Process for Discharging Homeless Patients From Inpatient Medical Facilities to DHS Shelters

Effective July 1, 2010
Overview of Training

1) Why change and process overview
2) Brief overview of services for street homeless individuals
3) Step-by-step review of process
   a. Treatment Team roles
   b. Shelter/Safe Haven Director/Outreach team roles
   c. Specifics of process
   d. Review of forms
4) Case studies – inappropriate vs. appropriate discharges
5) Open up for questions
Why Change?

- Effective July 1, 2010 there will no longer be an MRT contract or a PRU unit at DHS.
- DHS will now be allowing inpatient medical facilities to discharge appropriate patients directly to the DHS shelter system with no lengthy approval process.
- DHS has also set up a process for appropriate clients to be referred to Safe Haven and Outreach Programs.
- Based on a decades of experience, we have revised and streamlined the hospital discharge forms to make the process quick and easy.
Services for Street Homeless Individuals

• In September 2007, we re-procured the outreach portfolio, pooling the resources of DHS and DOHMH, and specified clear catchment areas and single, responsible contractors for each area.

• We implemented four new contracts with aggressive, measurable performance targets.

• Teams are funded to provide general outreach services and to focus case management and housing placement resources on most chronic and vulnerable individuals. We define chronic homelessness as spending 9 months of the last 2 years on the streets, in parks, or on the subway.

• DHS developed lower threshold transitional housing options, such as safe havens and stabilization beds, based on feedback from individuals sleeping on the streets.
Overview of process

• First, inpatient medical facilities are expected to make every attempt to discharge a patient to a non-shelter setting and prevent a patient from entering or re-entering the shelter system.

• If a homeless individual’s discharge to shelter cannot be prevented, inpatient medical facilities will communicate directly with shelter/safe haven staff/outreach teams regarding appropriate discharges of their shared patients/clients.
REFERRAL AND DISCHARGE OF HOMELESS INDIVIDUALS TO DHS

Calls DHS Hospital to Shelter Referral Line at 212-361-5590

Client is street homeless 9 months of the last 2 years

Inpatient medical facility has homeless patient

Patient was in shelter within past year and is willing to return:
- Inpatient medical facility begins process to discharge patient directly to patient’s official shelter, and follows below process, sending forms directly to appropriate shelter

Patient was not in shelter in past year OR has never been in DHS shelter but is willing to go:
- Inpatient medical facility begins process to discharge patient to the appropriate intake site and follows below process, sending the forms directly to the Intake site

Patient was in Safe Haven within past year and is willing to return:
- Inpatient medical facility reaches out to see if the Safe Haven has a bed and if patient can be accommodated. If they do not, inpatient facility offers shelter and/or contacts outreach

Patient reports or is known to be chronically street homeless and is unwilling to enter shelter:
- Inpatient medical facility contacts borough outreach team and works with team to determine appropriate actions. If d/c to outreach, Inpatient medical facility follows below process, sending forms directly to outreach

SHELTER AND OUTREACH REFERRAL FORM SUBMISSION PROCESS

Forms are faxed at least 24 Hours before patient discharged from inpatient medical facility

Faxed the day the patient is discharged from the inpatient medical facility

Submitted to the DHS Office of the Agency Medical Director, if requested

Form 1 – Screening
Form 2 – Discharge Planning
Form 3 – Shelter/Outreach Referral
Form 4 – Day of Discharge
Form 5 – Post-Discharge Review
During Inpatient Stay (Shelter/Safe Haven)

• Inpatient Medical Facility will contact Hospital to Shelter Referral Line (212-361-5590) to determine shelter/safe haven history of a patient and obtain official shelter/safe haven contact numbers.

• If patient has official shelter/safe haven that s/he stayed in the past year, inpatient medical facility will forward a completed referral to that shelter/safe haven.
  – If patient can not be accommodated at the safe haven, inpatient medical facility should encourage them to go to Intake. If they refuse, the medical facility should refer to the borough Outreach Team.
  – Exceptions may be made for street homeless patients, who may have had a shelter stay, but, are unwilling to return, and meet the definition of chronic street homelessness. These should be routed through Outreach.

