NHCHC Conference 2023
Fostering Partnership: From In-Patient Psych, to Medical Respite, to Permanent Housing

NYC Housing for Health

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About NYC Health + Hospitals

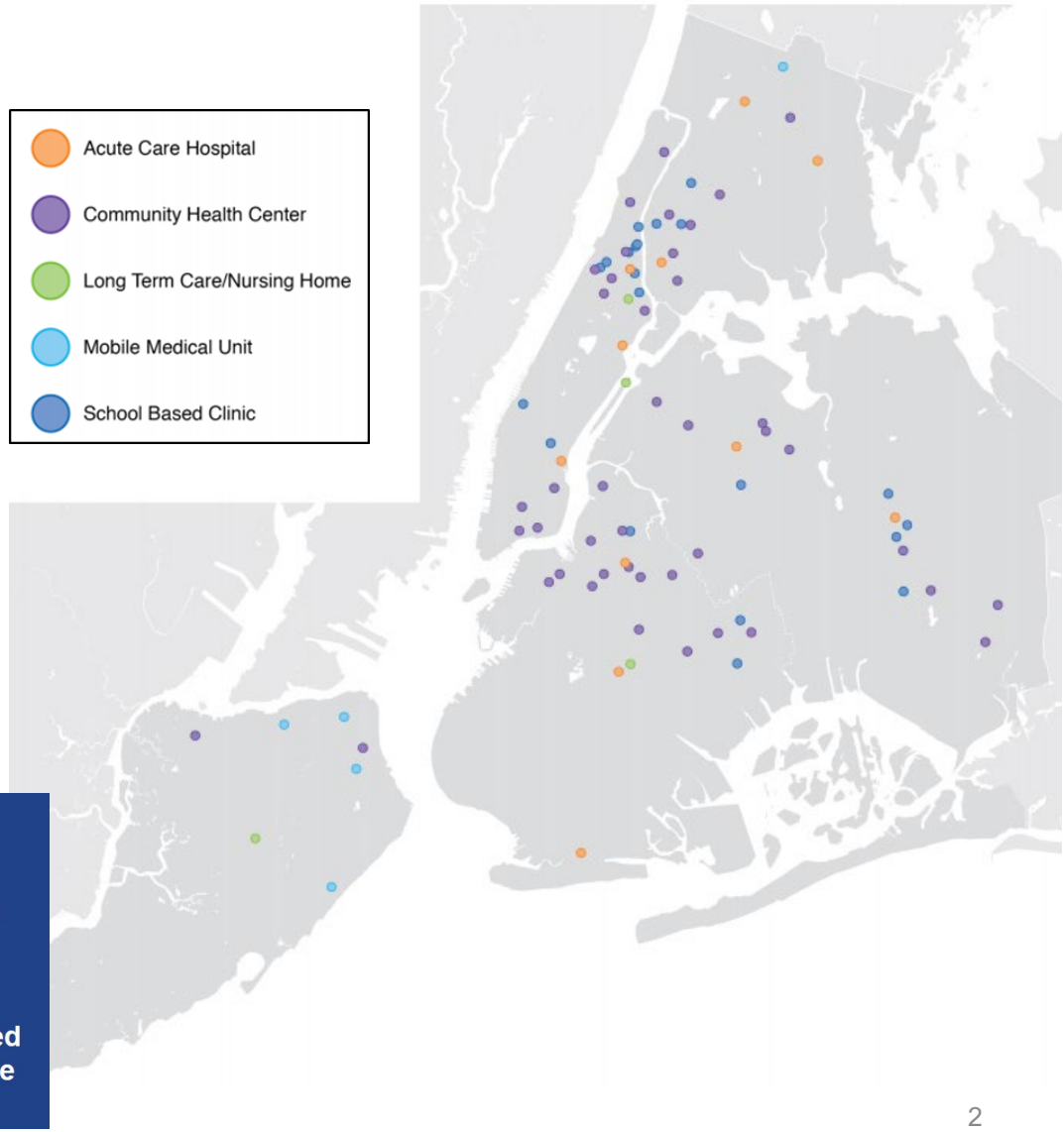
H+H is the nation's largest safety net healthcare system

