Hospital Discharge: Safe and Effective Models for People Experiencing Homelessness

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Docs # 1374554

Table of Contents

Introduction

As varying levels of government come to realize the extraordinary healthcare costs associated with homelessness, strategies for hospital discharge planning which focus on housing first approaches have become increasingly common. Effective models of discharge planning have been located in various cities across the United States and the United Kingdom (see Bendixen, 2006, Department of Health, St. Mungos, 2012, Department of Health, 2009, Evans, 2012, Tansley and Gray, 2009). The creation and implementation of these models stem from the knowledge that housing stability is one of the key determinants of health. For example, those experiencing homelessness are at greater risk when unsafely discharged from hospital to situations which may put their health at further risk. By promoting housing stability through safe and effective hospital discharge processes, financial savings will be realized by hospitals in the long-term, and "systemic health inequalities" will be reduced (Gaetz, 2012: 9).

To underscore the importance of safe and effective hospital discharge practices and to encourage hospitals to develop such practices, Hwang et al (2011) provide some statistics from a study completed in the city of Toronto which indicate the staggering costs of homelessness for the delivery of healthcare:

> *Among a large administrative sample of hospital discharges, homeless discharges cost on average $960 more than housed discharges. After adjustment for age, sex, and resource intensity weight, homeless discharges cost $2559 more than housed discharges for all health care services* (496).

Through the use of these statistics, Hwang et al encourage hospitals to develop discharge practices for people experiencing homelessness which includes a housing component, intensive case management practices, and streamlined care coordination which is inclusive of local authorities, not-for-profit agencies and community based outreach organizations (2011). Additionally, the importance of adequately educating and training hospital staff cannot be emphasized enough for ensuring patients receive high quality care and the appropriate supports (Department of Health, St. Mungos, 2012).

This report provides an environmental scan of safe and effective models of hospital discharge, including a chart citing the location, a brief description of each model, achieved outcomes, and the cost savings realized. Ultimately, this report posits that developing a safe and effective hospital discharge protocol for people experiencing homelessness provides an immense financial benefit for hospitals. As Stephen Gaetz (2012) argues, "the average monthly cost of housing people while they are homeless [is] $10,900 for a hospital bed," while the average monthly cost to provide stable housing to people in Toronto is $701 for rent supplements or $200 for social housing (p. 5). Not only will hospitals be acting morally and socially responsible while saving money, but they will also be positively contributing to local efforts to prevent homelessness, and to the promotion of the health and well being of patients who have been experiencing homelessness.

Environmental Scan: Effective Hospital Discharge Models in the Literature

On conducting a review of the models of hospital discharge discussed in the literature, three models from the United States and seven models from the United Kingdom were selected to be reviewed in this report. The review of these models will include a focus on the models themselves, the common outcomes and cost savings of the models during the time they were piloted, and an analysis of the strategies utilized by these models to ensure that everyone is discharged safely from hospital.

The vast majority of these models began as pilot programs with specific objectives and timelines, and because of the success in outcomes and the cost savings realized by hospitals, the models have continued. Every single model involved the coordination of multiple systems including healthcare, housing and not-for-profit sectors, with some models also including the local health authority.

Eight of the ten models are comprised of staff – housing and/or discharge coordinators, outreach workers, and social care coordinators – hired by hospitals to work with patients experiencing homelessness onsite. These models saw a value in directly employing one or more staff to work exclusively with patients experiencing homelessness from the time they are admitted right through to their safe discharge to housing. In addition to coordinating care, completing intensive housing searches, networking with landlords and tracking discharges, these specialized coordinators also often create and implement safe hospital discharge protocol, and are responsible for training and educating hospital staff on the protocol. Even when these models were implemented with an inadequate number of coordinators, hospitals still benefited in numerous ways from the knowledge and networking skills provided by these coordinators.

The other two models utilize a strong partnership with a not-for-profit organization and have trained staff members from these organizations come to the hospital to work with patients experiencing homelessness to find housing, network, and coordinate services. These organizations are responsible for providing support to patients experiencing homelessness throughout the discharge process. Much of the services that these organizations provide to hospitals are aligned with the service provision accomplished by the coordinators hired by hospitals in the eight other models discussed above. One of the limitations of this type of offsite-onsite model is that hospital staff are not always trained on safe hospital discharge for patients experiencing homelessness, and protocols around discharge seldom exist. One of the pilot programs using this model realized the importance of properly training hospital staff on the safe discharge of patients experiencing homelessness and followed that with the development of a safe discharge protocol later in the pilot.