• If patient is new or has been out of shelter for more than one year, the inpatient medical facility should fax a completed referral to the appropriate intake center:
  • For Men: Intake at 30th Street (wheelchair accessible) - fax # 917-637-7372 (DHS Office of Medical Director)
  • For Women: HELP Women’s Center in Brooklyn - fax # 718-240-9178 / phone # 718-483-7700
  • For Women: Franklin Shelter in the Bronx (wheelchair accessible) - fax # 929-281-2312 / phone # 929-281-2330
During Inpatient Stay (Street Homeless)

• A client must meet the following 3 conditions in order for the inpatient medical facility to contact Outreach:
  – Is chronic street homeless (spent at least 9 months of the last 2 years on the streets)
  – Client is unwilling to go to shelter
  – Hospital has not identified an alternative placement

• Medical facility will contact appropriate borough Outreach Team to collaborate on a discharge plan.

• If client is known to Outreach and meets eligibility for caseload, the team will attempt to place the client directly from the medical facility.

• If client is unknown to Outreach, the team will be expected to visit and engage the client within 24 hours of the medical facility reaching out.
24 Hours Pre-Discharge

- For patients/clients being referred to Intake, Shelter, Safe Haven or Outreach, Inpatient Medical Facility faxes Forms 1, 2, and 3 to the appropriate contact.

1) *Form 1* – DHS Screening Form For Shelter and Outreach Referral

2) *Form 2* – DHS Discharge Planning Worksheet

3) *Form 3* – DHS Shelter and Outreach Referral Form
Day of Discharge

- *Form 4* – Inpatient medical facility sends DHS Day of Discharge Form – to shelter, safe haven or outreach
Shelter/Safe Haven Director Role: Reviewing Forms

- Shelter/Safe Haven Directors or Directors of Social Services will closely monitor and review incoming forms.
- If client cannot be accommodated in official shelter, Shelter Director will contact Inpatient Medical Facility directly, with an alternative shelter to which to send patient.
- If patient cannot be accommodated at the Safe Haven, the Director will contact Inpatient Medical Facility, directly, with suggestion to refer to shelter/Intake or contact borough Outreach Team.
- If there is need for clarification, shelter/safe haven staff will contact inpatient medical facility directly.
Shelter/Safe Haven Director Role: Bed Placement

• Next bed at shelter is prioritized for incoming client.
• If no bed is/will be available, the Shelter Director should notify Program Administrator. Shelter Director will notify inpatient medical facility of alternative placement.
• If the client arrives and there is no bed, arrangements will be made to transfer the client to another shelter where a bed is available.
• The original shelter will work with the new shelter on getting client moved and forwarding case files and inpatient service paperwork.
Possible Inappropriate Discharges to DHS

- If upon arriving to shelter, it is determined that client is in need of emergency medical care, shelter staff will contact EMS for transport to emergency room.
- If a client arrives in a condition different than as described on Forms 1-3, and is possibly medically inappropriate for discharge to DHS, the Shelter/Safe Haven Director will contact their Program Administrator.
- DHS Office of the Medical Director will then review the case to determine whether it is medically inappropriate for discharge to DHS.
- The Office of the Medical Director will call the designated inpatient medical facility contact to request further information from the medical facility (Form 5 – DHS Post-Discharge Review Form).
- Upon receipt of the completed Form 5, within one business day, the Office of the Medical Director will render a decision as to the individual’s appropriateness for shelter/safe haven placement.
  - Note that while the decision is pending the shelter/Safe Haven is responsible for ensuring the client has a bed.
Review of Forms

• Form 1: Screening Form for Shelter and Outreach Referral
• Form 2: Discharge Planning Form
• Form 3: Shelter and Outreach Referral Form
• Form 4: Day of Discharge Form
• Form 5: Post-Discharge Review Form
  – Form 5 is only submitted on request of DHS Office of the Medical Director
FORM 1:

DHS Screening Form – Page 1

• “Yes” answers to unshaded items indicate patient is appropriate for shelter.
• On the shaded items, a “no” means patient is appropriate for shelter.

