Testimony of Daniel Tietz

The New York City Department of Social Services | Human Resources Administration

New York City Council General Welfare and Health Committees

Oversight Hearing Part 1 – Medical Health Services in the DHS Shelter System

November 17, 2016

Good morning, Chairman Levin and Chairman Johnson, and distinguished members of the General Welfare and Health Committees. Thank you for inviting us to appear before you today to discuss medical health services in the DHS shelter system. My name is Daniel Tietz and I am the Chief Special Services Officer for the New York City Human Resources Administration (HRA) in the Department of Social Services, which also includes the Department of Homeless Services (DHS). Since the start of the 90-day review of DHS that was conducted earlier this year, I have assisted in oversight of program services at DHS. I am joined today by my colleague, Fabienne Laraque, the DHS Medical Director who started in early September after a distinguished career at DOHMH.

As you know, DHS is responsible for providing shelter and other services to homeless New Yorkers, which includes those who are on the street and those seeking or residing in shelter. In my testimony today, I will provide an overview of the DHS system – which provides temporary and transitional housing, and serves as a place of last resort, for those in need of shelter. I will also update the committees on the progress of relevant reforms following the completion of the 90-day review of the homeless services system in New York City. More specifically, I will provide an overview of the programs and services for families with children, as well as for single adults and adult families, to address clients' medical needs while in shelter and the associated outcomes.

First I'd like to provide some context and note several ways in which HRA and DHS work closely to serve our shared constituents, most especially to prevent homelessness. HRA has always provided homelessness prevention services. But we have now consolidated all of the HRA homelessness prevention programs into a single unit called the Homelessness Prevention Administration (HPA). Most recently, Homebase, which had been administered by DHS has been moved to HRA. In addition to Homebase, the HRA Early Intervention Outreach Team receives early warning referrals from Housing Court and from NYCHA for tenant arrears cases, Adult Protective Services referrals, and referrals from New York City marshals. This team also works closely with the City's Tenant Support Unit to refer low-income New Yorkers to legal

services providers under contract with HRA to help them avert eviction, displacement, and homelessness.

Another key component of HRA's homelessness prevention work is rental assistance. Rental assistance programs to keep families and individuals in their homes and to help those in shelter exit to permanent housing are both better for families and individuals and more cost-effective for taxpayers. After Advantage – the State-City rental assistance program supporting thousands of families – was ended by the State and the City in 2011, the City's shelter population increased exponentially from about 37,000 in 2011 to nearly 51,000 in 2014. Over the past two years, the new rental assistance programs and other permanent housing efforts have enabled 40,540 children and adults in 13,806 households to avert entry into or to move from DHS and HRA shelters.

Further, from January 2014 through June 2016, about 131,000 households – including approximately 390,000 people – received emergency rental assistance to help them stay in their homes, averaging about $3,600 per case, which is much less than the $41,000 it costs each year to shelter a family.

And finally, within HPA, the HRA Office of Civil Justice oversees the City's civil justice services and monitors the progress and effectiveness of these quality, free, legal assistance programs, a key component of the Administration's plan for addressing the needs of low-income New Yorkers and reducing poverty and income inequality. Providing coordinated homelessness prevention programs, including legal services and rental assistance, is much less expensive than the cost of a homeless shelter. This Administration has increased funding for legal services to prevent evictions, harassment, and homelessness 10-fold, from $6.4 million in FY2013 to $62 million in this fiscal year when the program is fully implemented. We are seeing results, even before full implementation, including a 24% decrease in evictions by City marshals over the past two years and an increase in legal representation of tenants in Housing Court from 1% as reported by the State Office of Court Administration for 2013 to 27% this year. When this tenant legal services program is fully ramped-up, the funding will enable legal services organizations to provide legal assistance to 33,000 low-income households, including some 113,000 New Yorkers.

Those most at risk of homelessness are affected by high rates of poverty, family conflict and domestic violence, and poor health, including high rates of chronic disease, and low access to care. At DHS intake points, which I will identify shortly, clients arrive with a host of complex and interrelated challenges, but have one thing in common: a lack of safe and affordable permanent housing. It is both our legal and moral obligation to shelter those New Yorkers who are found to be eligible for and in need of shelter.

In collaboration with HRA, DHS works to prevent homelessness when possible; to provide temporary, emergency shelter when needed; and to help individuals and families transition to permanent affordable housing. DHS achieves this through providing coordinated, compassionate, high-quality services and supports in our homelessness prevention work; street and subway outreach; sheltering individuals and families; and moving clients to housing permanency and supporting their transitions with aftercare services. We do this in furtherance of our system-wide, collective efforts to reduce homelessness and to improve the lives of all the clients we serve.

As of November 15, 2016, DHS is sheltering 60,588 individuals, including:

- 23,760 children
- 36,828 adults

These individuals and families are housed across DHS's system at facilities for singles, adult families with no minor children, and families with minor children utilizing shelters, cluster units, and commercial hotels. Among the facilities that constitute the DHS portfolio, 47 single adult shelters and 23 families with children shelters have access to on-site health care. The facilities with on-site health care are operated through contracts with non-profit organizations, including:

- Care for the Homeless
- Harlem United
- Project Renewal
- Bowery Residents Committee
- Floating Hospital
- Montefiore Children's Project
- ICL/HHC
- William F. Ryan
- HELP/PSI
- Housing Works
- Lutheran Family Health Services
- Interfaith Medical Center
- Janian Health

The remainder of facilities within the DHS portfolio secure and maintain connections to neighborhood and community health care providers to which clients are referred.

Consistent with City and State laws governing the right to shelter and the Americans with Disabilities Act, reasonable accommodations are made available to all clients either at the same shelter or via transfer to a more suitable facility upon demonstration of need. Reasonable accommodation may include modification to a facility's policies and practices, addressing architectural, communication or transportation barriers, and the provision of auxiliary aids, such as refrigerators, or accommodations for service animals. Additionally, many shelters have art therapists, occupational therapists and recreational activities, such as outings, yoga, and health classes. Further, all shelters follow the NYC DOHMH food standards and dietary

guidelines and all single adult shelters provide three nutritious meals per day and snacks. In addition, special diets are provided as needed.

Reforms

As a result of the 90-day review, DHS is implementing a series of 46 reforms in order to address gaps in service delivery, inadequate programming, and the safety and security of shelter clients. This includes significant improvements in how DHS delivers and ensures health care for those seeking or residing in shelter. The improvements, for example, include adding appropriately licensed and experienced clinical staff to the DHS Medical Director's office. These individuals will assist the Medical Director in designing evidence-based standards of care, planning and implementing newly-expanded program monitoring and oversight, and will conduct evaluations of existing programs and services.

Currently, in addition to the existing licensed Medical Director, there is one social worker with a MSW, one administrator/deputy to the medical director, three administrative/clerical staff and one staff analyst. As part of the findings of the 90-day review, we are adding experienced and qualified licensed clinical staff. These funded positions will include a deputy medical/clinical director (MD or nurse practitioner or clinical psychologist or licensed clinical social worker), a licensed nutritionist, a MPH/PhD health services analyst, and a registered nurse/MPH. These additional staff will allow DHS to better respond to those in shelter with medical and behavioral health needs and to design, plan, and oversee such services.

Among the improvements identified as part of the 90-day review that began in December 2015, we are presently:

- Improving the hospital and nursing home referral process by revising and automating the referral system, and centralizing review of the referrals, including addressing the need to allocate additional qualified staff. DHS is consulting with shelter providers and with selected hospitals, as well as hospitals and nursing homes associations, to obtain input to optimize the process. With the improvement of the referral process from medical facilities we intend to reduce the number of inappropriate referrals.

- Developing and revising medical and mental health standards for the screening at intake and comprehensive assessments in the Assessment shelters to ensure that such assessments are completed, clients are transferred in a timely manner to program shelters, and all data is entered into the DHS client database, so as to ensure that clients' clinical information and needs are available to providers in shelters or via referral. This will include revising and reissuing the RFP for the medical providers at intake and assessment for adults and families.

- Reviewing the possibility of requiring providers to conduct (or refer for) regular medical assessments of residents in the system for more than six months.

- Enhancing the assessments for FWC to obtain a more thorough profile of the health of each family member so as to identify issues early and to better facilitate linkages and coordination of care.

- Developing standards of care for medical and mental health care (which is underway) on-site at shelters or via MOU and linkage agreements, and strengthen linkage with medical providers in the community.

- Using newly-developed standards of care, including the use of evidence-based tools and interventions, to inform open-ended Requests for Proposals to solicit shelter and services providers.

- Revising program monitoring and quality management tools and systems, including adding regular site visits by appropriately trained and skilled DHS staff. This includes:
  - Training DHS program staff that monitor the shelters in performance-based program monitoring related to health services and provide them with tools and data to inform the review;
  - Hiring data analysts and epidemiologists to create and analyze indicators and create a quality management program;
  - Hiring a nutritionist to improve food services and outcomes for those who require special diets due to illness;
  - Establishing a mortality review program to review all deaths and identify those that could have been prevented and develop interventions to prevent such deaths.

- Collaborating with providers of health care for the homeless and public and not-for-profit providers to create a seamless system of care for the homeless, capitalizing on existing care systems in New York City and using shelter providers as points of clinical assessment, entry into care, coordination of care, and health and wellness promotion, from medical to dental care and nutritional education and services.

- Expanding on health education and health promotion to increase self-sufficiency and examining effective ways to measure improvements.

- Working closely with hospitals and other providers, we are also focusing on the needs of a modest group of chronically homeless persons who are high utilizers of Medicaid-paid

services and have significant health and/or behavioral health conditions so as to better coordinate their care and services, including facilitating their transition to appropriate housing and services.

I will now describe our Families with Children system, followed by our Single Adult system.

Families With Children

Families with minor children enter DHS shelter through the central intake center called the Prevention Assistance and Temporary Housing (PATH) center. Many families have existing medical and mental health care providers and thus not all families at PATH are referred to the on-site medical provider for comprehensive assessments. At PATH, each woman of childbearing age in the family is asked about pregnancy, the presence of an infant under four months of age, any acute medical needs, or the presence of a communicable disease. If any of these are present, the family is referred to The Floating Hospital, which is the on-site clinical provider. The on-site clinicians then conduct a more in-depth screening and offer indicated and necessary emergency services, referrals for follow-up in the community, and health education, as well as coordination with the client's existing health care providers. Once in shelter, clients are encouraged to and assisted in seeking care from their primary care physicians or a local clinic of their choice.

In Families with Children (FWC) shelters, the Clinical Services Unit was launched in the winter of 2015 and consists of a team of social workers who serve the FWC shelter system. At full scale, the unit will include 24 social workers (MSWs and LMSWs), plus two supervisors (LMSWs), one Deputy Director (LMSW), and a Director (LCSW). Through referrals from DHS colleagues, staff from the Clinical Services Unit work with families to provide support and guidance as families search for permanent housing. The social workers also connect the families they assist to secure services and resources in the community so as to better ensure that they remain permanently housed once they leave shelter. The social workers do this by:

- Completing a comprehensive biopsychosocial Family Assessment to learn the family's history, to understand their social context and risk factors for poor outcomes, and assess their service needs.
- Using the Family Assessment, which guides the provision of short-term counseling.
- Making referrals to community services, such as behavioral health treatment, preventive services, or other resources as identified.
- Obtaining consent from the family to speak with any existing service provider in the community to determine if such services meet the family's needs. If not, they will present alternative services to the family.

