CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON GENERAL WELFARE JOINTLY WITH THE COMMITTEE ON HEALTH

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HELD AT: 250 Broadway –Committee Rm. 16th Fl

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COREY D. JOHNSON
Chairperson

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A P P E A R A N C E S (CONTINUED)

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[sound check, pause]

CHAIRPERSON LEVIN: Good morning, everybody. My name is Stephen Levin. I'm Chair of the Council's Committee on General Welfare. Today, we are joined with the Committee on Health to hold a hearing on medical health services in the DHS Shelter System. We will also be considering Intro No. 929, a local law to amend the Administrative Code of the City of New York in relation to requiring information on health services in shelters, sponsored by my co-chair for today Council Member Corey Johnson, Chair of the Health Committee. I want to thank Chair Johnson for holding this important hearing together with the General Welfare Committee, and I'd also like to acknowledge other council members who are here, Barry Grodenchik of Queens, and that's it right now. We hope to have others join us throughout the course of the morning. Given the complexities of homelessness, there is on added layer to the challenges that homeless individuals face, individuals and families face, and that's access to medical health services. The detrimental impact of homelessness on the health and individuals and health of individuals and families has been widely

documented. People experiencing homelessness encounter high rates of physical and mental illness, increased mortality and frequent hospitalizations. Homeless persons are three to four time more likely to die prematurely than their housed counterparts. While families in shelter may be more likely to be connected to a primary care provider, entering the shelter system may make it more difficult to access that care. One of the major topics that we want to address today is the issue of individuals being discharged from hospitals and nursing homes, and ending up in the shelter system or on the streets. When individuals no longer require the services of one of these in-patient facilities, these entities are able and in certain cases required to discharge that person regardless of the fact that they may have no other housing options other than the shelter system. This means in real terms that individuals may—who may be recovering from surgery receiving dialysis, receiving chemotherapy, on oxygen, having extenuating med—medical needs with regard to refrigeration of medication or other serious medical issues may be place in the regular shelter system or go back on the street. That is unacceptable in our

city. Other than those fortunate enough to—to access one of those limited medical respite beds available in the city, and they are limited, homeless adults with serious health issues are forced to go through the regular system starting at intake, then to an assessment shelter with hundreds of beds in congregate—in a congregate facility, and finally to a general or a program shelter for adults. These locations are generally not appropriate for individuals with serous health needs because they are communal, require individuals to leave during daytime hours, and typically do not have on-site medical staff. Today, we hope to have a productive conversation with the agency in attendance about how we can work together to better develop a solution. Families in the shelter system also face difficulties in accessing healthcare services. While some families may be placed in a Tier II Shelter run by one of the providers who are able to offer residents robust services including on-site healthcare, many families do not have that opportunity. With the ongoing capacity crisis in the DHS sys—system on a nightly basis, the city must turn to commercial hotels to fill its legal and moral obligation to

provide shelter to every individuals and family in need. I believe we can all agree that the use of these hotels while necessary at the moment is not a sufficient option for families. Families placed in locations without on-site services like commercial hotels and cluster sites, often end up living far from their communities. In addition to these problems that this creates that—that others have—that are often discussed such as difficulty maintaining education continuity for children, these families may no longer be able to access their existing healthcare providers as well. Today, we want to speak on these issues and ask how we as a city are ensuring that families are not losing access to healthcare. You know, on a side, you know, on a side note, I—I look a—there's testimony from New York Legal Assistance groups, legal health program that they'll be delivering later, but they identify a client of theirs whose name was Demetrius and I forget his last name. Demetrius Davis, who's suffering from pancreatic cancer, and had to go through the system with the assistance of NYLAG and that experience was harrowing for anybody especially for somebody with an advanced stage cancer, and they'll be detailing his

ordeal, but Mr. Davis passed away before he was able to testify, and I know that he—he wanted to testify at this hearing, and we need to look at this problem as how it affects individuals, and how it affects their—their experience through life. We have an obligation as a society to make sure that those that are in need are having their needs met to the best of our collective ability, and I believe the right now, we are not meeting that obligation, and—and I'm eager to work with the Administration with DHS with the Department of Health with HHC, with our state partners to make sure that we are truly creating a fuller safety net for those that all too often fall through the cracks. With that, I'm going to turn it over to my co-chair, but I also want to just acknowledge our committee staff who have prepared for today's hearing Counsel Andre Vasquez; Policy Analyst Tonya Cyrus; Finance Analyst Samara News-Hutton (sic); Finance Unit Head Dohini Sompura as well as my Legislative Director Julie Barrow, Communications Director Ed Paulino, and Chief of Staff Jonathan Boucher, and with that I'll turn it over to my colleague Corey Johnson.

