



# **2017 HOSPITAL HOMELESS COUNT**

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## **RESULTS AND REPORT**

PREPARED BY THE BRONX HEALTH & HOUSING CONSORTIUM, INC.  
April 2017, Revised July 1017

## ABOUT THE BRONX HEALTH & HOUSING CONSORTIUM, INC.

The Bronx Health & Housing Consortium, Inc. (“the Consortium”) organized in 2011 as a collaborative network of health, housing, social service, government agencies and the four main Bronx Health Homes with the shared goal of streamlining client access to quality health care and housing in the Bronx. Since that time we have expanded our work to more hospitals, housing organizations, Managed Care Organizations and Performing Provider Systems. The Consortium achieves its mission through research, advocacy, training, and supporting collaboration among its more than 50 member organizations.

One of ways the Consortium works to better understand the extent and needs of homeless people is through an annual **hospital** homeless count it organizes alongside the official NYC Homeless Outreach Population Estimate (HOPE) count. This is the fourth hospital homeless count that the Consortium has conducted in the Bronx and the first year to include hospitals in Manhattan, Brooklyn, and Queens. Please refer to our website ([www.bxconsortium.org/hospital-homeless-count](http://www.bxconsortium.org/hospital-homeless-count)) for past (2014, 2015, 2016) reports. This report shares the results and analysis of the 2017 hospital homeless count, which took place on February 6-7, 2017 during the hours between midnight and 4 a.m.

## ACKNOWLEDGEMENTS

The Bronx Health & Housing Consortium wishes to acknowledge the hospitals that participated in this count:

### Bronx Hospitals:

*Bronx-Lebanon Hospital Center: Concourse and Fulton Divisions*

*Montefiore Medical Center: Moses, Wakefield, and Weiler Divisions*

*New York City Health + Hospitals: Lincoln, Jacobi, and North Central Bronx*

*St. Barnabas Hospital Health System*

### Other Borough Hospitals:

*Interfaith Medical Center*

*Jamaica Hospital Medical Center*

*New York City Health + Hospitals: Metropolitan, Coney Island, Harlem, Woodhull and Bellevue*

*NYU Lutheran Medical Center*

The Consortium extends particular thanks to the organizations that helped organize the count and those which provided the volunteers who worked into the early morning to conduct this count. Special thanks to BronxWorks for organizing and training the volunteers:

*BronxWorks: Adult Homeless Services, HomeBase, and the Department of Supportive Housing & Health Policy*

*Geel Community Services*

*Montefiore Medical Center: Housing at Risk Program*

*New York Legal Assistance Group (NYLAG)*

*HELP USA*

*NYU Medical Students*

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## BACKGROUND

With the growth of homelessness in New York City, the implementation of healthcare reform, and the establishment of Health Homes and the Delivery System Reform Incentive Payment program (DSRIP) to focus on high cost Medicaid populations, it is apparent that homeless and unstably housed populations are a significant driver of hospital-based health care utilization. This increased utilization results in high Medicaid costs due to a lack of integrated, coordinated services – including stable housing.

Consequently, the Consortium has been involved in several research projects to better understand the unstably housed/homeless population that our member organizations collectively serve. Only by counting and questioning can we understand and address the needs of both the population and the organizations that serve them.

On the night of February 6<sup>th</sup>, 2017, the annual Homeless Outreach Population Estimate (HOPE) count took place in New York City. This event, facilitated by the NYC Department of Homeless Services (DHS), consists of an outdoor/street and subway count between midnight and 4am throughout the five boroughs and MTA system to identify homeless individuals.

Through collaboration between the DHS and the Consortium, six Bronx hospitals on nine sites worked to identify and count homeless people in their respective Emergency Departments (EDs). These patients can be considered the “hidden homeless” because they are indoors and not subject to being counted during HOPE. In addition, eight hospitals in other boroughs joined the Consortium in this count because they, too, want to better understand this population and how they may address their needs.