- Following-up with the family to ensure that services to which they were referred are satisfactory and addressing the family's needs. Again, the social workers also obtain consent to directly coordinate with the service provider, as needed.
- Serving as a liaison with the New York City Administration for Children's Services (ACS) if a family has ACS involvement and assisting ACS in determining service needs.
- Serving as a mediator with shelter staff if there are tensions and conflict among staff and the family.

Service planning is an integral part of case management. Staff assist the clients in creating an independent living plan (ILP) and making the right referrals, finding the needed resources that will have the greatest impact on a family's success in achieving housing permanency goals. As part of a family's permanent housing plan, family shelters are required to establish linkage agreements with health clinics and providers in the community for convenient and ready access to medical services.

Additionally, the provider at PATH delivers health education for new parents, including counseling on safe sleeping, such as placing their infant on his/her back to sleep and keeping the crib free of clutter and soft bedding, and never placing or sleeping with an infant on an adult bed or sofa. Families are counseled on other relevant health subjects, such as the dangers of second-hand smoke, and referrals are made to the Nurse Family Partnership program, if applicable. Nurse-Family Partnership is a nurse home visiting program for women who are having their first baby. When enrolled in the program, a specially trained nurse will visit the mother throughout pregnancy and until the baby is two years old.

To summarize, in CY15, there were 9,453 health-related visits among 4,608 patients who sought services from the on-site medical clinic at PATH.

Single Adults

For single adult men (and adult families), shelter intake occurs at the 30th Street site in Manhattan, while single adult women access shelter at the HELP Women's Shelter in Brooklyn or the Franklin Shelter in the Bronx. Some of these individuals (and adult families) are under established care with private or hospital-based clinicians. For many, however, entry into the DHS system may be the first contact they've had with the health care system in several years. As such, DHS has comprehensive screening services for clients with medical and/or behavioral health conditions at six assessment shelters and require that shelter medical providers offer each client the opportunity to engage in a medical history and physical, as well as a brief psychiatric assessment, within five to ten days, respectively, of the client's arrival. The medical history and physical includes routine laboratory testing and preventive care, including Pap smears, screening for colon and prostate cancer, and referral for mammograms. The physical

examination is followed by screening for communicable or infectious diseases, such as tuberculosis and HIV. The brief psychiatric assessment includes, but is not limited to, any chief complaint, history of present illness, past psychiatric history, substance use history, medications, family and social history, and a full mental status examination. In addition to the medical, behavioral and social health assessments, each client's financial and housing history are obtained at intake.

This comprehensive screening is used to determine the needs of each applicant and to select the shelter that may best meet their needs, as available. Clients with medical needs are, where possible, assigned to shelters closer to their medical providers or with elevators for those with limited mobility. Currently, there are two shelters that house adults with medical needs with home care on-site; unfortunately, these beds are quite limited.

If a client remains in the shelter system beyond the initial assessment period, the client may receive medical and psychiatric care, as appropriate. At shelters without on-site healthcare, clients are able to take advantage of a clinic close to their assigned shelter through linkage agreements. At those shelters with on-site clinics, medical providers can complete medical histories and physical examinations for all clients. In addition, the medical provider is able to provide the following services: annual history and physical examinations; episodic care and first aid; limited ongoing primary care, as needed; tuberculosis skin testing; specimen collection for laboratory testing; writing of prescriptions or directly facilitating obtaining medications for the client; HIV counseling and testing; gynecological examinations; monitoring of chronic diseases; medication administration, management, and supervised self-administration for select clients who are unable to consistently medicate themselves; and referrals to specialty medical care.

The Permanency Unit is currently working with the top 200 clients with the longest lifetime length of stay in the adult service shelter system. These clients present significant barriers to housing permanency. Among the most common barriers are mental illness, substance use disorders, immigration status, or a combination of these factors. Our team partners with shelter staff to use client-centered approaches to address these barriers and explore additional services or resources for the clients. We coordinate all services to create the best path out of the shelter for these clients.

Outreach Programs and Facilities

Among the 24 Safe Havens and Drop-In Centers, all have clinical services on-site, save for one Safe Haven. DHS Outreach teams provide emergency and crisis intervention, counseling, case management, assistance with entitlements, benefits, housing and other resources, and provides referrals and linkages to health care services, as necessary, to individuals choosing to live on the streets. All clients are provided a clinical assessment upon intake to a Drop-in or Safe

Haven. These initial assessments do not include psychosocial or psychiatric evaluations; they are straightforward risk assessments.

In FY16, 9,365 Drop-in clients and 1,482 Safe Haven Clients received clinical assessments and were connected to care at intake.

Supportive Housing

Late last year, the Administration made the largest-ever investment in expanding the stock of supportive housing units by committing to funding 15,000 new or converted units in the next 15 years. These units are critical to reducing the DHS census by making available permanent affordable housing with behavioral health and social services for those who require such support in order to live in the community. In FY16 DHS submitted a total of 6,824 HRA 2010e applications for supportive housing. The need for supportive housing far outpaces the current supply; as such, these new units are vital to addressing that need.

Referrals from acute care hospitals and long-term care facilities

Referrals from acute care hospitals and nursing homes often include individuals with acute and chronic medical conditions. DHS has established a standard referral process to ensure only those who are medically appropriate for shelters enter the system, pursuant to 18 New York Codes, Rules and Regulations (NYCRR), Chapter II, Part 491 (Shelter for Adults). In FY16, there were 1,843 referrals from acute care hospitals for single males entering the shelter system for the first time, and 65 from nursing homes. Of those, 33 and 14 were inappropriate, respectively.

Families with a household member with significant medical needs may gain entry to shelter if they can be assisted by another family member and/or home care services as they are afforded a private room or unit while in shelter. Single adults must be able to care for themselves in what are usually congregate settings as shelters are not skilled care facilities nor will home care providers deliver services on-site to those not being sheltered in private units. To ensure that only persons medically appropriate for shelter are admitted, DHS screens hospital and nursing homes referrals through a standard questionnaire, in use since 2010, and oversees the placement of homeless single adults after hospitalization or a stay in another skilled care facility. DHS also facilitates appointments for medical and behavioral health follow-up and can provide limited medication management support during business hours at those shelters with on-site medical clinics. For the remainder of the system, we offer safe storage and supervised self-administration of medication.

All hospitals and nursing homes are required to complete and submit a standard DHS referral package at least 24 hours prior to the individual's anticipated discharge from an acute care or

other medical facility. At present, for single male clients who are new to DHS or returning to shelter after more than one year the Medical Director's office reviews and approves the referrals; for women who are new or returning after one year the referral is reviewed and approved by the providers at the women's Assessment Shelters; for those clients already in shelter and returning after a hospitalization the referral is reviewed by the client's assigned shelter. Because clients returning to their shelters after a hospitalization are not screened by a centrally-located medical provider, DHS created the Shelter Referral line that medical providers can call to request information on their patents' assigned shelter, and a fax number to forward the hospital materials. DHS then reviews the materials and provides a response within 24 hours.

It is worth noting that during the 90-day review we found this system to be inadequate. Dr. Laraque is quickly working to improve this process and the related systems to better ensure clients discharged from acute and other skilled care settings are medically appropriate for shelter.

Connection to Insurance

DHS collaborates with numerous city agencies, as well as relevant state agencies, in order to connect clients to appropriate medical insurance. For example, in 2012, through a collaboration with NYS DOH and Maximus, which brokers Medicaid enrollment for the NYS Department of Health, homeless clients were assisted with enrollment in a Medicaid Managed Care program via facilitated enrollers at single adult and family shelters. Currently, upon entry into shelter, staff will call the NY Medicaid Choice hotline to enroll clients and case managers further assist and refer interested clients for enrollment in health insurance.

Because of their high level of need, homeless individuals may also benefit from enrollment in a Health Home, a care coordination and case management model for those with chronic illnesses in which providers coordinate care and services to effectively address a patient's needs. Health Home services are provided through a network of organizations – direct health, mental health and other care providers, health plans, and community-based organizations. Since 2013, in collaboration with SDOH, DOHMH, and H+H, DHS enrolls eligible clients in Health Homes, as available. Additionally, since 2013, we've been pairing specific Health Homes with designated singles shelters, based on geography, population type, availability of health care services on-site, and the capacity of each individual Health Home to accept new enrollees. Case managers call the identified Health Home, which then dispatches an enroller.

I would now like to respond to the bill before this committee, Intro. 929, which would require the Department of Homeless Services to submit to the Council and post on its website annually a report containing information on health services in shelter. We support the intent of this

legislation and agree with this body on the importance of reporting to promote transparency and accountability. We welcome working with the Council on potential modifications in order to develop reporting metrics that will be clear and useful, and which will accurately capture the work of DHS as it relates to health care services in shelter.

Thank you for the opportunity to testify today and to respond to the bills before each committee. We welcome your questions.

Testimony: New York City Council Health Committee and General Welfare Committee
November 17, 2016

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Good morning.
Thank you Chairman Levin and Chairman Johnson for recognizing the importance of providing comprehensive care for a Special, vulnerable population with significant disparities- namely the Homeless.

As the Chief Medical Officer of Care for the Homeless and as a board certified pediatrician and internist, I am painfully aware of the importance of providing comprehensive health care to this most vulnerable group.

As you are aware, homelessness in NYC has reached the highest levels since the Great Depression. This September, estimates of over 60,000 homeless with 24,000 children were published.

Providing care to the homeless population is distinctly different from conventional primary care due to the complex nature of the social and medical issues facing this population. A medical home with the one stop shopping model of support in place is needed to address addiction, behavioral health conditions and medical conditions. This model can address ongoing overlapping conditions and prevent the decompensation resulting in this population being a high utilizer of expensive acute care services.

The high costs associated with a lack of care coordination for this population have been documented. In a published study of homeless patients discharged from Bellevue hospital .70% were readmitted within 30days. The lack of effective coordination speaks for itself.

Unfortunately there are many stories I have witnessed that can illustrate the different paradigm for homeless individuals' and their health care. Due to their social circumstances, health care is not the top priority for most homeless people until a situation becomes urgent. They live with discomfort and disability and pain, often unnecessarily.

Let me tell you a story about a 47-year old woman came to one of our clinics because of a draining ulcer. We discovered she also has a seizure disorder due to domestic violence induced head trauma, so a prescription was offered for her anticonvulsant medication . She stated that she usually waits for her refills to run out and have a seizure so she can go to the ER to get her medication refilled because care was not readily accessible to her, it did not occur to her to obtain medication refills proactively

Accessible (which usually means), on-site care reduced her ER use and improved her health because we are able to work with her regularly to improve her adherence to her medication.

Most homeless people in shelters are families with children. The tragic lifelong effects of early childhood adversity have been well documented in the medical literature. Children in shelters miss twice as many school days compared to non-homeless children and are at increased risk for childhood depression, obesity and being the target of bullying. Conditions resulting from trauma attest to the long term impact upon an individual's health a single event or traumatic period may have. Many chronic conditions—hypertension, diabetes, depression, anxiety can be traced to the long term outcomes of trauma, adversity and social toxicity.

