Supporting Safe Discharge from Health Care Facility to Shelter in NYC

National Health Care for the Homeless Symposium 2024

Department of Homeless Services
Department of Social Services

Presentation Overview

- **NYC Department of Homeless Services Institutional Referral Program**
  - Background and setting
  - Client health characteristics
  - Standard discharge review procedures to determine medical appropriateness
- **Assisted Discharge Planning Intervention**
  - Diversion assistance
  - Follow-up care plan support
  - Applications for community health programs
  - Shelter placement assistance methods and outcomes

NYC Department of Homeless Services (DHS) Overview

- **Right to Shelter law in NYC**
  - Mission to provide temporary shelter and access to permanent housing
  - Critical objectives:
    - Maintain shelter safety and sanitation
    - Reduce street homelessness
- **Serves over 100,000 households in a year**
  - Currently over 80,000 individuals per night, Including asylum seekers
- **Over 550 shelter facilities throughout NYC**
- Dozens of shelter provider organizations:
  - DHS, non-profit and for-profit providers
  - Varied culture, structure and services

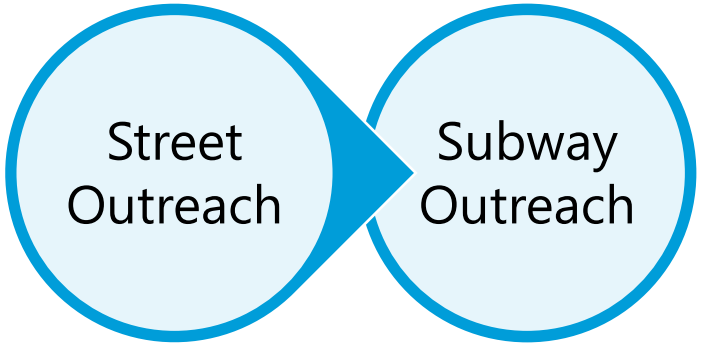
DHS Settings

Single Adult Shelter (Congregate)

Safe Haven (single, double, & congregate)

Families with Children Shelter (Single Unit)

Adult Family Shelter (Single Unit)



Over 95% of people experiencing homelessness are in shelter in NYC.

Approximately **4,000 chronic street/subway homeless***

*2023 Homeless Outreach Population Estimate (HOPE Cou

Shelter Client Health Characteristics

Among people experiencing homelessness in NYC

- Overdose is leading cause of death
- Alcohol is the fifth leading cause of death
- Suicide and homicide are in top 10 causes of death

2018 NYU Medicaid claims analysis found among DHS single adults:

- **66% chronic substance use**
- **51% serious mental illness**
- **32% Diabetes**
- **30% Cerebral Vascular Disease**
- **10% Chronic Obstructive Pulmonary Disease**
- **5% Congestive heart failure**

DHS Shelters Provide

- Right to shelter: anyone will get a bed same day, unless they are deemed medically inappropriate
- Social services and benefit access
- Three meals a day plus snacks that meet the NYC Food Standards
- Medically necessary and religious diets
- Overdose prevention and naloxone
- Medical assessment and linkage to care
- Reasonable accommodations, including ADA accessibility and emotional support animals

Client Facing Shelter Staff

Core Staff

- Shelter Director
- Social Service Director
- Case managers
- Housing specialists
- Residential staff
- Security

Sometimes

- Substance use counselors
- Social workers
- Peers
- Clinicians
- Food handlers
- DHS Police (very few shelters)

Congregate Shelter Limitations

Cannot provide or accommodate “Homecare” services

- Client must be independent in activities of daily living
- Cannot accommodate home health aides due to congregate setting
- Can accommodate visiting nurse for a short time

Cannot ensure treatment or medication management

- Only a few shelters have clinics and/or staff on site to offer treatment or medication management. Transfers are common, so this service is likely to be disrupted.

