

**HOSPITALS DISCHARGING PATIENTS TO EMERGENCY HOMELESS
SHELTERS IN ALLEGHENY COUNTY, PENNSYLVANIA: AN ECOLOGICAL
PERSPECTIVE**

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Abstract

Objectives: This study, utilizing the socio-ecological perspective, assesses the number of hospital discharges to shelters, their perceived appropriateness, and possible solutions to problems of inappropriate discharges. The socio-ecological perspective is employed to explore individual, community, and political factors involved in inappropriate discharging. *Methods:* Twenty-two staff and administrators from 12 of the 16 emergency homeless shelters in Allegheny County, PA were recruited by mailings (response rate=75%). A face-to-face, semi-structured interview was conducted with each of the 22 participants. Participants were asked to report on the number of discharges they received from hospitals in the past 12 months, whether or not these discharges were appropriate, and on possible solutions to the problem of “inappropriate discharges.” *Results:* Participants reported a total of 415 discharges from hospitals to shelters; 91 (22%) of the discharges were considered to be inappropriate. The two solutions most often reported by participants to the problem of “inappropriate discharge” were to cultivate bidirectional communication between hospitals and shelters, and to develop medical/psychiatric respite for the homeless population (50%, and 32% the respectively). Participants believed that the responsibility for the problem of inappropriate discharges rested at multiple levels of the ecological system including the individual, organizational, and political levels. Participants proposed solutions that targeted homeless individuals, shelters, hospitals, and policy makers.

Conclusions: Inappropriate discharges are a problem in Allegheny County, PA and better communication amongst providers and the development of respite services are possible solutions. The etiological nature of this problem rests at multiple levels of the ecological system including the individual, organizational, and political levels, and thus interventions ought to be targeting these levels. *Public Health Significance:* Ensuring that homeless persons receive appropriate follow-up care may eventually reduce the number of re-hospitalizations, improve the overall health of the homeless population, and aid in the fight to eliminate homelessness.

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PREFACE

This research is a product of a collaborative effort involving the University of Pittsburgh Graduate School of Public Health and the Health Resource and Delivery Committee (HRDC), a sub-committee of the Homeless Alliance in Allegheny County, Pennsylvania. The members of the HRDC were interested in how, why, and to what extent hospitals in Allegheny County discharge patients to emergency homeless shelters. To learn more about this issue of discharging from hospitals to shelter, the HRDC suggested that a survey be administered to the 16 emergency homeless shelters in Allegheny County. By way of a verbal agreement between HRDC members and Dr. Chris Keane, assistant professor at the University of Pittsburgh's Graduate school of Public Health (GSPH), it was agreed that Dr. Keane's students would write proposals to be evaluated by the committee. I agreed to write a proposal to assess the shelter community regarding hospitals discharging to their facilities which was accepted by the HRDC members. Throughout the development, administration, and analysis of the survey, as well as the subsequent data analysis, HRDC members and several faculty members at the GSPH supported and advised me with respect to the technical, theoretical, and ethical aspects of the project. I would like to formally thank both Dr. Keane and Karen Peterson for their oversight and guidance; without their advisement this project would not have been possible. I would also like to thank both Dr. Scott Beach and Dr. Donald Musa for their expertise and guidance in refining

the survey instrument. Valerie Stallworth, co-investigator on this project, was involved in every aspect of this study from data collection to data analysis. Her devotion and hard work have made this research an enjoyable and worthwhile endeavor. Finally I want to thank the shelter community for its participation in this research. Their dedication and true desire to help the homeless lets me believe that we can fight the causes of homelessness by working together to find real and practical solutions.

1.0 INTRODUCTION

Are hospitals adding to the problem of homelessness? Are they missing a window of opportunity to help those who are homeless or at risk for becoming homeless? Recently these questions have been given national attention when a video, aired on CBS news, caught healthcare workers dumping a patient dressed in a hospital gown onto “Skid Row” (CBS News 2006). In the news report accompanying the video, the issue of “patient dumping” was presented as a novel problem; however, the practice of “patient dumping” has been going on for sometime. A case in point: in 1978 Reich and Siegel wrote an article published in the *Psychiatric Quarterly* entitled “The emergence of the Bowery¹ as a psychiatric dumping ground.” The article discusses how many patients who were cared for by state psychiatric institutions and then discharged live on the streets eventually ending up on the Bowery where they are cared for by The Men's Shelter. More recently, Western State Hospital (WSH) in Seattle, Washington, was accused of dumping unstable, mentally ill patients onto the streets and into homeless shelters and soup kitchens. According to court documents, an analysis of 82 randomly selected discharges from WSH revealed that nine patients were released to the streets or homeless shelters (Martin & Perry 2005).

¹ Area in lower Manhattan, New York City

Homeless persons are being discharged directly from hospitals to the streets, soup kitchens, and emergency shelters. The practice of discharging patients into unaccommodating circumstance likely results in a higher incidence of re-hospitalization and poorer health outcomes. To ensure that homeless persons receive appropriate follow-up care, it is crucial that we take the first steps to understanding the magnitude and scope of this potential. We can focus our efforts and develop appropriate solutions that can improve the overall health of homeless persons and reduce their likelihood of numerous re-hospitalizations, if we can identify where, why, and to what extent inappropriate discharges are occurring.

The aim of this study is to systematically assess the issue of inappropriate discharges from hospitals to emergency shelters in Allegheny County, Pennsylvania. This study is exploratory in nature. To my knowledge little has been published on this topic, therefore the information gathered by this study will help to develop a base of knowledge regarding inappropriate discharges from which new ideas and research questions can emerge. In this initial stage of inquiry, the goal was to determine if there is a problem of inappropriate discharging in Allegheny County. In order to do this, the emergency homeless shelter community is assessed. The overarching research questions guiding this study can be articulated as follow:

- What is the magnitude and scope of this potential problem in Allegheny County?
- Do Emergency Homeless Shelters (EHS) have policies or practices for the intake of hospital discharges?
- Are EHS able to manage physically and mentally compromised homeless persons?
- What are shelter staff attitudes and opinions regarding hospitals discharging patients to emergency homeless shelters?

