July 2019

2019 Hospital Homeless Count

Results and Report

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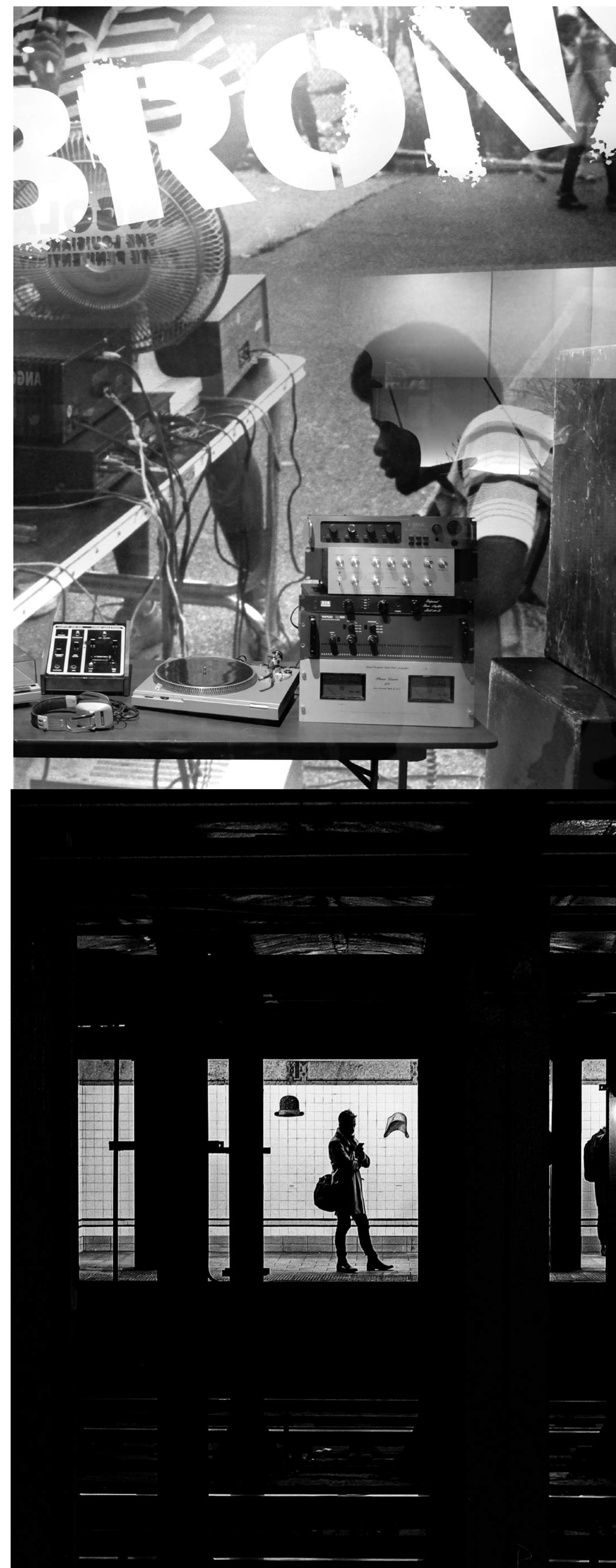
ABOUT THE BRONX HEALTH & HOUSING CONSORTIUM

The Bronx Health & Housing Consortium ("the Consortium") organized in 2011 as a collaborative network of health, housing, social service, and government agencies with the shared goal of streamlining 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 70 member organizations.



One of the ways the Consortium works to better understand and publicize the full extent of homelessness in New York City is by implementing an annual **hospital** homeless count alongside the Homeless Outreach Population Estimate (HOPE) count, the City's federally-mandated annual census of people experiencing street homelessness.

This year marks the sixth hospital homeless count that the Consortium has conducted in the Bronx and the third year that hospitals across the City have joined us. Please refer to our website (www.bxconsortium.org/hospital-homeless-count) for past reports from 2014 through 2018. The following report shares the results and analysis of the 2019 Hospital Homeless Count, which took place on January 29, 2019, between the hours of midnight and 4 a.m.

BACKGROUND

With the growth of homelessness in New York City, the implementation of healthcare reform, innovations in health systems design and payment structures, and Medicaid redesign in New York State to focus on high-cost Medicaid populations, homeless and unstably housed populations continue to have higher than average hospital-based health care utilization. For a small group of hospital "frequent users", factors such as a lack of integrated, coordinated services and particularly a lack of stable housing result in high Medicaid costs.

Consequently, the Consortium has been involved in several research projects to better understand the unstably housed/homeless population that our member organizations collectively serve. The Hospital Homeless Count is one way we begin to measure the full scope of homelessness in New York City, recognizing that hospitals are a place homeless people frequent, whether for medical care, shelter, or both. While this research began in the Bronx, it has expanded to Manhattan, Brooklyn, and Queens as hospitals in these boroughs also want to learn how to better address this population's needs. Only by counting, questioning, and collaborating can we understand and address the needs of people experiencing homelessness and the systems that serve them. For this reason, the Consortium has urged the City to include hospital emergency rooms in the annual HOPE Count. Until they do so, the Consortium will continue to conduct this independent Hospital Homeless Count in order to draw attention to the "hidden" population of people experiencing homelessness in New York City hospitals, who are missed by the City's HOPE Count and who may not be engaged in services to obtain housing.

Methodology

The U.S. Department of Housing and Urban Development (HUD), authorized by the McKinney-Vento Homeless Assistance Act, requires Continuums of Care (CoC)[1] to conduct Point-in-Time (PIT) counts of sheltered and unsheltered homeless people. In 2014, HUD published a Point-in-Time Count Methodology Guide to provide standards and guidelines to CoCs, concerning acceptable methodologies and approaches to conducting PIT counts of homeless people. In this guide, HUD lists hospital emergency rooms as known locations where homeless people might be found as well as provides the following guidance for counting people in hospitals:

> "Some CoCs might choose to send count enumerators to local emergency rooms to see if any persons who are homeless are using the facility to keep warm or for emergency medical care and are not otherwise admitted or going to be admitted for an overnight stay in the hospital. CoCs surveying homeless peoples in these locations should include screening questions to determine where the person was staying on the designated PIT count night." [2]

In New York City, the Homeless Outreach Population Estimate (HOPE) Point-in-Time count is organized by the NYC Department of Homeless Services (DHS) and has been conducted since 2005, typically on the fourth Monday of January. The HOPE Count—which took place this year on the night of January 28, 2019, from midnight to 4 am on January 29, 2019—consists of an outdoor/street and subway count throughout the five boroughs and Metropolitan Transit Authority (MTA) system.

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1 https://www.hudexchange.info/programs/coc/
2 Page 53 https://www.hudexchange.info/resources/documents/PIT-Count-Methodology-Guide.pdf

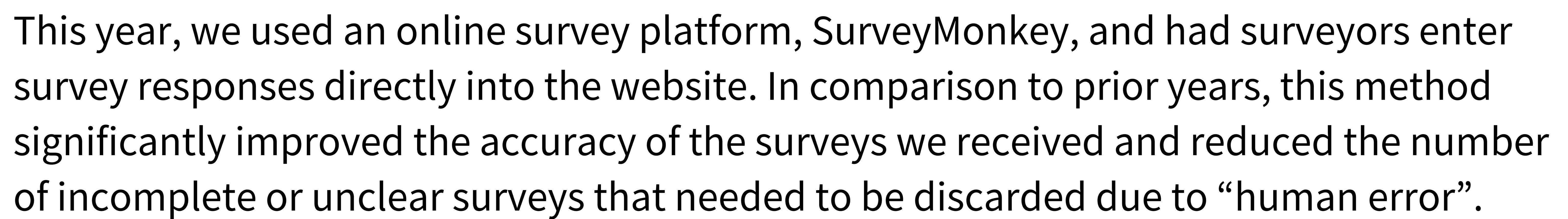
The HOPE Count does not include hospital emergency rooms, but every year, DHS asks the Greater New York Hospital Association (GNYHA) to have its member hospitals administer surveys in their emergency departments (ED) on the same night as the HOPE Count. Hospitals are asked to categorize people into three groups: (1) the number of unsheltered homeless adults registered in the ED (those who are seeking care and who do not provide a current address), (2) the number of sheltered homeless adults registered in the ED (those who are seeking care and provide the name or address of a shelter as their current residence), and (3) the number of homeless adults present in the ED who have not registered (those who are not seeking care).