Do not have the type of security available in hospital to manage violence

Shelter is voluntary, do not have means to retain clients

New York State Regulations: Department of Social Services

Shelter for Adults
Section 491.9

Referrals and assessments, N.Y. Comp. Codes R. & Regs. tit. 18 § 491.9

According to State regulations, a person should not be placed in shelter if they:

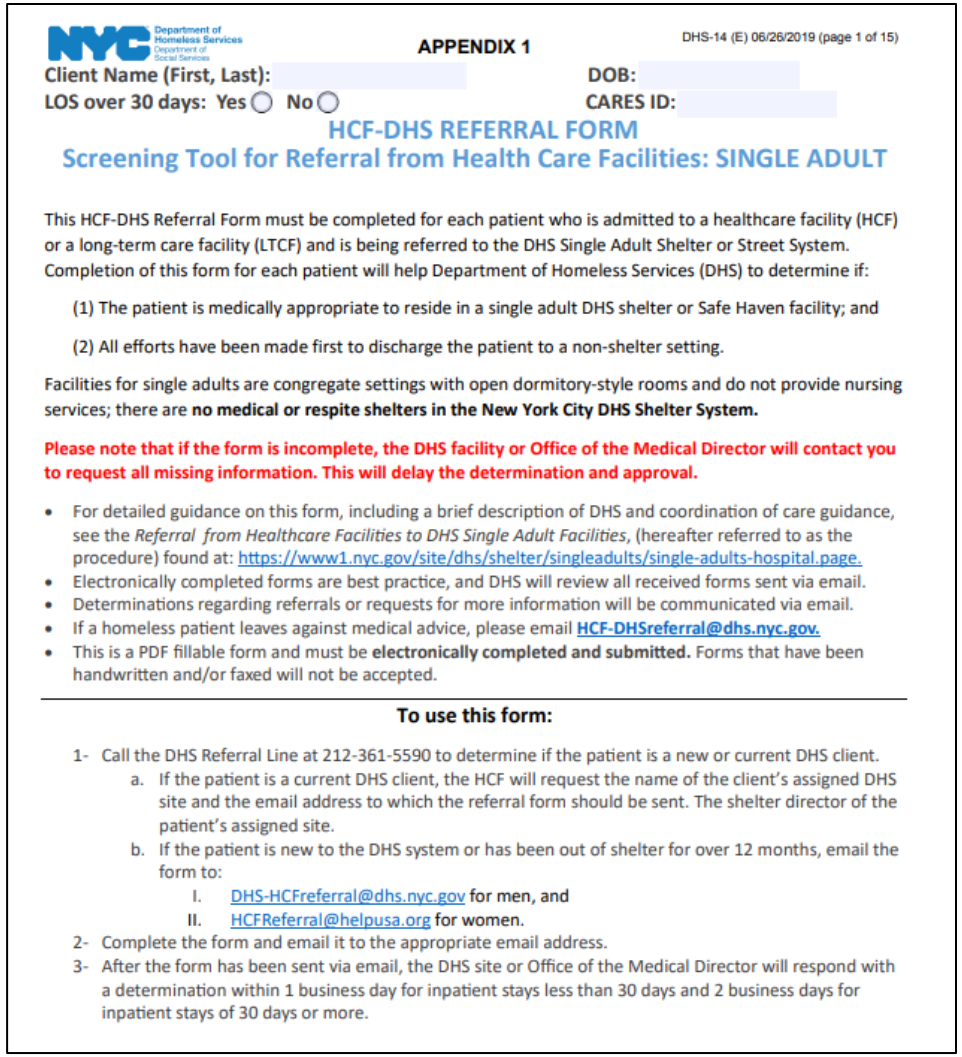
- Have a mental or physical condition that may cause danger to self or others
- Requires services beyond what shelter is authorized to provide by law and regulation and/or through assistance of other community resources

DHS Institutional Referral Program

- **DHS established the Institutional Referral Program to:**
  - **Determine if patient is medically appropriate for shelter based on**
    - patient clinical characteristics
    - shelter environment, staffing and resources
  - **Coordinate a safe discharge plan**
    - to meet client health needs
    - given the unique congregate single adult shelter setting
- **Required after in-patient hospital or health care facility stay** (including skilled nursing facilities)