On the night of the HOPE count, these hospitals allowed our 34 volunteers, comprised mostly of licensed social workers, to conduct the DHS-designed homeless count. The following Bronx hospitals agreed to participate in this study: St. Barnabas Hospital, Bronx Lebanon Hospital Center (Grand Concourse and Fulton Divisions), NYC Health + Hospitals (Lincoln, North Central Bronx, and Jacobi), and Montefiore Medical Center (Weiler, Wakefield, and Moses Divisions). The hospitals in other boroughs that also participated were Jamaica Hospital Medical Center, Interfaith Medical Center, NYU Lutheran Medical Center, and NYC Health + Hospitals (Bellevue, Harlem, Metropolitan, Coney Island, and Woodhull.)

Every year, DHS asks the Greater New York Hospital Association (GNYHA) to have its member hospitals administer surveys in their emergency departments and categorize people into three groups: those registered for care in the ED who report being unsheltered, those registered for care in the ED who report living in a shelter, and those not registered for care in the ED. The Consortium followed these same rules and our volunteers also collected additional information related to household demographics and health resource utilization through a questionnaire developed by the Consortium.

Our findings and analysis follow. As the Consortium is a Bronx-based organization, we provide additional analysis for our findings in the Bronx in addition to our total findings across the four participating boroughs.

## HIGHLIGHTS OF FINDINGS

### Hospital Homeless Count Data - Total

- 131 homeless people were identified in the 17 hospital EDs at a single point in time on the night of February 6<sup>th</sup>, 2017. 88 (67%) of these were people who registered to receive medical care, of whom 58 (66%) identified as unsheltered homeless and 30 (34%) reported living in a shelter. The remaining 43 (33%) were found in the ED waiting rooms or hallways usually sleeping, but had not registered to receive medical care. We assume that those who identified themselves as unsheltered and those who did not register were the homeless population that the street HOPE count essentially missed. They represent 101 (77%) of the 131 people identified that night in these hospitals.
- Of the 101 homeless people (unsheltered registered and unregistered), 75% were male.
- For the total 131 people identified that night, over half (53%) were found in St. Barnabas, Bellevue, Harlem and Interfaith hospitals. The total list is as follows:

<b>Hospital</b>	<b># Homeless</b>
St Barnabas	24
Bellevue	19
Harlem	14
Interfaith	13
Montefiore (3 locations)	12
Metropolitan	10
Lincoln	9
Coney Island	6
Woodhull	6
Bronx Lebanon (2 locations)	5
North Central Bronx	4
Lutheran	4
Jamaica	3
Jacobi	2
<b>TOTAL</b>	<b>131</b>

Shaded are Bronx Hospitals

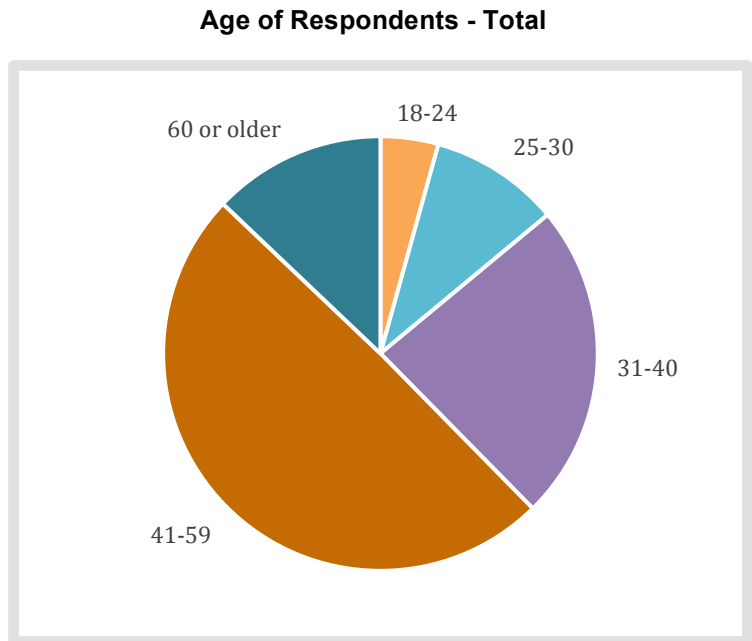
### Hospital Homeless Count Data - Bronx

- 56 homeless people were identified in the nine Bronx sites. 26 (46%) of these were people who registered to receive medical care, of whom 15 (58%) identified as unsheltered homeless and 11 (42%) reported living in a shelter. The remaining 30 (54%) were found in the ED waiting room or hallways but had not registered to receive medical care. We assume that those who identified themselves as unsheltered and those who did not register were street homeless missed by the HOPE count.
- Of the total homeless people identified, 71% were male.
- Almost half (43%) of the total people responding to this survey in the Bronx were found in St Barnabas hospital.