This data from hospitals has never been made public and it is unclear what the hospital response rate was before the Consortium began organizing its own count. Anecdotally, we have heard that hospitals receive very short notice of the count, leaving little time to adequately train staff to administer the survey appropriately. For those hospitals that do conduct the survey and send this data to DHS, it is unclear what DHS does with the data.

For this reason, the Consortium has led a collaborative effort to conduct an independent survey in hospitals on the same night as the HOPE Count. This year, the Consortium worked with GNYHA to notify their hospital partners of the count in advance and to offer training on how to administer the survey. We used the questions asked by DHS in their count as a model, but also added questions that would provide additional information about this population.

This year, 30 hospital sites across four boroughs allowed their staff and/or our volunteers—comprised mostly of licensed social workers—to conduct the homeless count in their respective ED waiting rooms and non-medical areas such as hallways, lobbies, and chapels. In some cases, hospitals also allowed volunteers to survey ED treatment areas or had their own staff conduct the survey in the treatment areas (though this was not standard across all sites). The 30 participating hospitals in 2019, up from 24 in 2018, indicate the growing interest in our initiative.

The Consortium designed this survey such that it meets the DHS criteria. We provide training to all volunteers and hospital staff on how to conduct the count, including how to approach people, which questions to ask people directly and which to respond to using their own observations, and how to submit completed surveys to the Consortium, or in some cases, to DHS directly. As with the DHS HOPE Count, surveyors were instructed not to wake individuals who were sleeping if they did not respond to an initial greeting. In these cases, the surveyor was asked to make a judgment on whether the individual appeared to be homeless. We eliminated any surveys in which the person was determined <u>not</u> to be homeless.



This year, we used an online survey platform, SurveyMonkey, and had surveyors enter survey responses directly into the website. In comparison to prior years, this method significantly improved the accuracy of the surveys we received and reduced the number of incomplete or unclear surveys that needed to be discarded due to “human error”.

In total we received 658 surveys. After reviewing the raw data to ensure that the surveys were completed correctly, we eliminated a total of 296 surveys. First, we eliminated 265 surveys in which the surveyor assessed that the person was not homeless. Next, we eliminated 20 surveys in which the person reported that someone else had already asked them questions about their housing situation that night. Finally, we eliminated 11 incomplete surveys that did not indicate the name of the hospital where the survey was completed. After these eliminations, we were left with 362 valid surveys for individuals who were determined to be homeless.

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

HIGHLIGHTS OF FINDINGS

As we do every year, we include all three DHS categories in our count: (1) unsheltered and registered for care, (2) living in shelter and registered for care, and (3) unsheltered and not registered for care. Figure 1 indicates the total number of homeless people found at each participating hospital across all three DHS categories.

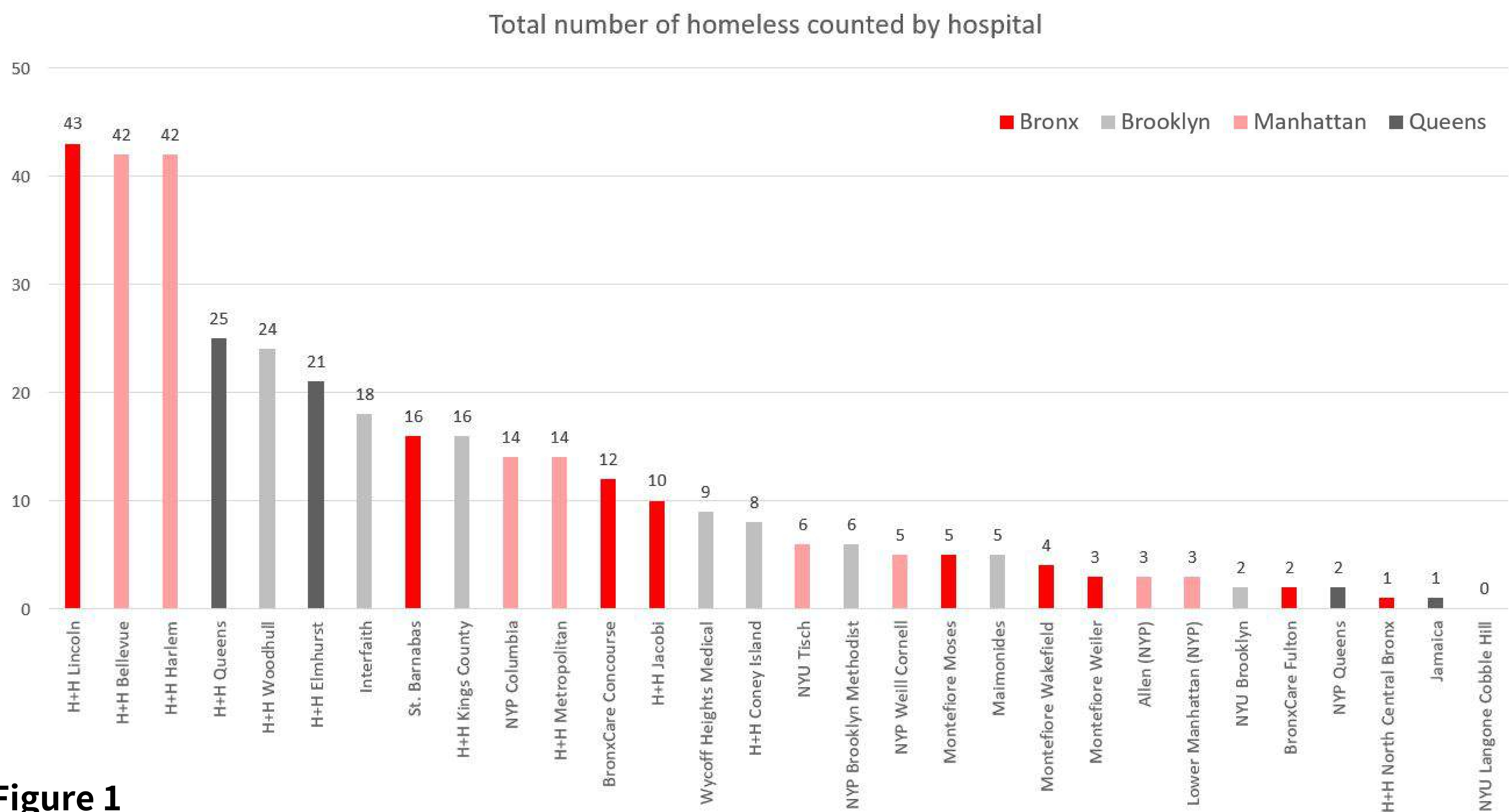


Figure 1

Hospital Homeless Count Data - Total

362 homeless people were identified in the 30 participating hospital EDs. Of these 362 people identified as homeless:

- 326 (90% of total) reported living in a place not meant for human habitation, such as the street, sidewalk, park, outside, abandoned building, lobby, subway, bus, train station, or car or volunteers/staff believed them to be unsheltered.
- The remaining 36 people identified reported living in a shelter, drop-in center, Safe Haven, or residential program.
- 121 (33% of total) were known to be registered to receive medical care in the ED. Of those 121 people who registered for care, 96 people (79%) were determined to be unsheltered and 25 (21%) reported living in a shelter.
- The remaining 241 people (67% of the 362) did not report being registered to receive medical care in the ED or were found in waiting rooms, hallways, or other non-medical areas, often asleep, and volunteers/staff did not believe them to be registered for care.

We assume that the 326 people who were identified as unsheltered were the "hidden homeless" population that the street HOPE count essentially missed because they were in a hospital on the night of the Count rather than on the street. They represent 90% of the 362 people identified in the participating hospitals that night. Of these 326 unsheltered homeless individuals:

- 107 (33%) were known to be registered to receive medical care in the ED.
- The remaining 219 people (67%) did not report being registered to receive medical care in the ED or volunteers/staff did not believe them to be registered for care.
- 70% were found in New York City Health + Hospitals (H+H) sites; the six hospitals with the highest counts in the City were H+H sites: Lincoln, Harlem, Bellevue, Queens, Woodhull, and Elmhurst.

