Building Bridges Across Sectors: How to Build Lasting Partnerships Between Hospitals & Street Homeless Outreach

Moderator:
Patricia Hernandez, LCSW

Associate Director, Metro Team
Corporation for Supportive Housing
Today’s goals

Learn about the intersection between health, homelessness, and racial disparities and the critical need for health and housing partnerships.

Hear from panelists on:
• Using data to inform programming and to address health and racial disparities
• Challenges and opportunities during COVID-19
• Building and sustaining partnerships
Hospitals will keep a homeless patient up to 8 days longer than their housed counterparts incurring millions of dollars in additional costs.

True or False

75% of homeless patients return to the Emergency Department within 2 weeks of discharge.

True or False

Homeless adults die at a rate of four to five times greater than would be expected in the general population.

True or False

Source: Facts About Homelessness - Ascending to Health Respite Care (athrc.com)
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Housing and Social Determinants of Health

Mortality rates 3-4 times higher

Higher rates of multiple chronic conditions

Geriatric symptoms and death 15-20 years earlier

Undomiciled vs. Domiciled Individuals

https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/health/#:~:text=On%20a%20given%20night%20in,10%2C000%20people%20had%20HIV%2FAIDS.

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Across 17 systems and categories, Black populations have the highest overrepresentation in all 17 systems.
Health Disparities Among BIPOC

The healthcare field has long acknowledged striking health outcome disparities. This is especially pronounced in rates of chronic disease and disease mortality rates, among people of color, particularly for people who are Black or African American, American Indian or Alaska native, and Hispanic/Latinx.

<table>
<thead>
<tr>
<th>Measure</th>
<th>White, non-Hispanic</th>
<th>Black, non-Hispanic</th>
<th>Hispanic</th>
<th>American Indian/Alaska Native</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth, 2014\textsuperscript{vi}</td>
<td>79 years</td>
<td>75.6 years</td>
<td>Not provided</td>
<td>Not provided</td>
</tr>
<tr>
<td>Age-adj. prevalence of diabetes (≥25yrs), 2015\textsuperscript{vii}</td>
<td>8.1%</td>
<td>13.1%</td>
<td>12.2%</td>
<td>Not provided</td>
</tr>
<tr>
<td>Age-adj. death rate/100,000 from diabetes, 2014\textsuperscript{viii}</td>
<td>18.6</td>
<td>37.3</td>
<td>25.1</td>
<td>31.3</td>
</tr>
<tr>
<td>Age-adj. prev. hypertension, (≥18yrs), 2007-10\textsuperscript{ix}</td>
<td>28.6%</td>
<td>41.3%</td>
<td>27.7%</td>
<td>Not provided</td>
</tr>
<tr>
<td>Age-adjusted death rates per 100,000 from persons with coronary heart disease &amp; stroke\textsuperscript{x}</td>
<td>117.1</td>
<td>141.3</td>
<td>86.5</td>
<td>92</td>
</tr>
<tr>
<td>Estimated rate of HIV infection diagnoses per 100,000 population, (adults≥18 years), 2010\textsuperscript{xi}</td>
<td>9.1</td>
<td>84</td>
<td>30.9</td>
<td>13.5</td>
</tr>
<tr>
<td>Age-adj. death rate/100,000 from HIV, 2014\textsuperscript{xii}</td>
<td>0.9</td>
<td>8.3</td>
<td>2.0</td>
<td>1.2</td>
</tr>
</tbody>
</table>

\textsuperscript{vi} Source: CSH and Health Care for the Homeless Council “Addressing Health Equity through Health and Housing Partnerships” (2019)

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On January 27, 2020 during the HOPE Count, how many unsheltered people were found on the street or subways?

POLL

- 100-500
- 500-1,000
- 1,000-3,000
- Over 3,000

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On January, 27, 2020 – the same night of the NYC Homeless Outreach Population Estimate (HOPE) – the Health & Housing Consortium led an independent effort to count the number of people experiencing homelessness who are seeking care or shelter in NYC Hospitals.

Source: The Health & Housing Consortium – Hospital Homeless Count Highlights

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Meet our Panelists

Juan Rivera
Program Director
Bronxworks

Casey Burke
Program Director
Bronxworks

Shane Cox
Assistant Commissioner
NYC DHS

Yinan Lan
Director
Bellevue Safety Net Clinic
NYC H+H
**BronxWorks** helps individuals and families improve their economic and social well-being. From toddlers to seniors, we feed, shelter, teach, and support our neighbors to build a stronger community.