## Additional Data

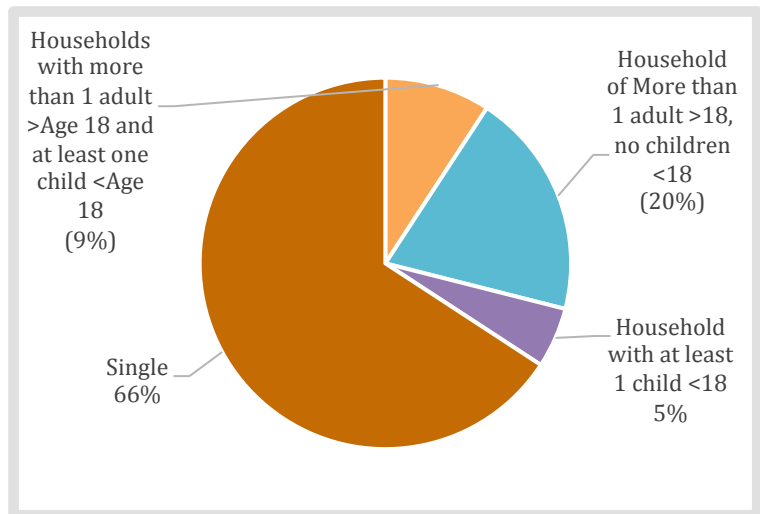
- In addition to the DHS questions, 131 people participated in the Consortium’s survey, completing at least some of the additional questions<sup>1</sup>. The following is a profile of those who completed the questionnaire:

- *Age - Total (n=93)*: The age group that comprised the highest number of homeless people was those aged 41-59 years old (49%), followed by 31-40 year old adults (24%), Seniors over 60 years of age (13%), those aged 25-30 years (9%) and finally people under 25 (5%)



- *Age - Bronx (n=31)*: Those aged 41-59 years old comprised the highest number of homeless people (45%), followed by 31-40 year old adults (23%), Seniors over 60 years of age (13%), those aged 25-30 years (16%), and people under 25 years of age accounted for 3% of respondents. Overall, Bronx respondents were slightly younger than the total, especially those 18 to 30.