CHAIRPERSON JOHNSON: Thank you, Chair Levin. Good morning everyone. I'm Council Member Corey Johnson, Chair of the Council's Committee on Health. I want to thank you for joining us for today's hearing on medical health services in the DHS Shelter System. We'll also be hearing legislation that I'm proud to sponsor, Introduction 929, which would require DHS to provide an annual report on health services provided to individuals and families in the shelter system. It seems to be common knowledge now, at least I hope, that housing and healthcare go hand in hand. Homeless persons are three or four times more likely to die prematurely than their housed counterparts. Homeless exacerbates health problems, complicates treatments and disrupts the continuity of care. Unfortunately, it is often a cyclical process where homeless individuals lack access to many basic medical services and cannot adequately control chronic illnesses, which can lead to hospitalization. Then upon discharge without a support system and a stable home, patients often find themselves unable to adhere to their medications, physicians' instructions and follow-up appointments increasing the chances of ending up in the hospital

once again. It is our responsibility as a city to end this cycle, and ensure that housing instability does not continue to negatively impact the health of our fellow New Yorkers. My bill would add transparency to the complicated system of providing medical services to those in the DHS Shelter System so we can have a full picture of what health issues are there to address, who is being served and where they're being served or not being served. Only then can we see holes in our system, and track progress. I would like to thank my friend and co-chair of today's hearing, Council Member Steve Levin, Chair of the General Welfare Committee for co-sponsoring this important legislation with me, and for joining me in chairing this hearing today. I want to thank my Legislative Director Louis Cholden-Brown, the counsel for the Health Committee David Seitzer, the Policy Analyst for the Health Committee Crystal Pond, and now I—we've been joined by Council Member Annabel Palma from the Bronx, and I would like to swear in the folks that are here from the Administration. If you could please raise your right hand. Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this

committee, and to respond honestly to Council Member questions?

DANIEL TIETZ: Yes.

DR. FABIENNE LARAQUE: Yes.

CHAIRPERSON JOHNSON: Thank you very much. You may begin.

DANIEL TIETZ: Good morning Chairman Levin and Chairman Johnson, and distinguished— distinguished members of the General Welfare and Health Committee. 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 in the Department of Social Services, which includes the Department of Homeless Services. Since the start of the 90-Day Review of DHS that was conducted earlier this year, I have assisted in oversight of programs 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 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 homeless prevention services, but we have now consolidated all of the HRA homelessness prevention programs into a single unit called the Homelessness Prevention Administration. Most recently, Home Base, which had been administered by DHS has been moved to HRA. In addition to Home Base, the HRA early intervention outreach team receives early warning referrals from Housing Court and from

NYCHA for tenants arrears cases, Adult Protective Services referrals and referrals from the New York City Marshals. This team also works closely with the City's Tenant Support Unit to refer low-income New Yorkers to legal service providers under contract with HRA to help them avert eviction, displacement and homelessness. Another key component of HRA's homeless 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 City-State rental assistance program supporting thousands of families was ended by the State and 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 enable 4,540 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 households, including approximately 390,000 people received emergency rental assistance to help

them stay in their home 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 HTA, 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.

CHAIRPERSON LEVIN: And I'm sorry, can you speak a little bit closer to the microphone?

DANIEL TIETZ: [pause] Providing coordinated homeless prevention programs 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 homeless tenfold form $6.4 million in FY13 to $62 million in this fiscal year when the program is fully implemented. We are seeing results even before full imple—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 State Office of Court Administration for 201 to 27% this year. With this tenant legal services program—I'm sorry. When this tenant legal services program is fully ramped up, the funding will enable legal services organ— organizations to provide legal assistance to 33,000 low-income households including some 113,000 New Yorkers. [coughs] 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 the intake point, 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--[coughs]--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 coordinate compassionate and 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. [coughs] As of November—November 15, 2016, DHS is sheltering 60,588 individuals including 23,760 children and 36,828 adults. These individuals and families are housed across DHS' system at facilities for single adult families with no minor children and families with minor children being left in shelters, cluster units and commercial hotels. Among the facilities that constitute the DHS portfolio, 47 single adult shelter and 23 families with children shelters have access to on-site healthcare. The facilities with on-site healthcare are operated through contracts with non-profit organizations including Care for the Homeless, Home United, Project Renewal, Bowery Residents Committee, A Floating Hospital, Montefiore's Children—Children's Program, ICL HHC, William F. Ryan, Help PSI, Housing