Hospital Homeless Count Data - Bronx

96 people who were homeless were identified in the nine Bronx ED sites, nearly double the 54 found last year. Of these 96 people identified as homeless:

- 83 (86% of total) reported living in a place not meant for human habitation, such as the street, sidewalk, park, outside, abandoned building, lobby, subway, bus, train station, or car, or volunteers/staff believed them to be unsheltered.
- The remaining 13 people (14%) identified reported living in a shelter, drop-in center, Safe Haven, or residential program.
- 32 (33%) were known to be registered to receive medical care in the ED. Of those 32 people who registered for care, 22 people (69%) were determined to be unsheltered and 10 (31%) reported living in a shelter.
- The remaining 64 people (67%) did not report being registered to receive medical care in the ED or volunteers/staff did not believe them to be registered for care.

Looking only at the 83 people who were identified as unsheltered in the Bronx:

- 25 (30%) were known to be registered to receive medical care in the ED.
- The remaining 58 people (70%) did not report being registered to receive medical care in the ED or volunteers/staff did not believe them to be registered for care.
- More than half (51%) of the total unsheltered homeless people in the Bronx were found in the Lincoln Hospital ED alone.

Sheltered vs. Unsheltered Homeless Data

While the Consortium is interested in health care utilization and the needs of people who are living in homeless shelters as well as those who are without shelter, for the sake of this report and its correlation to the DHS HOPE Count, we will exclude from this analysis people who reported being sheltered, as they would similarly be excluded from the DHS HOPE Count. The data and analysis that follow represent only those who reported being without shelter or who were identified by volunteers/staff as being homeless without shelter. We believe that this group represents the population of people who, were it not for the availability of the hospital, would be outside or on the subway on this night and therefore counted in the HOPE Count.

Demographic Health and Resource Utilization Data

The DHS HOPE Count survey, on which our Hospital Homeless Count survey is based, also asks questions related to demographics (age, gender identification, and race/ethnicity). For questions about age, if the person was asleep or refused to answer, surveyors were asked to make a guess. Surveyors were instructed not to ask someone their gender or race/ethnicity but instead were asked to make an observation. This, of course, limits the accuracy of this information as gender identification and race/ethnicity may not be discernible by exterior appearance.

The Consortium added additional questions about family structure and health resource utilization to gain further insight into this population. We asked about other adults and/or minor children that would live with the person if they had a home of their own. We also asked people how often they visit the ED and if they have a regular doctor they see outside of the ED.

Most people responded to at least some of the additional questions. However, some identified persons may have been asleep, refused to participate in the additional questionnaire, or refused to respond to particular questions. Because not every person answered every question, sample sizes for each question vary in the report. The data provided only reflects the surveys where a response was given or the surveyor was able to make a determination. For each question, we indicate the number of responses received.

The following is a profile of those who completed the questionnaire from all participating hospitals citywide and who were determined to be unsheltered.

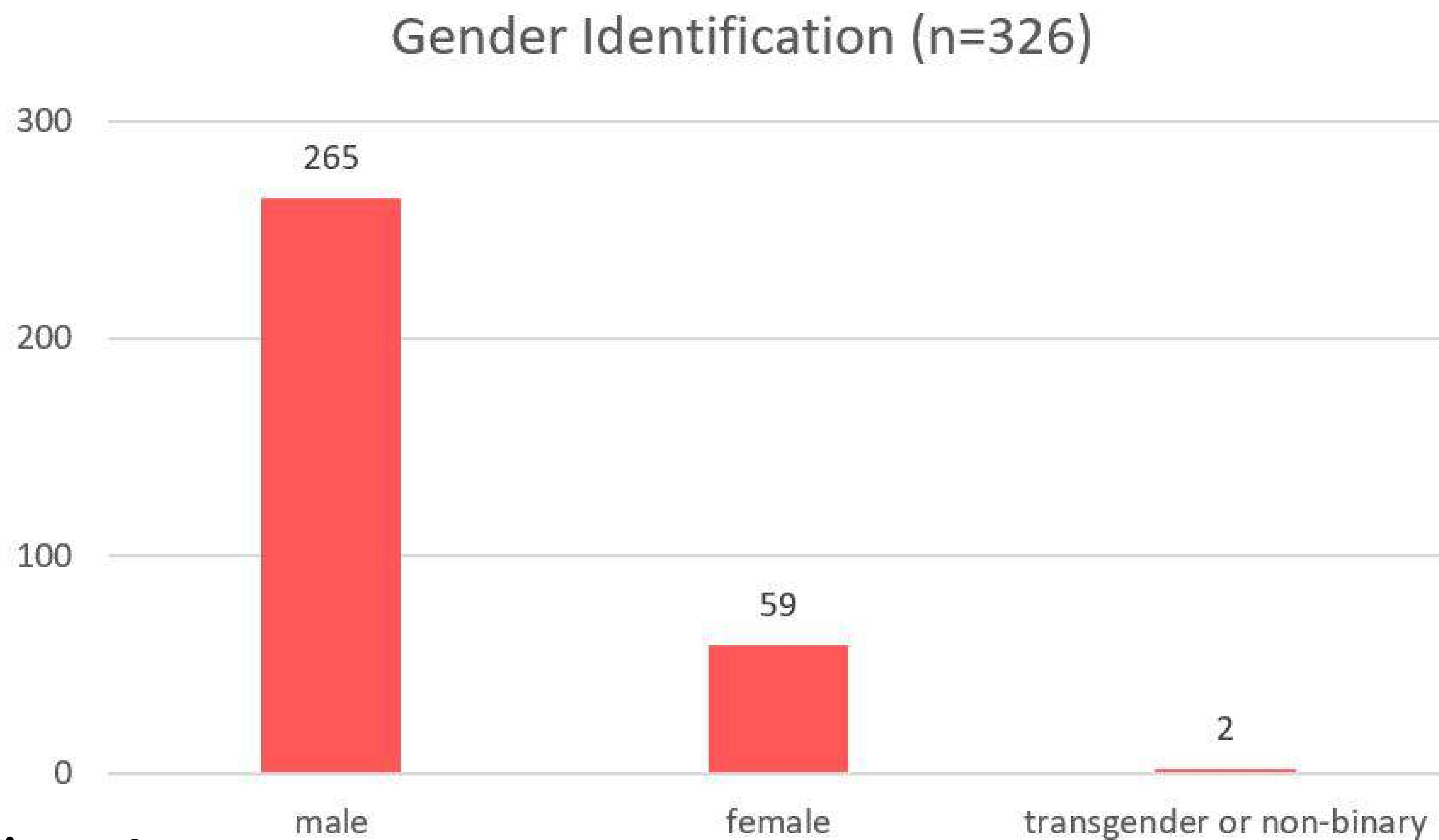


Figure 2

Gender (n=326): 265 respondents (81%) were identified by surveyors as being male, 59 respondents were identified as female (18%), and 2 respondents were identified as transgender or non-binary (1%).

