Policy for Avoiding Discharge into Homelessness

Overview:

HUD Definition of Homeless: According to the U.S. Department of Housing and Urban Development (HUD), a person is considered homeless if they are living in places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings or on the street. In addition, persons are also considered homeless if they reside in Emergency Shelters; reside in Transitional or Supportive Housing for persons who are homeless and originally came from the street or emergency shelters; came from any of the above but are spending a short time (up to 90 consecutive days) in a hospital or other institution; are being evicted within 14 days from a private dwelling unit and no subsequent residence has been identified; are being discharged within a week from an institution, such as a mental health or substance abuse treatment facility or a jail/prison, in which the person has been a resident for more than 90 consecutive days and no subsequent residence has been identified; are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or lie-threatening conditions that relate to violence, and the person has no other residence and lacks the resources or support networks to obtain other permanent housing.

Guiding Principles:

- Homelessness in unacceptable in Wisconsin.
- In no instance should a person be discharged from a state or public facility without directions to seek housing or shelter in an emergency shelter.
    - Every effort must be made through careful discharge planning to work with the client and are resources to seek adequate, permanent housing.
- If after having exhausted all efforts to engage the client in a discharge plan, if the client continues to refuse services, the efforts will be noted in detail and the client will confirm their refusal with their signature.
- If a client receiving out-patient services becomes homeless, the state or public facility should work actively with the client and community resources to locate suitable housing.

The McKinney-Vento Act requires that State and local governments have policies and protocols in place to ensure that persons being discharged from publicly funded institutions or systems of care **ARE NOT** discharged immediately into homelessness.

- **Health Care**: Under 42 CFR 482.43(b) and (6) all hospitals must have in place a discharge planning process that applies to all patients and the discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and the availability of those services. The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and the hospital must discuss the results of the evaluation with the patient or the person acting on the patient's behalf. Wisconsin Administrative Code HFS 124 defines the requirements for discharge planning.

- **Skilled Nursing Facilities**
    - <u>§483.15(c)(7) Orientation for transfer or discharge</u>: A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.
    - **Refer to "*More Information*" page at the end of this document for further details**
- **Hospitals**
    - <u>§482.43 Condition of Participation: Discharge Planning</u>: The hospital must have in effect a discharge planning process that focuses on the patient goals and treatment preferences and includes the patient and his or her caregivers support person(s) in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to a preventable hospital readmissions.
        - **For further information and specific regulations and Interpretive Guidelines please following the link provided below:**
            - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf
                - *Discharge planning starts at A-0799 and goes to A-0843*

- **<u>Foster Care</u>**: Chapter 48 and 938 WI Stat and CDF 38 and 56 of the Wisconsin Administrative Code govern foster care and compliance with the Federal Program. The WI Dept. of Children and Families (DCF) is responsible for youth in foster care and its policies prohibit discharge into homelessness. Youth aging out of foster care may be eligible for room/board assistance if Wisconsin and Federal eligibility is met and the child welfare agency has funds to assist.
- **<u>Mental Health</u>**: The WI Dept. of Children and Families has protocol in place, Sec. 51.35(5) Wis. Stats., to not discharge to the streets or to a homeless shelter. Part of the discharge planning process is the development of a plan for placement in the least restrictive setting in the client's home community. The law states that a hospital director or 51.42 board discharging a person from a psychiatric hospital or unit will ensure that a proper residential living arrangement and necessary transitory services are available and provided for the patient being discharged. The provisions pertain to both voluntary and involuntary patients.
- **<u>Corrections</u>**: The WI Dept. of Corrections has policies and procedures set in place to ensure planning and communication between the correctional institution and community corrections regardless of whether the inmate is being released on discretionary parole, mandatory release or maximum discharge from sentence. These procedures involve advance communication and planning between the inmate, institution staff and the assigned community corrections agent. The planning process, at a minimum addresses housing, employment, treatment, and reunification with family. Because the administration of the local jails is based on a county-by-county system determined by the locally elected sheriff, there is no statewide policy in place to facilitate the placement of persons serving a short term sentence in the county jail.

1. Purpose:
    - The purpose of this policy on Avoiding Discharge into Homelessness is to ensure agencies receiving funding (state and/or federal) and Local Continuum of Cares within the Balance of State to end homelessness are not incorrectly discharging individuals experiencing homelessness back to the conditions that may have caused them to be admitted to that agency.
    - This policy is intended to supplement, but not replace, any applicable state and federal laws protecting private property.
    - Local Continuum of Care's will provide information to the agencies about housing options in order to assist the agency to develop a discharge plan.
    - Housing options will include information about Housing Authorities, agencies that provide rental assistance, and as a last resort, Shelter information
    - Foster Care Agencies, Health Care and Mental Health Care Institutions, County Law Enforcement, and Community Corrections will be invited to attend local Continuum of Care meetings and be made aware of the WI balance of State meetings to offer an opportunity to collaborate with other agencies about housing issues and/or lack of housing.
2. **Common Reasons for Discharge back to Homelessness:**
    - Lack of social support
        - Individual = family/friends/other close relationships
    - Lack of room to keep patient admitted
    - Lack of funding (agency) / income (individual)
    - Lack of knowledge on how to serve individuals
    - Maybe they don't know the individual is homeless
    - **List is not expected to be exhaustive…**
3. Procedures:
    - Each local coalition must develop a regional plan to address discharge planning in their communities.
        - The plan must include strategies to educate and engage local coalitions and service providers that work with individuals experiencing homelessness.
        - Each coalition will review the plan annually and make necessary revisions.
4. Local CoC Responsibilities / Records of Proceedings:
    - Agencies will incorporate the policy into their program procedures.
    - Contact agencies to do Outreach and Education to make them aware of the resources for housing in the community.
    - Invite them to the local Continuum of Care meeting.
    - Provide dates and locations for the Balance of State meetings.
    - Contribute information for grant writing or provide a letter of support.

For any questions, comments, or concerns please contact the following individual according to your COC coverage:

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Teresa Reinders
COC Director
2000 DeKoven Avenue, Unit 1
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racinecocorg@gmail.com

Madison & Dane County COC
Torrie Kopp Mueller
COC Coordinator, Homeless Services Consortium
Department of Planning and Community &
Economic Development
Community Development Division
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Milwaukee City & County COC
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More Information

Skilled Nursing Facilities:

F622
§483.15(c) Transfer and discharge-

§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.

(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

F623
§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must—
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when—
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.

If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure

In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).