ASSESSMENT OF HOSPITAL DISCHARGES TO EMERGENCY HOMELESS SHELTERS IN ALLEGHENY COUNTY, PA

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Abstract

The United States has an increasing rate of homelessness due to unemployment, an absence or low availability of affordable housing, high rates of mental illness, and physical ailments that prevent productive employment. Due to economics, these homeless tend to only receive medical care through the emergency department (ED). Since the ED is not equipped to handle social issues such as housing, these individuals are often discharged directly onto the street or to shelters. As a result, these inappropriate discharges increase re-hospitalization and poorer health outcomes among this population. The purpose of our study is to explore the issue of hospitals discharging patients to emergency homeless shelters in Allegheny County. Researchers sent mailings to all of the 16 emergency homeless shelters in Allegheny County for recruitment. As a result, 22 shelter administrators and staffs from 12 of the 16 shelters (response rate=75%) participated in a face-to-face, semi-structured interview conducted at their facility. Participants shared the number of discharges they received from hospitals in the past 12 months, the appropriateness of these discharges, and possible solutions to the problem of "inappropriate discharges." Shelter administrators reported receiving 415 discharges from hospitals; they deemed 91 (22%) of the discharges as inappropriate, meaning the patients' needs exceeded the resources of the shelter. Even though a majority of participants reported that their shelter was equipped to handle the medical/psychiatric care of their population, their facilities lacked the

means to treat those who needed extensive medical and/or psychiatric care. To address this issue of inappropriate discharges, participants suggested that better communication between hospitals and shelters as well as the development of a medical/psychiatric respite for the homeless population (50% of participants stressed the former and 32% the latter) would alleviate this problem. Shelters, aware that this issue is a multi-faceted one, recognize the need for multiple interventions at the individual, community, and government levels to successfully combat this problem. This is a significant public health problem because by addressing the medical and psychiatric needs of the homeless population both prior to and after hospital discharge may eventually reduce re-hospitalizations and improve the health outcomes of this population.

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PREFACE

A special thank you to the Homeless Alliance of Allegheny County and the University of Pittsburgh Graduate School of Public Health for their expertise and support.

1.0 INTRODUCTION

Homelessness poses a major public health concern in the United States that can affect individuals during any period of their lifetime. On any given night, approximately 600,000 individuals experience homelessness in the United States. Also, more than 2 million individuals are homeless throughout the year. It is estimated that one-third of this population suffers from mental health disorders and/or struggles with substance abuse (National Mental Health Association, 2007). Those more vulnerable to homelessness include the unemployed, elderly, people with mental and physical ailments, not insured/underinsured, substance abusers or those on low/fixed incomes. Families with children usually make up half of the homeless population.

Nationally, there have been reports of hospitals "dumping" or "inappropriately" discharging homeless individuals onto the street. In the New York Times article, "*Dumping of homeless by hospitals stirs debate*," Archibold reports that Los Angeles hospitals have been 'dumping' homeless individuals discharged from hospitals onto Skid Row. This is an area that is heavily populated with homeless individuals living in sidewalk tents and cardboard houses. There have been reports of individuals being dropped off in Skid Row dressed in hospital gowns. Many of these individuals are discharged onto Skid Row in unstable medical and psychiatric conditions. As a result, California is in the process of developing a law that holds hospitals accountable when individuals are discharged prematurely. This law is tackling the issue of hospitals discharging directly onto the street and forcing hospitals to transport these individuals

to a residence or a shelter. It is known that many shelters are not equipped to handle individuals who need extensive medical care since they are neither a medical facility or have medical staff readily available. Therefore, additional solutions have to emerge to assist those homeless individuals who are not appropriate for a shelter due to their health issues.

The National Alliance to End Homelessness (2000) fact sheet estimates that nationally 150,000 people experience chronic homelessness. The chronically homeless are defined as individuals who suffer from a disabling condition and experience homelessness for a year or more. This population may have had several episodes of homelessness within the past 3 years. These individuals usually turn to shelters, abandoned housing, streets, or overcrowded family members. The chronically homeless also suffer from mental health disorders or drug and alcohol addictions, which eventually affect their physical health.

In a study presented by North et al., (1998), higher rates of substance abuse and other mental health disorders disproportionately affect the homeless population when compared with the non-homeless populations. Many of these homeless individuals seek treatment, but due to external factors such as no insurance and limited income, cannot sustain a healthy lifestyle. Since the challenge of homelessness is not one-dimensional, many solutions are needed to effectively address this problem.

2.0 BACKGROUND

The purpose of this paper is to examine whether emergency homeless shelters in Allegheny County, PA experience hospitals discharging to their facilities, and the frequency of this practice. Also, the study wants to determine the degree to which this practice is problematic. Inappropriate care of the homeless population usually increases recidivism rates into the emergency department that results in rising healthcare costs, despite proper insurance and housing. A broader purpose of this study is to raise awareness about how improper healthcare upon discharge not only results in re-hospitalization, but also increases the morbidity and premature disability in this population.

Hospital staff may rather automatically discharge homeless persons to shelters, simply because they are homeless. Research indicates the lack of care for the population after discharge can become very dangerous for these individuals and a burden on the healthcare system. Salut et al., (1998) states that, "physicians reported delaying the discharge of homeless patients' who required follow-up care, knowing these patients' access to ambulatory care and clean environments or their compliance with treatment might be limited." Homeless individuals are disproportionately hospitalized for conditions such as respiratory and skin disorders, trauma, and infectious or parasitic diseases that can be often treated through an outpatient visit.

This study will assess the number of hospital discharges to shelters and their perceived appropriateness. This information can be used to uncover possible solutions to the problem of

inappropriate hospital discharges and bring awareness to homeless service providers about the severity of the issue. This paper will inform readers about how homelessness is affecting our communities and how systems (i.e. government, hospitals, local stakeholders) and communities can work together to alleviate the health concerns of the homeless.

3.0 LITERATURE REVIEW

3.1 DEFINING HOMELESSNESS

The lack of a standard definition of homelessness can create discrepancies about which person is identified as homeless; it also can add to the instability of a person's housing status (Tsai, Weintraub, Gee and Kushel, 2005). According to the McKinney Act, 42 U.S.C. 11301, a person is considered homeless when he/she lacks a fixed, regular, and adequate night-time residence or has a primary night time residency that is: a) a supervised publicly or privately operated shelter designed to provide temporary living accommodation; b) an institution that provides a temporary residence for individuals intended to be institutionalized; or c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (National Coalition for the Homeless, 2005).

Articles suggest that by interviewing hospital staffs including doctors, administrators, nurses, and social workers, will better clarify how each hospital personnel defines someone as homeless. The study displays how shelters define homelessness, but it is important that this definition be compared to the hospital's definition in order to measure consistency. One article pointed out that if the term "homelessness" is not being defined universally among health professionals, many individuals might be identified as "housed," therefore missing the opportunity for any intervention (Tsai, Weintraub, Gee, & Kushel, 2005). Hospital personnel

need a shared definition because this could increase planning and communication among patients, hospital personnel, and social services. This is crucial because homeless persons who are not identified as such by staff may fall through the cracks, resulting in worsening health outcomes. Clearly, there are gaps in knowledge about how service providers can better address the health and well-being of this population.

3.2 HOMELESSNESS IN ALLEGHENY COUNTY, PA

The Allegheny County Department of Human Services (DHS) conducted a point-in-time survey in June 2005, which showed that 2,002 homeless individuals utilized various services. Those individuals who participated in the point-in-time survey included 1,388 adults and 614 children. Twenty-five percent of this sample had serious mental health illnesses, while 42% suffered from substance abuse issues. Homeless individuals who participated in this survey self-reported that they suffered from domestic violence (15%), physical disabilities (5%), HIV/AIDS (3%), or developmental delays (3%) (Allegheny County Continuum of Care Fiscal Year 2, 2004-2005). That survey provides crucial data for trying to alleviate the problem of homelessness. Those who participated in the point-in-time study are important because the number of people needing homeless provider services exceeded the staff and resource capacity of the 16 emergency homeless shelters in Allegheny County on any given day.

The 16 emergency shelter programs in Allegheny County provide 198 beds for individuals and 168 beds for adults with children. None of the shelters provide beds for individuals who need additional medical care to recuperate from serious injuries or those who need housing due to their mental health instability. Therefore, individuals discharged to

emergency homeless shelters that need extensive medical or psychiatric care usually end up being re-hospitalized, costing the health care system millions of dollars a year.

The solutions to homelessness are more complicated than just supplying an individual with affordable housing; they must also address the deep-rooted social issues such as universal healthcare, discrimination, and poverty. Dealing with these social concerns can lead to an increase in the quality of life for these individuals. Emergency Departments, the main healthcare system for this population, must create prevention strategies to help reduce the cycle of homelessness.

3.3 THE PROBLEM OF HOMELESSNESS: SOCIAL ECOLOGICAL MODEL

It is easy to blame hospitals when an individual in unstable mental or physical condition is discharged to a shelter. However, hospitals are just a small piece of the puzzle when compared to the greater picture. It may be less productive to assume the problem resides within any given agent in the system (hospitals, shelters etc). Rather the problem may relate to how the entire system is functioning, and how a given subsystem functions within the larger whole. Many factors, including drug and alcohol addiction, lack of education, social issues, loss of income, and mental health, contribute to homelessness. Hospitals can only do so much due to their limited staff and resources. It is not uncommon on any given night that an emergency department has too many patients with not enough physicians, nurses, or other medical staff to thoroughly assess the patient's situation. Homelessness goes beyond hospitals; part of the responsibility lies with government and neighboring community providers who must also tackle the issue.