Understanding the magnitude and scope of this problem may help to determine if and how quickly action needs to be taken in order to prevent inappropriate discharges and the illness and hardship that most likely result in the wake of this unjustifiable practice. If persons are being discharged to shelters, we want to know how often it is happening and who is doing it. Is it one or two hospitals, or are hospitals across the board discharging patients to shelters? Determining the scope of the problem has important implications when formulating interventions and solutions. If one hospital is doing all the discharging of patients to shelters then the shelter community and that hospital can work together to develop practices and policies that will prevent inappropriate discharges. However, if the problem is more global, solutions and interventions may require more extensive system-wide changes (e.g., new laws or regulations).

Assessing shelters with respect to their policies and practices regarding the intake of hospital discharges, if any, provides an opportunity to understand what has been done already to prevent inappropriate discharges, whether or not the current policies and practices are working, and what, if anything, can be done to enhance these policies and practices if they are not working. Likewise, it is important to gather information about whether or not shelters are equipped to handle medically and mentally compromised patients, because this directly speaks to the appropriateness of discharging to shelters. Some discharges to shelters may be appropriate and therefore it is important to determine what factors at the shelter level make a discharge from hospital to shelter appropriate or not. Furthermore, shelters that are able to accommodate hospital discharges may have policies or practices that could be put in place at shelters that are unable to accommodate hospital discharges.

Shelter staff and administrators are the voice of the shelter community in our study; it is important that we inquire about their attitudes and opinions regarding hospitals discharging to emergency homeless shelters. First, it is important that we hear their definition of an inappropriate discharge and what it means to them. Having the participants define “inappropriate discharges” will help us to understand the nature of the problem and to operationalize “inappropriate discharges” for future research. Second, having them prioritize the issue and talk about the severity of the problem as they know it will inform us of the immediacy involved in developing solutions. Most importantly it is crucial that we hear from participants what they believe are solutions to the problem.

Limiting research to the shelter community, a rather small and manageable community, allows for a strong focus on qualitative data. Qualitative data are essential at this stage of inquiry given that little is known about the practice of dumping in Allegheny County. Rather than attempt to determine the issues and causes for inappropriate discharges a priori, this study uses an open format, allowing the issues to emerge and for a dialogue to transpire around them when they do. To assess the shelter community, a face-to-face interview schedule is used allowing the flexibility needed to ask open-ended questions, yet providing enough structure that the information is collected reliably from shelter to shelter. The aim of this study is to provide the first step in gathering data regarding hospitals discharging to shelters. The ultimate goal is to ensure that homeless persons receive appropriate follow-up care that will improve their overall health.

Information gathered from this study will contribute to addressing the following longer-term goals:

- Ensure that hospitals are not creating more homeless by inappropriate discharging.
- Help hospitals reduce homelessness through detecting risk of homelessness. That is, if hospital staff can detect through better screening methods that a patient is at risk of becoming homeless, the staff may be able to appropriately redirect the patient at the time of discharge.
- Help shelters to develop practices and protocols to assess the appropriateness of accepting a hospital discharge.

The information from the survey may help with these longer-term goals in the following ways:

- Educate hospitals about what we are learning about the problems associated with discharging patients to emergency shelters.
- Eventually develop shelter protocols for accepting homeless persons, i.e. “We can accept this person if A, B and C are in place.”

2.0 BACKGROUND

A person living with homelessness is defined as “an individual who lacks a fixed, regular, and adequate nighttime residence, or an individual who has a primary nighttime residence that is: (a) ...designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill), (b) a public or private place 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, regular sleeping accommodations for human beings” (Burt, Laudan, Aron, Douglas, Edgar, Britta 1999). Here in the United States, 1.3 percent of the population experience homelessness every year. Homelessness has increased greatly in the United States over the past 20 years (Star 1998). The five-year prevalence of homelessness is about 2–3 percent of the U.S. population or five to eight million people (Link, Phelan, Bresnahan, Stueve, Moore, & Susser 1995) and according to a recent publication by the Department of Housing and Urban Development (HUD), *The Annual Homeless Assessment Report (AHAR)*, the number of homeless persons, sheltered and unsheltered, on any given night is 754,000 (HUD 2007).

Homeless persons have high rates of hospitalization, especially in emergency departments, longer hospital stays, and higher incidences of re-hospitalization (Tsai, Wientraub, Gee, & Kushel 2005). In addition, homeless persons have disproportionately higher rates of physical and mental illness, and mortality (Buchanan, Doblin, Sai, & Garcia 2006). Certainly

hospitals are faced with treating the homeless population, but the question remains as to how hospitals discharge the homeless and to what extent they provide services or appropriate referrals for these individuals once they leave the hospital.

Hospitals in the U.S. are not required to track, collect information about, or report on homelessness (Tsai et al. 2005). This makes it difficult to assess and evaluate how well hospitals are doing when it comes to providing a continuum of care for the homeless population. Crucial questions (i.e., how many persons are hospitals identifying as homeless? Where are homeless persons going post hospitalization? Are they following up with their treatments? And are they being re-hospitalized?) are difficult to answer because hospitals are not required to collect this type of information. What we do know from the recent AHAR report is that before becoming homeless (i.e., before they are sheltered), 12.4 percent of adults come from public systems and institutional settings (e.g., psychiatric facilities, substance abuse treatment centers, hospitals, jails, and foster care) and at least 2.4 % or ~ 11,280 of them are coming from medical and psychiatric hospitals. With so many people being discharged from hospitals to shelters, it is only fair to ask if hospitals are contributing to the problem of homelessness.

Studying the ability of hospitals to identify homelessness and change in housing status while hospitalized, Tsai et al. (2005) concluded that in order to improve clinical outcomes, develop more effective programs, and better track healthcare outcomes of the homeless, standardized methods for assessing both homelessness and change in housing status must be developed and maintained through routine data collection. It is important that we begin to effectively track the homeless through the healthcare system by screening and data collection, so that hospitals are aware of the housing status of their patients and can provide appropriate discharge plans based on that patient's needs. Otherwise hospitals may be inadvertently

contributing to the problem of homelessness by discharging patients to unaccommodating circumstances.

The problem of numerous inappropriate discharges is not a novel problem, there exists in the literature recognition of this problem across the country as well as internationally. The United Kingdom's Office of the Deputy Prime Minister released an information sheet stating that:

...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).

Furthermore the UK government recommends that hospitals, social services, and homeless providers build and maintain strong links through policy and practice in order to provide appropriate and comprehensive services to the homeless. Recognition that there is a problem and recommendations like the ones aforementioned are essential and represent an important step toward fighting the causes of homelessness (e.g., poor mental and physical health and addiction) by developing policy and programs that foster a continuum of care post-hospitalization.

