

Supporting Transitions of Care from Institutions

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Supporting Transitions of Care from Institutions: Toolkit Introduction

Overview: The following trio of documents highlights best practices for preparing for and facilitating smooth transitions of care across three distinct settings: from the carceral setting, after an inpatient psychiatric stay, and street medicine support during transitions after a hospitalization. Each resource provides an overview of the unique considerations relevant to that transitional setting and population, highlights opportunities and best practices to optimize support during the transitional period, including addressing housing instability and homelessness, and offers community-based examples of successful program models. These resources showcase the investments communities can make to improve transitions of care within their communities and, at the same time, highlight core philosophical approaches they can embrace to support individuals during transitions in the absence of fully formed programs.

Introduction

Transitions of care are defined as the period in which an individual who has been hospitalized or residing in an institutional setting moves from a highly structured, resource-intensive environment to a less structured, less supported, and more independent community-based setting. This is a critical and high-risk time during which individuals are vulnerable to medical or psychiatric destabilization, as well as complications of substance use with increased danger of unintentional overdose.

Transitions of care are dynamic periods and are not unidirectional; sometimes, the level of care and intensity of service needs will increase or decrease (“step up” or “step down”) based on an individual’s circumstances. Ideally, the level of care offered to an individual matches their level of need and support at any given time. However, there are additional factors that can affect engagement across levels of care: the availability of resources within the community, an individual’s openness to engaging with available programs and services, and the requirements—eligibility and financial—to access them.



Why Transitions of Care Can Be Destabilizing

- **Loss of care coordination:** Individuals returning to the community experience a shift from receiving integrated care within one institution to a fragmentation of care and support across a number of non-connected settings.
- **Loss of structure:** Exiting an institutional setting can result in the loss of a unified setting that provides housing, nutrition, medical care and self-management support, and social support.
- **Return to pre-existing challenges:** People may be returning to challenging circumstances (e.g., housing instability or homelessness, interpersonal violence, or communities in which they were using substances).
- **Need to reestablish community connections:** Often, people transitioning from high-support or structured settings will need to reestablish care with their primary and specialty care providers, restart disability or mainstream benefits, and reintegrate with family and community.
- **Need to adapt to new routines:** During institutional stays, people are often diagnosed with new conditions, develop new care plans, or modify their behaviors. When they return to their communities, they must learn how to maintain the changes they made while in care and adapt their behaviors to new settings. In addition, people are often still recovering during transition periods and may be exiting the institution in a different mindset and overall health status than they had entered care.

Key Considerations in Transitions of Care

To be most effective, care transition services and care coordination strategies should be tailored to the needs of the specific population of focus and the community in which they are based. Successful care transition approaches hinge on person-centered transition plans, recognizing that no single model or plan will be relevant or effective for every individual. Nonetheless, several key features apply to a wide range of transition program models and are core to supportive models.

Person-centered and responsive care transitions programs include the following features:

- Proactive transition planning that begins at the start of an individual's stay in care, recognizing that transitions can happen suddenly and unexpectedly, with limited time to plan unless foundations have already been set.
- Direct involvement of the individual throughout the planning process.
- A process to identify an appropriate place to stay post-transition.
- A warm hand-off for medical and behavioral health needs.
- A plan for medication access and support needs.
- A plan for supporting access to benefits, including insurance and financial resources.
- A plan for effective post-transition cross-sector collaboration.
 - ↳ Create a clear plan for how different services, sources of support, and resources will act in sync.



- ↳ Ensure that the individual experiencing the transition knows all the people and resources that will be available to them and what role each person or organization will have in providing step-down support.
- A plan for how individuals can access more intensive support, or “step up,” if the transition plan is not working for them.

Strategies to Address Service Gaps in Your Community

Not every community will have fully developed transition or step-down programs available to support all the unique populations in need. There are several strategies communities can use to identify their priority populations and determine the most effective transition programs.

1. Engage in a community self-assessment, including resource mapping.
2. Explore and develop cross-agency and cross-sector partnerships.
3. Engage in peer-to-peer learning and support locally, regionally, and nationally.

Additional Resources

- HHRC: *Guide to Resource Mapping and Assessing Community Needs*¹
- California Health Care Foundation (CHCF): *Playbook for Complex Discharges*²
- Center for Health Care Strategies (CHCS): *Partnerships for Action: California Health Care & Homelessness Learning Collaborative*³
- CHCS: *Building Cross-Sector Collaboration Between Health Care and Homeless Services*⁴

Learn More about the Homeless and Housing Resource Center



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Transitions of Care from Incarceration

June 2026

Overview: This fact sheet explores the challenges of meeting behavioral health needs for people leaving carceral settings, such as jail or prison, who are also facing housing instability or homelessness. It highlights best practices and features a national model developed and supported by the Transitions Clinic Network that uses community health workers with lived experience of incarceration to support reentry and engagement with primary care.

Introduction

People with a history of incarceration are over ten times more likely to become homeless compared to those with no incarceration history.^{1,2} This is the case for both those with longer prison sentences and those with short stays in local jails. A 2025 study found that in San Francisco, even after a median 4-day jail incarceration, 25% of people subsequently lost their housing.³ The transition back into the community can be a challenging period across multiple areas, including housing, employment, and health.