Works, Lutheran Family Health Services, Interfaith Medical Center, and Genuine (sic) Health. The remainder of facilities within the DHS portfolio secure and maintain connections to neighborhood and community healthcare providers to which clients are referred. Consistent with city and state law gov— governing the rights 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 the—of auxiliary aids such as refrigerators or accommodations for service animals. Additionally, [coughs] many shelters have art therapists, occupational therapists and recreational activities such as outings, Yoga and health classes. Further, all shelters follow the New York City 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. 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 its healthcare for those seeking or residing or residing in shelter. Improvements, for example, including—include adding appropriately licensed and experienced clinical staff to DHS Medical Director's Office. These individuals will assist the Medical Director in designing evidence based standards of care, planning and implementing new—newly expanded program monitoring and oversight and will conduct evaluations of existing programs and services. [coughs] Currently, in addition to the existing licensed medical director, there is one social worker with a MFW, one Administrator/Deputy to the Medical Director, three administrators, clerical staff, and one staff analyst. As part of the findings at the 90-Day Review, we are adding experienced and qualified licensed clinical staff. These funded positions will include a deputy medical director/clinical director. There will be an MD or Nurse Practitioner or a Clinical Psychologist or a clinical or a clinic or

licensed clinical social worker, a licensed nutritionist, an MPH or PHD health service analyst and a registered nurse or MPH. These addition stall 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 an automated referral system and centralize—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 home 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 of 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 needs are available to providers in shelter or via referral. This will include revising and reissuing the RFP for the medical provides at intake and assessments 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 families with children 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 strengthening—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 of management tools and assistances including adding regular site visits by appropriately trained and skilled DHS staff. This includes trained 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. Having data analysts and epidemiologists to create nine life (sic) indicators and create a quality of management program hiring a nutritionist to improve food services and outcomes for those who require special diets due to illness and 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 healthcare for the homeless and pubic and not-for-profit providers to create a seamless system of care for the homeless, capitalizing on the existing care systems in New York City, and using shelter providers as points of clinical assessment entering into care, coordination of care and health and wellness promotion for medical preventive care and nutritional education and services. Expanding on health education and health promotion and to increase self-sufficiency and examining effective ways to measure improvements. And working closely with hospitals and other providers who are also focusing on the need for 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 the 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—I'm sorry. Families with minor children enter DHS shelters through the Central Intake Center called the Prevention Assistance and Temporary Housing or 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 assessment. At PATH each woman of child bearing age in a family is asked about pregnancy, the presence of 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 providers. The on-site clinician is going to 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 healthcare provider. 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—in families with children's shelters, the Clinical Services Unit was launched in the winter of 2015 and consists of a team of social workers who serve the Families of Children Shelter system. At full scale, the unit will include 24 social workers, MSWs and LMSWs plus two supervisors, one deputy director and a director. Through referrals from DHS colleagues, staff in the Clinical Services Unit work with families to provide support and guidance as families search for permanent housing. The social worker is also to connect the family 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— I'm sorry. The social workers do this by completing a comprehensive bio—biopsychosocial family assessment to learn the family's history, to understand their social context and risk factors for poor outcomes, and assess their services 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—as identified, obtaining consent from the family to speak—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 in 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 New York City Administration for Children's Services, if the family has ACS involvement and assisting ACS in determining services needs, and serving as a mediator with our shelter staff if there are tensions and conflict among staff and the family. Service planning is an integral part of case management. The staff assists the clients in creating an independent living plan, and making the right referrals of finding the needed resources that will have the greatest impact on a family's success in achieving housing permanency

goals. As part of our family's permanent housing plan, family shelters are required to establish linkage agreements with health clinics and providers in the community for convenience and ready access to medical services. Additionally, the provider at PATH delivers its health education for new parents including counseling on safe sleeping such as placing their infant on his or 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 house subjects such as the danger of second hand smoke, and referrals are made to the Nurse Family Partnership Program, if applicable. The Nurse Family Partnership that's a nurse home visiting program for women who are having their first baby. When they enroll in the program, a specially trained nurse will visit the mother throughout the pregnancy until the baby is two years old. To summarize, in city year '15 there were 9,453 health related visits among 4,608 patients who sought services from the on-site medical clinic, PATH. 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 me, however, entry into the DHS system may be the first contact they've had with the healthcare system in several years. As such, DHS has comprehensive screening services for clients with medical or behavioral health conditions at six assessment shelter and require that shelter medical providers offer each client the opportunity to engage in the medical history and physical as well as a brief psychiatric assessment within five to ten days respectively under 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 referrals for mammograms. The physical examination is solved by a screening for communicable or infectious diseases such as TB and HIV. The brief psychiatric assessment includes, but is not limited to any chief complaints, history of present illness, past psychiatric history, substance use history, medication, 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 the client remains in the shelter system beyond the initial assessment period, the client may receive medical and psychiatric—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; TB skin testing; specimen—specimen collection for laboratory testing; writing a prescription or directing, facilitating and obtaining medications for their clients; 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 for 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 healthcare services as necessary to individuals choosing to live on the street. All clients are provided a clinical assessment upon intake to a Drop-in our Safe Havens. These initial assessments do not include psycho-social 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 investments in expanding stock supportive housing units by committing to funding 15,000 new or converted units in the next 15 years. These units are critical to reduce—to reducing the DHS census by making available permanent affordable housing with behavioral health, and supportive services for those who require such support in order to live in the community.