In the article, *Collaborative community empowerment: An illustration of a six-step process,* the authors state that by increasing community capacity will eventually enhance the health of individuals within the community and the community as a whole (Yoo et al., 2004). The Social Ecological Model (SEM) explains how different dimensions of an issue influence the community on a number of social levels and choosing intervention strategies for the condition at each of the levels. In order to alleviate the issue of homelessness, the Social Ecological Model (SEM) needs to be explored to examine the complexity of the problem. Taking the SEM approach opens us to the likelihood that problems and solutions may be found at multiple levels. Thus, interventions may need to take place at the individual, community, organizational, and policy level.

Homelessness is a multifaceted issue that needs multiple solutions since no one source holds the key. One has to work from the top down to produce the necessary changes in laws and regulations. Policy needs to either support or refute organizational and individual behavior. We also need action from the bottom up: Communities, individuals and networks have to collaborate to educate the upper strata of the hierarchy about the plight of homelessness and the potential medical and financial ramifications. Institutions such as hospitals and prisons receive a large percentage of the population who have experienced homelessness or are on the verge of becoming homeless. Therefore, at these levels more in-depth screening tools may need to be developed and implemented so the proper referrals can be made. While it's imperative that each level interacts with the individual to determine needs and capabilities, it is also important that each system works together to share ideas and provide input to alleviating homelessness.

3.4 HOSPITAL COSTS FOR THE HOMELESS POPULATION

Emergency Departments are the primary source of healthcare for the homeless because they are open 24/7 and serve the public's needs and demands, despite an individual's socioeconomics status. In New York City, one hospital reported a 20% to 30% incidence of homelessness among its ED population. Morris et al., (2006) found that "patients-who averaged six ED visits per year-were more likely to be middle-aged men suffering from tuberculosis, HIV, depression, schizophrenia, alcoholism, poor dentition, or penetrating trauma."

According to Tsai et al., (2005), homelessness is an expensive and frustrating problem for hospitals; homeless persons have high rates of emergency department utilizations, hospitalizations, and re-hospitalizations. The article "Homeless patients: Bridging the gap between hospital and health," explains that homeless individuals stay in hospitals an average 4.1 days longer than other low-income patients. Once these individuals are discharged, they fail to take medication or return for follow-up visits. When they eventually return to emergency departments, their uncompensated care cost hospitals hundreds of millions of dollars (Phillips, 1999). Every added day spent in a hospital costs an averaged of $2,414 per day (Canadian Medical Association Journal, 2001). Hospital discharges to shelters or even onto the streets cause those at a medical disadvantage a greater risk for infection, low rate of medical follow-up or even death. Even when hospitals discharge to shelters, they place guidelines and restrictions upon these individuals that may not allow them to fully recuperate. For example, because individuals have to leave shelters early to find work or food, they do not have time to rest or heal. Also, shelters have time constraints concerning how long an individual will be able to reside at the shelter. Shelters only allow residents to stay at their facility for a certain amount of days, those who require an extended stay need special permission from the shelter director.

Tsai et al., (2005) note that hospitals in the U.S. are not required to track, collect, or report on homelessness. This makes it difficult to assess and evaluate how well hospitals are doing when it comes to providing comprehensive health and behavioral health services for the homeless population. We see similar problems of assessment in other nations. For example, the United Kingdom Office of the Deputy Prime Minister released an information sheet stating, "It is crucial that hospital staff take into account patients' accommodation circumstances to ensure that they are not discharged into unsuitable accommodation or homelessness or that they become homeless as a result of their hospital stay" (Department of Health, 2005). The United Kingdom recommends that hospitals, social services, and homeless providers build and maintain strong links though policy and practice in order to provide appropriate and comprehensive services for the homeless.

3.5 TRACKING HOSPITAL DISCHARGES/HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)

Table 1 Distribution of Emergency Shelter referrals since May 1, 2005 to Oct 2006

Referred From	Duplicated Individuals	Unduplicated Individuals
Alcohol Treatment Program	1	1
Bridge Housing	1	1
Case Management Program	15	15
Children Youth Families	3	3
Domestic Violence Program	2	2
Emergency Shelter	17	17
Employment and Training Program	12	11
HUD Permanent with Disabilities	1	1
Homeless Day Program or Drop In Center	6	6
Hospital	11	11
In Patient Drug Treatment Program	8	8
Jail County	5	5
Mental Health Provider	27	26
Other - text required	35	34
Outpatient Drug Treatment Program	1	1
Outreach Team	4	4
Prison Federal or State	4	4
Self referral	2647	972
Soup Kitchen	23	23
Street Outreach	5	5
Transitional Housing	1	1
Veterans Administration	3	2
Unknown	6070	2259
Total	**8902**	**2827**

To track the services and referrals for the homeless population, the Homeless Management Information System (HMIS) was developed to assist homeless assistance providers coordinate care, mange their operations, and better serve their clients. Allegheny County designed and implemented the HMIS in October 2004. We were able to obtain HMIS data for Allegheny County for a 17-month period that tracked individuals entering shelters.

The HMIS county data only displayed 11 duplicated and unduplicated self-reports who were referred to a shelter by a hospital. The most important finding is that there were 6,070 (duplicated) and 2,259 (unduplicated) individuals in which the referral source was unknown. It

could be assumed that many of these individuals may have been referred by hospitals but may have been discharged onto the street before arriving at the facility. Also, many individuals may have been referred by a mental health hospital but chose not to disclose due to stigma. The purpose of the county data was to compare the HMIS report to the number of hospital discharges received by shelter administrators and staffs interviewed in our study.

3.6 MENTAL HEALTH AND HOMELESSNESS

The National Institute of Mental Health (NIMH) estimates that 26.2 percent of adults aged 18 and older suffer from a diagnosable mental disorder in a given year. When translating this information using Census data (2004), about 57.7 million individuals are affected. Mental disorders are also the leading cause of disability in the United States for ages 15-44. An estimated 4 million people with serious mental illness are homeless at any given time (Morris et al., 2006).

When looking at mental disorders and homelessness, approximately 20-25 percent of the single adult homeless population suffers from some form of mental illness. Many individuals, diagnosed with more than one mental health disorder, need more in-depth psychiatric care. Those with dual diagnosis may also suffer from other co-morbidities (i.e. HIV/Depression, Hepatitis C/Anxiety). Studies have shown that if a person's mental health is not stable or controlled, it can be devastating to that person's physical health. Sullivan et al., (2000) reports that "although homelessness increases the risk for certain physical health problems, such as pedal edema and abrasions, cuts, and rashes, evidence is accumulating that persons with mental illness and in particular homeless persons with mental illness suffer from more physical health

problems, both chronic and acute." Even though individuals who suffer from mental disorders often receive benefits and housing through government or local programs, a health disparity still exists when these individuals try to seek medical care. Sullivan et al. further states that "Even when individuals have Medicaid benefits, accessibility to health care remains problematic and resources available in most physical health programs for the homeless population are strikingly inadequate." While many hospitals may not treat individuals without insurance, sometimes the insured refuse proper medical or psychiatric treatment due to stigma, discrimination, or ignorance associated with mental disorders. Homeless individuals with mental disorders fare reasonably well in terms of income, entitlements, and health insurance, but they were more likely than homeless individuals without mental illness to experience problems with victimization, subsistence needs, and physical health" (Sullivan et al., 2000).

The homeless population faces additional problems when the stigma of a mental health disorder is attached to them. Society tries to ignore the issue and feels that it is an "individual" problem rather than a societal one. The stereotype of homeless persons with schizophrenia talking to themselves does not represent the mainstream of the homeless person with mental illness. It is far more common for a homeless person to suffer from severe affective than from chronic psychotic disorders (Sullivan et al., 2000).

Individuals who suffer from mental illnesses are less likely to find stable housing, even if the housing is affordable, because they are not able to manage their own household. Supportive housing programs have become one of the solutions for those with mental illnesses because they offer around the clock monitoring and support from staff. Due to limited funding, however only a few of these facilities exist. Therefore, many studies suggest "providers should emphasize

programs that ensure not only those mentally ill persons obtain housing but also that there housing situations are stable and durable over time" (Sullivan et al., 2000).

3.7 ALTERNATIVE HOUSING SOLUTIONS

The literature review also examines alternative housing in other cities in which could act as models for new prevention methods. Research shows that investment in housing and other services for the homeless will require allocation of public resources that will result to be cost-effective for hospitals and community programs.