**Household Composition - Total**

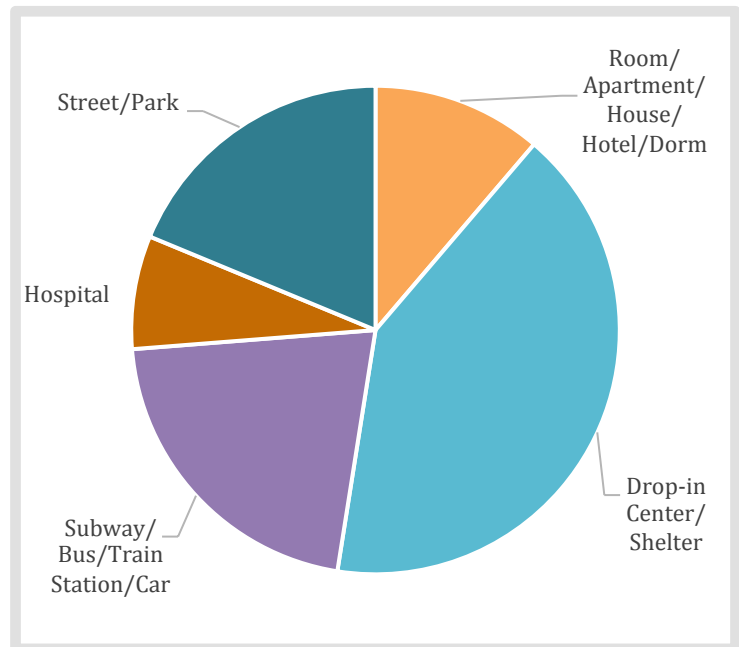


- *Household Composition - Total (n=76)*: 50 (66%) identified as single, 15 (20%) have at least one adult over the age of 18 and no children under 18 living with them, 4 (5%) households reported having at least one child under 18 and no other adults over 18, and 7 (9%) have at least one other adult over 18 and one or more children under 18

- *Household Composition - Bronx (n=25)*: 13 (52%) identified as single, 4 (16%) have at least one adult over the age of 18 and no children under 18 living with them, two (8%) reported having at least one child under the age of 18 and no other adults over 18 as part of their household, and six (24%) have at least one other adult over 18 and one or more children under 18 in their household. The Bronx group had significantly<sup>1</sup> more families with adults and children than the other boroughs.

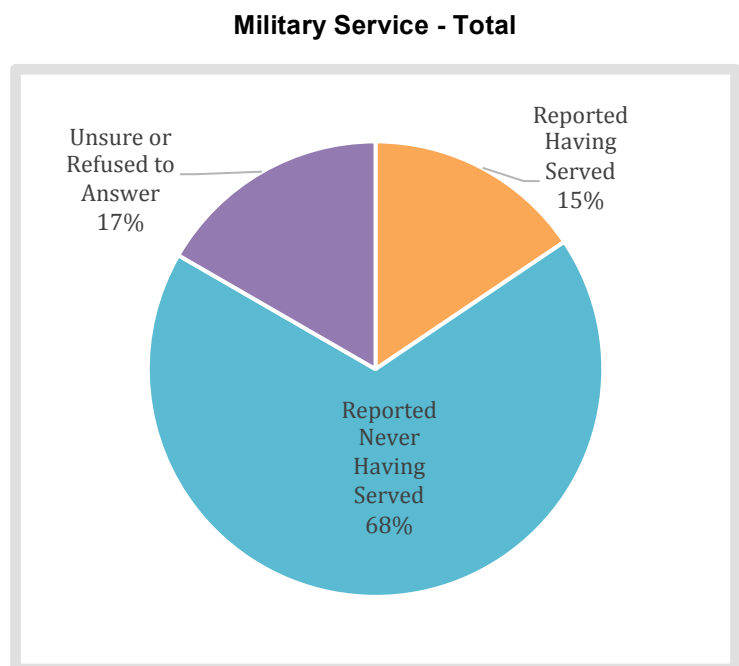
<sup>1</sup> As with the DHS HOPE Count, surveyors were instructed not to wake up individuals who were sleeping and others may have refused to participate for some or all of the additional questionnaire. In these cases, the surveyor was asked to make a judgment if the individual appeared to be homeless.

- *Usual Housing - Total (n=83)*: When asked about their current living situation, 17 (20%) reported staying in a subway, bus, train station, or car; 16 (19%) on the street or in a park; 6 (7%) in a hospital; five (6%) in a room, apartment, house, hotel, or dorm; and 31 (37%) in a drop-in center or shelter. It seems from this data that some people who consider themselves without a usual place to live and basically unsheltered include people who sometimes stay with friends or in a dorm situation.



- *Usual Housing - Bronx (n=32)*: When asked about their current living situation, five (16%) reported staying in a subway, bus, train station, or car; five (16%) on the street or in a park, four (13%) in a hospital; one (3%) in a room, apartment, house, hotel, or dorm; and 14 (44%) in a drop-in center or shelter. Compared to the total respondents, the Bronx had significantly<sup>2</sup> more people living in shelters and hospitals and fewer on the street and in apartment/hotel/rooms—57% vs 44%.

- *Military Service - Total (n=90)*: 14 (16%) reported having served in the United States Armed Forces, 61 (68%) reported never having served, and 15 (17%) were unsure or refused to answer.