“All of someone’s needs are up in the air when they leave incarceration.”
—Dr. Shira Shavit, MD, Executive Director, Transitions Clinic Network

People with mental health or substance use disorder diagnoses are more likely to have been unhoused prior to incarceration and are also more likely to lose housing following release.⁴ The stressful transition from jail or prison also represents a potential lapse or change in mental health and substance use supports. People leaving carceral settings face an increased risk of opioid overdose, particularly within the first two weeks after their release.⁵ According to the National Alliance on Mental Illness, 37% of people incarcerated in state or federal prisons and 44% of people incarcerated in jails have a history of mental illness; however, less than half receive

treatment for mental health conditions while incarcerated.⁶ The period following incarceration can be a time of significant change and stress with increased need for behavioral health supports.

Understanding Terms Used

- **Prisons:** Facilities that are operated by state or federal authorities and are designed for longer-term stays.
- **Jails:** Facilities that are usually operated at the city or county level and are designed for short-term stays (less than one year). People are often incarcerated in jails after arrest and while awaiting trial or sentencing.
- **Recidivism:** Refers to being rearrested or violating parole or probation and potentially returning to jail or prison.

Challenges and Opportunities After Transitions from Carceral Settings

Challenges faced by those leaving carceral settings are wide-ranging, including housing, family and community support, employment/income, food security, medical care, and substance use and mental health treatment. In addition, release dates, especially from jail, often come with little to no warning, and so plans may not be in place for a successful return to the community. While this is a potentially high-risk time, there are also multiple programs and interventions that have been shown to decrease recidivism and to improve stability, safety, and health. Below is information on the challenges faced by those transitioning out of incarceration, along with successful interventions.

Challenges

- **Housing:** Having a safe and stable place to live is foundational to one's ability to manage many other aspects of life, including caring for family, employment, nutrition and health management, and engaging in educational opportunities. Housing instability is a major issue for people transitioning out of incarceration, and the time immediately after release is the highest risk for becoming homeless. The U.S. Department of Housing and Urban Development (HUD) estimates that up to 50,000 individuals a year enter shelter directly from the carceral system.⁷ Even short-term incarceration in a local jail can have detrimental effects on housing stability, often through job loss, disruption of relationships, or missed rent payments.
- **Medical and behavioral health needs:** The time immediately following incarceration is a critical period for meeting both medical and behavioral health needs that may have been addressed within the carceral system, or that may have been interrupted in the case of shorter jail stays. People

frequently have multiple needs across medical, behavioral health, and social domains and need support with accessing and coordinating care. Specific needs include the following:

- ↘ **Medication support:** Although people may leave carceral settings with a short-term supply of medications, they need to identify and establish themselves with health care providers who can continue needed medications.
- ↘ **Insurance coverage:** Insurance coverage may lapse while incarcerated, or people may not be sure of their insurance status upon release. This presents significant access and cost barriers for people newly returning to the community in need of immediate care. Resulting lapses in medication and other medical needs can be dangerous.
- ↘ **Overdose risk:** Overdose risk increases significantly following release from incarceration, most often due to decreased opioid tolerance. Support with substance use treatment and access to overdose reversal medications like naloxone are vital and needed immediately upon release.
- **Employment:** Incarceration can disrupt employment and make finding work much more challenging. Having a criminal record makes securing employment difficult, as many employers require disclosure of any convictions and a background check, though there are few clear guidelines for using or making hiring decisions based on this information.⁸ Often, a criminal record simply disqualifies candidates. Additionally, for those who have been in prison for longer periods, the skills needed to find stable work may have changed significantly since their last employment.
- **Public benefits:** Public benefits, such as Medicaid and Medicare insurance, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), and the Supplemental Nutrition Assistance Program (SNAP), are all impacted by incarceration (both short and long-term stays). During incarceration, Medicaid and Medicare are suspended, portions of [Medicare will lapse](#) if premiums are not paid,⁹ and [SSI/SSDI payments may stop](#).¹⁰ Most benefits do not automatically start upon release, so people often experience a period without benefits, and many need support with getting benefits reinstated. An additional barrier may be the loss of identification documents during an arrest and incarceration, which can complicate the acquisition of benefits, including housing.
- **Family and community support:** Support systems are a key component of returning to the community after both jail and prison. Sometimes, family and community ties may have been strained by incarceration, while other times, people are released into communities they did not previously live in. People can feel isolated and worried about encountering stigma. They also may not want to return to a community within which they were using substances or were arrested. Support comes in many forms, and it is important to recognize that spiritual communities, employment, volunteering, and direct outreach and integration efforts can all foster social connections.
- **Meeting post-incarceration requirements:** The challenges of navigating housing, transportation, phone service, employment, and medical needs can be very difficult for people who may have no source of income and limited support. Meeting requirements set forward in the post-release period, such as check-ins with probation/parole or mandatory drug testing, can be challenging.