There are solutions to this problem. Your commitment to meet the medical needs of homeless people is essential to address the acute and long-term health conditions that otherwise would accompany the increasing epidemic of homelessness in New York City.

Thank you for your ongoing support.

<u>Top 10 Conditions evaluated in all CFH clinics 2016</u>

Adult Medical

1. General Examination
   PPD/Tuberculosis Screening or Positive
2. PPD

3 Tobacco
4 Hypertension
5 Immunization/Vaccination
6 Asthma
7 Cholesterol
8 HIV Screening
9 Diabetes
10 Sickle-cell, Anemia

Pediatric

Encounter for immunization
Asthma
Allergic Rhinitis
Acute upper respiratory infection, Acute laryngopharyngitis
Counseling
Acute Nasopharyngitis, Acute Pharyngitis
Dermatitis
Anemia, Iron Deficiency Anemia
Attention-deficit hyperactivity disorders
Rash and other nonspecific skin eruption
Symptoms and signs concerning food and fluid intake

Adult Behavioral Health

1. Major Depressive Disorders
2. Bipolar Disorders
3. Cannabis Related Disorders
4. Alcohol Related Disorders
5. PTSD
6. Schizophrenia, Schizoaffective disorder
7. Cocaine Related Disorders
8. Adjustment Disorders
9. Anxiety Disorders
10. Opioid Related Disorders

Number of patient visits during the most recent 12-month cost reporting year.

Patient visits: 35,682 (7,926 unique patients).

Payer composition

The payer mix of CFH's population served is as follows: (1) 63% is Medicaid; (2) 7.9% is Medicare; (3) 26% is uninsured; and (4) 2.9% is commercially insured.

Testimony by Noah Berland, Fourth Year Medical Student New York University School of Medicine

Re: Int. No. 0929-2015- In relation to: medical Health Services in the DHS Shelter System

Before the New York City Council, Committee on Health and Committee on General Welfare

November 17, 2016

Chairman Johnson and Chairman Levin, Council Members, and staff, good morning and thank you for the opportunity to speak about this proposed bill and the subject of addressing the medical needs of homeless individuals in New York City. My name is Noah Berland, and I'm currently a fourth year medical student at New York University School of Medicine. What brings me here today? A passion for ensuring that the most vulnerable and disenfranchised New Yorkers have their unique healthcare needs met.

As a first year medical student I and three other classmates began a partnership with the department of homeless services and the department of health at the 30th street Men's shelter to prevent opioid overdoses using naloxone (Narcan). We chose this because overdose is the leading external cause of death for all shelter residents. To date we have 2 verified and reported reversals for just under 200 distributed kits. But the most meaningful part of this project for me was interacting with the residents, who collectively taught me invaluable lessons about who they are and many of their needs. On the dinner line I learned more than anything the pervasive feeling of disenfranchisement and being left behind. Many residents felt devalued by society and that they and their fellow residents were undeserving of our attention and care. It quickly

became clear that residents were facing so many unique and complex medical needs all complicated by the present state of housing insecurity. We met individuals with Hepatitis C, HIV, multiple substance use disorders, numerous mental health disorders, and almost any other condition you could think of from diabetes to heart disease. But unlike you and I, shelter residents not only have a poverty of economic means, they also have a poverty of time and most other resources. Shelter residents, many of who are employed, don't have any flexibility in missing work, with erratic and often unpredictable schedules, making visiting health centers with long waits almost impossible to be access. As a medical student rotating working at Bellevue I saw often how long patients would have to wait, and while in the ED I would see many of the same shelter residents coming to the ED for what you and I would consider routine care.

As a medical student working on the wards of Bellevue and in the ED, our most complicated discharges were always to a shelter. We would often keep patients in the hospital at a much higher level of care than they needed, and at both greater expense to the city and at greater cost of freedom and comfort to patients because coordinating a safe discharge to a shelter was at times nearly impossible. Sometimes that barrier could be as simple as transportation and the patients mobility, having a wheelchair or complex medication needs could just throw a monkey wrench into our carefully thought out and planned discharges. It's hard to express how often problems like these would come up. These problems or lack of services and facilities able to meet these relatively simple needs, often would lead to the patient quickly returning to the emergency department and frequently being admitted back to the hospital, not uncommonly with complications or worsening condition due to inadequate treatment. Something that was simple would balloon into a worse and more complex problem. Not too different from what shelter residents would go through due to deferred care due to inadequate access to healthcare that meets their specific and unique needs.

These unique problems are often lost to most physicians, nurses and care providers. We rely on our social workers to navigate these processes and hurdles, but the systems that presently exist are inefficient and are often purely in one direction from the shelter to our programs, further complicating the situation. Better communication and clear understanding of the accommodations of each shelter could improve outcomes, cost, and discharge efficiency and safety.

To summarize some of the unique medical challenges facing shelter residents:

1. Access to onsite healthcare facilities designed to focus on and treat the unique healthcare needs of shelter residents
2. Centralized intake for patients even for patients with medical needs, leading to delayed discharge, inefficient placement of patients, and bounce backs to the hospital
3. Inability to provide healthcare to residents when residents need care, whether this is to accommodate work, or to accommodate specific healthcare needs such as the ability to stay in a shelter during the day, often leading to keeping patients in the hospital for much longer than necessary
4. Access to the critical medications needed for many residents, often leading to relapse and complications that would have otherwise been prevented by better and more consistent access to their medication
5. A better means of partnering and communicating with healthcare providers and social workers would strengthen our ties and hopefully improve patient outcomes, while streamlining and vastly improving the discharge process.

Data will help us understand and communicate better, but there are many low hanging fruit and small changes could truly advance and improve outcomes with large gains. What we need most are more services focused towards this truly unique and disenfranchised population.

Respectfully Submitted,

Noah Berland, MS

NYU School of Medicine

Class of 2017

November 17, 2016

Prime Sponsor: Corey Johnson - Chair of Committee on Health

Committee on General Welfare, Committee on Health

Chair of Committee on General Welfare: Stephen Levin

Good morning Chairperson Levin, Chairperson Johnson, members of the General Welfare and Health Committees, members of the City Council, Department of Homeless Services, and colleagues. Thank you for the opportunity to speak today.

My name is Barbara Conanan, and I am the Program Director at NYU Lutheran Family Health Centers' Community Medicine Program. The Community Medicine Program has provided medical services to homeless persons of New York City for 47 years, including initially as part of St Vincent's Hospital. I am also a member of the Providers of Health Care for the Homeless, a coalition of 14 organizations that provide health and mental health services to homeless people. I began my career as a nurse visiting homeless people on the streets and in single room occupancy shelters. Much has improved since then, as healthcare for the homeless gained national traction and substantial federal funding. However, we have not come far enough. We agree with and support the council's bill that increased reporting and data collection are necessary; however, these are only first steps to fully understanding the scale of the problem and taking action.

Today I want to introduce you to my colleague Dr. Miranda von Dornum, a physician with the Community Medicine Program.

Good morning. I am Dr. Miranda von Dornum. For the last four years I have provided primary care in a health center that serves the Volunteers of America's Schwartz Assessment Shelter and the HELP USA's Keener Men's shelter on Wards Island.

As someone who provides medical care in the shelter system, I would like to highlight three areas in need of change. First, shelters need to better accommodate those who are frail and sick; second, we need to facilitate information exchange between healthcare providers and shelter providers; and third, we must fund the physical infrastructure to enable health care for the homeless to be effective and safe.

First, let's discuss better accommodation for frail and sick people who live in shelters.

The shelter where I work is the home for many particularly frail and sick homeless residents.

One of the patients I care for is a young man with a spinal cord injury who is wheelchair bound. He needs to sit while showering. In the shelter where he lives there are benches in the showers instead of chairs. He has repeatedly slipped off the bench and fallen onto the floor while showering. Apart from the humiliation, this has led him to need medical attention and leaves the city open to liability. The cost

of installing appropriate chairs in showers would be modest in comparison. Data on the number of disabled residents in the homeless system and where they are currently being housed should be collected and used to make sites fully ADA compliant.

Another patient of mine is a 68 year old man with diabetes, heart failure, liver disease, lung disease, and chronic kidney disease. He is sent to the ER and admitted every few weeks, then discharged back to the shelter system. In the last six months has been admitted 6 times to 3 different hospitals. Each time, he is discharged with a new discharge plan, which is never implemented and so the cycle of hospitalization and discharge repeats itself.

I have even seen patients with organ transplants discharged to shelters. I care for patients in the shelter who are on chemotherapy.

These acutely or chronically ill patients live in homeless shelters designed for healthy people. They do not qualify for inpatient treatment or nursing home care. The only place for them is a homeless shelter. I suspect that many of you know someone who has been through chemotherapy. You understand that sleeping in a room with dozens of people and being awoken multiple times for bed checks while recovering from a major illness or intervention may be tough. You understand that being forced out of bed for the day when you are weak and nauseous could seem like cruel treatment.

Our shelters in NYC are neither equipped nor staffed to care for the acutely or chronically ill in a humane or cost-effective manner.

Let us think about this for a moment: these men and women have received good care in the hospital setting, but their placement in an ill-equipped or understaffed shelter imperils their recovery. They frequently suffer unnecessary complications and end up re-hospitalized. In light of the Medicaid Reform in NYS, such poor follow-up care is not only unfortunate for the patient but represents a squandering of health care resources as these patients cycle between the emergency room and the shelter system.

Respite care where patients could recover for several weeks and avoid re-hospitalization could save money and lives. Why not experiment with a few beds to see how it works? Additional support might be a system to identify the medically at-risk and provide them with intensive case management. This could mean assistance with getting to appointments, making sure medications are refilled, and perhaps most importantly, fast-tracking these patients into permanent housing. A cost analysis on respite care savings in NYC would be tremendously useful.

Second, we need the city to invest in systems that facilitate the exchange of information between healthcare and shelter providers. Currently, information is often lost or fragmented as clients move between DHS, the medical system and the benefits system. As medical providers we do not have access to the CARES system, the DHS database of where people are sheltered. We often lose patients to follow-up care when they are moved from one shelter to the next, and access to CARES could help us close the loop.

For example:

1) Patients are forced to repeat TB testing every time they change shelters, often multiple times per year. If this information were consistently available in CARES, and the medical providers had access to it, redundancy and unnecessary cost would be avoided. It would also decrease the risk that a patient with a positive test would be lost to follow-up. There was a case of active tuberculosis in one of the shelter earlier this year and it took several months to do contact tracing. During this time, many of the contacts had been transferred to other shelters or housing arrangements.

2) Patients are sent to the emergency room and discharged without any communication with their primary care provider regarding what was done and what follow-up is needed. A system that enables the hospital to send the shelter medical staff a discharge summary would address this issue.

3) Patients are often transferred before they receive their lab results. I have had patients with positive syphilis and hepatitis C tests that I was unable to inform of their result. This is a risk for the patient and a public health concern. If medical staff had access to the CARES system, we would know where patients have been transferred and flag an abnormal lab result to alert the next provider. This could be done in such a way as to respect patient confidentiality.

When information is not shared, it leads to redundancy, adverse health consequences, and increased costs to the system. Any data collection measure should include steps to improve information sharing.

