from hospitals who may have an individual who may not be known to the shelter. In these situations, the shelters should:
- **Engage in conversations** with discharge staff to determine if an alternative placement or safe and alternative housing would be appropriate, and use Diversion funds where possible
- **Coordinate placement from the discharging facility into shelter** if space is available in the shelter, the person does not require higher levels of care, and no other safe alternative placements exist.

It is hoped that these connections will, first and foremost, reduce shelter entries whenever possible by securing alternative placements and build relationships between shelters and healthcare facilities. When shelter entries are unavoidable, it is hoped these connections will allow shelters to be prepared if/when a guest returns to shelter HLC, DPH, DMH, and MassHealth stand prepared to help broker and foster improved connections between shelters and discharging entities.

As always, EOHLC, DPH, DMH and MassHealth stand prepared to help broker and foster improved connections between shelters and discharging entities.


Chris Thompson (Apr 18, 2025 11:36 EDT)

Chris Thompson
Undersecretary