Safety is an important element to consider in the hospital discharge of homeless patients, as the vulnerability of people experiencing homelessness to unsafe situations which may exacerbate their suffering is immense. Without adequate education and

devoid of some kind of official discharge protocol or strategy, inadequate discharges will continue to occur (Department of Health, St. Mungos, 2012).

Awareness raising and education of hospital staff are foundational to ensuring safe and effective hospital discharge for patients experiencing homelessness, and the creation of a hospital discharge protocol is a powerful safeguard ensuring that these educational efforts are protected through the following of a set procedure. Seven of the ten models reviewed here incorporate awareness raising and education efforts by training staff on the identification of patients experiencing homelessness on admission, factors influencing homelessness, the complex and unique health challenges faced by people experiencing homelessness, and on networking with multiple sectors, including the housing sector and not-for-profit sector. Additionally, six of the ten models included the development of a strategy, procedure or protocol for safely discharging patients experiencing homelessness from the hospital.

Outcomes

Increased networking among multiple sectors including healthcare, housing and not-for-profit organizations was a significant outcome noted by all ten models, resulting in improved care coordination for patients, a key foundational piece to safe and effective hospital discharge, and an increased awareness and knowledge of homelessness by hospital staff (Bendixen, 2006, Department of Health, St. Mungos, 2012, Evans, 2012, Tansley and Gray, 2009).

A substantial decrease in the number of inadequate and unsafe hospital discharges of patients experiencing homelessness was noted by all ten models, which directly resulted in a subsequent decrease in re-admissions to hospital, one of the patterns these models were implemented to prevent (Bendixen, 2006, Evans, 2012, Tansley and Gray, 2009). For example, the model employed in Wirral, UK, indicated that as a result of safeguards put in place to prevent the inadequate discharge of patients experiencing homelessness including a flagging system, “there was a decrease of one third in the number of episodes resulting in emergency readmission within less than 28 days” (Department of Health, St. Mungos, 2012, p. 28).

A noticeable reduction in the length of stay of patients experiencing homelessness was an outcome cited by seven of the ten models, likely due to efforts by the coordinators/ not-for-profit organizations who worked with patients experiencing homelessness to quickly secure stable housing for patients prior to discharge. In a London UK pilot entitled the London Pathway, this model utilized saved the hospital over $150,000/year after accounting for the cost to implement the model (Department of Health, St. Mungos, 2012, p. 27). This model also resulted in a reduction in the length of time a person experiencing homelessness remained in hospital by 3.2 days on average (Department of Health, St. Mungos, 2012). Additionally, the model implemented in Wirral, UK, indicated a cost savings of $67,500 in the six months the pilot project was

running, as a result of the decrease in the amount of delayed discharges of patients experiencing homelessness (Department of Health, St. Mungos, 2012).

A reduction in spending for hospital care and ER visits was a significant outcome noted by half of the models[1] (Bendixen, 2006, Department of Health, St. Mungos, 2012, Department of Health, 2009, Evans, 2012). Melanie Evans (2012) indicates that as the result of a discharge model implemented in New York City, hospitalizations decreased by almost half (47%), and that the spending for both hospital and emergency room care was reduced by 27% and 30% respectively. Further, the models in Wirral and London both cite a reduction in the admissions of homeless patients and the cost savings as a result. The London model cites that there was a reduction in the number of bed days over the year that the pilot took place and that this number was around 800 bed days (Department of Health, St. Mungos, 2012). Given that the cost per day is approximately $780, this equates to a savings of approximately $624,000 (Department of Health, St. Mungos, 2012). Additionally, the Wirral model indicates a savings of $39,750 through the decrease in hospitalizations as a result of the model. This equates to a savings of 1/3 in the two years the pilot was running for (Department of Health, St. Mungos, 2012).

Conclusion

An emerging focus on hospital discharge planning as a key component in housing stability for people experiencing homelessness has been noted locally in Waterloo Region, and in other municipalities. A new federally funded report through the Centre for Addiction and Mental Health in Toronto takes a close look at effective hospital discharge planning in relation to homelessness and mental health. This report, entitled *A Fork in the Road to Recovery: Preventing Homelessness among People with Mental Illness through Effective Hospital Discharge Planning*, is slated to be released by March 2014.