In Boston and Washington D.C. where homelessness is a large problem, both have developed respite facilities that provide a safe place where those who are ill can recuperate under the supervision of health professionals and a supportive staff. In particular, Boston developed the 60-bed Interfaith House (IFH) respite that includes nurses, physicians, case managers, and employment and substance counselors to assist patients in developing social and life skills to increase their quality of life (Phillips, 1999). The respite facilities have a referral system with local private and public hospitals that provide a care plan, a primary care physician, a month supply of medication, and home health services as needed. Allegheny County has one non-medical respite facility that assists the homeless and frail populations. This respite is not equipped to handle the extensive medical needs of those being discharged from hospitals. If respite facilities developed in Boston and Washington D.C. could be duplicated in Allegheny County, these types of respite facilities could help close the gap in the system of care for homeless individuals. Respite facilities turn out to be cost-effective for hospitals due to a

decrease in re-hospitalizations. Respite facilities also help individuals seek treatment (mental health, substance abuse) and develop life skills to reduce this cycle of homelessness.

As a possible solution, the Health Services and Resources Delivery Committee (HRDC) of Allegheny County is in the process of developing an Engagement Center that will act as another non-medical respite facility for homeless individuals who need to be placed in an environment for additional recuperation. The Engagement Center will act as a step-down program for homeless individuals who are not appropriate for a shelter but need additional recovery time.

4.0 METHODS

The purpose of this study was to provide a means for critically assessing the issue of inappropriate discharges from hospitals to emergency homeless shelters. Because there are only a small number of shelters in Allegheny County (16), there was no need for sampling. Rather, we could easily contact and attempt to interview all 16 shelters. Another purpose of the study is to provide findings that will help formulate action plans that will aid in the creation of comprehensive health and behavioral health services for homeless persons. At the very least, we hope this study will act as an intervention to raise awareness of hospitals discharging the homeless and build social networks within the community.

4.1 PROJECT BACKGROUND

In response to the United States Interagency Council on homeless, Allegheny County developed a ten-year plan to address the issue of homeless. The plan consisted of eight recommendations with actions steps. The purpose of the 10-year plan was to engage the Allegheny County Homeless Alliance and its committee members to assist in alleviating the problem of homelessness. In order to better focus on the issue, the sub-committee, Health Resources and Service Delivery (HRDC), was developed to focus on ways to address the recommendations and action steps listed in the report. The goal of the committee is to identify healthcare needs for

those who are homeless and to advocate for comprehensive health and behavioral health services that are reliable, accessible, and effective for this population.

At HRDC monthly meetings, committee members discussed the condition of homeless individuals being discharged from local hospitals to emergency homeless shelters in Allegheny County. There were some reports of individuals discharged from hospitals in unstable health conditions who needed additional care in which a shelter could not provide. In order to see how often these discharges were occurring the HRDC collaborated with one faculty member, Dr. Christopher Keane, and two students, Valerie Stallworth and Todd Bear, from the University of Pittsburgh, Graduate School of Public Health to determine whether hospitals discharging to emergency homeless shelters were problematic. The students had already written proposals for a prior course pertaining to the background and possible solutions to address the state of homelessness in Allegheny County. That team drew up an initial, brief proposal. After all agreed to the general scope of the proposal, the students greatly elaborated on the proposal and drafted questionnaires. The entire collaborative team presented the proposals to the sub-committee in which they agreed with the findings. Both students had practicum requirements to fulfill, as part of their coursework therefore conducting the questionnaires was a great opportunity for them to explore the issue. Their practice would be devoted to conducting the survey and reporting the results to the HRDC.

4.1.1 Goals and Aims

The University of Pittsburgh, Graduate School of Public Health and the HRDC collaborated in efforts to understand whether the health needs of homeless individuals upon hospital discharge were properly assessed. The Department of Behavioral and Community Health Sciences

(BCHS) faculty, students and the health services sub-committee, HRDC, decided to develop a study to explore the issue of hospitals discharging to emergency homeless shelters.

The major aims of our study were to: 1) determine the magnitude and scope of hospitals discharging to shelters; 2) assess the perceived appropriateness of any such discharges; 3) to assess shelter policies, protocols, and practices regarding the intake of hospital discharges to shelters; 4) evaluate homeless shelters' capacity to manage both physically and mentally compromised homeless persons; 5) assess shelter staff s' attitudes and opinions regarding hospitals discharging to homeless shelters. From the information collected, our team was anticipating in finding out whether hospitals' discharging to shelters is problematic.

4.1.2 Interviews

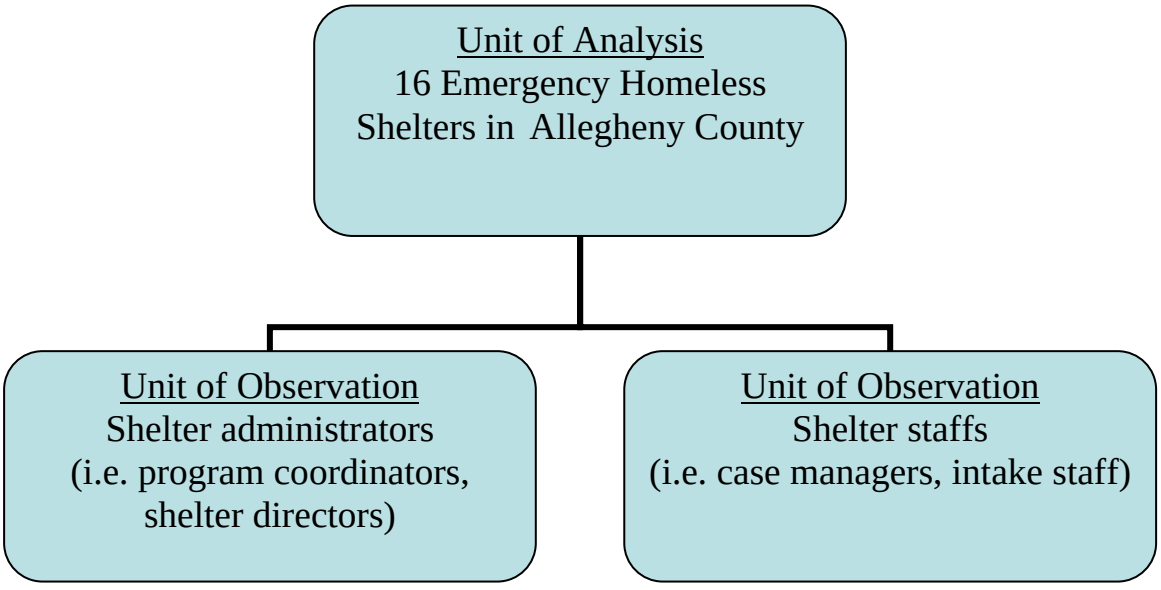

Figure 1 Unit of Analysis

All 16 emergency homeless shelters in Allegheny County were contacted to participate in the study. From each facility, a shelter administrator and staff were asked to participate since both have different interactions and experiences with this population. Each shelter administrator received an introductory letter (see APPENDIX A) explaining the purpose of the study, our collaboration with the Homeless Alliance, and how the study would be conducted. The introduction letter also explained the rights of each individual who chose to participate in the study. The authorization form (see APPENDIX B) was not consent to participate, once the authorization forms were received through fax or mail, the students contacted each administrator about their interest in participating in the study. This form gave students permission to contact the shelter administrator to explain the study and answer any questions.

The survey (see APPENDIX C) consisted of 26 questions that focused on the four aims of the study. Interviews were scheduled for a time period 30 minutes, but depending on discussion interviews could last up until 90 minutes. Interviews were only audiotaped with the permission of the participant. The recordings were later transcribed and coded for analysis. At the closing of the interview, all participants were asked permission for the students to contact them to verify that each response was captured accurately. At any time during the follow-up call participants could change or recant their responses.

4.1.3 Pilot

A pilot study was conducted to ensure that the questions in the survey addressed the concern of hospitals discharging to shelters and that the structure of the questionnaire was appropriate. Two members of Health Resources and Services Delivery Committee (HRDC) were asked to participate in the pilot study. Pilot interviews were scheduled with both committee members at

their facilities. Each interview was audiotaped with the permission of the participant. The results of those who participated in the pilot interview were not included in our final results nor were participants re-contacted to take part of the actual study. As a result of the pilot, participants did not give any recommendations about changing the questions or structure of the questionnaire. Students made changes to the questionnaire based on their experience. The students also presented the questionnaire to the HRDC to review, comment, and/or change any questions. Before the survey was administered to shelter providers, pilot participants, HRDC members, and faculty from the University of Pittsburgh, Graduate School of Public Health, had approved it. We obtained Internal Review Board approval from the University of Pittsburgh.

5.0 RESULTS

Table 2 Sample Characteristics

	Number participated	Percentage
# of shelters participating	N= 12/16	75%
# of shelter administrators interviewed	N=13*/16	75%
# of shelter staff interviewed	N=9/16	56%
# of interviews completed	N=22/32	69%
# of follow-up interviews completed	N=13/16	59%

*Two administrators participated from a single shelter

The response rate of the shelters that agreed to participate in our study was 75 percent (12 /16). Only 1 out of the 13 shelter administrators declined to be audio taped and 2 administrators were interviewed from the same facility. As a result, (22/32) 69% of the interviews were completed and (13/16) 59% shelters completed follow-up interviews.