Several solutions in the form of programs and interventions are already being carried out with some success. Under the major federally funded Health Care for the Homeless Program (HCHP), grantees are obligated to provide primary healthcare, outreach services, case management and other services to the homeless population at no cost. This program has the ability to reduce inappropriate discharges by reducing the number of health issues in the

population. That is, if homeless persons are able to receive adequate care from the HCHP, then there is less need for hospitals to treat them. If patients are being discharged to shelters where their health needs can be met through a program like HCHP, then the discharge may not be inappropriate. The HCHP has also been shown to reduce the number of inappropriate Emergency Department (ED) visits by approximately 40% in persons who used the HCHP two or more times (Han & Wells 2003). Again, if health services other than presenting at the ED are available to the homeless population, the likelihood that the homeless person will be re-hospitalized as a result of being discharged to a shelter will be decreased.

Another program initiated by shelters is helping to eliminate inappropriate discharges by becoming more accommodating to the needs of the homeless who are being discharged from hospitals. Many homeless persons who are chronically alcoholic and have increased health problems seek help through the Emergency Department because of alcohol intoxication, withdrawal, or their complications. A shelter based Management Alcohol Project (MAP) in Ottawa, Canada, delivers health care to the homeless to minimize the consequences of substance abuse. The program is a harm reduction program whereby they give chronically alcoholic persons hourly doses of alcohol. An analysis of seventeen adults over the course of five years (three years before the program started and two years following program initiation) concluded that participants of the project visited the ED nearly half as much per month than they did before they started the program. They also had improved compliance with medical care and health (Podymow Turnbull, Coyle, Yetisir, & Wells 2006).

Inappropriate discharges occur when people fall into a service provision gap; homeless persons are discharged from the hospital and have nowhere to recover or receive appropriate care. Both of the programs aforementioned may reduce inappropriate discharges indirectly by

helping to close the service gap, but they are not a permanent solution. A more direct approach to reducing inappropriate discharges is to fill the service gap. Respite care provides homeless patients with a place to reside while they recover and stabilize after being in the hospital. Recently the effects of respite care for homeless patients were investigated (Buchanan et al. 2006). They compared homeless persons who were referred to a respite care facility with those who were eligible but could not be admitted because there were no beds available. Those who received respite care after hospitalization showed a reduction in future hospitalizations. Providing hospitals with a viable and appropriate option like respite care is likely to reduce inappropriate discharges to the street, soup kitchens, and emergency shelters.

Tracking homeless persons through the healthcare system remains one of the toughest challenges to developing programs and practices that can prevent inappropriate discharges by providing adequate care. In discussing how to improve the HCHP, Han & Wells (2003) write “...if housing status information in ED records did become available, the HCHP and other programs serving the homeless could work with ED staff on improving access and quality of care for homeless people” (p. 535). The problem is that homelessness is difficult to detect and if hospitals are not screening for homelessness then what may seem like an appropriate discharge may really be inappropriate because once the person leaves the hospital that person may have no support system, no shelter, and no place to recover. The opportunity to help these individuals really comes down to being able to understand the magnitude and scope of the problem. That is, how often are people being discharged either directly or indirectly to shelters and other unaccommodating situations; where is it happening? Are the programs already developed working? These questions would be much easier to answer if we were collecting data that tracks the homeless through the healthcare system.

The homeless population is difficult to reach and when they present themselves at hospitals for care, it is an opportunity to assist and provide for them. Without proper policies that require adequate screening and follow-up care for the homeless, an opportunity may be wasted to provide the homeless with the services and care that could eventually bring them out of their unfortunate circumstances. It is important that not only hospitals but also shelter and other homeless providers develop policies and practices that prevent inappropriate discharges and track the homeless. If the tasks of proper screening, care, and follow-up provisions can be shared amongst hospitals, shelters, homeless providers, and policy makers the likelihood of comprehensive and practical solutions to the problem of inappropriate discharges increases. The ultimate goal is to develop solutions that ensure that homeless persons receive appropriate follow-up care that will improve their overall health and reduce the number of re-hospitalizations due to inappropriate discharges.

The problem of inappropriate discharges likely transcends individuals and organizations; the problem likely resides at the level of our healthcare system. The American health care system is complex with many levels and elements interacting all the time, and it is important that we understand what the elements of the system are and how they interact. Complex adaptive systems (CAS) theory purports that when studying elements of a system, the interconnections and interdependency of each element with all other elements should be considered and analyzed. Some of the elements that are of concern when thinking about inappropriate discharges are homeless persons themselves and their health; shelters that receive these patients; the hospitals and their staff that discharge the patient to the shelter, the policies that hospitals and shelters use when screening, discharging, or accepting patients, the community; and the political environment in which discharging is occurring.

At the level of the individual homeless persons, we are concerned that they may not have access to appropriate care after they are discharged to shelter facilities or that they may not be following treatment plans post-hospitalization. At the level of the shelter, there may not be in place policies or procedures to accept or decline homeless patients from the hospital, or shelters may not have enough resources to care for homeless individuals. At the level of the hospital, social workers may not have the resources or screening protocols to identify homelessness or they may lack awareness of community services that could aid in appropriately discharging homeless persons. At the community level there may be stigma regarding homelessness or a lack of responsibility to the plight of the homeless. At the governmental level, funding and policies may not be directed toward solving the problems of homelessness. All levels are in constant interaction with one another, and the system is never static. These elements interact with one another to produce extremely complex situations. If they are not at least considered, it will be extremely difficult, if not impossible, for solutions and interventions to be designed in a way that will result in effective and predictable outcomes. Rather than designing an intervention that adds to the complexity of the system (i.e., adding additional safeguards or additional policies), it may be more beneficial to evaluate the current system and then strengthen the interactions between the most critical elements.

The purpose of this study is to learn about the behaviors of individuals and policy makers in the hospitals, shelters, and communities that cause or prevent inappropriate discharges of homeless persons. Ideally the information gathered in this study would be used to formulate new strategies for caring and providing for the homeless population. In order to develop new strategies it is important that we understand how the elements of the system interact and behave with one another. The socio-ecological perspective guides this assessment because not only do

we want to learn about the behaviors, motivations, and attitudes of those involved in the inappropriate discharging, but we also want to look at the system that houses this problem and identify elements and interactions that either lead to an increase or decrease in inappropriate discharges. As McLeroy, Bibeau, Steckler, & Glanz state, the socio-ecological perspective:

“...holds that the potential to change behavior is considered within the social and cultural context in which it occurs. Interventions that are informed by this perspective are directed mainly at social factors, such as community norms and the structure of community services including their comprehensiveness, coordination, and linkages, in addition to individual motivations and attitudes (1988).