Given the tremendous moral, social, financial and capacity building outcomes achieved by each of these safe and effective models of hospital discharge in such short periods of time, it is difficult to understand why more hospitals are not piloting similar models. There is a massive body of research clearly citing the facts and statistics around the incredible health costs incurred by homelessness. As Goering et al (2012) state, “because each day of inpatient care is expensive, even modest differences in rates of use can translate into savings and among high users the differences in rates are more dramatic” (p. 28).

Out of the ten models discussed in this report, eight models are tangible proof that the costs associated with hiring housing or discharge coordinators is negligible when compared with the cost savings they will provide to the hospital, through ensuring the safe discharge of patients experiencing homelessness. The other two models illustrate the benefits that can be realized through hospital partnerships with not-for-profit organizations, and through the development of a safe discharge protocol through which

[1] Cost savings data was only available from five of the ten models reviewed in this document

the relationship will operate. Through this partnership, not-for-profit organizations can do the work of a housing or discharge coordinator at little or no cost to hospitals, and the cost savings will certainly be worth the networking and relationships involved.

The importance of stable housing in maintaining good health is widely documented. As Gaetz (2012) states, “safe, affordable and healthy housing is one of the most fundamental requirements for good health, but also a means to reducing systemic health inequalities and in some cases may lower associated long-term healthcare costs” (p. 9). The tremendous expense associated with continuing to operate within the status quo where emergency services – many of which involve health care – does not make economic or moral sense. Working towards ending homelessness through implementing strategies like models for the safe discharge of people experiencing homelessness from hospital will result in savings to hospitals and to the health care system more generally. Most importantly, it is the right thing to do.

Chart of Effective Models of Hospital Discharge Reviewed

Project Partners	Cross-Sector Partnerships	Details/Rationale	Program Outline/ Processes	Outcomes	Cost Savings
New York City Health and Hospital's Corporation, New York Health Department, Medicaid	Healthcare, Housing, Local Authority	The three year care-management pilot came out of pressure on state and federal Medicaid budgets. The pilot specifically targets Medicaid patients considered costly and complex	-Care coordination and social services, including housing, are provided to these targeted Medicaid patients by hired housing coordinators -One housing coordinator can work with a maximum of 40 patients at a time, assisting them in navigating subsidy applications, the rental market and landlord relationships	The pilot was extremely successful, so much so that the effort of the pilot has been expanded to house high-cost Medicaid patients with funding under the Patient Protection and Affordable Care Act	-Preliminary results of the pilot show that monthly Medicaid spending decreased by 1/5 or $855 US, to $3,426 a person -Hospitalizations dropped by 47% and the number of emergency room visits was cut in half -Spending for hospital care fell by 27% and emergency room spending by 30%
Minneapolis: Hennepin County Medical Centre, Medicaid	Healthcare, Housing, Local Authority	A strategy has been developed which links patients experiencing homelessness who have been admitted into the hospital at least 3x/year with two county housing coordinators. This strategy has come as a result of a push to focus on the housing needs of 'costly patients' as an attempt to reduce their healthcare costs	-County housing coordinators are responsible for working exclusively to find homes for medically complex Medicaid patients – they meet with landlords, locate rentals and secure housing for these patients	-In the span of six months, housing has been sought for 14 patients	-None given as the strategy had not yet been in operation for a year