- 11 acute hospitals, 50+ health centers, long-term care, home care, and correctional health services
- Over 45,000 staff
- Serve all patients regardless of documentation status or ability to pay

1.1 Million+ New Yorkers served annually

Our adult patients are:

- 30% uninsured
- 30% speaking a language other than English
- **6% experiencing homelessness (nearly 50,000 patients)**
- Racially and ethnically diverse:
  - 38% Hispanic/Latinx, 31% Black or African American, 10% White, 7% Asian/Pacific Islander, 14% Other



NYC Health + Hospitals' Housing for Health (HfH)

H+H Housing for Health facilitates housing opportunities and supports for patients experiencing homelessness

Why Housing for Health?

50,000 H+H patients are homeless or marginally housed and 22,000 H+H patients are also Department of Homeless Services (DHS) clients

- On average, patients experiencing homelessness visited the **ED 3x more often** than non-homeless patients
- Patients experiencing homelessness were more likely to have an inpatient visit and **stayed 3x longer** across their admissions
- Evidence is clear that where you live affects your health and well being.

Expediting this population into stable housing saves lives, improves health outcomes, and reduces the expensive emergency health care and in patient resources

Source: Pop Health Dashboard/DSS data

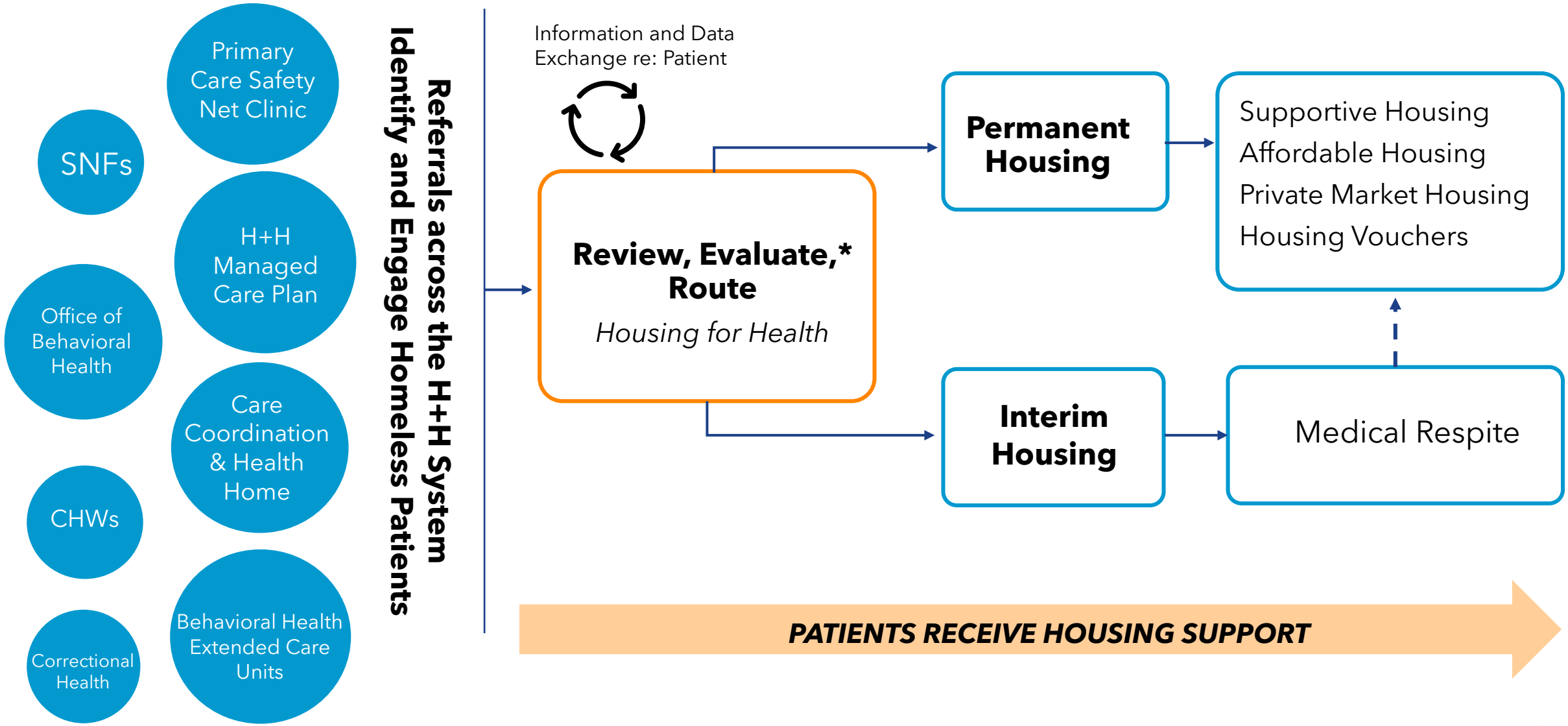
Housing Opportunity Strategy

- ★ **Provide Housing Navigation Services**
- ★ **Fund Medical Respite Beds for Frail Patients**
- ★ **Fund Supportive Services in Permanent Housing**
- ★ **Dedicate NYC Health + Hospitals Land for Affordable and Supportive Housing**

Nearly 600 H+H patients permanently housed

Over 1,000 H+H Patients utilized Medical Respite with 25% stably housed post stay

HfH Workflow to Identify, Engage, House



Fostering Partnership to address Housing Barriers

- Healthcare systems face myriad barriers to provide the coordinated care necessary to safely transition patients experiencing homelessness into permanent housing