- Benefits Access
- Children and Youth Programs
- Family Programs
- Services for Seniors
- Immigration Services
- Eviction Prevention
- Workforce Development
- Homeless Services

**BronxWorks** Adult Homeless Services (AHS) consists of the following programs/facilities:

- The Living Room Drop-in Center
- The Living Room Safe Haven
- The Homeless Outreach Team (HOT)
- The Pyramid Safe Haven
- The Westchester Avenue Safe Haven (WASH)
- Jerome Avenue Men’s Shelter (JAMS)

**BronxWorks** Housing Programs include:

- The Brook
- Cooper Gardens
- HUD Scattered Site Program
## Scope of the Issue

### Street Outreach HOPE Count vs. Hospital HOPE Count

**Street Outreach HOPE Count 2020 Results**

<table>
<thead>
<tr>
<th>Surface Areas/Street</th>
<th># Homeless</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronx</td>
<td>231</td>
</tr>
<tr>
<td>Manhattan</td>
<td>1,283</td>
</tr>
<tr>
<td>Brooklyn</td>
<td>400</td>
</tr>
<tr>
<td>Queens</td>
<td>218</td>
</tr>
<tr>
<td>Staten Island</td>
<td>55</td>
</tr>
<tr>
<td>Subways</td>
<td>1,670</td>
</tr>
<tr>
<td><strong>Citywide TOTAL</strong></td>
<td><strong>3,857</strong></td>
</tr>
</tbody>
</table>

**Hospital HOPE Count 2020 Results (Bronx)**

<table>
<thead>
<tr>
<th>Hospital</th>
<th># Homeless</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln</td>
<td>69</td>
</tr>
<tr>
<td>St. Barnabas</td>
<td>5</td>
</tr>
<tr>
<td>BronxCare</td>
<td>5</td>
</tr>
<tr>
<td>(2 locations)</td>
<td></td>
</tr>
<tr>
<td>Jacobi</td>
<td>6</td>
</tr>
<tr>
<td>Montefiore (3 locations)</td>
<td>12</td>
</tr>
<tr>
<td>North Central Bronx</td>
<td>7</td>
</tr>
<tr>
<td><strong>Bronx Hospitals TOTAL</strong></td>
<td><strong>104</strong></td>
</tr>
<tr>
<td><strong>Citywide Hospital Total</strong></td>
<td><strong>226</strong></td>
</tr>
</tbody>
</table>

74% (n=167) located in NYC Health & Hospitals  
26% (n=59) located in Private Hospitals
Medicaid Accelerated eXchange (MAX Series)

Lower Costs
Better Health
Better Care

DSRIP
Delivery System Reform Incentive Payment Program

MAX Series
BronxWorks
SBH Health System
Other Partners

See https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_workshops/docs/2017-jan-jul_imp_care_for_high_utilizers.pdf
Results: Social service benefits + Financial benefits

- Total clients engaged (unduplicated): 1920
- Total client contacts (duplicated): 7713
- Clients new to BronxWorks: 1273
- Caseload: 5-10 per Housing Navigator
- Total placed in transitional housing: 53
- Psychological evaluations completed: 18
- Psychosocials completed: 18
- 2010E submissions: 20
- Housing interviews: 4
- Placed in permanent housing: 1
Less ED visits
Less In-patient stays

- Hospital 2 data: 8 clients examined in-depth, pre- and post-placement to transitional housing
- Pre-placement: 253 ED visits
- Post-placement: 87 ED visits
- 65.6% reduction
- Pre-placement: 37 in-patient admissions
- Post-placement: 12 in-patient admissions
- 67.5% reduction
- $235,656.70 was saved during 82 cumulative months after post-placement
BUILDING RELATIONSHIPS WITH HOSPITALS FROM THE GROUND UP

- Incorporate ED canvassing as part of your every-day operations.
- Make efforts to engage hospital staff, including Security and Medical staff.
- Be transparent about what outreach can or can’t offer in terms of services.
- Hospital Coordinator position - key to filling in some of the gaps.
- Presentations and tours with hospital staff are very effective.
- High level meetings with Hospital Administrators provide deeper understanding.
- Ideas can slowly move forward if buy-in is achieved.
- Funding is the big question.