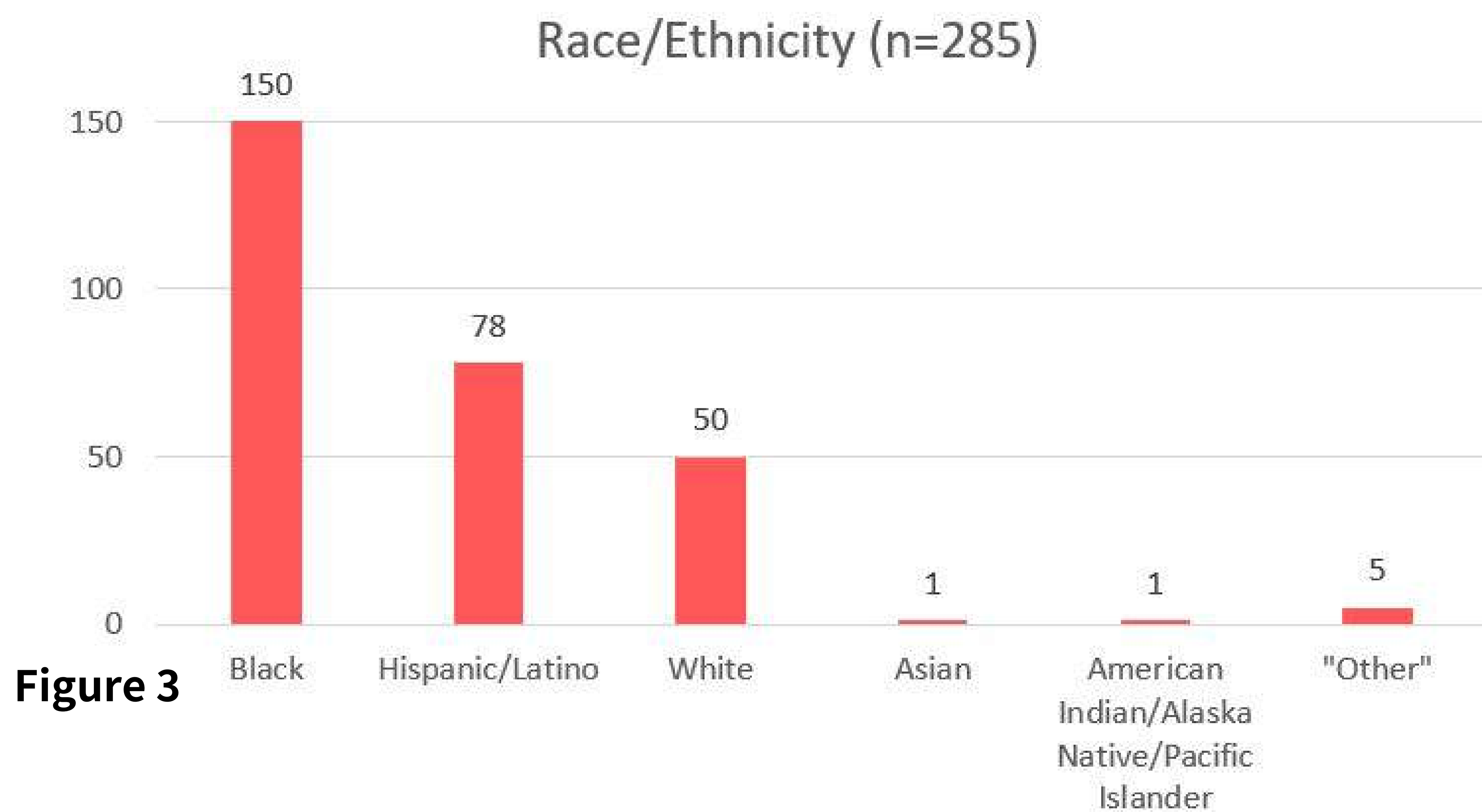


Figure 3

Race/Ethnicity (n=285): 150 respondents (53%) were identified by surveyors as Black, 78 respondents (27%) were identified as Hispanic/Latino, 50 respondents (18%) were identified as White. Just one person (<0.5%) was identified as Asian and another as American Indian/Alaska Native/Pacific Islander. Five people (<2%) were identified as “Other”.

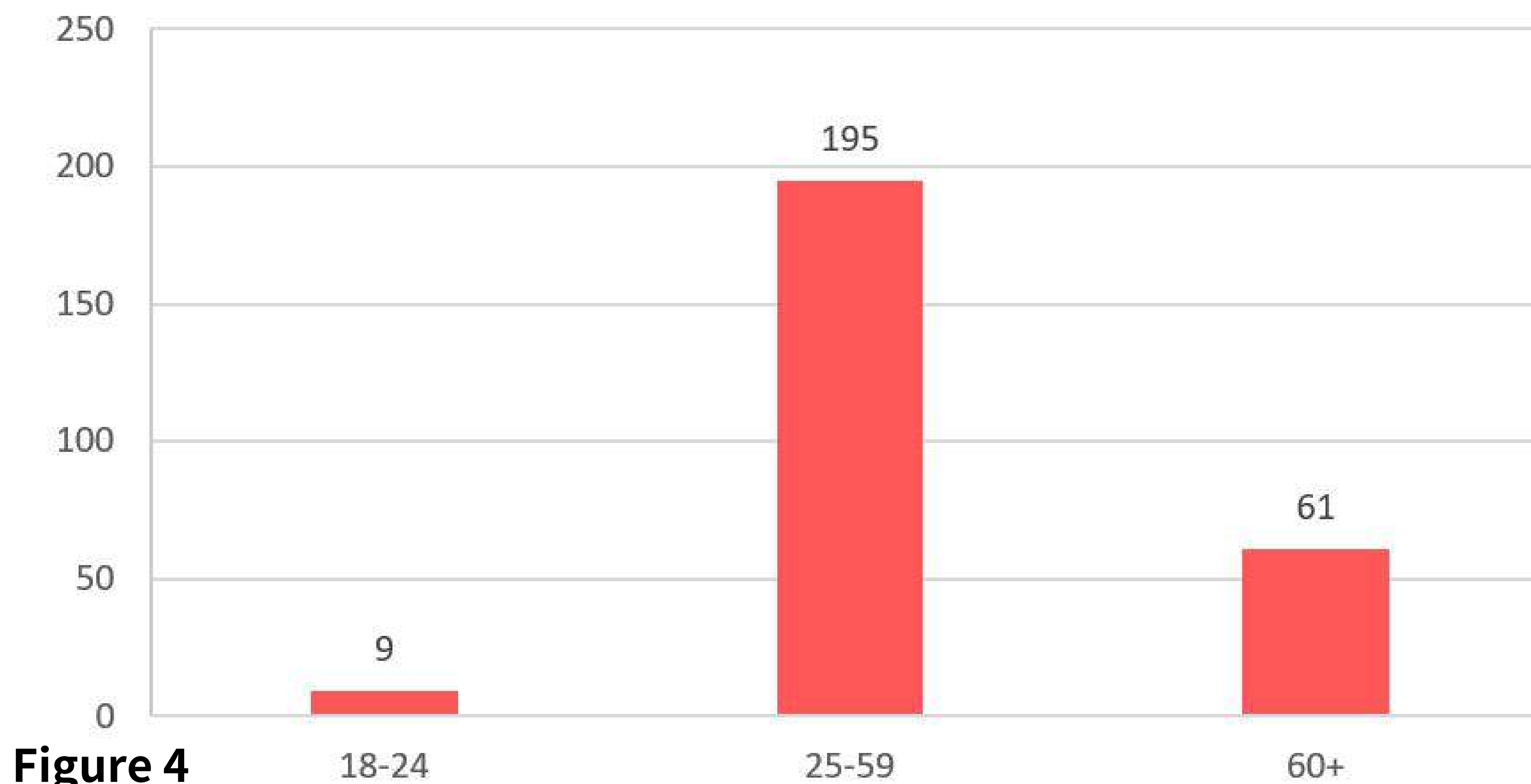


Figure 4

Age (n= 265): DHS response options include four age ranges: under 18, 18–24, 25–59, and 60 or older. The age group that comprised the highest number of homeless people was those aged 25–59 with 195 people (74%), followed by 61 seniors 60 years and older (23%), then 9 people who were 18–24 (3%). No one was under 18.