5.1 SUMMARY OF DISCHARGES

Table 3 Summary of Discharges reported by Administrators

Shelter #	Total # of D/C received	%Reported inappropriate	Number of Inappropriate
Shelter 1	10	20%	2
Shelter 2	0	0%	0
Shelter 5	9	50%	4.5
Shelter 7	54	50%	27
Shelter 8	52	17.5% (15- 20%)	9.1
Shelter 9	100	1%	1
Shelter 10	7	10%	.7
Shelter 11	88	5%	4.4
Shelter 12 (DV)	2	"unsure"	n/a
Shelter 14	2	0%	0
Shelter 15 (DV)	75	50%	37.5
Shelter 16 (DV)	16	32.5 (30-35%)	5.2
Total	**415**		**91.4**

(DV) Domestic violence shelters

Shelter administrators reported receiving 415 discharges from hospitals in the past year. These discharges reflect direct discharges (hospitals had direct communication with the shelter staff before discharge) and indirect discharges (hospitals had no communication with shelter staff before discharge). Indirect discharges were identified as individuals who presented to the shelter with medical bracelets, discharge papers, or in hospital gowns. The discharges recorded are self-reports from only the shelter administrators since they comprised most of the participants in our

study. There were 91 (22%) reports of inappropriate discharges. From the data collected, the amount of inappropriate discharges ranged from 0 to 37.5.

5.2 STUDY AIMS

Aim 1: Determining the magnitude and scope of this potential problem

Of the 12 shelters interviewed, 91% experienced one or more discharges from hospitals in the past year. Twelve shelters reported receiving individuals from a hospital who needed extensive medical treatment. Below are examples of the extensive treatment individuals needed when discharged from hospitals to shelters:

Table 4 Extensive medical treatment

Participant	**Extensive medical treatment:**
Administrator	"Yes, serious detox attention, a person had some type of phlebitis on her leg and I considered it very serious, she was discharged back to us."
Staff	"there was one woman who needed a respirator, we could not take her because we could not care for her appropriately….the other woman that got discharged here with open wounds on her legs, she had extreme amounts of medical issues…I called hospitals and said you did not call us and second of all there is no nurse of our floor, like people aren't trained to care for this woman. I mean we had to bathe [her], we had to help her treat her wounds, her wounds were pussing like on her legs and socks…she was 73 years old."
Staff	"Yes, one person on dialysis, we get several people on dialysis they go out and get it."
Staff	"Someone had been badly beaten and their wounds were treated at the time, but it was so severe that they still required to be off their feet to have their wound continuously wrapped and rewrapped and cleaned, and you know that is not really feasible in a shelter…"
Staff	"…one day we had a women just dropped off with a broken foot and she could not walk and we did not have a bed for her and we ended up opening up a chair for her to sleep on just so she would not have to be on the streets with a broken foot."

Shelter staffs were unable to care for these individuals due to a shortage of shelter & medical staff, supplies, and resources. When the medical or psychiatric needs of those discharged exceed the capacity of a shelter, participants reported that these individuals were sent back to the hospitals. Also, if individuals were not able to go back to the hospital, shelter staffs searched for alternative placement. Since finding alternative placement was time consuming, staff spent less time with issues pertaining to other residents in their facility. Therefore, direct communication by hospitals would allow shelters to assess the situation and determine if their facility would meet the needs of the individual being discharged.

Out of the 12 shelters interviewed, (7/12) 58% reported having patients discharged to their shelter from a hospital who had complex medication or no medication at all:

Table 5 Individuals arriving with complex or no medications

Participant	**Complex or no medications:**
Administrator	"…they either come here without their medication, so often there is some hiccup between them getting their prescriptions filled when they leave the hospitals and arriving here and so we have people who are not properly medicated…"
Administrator	"…we sometimes need clarification on how often a particular medication should be given or taken…Sometimes a hospital will discharge a patient and the discharge papers list a certain medicine that the patient does not have with him or her, so those [are] the kinds of problems we come up against."
Administrator	"…people who may not have their mental health medication are just not well sometimes, it is a volatile mixture…often times [we] have a person here who is not fitting in terms of who may be scaring other residents or requiring so much of my staffs time and I have victims who are left kind of without proper staff attention…"
Staff	"…we had people who were prescribed a ton of medications and it just seems that they are over medicated…"
Staff	"…they were given samples, they didn't have insurance they were given samples of a pain medication but in fact they were a recovering addict and could not take the narcotic."
Staff	"People who are on pysch meds don't even receive them at all. There is a period of time when they are coming from the hospitals where they haven't received their medication at all."

Individuals discharged to shelters without the proper medication for physical ailments and/or mental health illnesses can be stressful for staff and detrimental to that individual. If individuals are not properly medicated, especially those individuals suffering from mental illnesses, this can cause major disruption in the shelter community.

Aim 2: Assessing shelter policies, protocols, and practices regarding the intake of hospital discharges

Of the shelters having formal and informal policies, (9/12) 75% reported having some type of hospital intake policy or protocol:

Table 6 Informal policies

Participants	**Informal policies:**
Administrator	"…we won't accept anybody who is not ambulatory, who cannot get around we pretty much do not want to take people with respirators or IVs…"
Administrator	"Yes, we have one policy that we do not turn anyone away unless they are violent or use drugs…"
Staff	"we have policies that they have to do stairs, that's one policy they have to be able to do all their ADLs (activities of daily living) like dress themselves and bathe themselves…."

Formal policies reported are presented below:

Table 7 Formal policies

Participants	**Formal shelter policies:**
Administrator	"…so if we interview someone we always see people in the hospital before they are discharged so we can tell from record and from face-to-face whether or not if there medical needs extend beyond what we can manage."
Administrator	"…our medical advocate is involved so there's this ability to do some in person assessment of what that individual really needs and whether our shelter might be the best fit for that person…we have contracts with particular hospitals who are involved…"

Thirty-three percent (4/12) of shelters reported using recording instruments such as logs, client software, and intake forms to collect information about which hospitals were discharging to their facility:

Table 8 Shelters recording hospital discharges

Participant	**Recording instruments:**
Administrator	"Yeah, we always keep records. Have a log book…mainly used for county reports for funders, that kind of thing."
Administrator	"…We document and log everything and we have client software…We use it for our clients who are recidivist so that we know what their background records are..."
Administrator	"…we will put it on our intake discharge, from X, Y, Z hospital on so and so day, hopefully we have the doctor's name or counselor…"
Administrator	"…we write on the [intake form] which hospital the call is coming from and we keep track of that for our medical advocacy statistics..."
Staff	"Yes, we have a shelter log. That's given if we were able to know what hospitals they came from."

The remaining (8/12) 66% of shelters reported not collecting data on hospitals that discharged to their facility. Even though the information was not tracked, participants did feel that it would be practical and feasible to collect this information:

Table 9 Feasibility of collecting data

Participants	**Feasible to collect data:**
Administrator	"I think it is important to have and certainly we do have it, we just don't have it centralized to gain access [to] it, right now to do it we would have to pull the files individually."
Administrator	"…a lot of times when we are writing grants and looking for funding in certain areas, we look at is there a way we could partner with a certain hospital to have a better relationship. We also at that time [determine] which medical personnel in the community needs more awareness about what domestic violence is, so you know if we see someone referring inappropriately we would say that staff could use some domestic violence education so we'll send our education department out to give them a training if they're willing."
Administrator	"…it would help to know in a given year how many people we have received [from a particular hospital] and the process of the case while they were here."
Staff	"…I don't think it would be that difficult to write down their name, write down the date and write down the hospital that discharge them especially because we want to set up a system that tells [hospitals] that they cannot do that and if you know what I mean, it's just, I don't think that would be too difficult."

Aim 3: Evaluating homeless shelters' capacity to manage both physically and mentally compromised homeless persons

Fifty percent (6/12) of shelters reported having professionals at their facility who were capable of providing medical and psychiatric care:

Table 10 Shelter staffs capable of providing medical/psychiatric care

Participants	**Professionals capable of providing medical/psychiatric care:**
Administrator	"Case managers, have a nurse [that comes in Monday and Friday], visiting doctors from [a clinic who] come every other Monday, mental health clinic, psychiatric nurses, interns. Array of individuals, medical to whatever."
Administrator	"Yes, we have counselor advocates and medical advocates nobody has a medical degree or nursing degree but their trained in crisis intervention, CPR, first aid and in general options counseling…"
Administrator	"Yes, pysch nurse full-time, psychiatrist twice a week, [a] clinic once a week, a podiatrist once a month."
Staff	"Yes, almost everybody is CPR trained, we have a clinic downstairs and case management provides supportive counseling…we do have medical clinics who come in twice a week here and [there's] a mental health clinic downstairs…volunteers like healthcare for the homeless will come in 2 days a week…"
Staff	"Yes, we do have a psych unit that comes in, we are all trained in CPR, first aid treatment, [the hospital] has a unit that comes in made up of nurses and psychiatrists. We do have a medical nurse that comes down twice a month and a doctor twice a month…"
Staff	"…CPR, we are all CPR certified, our medical advocate can definitely do blood pressures and we do offer counseling…"

Fifty-eight percent (7/12) of shelters interviewed believed that their facility is equipped to handle the medical and psychiatric needs of their homeless residents:

Table 11 Shelter facilities equipped to provide medical/psychiatric care

Participants	**Shelter equipped to handle medical and psychiatric needs:**
Administrator	"Yes, we can refrigerate any medication that would need…"
Administrator	"Yes, designated refrigerators, blood pressure equipment, glucometers."
Staff	"Yes, designated refrigerator, blood pressure equipment, glucometer. We do have an AED in the building."
Staff	"…the only thing I know our medical advocates have is the blood pressure equipment…"
Staff	"…what we have is a refrigerator for medication, we have a sharps container for people who are diabetic to put their needles in. We have a medication log so we do log their medications and [the medications are] locked up so we oversee that they get there medication, the right amount at least"

There were a few occasions where administrators and shelter staff did not agree as to whether their facility was properly staffed or equipped to handle the medical and psychiatric issues. This discrepancy may be because shelter administrators and staff have different opinions of which health professionals and equipment are considered capable of providing services and treatment.