Opportunities

- **Direct linkages to care:** More than just a list of resources, direct linkages provide people with up-to-date information, referrals, and warm handoffs to services post-release, including for housing, employment, benefits, and medical care. These linkages often include wrap-around support¹¹ and ongoing involvement to support evolving needs. Other linkages include direct referrals from carceral settings to substance use or mental health treatment programs, including medication support.
- **In-reach to the carceral system:** Developing connections and relationships with people prior to their release is an important way to build trust and set up services and connections before people leave carceral settings. In-reach partnerships between the carceral system and public service providers, such as local public health entities, federally qualified health centers, or non-profit service providers, can be established through informal agreements or formal memorandums of understanding. These agreements outline the services to be provided pre- and post-release, the role each partner will play, and how information sharing and data protection will occur.
- **Medications at release:** It is vital that people leave carceral settings with a supply of needed medications; this is true regardless of length of stay. This may include providing medications for opioid use disorder (e.g., buprenorphine), overdose reversal drugs (e.g., naloxone), and mental health medications. It is important for people to leave incarceration with an updated, printed medication list if they were taking medications while incarcerated. The list should include the last dose dates of any medications administered, including long-acting injectable mental health medications, HIV or substance use injections, and treatments for hepatitis C or other infections.
- **Medicaid at release:** Restarting Medicaid coverage before release from carceral settings prevents lapses in medical and behavioral health care. Initiatives to restart Medicaid prior to or at release have been supported by 1115 Medicaid Waivers in over 20 states.¹² Additionally, the Fiscal Year 2024 Appropriations Act required states to suspend, rather than terminate, Medicaid coverage during incarceration, effective January 1, 2026.¹³ This allows for faster reactivation of coverage upon release. Even with the resumption of coverage prior to release or the ability to reactivate coverage post-release, there are steps that must be taken by service providers and the individual, and these can vary by state.¹⁴
- **Employment and vocational training:** As noted above, securing employment can be very challenging for people with a criminal record, with additional barriers for people who may have been incarcerated for longer periods or do not have up-to-date training or education to enter today's workforce. The Department of Labor provides resources about reentry employment opportunities. There are also many states and resources across the US that offer services to expunge criminal records, often easing the return to employment.
- **Supportive care coordination for benefits management:** A person is generally able to resume receiving benefits such as SNAP, SSI/SSDI, and Medicaid post-release from incarceration. However, this process often requires care coordination support to ensure that these benefits are reactivated, as there are often delays in the carceral system notifying the state systems that administer them.

Program Highlight: Transitions Clinic Network

Program Model

The Transitions Clinic Network is a California-based nonprofit organization with national reach that works to transform primary care health systems to better support formerly incarcerated people. They work directly with health centers in communities across the US towards this goal. The program was co-developed by people with direct lived experience of incarceration, and the basis of their model is integrating community health workers (CHWs) with lived experience of incarceration into health center systems and communities.

Dr. Shira Shavit, the Executive Director of Transitions Clinic Network, explained that by involving people with a history of incarceration from the start, they were able to create a program that could best meet the needs of those leaving carceral settings. For example, while there was an initial vision for a clinic located near the state prison, members of the team with lived experience guided their model towards full integration into the community; people did not want to visit a “prison clinic.” Dorel Clayton, a CHW and Transitions Clinic Network’s CHW Trainer, explained why integration is key: “The stigma is really difficult and makes people avoid care; people have a fear of being labeled.” Dr. Shavit emphasizes, “People want to be part of the community.”

Importance of Community Health Workers

CHWs are integral to the Transitions Clinic Network program. CHWs are part of the primary care team. They provide in-reach to prisons and jails, develop partnerships with community agencies, and help people navigate multiple needs, including medical care, substance use treatment, mental health, employment, and reintegration into their communities. Dr. Shavit and Dorel both described the CHW role as providing a bridge and being a “cultural translator” between individuals seeking care and the medical provider team. “Resource availability does not equal engagement,” notes Dorel, “Getting people to engage—that is where the CHW comes in.”

Putting the Model Into Practice

Transitions Clinic Network typically works with health centers for 6 months to 1 year, helping transform their programs to better meet the needs of formerly incarcerated people. They assist health centers in hiring and supporting CHWs with lived experience of incarceration and identifying sustainability strategies, and they provide ongoing support through their network. For more information, visit the [Transitions Clinic Network](#).

“People are really in survival mode in those first two weeks. Being able to meet a person who was also incarcerated creates a trust factor that diminishes some of the stigma. We can help get people into the clinic, into mental health care; we take that off their plate and can educate people that **health is their wealth.**” —Dorel Clayton, Community Health Worker Trainer, Transitions Clinic Network

Additional Program Examples

- The [Philadelphia Department of Prisons](#) continues to develop a comprehensive program to treat substance use and decrease overdose risk in city jails and link people to services immediately post-release.
- [Tribal Access to Justice Innovation](#) provides multiple resources for both formerly incarcerated people and those working within the carceral system. They also list multiple program examples.
- Pima County, AZ, has launched a [Transition Center](#) staffed by people with lived experience that supports individuals on pretrial release from jail in navigating the legal system and meeting housing, social, and medical needs.
- The [Veterans Justice Outreach Program](#) works to identify and engage Veterans who have been involved in the legal or carceral system and to help them receive eligible Veterans' services.
- [JusticeLink](#) in Tulsa, OK, provides navigators to help recently released people navigate both the legal system and complex post-release needs, such as medical care, housing, and behavioral health supports.

Additional Resources

- [Building Second Chances: Tools for Local Reentry Coalitions](#) is a toolkit available from the US Department of Justice and the National Reentry Resource Center.
- [Four Steps to Expand Access to Housing for People in the Justice System with Behavioral Health Needs](#) is a resource developed by the Bureau of Justice Assistance and the Council of State Governments Justice Center.
- A [screening tool](#) is available from the National Reentry Resource Center to assess housing needs and risk upon return to the community from jail or prison.



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Transitions of Care from Inpatient Psychiatric Settings

June 2026

Overview: This fact sheet explores strategies to support people stepping down from inpatient psychiatric hospitalization who are also facing housing instability or homelessness. It will highlight best practices and feature a program developed by South Carolina's Office of Mental Health to support individuals during this transition.