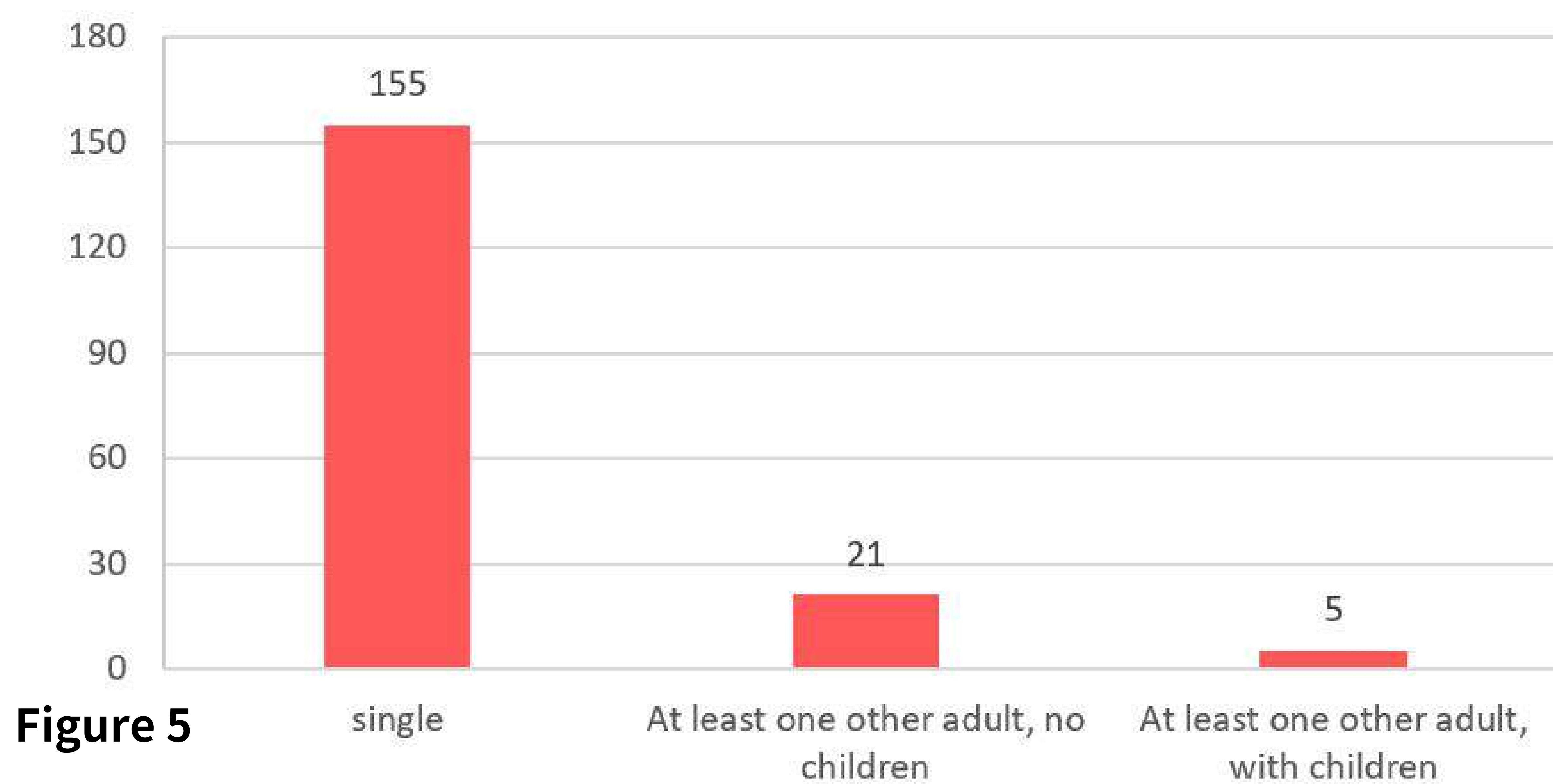


Figure 5

Family Structure (n=181): When asked who would be a part of their household if they had a home of their own, 155 (86%) identified as single, 21 people (12%) reported having at least one additional adult over the age of 18 and no children under 18 as part of their family, and five people (3%) reported having at least one other adult over 18 and one or more children under 18. No one reported having at least one child under 18 and no other adults over 18. For those who reported having minor children as part of their family, these likely included children who were not currently living with them while they were homeless but who might be able to if they had appropriate housing.

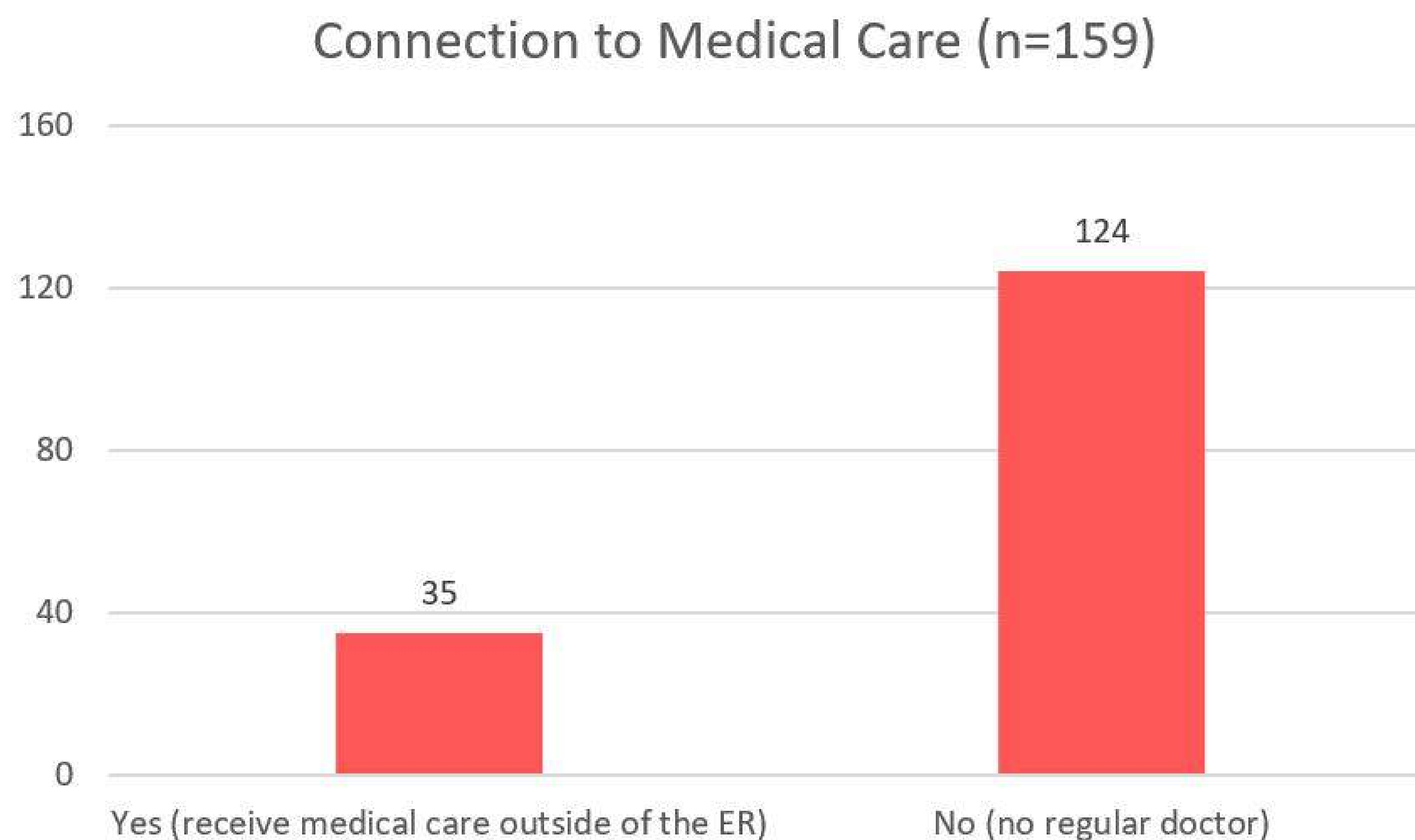


Figure 6

Connection to Medical Care (n=159): when asked if they have a regular doctor they see or a place they receive medical care other than the ED, 124 people (78%) reported they do not, and 35 (22%) reported that they do have a doctor they see.