- For persons experiencing homelessness hospitalized in inpatient psychiatric settings, often times the standard of care is to stabilize the acute issue then discharge to shelter or street, despite the destabilizing mental health impact of these settings

Today we will discuss NYC Health + Hospitals' innovative Psychiatric Extended Care Unit (ECU) and our partnership between the ECU, our Medical Respite program, and Permanent Supportive Housing.

During today's presentation we will:

- Provide an overview of the three programs and the partnership
- Share program data and successes
- Share a patient narrative
- Discuss facilitators, systemic barriers, and lessons learned

H+H Bellevue Extended Care Unit (ECU)

The subacute psychiatric unit is a 19-bed floor designed to:

- Provide care for patients with severe persistent mental illness with a history of poor community tenure
- Provide treatment through a social learning model, which, in addition to medication management and psychotherapy, highlights the role of community-based learning (groups) and behavioral reinforcement (rewards for prosocial behavior) to maneuver through challenges, stressors and other potentially anxiety provoking situations
- Focus on social determinants of mental health, recovery as well as person-centered care, with the individual's goals informing treatment
- Tailor aftercare planning to the particular needs of the patient and aims to maximize opportunities for the patient to use new skills to support meaningful community re-integration

The length of stay is approximately 90-120 days, with variation based on response to treatment and appropriate disposition.

The ECU is regulated by the New York State (NYS) Office of Mental Health, subject to Article 9 of the NYS Mental Hygiene law.

H+H Medical Respite Beds for Frail Patients

H+H Medical Respite provides temporary housing (30 to 90 day stays) for our medically vulnerable patients experiencing homelessness who are cleared for discharge, but still require access to care not available in shelter.

H+H contracts with two experienced CBOs, Comunilife and Institute for Community Living (ICL), to operate 51 interim housing beds in the Harlem neighborhood of upper Manhattan.