BronxWorks
WHAT WE DO AND HOW

Street Outreach
24/7 in Brooklyn, Queens and Midtown Manhattan

AND

Drop-In Center
Ozone Park, Queens
Serves 10 people daily (expanding to 75 in 2019)

AND

Transitional Housing
3 buildings
299 beds

AND

Permanent Supportive Housing
19 buildings + 171 scattered apartments
3,625 homes

...paired with supportive services

Medical care & substance abuse referrals
Mental health care
Benefits assistance
Self-sufficiency skills
Purpose and Goal

NYC Dept. of Homeless Services provides funding to one non-profit per borough to work with and house the street homeless.*

There are three main goals and measures of each outreach program:

1. Reduce the overall street homeless census (measured through the annual HOPE Count)
2. Permanently house chronically street homeless individuals
3. Connect with all community and government partners affected by street homelessness.

*Breaking Ground has the contract for both Brooklyn and Queens
Services Provided

We work with anyone experiencing homelessness, but can provide different services depending on the length of time a person has been homeless and some other factors.

If a person is experiencing homelessness, but has not been homeless long, or has been staying with friends/family, in the shelter, etc., that person is eligible for:

- Referral to shelter or drop-in services.
- Referral for street medicine services
- Referral for psychiatric services
- Assistance with public assistance, Medicaid & food stamps
If a person is experiencing homelessness, and has been staying on the street (not utilizing shelter for any significant length of time) for at least 9 months out of the last 24 months, that person is eligible for:

- Case Management
- Transitional Housing
- Medical and Psychiatric Services
- Benefits assistance (Public Assistance, SSI/D, Food Stamps, Medicaid)
Referrals

How do we receive referrals?

• From 311
• From elected officials
• From community groups
• From police
• From service providers
• From concerned citizens
• From hospitals
Together with our not-for-profit partners, our mission is to:

- Prevent homelessness when possible;
- Address street homelessness;
- Provide safe, temporary shelter and;
- Connect New Yorkers experiencing homelessness to sustainable housing.

We do this with accountability, empathy, and equity.
DHS’ Street Homeless Solutions Unit conducts 24/7/365 outreach to unsheltered New Yorkers, in coordination with not-for-profit social service providers.

SHS also provides an array of services and supports for individuals experiencing unsheltered homelessness to assist them in coming off the streets and subways and getting back on their feet.

Our goal is to provide a range of low-barrier, specialized services specifically targeted to individuals who have lived unsheltered for some time -- and who may be resistant to accepting other traditional services, having fallen through all available social safety nets.

These services and supports provided include:

- Drop-In Centers
- Safe Havens
- Stabilization Beds
- Street & Subway Outreach
STREET OUTREACH

- Not-for-profit service providers canvass the five boroughs 24/7/365
- Identify and engage individuals experiencing unsheltered homelessness
- Build relationships and trust with individuals, encouraging them to accept services
- Help clients rebuild their lives and get back on their feet, including helping them obtain permanent housing through on-going case management
- Implement extreme weather protocols that prioritize health-and-safety protection by intensifying focus most vulnerable clients during inclement conditions

<table>
<thead>
<tr>
<th>PROVIDERS</th>
<th>BOROUGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOC (CUCS, Breaking Ground, Goddard)</td>
<td>Manhattan</td>
</tr>
<tr>
<td>Breaking Ground</td>
<td>Brooklyn &amp; Queens</td>
</tr>
<tr>
<td>Bronxworks</td>
<td>Bronx</td>
</tr>
<tr>
<td>Project Hospitality</td>
<td>Staten Island</td>
</tr>
<tr>
<td>BRC</td>
<td>Subways</td>
</tr>
</tbody>
</table>
EXTREME WEATHER RESPONSE

CODE BLUE

- The Code Blue procedure provides guideline for the protection of the health and safety of unsheltered individuals - and the prevention of injury and death, ie resulting from cold exposure.
- Code Blue is activated when the temperature with wind chill hits temperatures below 32 degrees Fahrenheit (F) between the hours 4pm and 8am.
- Outreach maintains a list of vulnerable clients who are checked on during Code Blue periods.
- During Enhanced Outreach, teams double their coverage and check on vulnerable clients every 2 hours, engaging them about available services and helping them move to warmer settings.
HEALTH + HOSPITALS/BELLEVUE SAFETY NET INTERVENTION

Yinan Lan, M.D.
49% vs 33% Black in homeless vs general population
HOSPITAL AND STREET HOMELESS OUTREACH

- Shelter/street outreach case management warm handoff
- Internally reaching street-dwelling patients at the ED and inpatient units