Introduction

Transitions are often stressful. They can be especially vulnerable periods for people who are stepping down from inpatient psychiatric settings to the community and other levels of care, sometimes while also homeless. Following an inpatient psychiatric hospitalization, the risk of mortality, including by suicide and overdose, is significantly elevated.¹ Steady, coordinated support during this time is key to helping individuals work toward their goals.

The goals of inpatient psychiatric hospitalization include maintaining safety and helping to stabilize individuals in acute mental health crises. In the inpatient setting, comprehensive care can include conducting assessments, clarifying diagnoses, beginning or adjusting medications, and connecting with resources at a speed that is often not feasible in outpatient settings. During a hospital stay, meeting one's immediate needs for food and shelter is addressed, and the challenges of scheduling appointments, managing care, and arranging transportation are put on hold.

However, psychiatric hospital stays are often brief, and individuals are likely to deal with challenging ongoing conditions and situations upon discharge, including conditions that contributed to their hospitalization in the first place. Hospitalization itself can also be a source of stress, particularly when it is involuntary. Other sources of stress include separation from loved ones, pets, and possessions, as well as financial concerns such as medical bills and the inability to work. Another layer of this experience can be feelings of fear and uncertainty that

accompany navigating complicated treatment systems, which can further exacerbate mental health symptoms. The dramatic transition from the hospital's highly structured inpatient environment to the community can be difficult for people to navigate. As a result, disruptions to care may occur.

“We have to be creative, innovative, compassionate, empathetic, and non-judgmental.” —Tracy Richardson, MA, CPM, director of Transition Programs, South Carolina Office of Mental Health

While stepping down from inpatient psychiatric care is associated with risks, there are also unique opportunities to provide support. Hospitals have dedicated staff charged with comprehensive discharge planning, including connections to outpatient providers, housing, and other social services. When successful, these connections can help individuals gain stability and resources they may have lacked prior to hospitalization.

Challenges of Transitioning from Psychiatric Hospitalization to the Community

The realities of homelessness create numerous challenges for transitions in care:

Challenges

- **Financial resources:** Insufficient resources can make it difficult to carry out discharge recommendations, such as attending follow-up appointments, continuing medications, and engaging in therapy. Having limited financial resources impacts a person's ability to secure basic needs such as food, clothing, transportation, and shelter. When basic needs are not met, it is difficult for an individual to establish recommended routines for sleep, nutrition, and self-care.
- **Insurance status and type:** Insurance can dictate referral options for outpatient behavioral health care, and even with insurance, out-of-pocket costs such as copays and coinsurance can make care cost-prohibitive.
- **Medication access:** Insurance status also affects medication costs and access, and a person's living situation may make it difficult to securely store medications. In addition, side effects from medication, such as drowsiness or cognitive impairment, may cause a person to be vulnerable if they are in a congregate shelter or living on the streets.
- **Transportation:** Affordable transportation options may be limited, impacting individuals' ability to attend outpatient appointments and meet other needs.
- **Housing:** Living arrangements may be in congregate settings with sleep disruptions and limits on individual privacy, which do not offer a calm, stable environment that would support recovering

from a crisis. People with mental health diagnoses may also have challenges with staying in shelter settings and may choose or be forced to stay outside, bringing up additional concerns for safety and recovery.

- **Co-occurring disorders and complex medical needs:** Individuals who are homeless may also have complex medical and behavioral health needs. Co-occurrence of mental health, substance use, or cognitive challenges impacts access to services. Depending on where one lives, there may or may not be services available to support individuals.
- **Stigma and experiences with providers:** Past and current negative experiences with the health care system, including stigma and mistreatment due to homelessness, can also contribute to mistrust of care providers and decrease the likelihood of an individual engaging in planned care.

Addressing Barriers Through Transition Planning

While transition planning is a standard aspect of inpatient psychiatric care, with discharge planning ideally beginning shortly after admission, several elements have special importance in the context of homelessness:

- **Comprehensive assessment:** A comprehensive biopsychosocial assessment, including the individual's housing situation, employment or income, social support system, along with their mental and physical health status and history, can help identify resources that will be needed upon discharge. Assessment should include individual strengths, preferences, risks, and barriers. It is important to distinguish between ability and access during the comprehensive assessment and throughout the hospitalization; an individual may feel judged or defensive if they are asked questions in a way that suggests an inability to do something. Asking directly about access to resources (e.g., financial, caring for oneself, performing activities of daily living) will create the opportunity to collect the information necessary for a feasible discharge plan.
- **Recovery planning:** If the hospitalization was precipitated by a crisis, a [Wellness Recovery Action Plan](#) can help an individual articulate their goals for recovery and preferences should stressors recur.²
- **Housing options:** Planning includes understanding the individual's goals and preferences, along with what is available in the community and the parameters of various options (e.g., shelters, medical respite programs, and transitional or supportive housing) to find a suitable fit.
- **Treatment continuity:** Individuals should receive warm handoffs to community providers for first appointments within seven days of discharge; planned support for appointment follow-up (e.g., reminders, peer support); and a clear and complete medication list and 30-day medication supply, with support on how and where to obtain medication from pharmacies, to prevent disruptions. When appropriate, long-acting injectable medications can also be helpful, if desired by the individual, and any doses given while inpatient should be documented and shared with the receiving community care team.

- **Social supports:** Including the individual’s chosen supports, which could be family, friends, or community-based care coordinators, throughout the planning process can provide emotional support and help with identifying and mitigating barriers. Coordinating the benefits the person is eligible for, including submitting applications before discharge, is key when transitioning from inpatient care.