✓ **Medical and Behavioral Health Support**

Access to visiting homecare services such as wound care and PT/OT, arranged by H+H discharge planners
Clinical providers (RNs) on-site a minimum of 4 days/week to follow up on aftercare plans
Medication management by respite operators who schedule and ensure discharged patients take their medication
HfH physician advisor visits both sites on a biweekly basis

✓ **Intensive Housing Case Management**

Provide housing navigation and placement through supportive, affordable and private market housing, family reunification, and assisted living placement and assist patients in applying for other public benefits
25% of respite patients are discharged from respite to stable housing

Funded primarily by NYC Health + Hospitals through the New York State DSRIP Medicaid Re-Design waiver and grant support

H+H Medical Respite – On-site Services

Comunilife and Institute for Community Living (ICL) rent privately owned real estate in Harlem

- ✓ Three medically tailored meals per day
- ✓ Single or double rooms with shared bathrooms
- ✓ ADA accessible site and facilities
- ✓ OT/PT and wound care provided by visiting providers put in place by H+H discharge planners
- ✓ Care coordination for follow up appointments
- ✓ Case management for social service connections and entitlement enrollments
- ✓ Medication management
- ✓ Intensive housing case management

Institute for Community Living (ICL)

Founded in 1986, ICL's mission is to help New Yorkers with behavioral health challenges live healthy and fulfilling lives by providing comprehensive housing, healthcare, and recovery services.

As a multi-service organization, ICL operates mental health and primary career clinics, provides care coordination, manages several Assertive Community Treatment (ACT) and Intensive Mobile Treatment (IMT) teams and provide supportive housing.

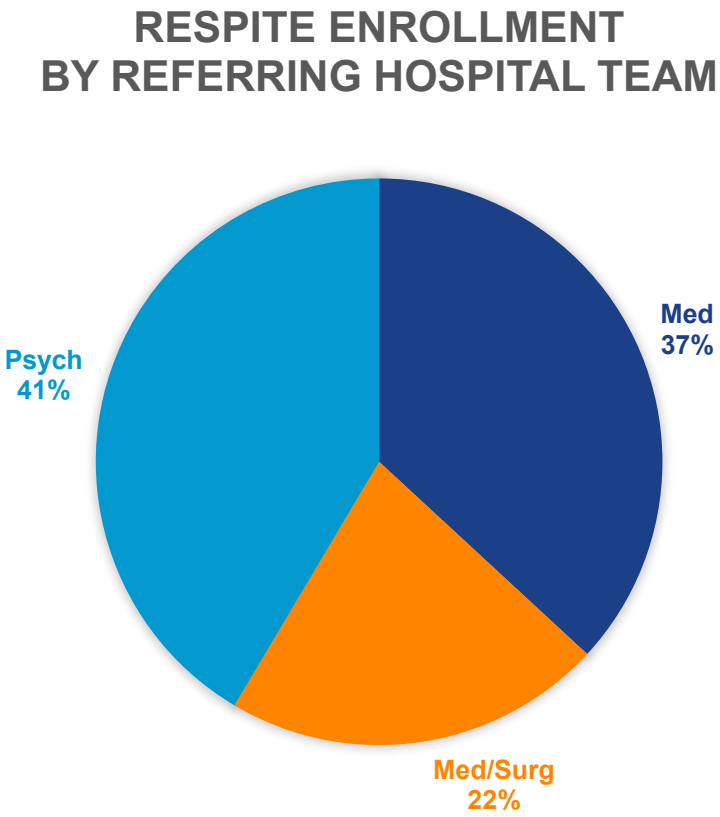
ICL's housing portfolio includes: 1,500 supportive housing beds, 14 community residences and three transitional housing shelters in locations around New York City where 3,200 individuals sleep each night.

In 2017, ICL was one of three organizations awarded the Excellence in Wellness Award by the federal agency, Substance Abuse and Mental Health Administration (SAMHSA) for ICL's impact on the health of people living with mental illness and substance use disorder.

Integrated Partnership: ECU, HfH, Medical Respite

From program design and inception, housing patients experiencing homelessness post-respite stay has a been a priority

- A pivotal selection criteria for respite operators is their experience in providing intensive housing case management and a portfolio of supportive housing units
- In June 2020, H+H expanded the Medical Respite program eligibility to patients experiencing homelessness needing safe discharge plan after inpatient psych hospitalization
- In Fall 2020, HfH formed a partnership with the Extended Care Unit and began case conferences about patients who were close to discharge and the type of support they needed
  - A specialized referral process, warm hand offs to ICL Medical Respite, and various forms of communication were established to foster ongoing collaboration