Chicago Housing for Health Partnership (CHHP), AIDS Foundation for Chicago (AFC), 3 Key Hospitals, 11 Supportive Housing Providers, 7+ Healthcare Foundations	Healthcare, Housing, Social Service Agencies, Not-For-Profit Organizations	4 Year Demonstration & Research Project: Sept. 2003 to Aug. 2007, was a response to hospitals discharging patients experiencing homelessness to overnight shelters or other inadequate places where their healthcare needs cannot be met	-Research involved the use of a randomized control trial design in order to study the number of ER, nursing home and hospital visits incurred by two different groups: those being supported by CHHP supportive housing (intervention group) versus those receiving the usual care (control group) -A system integration team supported those in the intervention group. This team included 2 hospital case managers, 3 case managers at interim/respite housing, 10 housing case managers and 1 coordinator	-In spite of the high rates of substance abuse and mental illness among the intervention group, of the 216 participants, 75% moved into permanent housing and 60% of those have maintained their housing for over a year -Illustrated the success of multiple system coordination	-The usual care group used twice as many nursing home days as the intervention group and were 2x more likely to visit the ER/ be hospitalized -"Preliminary cost estimates show that annual medical expenses for housed clients were at least $900,000 less than their usual care counterparts, after subtracting the annual expense of providing the CHHP supportive housing intervention ($12,000)"
London, UK: The Salvation Army and their Early Intervention and Prevention Team (EIPT), York Hospital	Healthcare, Not-For-Profit Organization	A protocol was established between the hospital and the Salvation Army's EIPT to ensure appropriate discharges are made when people experiencing homelessness present at the hospital. This protocol came about as a result of the number of people experiencing homelessness being discharged from	-If a homeless person comes to the hospital, the hospital contacts the EIPT to assess the person and ensure the person is adequately housed where possible (i.e. by making referrals/local connections) -The EIPT team also ensures that the housing which the person is referred (i.e. a hostel) is provided with the information concerning the individuals needs, and that the appropriate services are	- Has resulted in a shared understanding of the need to prioritize discharge and the mutual benefits involved in planning for both the person and the hospital -Additionally, training has been delivered to hospital staff around appropriate discharge for	-Better discharges have led to less re-admissions (no numbers provided)

		hospital to the street	coordinated (i.e. aftercare)	patients experiencing homelessness	
London, UK: Liverpool Royal Hospital, Brownlow Group Practice, the Basement, the Whitechapel	Local Authority, Healthcare, Voluntary/ Not-for-Profit Sector Agencies	Protocol established for the discharge of patients experiencing homelessness, as the Liverpool Royal Hospital houses the largest Accident and Emergency department in the country	-Homeless outreach worker based in the hospital -Hospital staff are specially trained to ask certain questions to reveal whether or not a patient is homeless – ensures early identification of patients experiencing homelessness, who are then identified to the homeless outreach worker -The hospital outreach worker contacts the patients and with the assistance of local agencies, works to find the patient housing on discharge	- Has been extremely successful in improving outcomes for patients with NFA, ensuring housing is secured and that appropriate referrals have been made -The hospital's senior management has been very supportive, ensuring that safe discharges remain a priority. -Local services have noticed improved outcomes for those they support because of the success of the protocol and the referrals that are made by staff	-No numbers are given, although the protocol did win the National Nursing Times Award
Hastings, UK: Conquest	Healthcare, Not-for-Profit	Wanted to implement a targeted approach to	-Patients experiencing homelessness in the ER	-Has resulted in increased	-No numbers given -Indicated there was

Hospital, St. John Ambulance Homeless Service (SJAHS), Local Authority Housing Services	Agencies, Housing	the discharge of patients experiencing homelessness in an area with a lower homeless population than traditionally larger urban areas	and those admitted are referred to the Local Authority Housing Services and to SJAHS as soon after admission as possible -These services assist with discharge planning, ensuring the person receives all necessary support and advocacy and linking the patient and the hospital staff with community agencies -Other supports include assisting with housing applications/accompaniment to appointments, referrals to other agencies and ensuring follow up medical appointments are attended	communication and connection between community agencies, the hospital and SJAHS. -Referrals have increased and the process has become quite streamlined. -Very few inadequate discharges since the development of this discharge planning process and partnership	cost savings in that there were fewer delays in discharging patients experiencing homelessness as a result of this targeted approach
London, UK: The London Pathway, Guys' and St. Thomas' Hospitals	Healthcare, Not-for-Profit Organizations	Involves the implementation of a model of integrated healthcare for single homeless adults. The aim of this model is to coordinate the care and discharge of patients experiencing homelessness.	-This model utilized a discharge coordinator for patients experiencing homelessness -This discharge coordinator was very experienced with the services and organizations provided in the area of homelessness. -This coordinator networked with homelessness services and other health services on behalf of patients, informed hospital staff of her role and that patients experiencing	Benefits of this model include: -Increased more knowledge and an increase of competence in hospital staff when working with patients experiencing homelessness -Increased service coordination between hospitals and homelessness	-The average length of stay for a homeless patient was reduced by 3.2 days. Annually, with approximately 250 homeless admissions, this equals a reduction of 800 bed days -Average cost per stay is £4,750 (approx. $7125). Estimates indicate the project has saved £100,000 (approx. $150,000) net after accounting for the