“Improving discharge planning requires collaboration, early engagement, and a focus on housing and income as healthcare interventions . . . Discharge planning is not just about where someone goes after the hospital—it is about building a coordinated system that supports stability, recovery, and long-term community integration.” —Corey Stubbs, MCJ, MRC, homeless services and outreach manager, Georgia Department of Behavioral Health and Developmental Disabilities

Partnering with Service Providers in the Community

In addition to centering the individual’s needs and preferences, effective transition planning requires engagement and partnership with a range of community service providers. Recognizing the strengths and resources of various partners can help planners connect individuals to appropriate support options. Strategies for effective partnerships include:

- **Collaborative agreements with other providers:** Formal or informal memorandums of understanding (MOUs) with partners foster coordination and create protocols to bridge gaps between different sectors. MOUs can define goals for collaboration, roles for each organization, referral protocols, information-sharing practices, and other aspects of supporting individuals during care transitions. Comprehensive coordination helps address a variety of needs and supports overall stability and well-being. Consider a broad range of potential collaborations, including Health Care for the Homeless (HCH) programs, community mental health centers, street medicine teams, shelters and drop-in centers, housing providers, emergency responders, and faith-based or civic organizations. Innovative programs, such as a partnership in which the local fire department provides transportation between hospitals and shelters, can help address community needs.
- **Engagement early in planning process:** Working with partners from the beginning of the planning process helps ensure referrals are appropriate for the individual and may increase the options available. Early planning helps individuals better prepare for the transition and gives service providers more time to confirm that various parts of the discharge plan are in place.

- **Referral to low-barrier services:** When possible, referral to partners with low-barrier practices can help mitigate the challenges homelessness creates for accessing traditional, appointment-based care. Low-barrier services provide continuity for individuals who may otherwise avoid care systems with rigid requirements for engaging in programs. Low-barrier programs are easy to enter and easy to stay engaged with.
- **Warm handoffs:** Patients are significantly more likely to follow up with outpatient appointments when a personal connection is made before hospital discharge, improving long-term outcomes. Direct introductions help reduce uncertainty and anxiety and provide opportunities to mitigate logistical and other barriers in advance. Treatment team meetings that include the individual, inpatient staff, and representatives from outpatient providers can facilitate personal connections. Using staff resources to support people at their initial appointments is balanced by the longer, more stable care relationships that result from the investment.
- **Shared communication and community case conferencing:** Creating shared care plans that are accessible to all service providers streamlines coordination. Information access should require individuals' consent, be limited to what is necessary for care coordination, and adhere to confidentiality protocols. Establishing routine opportunities for check-ins helps partners review people's housing and treatment plans, adjust as needed, and revise protocols based on experience. Complete release-of-information documentation as needed to coordinate care with partner organizations.

Person-Centered Care During Transitions from Psychiatric Hospitalization Program Model

Centering the needs and preferences of the individual is essential to effective support in care transitions. Person-centered care is a holistic approach built on a foundation of partnership and is tailored to the individual's needs and goals. With person-centered care, service providers in the hospital and in the community respect individuals' histories, which may include violence and mistreatment. These service providers offer support that both acknowledges the impact past experiences have on the individual's life (including emotions, thoughts, behaviors, relationships, and physical health) and takes care to not deepen their impact.

Core principles of person-centered care include the following:

- **Planning collaboratively with individuals and their chosen supports:** Person-centered care is collaborative and views individuals as the experts in their own lives. In person-centered transition planning, both the individual and the care providers are understood to have valuable information and skills to build on the person's unique strengths and support their goals. Planning may also include individuals' chosen support people as part of the process, and ongoing adjustment to the transition plan is important to incorporate new preferences or circumstances. Motivational interviewing (MI) is a person-centered counseling style that evokes and supports motivation for

change. Becoming trained in MI can be useful for care providers seeking to enhance their skills in supporting individuals' goals and respecting their autonomy.

- **Prioritizing safety in various forms:** Person-centered care emphasizes creating physical, emotional, and psychological security during both the discharge planning process and the individual's transition to the community. Comfortable, welcoming, and predictable environments, with attention to details such as lighting and accessible exits, encourage engagement and promote healing. Care providers can foster emotional and psychological safety by adopting a non-judgmental stance that allows individuals to express their thoughts and emotions without fear of shame or retribution.
- **Demonstrating trustworthiness and transparency:** Straightforward, clear communication about the discharge plan, including options for housing and other services, builds credibility and prevents unrealistic expectations. Service providers also build trust by following through on commitments made to individuals and providing timely updates on any issues with their discharge plan. Maintaining privacy and confidentiality, including sharing information only with the individual's permission, is also essential to person-centered care.
- **Supporting autonomy and choice:** While care providers undoubtedly bring expertise to transition planning, respecting the individual's understanding of the best options for themselves enhances the likelihood of follow-up and successful outcomes. It is important for hospital staff to understand the requirements of various community services and clearly communicate them to individuals so they can make informed decisions about what will work best for them. Programs, with policies that do not hinge participation on a person's willingness or desire to address their mental health and adhere to a treatment plan, can be an important part of the community's spectrum of offerings, when available. While the reality of what is available in a community will affect an individual's choices, service providers can still support an individual's autonomy by centering their goals and providing thorough information for decision-making.
- **Connecting individuals to peers with related life experience:** Throughout behavioral health treatment, including hospital discharge planning, connecting with others who have had similar experiences can be tremendously beneficial in offering hope and helping individuals feel understood and supported. Fellow individuals with a history of homelessness can help build trust and foster a feeling of belonging. This can be accomplished in a variety of ways, including having peer positions on the care team, peer-led groups to support individuals preparing for discharge, and encouraging participation in peer-led treatment modalities (e.g., therapeutic communities).