By identifying these social factors, we can focus our energy on improving the system by developing solutions and interventions that discourage those elements that contribute to inappropriate discharging and promote those elements that help prevent them. In this way we change the system so that those working in it can appropriately discharge people without difficulty. The intention of this research is not to find blame or assign responsibility; the intention is to find real and practical solutions to the problem of inappropriate discharging.

3.0 METHODS

3.1 THE INTERVIEW SCHEDULE

The development of the interview schedule took place over the course of several months and involved informant interviews, question design, and instrument piloting.

3.1.1 Informant interviews

Interviews were conducted to develop questions that would be included in the interview schedule administered to shelter staff. Members of the Health Resource and Delivery Committee, who had knowledge of the shelter community, were solicited and volunteers were interviewed regarding the issue of hospitals discharging patients to shelters. The purpose of these interviews was to gather information regarding the topic of inappropriate discharges from members of the homeless provider community. The interviewees were asked to:

- talk about the issues they thought were most relevant regarding inappropriate discharges
- provide details about the structure and organization of the shelter community
- develop and review questions suitable for shelter staff and administrators

Interviewees were also asked to identify other key informants, i.e., individuals with knowledge about the structure and functions of the emergency shelters in Allegheny County, who could be interviewed to gain additional perspectives on the issue. In total four of these interviews were carried out. The information obtained from the informant interviews was utilized in the following ways:

- To select appropriate participants (e.g., shelter intake staff, shelter medical staff, shelter administrators, and/or shelter volunteers)
- To determine the likely socioeconomic status (i.e., education level and age) of the shelter staff so that the interview schedule could be designed accordingly
- To construct relevant and appropriate questions to be included on the interview schedule

Key informants recommended that shelter intake staff and shelter administrators be the participants in the study because they are the persons most likely to have knowledge regarding intake policy and practices. Intake staff members were also chosen because they are often the staff members who have direct contact with the hospitals who are discharging a patient to their shelter. Key informants recommended that we use a 10th grade reading level or lower when developing the interview schedule given that most shelter staff did not have post secondary education.

3.1.2 Question development

Once the informant interviews were concluded and the information was compiled and organized, the interview schedule was constructed using the questions that key informants and the HRDC members had proposed or approved. The questions developed fell into four main domains, each domain corresponding to one of the overarching research questions. Questions regarding general shelter characteristics were also included so that we could compare information across shelters when applicable. The information in Table 1 corresponds to the questions on the final interview schedule (Appendix A). It defines each of the question domains, the scope of questions contained in each domain, and the overarching question that each domain targets.

The final instrument used to assess the shelter community was a semi-structured interview schedule. The interview was designed to be administered face-to-face. It consisted of open and closed- ended questions and it took approximately 30 to 45 minutes to administer.

Table 1: Question Domains and Corresponding Research Questions

Domain	Scope of questions contained in domain	Overarching research question
Shelter characteristics	Question aimed at the general characteristic of the shelter (including size, number of clients, staff, etc...)	Shelter characteristics will be used to look at data across shelters.
Magnitude and scope	Questions aimed at quantifying number of direct and indirect hospital discharges from hospitals to shelters and determining what effect this has on shelters.	What is the magnitude and scope of this potential problem?
Policies, practices, protocols	Questions aimed at determining if hospitals are collecting data regarding hospitals discharges. Questions aimed at determining if shelters are using protocols or policy to guide the intake of discharges from hospitals.	Do Emergency Homeless Shelters (EHS) have policies or practices for the intake of hospital discharges?
Capacity of shelters to manage hospital discharges	Questions aimed at determining if shelters have professional staff and the necessary equipment to provide health and mental health care	Are EHS able to manage physically and mentally compromised homeless persons?
Attitudes and opinions	Questions aimed at assessing shelter staff attitudes and opinions regarding the issue. That is questions about the appropriateness of discharges, possible solutions, and the severity of the problem	What is shelter staffs opinions and attitudes regarding hospitals discharging to their facility?

3.1.3 Piloting

To refine the interview schedule and to determine the most logical flow and order of questions, the interview schedule was reviewed by HRDC members and faculty at the University of Pittsburgh's Graduate School of Public Health. This resulted in several changes to the content of the questions as well as to the response options. Following these changes mock interviews were carried out with colleagues. The interview was also piloted with two shelter administrators who were excluded from the participants to be included in the actual research. Following the interviews, the interviewer asked the interviewee for feedback regarding the questions, the interview structure, and the flow of the interview schedule. Feedback was reviewed and modifications were made when appropriate.

3.2 PARTICIPANTS

Following approval by the University of Pittsburgh's IRB, initial contact with the shelter community was made through a mailed letter explaining the HRDC mission and the purpose of the survey (Appendix B). The letter explained the purpose of the study and contained authorization forms allowing the researchers to contact shelter staff. Once authorization forms were signed and received by the researcher, shelter administrators were contacted by phone. During this phone call potential participants were informed about the study, its aims, and their rights as participants. At this time, verbal consent was obtained from those interested, and an interview was scheduled.

All 16 Emergency Homeless Shelters (EHS) in Allegheny Co, PA were contacted. Both shelter staff and administrators were asked to participate. The goal was to enroll 32 participants, one shelter administrator and one intake staff from each of the 16 shelters. Shelter staff members were defined as “ones who have knowledge of shelter policies and protocols relevant to intake and discharge and who have daily face-to-face contact with the homeless population.” Shelter administrators were defined as “ones who have knowledge of shelter policies and protocols relevant to intake and discharge, have daily face-to-face contact with the homeless population, and who are responsible for management of the day-to-day shelter activities and shelter staff.”

3.3 ADMINISTERING THE INTERVIEW

Interviews took place at the participant’s respective shelter or office. Interviews were conducted face-to-face and were audio-recorded unless the participant objected. The interview took approximately 30-45 minutes to complete, but varied considerably based on the depth and breadth of the respondent’s answers. Interviewers followed the interview schedule, but departed from, changed, or omitted questions based on the interviewee’s style of response and his/her knowledge about the issue.