			homelessness should be referred to her, and did a lot of work with the history of the patient and their engagement with services in the past (i.e. assisting them to link back up with services they had accessed in the past).	services meaning better service provision -More knowledge sharing and cooperation on complex cases -Discharges have become more informed and proficient	cost to provide the service (£1,600 or $2400 per patient per stay)
Wirral, UK: Arrowe Park Hospital, NHS Wirral, Wirral Borough Council	Healthcare, Not-for-Profit Organizations, Local Authority	Project was developed as a response to the need to provide support to patients experiencing homelessness throughout the admission and discharge process at Arrowe Park Hospital.	-A one-year pilot project began in May 2010. This project involved the creation of targeted homeless discharge policy and procedures, the development of a hospital discharge protocol between the hospital and the local authority, establishing connections between the hospital, housing and community supports and medical treatment centers, raising awareness of homelessness within the hospital and among staff, and providing support to patients as they discharge from hospital into suitable accommodations	-The project funding was extended, and improvements were made to the practice. -An early flagging system was integrated to prevent patients experiencing homelessness from being discharged to the streets and to highlight the need to address the housing issues at the time of admission	-Savings of £26,500 (approx. $39750) in the total cost of NFA episodes (around 1/3 savings in two years) -The number of episodes of hospitalizations, admissions, ER visits and bed days decreased -There was a decrease of one third in the number of episodes resulting in emergency readmission within less than 28 days -The hospital believes they have saved £45,000 (approx. $67500) between April-September 2011 as a result of delayed discharge

West Sussex, UK: Worthing and Southlands Hospital Trust, West Sussex Hospital	Healthcare, Local Authority, Not-for-Profit	Project developed as the need for the increased coordination of services for the aging population of the area. This ended up expanding from a focus on aging adults who were unable to return to their housing after hospitalization to patients experiencing homelessness with no housing to return to/be discharged to	-A housing, health and social care coordinator was hired in order to review and revamp the hospital discharge process -This coordinator created resources for hospital staff, including a discharge procedure flowchart for patients experiencing homelessness, housing register applications, and a training program for hospital staff on housing and homelessness -The coordinator also performed research and investigations into homelessness and tracked the progress after the implementation of the changes	-Benefits of this model include: -A considerable reduction in a patients length of hospital stay as a result of housing needs (immense cost savings) -Improved relationships between organizations and better service coordination -Improved and earlier knowledge sharing about patients housing status so that as soon as they are admitted the housing search can begin	-No information on cost savings was provided in this study
Newcastle, UK: Housing Advice Centre (HAC), Neighbourhood Renewal Fund,		The need for the development of a protocol for the hospital discharge of people experiencing homelessness and relevant training materials to	-Hospital discharge protocol and training materials created -Protocol applies to hospital discharge in every department of the hospital, including the acute sector, mental health services and	-The protocol and the implementation of it has highlighted the importance of multi-agency partnerships -The development of the hospital	-No information around cost savings has been provided

		accompany this protocol was reinforced by the Local Authority, the London Network for Nurses and the Homeless Link. Additionally, homeless people were being discharged from hospital improperly with homeless shelters being listed as their discharge address.	accident and emergency -Model: Discharge liaison facilitator directs nurses and social workers to the protocol when working with a patient with no fixed address. Discharge may be delayed when appropriate long term housing cannot be secured -In the mental health unit, there are two case managers are responsible for securing housing and there is a mental health adviser that also plays a role in locating housing for patients	discharge protocol has resulted to the creation of a further protocol about how to better support those leaving hospital in order to avoid homelessness, an extended stay in hospital or a move to a residential care facility	

Annotated Bibliography

Bendixen, Arturo. (2006, August 16). *Hospital Discharge of Homeless Persons in Chicago by Arturo Bendixen*. Retrieved January 8, 2013, from the National Alliance to End Homelessness Web Site: Click Here to Access Bendixen's Presentation

This is a presentation of a four year (2003-2007) study around the discharge of those experiencing either short or long term homelessness from hospital in Chicago. The study involved three hospitals, 11 supportive housing providers, three respite/interim housing providers, and numerous health care foundations. There were 216 participants in the 'intervention group' and 220 participants in 'usual care' – the control group. Those participants in the intervention group included adults who were homeless, had at least one chronic medical illness, and were an in-patient at one of the three hospitals during the time of the study. The intervention group received supportive housing on discharge. Participants in the usual care group were supported by the fragmented system of emergency shelters, family and recovery programs on discharge.