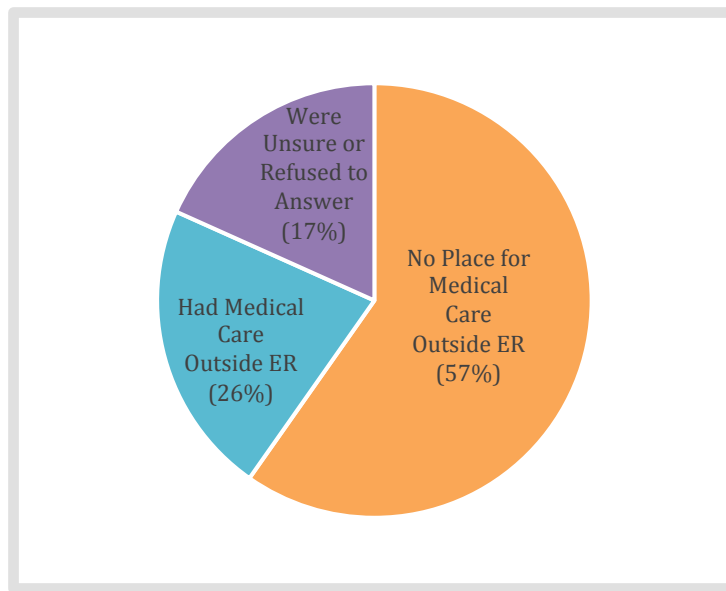


- *Military Service - Bronx (n=33)*: four (12%) reported having served in the United States Armed Forces, 23 (70%) reported never having served, and six (18%) were unsure or refused to answer. This is a similar profile of Armed Forces service among the total population surveyed.

<sup>2</sup> The sample size is too small to apply tests for statistical significance

- *Connection to medical care outside of the ER - Total (n=82):* 49 (57%) reported they do not have a place they receive medical care other than the ER; 18 (26%) reported that they do receive medical care somewhere other than the ER, and 15 (17%) were unsure or refused to answer.
- *Connection to medical care outside of the ER - Bronx (n=29):* 14 (48%) reported they do not have a place they receive medical care other than the ER, nine (31%) reported that they do have a doctor they see, and six (18%) were unsure or refused to answer. A higher proportion of Bronx respondents reported having medical care outside the ED compared to the other boroughs.

**Connection to Medical Care Outside the ER - Total**



- *Emergency Department Utilization - Total (n=70):* Almost all of the individuals who responded to this question reported having previous emergency department visits in the previous year. In total, four (6%) survey respondents reported that they go to the ED 365 days/year or in other words, spend every night in the hospital ED or waiting areas.

ED Visits in the Last 12 Months	Bronx-Percent of Respondents (N=23)	Total-Percent of Respondents (N=70)
0	1 (4%)	2 (3%)
1-4	11 (48%)	26 (37%)
5-9	3 (13%)	10 (14%)
10-19	3 (13%)	11 (16%)
20-99	3 (13%)	14 (20%)
100+	2 (9%)	7 (10%)



## ANALYSIS OF FINDINGS

This is The Bronx Health & Housing Consortium’s fourth consecutive year organizing and conducting a hospital homeless count in Bronx hospitals. This year we were able to add several non-Bronx hospitals to our analysis because more hospitals have noted more homeless people in their EDs and want to better understand this population to ensure that they are captured in a more accurate DHS HOPE count and appropriately supported. Of course most of these people are also in need of medical care and hospitals need to find ways to engage them while in the ED.

Comparable data for the last three Hospital Homeless Counts in the Bronx show the following:

<b>BRONX HOMELESS COUNT</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
<b>DHS HOPE Count Total</b>	<b>69<sup>3</sup></b>	<b>43<sup>4</sup></b>	<b>255</b>
<b>Hospital Count Total</b>	<b>120</b>	<b>89</b>	<b>56</b>
Unsheltered homeless-registered for care	28	22	15
Living in a shelter-registered for care	26	2	11
Not registered for care	66	65	30

Whereas the overall NYC increase in street homeless was 39%, the Bronx increase was 493% over last year. We now assume that this increase may be due to an undercount in 2016, based on the experience in the rest of the City. The count in 2016 was postponed twice due to cold and snow. Each postponement decreases the number of volunteers available and it may be that this situation affected the accuracy of the 2016 street count. It may also be the result of more homeless people relocating in the Bronx as other parts of the City are gentrified.