The integrity and validity of data were maintained by calling the participants who were interviewed and presenting their responses back to them in summarized manner. If the information was captured or interpreted incorrectly, respondents had the opportunity to recant or change their responses.

3.4 ANALYSIS

All tape recordings of the interviews were transcribed for analysis. For open-ended questions responses were coded based on content. Open coding was first completed on all 21 transcripts, followed by axial coding. All coding was conducted by the two interviewers who collected the information; any coding discrepancies were discussed by the two interviewers until consensus was reached. Once coding discrepancies were resolved and consensus was reached, themes were extracted.

For closed-ended questions and quantitative information, data were entered into a spreadsheet and were analyzed to produce frequencies and descriptive statistics. We calculated percentages of responses for categorical data and examined means and standard deviations for discrete data.

4.0 RESULTS

Direct quotes are referenced in the text using the participant's position at the shelter i.e., shelter administrator or shelter staff.

4.1 SAMPLE CHARACTERISTICS

Twelve of the 16 emergency homeless shelters in Allegheny County participated. The remaining four shelters failed to return the authorization form that would have allowed research staff to contact them and their staff. The shelters that participated included both urban and suburban shelters and both traditional (i.e., non-restrictive, walk-in shelters) and non-traditional shelters (abuse shelters, women's shelters, and family shelters). Eight traditional shelters and four non-traditional shelters participated. A total of 22 shelter staff and administrators from the 12 shelters participated in the study. Of the 22 participants, 13 of them were shelter administrators and 9 were intake staff. In total 21 interviews were conducted. Two administrators from one shelter chose to be interviewed at the same time; otherwise all interviews were conducted separately with one staff or administrator.

Research staff attempted to re-contact all 22 participants for follow-up interviews; 13 were available and participated. Of the remaining eight, two were no longer employed at the shelter at the time of follow-up and six did not respond to multiple phone calls and phone messages.

4.2 MAGNITUDE AND SCOPE

At 11 of 12 shelters participating (91%), staff or administrators reported having had received a discharge from a hospital in the past 12 months. On average the number of hospital discharges received per shelter was 34.4 (Std. Dev. 37.3) and the reported percent of inappropriate discharges received by shelters from hospitals ranged from 0% to 50% (Mean = 23.6, Std. Dev. 20.6). Based on the total reported number of discharges received and the reported percent that was considered inappropriate, the approximate number of inappropriate discharged received per shelter was calculated and ranged from 0 to 37.5 (Mean = 23.6, Std. Dev. 20.6). The total number of inappropriate discharges from hospitals to shelters in a 12-month span was 91.4 (see Table 2).

Table 2: Inappropriate Discharges Reported by Shelter Administrators

Shelter ID#	Total # of D/C received	Total # of Inappropriate D/C	% Reported as inappropriate
Shelter 1	10	2	20%
Shelter 2	0	0	0%
Shelter 5	9	4.5	50%
Shelter 7	54	27	50%
Shelter 8	52	9.1	*17.5% (15-20%)
Shelter 9	100	1	1%
Shelter 10	7	.7	10%
Shelter 11	88	4.4	5%
Shelter 12	2	n/a	“unsure”
Shelter 14	2	0	0%
Shelter 15	75	37.5	50%
Shelter 16	16	5.2	*32.5% (30-35%)
Total	415	*91.4	22%

* = Approximated

When participants were asked if they had received patients from hospitals that needed “extensive medical care” nine of 12 shelters (75%) had staff or administrators report receiving at least one patient in the past 12 months who needed extensive medical care. Examples included:

- A patient who needed extensive wound care after stabbing
- A patient with severe burns

- A patient in the middle of detoxification from illegal substances
- A blind woman needing nursing care and assistance with activities of daily living

At 7 of the 12 shelters participating, staff or administrators reported having had patients discharged to their shelter from a hospital who were given complex medication instructions or no medication at all. One Example is that of a one-year-old baby who needed breathing treatments for asthma; the mother was unclear and unsure how to administer the treatments. Staff needed to assist her, but did not have the expertise or knowledge. Another is:

...people who are on psych meds [that] 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 medications at all. (Shelter Staff)

4.3 POLICIES, PROTOCOLS, AND PRACTICES

Nine of 12 shelters (75%) had staff or administrators report that they had some type of hospital discharge intake policy or protocol; however, no shelter had any policies with hospitals or other shelters regarding the intake of patients. The nine shelters which had staff or administrators that reported having policies and practices also stated that their policies were informal and internal, meaning there was nothing in writing and that the policies were not shared outside of the shelter. One administrator, talking about the informal policy his shelter operated under, said that before he will intake a person from a hospital he must speak with a social worker or other hospital staff in charge to determine if the patient is capable of walking up stairs and attending to activities of

daily living. The administrator also reported that he asked the hospital personnel if the person was mentally and physically stable, meaning that the person could maintain his or her own health. If not, he refused to intake that individual unless proper services were in place or provided. None of the shelters participating provided written documentation of an intake policy regarding hospital discharges.

Four of the 12 shelters (33%) had staff or administrators report that they were tracking hospital discharges to their facilities. They reported using logs, client software, and intake forms to track discharges to their shelter. Participants reported that though they collected the information, it was not easily accessible because the information was not aggregated; the information was captured most often in individual client charts. The remaining eight shelters indicated that they were not collecting data on hospital discharges, but staff and administrators from these shelters thought it would be practical and feasible to collect this type of information. One shelter administrator thought that “it would help to know in a given year how many people we have received [from a particular hospital] and the success of the case while they were here.”

4.4 CAPACITY TO MANAGE PHYSICALLY AND MENTALLY COMPROMISED HOMELESS PERSONS

Six of the 12 shelters (50%) had staff or administrators report that they had professionals, including visiting registered nurses and medical doctors, capable of providing medical/psychiatric care to their clients. Several shelters had therapists and drug and alcohol counselors. In most cases these professionals were not employed by the shelter, but offered

services voluntarily. Many of the medical personnel were available only on specific days at specific times (e.g., every Tuesday and Thursday from 10am to noon). Almost half the shelters (42%) reported that they were not materially equipped to handle the medical and psychiatric needs of their clientele (e.g., blood pressure equipment, AED, proper medication storage, and treatment rooms).