Institutional Referral Process

- Healthcare Facility completes forms and emails to DHS
  - **DHS-Institutional Referral Form**
  - Consent to be discharged to shelter, signed by patient
- DHS reviews and responds within 24 hours (business days) with questions or a determination



NYC Department of Homeless Services / Department of Social Services

APPENDIX 1

DHS-14 (E) 06/26/2019 (page 1 of 15)

Client Name (First, Last): **DOB:**

LOS over 30 days: Yes ◯ No ◯ **CARES ID:**

HCF-DHS REFERRAL FORM

Screening Tool for Referral from Health Care Facilities: SINGLE ADULT

This HCF-DHS Referral Form must be completed for each patient who is admitted to a healthcare facility (HCF) or a long-term care facility (LTCF) and is being referred to the DHS Single Adult Shelter or Street System. Completion of this form for each patient will help Department of Homeless Services (DHS) to determine if:

(1) The patient is medically appropriate to reside in a single adult DHS shelter or Safe Haven facility; and

(2) All efforts have been made first to discharge the patient to a non-shelter setting.

Facilities for single adults are congregate settings with open dormitory-style rooms and do not provide nursing services; there are **no medical or respite shelters in the New York City DHS Shelter System.**

Please note that if the form is incomplete, the DHS facility or Office of the Medical Director will contact you to request all missing information. This will delay the determination and approval.

- For detailed guidance on this form, including a brief description of DHS and coordination of care guidance, see the *Referral from Healthcare Facilities to DHS Single Adult Facilities*, (hereafter referred to as the procedure) found at: https://www1.nyc.gov/site/dhs/shelter/singleadults/single-adults-hospital.page.
- Electronically completed forms are best practice, and DHS will review all received forms sent via email.
- Determinations regarding referrals or requests for more information will be communicated via email.
- If a homeless patient leaves against medical advice, please email **HCF-DHSreferral@dhs.nyc.gov.**
- This is a PDF fillable form and must be **electronically completed and submitted.** Forms that have been handwritten and/or faxed will not be accepted.

To use this form:

1- Call the DHS Referral Line at 212-361-5590 to determine if the patient is a new or current DHS client.
   a. If the patient is a current DHS client, the HCF will request the name of the client's assigned DHS site and the email address to which the referral form should be sent. The shelter director of the patient's assigned site.
   b. If the patient is new to the DHS system or has been out of shelter for over 12 months, email the form to:
      I. DHS-HCFreferral@dhs.nyc.gov for men, and
      II. HCFReferral@helpusa.org for women.
2- Complete the form and email it to the appropriate email address.
3- After the form has been sent via email, the DHS site or Office of the Medical Director will respond with a determination within 1 business day for inpatient stays less than 30 days and 2 business days for inpatient stays of 30 days or more.

Determining Medical Appropriateness

Possible Determinations:

- **Appropriate**
- **Incomplete**
- **Inappropriate:** absolute exclusion criteria as listed on Institutional Referral Form
  - DHS provides suggestions on more appropriate discharge placement

Absolute Exclusion Criteria[6]

The following absolute exclusion criteria render a single adult client de facto medically inappropriate for DHS facilities:

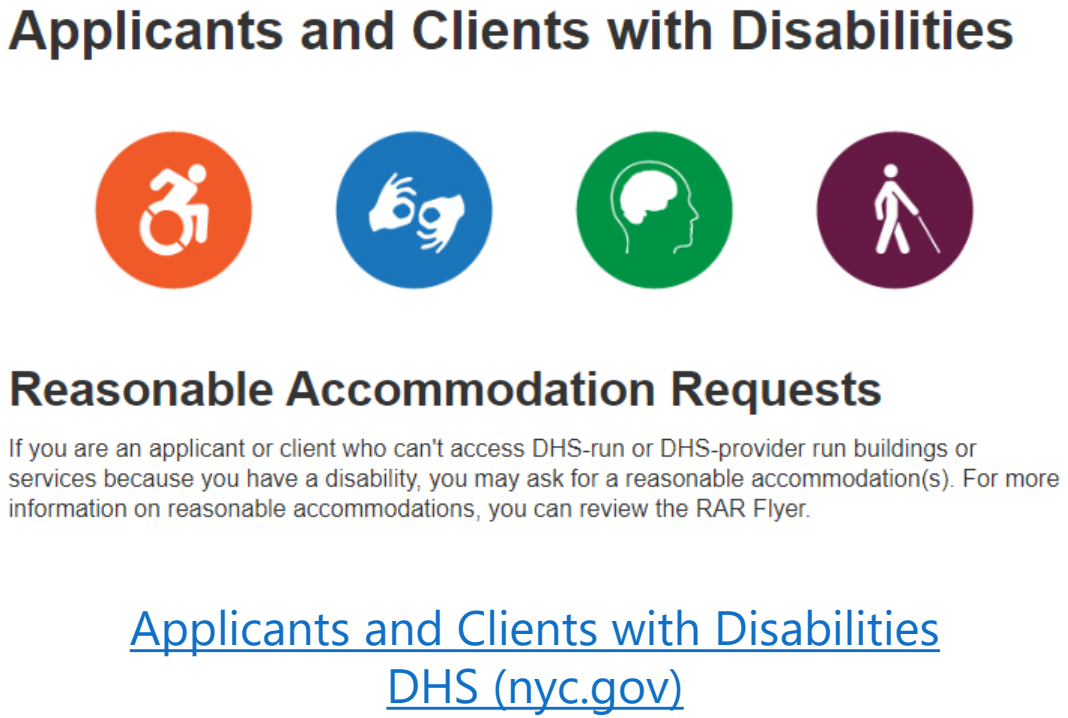
- Inability to care for self and independently manage activities of daily living; use the ADL Assessment Form included on the Referral Form. An ADL score <12 indicates medical inappropriateness for shelter. The DHS ADL Assessment For Institutional Referrals form must be completed by a clinician on the client's team (Appendix 2 [**DHS-14a**]);
- Lack of decisional capacity;
- Need for home care or nurse visits beyond wound care or IM/IV medication administration and beyond 2 weeks;
- Severe immunosuppression (chemotherapy, end-stage AIDS, post-transplant, with an Absolute Neutrophil Count (ANC) <500mL);
- Major dementia with cognitive deficits (MMSE <25);
- Inability to understand spoken, signed, visual, or tactile language with or without an interpreter;
- Inability to make needs known or follow commands;
- Poses imminent risk of physical harm to themselves or others;
- Inability to independently manage chronic illnesses or medication administration, schedule, and reminders, including inability to self-administer insulin;
- Inability to independently manage urinary catheters;
- Peritoneal dialysis;
- Inability to manage urinary or bowel incontinence or explosive diarrhea;
- Oxygen-dependence requiring an oxygen tank/cylinder of any size, containing liquid or compressed oxygen;
- Unresolved delirium;
- Cranial Halo Devices or stabilizing protective gear worn continuously; or
- On a ventilator.

DHS-Institutional Referral Form

DHS Reasonable Accommodation

Reasonable Accommodation can be requested to address health needs:

- Location near medical care
- First floor room
- Access to refrigerator
- Wheel-chair accessible bathroom
- Oxygen tank
- Medically necessary diet
- And more