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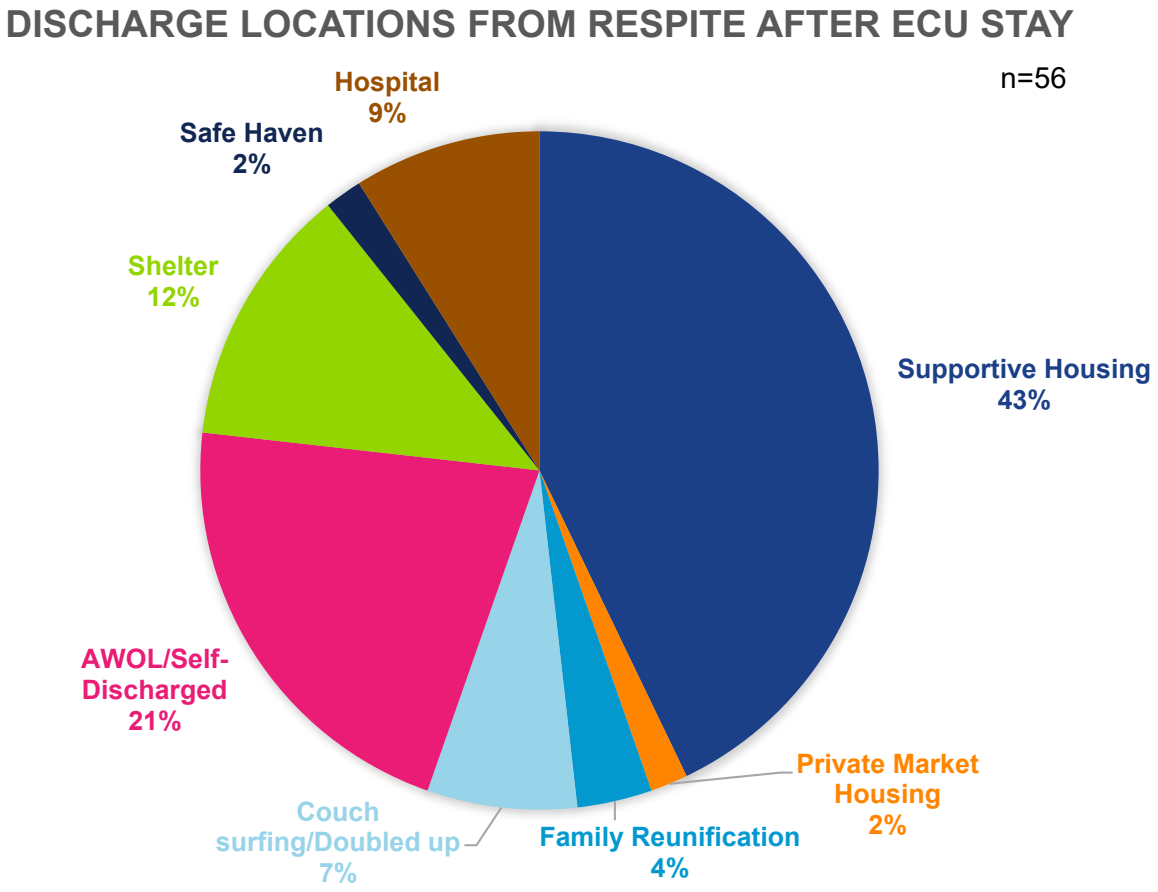
Success to Date

Since 2020, 57 patients have been enrolled in medical respite from the ECU (6% of all respite enrollees)

- Average length of stay (LOS) at respite is 55 days
- 43% of former ECU patients enrolled in respite were discharged to permanent supportive housing post-respite stay, compared to 17% of Inpatient Psych
- Shortened respite length of stay for former ECU patients discharged to supportive housing from respite (67 days for respite patients from ECU vs. 84 days for patients from Inpatient Psych)

Referring Unit	% Discharged to Supportive Housing	Total % Discharged to Stable Housing
Extended Care Unit	43%	48%
Inpatient Psych	17%	32%
Med/Med-Surg	3%	16%
All Respite Patients	10%	24%



