

Video Transcript: Getting Started- Introduction to how hospital staff can use the Housing Tool for Hospital Discharge Staff (HTHDS)

Hello, I'm Linn Torto the Executive Director at the Interagency Council on Housing and Homelessness. First of all I would like to thank you all for joining us to learn more about one of several new resources created through a multi-departmental collaboration on hospital discharge planning for people who are experiencing homelessness or housing instability and are expected to be able to care for themselves independently after discharge. We are grateful for all of the work that you do to support our most vulnerable citizens. This initiative is designed to provide you with essential tools to support this work and to insure that you have the resources to engage in thoughtful and successful discharge planning efforts so we collectively can avoid discharging individuals to the streets or shelters.

This initiative is not an independent effort. Rather it is a mission developed as part of the MA Olmsted Plan promulgated in 2018 which provides a road map and identifies resources to support individuals with disabilities including homeless individuals so they can successfully live and thrive in the community. This plan was a product of the work of the sub-committee to the ICHH and was approved by all 26 agencies who are members of the council.

People experiencing homelessness often are high-users of hospital care and many hospitals throughout the state of Massachusetts struggle to provide safe discharge for patients who have no place to call home. The state is investing in new efforts and additional resources to help better coordinate hospital discharge planning for our most vulnerable citizens.

Studies have shown that the best patient outcomes occur when discharge planning begins at the time of initial admission to the hospital. For individuals with a history of homelessness or housing instability, this admission should include a discussion around safe current living arrangements; with this early planning, some housing situations can be preserved while the individual is hospitalized.

We can all agree that safe housing is healthcare. In the near future the state will be incorporating language in hospital state contracts to require appropriate and adequate hospital discharge planning for people who are experiencing homelessness.

This short video will provide an overview of the on-line decision tree tool. This decision tree tool is a part of a larger initiative to prevent individuals from becoming homeless upon discharge from a hospital setting. These tools and resources will provide support to both hospital discharge staff and homeless shelters and service providers. This work in partnership with patients experiencing homelessness aims to achieve timely, holistic and compassionate assessment, treatment and discharge plans that improve overall health and housing outcomes.

Thank you Ms. Torto. Now that we have heard how impactful hospital discharge planning for people who were homeless or unstably housed is for a person's health, we want to walk you through a short video that will showcase the features of the tool and provide instructions of how to use the online decision tree in your discharge practices.

The Housing Tool for Hospital Discharge Staff is part of a larger initiative to prevent individuals from becoming homeless upon discharge from a hospital setting. There is a toolkit comprised of a series of guidance documents and technical assistance products. All of these materials are available online at the [Helping Patients who are Homeless or Housing Unstable](#) page.

This tool is an interactive on-line platform that asks discharge planners to answer specific questions regarding the patient's situation and then be led to identifiable action steps towards a safe discharge. We will use the term "discharge planners" as a broad term to describe the staff at the hospital who will hold conversations with patients about their housing plans once they leave the hospital setting.

You will see that there are different pathways and protocols based on the patient's length of stay in the hospital – with longer stays, over 14 days, allowing time for hospital staff to do more intensive engagement, especially for those people who have significant needs that cannot be met in shelter.

Let's start with the landing page, which provides a summary of key features, and some definitions of terms that are used throughout the tool. Let's quickly review these key term definitions: homelessness, housing instability, diversion and collateral contacts.

Homelessness refers to patients who were staying in a homeless shelter or places where people should not be living, such as the street, their car, or an abandoned building, prior to admission. Housing instability refers to patients staying indoors in some form of housing (not shelter) prior to admission and may not be able to return to this environment for a variety of reasons. For example, a patient who was staying temporarily at a friend's house and is unsure if they are able to return there after discharge would be considered unstably housed. Diversion refers to the act of identifying safe alternatives to homelessness and discharges to shelter. You may have heard diversion also referred to as housing problem solving. Collateral contacts refer to any person with a relationship with the patient that may have resources and/or willingness to help provide a housing option, such as a case manager, family member, friend, clergy, or other trusted individual.

The features of the tool allow discharge planners to answer specific questions regarding the patient's situation and then be led to identifiable action steps.

As you move through the on-line screens answering the questions, you will see that depending on the person's living situation prior to hospital admission, whether they were unstably housed, living on the streets or staying in an emergency shelter, you will be directed to different additional questions and information gathering needed. Also, if a person is expected to be at your hospital for less than 14 days or over 14 days, you will be led to different questions and additional information gathering from the patient. Keep in mind that if the expected length of stay for the patient changes, it is easy to go back and adjust your answers.