In total, 311 people were found in the Bronx on HOPE night 2017, either on the street or in hospital EDs. By including Bronx hospital EDs in the count, the total number of homeless people identified was 22% higher than the street count alone. If we extrapolate this percentage increase to the City, it would mean a total count of 4,748 rather than 3,892. What is certain is the need for more housing for this population, which we will discuss later in the report.

In 2015 and 2016, the Bronx hospital ED homeless counts were higher than the DHS HOPE count. The 2014 Consortium Hospital Homeless Count focused on inpatients, so a comparison for that year is not available. We think that the ED counts were higher than the street counts in 2015 and 2016 largely due to the fact that those years’ counts were conducted during ‘Code Blue’ nights when the temperature was under the freezing point. Anecdotally, homeless people we have spoken with have told us that they tend to use hospitals as shelters when it is too cold to sleep

<sup>3</sup> This is the number of people identified in “surface areas” in the Bronx in 2015, with another 1,976 individual identified on subways systems, which are not attributed to borough.

<sup>4</sup> This is the number of people identified in “surface areas” in the Bronx in 2016, with another 1,573 individuals identified on subways systems, which are not attributed to borough.

outdoors. Moreover, during Code Blue nights the City (via outreach teams, police, and others) urges people to move indoors and will often transport people to a drop-in center or hospital, if needed. In addition, hospitals are instructed that they are required to allow homeless people to sleep in their waiting rooms or lobbies during Code Blue nights, in contrast to other nights when people can be “kicked out” of the hospital waiting rooms. This is one reason the Consortium has continued to urge DHS to include hospital waiting rooms in its official HOPE count.

Since the DHS street count was so much higher in 2017, we hypothesize that the weather may play a major role—some homeless people go to hospital EDs when the weather is severely cold and do not when it is warmer. This means that it is likely that some proportion of people unregistered for care on colder HOPE nights would have been sleeping on the street and counted in the official HOPE numbers if the temperature had been warmer. The temperature in 2017 was warmer—43 degrees at midnight<sup>5</sup>—which may explain the lower total number in hospitals that night and higher number on the street. In any case, it is the same group of people and they need to be counted wherever they are—in EDs or the streets. The HUD HOPE guidelines<sup>6</sup> include the need to count people in “emergency rooms if the persons are not being admitted or seeking overnight care.”

Another interesting finding is that the proportion of people in each of the three different categories captured in the hospital homeless count varied significantly from hospital to hospital. This could mean that hospitals are addressing this population differently. For example, some may be more aggressive about registering everyone for care and examining them, even if they are only there to sleep. This is critically important because homeless people are often in need of medical care, even if that was not their primary reason for coming to the hospital. Some hospitals may decide to allow people who do not choose to register for care to just sleep, as long as they do not disturb others. Others may ask people who are not registered for care to leave the hospital. We have anecdotally heard about each of these scenarios.

The following table shows the variation for the Bronx versus all participating hospitals. In particular, Bronx hospitals had a much larger percentage of people who were unregistered for care than the other borough hospitals.

**Bronx Health & Housing Consortium Hospital Homeless Count Data 2017**

	Unsheltered Homeless registered in ED		Sheltered Homeless registered in ED		Homeless not registered in ED	
	Number	Percentage	Number	Percentage	Number	Percentage
Bronx Hospitals	15	27%	11	20%	30	54%
Non-Bronx Participating Hospitals	43	57%	19	25%	13	17%
<b>Overall Total</b>	<b>58</b>	<b>44%</b>	<b>30</b>	<b>23%</b>	<b>43</b>	<b>33%</b>