Program Highlight: South Carolina Office of Mental Health Transition Specialist Program

South Carolina's Transition Specialist Team, housed in the [Office of Mental Health](#),³ provides comprehensive discharge planning as individuals transition from psychiatric hospitalization or inpatient substance use treatment. Specialists assess the individual's needs and goals and work to match them with available



community resources. Transition specialists meet with individuals and their treatment teams, along with representatives from outpatient care providers and housing providers, in the hospital prior to discharge to facilitate effective planning.

Transition specialists use the Daily Living Activities-20 (DLA-20) functional assessment tool to identify needs and assist in treatment planning, often informing appropriate housing options. After-care appointments are set within three business days of discharge, a practice that program director Tracy Richardson calls “non-negotiable.” Entitlement specialists also help ensure individuals receive benefits they are eligible for, starting the process to restart or apply for benefits before discharge. South Carolina’s Bull Street Trust, proceeds of which benefit patients from the state’s Department of Mental Health, also helps to cover care costs if an individual discharges before benefits are approved.

Transition specialists can also refer individuals to programs like assertive community treatment (ACT) for intensive case management and peer support. The Transition Specialist Team includes peers who lead recovery groups in the hospital that support individuals as they prepare to discharge.

Ms. Richardson emphasizes the importance of relationships throughout the transition process, including involving individuals’ chosen supports: “We need to look at the individual needs of the patient.” She has this to say about building partnerships: “Part of complex discharge planning is relationship-building in the community,” along with integrating with systems such as state programs for individuals with disabilities and the carceral system.

Additional Program Examples

- [Georgia Department of Behavioral Health Homeless Services Program⁴](#)
- [King County SOUND Program⁵](#)

Additional Resources

- HHRC: [*Coordinating Systems of Care to Provide a Comprehensive Behavioral Health Crisis Response to Individuals⁶*](#)
- National Action Alliance for Suicide Prevention: [*Best Practices in Care Transitions⁷*](#)
- NHCHC: [*Innovative Approaches for Mental Health Care and Homelessness⁸*](#)
- NHCHC: [*Creating Care and Discharge Plans for People Who Are Hospitalized Toolkit⁹*](#)



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Street Medicine as a Transition of Care Strategy

June 2026

Overview: This fact sheet discusses the unique challenges and opportunities that occur when a person is discharged after being admitted to the hospital for medical concerns and the role that street medicine teams can play in supporting that transition. It will introduce best practices that hospital discharge planning teams can implement early in the discharge planning process and demonstrate how investing in street medicine as a model can improve these transitions.

Introduction

For people living unsheltered, accessing care at a hospital may be a last resort, a matter of preference, forced intervention, or the only option for receiving care for their health needs. Individuals without housing are disproportionately more likely to seek care in the emergency department compared to stably housed individuals.¹ One study showed that over 10% of people screened in the emergency room had unstable or no housing.² Regardless of the reason a person goes to the hospital, if they are admitted for any length of time, the transition back into the community can be challenging due to the loss of the stability and consistent access to food, shelter, medication, and safety that the hospital provided. During this transition, a person is moving from one system that was providing both health care and housing to a disjointed network of supports. Whether a person is discharged to a shelter, respite program, family/friends, or the streets, the disruption in the continuity of access to ongoing medical and mental health care is sizable. It requires significant coordination to sustain an ongoing recovery from the conditions that led to a person's hospitalization.

Understanding Terms Used

- **Street Medicine:** The direct delivery of health care to an unsheltered person in the exact location they are encountered (e.g., encampments, alleyways), to reduce barriers to care and increase treatment follow-through.³

Overview of Street Medicine

The model of street medicine focuses on bringing care exactly to where a person is and continuing to follow them as their housing and circumstances change. A core principle of street medicine is to “go where the people are and then go where they go.”⁴ In practice, this means the street medicine team is mobile and continually engages individuals in the locations they choose to be. This model also shifts the power dynamic that is inherent in health care. By going where the people are, the street medicine team becomes a guest in their space, and the individual has the ability to say when, if, how, and under what circumstances they would like to interact with the team. Central to the street medicine model is developing relationships and earning the individual’s trust before any health care services are offered.

Street medicine teams can vary in composition and should be built on the unique needs of the homeless community they aim to serve. Teams typically consist of a combination of:

- **Prescribing provider:** This person serves as the primary care provider and is able to treat acute and chronic health conditions on the streets.
- **Nurse and/or medical assistant:** Depending on professional training, these individuals help triage, provide wound care, offer patient education, support registration and referrals, as well as other administrative tasks to facilitate care on the streets.
- **Peer/community health worker:** This position is essential for relationship-building, street knowledge, and earning the team’s respect in the community. They are people who have shared experiences and can relate to and connect with individuals in ways the other team members cannot.

Other positions that may be on the street medicine team are:

- Mental health providers
- Psychiatrists
- Substance use specialists
- Outreach staff

Role of Street Medicine During Hospitalization and Hospital Transitions

Street medicine's goal is to provide comprehensive health care to people where they are located. While street medicine teams most commonly connect and engage with individuals in community settings, this model of care is perfectly positioned to support a person's transition from hospitalization. A street medicine team can "follow" individuals they already support into their hospitalization, providing collateral information to care teams and proactively engaging in discharge planning. They can also engage with newly referred individuals, meeting with them prior to discharge and then following them to their post-discharge location. Integral to this model of care are close coordination and communication, ideally through shared medical records of street medicine and inpatient hospital teams.