And lastly, we have to invest in the physical infrastructure of the shelters and the health centers that are housed within the shelters. DHS must include in its budgets to shelter providers not only funds to operate clinics, but funds to renovate and maintain clinics at a standard that meets NYS Department of Health regulatory requirements. Medical providers, nurses, medical assistants put their all into treating patients with histories of poor primary care. We need to do this in settings that are safe and licensable, and that takes dollars.

There are many other issues: patients have reported feeling too scared to report being bullied in the dorms at night; the single men's intake shelter on 30th street in Manhattan, which houses 850 men, has no health services – a public health crisis waiting to happen; but for today, I want to remind you that our shelters are housing people who are frail and who are costing our system because we are failing to manage them with humanity and dignity.

In summary, we need shelters that can better accommodate those who are frail and sick; we need to facilitate information exchange between healthcare providers and shelter providers; and we must fund the physical infrastructure to enable health care for the homeless to be effective and safe. We ask the council to pursue quality data on the medically vulnerable subset of the shelter population and to allocate resources towards a concrete strategy for improving the conditions and care available to this particularly vulnerable group.

We commend Councilmembers Levin and Johnson for putting out this call for data collection, and urge you to press for action. We cannot wait for another year to pass before we implement some of these changes.

I thank you again for this opportunity to speak today.

BARBARA A. CONANAN, RN, MS

DIRECTOR, COMMUNITY MEDICINE PROGRAM,

NYU LUTHERAN FAMILY HEALTH CENTERS

Throughout her career, Barbara Conanan has worked as a nurse clinician, educator, and advocate, focusing on providing the highest quality of care to homeless individuals. At the closure of St. Vincent Catholic Medical Center in 2010, Ms. Conanan led the Health Care for the Homeless (HCH) program through a seamless transition to become part of NYU Lutheran Family Health Centers with no interruption in care for the program's 7,000 patients. Prior to her employment at Saint Vincent Catholic Medical Centers in 1983, Ms. Conanan worked at the Manhattan Bowery Corporation as supervisor in clinic that provided outpatient substance abuse and supportive services.

Ms. Conanan is a nationally recognized expert in HCH program management, sharing her wealth of experience at local and national conferences, and providing technical assistance to numerous agencies and programs in creating health care delivery systems for homeless patients. She co-authored a chapter entitled Health Problems of Homeless People in the Institute of Medicine's Homelessness, Health, and Human Needs (1988) and co-edited Under the Safety Net (1992). Currently she serves as a board member on the National Health Care for the Homeless Council and has served as Board President twice. She is one of the founding members of New York City Providers of Health Care for the Homeless, and served as chair from 2004 to 2007. In 2014, Ms. Conanan received the Dr. Philip W. Brickner Visionary Clinician's Award for her leading role of the Health Care for the Homeless program for over 30 years. Ms. Conanan is the first recipient of this award, which was established in honor of the late Philip W. Brickner, M.D., the father of the national Healthcare for the Homeless program.

Barbara Conanan served in the National Program Office for the original Robert Wood Johnson and Pew Memorial Trust, HCH Demonstration Programs. Under Dr. Philip Brickner's leadership, these national programs were built on his model of care: patient centered, high quality, accessible, compassionate and dignified health care services delivered by multidisciplinary teams where people congregate or live.

MIRANDA VON DURNAM, MD, PhD

MD, COMMUNITY MEDICINE PROGRAM,

NYU LUTHERAN FAMILY HEALTH CENTERS

Dr. Miranda von Dornum has been a staff physician with the NYU Lutheran Community Medicine Program since 2012. She works full time providing care to homeless and formerly homeless clients. Her primary site is located on Ward's Island and serves both the VOA Schwartz Assessment Shelter and the HELP USA Keener Men's Shelter. She received her MD from Mount Sinai School of Medicine in 2006 and completed her residency in Internal Medicine/Primary Care at Alameda County Medical Center in 2009.

Testimony of
Coalition for the Homeless
And
The Legal Aid Society

On

Oversight – Part 1: Medical Health Services in the DHS Shelter System

Presented before

The New York City Council
Committee on General Welfare
Committee on Health

Giselle Routhier
Policy Director
Coalition for the Homeless

Beth Hofmeister
Staff Attorney
The Legal Aid Society

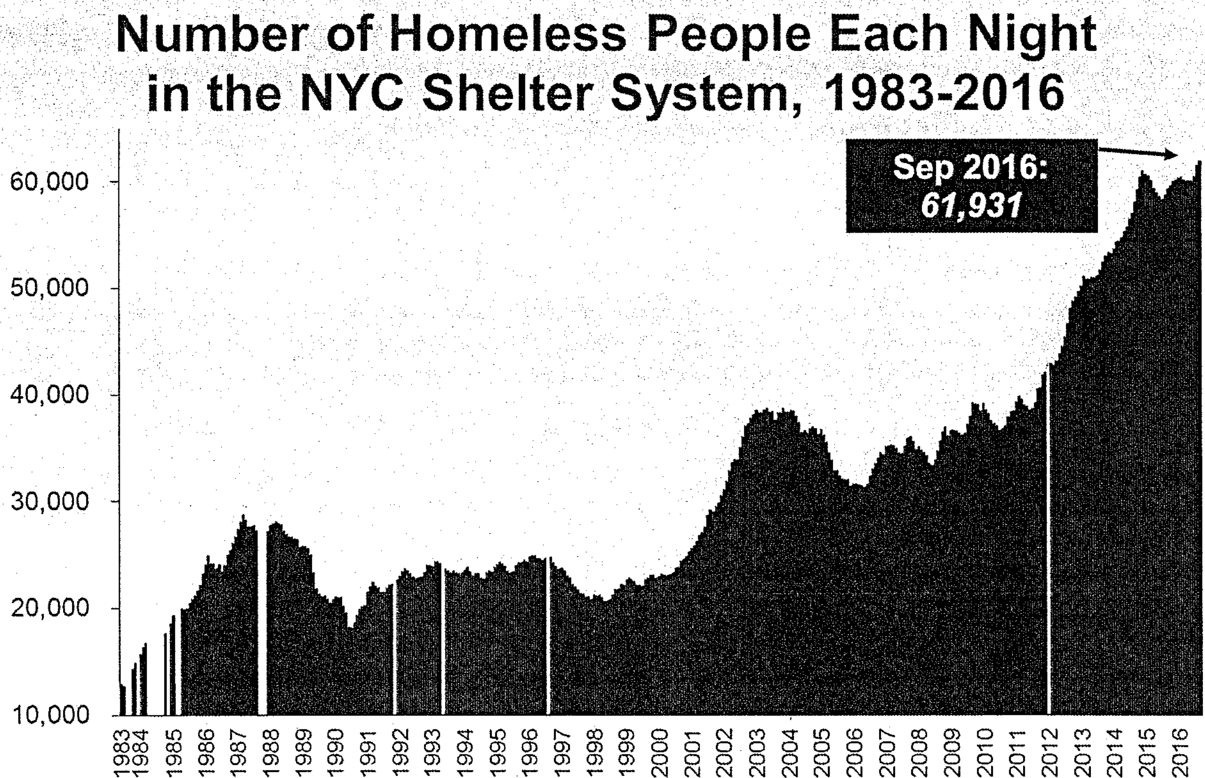
November 17, 2016

Coalition for the Homeless and The Legal Aid Society welcome this opportunity to testify before the Committees on General Welfare and Health regarding medical health services in the DHS shelter system.

Background: Homelessness in NYC

New York City remains in the midst of the worst homelessness crisis since the Great Depression. In September 2016, an all-time record 61,931 men, women, and children slept in shelters each night. Over the past decade, homelessness among single adults has nearly doubled and family homelessness has increased by more than 80 percent.

Homeless individuals experience increased rates of chronic and acute health problems compared with these rates within the general population, and they also have a higher mortality rate.[1,2] Forces that contribute to this disparity include environmental, social, and financial stressors that place a physical toll on the body and also lead to reduced levels of care.[3] Homeless children have also been shown to experience worse health outcomes than their permanently housed peers.[4]



Source: NYC Department of Homeless Services and Human Resources Administration and NYCStat, shelter census reports

Health Services in DHS Shelter System

The DHS shelter system is not regulated or licensed to provide medical services to clients. Under state law, only individuals holding licenses to perform medical tasks within their lawful scopes

of practice may perform those tasks, and only in settings for which the provision of medical services are statutorily authorized.

A small number of shelter sites are co-located with facilities licensed by the State Department of Health to operate on-site clinics. Because the shelter system is not equipped to provide medical care, it should not be viewed as an extension of the existing public health system in New York City. However, it often acts as a last resort referral source for hospitals and nursing homes discharging patients because of the broader lack of housing options for extremely low-income individuals.

This situation is problematic for two critical reasons: 1) shelters are not optimal settings for the health and safety of individuals being discharged (whose health problems may be exacerbated or not well attended within shelters), and 2) individuals currently living in shelters may be exposed to communicable diseases, opportunistic infections, or unsafe behavior when people are prematurely discharged from health care facilities.

We recommend a thorough analysis of hospital and nursing home discharges to shelters and the policies underlying them and the establishment of protocols for medically safe discharge planning. We further recommend a strong policy prioritizing permanent housing options for those with the most acute medical needs. Finally, we recommend the establishment of a state regulated network of stand-alone medical respite facilities that would operate apart from the shelter system. This network would provide needed oversight and a proper standard of care for individuals with serious health needs, and at the same time reduce strain on the shelter system from those whose needs are ultimately not being met in facilities not equipped to handle them.

We also want to note that the shelter system is in need of reforms to better accommodate people with disabilities. The Legal Aid Society, on behalf of the Coalition for the Homeless and the Center For Independence of the Disabled, New York (CIDNY), brought Butler v. City, a class action lawsuit on behalf of all disabled shelter residents, and they are in negotiations with the City to address these issues.

We thank the Council for the opportunity to testify. We look forward to working together on our mutual goal of ending homelessness in New York City.

About Coalition for the Homeless and The Legal Aid Society

Coalition for the Homeless: Coalition for the Homeless, founded in 1981, is a not-for-profit advocacy and direct services organization that assists more than 3,500 homeless New Yorkers each day. The Coalition advocates for proven, cost-effective solutions to the crisis of modern homelessness, which now continues past its third decade. The Coalition also protects the rights of homeless people through litigation involving the right to emergency shelter, the right to vote, and life-saving housing and services for homeless people living with mental illness and HIV/AIDS.

The Coalition operates 11 direct-services programs that offer vital services to homeless, at-risk, and low-income New Yorkers. These programs also demonstrate effective, long-term solutions and include: supportive housing for families and individuals living with AIDS; job-training for homeless and formerly-homeless women; and permanent housing for formerly-homeless families and individuals. Our summer sleep-away camp and after-school program help hundreds of homeless children each year. The Coalition's mobile soup kitchen distributes over 900 nutritious meals each night to homeless and hungry New Yorkers on the streets of Manhattan and the Bronx. Finally, our Crisis Intervention Department assists more than 1,000 homeless and at-risk households each month with eviction prevention, individual advocacy, referrals for shelter and emergency food programs, and assistance with public benefits as well as basic necessities such as diapers, formula, work uniforms and money for medications and groceries.