A systems integration team was comprised of two case managers at the hospital, three case managers at the interim/respite housing, 10 housing case managers and one coordinator. The goal of this team was to assist those participants in the intervention group to reach stable housing. The result of the study was that 3/4 of participants reached permanent housing, and 60% have been able to maintain their housing for longer than one year.

As a result of this study, the success of multiple systems working together to assist those being discharged from hospital achieve housing stability is evident. The cost, on average, to house participants in the intervention group was $12,000 annually. Conversely, the annual medical cost associated with housed participants was at least $900,000 less than the usual care participants in the study – illustrating the immense cost-savings clearly. This study also shows that housing first programs cost less than ER visits, hospitalizations and emergency shelter stays.

Department of Health, St. Mungos. (2012, March). *Improving Hospital Admission and Discharge for People Who Are Homeless*. Retrieved December 28, 2012, from the Homeless Hub Web Site: Click Here to Access the Department of Health St. Mungos Report

Provides a national scan of hospital admission and discharge processes for people who are homeless in England and reveals examples of effective models in addition to identifying gaps/where improvements are necessary. Report utilizes the experiences of homeless people and those organizations – including hospitals, shelters, those involved in housing stability and outreach – involved in the hospital admission and discharge process.

The study involves peer led interviews conducted with 57 homeless men and women from London, Leeds, Birmingham and Bristol. Additionally, telephone interviews and/or case studies were completed with 38 staff members from organizations involved in the hospital admission and discharge process. Finally, a regional event and meeting was held on hospital admission and discharge where experts were consulted with, and recommendations for process change were shared. Two effective models with an integrated approach (hospital staff teams, organizations involved in the area of homelessness and local authorities) to hospital discharge of those who are homeless were shared along with a cost-benefit analysis.

Overall, this report indicates that an integrated approach to hospital admission and discharge of those who are homeless ensures that everyone is discharged from the hospital with both their housing and continuing support requirements having been accounted for. Additionally, this kind of approach results in a significant reduction in cost to the medical system.

Department of Health. (2009, June 29). *Homelessness Prevention and Hospital Discharge: Three Case Studies*. Accessed January 11, 2013 from the Housing LIN Web Site: Click Here to Access the Three Case Studies Report

This is an extensive document containing three case studies, two of which (London and West Sussex) are cited above. The third case study is entitled Newcastle and will be described here. This document includes the background and development of each case study, how the particular model works and its effect on services, and the wider benefits produced by the model.

In the Newcastle case study, a hospital discharge protocol and training materials were created to begin the work of the program. A protocol was created to work across the acute sector, mental health services and accident and emergency. This protocol outlines what process should be followed when working with a patient who identifies or is identified as having NFA. As a result of this protocol, a discharge liaison facilitator has been hired to identify under what circumstances social workers and nurses should be directed to follow the procedures outlined in the protocol for people experiencing homelessness. At times, discharge is delayed when appropriate long term housing cannot be secured. In the mental health unit of the hospital, two case managers are responsible for securing housing and there is a mental health adviser that also plays a role in locating housing for patients.

There has been some challenge around the knowledge sharing of the protocol with new staff, and the protocol is not always followed the way it should be. However, in general the discharge process has resulted in the successful housing of a much higher number of those with NFA on discharge. The effectiveness of the protocol is being monitored through data collection.

Evans, Melanie. (2012, September 24). *Residential Therapy: Hospitals Take On Finding Housing for Homeless Patients, Hoping to Reduce Readmissions, Lower Costs*. Accessed January 20, 2012 from Modern Healthcare Journal, 42(39): 6-16. Not available for access without a subscription.

Discusses how best to support patients who return to the hospital multiple times in a year, especially considering the new pressures on state and federal Medicaid budgets. While the article identifies a number of studies, only two are described in detail: a pilot taking place in New York City and a strategy that was developed for use in Minneapolis. Both studies involve the use of housing coordinators who work to secure housing for patients experiencing homelessness who are seen returning to the hospital repeatedly. Cost savings data is provided for the New York City study, indicating that monthly Medicaid spending decreased by 1/5 or $855 USD, to $3426 per person. No cost savings data available for the Minneapolis pilot, which has not yet been in operation for a year.