<table>
<thead>
<tr>
<th>CLINICAL CRITERIA</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to...</td>
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<td></td>
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<tr>
<td>ADLs</td>
<td></td>
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<tr>
<td>Communicate</td>
<td></td>
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<tr>
<td>Incontinence</td>
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<tr>
<td>Medication Admin</td>
<td></td>
<td></td>
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<tr>
<td>e.g., IDDM</td>
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<tr>
<td>Mobility</td>
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<tr>
<td>Oxygen care</td>
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<td></td>
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<tr>
<td>Wound care</td>
<td></td>
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<tr>
<td>Burns</td>
<td></td>
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<tr>
<td>Weeping wounds</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>FUNCTIONAL CAPACITY</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to...</td>
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<tr>
<td>Toilets, baths, etc.</td>
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<tr>
<td>Able to...</td>
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<tr>
<td>Manage, independently, care of indwelling catheters of any sort (e.g., anastomosis, suprapubic, PE)</td>
<td></td>
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<tr>
<td>Able to...</td>
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<tr>
<td>Manage, independently, care of external catheters (e.g., Foley), including timely replacement of same</td>
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<tr>
<td>Able to communicate needs adequately, able to understand verbal or ASL requests</td>
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<tr>
<td>Able to manage bowel and/or bladder regimen, independently, without the use of diapers</td>
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<tr>
<td>Able to self-administer all medications. Exceptions may be assumed for clients returning to mental health shelters or select special population shelters</td>
<td></td>
<td></td>
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<tr>
<td>Able to self-administer insulin</td>
<td></td>
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<tr>
<td>Able to ambulate and gauge sliding scale insulin requirement</td>
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<td></td>
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<tr>
<td>Able to ambulate, independently (cane, crutches, walker, &amp; wheelchairs permitted)</td>
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<tr>
<td>Able to transfer, independently (from wheelchair to seated or supine)</td>
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<tr>
<td>Able to...</td>
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<td></td>
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<tr>
<td>Transfer, independently (from wheelchair to seated or supine)</td>
<td></td>
<td></td>
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<tr>
<td>Able to arise from seated position or from bed (does not require turning/repositioning)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>MENTAL CAPACITY</th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>Cognitive...</td>
<td></td>
<td></td>
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<tr>
<td>Impairment</td>
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<tr>
<td>Decisional...</td>
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</table>
FORM 1:

DHS Screening Form – Page 2

• Immunosuppression
• Clinical criteria
• Vulnerability assessment for street homeless patients
• Statement of appropriateness for shelter

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**SCREENING FORM FOR SHELTER AND OUTREACH REFERRAL (continued)**

**CLINICAL CRITERIA**

**IMMUNOSUPPRESSION:**

- Immuno-competence: Immuno-competent and able to tolerate congregate living conditions, including congregate dining, bathrooms, and dormitories. Exceptions include:
  - AIDS: Meets CDC criteria (CD4<200 or opportunistic infection). Refer to IDRA/HASA.
  - Cancer: If extensively metastatic, or if patient is undergoing in/outpatient chemotherapy or radiation, with significant risk of immunosuppression and side effects of treatment.

**SPECIFIC CLINICAL CRITERIA:**

- Arson: Known history of recent fire-setting, especially, if in congregate settings or in response to command auditory hallucination.
- Cranial Halo Devices: Cranial halo device or other stabilizing/protective gear worn continuously.
- Diarrhea: Chronic diarrheal illness or condition resulting in explosive diarrhea, fecal incontinence, or requiring the use of bedside/commode.
- Diet: Requires regular or ADA diet, only. (Shelters have limited and variable ability to provide renal diets; there is no availability of pureed, soft mechanical, or liquid diets.)
- Medical Equipment: Need for infusion pumps or ventilator.
- Oxygen: Adequate saturation on room air.
- Tubes: Free of tubes (e.g., NGT) or drains of any sort (even if they are clamped).