Street medicine teams:

- **Eliminate the need for scheduling site-based follow-up appointments at brick-and-mortar clinics.** These can often be difficult to schedule while an individual is hospitalized and even more difficult for someone without stable housing to attend once they are discharged. Barriers to accessing this type of health care include transportation, housing, and navigating a new health care system.
- **Provide continuity of care.** Discharge paperwork and instructions are shared directly with the street medicine team, who can collaborate on discharge needs, such as medication, durable medical equipment, and follow-up lab work or care management. Regardless of whether the street medicine team knew the individual prior to the hospitalization, they can support the hospital discharge team with identifying an appropriate place for the individual and planning for any obstacles the individual may face in that discharge process.
- **Participate in discharge planning discussions.** For individuals with established relationships with the street medicine team, the team can support their decision-making about transition options and discharge plan details if the individual invites them to the discussion.

Concerns and Opportunities

When an individual transitions from hospitalization, regardless of the reason or length of stay, there are numerous risks and opportunities for engagement. Street medicine teams are uniquely skilled to address and mitigate some of these risks, which include the following:

- **An increased risk of overdose:** Disruption in the typical patterns of a person's substance use, including a break due to hospitalization, can increase the risk of experiencing an overdose upon discharge. The risk can come from a number of sources: someone's use could have been modified during hospitalization, upon discharge, they could be in a new area and will be seeking substances from a new supplier, or they could have started a new medication in the hospital that could interact with substances. It is essential that an honest conversation about substance use and overdose risk

be discussed as a part of every hospital discharge; all people should receive naloxone for opioid overdose reversal when they return to the community.

- **Disruption in medication:** While a person is hospitalized, they have regular access to not only their medication but also the conditions under which the medications can be most successful. This includes access to food, hydration, bathroom facilities, and a safe place to rest. Upon discharge, a person with unstable or no housing may not have regular access to these resources, and they may have difficulty obtaining the medications that were prescribed upon discharge. Hospital discharges should include at least a week's supply of all medications, ideally more. It is best for these medications to be in hand at discharge rather than waiting at a pharmacy, as miscommunication, inability to travel to an unfamiliar pharmacy, and cost can be barriers to picking up medications.
- **Ongoing recuperation needs:** Hospital discharge does not indicate a complete resolution of a person's medical and mental health needs. For people without stable housing, full recuperation from their acute issue can be made more difficult without a place where they can adequately rest, or if they are in a location where access to running water, food, safety, and security are not consistent. This can prolong or inhibit the individual's ability to fully recover.

Street Medicine as a Transition Care Team

Returning to the street or an unstable housing situation can be extremely stressful for a person, especially as they are recovering from an acute medical need. Street medicine offers a unique opportunity to support a person through this transition and can be highly effective in preventing hospital readmission due to incomplete recuperation. The unique strengths brought by street medicine teams include the following:

- **Expertise in both health care and homeless services:** Street medicine teams are skilled healthcare providers and are also well-versed in their local homeless services system, which includes meal programs, shelters, and housing navigation. Because they work at this intersection of systems, they are able to support a person's health care needs during the transition from hospitalization to reentry into the homeless services system.
- **Shared medical knowledge:** Unlike traditional outreach teams, street medicine teams include medically trained providers who speak the same language as the hospital staff. This eases the individual's responsibility to fully understand all follow-up steps and makes it easier on hospital staff, who can feel more confident that the discharge plans were understood.
- **Mobility:** Street medicine teams are able to meet with an individual prior to discharge and then follow them through any step-down process to their final discharge location, including a transitional stay in medical respite. This flexibility and adaptability are different than traditional health care models that require individuals to come to specific locations on set dates and times.
- **Not time-limited:** Street medicine teams do not have a fixed amount of time they are able to work with someone, nor are they forced to terminate their relationships when a person's housing or

health status changes. This allows a person to receive ongoing care at the location of their choosing, which can support their overall health goals.

- **Knowledge and respect of the community:** Street medicine teams spend their time building relationships and earning the trust of the community of homeless people. They work hard to earn the respect and credibility that will allow them to better serve people and make it more likely that someone will accept care when it is offered.

Hospital-Street Medicine Partnerships

Communities that already have street medicine teams are perfectly positioned to build relationships between them and the community's hospital systems. These relationships often start when shared patients are identified, but can occur before then. To support the transition, hospital care and discharge teams can engage in several steps while a person is hospitalized. These include the following:

- **HOUSED BEDS Screening⁵:** This acronym ("HOUSED BEDS") will help the hospital staff identify the housing status of the individual prior to hospitalization, as well as essential factors that should be used to inform their discharge plan.
- **Communication and warm handoff with street medicine teams:** When a person who is living unsheltered is hospitalized, street medicine should be a first consideration to support the individual. Assessing for interest in engaging with a street medicine team early in a hospitalization, even if it is just an emergency room visit, can allow time to facilitate a warm handoff between the hospital and the street medicine team. This open line of communication will also help ensure that reasonable discharge plans are created and prevent delays in necessary follow-up care upon discharge.
- **Medication reconciliation before discharge:** Medications are often introduced and modified during a hospitalization. This new routine can be overwhelming, and sometimes unsustainable, upon discharge. Collaboration between the individual, the hospital staff, and the street medicine team can identify what a reasonable medication plan upon discharge is, and the street medicine team can support the acquisition of these medicines so there is not a lapse in care upon discharge.
- **Shared access to medical records:** Sometimes, street medicine teams have shared access to medical records, which greatly supports a successful discharge. This access is often read-only, but it allows street medicine providers to understand the events of a hospitalization that patients may not be able to summarize easily. Even without this access, when hospitals can direct discharge instructions to the street medicine team, it eliminates the team's significant administrative burden of tracking down recent labs and completing medication reconciliation. It can also be very helpful in supporting continuity of care for someone who does not have a full understanding of why they were hospitalized, any studies or procedures completed, or what things were worked on while they were there.