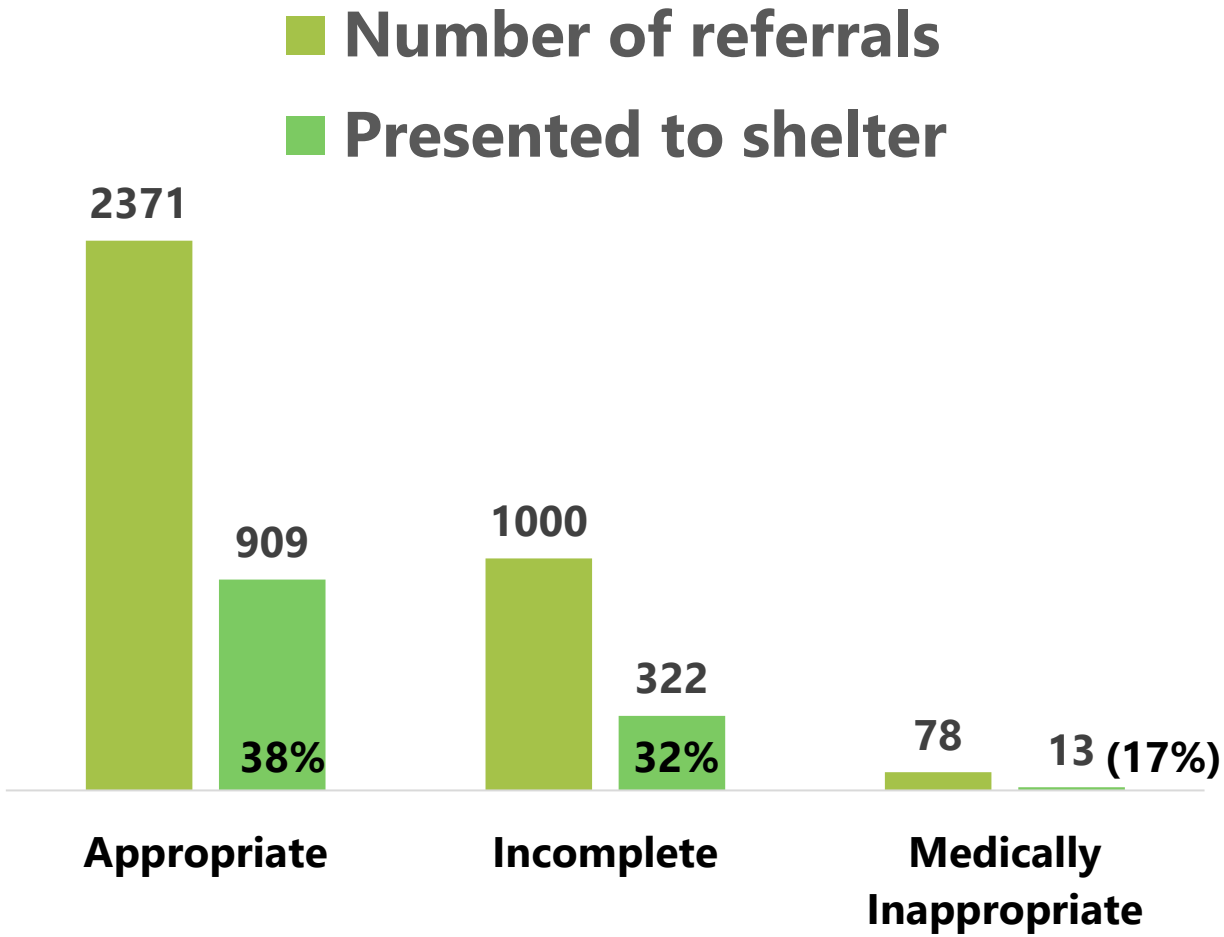


[Applicants and Clients with Disabilities DHS (nyc.gov)]

Obvious and apparent requests can be approved quickly (such as for wheelchair accessible shelter). Others can take several weeks to approve so patient may be discharged before reasonable accommodation is in place.

Presentation to Shelter by Medical Determination, 2023

- **3,449** referrals in 2023
- **1195 (35%)** presented to shelter after the referral



Supporting Safe Discharge to Shelter for High-Risk Patients Through Collaborative Discharge Planning

Assisted Discharge Planning

There is an opportunity to put a support plan in place while in the health care facilitate to:

- Prevent return to street or subway
- Improve health outcomes in shelter and/or the community
- Prevent crisis, rehospitalization
- Prevent harm to self or others (shelter residents, staff, community)

NYC Hospital to Shelter Discharge Planning Partners

Preparing for Single Adult Shelter Intake and Assessment Process

Intake Site

- **Few hours**
- **Centralized location**
- **In-person**

- **Goal:**
  - Diversion
  - Eligibility assessment
  - Assessment shelter assignment

Assessment Shelter

- **Average 21 days**
- **5 locations**
- **High volume**

- **Goal:**
  - Health and social services assessments
  - Program shelter assignment