Aim 4: Assessing shelter staff s' attitudes and opinions regarding hospitals discharging to homeless shelters

When shelter administrators and staff were asked to define an inappropriate discharge, three major themes were extracted from the data:

1) Lack of communication (50%)

Table 12 Defining an inappropriate discharge 1

Participants	**Responses to question about definition of inappropriate discharge:**
Administrator	"What I feel is appropriate is that we're given all of the facts over the telephone and I feel that that does not happen, which is why when someone gets here and we realize very quickly they're not appropriate for our shelter…I get the impression that [hospitals are] somewhat desperate, they need somewhere for the person to go and their reaching in terms of some of the things they say to us to make that client sound suitable."
Staff	"I think that the first and foremost what the most appropriate thing is for [hospitals] to call so that there can be direct communication about the patient/client you know. Because then we can know the extent of their issues and we can talk to that person, like a social worker about our concerns. You know we can say we're not equipped to handle, you know this situation or we're concerned because you know this problem might not work out in a community setting. Or even we can at least have that open dialogue with them, so I think that is really important to have."

2) Lack of follow-up (41%)

Table 13 Defining an inappropriate discharge 2

Participants	**Responses to question about definition of inappropriate discharge:**
Administrator	"Another incident, with a woman who was in car accident…she was in such serious medical condition, broken arms and staples in her skull and two black eyes. The staples in the scalped freaked us out and we had no directions regarding how to care for [this] woman and her wounds…it was like pulling teeth to find out what was the follow-up…"
Staff	"…you know there's times where they put them out where's there no set plan in place for the individual and they end up on the street for awhile."
Staff	"I think some people with mental health issues are discharged without meds, their put on meds while in the hospital…they have no meds and its like follow-up with your psychiatrist, well if your homeless you don't have insurance and you come here with no meds…if you're going to put them on a med give them enough to get through until they can get that follow-up appointment or have the hospitals make the follow-up appointment don't leave it up to [the individual]…"
Staff	"I think some people with mental health issues are discharged without medications their put on meds while in the hospital…and it's like follow up with your psychiatrist, well if your homeless you don't have insurance…
Staff	"Well like I said before, I feel they should have a plan in place you know because it does matter whether if it's [a] mental health or physical discharge. These individuals do need some follow-up care and being on the streets they fall through the cracks, I feel."

3) Dumping/Premature discharge (36%)

Table 14 Defining an inappropriate discharge 3

Participants	**Responses to question about definition of inappropriate discharge:**
Administrator	"Someone who is discharged and told to stay off [his or her] feet and sent to a shelter that is [an] inappropriate discharge. Someone who has dressing changes, needs dressing changes and is told to keep their wound site clean that is an inappropriate discharge."
Administrator	"Well, I think an inappropriate discharged would be putting them in a cab and sending them to a shelter. Our doors shut at 11 o'clock but we have occasions where people come to our shelter at 12 o'clock or 1 o'clock in a cab claiming that they came from a hospital, now I don't know if that's the case but that's what they state…"
Administrator	"People get discharged with an address and phone numbers, [hospitals] don't provide them with enough information about where there going, what [the shelter is] about."
Staff	"Inappropriate would be if they needed medications and [the hospitals] did not provide them with the medication."
Staff	"I would say it would be inappropriate to discharge someone knowing that they are homeless and especially if they're not mentally able to take care of whatever medical need …it would be inappropriate to discharge them in a way that they are not able to take care of themselves because basically most shelters are not equipped to take care of medical needs, they would have to be self-sufficient…"
Staff	"…it's inappropriate for the only assessment of a person [is] to be like as long as their homeless they are appropriate for a shelter. I don't think that is an accurate definition because there [are] homeless people that are medically and mentally [compromised] in such [a] severe situation that there ought to be other options for them…"

From all the possible solutions to the issue of hospitals discharging to shelters, participants agreed on the following top three suggestions that would assist in alleviating this problem:

1) Better Communication (50%)

Table 15 Possible Solutions 1

Participant	**Possible Solutions:**
Administrator	"Establishing [a] more formal network, I mean I think the benefit in the intimate partner violence community by having advocates in hospitals is that they do have this rapport like there's a face that a hospital can put to our medical advocate…I feel from my experience with intimate partner abuse having those alliances and actual staff people to link up with and talk to and case manage has [to] be helpful."
Administrator	"…. we have a great partnership and understanding and contract to some degree that we're going to work in tandem on the hospital end versus the residential end and we're going to communicate, we're going to go to seminars and we're going to go to trainings, we're going to go to county meetings, and we're going to go to places where we could have open discussion…"
Administrator	"We need to have an ongoing conversation and a contact person with the hospital…develop some type of relationships with the critical people in these decision-making situations so we can work with them. Because we know that [hospitals] are overburden and financially stressed and likewise with us, so we need to work on that together."
Administrator	"More communication on both parts it's not only the hospital, a lot of the time it's the shelter too."
Administrator	"…we develop relationships and get to know whose calling us from which hospitals and I think that is the ideal situation when you know who [you] are working with and they know what you can and cannot do, so I think knowing each other is the ideal…"
Staff	"I think [hospitals] could have a better kind of system developed where if they can't really address the needs of the homeless then they can communicate with different organizations instead of just dumping them."
Staff	"Communication, know each others resources and limitations. What can we do to help this person, what can't we do, what's beyond our scope."
Staff	"I really think communication is the key, I think that if we knew each other and we could have open [dialogue], this is who I am I know who you are, we have this person, this is that persons situation and I'm definitely willing to help and if I can't help you here's a number, maybe they can help you. We can just open those doors more I think that would definitely be a step in the right direction."

2) Develop medical and psychiatric respite (32%)

Table 16 Possible Solutions 2

Participant:	**Possible Solutions:**
Administrator	"A respite situation."
Staff	"Have more respite places strictly for the homeless and this place is strictly for the homeless who are discharged from hospitals and you know who need a continuum of care because a lot of people don't have medical insurance..."
Staff	"…it would be really nice if there was a place that was for homeless people with medical problems…it would be nice to have a general facility for people who are homeless that do have a high level of need, physically, or mentally."
Staff	"…there's a need for respite in the county…I don't think it's the hospitals fault that they have nowhere to put them and the shelters are not equipped for them…so they are just floating around. We need respite services to pick up this group that are falling between the cracks."

3) Shelters need to be more accommodating (27%)

Table 17 Possible Solutions 3

Participant	**Possible Solutions:**
Administrator	"Shelters need to be educationally equipped to provide as much energy and as much dedicated resources to get that person to a place and being a place in their mind that they are of good sound and healthy body to where they're not going to at least in the near future circumvent back through the ER..."
Administrator	"Again, it would be nice if shelters could provide um yet not have to ask people to leave during the day that get discharged from the hospital. If there are certain number of beds that could be reserved for people who have doctor orders to stay off of their feet…"

4) Increase hospitals' knowledge regarding homelessness (23%)

Table 18 Possible Solutions 4

Participants	**Possible Solutions:**
Administrator	"…sharing information in terms of education, that's the best thing we can do is educate hospital staff as to what is a victim of domestic violence so we're not wasting anyone's time including the client. Let's understand what our services can provide and the best [way] we can do that is through prevention and education…"
Administrator	"I do think hospitals should be embracing the understanding as much as possible of what homelessness is…come up with more of a strategic plan to desonate somebody that when they come in through the ER or when they come through an outpatient clinic or whatever, that maybe there's a checklist or some type of assessment piece that they can target and give a little bit greater emphasis for those individuals to gain [resources] and go places that they can go get help…"
Administrator	"They need to direct their staff regarding [homelessness] and a policy on how to work with the homeless people and a procedure and they should have the numbers and contact people of the shelters that they should call…"
Administrator	"Provide staff support to the shelters."
Staff	"A little more leg work, a little more depth to their resource pool exploring what's out there for their homeless patient…"

As to the severity of hospitals discharging to shelters, participants moderately agreed that the problem of hospitals discharging to shelters is a very severe problem (Based on a scale ranging from 1=strong disagree to 5=strongly agree):

Table 19 Severity of hospitals discharging to shelter facilities

Participant	**Severity of hospitals discharging to shelters:**
Administrator	"…because I think sometimes if someone is homeless what can the hospital do? They can't keep a patient in the bed until their housed, that's not what their there for so it really comes back to an issue of our culture, a system allowing this persistent homelessness. I do not see it as the hospitals fault, I see it as the system of homeless that exist."
Administrator	"…it is not the vast majority, its important enough that it is a serious problem. It is not a constant problem, it happens often enough and could be life threatening."
Administrator	"…again I'm looking at the process…things are getting better with that situation, if you would of asked me a couple years ago it wasn't real pretty."
Administrator	"…the seriousness that homelessness exists in housing affordability is severe."
Administrator	"…it's not a daily issue where we are combating whether this was an appropriate [discharge]…often we have interactions with the hospital staff ahead of time…not a daily occurrence…"
Staff	"…it's not like it happens all the time, but when it happens it's just so unbelievable to me those situations are generally pretty bad…"
Staff	"…people who are discharged with mental health and there needs were not really met."
Staff	"… there's been so many cases that we have heard from different shelters that are in Pittsburgh where people have been discharged inappropriately, just not really taken care of while in the hospital and just kind of put out there to take care of themselves even if they are able to."