4.5 SHELTER STAFF ATTITUDES AND OPINIONS

All participants (n=22) were asked to define an inappropriate discharge (see Figure 1 below). Essentially all definitions of an inappropriate discharge involve a situation that resulted in the shelter's being unable to provide adequate care for the client (i.e., the client's needs exceeded the shelter's capacity to care for the patient).

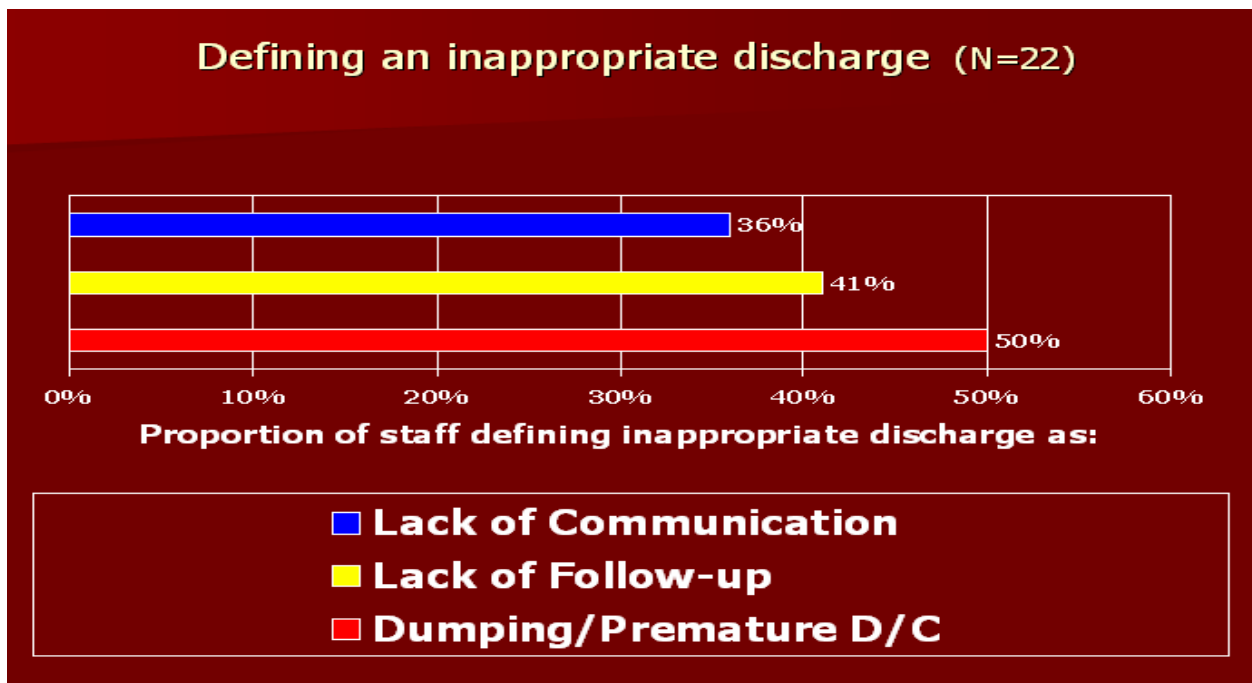


Figure 1: Participants Defining Inappropriate Discharges

Eight staff defined an inappropriate discharge as a discharge from a hospital to shelter where there is either inadequate communication between shelter and hospital personnel (e.g., deceptive or limited information about the patient's status), or there is no communication at all. One intake staff defines an appropriate discharge from a hospital to a shelter as follows:

The most appropriate thing is for [the hospital] to call us so that there can be direct communication...then we can know the extent of [the patient's] issues and we can talk to that person, like [a] social worker about our concerns. (Shelter Staff)

Nine of the participants defined an inappropriate discharge as one where there is inadequate follow-up care in place. These participants reported that if hospitals are going to appropriately discharge patients, hospital personnel should have in place for them wrap-around services, case managers, or social workers that facilitate post hospitalization care.

If the person needs any sort of recovery time, a shelter is not the most appropriate place to be. (Shelter Staff)

The definition most frequently mentioned by shelter staff was that a hospital discharges patients onto the street or at a soup kitchen before they have been adequately treated or assessed. Participants often referred to this as “patient dumping.”

An inappropriate discharge is ...dismissing a... [patient] before they've been completely assessed...Not giving them adequate help. (Shelter Staff)

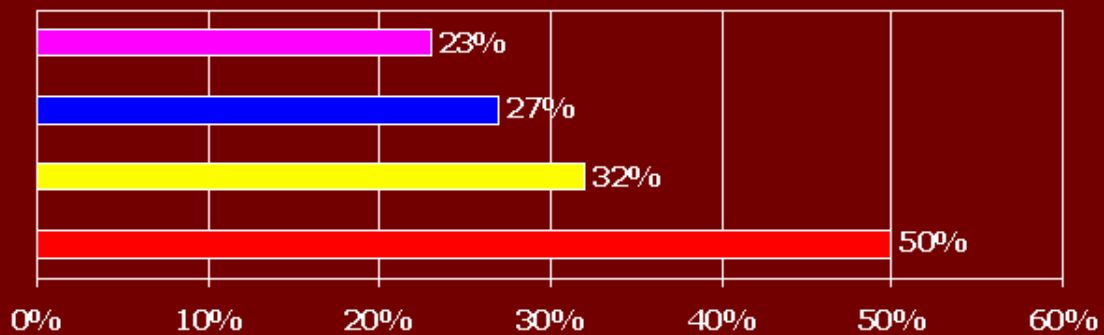
“When they get here their mental state is inappropriate and they should be put somewhere to deal with that. A lot of hospitals...just want to find a place for people, and not necessarily the place that they need to be, because of their particular problems.”
(Shelter Administrator)

On a scale of 1 to 5 in which 1 is “strongly disagree” and 5 is “strongly agree,” participants “moderately agreed” (mean = 3.4, Std. Dev 1.1) with the statement “The problem of hospitals discharging to shelters is very severe.” Several participants noted that although the problem is not that severe on a day-to-day basis, it becomes a severe problem when they have to manage an inappropriate discharge at their facility. One participant reported that inappropriate discharges to his or her facility strain the resources of the shelter and shelter staff and ultimately distract the staff from their task of providing other clients with the means to find more permanent shelter.