The Coalition was founded in concert with landmark right to shelter litigation on behalf of homeless men and women in Callahan v. Carey and Eldredge v. Koch and remains a plaintiff in these now consolidated cases. In 1981 the City and State entered into a consent decree in Callahan through which they agreed that, "The City defendants shall provide shelter and board to each homeless man who applies for it provided that (a) the man meets the need standard to qualify for the home relief program established in New York State; or (b) the man by reason of physical, mental or social dysfunction is in need of temporary shelter." The Eldredge case extended this legal requirement to homeless single women. The Callahan consent decree and the Eldredge case also guarantee basic standards for shelters for homeless men and women. Pursuant to the decree, the Coalition serves as court-appointed monitor of municipal shelters for homeless adults, and the City has also authorized the Coalition to monitor other facilities serving homeless families.

The Legal Aid Society: The Legal Aid Society, the nation's oldest and largest not-for-profit legal services organization, is more than a law firm for clients who cannot afford to pay for counsel. It is an indispensable component of the legal, social, and economic fabric of New York City – passionately advocating for low-income individuals and families across a variety of civil, criminal and juvenile rights matters, while also fighting for legal reform.

The Legal Aid Society has performed this role in City, State and federal courts since 1876. It does so by capitalizing on the diverse expertise, experience, and capabilities of more than 1,100 lawyers, working with some 800 social workers, investigators, paralegals and support and administrative staff. Through a network of borough, neighborhood, and courthouse offices in 26

locations in New York City, the Society provides comprehensive legal services in all five boroughs of New York City for clients who cannot afford to pay for private counsel.

The Society's legal program operates three major practices — Civil, Criminal and Juvenile Rights — and receives volunteer help from law firms, corporate law departments and expert consultants that is coordinated by the Society's Pro Bono program. With its annual caseload of more than 300,000 legal matters, The Legal Aid Society takes on more cases for more clients than any other legal services organization in the United States. And it brings a depth and breadth of perspective that is unmatched in the legal profession.

The Legal Aid Society's unique value is an ability to go beyond any one case to create more equitable outcomes for individuals and broader, more powerful systemic change for society as a whole. In addition to the annual caseload of 300,000 individual cases and legal matters, the Society's law reform representation for clients benefits more than 1.7 million low-income families and individuals in New York City and the landmark rulings in many of these cases have a State-wide and national impact.

The Legal Aid Society is counsel to the Coalition for the Homeless and for homeless women and men in the Callahan and Eldredge cases. The Legal Aid Society is also counsel in the McCain/Boston litigation in which a final judgment requires the provision of lawful shelter to homeless families.

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Rosa M. Gil, DSW
President/CEO

PUBLIC TESTIMONY PRESENTED BY:

ROSA M. GIL, DSW

PRESIDENT/CEO

COMUNILIFE, INC.

JOINT PUBLIC HEARING SPONSORED BY THE COMMITTEE ON GENERAL WELFARE AND COMMITTEE ON HEALTH, NEW YORK CITY COUNCIL, NOVEMBER 17, 2016

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BBB ACCREDITED CHARITY

Good Morning. My name is Dr. Rosa M. Gil, President & CEO of Comunilife, Inc. I want to thank Council Member Stephen T. Levin, Chair of the Committee on General Welfare and Council Member Corey Johnson, Chair of the Committee on Health for holding this Public Hearing to recognize the need of Medical Health Services for Homeless New Yorkers. I also appreciate the participation of Members of the Council who serve on these two very important committees.

I am grateful for the invitation to present testimony on Comunilife's Social/Medical Respite Program developed in collaboration with Montefiore Hospital Care Management Organization (CMO) (2011) and Bronx Lebanon Hospital (2012). It is the first and only program of its kind in the City of New York.

Comunilife's mission is to improve the quality of life and create a healthier tomorrow for New Yorkers with special needs in the Hispanic and the broader community by providing culturally competent health and human services and a continuum of affordable and supportive housing. Our programs reach NYC's most high-need, high-cost health care consumers – citizens with histories of repeated emergency room visits, hospital admissions, and long-term institutionalizations in the City's psychiatric, correctional, and homeless shelter systems.

National attention is increasingly focused on homelessness and hospital admissions; re-admissions; and Emergency Department utilization. Throughout the Country, many medical Respite Programs have been developed to stabilize homeless patient's medical and social needs after hospital discharged. Medical Respite programs provide acute and post-acute medical care for homeless individuals who are too ill or frail to recover from a physical illness or injury but who are not ill enough to be hospitalized. Respite is short-term residential care that allows homeless persons the opportunity to rest in a safe environment while accessing medical care and other supportive services. Respite care meets the post hospital recuperative care needs for persons who are homeless while reducing public costs associated with frequent hospital utilization.

Comunilife's Social/Medical *Program* is unique. It blends short term transitional housing accommodations including meals, transportation, health management, care coordination, and case management services to adults who have received appropriate hospital care and are medically cleared but cannot be safely discharged because they have no home-based support system within which to fully recuperate. Unlike most other respite programs, Comunilife's program goes far beyond addressing clients' immediate, post-hospital needs. We offer the comprehensive supports required to stabilize their lives, place them in permanent housing thus reducing rapid re-utilization of the hospital system and the homeless shelter system.

Population Served

The *Respite Program*'s clients are typically African-American or Latino men – age 46 and older - with multiple health, mental health, and substance abuse issues – and highly unstable housing situations. Prior to their hospital admission, some clients lived with family members or friends who do not want to take them back. Some lived within the City's shelter systems. And some lived on the streets.

Services Offered

Respite Program staff work closely with hospital teams to identify and prepare medically-stabilized patients who could benefit from our services. Once discharged, patients are moved to Comunilife's Respite Program. During their stay in the Respite Program, we offer:

- Comprehensive care coordination.
- Entitlement and documentation support.
- Medication management.
- Three meals per day.
- Assistance with transportation to medical appointments.
- Ongoing medical coordination with hospitals and community based nursing and medical facilities.
- Assistance with housing search and transition to long-term housing.
- Family reunification interventions as needed
- Ongoing periodic "check-ins" following the intensive program service delivery period to ensure that clients remain stably housed and out of the hospital, as appropriate.

DISCHARGE

Clients' length of stay varies depending on their readiness to transition into permanent housing, income and/or eligibility for financial assistance/entitlements and identification documents available. Our goal is to transition clients, to a permanent housing situation, within 4 to 12 weeks.

BENEFITS OF RESPITE CARE FOR HOSPITALS

Comunilife's Social/ *Medical Respite Program benefits not only the patients but also our hospital partners and the New York City Homeless Shelter System*

The benefits to the hospitals are considerable and include:

- Receiving vitally-needed assistance reaching appropriate discharge decisions for some of the most high-needs, long-stayer patients.
- Achieving significant reductions in *per diem* costs. The daily costs for a hospital bed can be in the thousands of dollars.
- Achieving significant reductions in the long-term costs associated with preventable ER utilization and hospital re-admission. Patients discharged to our *Respite* program have markedly reduced presentations for emergency room visits and in-patient re-admissions compared to peers discharged directly to unstable living situations.
- Avoidance of penalties for maintaining high re-admission rates under the *Medicare Hospital Readmissions Reduction Program.*

"A seamless transition from acute hospital care to temporary housing so that you can get on with your life" *–Participant Hospital partner*

New York City's shelter system benefits from Comunilife's Respite Program by

- Reducing utilization of shelter beds and Drop-in centers, which results in significant cost reductions
- Improving recuperation from illness or surgery at a faster rate
- Reducing frequent hospitalizations
- Better management of chronic medical conditions; and
- Rapid re-housing

Finally and most importantly our Respite Program BENEFITS PATIENTS. Clients report a host of personal benefits going beyond the core outcomes of achieving more stabilized housing situations, re-unifying with families, reducing hospital re-admissions. They note increased access to neighborhood health services; better medications management; improved options and outlook. One participant, a 49 year old gentleman said

> "Before I came into this program, I lived on the streets. I didn't want to live; I didn't know what to do. All my life, all I've known are strangers. But this place showed me there is meaning. I can never repay them for what they have done for me."

I thank you again for the opportunity to share information about Comunilife Social/Medical Respite Program.

NYLAG testimony, J. Brandfield

Co-Chairs Johnson & Levin, Council Members, and staff, good morning. Thank you for the opportunity to speak about Medical Health Services in the DHS Shelter System. My name is Julie Brandfield and I am an attorney and Associate Director of LegalHealth, a division of the New York Legal Assistance Group, NYLAG. NYLAG is a nonprofit law firm dedicated to providing free legal services in civil law matters to low-income New Yorkers.

LegalHealth, a medical-legal partnership, works with 26 hospitals across New York City. In doing so we complement health care with legal care – providing free legal services in medical facilities and community-based health organizations as well as training healthcare professionals to understand the legal issues their patients face. As a provider of legal services to patients of hospitals, LegalHealth attorneys are first-hand witnesses to the hardships and challenges that a homeless individual goes through while dealing with a serious and complex illness. In particular, we have seen the unique shelter needs of the medically homeless population go unaddressed. The medical issues of these homeless individuals range from severely immunocompromised cancer, end stage renal failure, oxygen dependency, in need of IV antibiotics or therapies, and wound care or ulcer care needs.

During the course of trying to find effective solutions for this population, LegalHealth joined forces with medical and housing professionals across New York City, forming the Coalition for Housing & Health, some of whom here today in support, including Montefiore and Memorial Sloan Kettering. The Coalition's mission is to develop actionable steps for addressing the pressing housing needs of New Yorkers with serious medical conditions such as cancer, renal disease, diabetes, chronic heart disease and others.

The Coalition is also a part of a national movement driven by the grim reality of housing and other social determinants of health dramatically impacting a person's access to medical services and

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treatment. As we know from our own experience and research, unmet housing needs are significant predictors of missed clinic appointments and worsening of health conditions, leading to negative health outcomes for the homeless. Unmet housing needs also result in lengthy and avoidable hospital readmissions and stays, which ultimately contributes to increases in health care costs for the hospital systems. Our long term goal is to see a sustainable plan of housing options for the medically homeless population which includes supportive housing, vouchers and rent subsidies, respite care beds and a shelter system that can accommodate the needs of our medically frail clients.

As we work towards this goal, we helped draft a bill that was introduced earlier this year by the City Council Health Committee as well as the General Welfare Committee. The bill would address one significant aspect of the issue, the failure of the shelter system to house the medically frail homeless. The bill that was introduced would have created a new definition to describe these clients and the legislation would have mandated that single adult individuals entering the system from a hospital receive health assessments, and when appropriate, are placed at medically supportive shelters that can meet their individual needs. These medically appropriate shelters will offer patients on-site medical support staff, easy access to medication and their beds at all times as well as other services.

One of my recent clients, Demetrius Davis, plainly illustrates the need to create shelters for the medically frail. His case arose at the same time the Coalition for Housing & Health was gaining momentum, and he in essence became the face of the need within our group. Demetrius had been in the shelter system for over 4 years and the City's help to find him permanent housing had been completely unsuccessful. In late September 2015, he was rejected from the last place he had interviewed. No surprise. When he went to that interview he had a high fever, chills, and was sweating profusely. The panel interviewing him grilled him on whether he abused drugs, no doubt because of his presentation. A few days later, he became so sick that he went to the emergency room where he was diagnosed as severely jaundiced, septic, and having stage three pancreatic cancer. He was admitted immediately.

Testimony by Henie Lustgarten, Bronx Health and Housing Consortium

Re: Int. No. – In relation to: Providing medically appropriate shelter to medically frail homeless individuals.