Gaetz, Stephen. (2012). *The Real Cost of Homelessness: Can we Save Money by Doing the Right Thing?* Accessed January 25, 2013 from the Homeless Hub Web Site: Click Here to Access Gaetz's Report

Stephen Gaetz's report outlines the financial burden incurred by homelessness, pointing to the fact that it is much more expensive to rely on emergency services including shelters, health care and the criminal justice system than to do something about the root causes of homelessness. He argues that by providing those experiencing homelessness with the housing and supports they desperately need, long term cost savings will be experienced by emergency services, including the health care sector. In addition to the money savings, addressing the root causes of homelessness is also the morally right thing to do, Gaetz argues.

Goering, Paula, Scott Veldhuizen, Aimee Watson, Carol Adair, Brianna Kopp, Eric Latimer and Angela Ly. (2012, September). *Mental Health Commission of Canada's At Home/ Chez Soi Interim Report*. Accessed February 6, 2013 from the Mental Health Commission of Canada's Web Site: Click Here to Access the At Home/Chez Soi Report

This report outlines the At Home/Chez Soi research project being carried out in five Canadian cities involving a Housing First approach to addressing homelessness. Goering describes the housing first model as "an evidence-based practice that provides immediate access to both permanent, independent housing and to mental health and support services offered by community teams" (8). The housing first approach is an alternative to the mainstream system of relying on emergency shelters/transitional housing, and instead provides direct access to stable housing. This report was utilized not only for the background information provided on the costs of homelessness in general, but also for the information provided specifically regarding the health related costs of homelessness (i.e. hospitalizations, ER visits, re-admissions).

Hwang SW, Weaver J, Aubry T, Hoch JS. (2011). *Hospitalization Costs Associated with Homelessness in Canada*. Retrieved January 27, 2013 from the Turner White Communications Inc. Web Site: Click Here to Access the Hwang et al Report

This report discusses a research study undertaken in the City of Toronto in order to compare hospitalization costs for homeless and housed patients. The study utilizes hospital administrative data from the past to engage in a retrospective analysis of the data. Ultimately, the study argues that homeless discharges cost substantially more than housed discharges, and that even after making adjustments for "age, sex, and RIW, homeless discharges cost $2559 more than housed discharges for all health care services" (496). Through the use of statistics, Hwang et al encourages hospitals to develop discharge practices for people experiencing homelessness that include a housing component, intensive case management practices, and streamlined care coordination which is inclusive of local authorities, not-for-profit agencies and community based outreach organizations.

Tansley, Kate and Jane Gray. (2009, October 9). *Ensuring Safe and Appropriate Discharge for People Who Are Homeless or in Housing Need.* Accessed January 9, 2012 from the Nursing Times Journal Web Site: Click Here to Access this Article

This article discusses the inadequate admission and discharge practices of those who are homeless in England, and includes two case studies which describe processes undertaken to ensure appropriate discharge and housing of patients experiencing homelessness. The first case study took place in London at Guy's and St Thomas' Hospitals. In this case study, the model utilized a discharge coordinator for patients experiencing homelessness. This discharge coordinator was very experienced with the services and organizations provided in the area of homelessness. This coordinator networked with homelessness services and other health services on behalf of patients, informed hospital staff of her role and that patients experiencing homelessness should be referred to her, and did a lot of work with the history of the patient and their engagement with services in the past (i.e. assisting them to link back up with services they had accessed in the past). As a result of this coordinator, there have been many benefits including: more knowledge and an increase of competence in hospital staff when working with patients experiencing homelessness, increased service coordination between hospitals and homelessness services meaning better service provision, more knowledge sharing and cooperation on complex cases, and discharges have become more informed and proficient. There was no information about cost savings with this case study.

The second case study took place in West Sussex where a housing, health and social care coordinator was hired in order to review and revamp the hospital discharge process. This coordinator created resources for hospital staff, including a discharge procedure flowchart for patients experiencing homelessness, housing register applications, and a training program for hospital staff on housing and homelessness. Additionally, the coordinator performed research and investigations into homelessness

and tracked the progress after the implementation of the changes. Benefits of this model included a considerable reduction in a patients length of hospital stay as a result of housing needs (immense cost savings), improved relationships between organizations and better service coordination, and improved and earlier knowledge sharing about patients housing status so that as soon as they are admitted the housing search can begin.

This article also includes lessons to learn and key aspects of appropriate and safe hospital discharge.