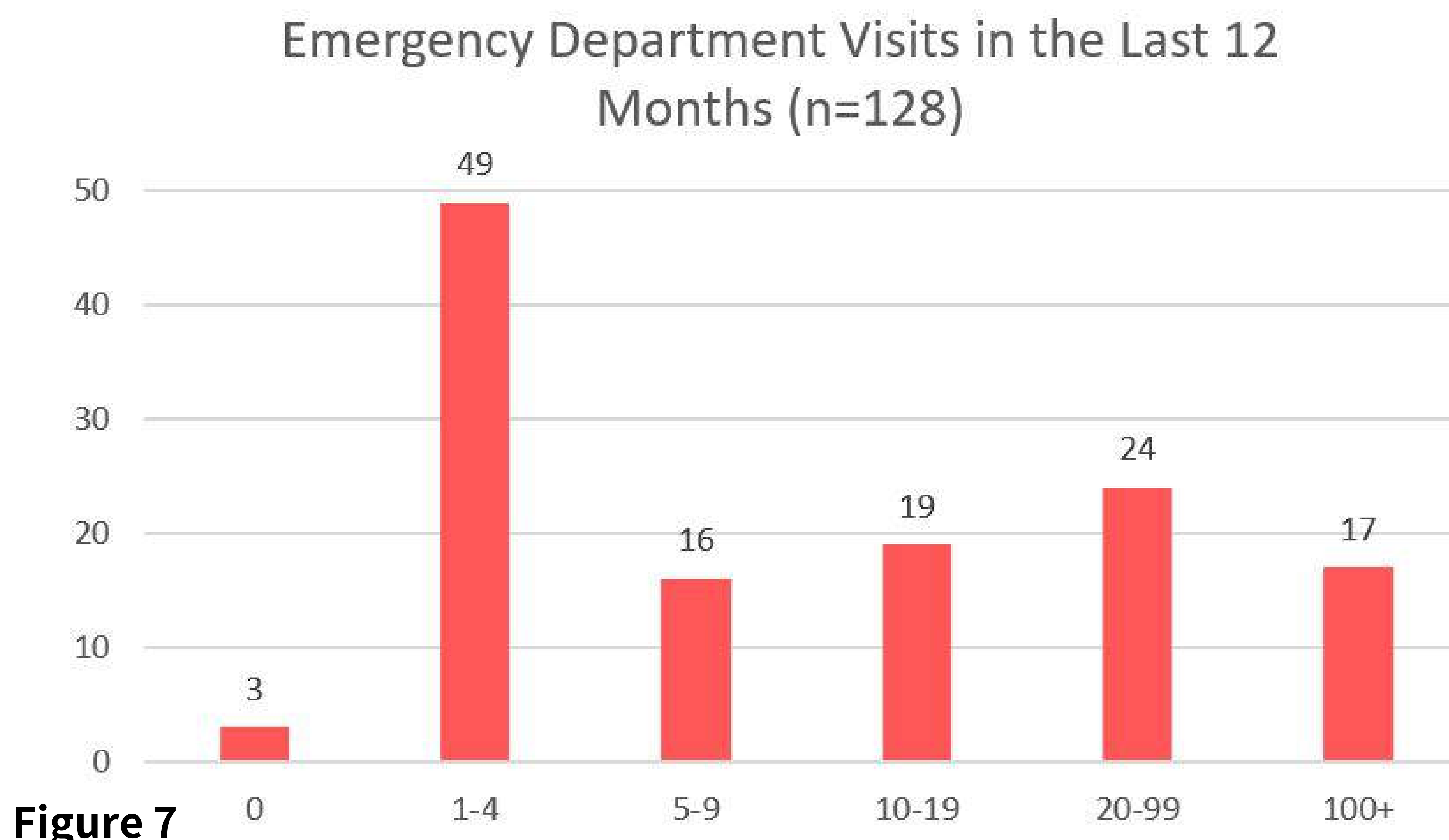


Figure 7

Emergency Department Utilization (n=128): Almost all of the individuals who responded to this question reported having previous emergency department visits in the past year. In total, 12 (9%) survey respondents reported that they go to the ED 365 days/year, thus spending every night in the hospital ED or waiting areas. An additional 12 people (9%) reported visiting the ED 50 or more times in the previous year, and another 36 people (27%) reported 10 or more visits. In total, nearly half of respondents (47%) reported 10 or more visits to the ED in the previous year.

ANALYSIS OF FINDINGS

Comparison by Hospital

During this count, some hospitals only granted volunteers access to non-medical areas of the hospital—including waiting areas, hallways, auditoriums, and chapels—while others allowed access to the ED treatment areas in order to survey patients. In these hospitals, volunteers were able to identify some homeless people in the ED treatment areas, typically with the help of hospital staff. We therefore assume that access to these treatment areas in all participating hospitals would have produced higher numbers. This also may have impacted the number of people who were known to be registered for care. If more ED treatment areas had been surveyed, we expect the number of people registered for care would have been higher.

According to HUD guidelines, people who are in the hospital to receive emergency medical care may be counted as long as they are not going to be admitted for overnight care. Therefore, ED treatment areas are permissible locations to conduct the count according to HUD, and we will encourage more hospitals to allow volunteers access to these treatment areas in future counts.

Among the unsheltered homeless population identified, the number of people identified and the proportion of people who were registered for care varied significantly from hospital to hospital. Hospitals have different policies and practices in regard to treating patients experiencing homelessness. Some hospitals have a strict policy not to allow anyone who is not seeking medical care to sleep in the hospital and will ask those people to leave. Others have an “open door” policy, allowing people to sleep in their waiting areas and lobbies or even opening up non-medical areas such as the chapel. Still others have a practice of registering and examining anyone who comes in. This is critically important because people experiencing homelessness are often in need of medical care, even if they state otherwise or staff assumes that their primary reason for coming to the hospital was for a place to sleep. We have anecdotally heard about each of these scenarios and next year we hope to collect information from hospitals on their policies and practices to help us better understand the data we collect and advocate for more standardized processes.

Of all hospital EDs that were surveyed that night in four boroughs, the hospitals that found the highest number of unsheltered homeless people were H+H Lincoln Hospital, H+H Bellevue Hospital, and H+H Harlem Hospital. These three hospitals alone accounted for more than a

third (37%) of all unsheltered homeless individuals identified in the 30 hospitals surveyed. Overall, the large majority (70%) of the people who were identified as unsheltered homeless were found in H+H public hospitals, which only make up 11 of the 30 hospitals surveyed. The other 30% were in private hospitals.

This is an increase from last year, when 47% of the unsheltered homeless people were found in H+H public hospitals and 53% in private hospitals. In previous years, there was also a more even split between public and private hospitals. While all 11 H+H hospitals participated in the count this year, only 19 out of 40 private hospitals in New York City participated, so we know that we are undercounting private hospitals. This undercount of private hospitals does not fully explain the difference and we are unable to draw conclusions about why the numbers were so much higher in H+H hospitals this year. In general, we believe that both public and private hospitals see patients who are experiencing homelessness, and all should be involved in efforts to better connect those patients to housing resources.

Comparison to DHS Hope Count

As more hospitals across the city participate in the Bronx Health & Housing Consortium's annual Hospital Homeless Count, we get a fuller picture of the number of people experiencing homelessness who are not being counted in the DHS HOPE Count. There are 51 hospitals in New York City that have emergency departments. In 2019, 30 of these 51 hospitals participated in the Hospital Homeless Count. We do not have data on the 21 hospitals that did not participate and are therefore undercounting the total number of homeless people in NYC hospitals on the night of the HOPE Count.

Still, we can begin to compare the data we do have to the DHS HOPE Count to get a sense of the scope of people being missed by the City. Adding the total number of unsheltered homeless people found in hospitals (n=326) to the 3,588[3] unsheltered homeless people counted by the DHS HOPE Count this year, there would be nearly 10% more homeless people counted than reported by the City.

DHS counts and reports on numbers for "surface areas" (i.e. streets and parks) and the MTA subway system. The surface area totals are broken down by borough, with Manhattan having the

[3] NYC HOPE 2019 Results https://www1.nyc.gov/assets/dhs/downloads/pdf/hope-2019-results.pdf

largest number (n=829) followed by Brooklyn (n=237), Queens (n=175), the Bronx (n=115), and Staten Island (n=54). The total for the subways, which is not attributed to any borough, was 2,178, 61% of the total. This subway total is an increase of 26% from last year, likely in part due to the colder weather on the night of the 2019 count.

Comparison to 2019 DHS Hope Count

HOPE Total	3,588
HOPE Subway	2,178
HOPE Surface	1,410
Hospital Total	**326**

Table 1

This is the Consortium's sixth consecutive year organizing and conducting a hospital homeless count, which allows us to look at the data over time. The 2014 Consortium Hospital Homeless Count focused on inpatients, therefore an ED comparison is not available for that year. We will restrict the following analysis to the Bronx since that is the only borough where all hospitals participated every year.