Before the New York City Council, Committee on Health and Committee on General Welfare

November 17, 2016

Chairman Johnson and Chairman Levin, Council Members, and staff, good afternoon and thank you for the opportunity to speak about this proposed bill and the subject of addressing the needs of the medically homeless in New York City. My name is Henie Lustgarten and I am pleased to represent the Bronx Health and Housing Consortium (Consortium). We are an organization of over 40 health, housing, community-based service and government organizations that have been collaborating for several years to provide quality services to people with complex health and housing needs.

We support this bill as one key part of addressing the healthcare and housing needs of the medically homeless. This group is important to us for many reasons. First, one of the Consortium's key member organizations are the Health Homes which serve Medicaid recipients with complex and chronic medical conditions. These organizations are faced with more homeless members than anyone expected. Last year about 18% of the 30+ thousand Health Home enrollees in the four Health Homes affiliated with the Consortium (Bronx Health Network, Bronx Accountable Healthcare Network, Community Care Management Partners and HHC Health Home) identified themselves as homeless.

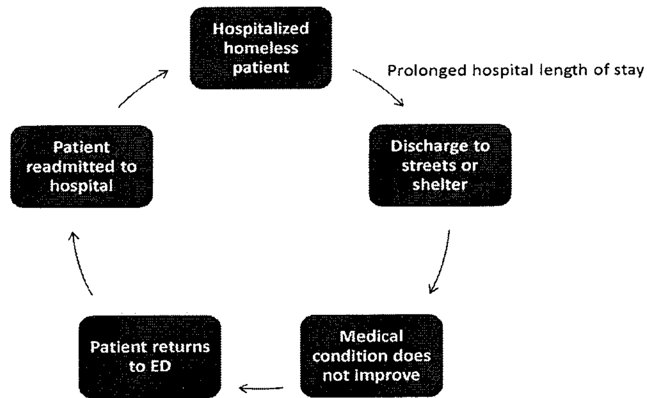
The Consortium conducts a HOPE count in hospitals annually on the night of the official HOPE count to better identify and understand homeless people who choose to spend the night in hospital waiting rooms or are hospitalized that night. In 2016, we counted 89 people in the

Bronx Hospitals: 73% of them did not register for hospital care and were using the waiting rooms as shelters. In 2014 we also were able to count 54 people who were homeless and in hospital beds that night. Of there, 20 patients were identified whose homelessness affected the hospital's discharge planning, resulting in delayed discharge and over 200 unnecessary hospital days. This included someone who lived in a shelter and whose medications required refrigeration. The shelter could not accommodate this need. Another patient who was over 60 had a new diagnosis of brain cancer with no place to live. The shelter would not accept her. There needs to be some accommodation in the shelter system for people in these circumstances.

The National Health Care for the Homeless Council defines medical respite as "acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital." Some of the people whom the Bronx Health & Housing Consortium serve who are homeless and ill require more intense medical support than others. This is why we support a range of services—one size does not fit all. After hospital discharge, some people will require ongoing clinical monitoring while others will be able to get their clinical needs met offsite, but require support to access those services appropriately.

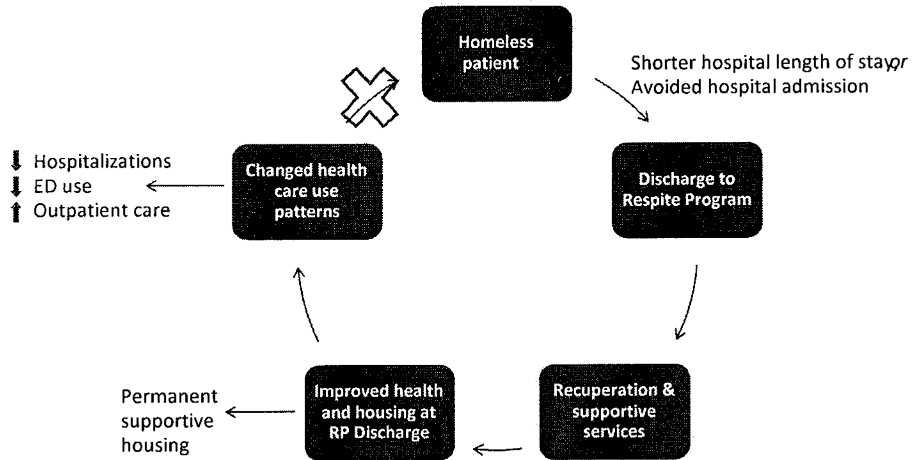
We have learned from experience with patients in the Bronx as well as from experts in the field that there is a Hospital-Homeless cycle of homeless patients. When they are ready for discharge, if they are not provided appropriate shelter they often end up on the street, where their medical condition does not improve. They then go to the Emergency Department and may be readmitted, which starts the cycle again. Only if we change where they are discharged to—what we sometimes call a respite facility, can we address their medical and social needs to break this vicious and expensive cycle (Kelly M. Doran, 2015).

The Current Hospital-Homeless Cycle



High Costs, High Hospital Use, Poor Health, Continued Homelessness

Ending the "Revolving Door" of Homeless-Hospital with a Respite Program



Better Health, Lower Costs, Improved Care
Ending Homelessness

There is growing evidence that these types of programs reduce ED and inpatient hospital utilization as well as avoidable readmissions to hospitals. This is especially true when linked to permanent housing. The National Health Care for the Homeless Council 2016 Directory lists 78 programs around the country, with over 1500 beds, including almost 450 beds in California. Of these, almost half (46%) are located in or next to shelters. The national median length of stay is about a month and most have nursing staff. Many have social workers and physicians. New York City lists 2 programs—the Bowery Resident's Committee with 24 beds available to people with recurring Substance Use Disorder (SUD) and the Comunilife program with 10 beds for 'social' respite available to 2 hospitals in the Bronx. This is not enough supply to meet the demand for these services.

We urge you to develop a system to support the medically homeless rather than the non-system currently in place. Not only do we have too few services but there is no system to access what exists that is fair and known by all. New York City is paying to shelter the medically homeless whether they are in shelters or hospitals. According to the NY State Department of Health, 2014 Medicaid expenditures for NYC was almost $30 Billion and growing. According to Baruch College, a shelter night costs about $79 (http://www.baruch.cuny.edu/nycdata/social_services/homeless-services.htmin). A day in the hospital costs significantly more. Hospitals are nohttp://www.thesalweyarms.co.uk/assets/uploaded/downloads/Autumn_2016.pdfhe NY State t only unhealthy places for people who are medically homeless and have compromised immune systems, they are expensive and under increased pressure to avoid admitting and to discharge people who do not require a hospital-level of care. That means the need for these services will grow. We need a range of services for the range of people who need care managers,

medications management, housing specialists, special meals, help with appointments and similar services. If we do not address these needs we will never break the cycle.

Once again, thank you so much for your time and attention to our testimony about our patients and their experiences. The Bronx Health and Housing Consortium welcomes the opportunity to work with you, DHS and other stakeholders to address these issues and support the medically homeless in their need for appropriate clinical care and ultimately permanent housing.

Respectfully Submitted,

Henie Lustgarten, MUP

IHCD testimony

1.7 million New York City residents live below the poverty line. Socioeconomic factors are key determinants of cancer outcomes. In NYC roughly 1.3 million people are food insecure, and over 60,000 are homeless. These patients are less likely to finish cancer treatment, leading to glaring disparities in cancer care and outcomes and health inequities across the system. Our research has shown that we are lucky to be practicing and working in NYC. We have a system that does not exclude based on a patient's ability to pay or on immigration status. However, for all of the good work that the system accomplishes, and all of the resources that go into supporting this system, we doom it and our patients to poorer outcomes by not supporting the socioeconomic factors that make or break their treatment, their cure rates, and their disease-related quality of life.

We are here today to speak specifically about the scourge of homelessness and insecure housing as it affects our most vulnerable patients. It is heartbreaking and totally unacceptable to treat a patient for cancer and then have that patient leave his/her chemotherapy session to "recuperate" under the subway trestle. What are we actually doing for these individuals? Exposing them to an increased infection risk, and relegating them to battle their chemotherapy side effects while on the street or sleeping on someone's basement floor. We are almost guaranteeing a poor treatment outcome despite the availability of the actual medical care. We need to do something about this. We need to ensure that there are designated medically responsive shelter beds available for the medically frail, unstably housed or homeless.

Eligibility for these beds should be determined by the patient's treating health care provider, based on the patient's medical needs.

These beds need to be accompanied by medical support services that step up according to the patient's medical situation.

Patients need to be provided with clean, single bedded rooms when medically necessary, such as when one is at risk of infection, e.g. post-chemotherapy, to decrease the risk to the patient and to stem the expensive cycle of treatment and readmissions.

Thank you for your consideration of these vulnerable populations for whom we care and who desperately need these services. Their health and the fiscal health of the medical care system will benefit from the provision of this urgently needed housing.

Testimony by John Betts, Program Director Living Room/Safe Haven, BronxWorks

Re: Int. No. 0929-2015 – In relation to:

Requiring information on health services in shelters.

Before the New York City Council, Committee on Health and Committee on General Welfare

November 17, 2016

Chairman Johnson and Chairman Levin, Council Members, and staff: good morning and thank you for the opportunity to speak about this proposed bill and the subject of addressing the needs of the medically frail homeless in New York City. My name is John Betts and I am the Program Director of the Living Room Drop-in Center and Safe Haven at BronxWorks. I currently oversee our 50 bed Safe Haven transitional shelter and the only drop-in center for homeless adults in the Bronx. BronxWorks is a large multi-service agency that has worked in the Bronx since 1972 and runs a number of programs including after-school programs, ESL classes, and benefits access programs. BronxWorks currently provides a wide range of homeless services including eviction prevention, family shelters, transitional housing for homeless single adults, Safe Havens, homeless outreach, a drop-in center for homeless adults, and permanent supportive housing. We are proud of our collaborative relationship with the Department of Homeless Services (DHS) that has allowed us to provide innovative solutions which have helped reduce street homelessness in the Bronx by 88% between 2005 and 2015.[1] Since we provide a continuum of care for homeless individuals and families--beginning from street outreach all the way through transitional housing and into eventual placement in permanent housing--we have an in-depth understanding of the wraparound services that are needed in order to move someone from homelessness to permanent housing. Medical care to address the wide range of medical challenges our clients face is an integral part of these services.

The medical needs of the adult homeless population are especially complicated and often contribute to individuals' continued homelessness. The most frequent medical conditions we see in our client population range from avoidable, acute, and treatable afflictions, such as severe leg swelling and open sores on the legs and feet, to complex, chronic conditions, such as diabetes, asthma, and COPD, that often go uncared for due to the person's homelessness, continued instability, and lack of access to consistent medical care. For that reason we support this bill because it will serve as a valuable starting point from which to drill down on the core issue at hand, which is the inability of the shelter system and the hospitals to effectively collaborate in order to best meet the medical and housing needs of homeless people.