Participants reported that hospitals' discharging to their facility was a moderate (2.2) priority (Based on a scale ranging from 1=little to no priority to 4=very high priority):

Table 20 Prioritization of hospitals discharging to shelter facilities

Participants	**Priority:**
Administrator	"…that's pretty much what we do, we fill a gap, we fill a need that other shelters cannot provide because we are 24 hours a day and we are staffed 24/7 and we can provide a cleaner and more structured healthy environment for someone who is homeless and in need of more healing time."
Administrator	"…a priority for us because most of our folks are associated inpatient or outpatient on some ongoing basis with the hospitals that's the make up of our building. So it's a high priority that hospitals recognize that this is a place for folks to come…"
Administrator	"… not a daily issue…I think it's becoming an increasing issue where there's fewer options for people to go so I think we would continue to encounter it more, but I don't think it is a high priority now."
Administrator	"… because it is not the majority of the cases we get…hospitals are a fairly small percentage of our total referrals, yet within that percentage there is a lot of concern. So, I say moderate because it is not happening 20 times a day."
Staff	"…in the past it use to be pretty bad…but because of a restructuring of our program it's not so bad. I would say a moderate priority."
Staff	"…I think these people, in all cases I have seen or the people I have mentioned, their really vulnerable people and its just not safe to leave them you know…we can make room for them, its still not necessarily appropriate due to their needs you know. "
Staff	"…we don't experience it a lot I would not say it happens a lot not for us. I really do not hear it happening a lot, so I really don't think [it] is a high need…"

Shelter administrators and staffs moderately agree that hospitals' discharging to their facility is neither a severe problem nor a high priority. Even though shelters reported receiving inappropriate discharges, shelter administrators and staffs report that inappropriate discharging does not occur on a daily basis. The major concern is that when an individual is inappropriately discharged it is usually a serious case that demands a lot of time and effort.

When shelters were asked about what responsibility did they believe hospitals had regarding the homeless their responses varied:

Table 21 Responsibility of hospitals regarding homelessness

Participants	**Hospitals responsibility to the homeless:**
Administrator	"…the women we work with is so specific to intimate partner abuse that I think they have a huge responsibility to be assessing for that abuse and help women, you know be a safe place for women to disclose and for hospital staff to be informed on how to respond to disclosure and refer women…especially thinking about psychiatric, I think you know also its their responsibility to make sure that they are hooking people up with the best resources…I think [it's not] their job to find housing for that individual by any means, but at least that they are well informed about the resources in the community and that the time spent with patients is connecting them up with the best fit…"
Administrator	"I believe that their responsibility is to find the appropriate services. I know that they are struggling so much with insurance not covering, they have no choice but to get them out. They are in a catch 22 as well…hiding information to get a patient a space is not in the best interest of that patient, so their responsibility to me lies on honesty…"
Administrator	"Very difficult. I'm really not sure, I think they [have] no more responsibility than any other institution in the city…On the other hand sometimes we see absolutely wonderful actions on the parts of the hospitals, it seems almost random, but I don't think they can bare the burden of homelessness alone."
Administrator	"Well, I think they have a high moral obligation to provide as much reasonable effort given whatever the situation may be to get that person as much of a start out of the door as they can…a lot of those individuals are on some type of psychotropic medication or some type of preventive medication. They're on something usually that there going to need adequate access and maybe some assistance to maintain their health. So, the just shipping them out with a word or two, a hey kind of good luck type of thing isn't going to cut it…."
Staff	"I think they have a huge responsibility to them, I won't even get started on medical insurance and those issues, but I mean people should be able to be treated. They should be treated to the extent that their in good health if there is a treatment out there for them…I don't think that homeless or even sometimes poor people who are not homeless are treated like people, they are not animals, these are human beings here you know…"
Staff	"I would say they have a responsibility that if somebody is being discharged who needs care that their not going straight out on the street…I think a little more work on the part of the social workers and the availability of their resources, I mean in this field all it takes is phone calls and some digging and you can find the resources you need, we do it you know just putting forth a little extra effort for the concern of the patient really."

Shelter administrators and staffs had varied responses when asked if they felt obligated to admit individuals into their facility:

Table 22 Shelters obligation to admit homeless individuals

Participant	**Shelters feeling obligated:**
Administrator	"I don't feel obligated, I feel obligated to admit individuals who fit the criteria of the program. To have someone call from a hospital makes no difference."
Administrator	"Absolutely not, well for one regardless where they're coming from it would not change our perception in fairness and balance because you have to remember just taking someone because someone says to could number one actually hurt that individual in terms in fairness of treatment…We do not want to place people in a position that their not going to succeed or at least have a reasonable chance of succeeding so we would not want to just [accept them] because someone from the hospital said put this person in your housing unit…"
Administrator	"Yes somewhat, it's our job."
Administrator	"Oh yeah, that's what where here for, that's our mission, its part of our mission."
Administrator	"Um, in our situation not if its not intimate partner abuse…"
Staff	"I would say no, we do it but we're not obligated especially because we are a domestic violence shelter not a homeless shelter…"
Staff	"Yeah I do absolutely, because if we do not take them and nobody [else] will take them, then their sick on the streets. Its bad enough being on the streets but to be on the streets and have a physical ailment…we want to be able to help them you know."
Staff	"Of course, as an emergency shelter we feel obligated to let anyone in who is in severe need…especially when the weather is cold. You know even if we have to have people sleep on chairs and make a bed for them we see it as a priority in general, especially if when they have medical needs."

5.3 ADMINISTRATORS DEFINING HOMELESSNESS

The specific criteria of each shelter determined whether staff accepted someone into their facility. Each shelter serves a sub-population of the entire homeless population. Some shelters deal solely with women and/or children, domestic violence shelters only admit women who are

victims of domestic violence and key issues are safety; and other shelters cater only to single men over 18 years of age. The definition of homelessness varied between the shelters participating in our study. Shelter administrator's defined homelessness based on the population served and services offered. Interviewing shelter administrators of each facility gave a clear understanding of how they define homelessness:

Table 23 Shelter administrators' definition of homelessness

Defining homelessness
"…women who do not have a place to live temporarily and in the case of our services ideally we're trying to focus our services around women who are in intimate partner abuse situations, as soon as they have to leave their partner they are considered homeless at that point."
"For us we have two different categories, we have a 30 day stay for families, women, and their children who are in a domestic violence crisis. We also have a 3 day stay for people who just define themselves as homeless and who have no place to stay that night…"
"Quite a few different definitions of homelessness depending who you talk to, …you got HUD standards I don't know specific terminology I just know we define homelessness as any individual that needs housing and that is not doubled up."
"Anyone who has been homeless due to fire, overnight staying in cars [or] on the streets…males 18 years and older"

Therefore, it is crucial for hospitals to understand that each shelter does not provide placement just because a person is homeless. Each shelter has a criteria set in place that addresses the needs for different sub-populations within the homeless community.

6.0 LIMITATIONS

A major limitation of this study is that the hospital perspective on the issue of inappropriately discharging to shelters was not studied. Like shelters, hospitals are financially stressed, overburdened and understaffed. Interviewing hospital staffs such as administrators, emergency department and discharge nurses, and social workers would identify whether they have the proper screening tools to assess homelessness. Also, these interviews would give insight to their thoughts of homelessness and whether they feel obligated or responsible for finding adequate and safe housing once these individuals are discharged. Through interviews, hospital staffs could inform researchers of the barriers that exist within the hospital system such as medical insurance (i.e. Medicaid, Medicare) and prescription drug costs that they have no control over. Identifying barriers such as the above would explain why homeless persons do not receive adequate treatment and/or a thorough assessment. Also, staffs could explain what responsibility hospitals have in discharging the homeless and any possible solutions to those who are inappropriately discharged.

A second limitation is that homeless individuals were not interviewed for the study. It is possible that this target group could have explained some of the reasons as to why they are discharged inappropriately. It is not always the hospitals fault that these individuals are discharged prematurely. A large proportion of homeless individuals suffer from mental health disorders that may cloud their judgment to treatment. As a result, it is possible that these

individuals may leave the hospital against medical advice, refuse to take medications or receive treatment while hospitalized. Therefore, input from the actual population itself may have provided insight into some of the reasons these individuals are discharged early.

Twenty-five percent of the shelters in Allegheny County were not represented in our study. Those shelters not included in this study may have given additional information to refute or accept the notion of hospitals inappropriately discharging to shelters. Also, interviews were only conducted with shelter administrators and staffs in Allegheny County. Even though emergency homeless shelters are not abundant in neighboring counties, it would have been interesting to determine whether hospital discharges to shelters in these counties are problematic.

