

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

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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 patients' 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.