At this time, DHS and the hospital system are unable to effectively coordinate and transition care from the hospital to shelter and vice versa. Homeless individuals are often discharged to a shelter and then, often within days, they have another medical emergency because of the lack of information sharing or proper medical respite services. One of numerous examples is a 70-

[1] New York City Department of Homeless Services. "HOPE NYC Street Survey 2015 Results." http://www.nychomeless.com/downloads/pdf/Latest_News/HOPE_2015_Presentation-07242015.pdf.

year-old blind, homeless male, who was chronically homeless and had been in and out of shelter for over 2 years. He was frequently hospitalized, including 6 hospitalizations from his assigned shelter, and another 3 times from the BronxWorks drop-in center either at his request or because his condition had deteriorated to a point where it required medical intervention. This elderly, disabled, and psychiatrically vulnerable patient went through frequent re-admissions (and often unsafe discharges) to facilities incapable of meeting his needs. Rather than being able to work together to coordinate care to facilitate proper placement and ongoing care, the client was bounced around from shelters to hospitals—effectively a band-aid for a larger issue. Cases like these serve as prime examples of how medical respite, or medical shelters could serve frail individuals, and how the accessibility of information sharing throughout shelters and hospital centers can facilitate coordinated care, and improve quality of life for those who are most vulnerable.

Further, there is a significant population of hospital homeless individuals who completely circumvent the shelter system due to this breakdown in communication. During this year's HOPE Count (a HUD-mandated annual point-in-time estimate of unsheltered homeless individuals), which counts all street homeless individuals in the city during a night in January, 47 individuals were counted on the street in the Bronx. However, the Bronx Health & Housing Consortium conducts a parallel count of all homeless individuals staying the night in hospital waiting rooms, hallways, and emergency departments. The Consortium counted 87 homeless individuals across nine Bronx hospital locations, which is nearly double the HOPE Count total of individuals found on the street in the Bronx. The majority of these individuals reported more than 10 emergency department visits in the past year.[2]

At present, the shelter system is often falling short of providing appropriate wraparound services for these individuals to improve health outcomes and address chronic medical conditions. The proposed bill will provide an opportunity to develop further insight into how these issues can be addressed and would open up communication to help coordinate care for these individuals between social services and the healthcare system. Since March 2016, the BronxWorks Homeless Outreach Team (HOT) has engaged over 500 homeless individuals in Bronx hospital emergency departments (ED), and of those, they transported over 120 to either shelter, or a drop-in center.

When hospitals and shelters can collaborate effectively and have the necessary resources, we have had amazing successes. Through the Medicaid Accelerated Exchange Series as part of Medicaid Redesign in New York state, in collaboration with SBH Health System and Bronx Partners for Healthy Communities, our team was able to engage a chronically homeless young man who was among the top 25 users of Emergency Department (ED) services at St. Barnabas Hospital and transition him into his own Safe Haven room. Prior to engagement by BronxWorks, the client had 82 ED visits in 2015 and was living between the train and the ED at SBH. In the 4 months after his placement at the Safe Haven, he only visited the SBH ED 2-3 times. We believe that by using the data generated from the reports required by the bill in question today we can properly implement changes that could radically improve health outcomes for the medically frail homeless population.

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[2] Bronx Health & Housing Consortium, 2016 Hospital Homeless Count, http://www.bxconsortium.org/uploads/2/5/2/4/25243029/bronx_consortiums_2016_hospital_homeless_count_report.pdf

On average, BronxWorks receives over 28 calls per month from hospital staff regarding the discharge of homeless patients. This clearly demonstrates the need for an open line of communication between shelters and hospitals to ensure smooth discharges, and lower the number of readmissions due to poorly coordinated care. One of the easiest ways to begin this collaboration is to grant hospitals access to the DHS CARES database of record. The CARES database provides information about an individual's history of homelessness, medical and psychiatric conditions, and information about their last shelter stay. It is vital that hospitals be given access to this system so that hospitals and shelters can effectively share information to best serve homeless people with medical needs. If hospitals could provide a discharge summary through CARES when referring an individual to the shelter system, it would head-off many of the medical emergencies that force homeless people to leave shelter and re-enter the hospital.

In addition, unless an individual is registered in the DHS CARES system (the database of record for the Department of Homeless Services) they may not have access to some permanent housing opportunities because there may be not be a record of their length of homelessness in the database of record. This can be particularly problematic if the person has been circumventing the traditional shelter system by using hospitals or other non-shelter facilities as a de facto place of residence. Providing hospitals access to the CARES system would allow for hospitals, social service organizations and shelter providers to work together to build a fuller picture of the client's needs, including length of homelessness, so that individuals have more housing opportunities. For this reason, it is also vital that the hospitals be required to report on the number of referrals they make to the shelter system to be able to cross-reference instances in which individuals referred to shelter return to the street instead of entering shelter and thus fall through the cracks in the system.

Another innovative solution is to build upon the Safe Haven system to provide respite care through Medical Safe Havens. Safe Havens are a specially funded shelter program for chronically street homeless individuals. Safe Havens provide housing placement, benefits assistance, medical and psychiatric care, three meals a day, medication monitoring, substance abuse counseling, and drug and alcohol treatment referrals. Most importantly, Safe Haven beds are allocated directly to street homeless outreach teams who prioritize the most vulnerable and needy street homeless individuals. This system allows chronically homeless individuals who are shelter resistant to be placed directly into a Safe Haven instead of going through the standard DHS intake process. The Safe Haven program alongside the existing shelter system has allowed DHS to effectively combat homelessness by providing a bridge between street homelessness and permanent housing for individuals who are resistant to entering the shelter system.

We know that the best solution for homeless patients, who often have a high number of emergency department admissions, is permanent housing. However, there is currently a gap in the transitional housing options available to the medically frail homeless. This gap extends their hospital stays, contributes to continued homelessness, and delays access to permanent housing. Safe Havens are a demonstrated solution for street homelessness and are a necessary part of the continuum of care for homeless services in New York City. However, not all medically frail homeless individuals currently qualify for Safe Haven beds because while homeless, they do not necessarily meet the very specific DHS or HUD definition of chronically

street homeless. We believe that an enhanced Safe Haven model could be used to bridge the gap in the continuum of care for the medically frail homeless population. Other programs similar to this model were found to save hospitals an average of $6,307 per year per client and to reduce emergency room visits and inpatient hospital stays for clients. Further, clients who entered programs like the Medical Safe Haven were shown to find more stable permanent housing.[3] The current Safe Haven model prioritizes the most vulnerable street homeless individuals, whereas Medical Safe Havens would prioritize the medically frail homeless population described earlier—those that are too well to remain in the hospital, but too sick to enter the traditional shelter system. Medical Safe Havens would provide private and semi-private rooms to clients. Medical Safe Havens would provide case management, life skills training, special activities for residents, on site medical and psychiatric care as needed, three medically appropriate meals a day, medication monitoring, and housing placement and care coordination, which will link clients to primary care. In these instances, it is often clear that these individuals are homeless. However, if they are not connected to the Department of Homeless Services system, such as if the hospital is their de facto residence, they are unable to access permanent housing. Medical Safe Havens will expand the current homeless services to fill a gap in the continuum of care by targeting a currently underserved population.

We are at a critical juncture in this discussion and the climate is right for the medical community and homeless services to come together to address the interlinked health and housing issues of the homeless. Medical Safe Havens, greater information sharing through hospital access to CARES, and the reporting requirements listed in this bill are concrete solutions that can be implemented at this time to address the larger issues surrounding the social determinants of health.

Once again, thank you for your time and attention to our testimony. BronxWorks looks forward to continuing to collaborate with DHS to find valuable solutions for the homeless population. We welcome the opportunity to discuss these issues further with you and DHS.

Respectfully Submitted,

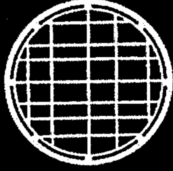
John Betts, LMSW

Program Director, Living Room/Safe Haven
BronxWorks

Sarah Zammiello, LMSW

Hospitals Coordinator, Adult Homeless Services
BronxWorks

[3] Doran, Kelly M., Kyle T. Ragins, Cary P. Gross, and Suzanne Zerger. "Medical Respite Programs for Homeless Patients: A Systematic Review." Journal of Health Care for the Poor and Underserved 24, no. 2 (2013): 499-524. doi:10.1353/hpu.2013.0053.



SAFETY NET ACTIVISTS

Supported by the Safety Net Project at the Urban Justice Center

WENDY O'SHIELDS TESTIMONY
THE CITY OF NEW YORK'S
Committee on General Welfare jointly with the Committee on Health
Oversight - Part 1
Medical Health Services in the DHS Shelter System
Int. No. 929 - in relation to requiring information on health services in shelters

November 17, 2016

My name is Wendy O'Shields and I'm testifying as a Safety Net Activists. Many times an ambulance is called for medical issues that might be easily solved if medical staff were onsite at DHS Shelters. The costs of EMT runs taking residents to the hospital for minor illness could be greatly reduced.

There is a definite need for medical staff onsite during the evenings at DHS Shelters. Possibly a General Practitioner Doctor, a Physician's Assistant, and a Registered Nurse per shelter. A medical staff could attend to the minor aches and pains of residents or assess the situation properly.

Please stop the DHS staff from referring residents to unscrupulous, profit driven, and Medicaid-bilking small-time operations immediately!

Please compile a list of the largest accredited medical institutions in New York City. This document should be given to DHS Homeless residents at intake and by request. This will aid and safeguard residents' proper medical care.

Thank you for hearing my concerns.

Testimony of Bobby Watts, Executive Director of Care for the Homeless
To the Health Committee and General Welfare Committee of the City Council of New York
November 17, 2016

Committee Chair Johnson, Committee Chair Levin, and all of the esteemed members of the City Council Health Committee and General Welfare Committee, Good morning.

I am Bobby Watts, the Executive Director of Care for the Homeless, a federally qualified health center that is the only health care organization in NYC that is exclusively dedicated to serving homeless men, women, and children of all ages. Care for the Homeless also operates a shelter for medically frail and/or mentally ill women. We are proud members of Homeless Services United and also of the Providers of Health Care for the Homeless, whose 14 member organizations provide health services to more than 60,000 homeless people each year. With me is Care for the Homeless' Chief Medical Officer, Dr. Regina Olasin, who will also be sharing her own testimony.

I have been working with homeless people for more than thirty years, so with that perspective, I want to congratulate the Committees for their proposed legislation and today's hearing. One reason it is important is that your effort can help to set parameters around what the City's philosophy and stance should be towards meeting the medical needs of homeless people. Over the years, the position the Administration has taken towards clinics in shelters has been variable – sometimes very supportive, at other times, very resistant. Even to the point that about ten years ago, a homeless health care provider received federal funding to establish a clinic in a shelter, and was initially denied permission by DHS and almost had to return the funding. So, the work the Council is beginning can set a common understanding that transcends one administration or Commissioner (even one as great as Steve Banks).

As a health care provider and shelter operator, I can firmly state that that adequately addressing the health care needs of homeless people in shelters is better for all residents, and by keeping the shelter resident healthy and out of the hospital, allows him or her to move out of the shelter into appropriate

housing more quickly, reducing the average length of stay in the shelter. For twelve years, Care for the Homeless has worked alongside street outreach teams, embedding primary care providers in those teams to provide medical care to people on the streets – people who wouldn't go into shelters. The health interventions brought them into care, eventually into housing, and we played a part in the consortium led by BronxWorks that led to a 72% decrease in street homelessness in the Bronx.