Bronx Homeless Count by Year

	2015	2016	2017	2018	2019
Bronx Hospital Count Unsheltered (HOPE Equivalent)	**94**	**87**	**45**	**47**	**83**
Unsheltered homeless-registered for care	28	22	15	23	25
Unsheltered homeless-not registered for care	66	65	30	24	58
DHS HOPE Count Bronx	**69**	**43**	**255**	**119**	**115**
Bronx Total (street + hospital)	**163**	**130**	**300**	**166**	**198**
Temperature	**25℉**	**28℉**	**40℉**	**37℉**	**28℉**

Table 2: Comparison of Bronx data from DHS HOPE Count and the Consortium's Hospital Homeless Count in the Bronx (unsheltered) from 2015 to 2019. DHS numbers only reflect people identified in "surface areas" of the Bronx and do not include people identified in the subway system (which accounted for another 1,976 people in 2015, 1,573 in 2016, 1,812 in 2017, 1,771 in 2018, and 2,178 in 2019) as those numbers cannot be attributed to a borough. In two of the five years for which we have data from both the Consortium's hospital ED count and the DHS HOPE count, we found more unsheltered homeless people in Bronx hospitals than DHS found on the streets of the Bronx.

The Hospital Homeless Count numbers for 2015 (n=94) and 2016 (n=87) were relatively close, followed by a 48% drop between 2016 and 2017 (n=45). From 2017 to 2018 (n=47) the numbers remained roughly the same, yet from 2018 to 2019 (n=83) there was a 77% increase. We think the higher numbers in 2015 and 2016 counts were largely due to the fact that these counts were conducted during 'Code Blue' nights, when the temperature was below freezing and/or weather was inclement. The temperature was much warmer in 2017 and 2018, which most likely explains why fewer people were found in hospitals those years. In 2019, the count was conducted on a Code Blue night, and again, we saw the number of homeless people in hospitals jump.

Looking at the DHS HOPE Count surface area totals, the numbers in the Bronx have varied significantly over the past four years. The dramatic 493% increase in the DHS HOPE Count in the Bronx from 2016 (n=43) to 2017 (n=255) compared to the 48% decrease in the Bronx Hospital Count over the same period raises questions about the accuracy of the HOPE Count numbers.

Some of these changes may be explained by the temperature outside. The 2016 HOPE Count was postponed due to the cold and snow. Postponement can decrease the number of volunteers available, which means map areas may not get fully covered. Furthermore, the cold temperature on the night of the 2016 Count may have driven more people off the streets to find shelter inside. Anecdotally, people experiencing homelessness with whom we have spoken have told us that they tend to use hospitals for shelter when it is too cold to sleep outdoors.

Moreover, during Code Blue nights, the City—via outreach teams, police, and others— urges and often escorts people indoors from the street, including to hospitals. Hospitals are required to allow homeless people to sleep in their waiting rooms or lobbies during Code Blue nights, unlike on other nights. This is one reason the Consortium has continued to urge DHS to include hospital waiting rooms in its official HOPE count.

In 2017, the HOPE Count was conducted on a warmer night, so there may have been more people outside rather than seeking shelter in a hospital or elsewhere. The warmer temperature may also explain partly why there were increases in every borough (except Staten Island) between 2016 and 2017. However, no other borough came close to the nearly 500% increase seen in the Bronx in 2017, so weather alone cannot explain the results from that night.

From 2018 to 2019, the DHS HOPE Count numbers in the Bronx remained relatively unchanged while our Hospital Homeless Count in the Bronx saw a 77% increase. This increase may be due, in part, to the improved methodology used this year with electronic rather than paper surveys.

Looking at the combined totals of homeless people identified on the street and in hospitals, 198 unsheltered homeless people were identified in the Bronx in 2019, either on the street (n=115) or in hospital EDs (n=83). By including hospital EDs in the count, the total number of unsheltered homeless people in the Bronx was 72% higher than the street count alone, assuming these people would have been counted on the street if they were not in the hospital that night.. It is also possible that some of these people would have sought shelter elsewhere, whether on the subway or in a City shelter or drop-in center.

Although it is difficult to draw conclusions from the street count numbers in the Bronx in recent years, the City has made investments in additional Safe Haven beds which have been instrumental in moving people off the street. Homeless Outreach teams have made efforts to target high population areas and rapidly place people from the street into Safe Haven beds as they become available. These Safe Haven beds are a critical transitional step for people who have been chronically street homeless to move towards living in permanent housing.

Implications on Healthcare System

The Consortium conducted this hospital count not only to more accurately estimate the homeless population in the Bronx and elsewhere, but also to better understand the implications of homelessness on the healthcare system. Nearly all of the individuals who responded this year had multiple visits to the emergency department, and 78% did not have a regular place other than the ED where they received care.

From the hospitals' perspective, people experiencing homelessness do not only include those who are unsheltered but also those in shelters and those who are "doubled-up" or "couch-surfing", because their housing situations are very unstable. Unstably housed people, especially singles, often move around between various shelters, return to the street, or stay with friends for short periods. This housing instability can impact their healthcare utilization and a hospital's ability to discharge them safely.

We note that our sampling strategy (a point-in-time count in the ED) biases toward people who frequently use the ED. We also note 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 consider that some homeless people may be unknown to DHS, as the shelter system is not available to homeless people who are ill and do not meet the screening[4] criteria for admission to shelter. Consequently, they may not be receiving the housing support they need.

Volunteer Observations

The Consortium had 75 people from community-based organizations and hospitals volunteer to conduct the Hospital Homeless Count across the New York City. We offered three live training webinars for these volunteers to accommodate their schedules and gave them the opportunity to practice using the online survey up until the night of the Count. Following the Count, we emailed everyone who participated (volunteers and hospital staff) asking them to complete an evaluation to provide feedback on their experience. We received a total of 35 evaluations from these volunteers and hospital staff.

When asked to share stories about any conversations they had with individuals who reported being homeless, the most common narrative that volunteers shared with us was that the people they spoke with preferred to stay on the streets and sleep in the hospitals rather than go into the shelter system. Many expressed fear of violence, theft, and drug use in the shelters, and others felt they did not receive assistance from shelter staff in finding housing. One volunteer shared that some of the people they spoke with seemed to be off the radar of the shelter system or homeless outreach teams. In future counts, we will add questions about previous shelter stays and interaction with homeless outreach teams to try to get a better understanding of this population's engagement with existing homeless services.

Another trend we saw in volunteer feedback was that people saw the hospital as a safe, comfortable place to stay. Sometimes people register for care just to get a hot meal and sleep on a stretcher, as well as for the care they receive. One man expressed that he felt connected to the hospital through his methadone program. Volunteers in some hospitals observed the relationship between security staff and homeless individuals who are there frequently. Security staff seemed to know people by name and look out for them—in one case, by buying someone a sandwich. With training, these security staff could be valuable partners in engaging people into services and liaising with outreach teams.

[4] https://www1.nyc.gov/assets/dhs/downloads/pdf/061410_dhs_form_1_screening_form.pdf

Finally, volunteers shared that for the most part, people seemed to want help and services. Some volunteers felt uncomfortable that they were not able to offer them anything on that night and thought this was a missed opportunity for engagement. While it is important to keep an anonymous survey distinct from providing services, this feedback shows that if the designated and properly trained outreach workers were able to come into hospital EDs, this would be an opportune time to engage individuals into services and eventually, housing.

RECOMMENDATIONS

For the fifth 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. Based on the information we have gathered over these past five years, we have the following recommendations for how to better serve this highly vulnerable population.

RESOURCES

Acknowledging this “hidden homeless” population is significant for several reasons. Without including hospital emergency departments in the annual HOPE Count, the number of homeless people identified in NYC may be significantly underestimated. This underestimation results in underfunding and under-resourcing of critical services for people experiencing homelessness. Resource allocation should take into account the number of people within the ED in addition to those on the street/subway.

From our count in 2014, we also know that there are people in inpatient wards who are homeless and are not counted. Without a place to go, they often cannot be safely discharged from the hospital. As the number of people experiencing homelessness in NYC grows, the resources that are available to support them are more necessary than ever.

LINKS BETWEEN HOMELESS OUTREACH TEAMS AND HOSPITALS

Individuals experiencing homelessness tend to be transient and can be difficult to engage on the street. 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 a place to sleep for a significant number of people. Therefore, citywide outreach efforts to locate and work with these individuals need to include most, if not all, NYC hospitals in order to address both health and housing needs.

The Bronx Homeless Outreach Team, run by BronxWorks, has used the data and analyses from our annual Hospital Homeless Counts to develop stronger relationships with various hospitals that have high homeless counts. BronxWorks has even hired a Hospitals to Homes Coordinator as part of their outreach team to build and maintain relationships with hospitals in the Bronx. That team and the Bronx hospitals they visit have reported improvement in the ability to address the housing and health needs of people who are homeless. However, not all hospitals have developed this type of relationship with the homeless outreach teams in their respective boroughs. We hope to discuss with DHS how street outreach teams in the other boroughs can better engage with hospitals across the City.