Potential Limitations

Although street medicine teams might always be the preferred transition plan, each team will have a finite capacity to accept referrals and may be limited by geographic location and hours of operation. Street medicine teams can help hospital discharge teams to strategize resources and locations that could support the individual, even if the person will not be working directly with the street medicine team. An eligibility criterion may also be developed between the hospital and the street medicine team to prioritize those who require the level of support and flexibility offered by a street medicine team.

“We would love to be able to educate all hospital social workers on our services, but my biggest concern is that we do not have the capacity for all of those referrals. I don’t want to raise the expectations and then not be able to meet them,” —Beth Rittenhouse-Dhesi, Director of Community Services at San Francisco Community Clinic Consortium

How to Start a Partnership Between Hospitals and Street Medicine Teams

Partnerships between street medicine teams and hospitals can exist at the individual level, between organizational employees, or at the systems level in a more formalized way. Often, these partnerships are started because of shared patients, and the hospital and street medicine program staff become familiar with each other.

In order for these partnerships to exist, there needs to be investment by the community, including hospital partners, in creating and then sustaining street medicine teams. Communities that invest in street medicine can have highly responsive teams that readily adapt to the changing needs of people living in unsheltered environments. In some communities, hospitals have developed their own street medicine teams, while others seek funding to create them—even in areas where there are no health centers specializing in homeless health care. Addressing continuity of care challenges can reduce the likelihood that a person will have to be readmitted to the hospital for the same condition.

Key Strategies from the Field

Although there is no formal partnership between their street medicine team and the local community hospital, the San Francisco Community Clinic Consortium has supported specific patients during their transition from hospital to community. They have found these components critical to their success:

- **Shared communication:** Having secure ways to share all necessary patient information (e.g., email and/or shared medical record access), including name, date of birth, locations, diagnoses, and medications. This information is invaluable, especially if a warm hand-off is not possible.
- **Identified points of contact:** Have identified points of contact for both the hospital and street medicine team to ensure the information is received.
- **Consent before discharge:** Receiving consent from the individual to refer them to the street medicine team allows the two programs to communicate with one another even after they have been discharged.
- **Triage the level of need:** While a street medicine team is a great resource for any person who is unstably housed, the realities of limited capacity make it important for triage to occur to identify those patients who will likely be readmitted to the hospital without the support of a street medicine team. This consult can be conducted by hospital staff in collaboration with street medicine providers. This can also yield valuable information on need vs. capacity, which can provide data to support expanding street medicine resources.

Program Examples

Street Medicine Program, Los Angeles, CA

The [University of Southern California \(USC\) Street Medicine program](#)⁶ has multiple robust street medicine teams providing comprehensive primary and behavioral health care to people living on the streets. [They conducted a study](#)⁷ of the 206 inpatient consultations for unsheltered homeless individuals they provided over a 12-month period. The results showed that after one year, there were positive effects on post-discharge follow-up rates, patient experience, and acute care utilization.

Inpatient Consult Teams, Chicago, IL

Two programs in Chicago are using an innovative, inpatient consultant model to support people living in unsheltered environments who are hospitalized. Theresa Nguyen, MD, at [Loyola University Chicago Stritch School of Medicine](#),⁸ and Stephan Koruba, NP, at the [University of Illinois College of Medicine Rockford](#),⁹ lead programs that utilize medical students who are doing a two-to-four week rotation on the consult team. In this model, hospital staff identify individuals who have been admitted to the hospital and lack housing stability and refer them to the team. The team meets with individuals, conducts rounds on them while they are in the hospital, and serves as a bridge to community services, including street medicine programs and medical respite care.

“The goal of the program is to bridge the gaps in care the best we can, but also to help providers in the hospital understand the complexities of . . . homelessness.” —Dr. Theresa Nguyen, Loyola University Chicago Stritch School of Medicine

The inpatient consultation model allows individuals who are homeless to be seen by providers who are trained to consider some of the unique challenges a person might face when they are transitioning back to an unstable housing situation. Both Loyola and the University of Illinois team use the [HOUSED BEDS](#)¹⁰ tool to collect essential information to support their care plan development. Consult team members are not only familiar with community-based resources but also have developed relationships and lines of communication with these programs, which enable them to facilitate a warm handoff when a person leaves the hospital. Both organizations also have street medicine teams that can assist with following up with patients after discharge: University of Illinois’s [street medicine team](#)¹¹ goes to a variety of locations across Chicago, and Loyola University [offers a weekly clinic](#)¹² at a nearby Chicago Transit Authority (CTA) train station.

Additional Resources

- HHRC webinar: [Street Medicine for Unsheltered Individuals: Serving People Where They Are](#)¹³
- California Health Care Foundation (CHCF): [Street Medicine: A Critical Pathway for Behavioral Health in California](#)¹⁴



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