Finally, there needs to be a continuum of care that includes 1) shelters that are designed, and have the right staffing pattern, to serve the medically frail and 2) Medical Respite in shelters. Medical Respite is a service or facility to allow homeless people to recuperate when they no longer clinically need to be in a hospital, but are not ready to be in a regular shelter. Medical Respite occurs in different settings, but the National Health Care for the Homeless Council states that Medical Respite in shelters is the most efficient way to meet these needs.

I thank the Committees for their foresight and forward-thinking in looking to more systematically assess and address the health needs of our homeless neighbors.

Testimony by Deirdre Sekulic, Assistant Director, Social Work, Montefiore Medical Center

Re: Int. No. 0929-2015- In relation to: medical Health Services in the DHS Shelter System

Before the New York City Council, Committee on Health and Committee on General Welfare

November 17, 2016

Chairman Johnson and Chairman Levin, Council Members, and staff, good afternoon and thank you for the opportunity to speak about this proposed bill and the subject of addressing the needs of the medically homeless in New York City. My name is Deirdre Sekulic and I am the Assistant Director of Social Work at Montefiore Medical Center in the Bronx. I am responsible for several programs that we have developed to address the health and housing needs of our patients who are homeless and unstably housed. Unfortunately, that number has been growing. A system we developed to alert us to people in the Emergency Department who are probably homeless (shelter address, etc.) found 1,704 ED alerts created by 937 people in 2015, up 11% from 2014.

Over the past nine years Montefiore has worked with community partners on behalf of the homeless and unstably housed population. Through our housing program and our collaboration with the Bronx Health and Housing Consortium we understand both the health needs and housing needs facing this group. We greatly appreciate the efforts of the Council to have DHS reports on these issues which will serve to highlight to the Council, DHS and other health providers the type and extent of services needed. We are hopeful that these reports can assist in the safe discharge process from hospital to shelter. In the past six months we have encountered several patients residing in shelter with severe medical needs. We have a 38 year old patient, Ms. T from a shelter with breast cancer who needed a double mastectomy. We have a 39 year old female with diabetes and a chronic leg ulcer that needs daily wound care. From our experience with this population we feel that we have suggestions/recommendations that could to start improving the shelter system services to better support clients with various behavioral and medical problems.

Some examples of issues that affect the health outcomes of patient's that are in the shelter system are:

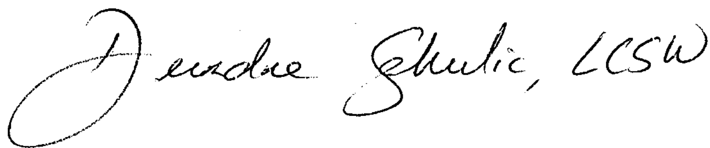
1. Reasonable accommodations for wheelchair bound patients. We have issues after discharging patients in wheelchairs who can independently handle their activities of daily living in the hospital, when they enter shelter they have difficulty transferring from chair to bed as the shelter beds are usually small cots that are very low to the ground.
2. In the past when discharging patients from the hospital the intake shelters, have not allowed the hospitals to send patients in an ambulette as they claimed that this showed patients were not independent enough to get to shelter. When a wheelchair patient arrives at the shelter a reasonable accommodation would be to have the ambulette

driver assist them into the shelter with their belongings. A wheelchair bound patient cannot push themselves in their chair and carry their belongings.

3. Post discharge many patients need to be able to stay inside the intake shelter during the day to rest/recuperate and to receive home care services.
4. Knowing the ability of each shelter to store and assist patients with medications would be helpful and would increase the health outcomes of already existing shelter clients. Patients need to be able to store insulin and access not only medication but also food in order to correctly take their medication.
5. Having a stronger relationship between hospitals and shelters and better communication would be useful in assisting patients to get placed in a shelter within the borough that they already receive their medical care. We have numerous patients in shelters scattered throughout the five boroughs that have to travel to clinics for daily chemotherapy, radiation therapy and dialysis treatments.

Gathering data and publicizing it is a wonderful idea and will allow us all to know and think about solutions, however, there is an need to act immediately to positively affect the health outcomes for shelter residents.

Respectfully Submitted,



Deirdre Sekulic, LCSW

Assistant Director, Social Work

Montefiore Medical Center

September 2016

NYLAG testimony, W.M. Hunt

To Whom It May Concern regarding the history of **Demetrius Davis** and his relationship with NYLAG and the need for appropriate medical shelters in New York City.

I was actively involved with Mr. Davis for the past 40 years. I was, in effect, his “Big Brother” from age 5 on, for 40 years. I was not his father, but I was the only person who was supportive of him for most of his life.

When I met him, he was a client of Jewish Child Care, a ward of the State, without any immediate family, placed in a facility called Childville on the Upper Eastside. The chronology of this is now spotty for me, but over the next 12 years he was a resident of Children’s Village in Dobbs Ferry, then ultimately of the Children’s Psychiatric Unit on Wards Island. He stayed there until he was 17 or so when he was moved as an adult to Manhattan Psychiatric Hospital.

Against all odds, Demetrius - aka Buddy - was always a very special fellow: personable and generous, caught in a nightmare of institutions. He was never properly diagnosed yet treated with a range of psychotropic drugs over the years. I am amazed he survived.

This is truly a much longer story, worthy of Charles Dickens or Nikolai Gogol without any happy resolution. In spite of any number of problems, including prison and homelessness, we sustained a long deep association. When he was diagnosed with cancer of the pancreas last summer, I became his legal proxy imagining I might be able to advocate for him and to facilitate his care.

Literally the only good thing that happened to him from any sort of institution was NYLAG and Julie Brandfield’s commitment to trying to find some solutions, specifically to his housing issues (although they helped with his SSI benefits too). They truly advocated for him.

About 4 years ago, Demetrius went into the shelter system as a way of finding subsidized housing. One can imagine the impact of the stress of that environment had on him physically and psychologically.

Last summer he reported that he felt increasingly sick with stomach problems; he was simply trying to survive, ignorant of his medical condition. Stage 3 cancer of the pancreas was diagnosed exactly a year ago first at a walk in clinic then at an emergency room the following day. When he became too sick to take care of himself, he was admitted to Roosevelt/Mt Sinai to deal with infection and jaundice. After recovery from those conditions, he entered a treatment program.

When he finished his initial rounds of chemotherapy, he was told by his doctors that he could continue treatment as an out patient. There was no appropriate place for him to go.

If he returned to a shelter, he could not have survived because he was too vulnerable, both to infection and to physical threats that he could not defend himself from. Further there would be no adequate dietary support. Shelters are not for compromised people. Again, there was no place for him to go.

Mercifully the hospital was ethically prohibited from releasing him into such a situation. This is the reason he stayed as an in patient for a total of FOUR months. He was safe.

However, the hospital environment left him morbidly depressed and barely able to sustain himself physically or psychologically for treatment which had to be adjusted. There was no chance to go outside, to move, to live. It is impossible to know the impact of this on his condition although he complained constantly about the amount of stress he felt.

His situation was the lesser of two evils, but the hospital was **not** a place to recover, which he ***might*** have been able to do.

We will never know because he died last month.

At the beginning of the year, the NYLAG team was able to secure him a second interview at Ruby's Place, a relatively new independent living, subsidized housing environment. They accepted him. (It still took almost a month to get through the paper work.)

That moment is indelible to me because it changed his life. For the first time, he would have his own: his own apartment, his own stuff - a kitchen and bathroom and bed, and privacy, and some pride and some dignity. All of this for the first time in his life.

His physical and psychological condition changed completely albeit briefly because the cancer was not in remission only stalled.

That there was no interim facility for someone in his situation undoubtedly hastened his death. It was a nightmare and inhumane. I urge you to consider the case that is being argued here today and in Demetrius Davis' memory take some positive action.

Thank you.

WM Hunt, Proxy for Demetrius Davis
186 Riverside Drive, New York, NY 10024
wmhunt@wmhunt.com

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 0929-2015 Res. No. ______

☑ in favor ☐ in opposition

Date: 11/17/16

(PLEASE PRINT)

Name: John Betts

Address: 30 Westminster Rd., 1D Brooklyn, NY 11218

I represent: BronxWorks

Address: 60 E. Tremont Bronx, NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☐ in favor ☐ in opposition

Date: 11/17/16

(PLEASE PRINT)

Name: Kelly Doran

Address: 1638 8th Avenue, #1H Brooklyn 11215

I represent: NYU School of Medicine

Address: 462 1st Ave, A-345 NY 10016

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Noah Berland

Address: 108 Terrace Place, Bklyn 11218

I represent: NYU SoM

Address: 258 1st Ave 10016

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 932 Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Barbara A. Conanan
Address: 159 Branch ave, Freeport, N.Y. 11520
I represent: NYU Lutheran Family Health Centers
Address: 300 Skillman ave, Brooklyn NY.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 0929 ~~932~~ Res. No. ______
☑ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Julie Brandfield
Address: NYLAG, 7 Hanover Sq. 18th F NY, NY 10004
I represent: Medically homeless
Address: ______

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Miranda von Dornum
Address: 200 Lincoln Pl #3 Bklyn
I represent: NYU Lutheran Community Medicare
Address: 300 Skillman Pl Bklyn

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Fabienne Laraque

Address: 33 Beaver Street

I represent: Dept of Homeless Services

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Catherine Trapani

Address: 446 W. 33rd St 6th Fl

I represent: Homeless Services United

Address:

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Luke Paolantonio

Address: 303 W. 122nd St.

I represent: Immigrant Health + Cancer Disparities

Address: 485 Lexington Ave

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 0929-2015 Res. No. ______
☑ in favor ☐ in opposition

Date: 11/17/16

(PLEASE PRINT)

Name: DEIRDRE Sekulic
Address: 111 E210th St 3rd NY 10467
I represent: Montefiore Medical Center
Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: David Tietz
Address:
I represent: DSS
Address:

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Fabienne Laraque
Address:
I represent: DHS
Address:

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☒ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: DR ROSA GIL

Address: 214 West 29 st. NY NY 10001

I represent: COMUNILIFE Inc

Address: 214 W 29 st NY NY 1001

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 929 Res. No. ______

☑ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Lea Yoon

Address: NYLAG 7 Hanover Square, 18th F NY NY 10004

I represent: medically homeless

Address: ______

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☑ in favor ☐ in opposition

Date: 11/17/16

(PLEASE PRINT)

Name: Ericka Moore

Address: ______

I represent: NYC DOHMH

Address: 42-09 28th Street, LIC

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☐ in favor ☐ in opposition

Date: 11/17/2016

(PLEASE PRINT)

Name: Beth Hofmeister Giselle Routhier

Address: The Legal Aid Society Coalition for the Homeless

I represent: 199 Water Street 129 Fulton St

Address: ______

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Dr Regina Olasn

Address: 30 E 33 St, 5th Fl NY

I represent: Care for the Homeless

Address: above

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☑ in opposition

Date: ______

(PLEASE PRINT)

Name: Bobby Watts
Address: 30 E. 33rd Street, 5th Floor
I represent: Care for the Homeless
Address: 966 E. 224th St. Bronx, NY

Please complete this card and return to the Sergeant-at-Arms

O.F. ROOM

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☑ in favor ☐ in opposition

Date: 11-17-16

(PLEASE PRINT)

Name: Wendy O'Shields
Address: 40 Rector Street
I represent: Safety Net Activists
Address:

Please complete this card and return to the Sergeant-at-Arms