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Patient Narrative – "Lisa"

2020
Lucy lost her job and housing, became homeless and slept in train stations

April 2021
Hospitalized at H+H inpatient psych for delusions and auditory hallucinations

18 days later,
Transferred to Extended Care Unit (ECU)

65 days later,
Discharged from ECU to ICL Medical Respite

121 days later,
Moved into ICL Supportive Housing

Lisa is a 32 year old woman from Sierra Leone diagnosed with Schizophrenia and was experiencing homelessness prior to hospitalization.

In the **Extended Care Unit**, Dr. Carine Nzodom and ECU team helped Lisa:

- Continue to stabilize and manage her symptoms
- Renew her green card and submit her taxes
- Complete the supportive housing application

At **ICL Medical Respite**, staff helped Lisa:

- Apply for social security income
- Apply for housing opportunities with her completed supportive housing application from the ECU
- Advocated for her acceptance into an ICL Supportive Housing program.

"Dr. Nzodom encouraged me to start taking [medication] and the voices decreased. I started feeling much more normal. They helped me out with housing and going to medical respite, very grateful that they did that."

"[Dr. Nzodom] checked in with me like family. She really did that and put me in better housing. I was going through a lot and they all really helped me."

Today, Lisa is still housed in ICL Supportive Housing and obtained her US Citizenship. She has since reunited with her family and continues to communicate with them frequently. She obtained her GED, home health aide certificate, and is now working full time as a home health aide. Lisa reports that now she's overall doing well.

Facilitators for Housing Post Respite Stay

- **On-going strong communication** and information sharing between partners
  - **Monthly and weekly meetings** for care coordination between all parties
  - **Trouble shooting** before sending a referral to ensure an respite is the best plan for the patient, helping set patients up for success
  - **Leverage organizational resources** to address any concerns and facilitate acceptance into programs
- **Warm hand-offs** from hospital, to respite, to supportive housing
- **Access to hospital system's Electronic Health Record (EHR)**
- **Respite operator's inventory of supportive housing** and expertise in navigating the housing process
- **Unique housing landscape in NYC:** New York's supportive housing eligibility specifically for individuals living with serious mental illness (SMI) and substance use disorder (SUD)
  - Additionally, majority of patients come from ECU with a completed supportive housing application package, speeding up the housing navigation process for respite team

Systemic Barriers

- **Bias from Supportive Housing providers** who may view extended psych hospitalization as an indication that patient will not be able to live independently in the community
- **Low vacancy rates for supportive housing** units with on-site supports vs. scattered site supportive housing
- **Barriers with HUD definition of homeless chronicity**
- **Challenges if re-hospitalized from respite:**
  - Currently, if a patient is re-hospitalized at an H+H facility, the hospital staff may not be aware they came from respite
    - HfH is working on integrating medical respite documentation into shared Electronic Health Record (EHR), which will help facilitate information sharing
  - If a patient has a short hospitalization at a different hospital outside of the H+H healthcare system, they are unable to return to respite which can be disruptive to the patient's care

Lessons Learned

Referral Process

- Program implementation takes time and requires constant outreach to reach critical mass especially in a large healthcare system
- Feedback and focus groups with referrals sources is critical for process and quality improvement
- Strive to create low barrier referral process for hospital staff making referrals

Clinical Support

- Recently added an RN to respite team, but without an on-site Psych MD/NP it's difficult to quickly intervene or adjust medications after a patient leaves ECU's care

Patients' Experiences

- Create opportunities for people who have gone through the program to provide their input for changes

Housing Opportunities

- When developing an Extended Care Unit, it's helpful to facilitate throughputs to permanent housing post-ECU stay
- Partner with CBOs for medical respite who have their own inventory of supportive housing

On-going Communication and Site visits

- Access to Electronic Health Record (EHR) allows the respite operator to help coordinate ongoing care for the discharged patient
- Facilitate on-going communication and site visits for all partners, especially during periods of staff transition

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