Another limitation to the study is that participants did not have documentation or records of homeless individuals discharged from hospitals to their facility during the interview. Therefore, all information collected was based on recall rather than actual data. This could negatively skew results since many individuals could not recall the actual number of individuals discharged from hospitals in the past year.

The structure of the questionnaire itself may have been a limitation to the study. Even though the survey was piloted on committee members who were knowledgeable about the topic and with shelter procedures, multiple participants could have misunderstood many of the questions. As a result, participants may have interpreted the questions differently resulting in a range of responses. Even though a list of definitions was created to define each question, it is still possible that participants may have had problems understanding what the question was asking. Therefore, it is possible that if a larger sample was used for the pilot additional questions or suggestions may have been raised.

7.0 FUTURE RESEARCH AND RECOMMENDATIONS

This study indicates the need for hospitals and shelters to create a systematic approach where there is a forum for communication and problem solving. Since the issue of homelessness cannot be solved by one organization or system, it is imperative that dialogue be created to find commonalities on each side to take steps toward change. Even though hospitals are seen as a profitable industry, they are also financially bound and understaffed to meet the needs of this underserved population. In dealing with a sensitive subject such as homelessness, it is important to work top down in order to convince those in charge that this is a serious issue.

Not only do shelter staffs feel that communication needs to be increased with the hospitals, but they also feel communication could be improved between the shelters and the wider community, and with other organizations at the local and state level. Only through dialogue, can stakeholders such hospitals, mental health providers, social services, and homeless service providers understand how homelessness is affecting a community's overall health. Also, stakeholders can determine what role they play in alleviating some of the social issues that surrounds this population. Creating collaborations and networking will eventually create possible solutions to the issue of hospitals discharging to shelters in Allegheny County.

Shelter administrators and staffs also propose the development of medical and psychiatric respites for those individuals who need additional care after hospital discharge. Respite facilities would act as a step-down program that would reduce the stress of social workers struggling with

discharging individuals onto the street or to a shelter. Those individuals who suffer from mild to severe mental disorders are not able to function and perform in a community setting. Therefore, a respite facility with mental health supports would encourage therapy treatment and medication adherence. Respite facilities would act as the short-term link between the hospitals and the streets. As shown in other cities, respite facilities can keep individuals off the streets to recuperate and connected to resources within the community while receiving intermediate care.

Also noted in this study, a majority of these shelters were not collecting data on which hospitals referred homeless individuals to their facility. It is understandable why shelters do not track this information since they are usually tracking other indicators for the purpose of funding. Many participants did report that this information was being recorded on client software, intake forms, or log books but was not compiled into a report that could be readily available. Gathering information on which hospitals are inappropriately discharging to shelters is an opportunity for shelters to educate those hospitals on the capabilities and resources of their facility.

Finally, it is recommended that these results be presented to the larger community so everyone can understand how each individual, organization, and institution plays a vital role in keeping these individuals safe and as healthy as possible. Again, collaboration and dialogue must occur amongst the key stakeholders in order to develop creative solutions to the issue of hospitals discharging to shelters.

8.0 DISCUSSION

Even though all the shelters in Allegheny County did not participate, a significant amount of data was collected pertaining to hospital discharges in Allegheny County. From the results of the study, participants reported that hospitals discharging to emergency homeless shelters in Allegheny County are problematic. In contrast to the Homeless Management Information System (HMIS) county data, our study indicated that many homeless individuals are referred to shelters by hospitals. Shelters feel that the issue of hospitals discharging to their facility is a matter that needs to be addressed even though these discharges are rare. Participants stressed that these inappropriate discharges are very severe and chaotic when they arrive at their facility. Inappropriate discharges not only cause stress to the shelter staff and those discharged but also to the homeless residents who are already living in that community setting.

Shelters receiving hospital discharges reported that many of these individuals arrived needing extensive medical treatment. This can be detrimental to shelter facilities because stress and strain is placed on staff to look for alternative placement. Shelters administrators reported having a limited number of staff employed at their facility. Therefore, many shelters do not have the manpower to handle these individuals who have more extensive medical or psychiatric needs. As a result, the health condition of these individuals' worsens due to improper follow-up care.

Shelter administrators and staffs reported that a lack of communication, lack of follow-up, and premature discharge/dumping were the causes of many inappropriate hospital discharges.

Participants stated that better communication between shelters and hospitals and developing a medical and psychiatric respite would assist in alleviating this issue. Shelter administrators and staffs not only stressed that hospitals have direct communication with shelter staff before discharge, but that the information received from hospitals is truthful. Some participants commented that there was several incidents where they spoke with hospital personnel and the information received completely contradicted the initial report given over the phone. Direct and truthful communication will not only decrease inappropriate discharges but also strengthen the trust between hospitals and shelters.

Communication did not only extend to hospitals but to community agencies, local and state officials to advocate for the rights of homeless individuals. Many of the shelter administrators and staffs suggested that hospitals, shelters, and other homeless service providers collaborate to work with local and state levels to obtain more funding and create awareness.

Three domestic violence shelters participated in the study. One domestic violence shelter reported having formal contracts with local hospitals. This policy consisted of collaborating with local hospitals to have medical advocates meet with homeless individuals while hospitalized. The assessments done by the medical advocates ensured that the person brought into their facility would be a great fit and not exceed the shelter's resources. Another domestic violence shelter spoke about an alliance with a mental health hospital. As a result, discussion has emerged on issues pertaining to intimate partner violence among the homeless population. This link between professionals supports the homeless community and creates dialogue between the hospital and shelter. It is assumed that the formal policies presented by domestic violence shelters would lessen inappropriate discharges, but this study did not indicate the above since one of the domestic violence shelters reported receiving the highest number of inappropriate discharges.

This may be because hospitals are not aware of the differences between a domestic violence shelter and an emergency homeless shelter. Also, hospitals may not understand that a domestic violence shelter has a strict criterion that makes an individual eligible for their services.

Creating medical and psychiatric respite facilities were another solution to this issue. One facility interviewed was a non-respite facility that housed the homeless and frail populations. At the non-medical respite facility, participants clearly established a thorough assessment that limited inappropriate discharges. The intake procedure consisted of a telephone screening, a recent physical history (e.g. recent X-ray/PPD), psychiatric evaluation, and a list of medications. The formal policy demanded that staff go into the hospital to determine whether a person was a good fit for their facility. This facility always had direct communication with hospitals before discharge. Staff also obtained medical records and conducted face-to-face interviews with individuals who were hospitalized to determine any unmet needs. Due to these policies, this facility reported minimal inappropriate discharges.

Therefore, additional respite facilities are needed in Allegheny County to alleviate this issue. To solve part of this problem, the Health Resources and Service Delivery Committee (HRDC) is in the process of developing and implementing an Engagement Center to act as another non-medical respite to address some of these unmet needs.

A majority of shelters do not collect data on which hospitals discharge to their facility nor do shelter staffs record whether these discharges are appropriate or inappropriate. Tracking this information creates the opportunity for shelters to educate those hospitals about their services and strengthen the idea of the need for a medical and psychiatric respite. Even though half of shelter staffs and administrators felt that their facilities had professionals and equipment capable

of providing medical and psychiatric care, these facilities were not equipped to handle those who needed in extensive care.

Also, shelters felt that hospitals had some responsibility when discharging individuals. Shelters reported that hospitals were responsible for providing the appropriate resources and referrals, reviewing the existing resource pool, and being honest with shelters about the condition of an individual. Several shelters did not feel obligated to admit individuals into their facility. Many participants were very clear that acceptance into a shelter is not just based on homelessness, but whether an individuals met the criteria for their shelter. Therefore, hospitals should not just assume that homelessness is the only decisive factor for a shelter since shelters have their own criteria for eligibility.

It could be assumed that shelters in close proximity to local hospitals would receive the most inappropriate discharges due to convenience, but the study has shown otherwise. Inappropriate discharges were reported by shelters who were both close in proximity and a distant from local hospitals.

9.0 CONCLUSION

Hospitals discharging to emergency homeless shelters in Allegheny County are problematic. The majority of participants felt that better communication between hospitals and shelters would facilitate appropriate discharges. Blame is not assigned to any one party; shelters understand the dilemma of hospitals and also take on the responsibility of this issue. Hospitals are not responsible for housing this population, therefore accountability also lies at the local, state, and government levels that allow homelessness to exist. Providing affordable housing is not the only answer in solving this problem. Social services need to be in place once these individuals are discharged from the hospital. It is imperative that alternative medical and psychiatric respites, such as the Engagement Center, are developed to act as an intermediate between hospitals and shelters. It is important to understand that even though these individuals do not fit into the social norms of American culture, they still are entitled to proper healthcare, treatment, and compassion as any other individual.

APPENDIX A

INTRODUCTION LETTER

Date_____

Dear _____,

We are writing to you because we are interested in learning about particular concerns that you and your staff may have when you are being asked to provide shelter and services to those who are experiencing homelessness. We are students from the University of Pittsburgh, Graduate School of Public Health. We are working with faculty from the Graduate School of Public Health and with members of the Homeless Alliance Health Resources and Service Delivery Committee to explore some particular issues faced by organizations such as your organization.

