

2014 Bronx Hospital HOPE Count Snapshot

The Bronx Health and Housing Consortium organized in 2011 as a collaborative network of health, housing, social service, government agencies and the four Bronx Health Homes with the shared goal of streamlining client access to quality health care and housing in the Bronx. The underlying premise is that shared housing and health care provider understanding is necessary to support high cost/high need clients who require intensive, coordinated services to achieve improved health outcomes. With the recent implementation of health care reform and the establishment of Health Homes to focus on high cost Medicaid populations, it became apparent that the homeless and unstably housed populations are a significant driver of hospital-based health care utilization and high Medicaid costs due to the 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 it collectively serves. Recently, on the night of the Homeless Outreach Population Estimate (HOPE) count by the Department of Homeless Services in NYC, several Bronx hospitals worked with the Consortium to identify and count unstably housed (homeless and potentially homeless) people in their facilities. These patients are part of the 'hidden homeless' who are not currently included in the HOPE count, which only includes people who are found on the street and subways.

The definition of homeless that was used for this study was based on the State Department of Health's definition that people are homeless if they do not have "one's own residence that one has access to at any time. Being in a shelter or couch surfing would be considered homeless." St. Barnabas counted people in its Emergency Department as well as inpatients, Bronx Lebanon Hospital Center counted inpatients in two buildings and Montefiore Medical Center counted inpatients in one of its buildings. In each case, social workers reviewed people who were in the hospital between 12 and 4 am on January 27, 2014, the night of the official HOPE count.

Highlights of the findings for these institutions are as follows:

- 62 homeless patients were identified. Of these, 8 were in one emergency department. For the three participating hospitals, 27 were in inpatient psychiatric beds and 27 were in other inpatient beds.
- 20 patients were identified whose homelessness affected the hospital's discharge planning, resulting in delayed discharge
 - This group alone accounted for at least 214 unneeded hospital days due to delayed discharges created by their housing situation, as reported by the hospital social workers. One person, aged over 60, was already in the hospital for 73 days because the inability to ambulate prevented the shelter from taking him/her back. There were no relatives to offer a bed.
- 17 patients were identified as currently insured by Medicaid
 - 8 of the 20 with delayed discharges were covered by Medicaid. This group accounted for at least 146 delayed discharge days. Using average Medicaid Medical/Surgical Hospitalization (from MRT website) reimbursement of \$2,219/day this group of 8 people potentially added \$324,000 in unnecessary Medicaid costs.

Conclusions There is a significant group of “Hidden Hospital Homeless” people who are in hospital inpatient wards and emergency departments. We also note from this data that within this group are “Newly Medically Homeless” people. These are people who were not homeless upon arriving in the hospital, but whose medical situation prevented them from being discharged to their homes. For example, one 60+ year old who lived in an apartment was diagnosed with dementia with no capacity to live alone and no family. Similar examples included people who lived with families who refused to take them back. These people are not currently counted as homeless because they are not in shelters or subways on HOPE night.

Next Steps A more concerted effort is needed to include hospital emergency departments and inpatient wards on HOPE night to get a more accurate count of homeless people and more fully understand the implications of homelessness to the healthcare system. Hospital staff, medical students and community partners can be engaged to assist in the count. There is clear need for 1-stronger Hospital to Home programs to support high public resource utilizers and 2-more Post Hospital Medical/Respite services with clear links to supportive, transitional and other housing. These steps are necessary to 1-address the high cost of delayed discharges and vacate beds for other patients who need them and 2-reduce utilization of EDs as a housing option of last resort.