You will also see many additional resources embedded in the tool, for example

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- the Alternatives to Shelter Discussion Guide to support your collaboration with patients to identify a safe place to discharge and avoid shelter
- [Discharging to Shelter Question Guide to help you gather important information from shelters](#)
- Shelter Realities to help you explain what shelter might be like to someone who has not recently stayed in a shelter
- [Homeless Support Line for Discharge Staff](#) for the situations when you have taken all of the instructed action steps and still need support
- You will also find links to various existing housing support resources.

It's important to familiarize yourself with the tool before discussing options with the person being discharged. Familiarizing yourself with the tool will help you understand the information you will need to collect before sitting down with the patient.

Let's highlight some key features:

- Once you're ready to begin, here at the bottom of this landing page you click on "Start Here" link.
- The tool will now start to ask a series of questions based on your previous response
- As you go through the tool, you will be able to "go back"
- You will also be able to print out the question, in case you need to stop answering the question to gather additional information
- The tool will also instruct you to visit the linked resources. You can do so by clicking the link directly, or right clicking to open the resource in a new tab. Opening the resource in a new tab will give you the ability to keep the tool's webpage open.
- On the right hand side of the screen showing the 'next' question, you will see a list of "Your Response". As you answer more questions, that list shows each new response.
- Once you see the green banner that says "Answer" towards the top of the page, you'll know you have reached the final step for discharge planning. We recommend printing the final page or saving it as a PDF for your patient's records.

Now that we've reviewed the features of the decision tool, let's walk through two scenarios. The first scenario will be for someone who was homeless and living in a shelter prior to hospital admission and is expected to be in the hospital for over 14 days.

The second scenario will show the path if someone was unstably housed at hospital admission and is expected to be in the hospital for less than 14 days.

As you can see the first question: Is the patient able to care for themselves independently after discharge, and is not a danger to themselves or others. Answer "yes"

This leads to the second question: Was your patient experiencing homelessness immediately prior to admission Answer 'yes'

Then you will see this next question: Was your patient staying in a shelter or living on the street, in a car, in an abandoned building, etc. immediately prior to admission? Answer 'shelter'

The next question will ask you about length of hospital stay. Remember 14 days is the timeframe that will change the path. Is the expected length of stay for your patient less than 14 days? Click on 'no', as in this path we're looking at someone who will be in the hospital for more than 14 days.

Also you can review your answers on the right hand side of the screen.

As you can see the way we answered the questions the path has led us to this screen with instructions of next steps for the discharge planner. These action steps aim to find alternatives to shelter, but if alternatives are not identified you will move to the next screen by answering "No".

This screen provides you with actions that should be taken if the patient is returning to a shelter. Call the shelter in the community from which the patient came at least 24 hours BEFORE scheduled discharge to inform them that the patient will be returning to the shelter. The shelter is expected to accommodate the patient if space is available. Discharge staff should ask about any shelter entry policies and communicate this to the patient. See the [Discharging to Shelter Question Guide](#) for more guidance.

I want to point out the imbedded resources. We are going to click on [Discharging to Shelter Question Guide](#) link. Use this guide to learn what questions to ask shelter when planning for a discharge.

Let's move down to the bottom of the screen. If you have completed all these tasks and have not been able to successfully identify a post-discharge option, contact the [Homeless Support Line for Discharge Staff](#).

This support line will help you identify any potential additional options.

Okay, let's walk through one more scenario.

As you can see the first question: Is the patient able to care for themselves independently after discharge, and is not a danger to themselves or others. Answer "yes".

This leads to the second question: Was your patient experiencing homelessness immediately prior to admission. Answer 'no'.

Then you will see this next question: Is your patient experiencing housing instability, like couch-surfing or at risk of eviction? Answer 'yes'.

As you can see, the fourth question is asking where was your patient staying prior to admission. In this path we're going to click on "staying with friends and family".

This next section brings us the expected length of stay in the hospital. Is the expected length of stay for your patient less than 14 days. Click on "yes".

This will then bring you to a resource page that explains ways to help the person return to safe housing. As you scroll down on this page you will see the next question, asking if you're able to establish if the patient can return to the living situation with friends or family.

Let's say the person is not able to return, so click on "No".

Clicking 'no' will bring you to this next resource page Identifying Safe Options for Discharge. You can read this page and take action on any appropriate linkages that will help the patient.

Let's assume that you were able to connect the person to a resource that will help them without having to contact an emergency shelter. Click 'yes'

Then next page will then conclude the scenario on this path.

Thank you for watching this video and we hope the resources it includes will help you, as hospital staff, as you go through discharge planning for patients who entered the hospital and were homeless or unstably housed.