On a scale of 1 to 4 in which 1 is “a low priority” and 4 is “a very high priority,” participants rated the priority of the issue of hospitals inappropriately discharging to their facility as moderate to high (mean=2.2, Std. Dev. 0.71). Again, several participants noted that it only becomes a priority when they are confronted with an inappropriate discharge; otherwise on a day-to-day basis it is not much of a priority.

Participants were asked what they thought were possible solutions to the problem of inappropriate discharges (see Figure 2). They were asked to provide possible solutions from the shelter’s perspective. They were also asked to think about what hospitals could do to resolve inappropriate discharges.

Shelter staff's opinions on possible solutions (N=22)



Proportion of staff mentioning category

- Increase hospitals' knowledge regarding homelessness
- Shelters More Accommodating
- Develop Respite
- Better Communication

Figure 2: Solutions to Inappropriate Discharges

Five of the participants thought that hospitals should increase their knowledge regarding homeless. Several participants thought that if hospitals knew more about homeless shelters and the services they provide and also other homeless services and programs, they could more appropriately place these individuals at the time of discharge. Examples given by participants of how hospitals could increase their knowledge of homelessness include:

A little more legwork, a little more depth to their [the hospitals] resource pool exploring what's out there for ... homeless [persons]. (Shelter Staff)

Somebody from the hospital could spend a day here [at our shelter] so they can get a good feel of what goes on here and they would know whether or not a patient would be good for this shelter. (Shelter administrator)

Six of the participants thought that shelters could be more accommodating to those discharged from the hospital. Some remarks related to this include the following:

...it would be nice if shelters could not have to ask people to leave during the day that get discharged from the hospitals... if there...[could be] a certain number of beds reserved for people who have doctor's order to stay of their feet... (Shelter administrator)

We [the shelter] could have some sort of counseling services...it would help with the persons who come here. (Shelter administrator)

Of the 22 participants, 7 thought that a good solution to inappropriate discharges would be to develop medical/psychiatric respite care. One shelter staff member offers her thoughts on the matter:

...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. (Shelter Staff)

The most often cited solution to hospitals inappropriately discharging patients to shelters was improved communication between shelters and hospitals.

Possible solutions are “to have better rapport between hospitals and shelters...Communicate better. Maybe every other day hospitals could call and ask about our capacity. (Shelter Staff)

...develop some type of relationships with the critical people in these decision making situations...we know [hospitals] are overburdened and financially stressed and likewise with us, so we need to work on [appropriate discharges] together. (Shelter administrator)

5.0 DISCUSSION AND RECOMMENDATIONS

The results of this study indicate that hospitals are discharging to nearly all the emergency homeless shelters in Allegheny County, and that in many cases the discharges are considered to be inappropriate by shelter staff. Given that the problem of inappropriate discharges appears system-wide, it is likely that the causes and solutions of inappropriate discharges reside at the healthcare system level and not solely at an individual or organizational level.

The problem of inappropriate discharges and the solutions lie at multiple levels of the system. At the individual level, homeless persons must take responsibility to follow through with hospital discharge orders and treatment plans. At the shelter level, administrators need to discover ways of expanding their services to accommodate the medically and mentally compromised, and begin to develop intake protocols that assess appropriateness of discharge. Shelters should also track hospital discharges to their facility and the success of those cases in a formal and systematic way. At the hospital level, better screening for homeless needs to be implemented and knowledge of existing homeless resources should be encouraged i.e., hospital personnel responsible for discharging patients should be educated about the available local resources for the homeless population and the capabilities of shelters to provide for patients. It is essential that stakeholders from the hospitals, shelters, and homeless provider organizations communicate with community leaders and advocates about the problem of inappropriate discharges so that policies and funding can be put in place that will prevent these discharges

from occurring. If the community can move past a stigma that homeless persons are mentally ill, violent, alcoholics, and see the homeless as people in need of help and compassion, then that, I believe, will be progress in the fight against homelessness.

The results of this study indicate a lack of communication between shelters and also between shelters and hospitals. None of the 12 shelters had any formal or informal policies of protocols with shelters or hospitals. If there is no communication amongst the stakeholders, it will be difficult to design interventions to prevent inappropriate discharges and it will be difficult to develop standard operating procedures for accepting hospital discharges in an appropriate fashion. This study provides evidence that social ties between hospitals and shelters are weak; solutions to the problem of inappropriate discharges proposed by shelter staff point to strengthening the social ties by building relationships and increasing bi-directional communication.

Poor communication may be the underlying simple problem manifesting at many levels, and between levels. It may be that if only shelters and hospitals were communicating about how to appropriately provide for homeless patients post-hospitalization then inappropriate discharges would not occur. Through better communication hospitals and shelters could pull their knowledge and resources collectively to ensure that patients receive an appropriate level of care and adequate time to recover. It may be that solutions to the problem of inappropriate discharging already exist and all that needs to be done is for people to start communicating about how best to provide care to the homeless post-hospitalization.

In order to facilitate communication between stakeholders, better tracking should be implemented. First, it is important that hospitals are screening for homelessness in the emergency room and again when patients are admitted in to the hospital. If hospitals are not

aware that a person is homeless or at risk of becoming homeless, it will be difficult to place that person appropriately at the time of discharge. Second, shelter intake staff should be documenting discharges from hospitals, so that they have a record of the cases and can provide hospitals with feedback regarding the appropriateness of the discharges. One of the shelter administrators reported using a computer based system, the Health Management Information System (HMIS), to track discharges. HUD requires that all of its grantees use this tracking system to collect data on the homeless population; however it is only starting to become an effective tool as it is being used to a greater extent. In a recent HMIS report, furnished by an Allegheny County representative, that indicates where emergency shelter clients were referred from over an 18-month period, nearly 70% were classified as “unknown” (see Table 4 below). According to this HMIS report hospitals accounted for only 11 referrals over 18 months; this is in stark contrast to the 415 reported by shelter staff in this study.

Table 3: Source of Referrals to Emergency Homeless Shelters (HMIS May 05 – Oct. 06)

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

As the HMIS is utilized more frequently, it may provide evidence about the true frequency of hospital discharges to shelters, and prove to be an effective tool to track the homeless population. If hospitals and shelters track homeless individuals through the system and share information, they can begin to work together and implement effective strategies to prevent inappropriate discharges.