As you may know, the Homeless Alliance is a public/private partnership formed to implement a ten-year plan to eliminate homelessness in Allegheny County. The Health Resources and Service Delivery Committee, co-chaired by Diane Johnson and Karen Peterson, has as its mission to recommend ways to overcome barriers to the access of healthcare for the

homeless population. The focus of the survey is to identify any concerns that shelter staff may have when a patient discharged from a hospital is referred to or arrives at a shelter site for shelter and other additional services. It has been suggested that this may be an issue and we hope to determine if this is a concern for you and, if so, why it is a concern. Knowing that you are the individuals who have an interest in providing a needed service to this population and the knowledge of how to best provide this care, we are interested in learning your views and ask for your help with this survey.

Our team plans to interview an administrator and another staff person at 16 shelters in Allegheny County in order to get a better understanding of this issue. Our interview consists of questions about past or current experiences you have had with respect to hospital discharges to your shelter. The interview should take about thirty minutes, but, if you have more time, it could take up to 90 minutes. For your convenience, we would conduct the interview at your shelter. All of the information obtained from this survey will be kept in strict confidentiality. Your shelter will be identified only by an identification number and all information will remain in a secured facility. The analysis, presentation, and summary of the collected data will not identify shelters or shelter staff members. At any time during the interview you can choose to discontinue your participation or decline to answer any of the questions presented.

Again, we value your views and would greatly appreciate it if you would agree to participate. We also ask that you tell us who, as a shelter staff person, we can interview, as well. Enclosed is an authorization letter that is required by the Institutional Review Board of the University of Pittsburgh. By completing this form you and your staff <u>are not</u> consenting to participate, but rather you are allowing us the opportunity to contact you and possibly your staff to discuss further the study and your potential participation. The authorization form can be

returned in the self-addressed stamped envelope provided or faxed to (412)-XXX-XXXX. Once we have received authorization, you will be contacted within two weeks via telephone by either Valerie Stallworth or Todd Bear in order to answer any questions you may have about the survey and to ask your permission to conduct the interviews. If you have any questions in the meantime, you can contact Valerie A. Stallworth at (412)-XXX-XXX or Todd Bear at (412) XXX-XXXX.

Thank you for your consideration.

Sincerely,

_____

Karen Peterson, Health Resources and Services Delivery Co-chair

_____

Christopher Keane, Sc.D., Assistant Professor, Graduate School of Public Health

_____

Todd Bear, Graduate Student

_____

Valerie Stallworth, Graduate Student

APPENDIX B

AUTHORIZATION FORM

*By completing this form you and your staff <u>are not</u> consenting to participate, but rather you are allowing us the opportunity to contact you and possibly your staff to discuss further the study and your potential participation. This authorization form can be returned in the self-addressed stamped envelope provided or faxed to (*412)-XXX-XXXX ATTN: Todd Bear.

I, _____, authorize Todd Bear and/or Valerie Stallworth, graduate students at the University of Pittsburgh's Graduate School of Public Health, to conduct research at our shelter and contact our staff regarding research pertaining to "Hospitals Discharging to Shelters."

Shelter name: _____.

Title: _____.

Signature: _____.

Date: _____.

APPENDIX C

QUESTIONNAIRE

Participant ID# _____

DATE: / /

If participant has agreed to be recorded, start audiotape now.

INTRODUCTION: *Before we begin, I would like to reiterate that this interview will take approximately 30 minutes and that all your responses will be kept in strict confidentiality. At any time during the interview you can opt not to participate or choose not to respond to any of the questions. Do you have any questions?*

Administrators only: *"The first several questions are about your shelter in general, its mission, service, and size."*

1. What is the mission of your shelter? **If respondent has trouble, probe:** What are the general goals of your shelter, what do you hope to accomplish?

2. What are the primary services your shelter provides?

3. How does your shelter define homelessness?

4. How do you define those whom you serve (i.e. who is eligible for your services? What criteria must a person meet to receive your services)?

5. On average how many individuals does you shelter serve per year? _____

If respondent has difficulty estimating individuals per year, ask:

Can you estimate how many individuals do you serve per month/week? _____

6. How many staff members does your shelter employ? _____

7. What are your shelters criteria/protocols for the intake of individuals?

"The following questions pertain to hospitals discharging patients to your shelter"

8. In the past year have hospitals *directly* discharged homeless clients to your shelter whereby there <u>was</u> direct communication between shelter and hospital staff?

☐ YES

- On average how many of these individuals does your shelter serve per year? _____. **If respondent has difficulty estimating individuals per year, ask:** Can you estimate how many of these individuals your shelter serves per month or per week? _____ month/week

- Did your shelter decline to intake any discharges from hospitals over the past year, month, week? **If yes, how many and why?**

☐ NO

- Did your shelter decline to intake any discharges from hospitals over the past year, month, week? **If yes, how many and why?**

9. In the past year have hospitals *indirectly* discharged homeless clients to your shelter whereby there was no communication between shelter and hospital staff?

☐ YES

- How are these indirect discharges identified?

- On average how many of these individuals does you shelter serve per year? _____**If respondent has difficulty estimating individuals per year, ask:** Can you estimate how many of these individuals do you serve per month or per week? _____ month/week

- Do you view this as a problem?

- Why or why not?

☐ NO

- **Skip to next question**

If respondent cannot recall ever the intake of a hospital discharge or indirect discharge, skip to Question 16.

10. Do you have any means by which you track which hospitals discharge to your shelter?

☐ YES

- Could you elaborate on what they are (do you have a log or other written documentation)?

- How do you use this information?

- Is it useful?

☐ NO

- Do you believe it would be practical or feasible to collect this kind of information?

- Why or why not?

11. Of homeless persons who arrive at your shelter after having been discharged from a hospital, what would you say on average is their physical condition? Would you say it is:

a) Poor
b) Fair
c) Good
d) Excellent

12. Of homeless persons who arrive at your shelter after having been discharged from a hospital, what would you say on average is their mental condition? Would you say it is:

a) Poor
b) Fair
c) Good
d) Excellent

13. Within the past year have you received any individuals discharged from hospitals that required extensive medical care?

☐ YES

Can you elaborate on what care they needed?

☐ NO

Skip to next question

14. Are individuals discharged from hospitals given medications with complex or unclear instructions?

☐ YES

Can you elaborate on particular instances?

☐ NO

Skip to next question

15. To what extent are individuals who are discharged from hospitals in poor physical/mental conditions problematic for your shelter and staff?

a) A very severe problem
b) A severe problem
c) A moderate problem
d) Little or no problem **(ASK WHY)?**

If a moderate problem or more ask:

Could you tell me more about this? In what ways is it problematic?

"The next few questions pertain to your shelter's ability to serve those who are medically or mentally compromised"

16. Do you have shelter staffs that are capable of providing medical/psychiatric services (i.e. CPR, blood pressure, or counseling)?

☐ YES

- What are their professions/titles?

☐ NO

- **Skip to next question**

17. Is your facility equipped to handle the medical and psychiatric needs of your clients? (I.e. designated refrigerators for medications, BP equipment, glucometer)

☐ YES

- What ways is your facility so equipped?

☐ NO

- What would your facility need to have what it currently lacks?

"The next few questions pertain to policy practices or protocols your shelter may have regarding the intake of hospital discharges"

18. Do you have any formal or informal shelter policies regarding the intake of hospital discharges?

☐ YES

- What are they (do you have any written documentation)?

- Are they effective, why or why not?

☐ NO

- **Skip to next question**

19. Do you have any formal or informal agreements with hospitals regarding intake of hospital discharges?

☐ YES

- What are they (do you have any written documentation)?

- Are they effective, Why or why not?

☐ NO

- **Skip to next question**

20. Do you have any formal or informal policies or agreements with other shelters regarding intake of hospital discharges?

☐ YES

- What are they?

- Are they effective, why or why not?

☐ NO

- **Skip to next question**

The final set of questions pertains to your attitudes, thoughts, and feelings regarding hospitals discharging to shelters"

21. How do you define an appropriate or inappropriate hospital discharge of a homeless person (Differentiate between psychiatric and medical)?

a) **If respondent has indicated above that they have received discharges from hospitals (directly or indirectly) ask:** In your opinion, what percent of discharges from hospitals have been 'inappropriate?" _____%

b) **Can you elaborate on these inappropriate discharges (i.e. case specifics)?**

22. How much do you agree with this statement: "The problem of hospitals discharging to shelters is very severe:"

a) Strongly agree

b) Moderately agree

c) Neither agree nor disagree

d) Disagree

e) Strongly disagree.

Ask Why?

23. How would you prioritize the issue of hospital discharging to your facility?

a) A very high priority

b) A high priority

c) A moderate priority

d) a low priority

Ask Why?

24. What responsibility, if any, do you believe hospitals have regarding the homeless?

25. Do you feel obligated in admitting individuals from hospitals if they are homeless? Why or why not?

26. What do you believe are possible solutions from either the hospital's or shelter's perspective to the problem of discharging person from the hospital to a shelter?

- What can shelters do?

- What can hospitals do?

- How can Shelters and hospitals work together?

"Thank-you again for your participation, we greatly appreciate your time and willingness to share your thought and feeling regarding this topic. Do you have any questions, concerns, or anything to add or do you think there is something we missed or need to add to the survey regarding this topic?

"After we have a chance to review the information we collected today, may we contact you to verify that we have captured your responses accurately?"

□ **YES**

□ **NO**

Stop tape recording.

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