<sup>5</sup> [https://www.wunderground.com/history/airport/KJRB/2017/2/6/DailyHistory.html?req\\_city=&req\\_state=&req\\_statename=&req\\_db.zip=&reqdb.magic=&reqdb.wmo=](https://www.wunderground.com/history/airport/KJRB/2017/2/6/DailyHistory.html?req_city=&req_state=&req_statename=&req_db.zip=&reqdb.magic=&reqdb.wmo=)

<sup>6</sup> <https://www.hudexchange.info/resources/documents/PIT-Count-Methodology-Guide.pdf>

During this count, many of the volunteers had access only to the ED waiting areas. A few were able to access the ED itself and interview some patients there. These volunteers were able to identify some homeless people in the treatment areas, so we assume that access to these areas in all participating hospitals would have produced higher numbers.

The Consortium conducted this hospital count not only to get a more accurate estimate of the unsheltered homeless population in the Bronx and elsewhere, but also to better understand the implications of homelessness on the healthcare system. Among the individuals who responded to questions about connections to medical care (n=82), only 22% in total reported having a place outside of the ED where they received medical care. Of those who responded to the question about previous ED visits (n=70), 97% of all individuals reported having had at least one other ED visit in the previous year.

Of the Bronx participants who responded to these questions, only 30% reported a connection to medical care outside the ED and 96% had at least one other ED visit in the previous year. We note that our sampling strategy (a point-in-time count in the ED) biases toward people who use the ED more frequently and also that other studies have found different findings about homeless ED patients lacking other sources of health care. Nonetheless, our findings illustrate how the complex concurrent medical and social needs of people who are homeless play out in high frequency ED use. We also note that some homeless people are not part of the shelter system and may be unknown to DHS and therefore not receiving the housing support they need.

Of all hospitals we surveyed that night, the hospital with the highest number of homeless people found was St. Barnabas hospital in the Bronx. Partly as a result of the Consortium's hospital homeless counts in previous years and its own analysis of patients who are high utilizers of the ED, St. Barnabas has developed a strong relationship with the BronxWorks Homeless Outreach Team. The outreach team visits the hospital every night and works to bring people into the shelter system or drop-in center to begin the process of finding housing. We know from the outreach team that this approach has been successful and strongly recommend that more resources be provided to hospitals with high homeless numbers and borough outreach teams to be able to cultivate these relationships on a larger scale.

## CONCLUSIONS

For the third year in a row, The Bronx Health & Housing Consortium discovered a significant group of “hidden homeless” individuals in emergency departments who are not traditionally counted in the annual DHS HOPE Count. Nearly all of these individuals had multiple visits to the emergency department and many did not have a regular place other than the ED where they received care. We continue to urge DHS to work more closely with hospitals as part of their outreach service.

Acknowledging this “hidden homeless” population is significant for several reasons. First, without including hospital emergency departments in the annual HOPE Count, the number of homeless people identified in NYC may be *significantly* underestimated. From our count in 2014, we also know that there are people in inpatient wards who are also homeless, although they are not considered so by DHS. Without a place to go, they cannot be safely discharged from any hospital. Second, since Safe Haven beds for homeless individuals are directly allocated based on the annual DHS HOPE count results, this underestimation results in underfunding and under-resourcing services for homeless people. Third, we are missing out on a crucial point of engagement in homelessness intervention by not working with and involving hospitals more. We know that hospitals are reaching a large number of homeless people due to their medical and behavioral health needs as well as serving as de facto shelters for a significant number of people. Therefore outreach efforts to locate and work with homeless people need to include most if not all NYC hospitals to address both health and housing needs.

This inclusion of hospitals as partners in the homeless services system cannot be limited to the public hospitals. If we compare New York City Health + Hospitals (H+H) public hospitals to the others in the sample, H+H had an average of nine homeless people that night and non-H+H had an average of 10. Clearly efforts to identify and intervene to work with homeless people in hospitals need to include *all* hospitals in NYC.

Furthermore, homeless individuals tend to be transient and difficult to engage when on the street. To overcome this challenge, we believe the hospital is an advantageous place for intervention. When people enter the hospital, there is a better opportunity to engage with them when they are safe. Better coordination between borough-based homeless outreach teams and hospitals is important.