**STREET HOMELESS PATIENTS ONLY: VULNERABILITY ASSESSMENT**

Please review all of the conditions and check “Yes” or “No” in the boxes provided; responses can come from hospital records and/or client report.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td></td>
<td></td>
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<tr>
<td>Kidney Disease</td>
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<td>History of pneumonia, hypothermia or immunosuppression</td>
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<tr>
<td>Chronic liver disease</td>
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<tr>
<td>Arrhythmia</td>
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<tr>
<td>Over 60 years of age</td>
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<tr>
<td>Three or more hospitalizations in the past 12 months</td>
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<tr>
<td>Three or more ER visits in the past 6 months</td>
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</tbody>
</table>

**STATEMENT REGARDING MEDICAL APPROPRIATENESS FOR SHELTER**

I, the Physician/Nurse Practitioner/Physician’s Assistant (circle one), caring for this patient, attest that the answers to the above items accurately reflect the patient’s condition. This patient meets all screening criteria, above, and is medically appropriate for shelter or outreach placement.

(Name of Physician/NP/PA)  (Date)  (Contact number)
FORM 2:

DHS Discharge Planning Worksheet – Page 1

• Benefits data is very important
• AOT and ICM
• Housing applications
• Efforts to place outside of DHS
FORM 2:

DHS Discharge Planning Worksheet – Page 2

• Referrals to outreach – assessment of street/park/subway chronicity
• Attestation of placement efforts

8. List any housing applications that hospital has submitted, indicating if the patient has an interview scheduled. Attach additional page(s) as needed. If it was difficult to place pt in supportive housing, documented contact with CUCS is required.

9. If patient has advanced HIV disease or AIDS, was the patient referred to HASA? What was the outcome?

10. Detail any involvement with other organizations, departments, or government agencies (e.g., CUCS, APS, ACS, Dime, Blue H, GMH, HASA, Homeless Prevention, etc.).

REFERRALS TO OUTREACH – FILL OUT FOR STREET HOMELESS INDIVIDUALS ONLY
(This information can be obtained through patient’s self-report, and/or through hospital records.)

1. Length of time on the Streets/Parks/Subways over last two years:

2. Length of time on the Streets/Parks/Subways over lifetime:

3. Location (Streets/Parks/Subways) where patient sleeps when not hospitalized (as specific as possible):

ADDITIONAL DISCHARGE PLANNING NOTES:

ATTESTATION OF DISCHARGE PLANNING EFFORTS:
The patient’s full range of non-shelter housing options has been explored and the Treatment Team has found no viable, safe alternative to shelter for the patient.

Signature of Treatment Team Member

05/09/10

Date

Page 2 of 2

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DHS Shelter and Outreach Referral Form – Page 1

• Patient data
• Inpatient medical facility contact info
• Wheelchair needs
• Medical Care Provider
• Next of Kin
II. PATIENT’S RELEASE OF INFORMATION AND STATEMENT OF CAPACITY

A. PATIENT’S RELEASE OF INFORMATION:

I, __________________________ (name of patient), give permission to the medical and social work staff at __________________________ (name of hospital), to release the information, below, to the NYC Department of Homeless Services Agency Medical Director’s Office, and the Social Services and Medical staff, if any, at my assigned shelter or outreach placement. I understand that this information will be used to help determine if a shelter or outreach placement is an appropriate place for me and, if so, to which shelter or outreach placement I might go. By giving the information to the staff at my assigned shelter or outreach placement, I will be helping them to care for me and to place me into permanent housing more quickly, and avoid having to repeat the blood tests and examinations I have had while I have been in the hospital. I agree to this plan for discharge to a shelter or outreach placement and have rejected, when offered, a more appropriate setting. I understand that I can come into the shelter system without releasing this information. I know, that, if I change my mind about releasing this information, I can write or ask someone else to write down this decision and give it to a member of my hospital treatment team. I understand that if the information has already been sent, I cannot ask the hospital to take it back again. I also understand that it is possible that this information will be further disclosed and will no longer be protected. I have a right to a signed copy of this release form. This release is good for three months after my discharge from the hospital.