Program Shelter

- **Longer term**
- **100s of locations**
- **Program types:** general employment, senior, TGNC behavioral health

- **Goal:**
  - Housing placement

Oliver - High-risk patient case example

Information on Institutional Referral Form and psych eval

- 48-year-old male
- Schizoaffective disorder, diabetes
- Recent incarceration for multiple assaults, including punching elderly stranger on bus in last year
- Involuntarily removed from subway prior to hospitalization
- Lack of insight into mental illness, declines voluntarily mobile mental health programs

Hospital states:

- Patient has been compliant with medications and treatment in hospital and is “at baseline”
- Not acutely danger to self or others, and can not retain

What should DHS coordinate to:

- Prevent return to subway/street
- Support treatment initiated in hospital
- Ensure safety of patient, shelter residents and staff

Assisted Discharge Planning Intervention

- In 2023 the DHS Institutional Referral Program:
  - Developed a new Redcap database to document patient characteristics and assisted discharge planning activities & outcomes
  - **Reviewed 3,028 referrals** from health care facilities

Referral source

- **70%** hospital
- **40%** inpatient psych hospital
- **18%** jail or prison forensic mental health program

Client risks

- **2219 (80%)** high risk medical, mental health or substance use condition
- **1243 (45%)** history of street or subway homelessness
- **248 (8%)** court ordered mental health treatment (AOT/Kendra's Law)

Institutional Referral Program Team

Processor
Receives and triages referrals, data entry

Reviewer
Initial review, basic care coordination, approval

Medical Consultant (MD)
Review high risk cases, care coordination, medical determination

Director of Special Populations (LCSW)
Advocates in critical cases, tests new methods

Chief Medical Officer
Advocates in critical cases, legal negotiation

Shelter Diversion Assistance

Assisted Living

- For those with health insurance
- Challenges for people with severe mental illness

Skilled Nursing

- Insured and public options for uninsured
- Challenges for people with severe mental illness
- Not enough beds

Development Disabilities Housing (OPWDD)

- Must have been diagnosed by age 22
- Challenges for people with

Return to Housing

- Can negotiate return to supportive or subsidized housing
- Families may agree to accept back with support

Medical Respite

- For insured and uninsured
- Short term (90 days)

Long-term Psychiatric Hospitalization

- Stringent admission criteria

Patient often has no other viable option than shelter

Follow-up Care Plan Review and Assistance

Medical Needs at the Shelter

- Equipment needed, storage plans
- Special shelter feature needs (such as elevator or smaller dorm)
- Onsite services (clinic, DHS police)
- Location near follow-up care

Follow-Up Care Plan

- Follow-up visits scheduled, based on patient health needs
- Viable medication and treatment adherence plan
- Short-term visiting nurse, if needed

Mobile Mental Health Program Coordination

Care Coordination and Health Homes

- Medicaid and **Non-Medicaid** options

Assertive Community Treatment (ACT)

- Intensive community-based treatment services, for patients with Medicaid.
- **Dedicated slots for DHS clients**

Assisted Outpatient Treatment (AOT)

- Court mandated treatment

Safe Options Support (SOS)

- Outreach and community mental health care for uninsured or insured patients with street/subway homelessness

Intensive Mobile Treatment (IMT)

- Intensive community-based treatment services for uninsured or insured patients who are highly transient, have history of incarceration and/or are more violent

Location Based Services – shelter placement coordination is needed to ensure engagement after discharge

DHS routinely recommends and expedites review and assignment for these and other programs

Special Health Services for People Experiencing Homelessness

NYC HEALTH+ HOSPITALS

Safety Net Clinics

- For people experiencing and homelessness with multiple medical conditions
- Integrated primary care, behavioral health and specialty care
- Care coordination, social work, community health work
- Conducts street outreach through medical mobile units
- **In four hospitals in NYC (location based)**