Another effective strategy suggested by several p[participants in this study was to develop respite care. This is promising and consistent with recent findings that respite care reduced re-hospitalizations. Here is what one shelter administrator said when talking about developing respite for the homeless:

I see medical respite as a need here in Pittsburgh....because [the homeless] do not have as many support services, family or individuals ...to care for them like you or I, we go to the hospital and we are going home, and maybe somebody is stopping by, or maybe someone is taking care of us 24/7. These individuals don't have that. They may say that they got that... and then they end up in the shelter. (Shelter administrator)

Respite care would provide a place that hospitals could feel comfortable discharging patients to and a place that would be suitable for the patient's needs post-hospitalization. Shelters could work with the respite staff to find permanent housing for the patient once the patient has recovered from his or her illness. It only seems logical that if time and energy are spent to treat someone's acute illness that providing him or her with a suitable place to recover is the necessary and appropriate thing to do.

An encouraging finding in this research was that shelters were not blaming hospitals for inappropriate discharges. Many shelter staff felt that hospitals were under great pressure to stay afloat financially, and that they were doing all they could for these individuals. One staff commented on the need for insurance industry to take more responsibility and be more compassionate.

One thing would be for the insurance industry to be more lenient and let people stay if they don't have an appropriate place to stay. (Shelter Staff)

Again, the problem of inappropriate discharges rests at many levels of the system. Blame is not assigned to any one party; shelters understand the dilemma of hospitals and also share responsibility for this issue.

Shelters are ready and willing to become more accommodating; they truly want to help and resolve this problem. The shelter staff members were impassioned when talking about inappropriate discharges. Like in the MAP program, aforementioned, shelter administrators are trying to change the way shelters operate, so that they can care for this vulnerable population and fill in the existing gaps in the healthcare system. Typically shelters require that clients leave the shelter during the daytime, but as one shelter administrator proposed, if patients who are discharged from the hospital need to recover, they should stay at the shelter to rest. She also thought that it might be a good idea to reserve a certain number of shelter beds just for hospital discharges. In a way she is proposing that her shelter take on the role of a respite service. Another shelter staff thought that their shelter could provide health services to shelter clients in an effort to accommodate those being discharged from psychiatric facilities.

A strong will and great passion to resolve inappropriate discharges were expressed by shelter staff; this was quite encouraging. And although some of the longer-term goals (e.g., to ensure that hospitals are not creating more homeless by inappropriate discharging and the development of respite care), the results of this study have practical implications that can be brought to bear quickly, especially given the apparent willingness of shelter staff to make a difference. Dissemination of the study results may have the following implications:

- Shelters may be encouraged to track hospitals discharging systematically and regularly.
- Hospitals will be informed about what we are learning about the problems associated with discharging patients to emergency shelters.
- Shelters and hospitals may engage in discussion and begin to communicate regarding inappropriate discharges
- Shelters may develop practices and protocols to assess the appropriateness of accepting a hospital discharge.

6.0 CONCLUSIONS

There is a real public health concern regarding the health and wellbeing of the homeless population; related to this is that homeless persons are being inappropriately discharged or “dumped” by hospitals and Emergency Departments to the street, soup kitchens, and emergency shelters. And although the concern about inappropriate discharges has recently received national attention, little is known about the extent to which inappropriate discharging occurs and what is being done to prevent and discourage inappropriate discharges. This study assessed the magnitude and scope of the problem as it exists in Allegheny County, Pennsylvania. The results clearly show that hospitals are discharging patients to shelters in Allegheny County, and many times this is inappropriate. Those interviewed believe that building relationships between hospital and shelters coupled with increased bi-directional communication could help to eliminate inappropriate discharges. Medical respite was also emphasized by participants as a possible solution.

Limitations:

- Only one perspective is represented; neither hospital staff nor homeless individuals were interviewed. Obviously the hospital community may have alternative views on inappropriate discharging, and thus by providing them with an opportunity to express their feelings and thoughts on the issue, creditability and validity will be increased in

the study of inappropriate discharges. Furthermore, homeless persons who have experienced firsthand the problem of an inappropriate discharge may provide insight into the consequences of inappropriate discharges and how it affected their recover.

- 25% of Emergency Shelters in Allegheny County are not represented. Future studies may benefit by using a multitude of recruitment methods (e.g., fax, mailing, phone, email).
- Data are based upon participant recall rather than documentation. Given that this study was exploratory in nature and that not much was known about the practices and protocols shelters had around the intake of hospitals discharges to their facilities, this study relied heavily on participants' ability to recall and enumerate the number of discharges their shelter received. Now knowing that very few shelters collect this data in a consistent and usable manner, future studies could involve prompts that instruct participants months prior to data collection to track hospital discharges to their facilities.
- Qualitative and quantitative methods were engaged in this study at the same time. That is to say the major study instrument was a semi-structured interview with some closed-ended questions and other questions open-ended. The instrument was designed to engage the interviewee in dialogue to learn more about the practices, contexts, and consequences of patient dumping. The problem often encountered was that the tone was set early in the interview to be more like a survey and when it came time to switch to an open dialogue, the transition was often rough or awkward. In future studies, I believe that qualitative and quantitative methods should be administered separately, i.e., use a quick survey to determine the magnitude and

scope of inappropriate discharges, and then investigate further with in-depth interviews and other qualitative methods where the problem is occurring frequently.

This will increase efficiency and still produce rich qualitative data.

Although the interviews and the data collected through the methods above are in themselves sufficient as means for assessing the shelter community, I feel that in order to mobilize the larger community into action, additional assessments and interventions are needed. In harmony with the community participatory methodology, I feel it is necessary to broaden the participation in the research to include the hospital communities, homeless persons, and other homeless social service programs and agencies (i.e., transitional housing services). Using the data collected from the interviews as a focal point, future researchers can work with community members to develop strategies to reduce and prevent inappropriate discharges. The next steps in this research should be to bring stakeholders together, present the findings, and begin working together toward solutions that prevent inappropriate discharges.

APPENDIX A SURVEY INSTRUMENT

Participant ID# _____

DATE: / /

If participant has agreed to be recorded, start audio tape 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 your 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 was 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 can not 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.

APPENDIX B RECRUITMENT LETTER TO ADMINISTRATOR

To Whom It May Concern:

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 whom, 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 are not 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 888-888-8888. 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 or Todd Bear at (888-888-8888).

Thank you for your consideration.

B.1 AUTHORIZATION FORM

By completing this form you and your staff are not 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 888-888-8888 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: _____

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