We also know that there are a number of people in hospitals who cannot be discharged because they have no home, inappropriate homes (e.g. buildings with flights of stairs for those with severe heart disease, COPD, or physical disability) and are too sick to go to shelters. We need to move this population from their expensive and unstable housing in hospitals to specialized shelters or respite services and, eventually, appropriate permanent housing. We believe that close collaboration between hospitals, outreach workers, and shelters to target these populations will ensure rapid and stable housing for those in need and prevent avoidable hospital utilization.

We also note that, compared to the citywide total, the Bronx had a significantly higher proportion of people with households larger than themselves. This is important to note because there is a real shortage of permanent housing for homeless families. These units are necessary to keep families stably housed. Homeless households are often split up in the housing search, then when reunited they are evicted because the real household size is larger than the one on record.

We conclude that additional housing outreach resources should be allocated to hospitals that serve large numbers of homeless patients to obtain stable housing for these individuals, especially those who are frequent emergency department users. Without stable housing, many of these individuals will be unable to appropriately address their medical conditions and will most likely return to hospitals for further medical attention. They may never or rarely touch the DHS shelter system, as the shelter system is not available to homeless people who are ill and do not meet the screening criteria<sup>7</sup> for admission to shelter. For all of these reasons, hospitals are key locations to reach this population.

There is clear need for: 1) stronger Hospital-to-Home programs to support high public resource utilizers and link them to housing and community-based health care and 2) more post-hospital medical/respite services with clear links to supportive, transitional and other housing. These steps are necessary to reduce utilization of EDs both for homeless patients' medical and behavioral health needs, and also as a provider of shelter. Health and housing organizations must work more closely with each other and with government agencies to identify and support this population's health and housing needs. Although there are many organizations that work with this population, we find that they are not always well coordinated, not adequately resourced, and not able to provide needed housing. The results of the Consortium's Hospital Homeless Count confirm that this need continues to be real and important.

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<sup>7</sup> [https://www1.nyc.gov/assets/dhs/downloads/pdf/061410\\_dhs\\_form\\_1\\_screening\\_form.pdf](https://www1.nyc.gov/assets/dhs/downloads/pdf/061410_dhs_form_1_screening_form.pdf)

## NEXT STEPS

The Bronx Health & Housing Consortium's Hospital Homeless Count continues to show a high number of homeless individuals found in hospital emergency departments and waiting rooms on the night of the annual DHS HOPE Count. We have been successful in adding non-Bronx hospitals to our efforts and will continue to reach out to more hospitals next year. While we continue to share the data from these counts with DHS, it is unclear whether and how DHS is including these numbers in its official count and how this information is being used.

The Consortium advocates the need to count people in medical and psychiatric emergency departments and inpatient wards on HOPE night throughout the City. This count is necessary to obtain a more accurate count of homeless individuals and provide greater understanding about the implications of homelessness on the healthcare system. The Consortium has shown over the past four years that hospital staff and community partners can be engaged to assist in the count. Interest is growing as hospitals are increasingly pressured to serve only people who require hospital-level care. Particularly with the goals of Medicaid Redesign and DSRIP in mind, it is recommended that hospitals utilize patient navigators and/or health home care coordinators and work with homeless outreach teams to connect these individuals to care and to the appropriate housing or shelter for their needs.

There is a model in the Bronx for cooperative relationships between hospitals and the homeless outreach team that can be replicated in the other boroughs. These outreach teams can be a resource to hospitals by working with patients who are very sick and frequent utilizers of hospital systems on a path to appropriate housing for their needs. Likewise, hospitals can be a source of information and coordinated treatment or discharge plans for outreach teams whose clients frequent those hospitals for emergency and inpatient care. From the example of the Bronx, there is eagerness from both hospital and homeless outreach staff, to have collaborative relationships.

Finally, there needs to be a recognition and response at the City and State level to provide housing for this population of people who cycle in and out of the hospital, some of who may be well enough to leave the hospital but too sick to be able to stay in NYC shelters. There needs to be an increase in existing housing options and development of new types of housing, including medical respite programs, for this specific population, which is currently left out of the existing housing stock.