ExpressCare | Virtual Urgent Care

- Available to everyone citywide, with special initiative for DHS clients
- Medical and behavioral health urgent care and medication prescription
- 24 hours a day, 7 days a week, in over 200 languages
- For insured and uninsured.
- Online or by telephone **(citywide, not location based)**

www.expresscare.nyc/dhs

Oliver – Discharge Planning Assistance

- Attempt to divert to specialized housing for people with history of incarceration
- Recommend petition for AOT
- Expedite enrollment in Shelter Partnered ACT Program, suggest wait listing for IMT
- Recommend referral to public hospital Safety Net clinic

Shelter Placement Assistance

- DHS can coordinate **expedited intake and shelter placement** to support engagement in follow-up care plan, considering:
  - Location near health care
  - Mobile health program assignment
  - Special shelter features such as elevator, clinic onsite, or shelter to mitigate risk

Reasonable Accommodation request is needed to ensure placement or accommodation is in place long term.

Shelter Prediction

Definition	• **Recommendation to be placed in a specific shelter**
Target Clients	• Complex clients who need location-based services
Process	• Health care facility or DHS determine client needs to be in a particular shelter or location to engage in follow-up care plan • DHS identifies shelter and places a flag in client record • Client goes through usual shelter Intake and Assessment process (average of 21 days) • Client should be placed at the Predicted shelter if possible (based on vacancy or other findings)
Considerations	• Only option to plan in advance - because bed can't be held for more than 2 days

Fast Track

Definition	• **Expedited Intake and same day Program shelter placement** • Bypass Assessment Shelter (average 21 days)
Target Clients	• Most complex clients at risk of destabilizing quickly or going back to street/subway
Process	• DHS checks for a bed/vacancy at Predicted shelter 1-2 days in advance of confirmed discharge • If bed is not available: delay discharge or identify another shelter (which may disrupt follow-up care plan) • Inform Intake of Fast Track request and plan. Be on call to assist with challenges • Bed must be claimed day of discharge (by 11 PM)
Considerations	• Client is "skipping in line" • Time and labor intensive to coordinate

Accompaniment

Definition	• **Mobile mental health program supports client through Intake process**
Target Clients	• Most complex/fast track clients
Process	• Program enrolls client while in health care facility • Day of discharge, program picks client up at health care facility to travels to Intake • Remains with client during Intake interview, advocates for client, encourages client to complete process • Travels with client to Predicted program shelter to claim bed
Considerations	• Takes a half to full day • Not always feasible

Oliver – Shelter Placement Assistance

- Predict to shelter based on location of health services
- Set up Fast Track, and coordinate accompaniment
- Inform Intake, DHS programs, and shelter of Fast Track request and plan to engage in care upon arriving at shelter
- Check if patient made it to shelter to engage in services, if not advocate for appropriate placement
- Inform Street Outreach if patient returns to street

Shelter Placement Assistance Outcomes

- From November 1, 2023 – March 31, 202 (5 Months) the program reviewed **1,728** referrals:
  - **1529 (88%)** had a serious medical risk
  - **102 (7%)** received shelter placement assistance to support engagement in follow-up care plan

Shelter Placement Assistance Outcomes

November 1, 2023 - March 31, 2024 (5 Months)

Coordinated Prediction Only	**47**	
Went to shelter intake	28	60%
Made it to predicted shelter	**0**	**-**

Coordinated Prediction + Fast Track	**37**	
Went to shelter intake	15	41%
Made it to predicted shelter of those who came to intake	**13**	**87%**

Coordinated Prediction + Fast Track + Accompaniment	**18**	
Went to shelter intake	9	50%
Made it to predicted shelter of those who came to intake	**7**	**78%**

Findings

For people experiencing homelessness and serious mental health, medical or substance use conditions:

- **Effective discharge and follow-up care plans depend on:**
  - Shelter placement near follow-up care
  - Availability of needed services at the shelter or nearby
  - Support to navigate Intake and placement process
- **Without shelter placement assistance, the patient has a lower probability of engaging in their follow-up care plan**

Future Planning

- Improve referral systems and infrastructure
- Expand team with staff who specialize in high-risk patient discharge planning
- Explore options for Peer and Community Health Workers to assist with transitions into shelter
- Pilot virtual intake and direct placement from health care facility to program shelter

Acknowledgements

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