I permit __________________________ (name of hospital) to release the following information:

☐ All information contained or referenced in this Shelter and Outreach Referral Form

☐ Information regarding my HIV status

☐ Information regarding my use of drugs or alcohol.

I understand that only the information checked off can be given to DHS.

Patient’s Signature: __________________________

Witness: __________________________

Date: __/__/_

(Include title, as appropriate.)

B. STATEMENT OF PATIENT’S CAPACITY

As the Physician/Nurse Practitioner/Physician’s Assistant (circle one) primarily responsible for this patient’s inpatient care, I attest that the information contained in this document reflects accurately the patient’s condition upon admission and hospital course through discharge, and that, in my clinical judgment, this patient has the capacity to decide to be discharged to a shelter or outreach placement. I have explained fully to this patient that a shelter or outreach placement has limited, if any, on-site medical care, no 24-hour nursing care, and limited medication administration. We have offered him/her more appropriate settings, if warranted by his/her medical condition. He/she has, nonetheless, chosen to go return to a shelter or outreach placement, and, at this time, has full decision-making capacity to do so.

______________________________ __/__/_

(Name of Physician/NPA) (Date) (Pager or phone number)
FORM 3:

DHS Shelter and Outreach Referral Form – Page 3

• Admissions data
• Allergies and TB clearance
• Diagnoses
• Medications and dosage
FORM 3:

DHS Shelter and Outreach Referral Form – Page 4

- Special assistance
- Follow up
- AOT/ICM contact info
### DHS Day of Discharge Form

- Medication updates upon discharge
- Follow up appointments
- Contact info for doctor, social worker/treatment team, ICM/SCM ACT team, and Koskinas worker, if appropriate

**FORM 4: DISCHARGE FORM FOR SHELTER PLACEMENT and OUTREACH REFERRAL**

#### A. UPDATE OF MEDICATIONS UPON DISCHARGE

<table>
<thead>
<tr>
<th>Medication (generic name, if possible)</th>
<th>Dosage</th>
<th>Route</th>
<th>Frequency</th>
<th>Disp. #</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<td>4.</td>
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</table>

*Use OD or BD dosing as possible, include dosing for Methadone maintenance (MMT).*

> Document whether medications will be supplied or prescriptions given.

**If patient is uninsured, will s/he be supplied with medication? □ Yes □ No □ If Yes, for how many days?**

#### B. APPOINTMENTS SCHEDULED FOR MEDICAL AND PSYCHIATRIC FOLLOW-UP

**Please provide actual appointment or times patient may access clinic without an appointment.**

<table>
<thead>
<tr>
<th>Service</th>
<th>Date</th>
<th>Time</th>
<th>Clinician or Purpose of Visit</th>
<th>Clinic/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
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<tr>
<td>Surgical</td>
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<tr>
<td>Psychiatric</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

**POST-DISCHARGE CONTACT NUMBER ( ) - for: MD/NT/PA**

**POST-DISCHARGE CONTACT NUMBER ( ) - for: SW/RN/FP**

**POST-DISCHARGE CONTACT NUMBER ( ) - for: ICM/SCM/ACT Team**

**POST-DISCHARGE CONTACT NUMBER ( ) - for: Koskinas Worker**

**SIGNATURE OF CLINICIAN UPON PATIENT’S DISCHARGE**

06/08/10
FORM 5:

DHS Post-Discharge Review

• If requested, to be submitted to DHS Office of the Medical Director by inpatient medical facility
Contacting Shelters/Safe Havens/Outreach Teams

• The DHS Office of the Medical Director provides, on a quarterly basis, to the Greater New York Hospital Association the contact information for shelters/safe havens/outreach teams, to be distributed to its members Directors of Medical and Psychiatric Social Work, for use in the referral process.

• The referral process and forms are available on the DHS and GNYHA websites.

  DHS website - www.nyc.gov/dhs
  GNYHA website - www.gnyha.org
Questions/Concerns

Contact DHS Office of the Medical Director