From our Bronx experience, we think that, at a minimum, hospitals need to recognize and support the people who are homeless within their walls by: 1) registering and examining all people who come to their ED, even those who did not come seeking medical care, 2) designing intake assessments that include housing questions, and 3) developing effective links with the homeless outreach teams to support housing and shelter interventions for this population. Housing assessments to understand people's housing situations will lead to more appropriate treatment plans. DHS could provide access to their homeless data system, CARES, to key hospital staff who may then identify their patients in the shelter system. Patients are not always able to provide this information, so having another means of obtaining housing status and histories of homelessness is important for their treatment.

The homeless outreach teams could personally meet key hospital staff, including ED social workers, social work managers, and security staff, who are very knowledgeable about people who frequent the ED. Together, the outreach team and ED staff could agree on protocols about identifying people who are homeless, contacting each other with key information (within HIPAA guidelines), and arranging follow-up plans. Homeless outreach teams could also make nightly visits to EDs known to serve large numbers of people who are homeless, some of whom might not yet be receiving street outreach services.

Employing a Hospital Coordinator as part of a homeless outreach team to liaise with area hospitals, as is done in the Bronx, is one way to bridge the health and housing sectors. Another approach is to employ a Housing Coordinator as part of the ED or hospital team, which has been successfully implemented at two hospitals in the Bronx. These Housing Coordinators are employed by BronxWorks (which also provides street outreach in the Bronx) and have proven critical to connecting unsheltered homeless patients to services and housing.

Although there are many organizations that provide care management services, this population requires staff to be specially trained and adept at working with them. Measures of success can be jointly developed, and ongoing case conferencing can be used to agree on interventions. Using information in this report allows resources and interventions to be more data-driven and helps develop relationships between hospitals and outreach teams where they are most needed.

NEED FOR APPROPRIATE HOUSING

Of course, the major issue is the **lack of housing** for these and all homeless people in NYC. Without stable housing, people are often unable to appropriately address their medical conditions and will most likely return to hospitals for further medical attention. Access to safe, appropriate, and affordable housing will foster better health outcomes and decrease system costs that stem from multiple ED visits, inpatient

hospitalizations, and number of nights in the hospital. **The cost of people staying in hospitals longer than necessary, or even staying in hotels or shelters, is often higher than the cost of supportive housing.**

High Medicaid utilization and frequent contacts with the hospital system are now accounted for when assessing vulnerability through the Coordinated Assessment and Placement System (CAPS) to prioritize people for supportive housing. This was an important step toward connecting this high need population to housing. The next step should be to make sure that supportive housing providers have the resources and training necessary to adequately support people who are more medically vulnerable. Efforts around improving health for homeless individuals—especially those by City agencies—must focus on the end goal of housing.

In terms of the type of units required, our ED sample on HOPE night found that 15% of respondents reported having other people (adults and/or children) in their household, which is slightly less than the 22% from last year. Still, this data indicates the need for more family housing units, of which there continues to be a shortage in the city. These units are necessary to keep families stably housed. If appropriate housing were available and affordable, many of the resources for the outreach teams, shelters, specialized medical care, etc. could be saved.

ALL-HOSPITAL APPROACH

This year, 70% of unsheltered homeless individuals identified were found in New York City Health + Hospitals (H+H) public hospitals. This was an increase from last year, when 47% were found in H+H hospitals. We are unable to draw any conclusions as to why more people were found in H+H hospitals this year compared to previous years and maintain that the inclusion of hospitals as partners in the homeless services system cannot be limited to the public hospitals. Efforts to engage homeless people in hospitals need to include all hospitals in NYC.

Hospitals serving homeless patients should find ways to engage this population while in the ED in order to address their significant health needs as well as more effectively address their social determinants of health (e.g. housing). Of note, the Emergency Medical Treatment and Active Labor Act (EMTALA) mandates EDs to, at the very least, perform a medical screening exam for everyone who presents to the ED and requests care. It is our recommendation that even those who come to the hospital primarily seeking shelter should be offered to be registered and examined.

NEED FOR MEDICAL RESPITE SERVICES

We know that there are a number of people in hospitals who cannot be discharged because they have no home or because they live in inappropriate homes (e.g. buildings with flights of stairs for those with severe heart disease or COPD) and are too sick to go to traditional shelters. We need to move this population from their expensive and unstable housing in hospitals to respite services and, eventually, to appropriate permanent housing. Medical respite provides short-term acute and post-acute care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be in a hospital. Close collaboration between hospitals, outreach workers, and shelters to target these populations will ensure rapid and stable housing to prevent avoidable hospital readmissions and stop the revolving door between hospitals and homelessness. Eighty medical respite programs exist throughout the U.S., several of which provide shelter to more than 50 people. In all of NYC, there are fewer than 20 medical respite beds, though interest is growing and there may be more soon. It is time that New York City catches up with the rest of the country by addressing this substantial gap in our homeless services.

CONCLUSION

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. When we began conducting this count in 2014, we wanted to better understand and draw attention to the scope of "hidden homeless" people in Bronx hospitals. Over the past six years, in part through the work of the Consortium and the Hospital Homeless Count, there has been a growing acknowledgement of the connection between housing and health. More and more hospitals across the city are showing interest in identifying their patients who are homeless or unstably housed and connecting them to services. Through DSRIP, the Medicaid Redesign Team (MRT), NYC 15/15, and the Empire State Supportive Housing Initiative (ESSHI), there are new investments in housing for people who are high utilizers of Medicaid.

Despite this progress, there is still work ahead. The Consortium will continue to meet with DHS to share this data and our findings. While DHS has told us that they will not include hospitals in the HOPE count, we hope that they will use the data from our Hospital Homeless Count to acknowledge this hidden homeless population and allocate adequate resources to connect them to appropriate housing. Hospitals in New York City are clearly seeing a significant number of people who are homeless and who could be integrated into system-wide solutions to reduce homelessness across the city.

If we intend to end homelessness in our city—which should be our ultimate goal—we must acknowledge the entirety of the homeless population, wherever they are. As the Consortium's Hospital Homeless Count continues to show, this must include hospitals.

ACKNOWLEDGMENTS

The Consortium wishes to acknowledge the hospitals that participated in this count:

- BronxCare Health System (formerly Bronx-Lebanon Hospital Center): Concourse and Fulton Divisions
- Montefiore Medical Center: Moses, Wakefield, and Weiler Divisions
- New York City Health + Hospitals: Bellevue, Coney Island, Elmhurst, Harlem, Jacobi, Kings County, Lincoln, Metropolitan, North Central Bronx, Queens, Woodhull
- St. Barnabas Health System
- Interfaith Medical Center
- Jamaica Hospital Medical Center
- Maimonides Medical Center
- NYU Langone Hospital: Brooklyn, Tisch, Cobble Hill
- NewYork-Presbyterian: Allen, Queens, Brooklyn Methodist, Columbia, Weill Cornell
- Wyckoff Heights Medical Center

The Consortium extends particular thanks to the organizations that provided the volunteers who worked into the early morning to conduct this count and to Keona Serrano for organizing and training volunteers:

- BronxWorks: Adult Homeless Services, HomeBase, Department of Supportive Housing & Health Policy
- CAMBA
- Empire BlueCross BlueShield HealthPlus
- GEEL Community Services
- HELP USA
- Montefiore Medical Center: Housing at Risk Program
- RiseBoro Community Partnership
- Staff and volunteers from all participating hospitals

Finally, the Consortium wishes to thank the New York City Department of Social Services for reviewing this report and providing valuable feedback. We look forward to continued collaboration in order to support all people experiencing homelessness in New York City.

The Bronx Health & Housing Consortium encourages nonprofit organizations and government agencies to freely reproduce and share the information from our publications. The organizations must cite the Consortium as the source and include a statement that the full document is posted on our website, www.bxconsortium.org/hospital-homeless-count. Permissions requests from other entities will be considered on a case-by-case basis and may be made to info@bxconsortium.org.

Suggested Citation

The Bronx Health & Housing Consortium. 2019
Hospital Homeless Count: Results and Report. 2019.