In FY16, DHS submitted a total of 6,824 HRA 2010 E-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 shelter and to the system pursuant to 18 New York Codes, Rules and Regulations Chapter 2, Part 491. In FY16, there were 1,843 referrals from acute care hospitals for single males entering the shelter system for the first time and 65 for nursing homes. Of those, 33 and 14 were inappropriate respectively. Families with a household member with significant medical—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—afforded a private room or unit while in shelter. Single adults must be able to care for themselves in what are usually congregate settings, and our 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 home referrals to a standard questionnaire in use since 2010, offers the placement of homeless single adults after hospitalization or a stay in another skilled care facility. Did I say that right? No, and oversees the placement of homeless single adults after hospitalization or stay in another field care facility. DHS also facilities appointments for medical and behavioral health follow-up and can provide limited medication management support during business houses at those shelters with onsite medical clinics. For the remainder of the system, we offer safe—safe storage and supervised self-administration of medications. 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—individual's anticipated discharge from the key care other medical facilities. 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 to assigned shelter. Because clients returning to their shelter after a hospitalization are not screened by a centrally located medical providers, DHS create the Shelter Referral Line that medical providers can call to request information on their pal—on their patients assigned a shelter and their fax number to forward the hospital materials. DHS then reviews the materials and providers a response with 24 hours. It is worth noting that during the 90-Day Review, we found the system to be inadequate. Dr. Laraque is quickly working to improve this process, and the related systems to better ensure client's discharged from acute—from acute and other skilled care things are medically appropriate for shelter.

Connection to Insurance: DHS collaborates with numerous city agencies as well as state agencies in order to connect clients to appropriate medical insurance. For example, in 2012 through a collaboration with New York State DOH and

Maximus, which brokers' Medicaid enrollment for the New York State Department of Health, homeless clients were assisted with enrollments in the Medicaid Managed Care Program via facilitated enrollers at single adults and family shelters. Currently, upon entry into shelters, staff will call the New York Medicaid Choice Hotline to enroll clients in case management's further assistance and refer interested clients for enrollment in health insurance. Because of their high level of need, homeless individuals may also benefit from enrollment in the 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 in the community based organizations. Since 2013 in collaboration—in collaboration with State DOH—DOHMH and Health and Hospitals, DHS enrolls eligible clients to in Health Homes as available. Additionally, since 2013, we've been pairing Pacific Health Homes with designated single shelters based on geography, population type, availability of

healthcare 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 healthcare services in shelter. We support the intent of this legislation on health—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—as it relates to healthcare services in shelters. Thank you for the opportunity to testify today, and to respond to the bills before each committee. We welcome your questions.

CHAIRPERSON LEVIN: Thank you very much, Mr. Tietz. We've also been joined by Council Members Cabrera and Gibson of the Bronx. So I want to—so

I'll thank you very much for your testimony, and—and for the work that this administration has done over the last—particularly over the last year with regard to really taking a deep dive look at the DHS system and really you're looking at ingrained systems of 20 years or more that have to be updated and brought in. You know, brought into a more modern era, and that's not an easy job. So I appreciate the work that you've done so far and—and also, you know, appreciate the limitations that—that are—are there for those. I want to ask first off, does—does DHS within the continuum of services that DHS provides, do—does DHS see a medical respite as defined by kind of national practices as—as part of the continuum of services in the DHS portfolio? I mean is it—it is seen as a—a core functionality of—of DHS?

DANIEL TIETZ: No. So, it's a shelter system. It's—you're not, you know, in the business of licensed healthcare. So it's not—they're not licensed care facilities. They're shelters. We obviously folks with substantial needs come to the front door. Under current State Regs in Part 900, we are free to reject shelter for those who are deemed medically inappropriate, whose medical needs are too

great to be handled in shelter, and then they're referred to hospitals for services and then appropriate placements. I will say, though, that we certainly have had conversations with our city partners about what we can do to serve folks who need a certain level of care and services that may be less than, you know, acute care hospital level of care and services maybe aren't particularly fitting for a skilled nursing facility, and so I think that it's a fair question about where should these folks go, and we're working with our city partners on—on just that.

CHAIRPERSON LEVIN: Because there are models out there, and it's—have you seen there's a report by the—the National—National Healthcare for Homeless Report from just last month that lays out best practices for establishing medical respite and, you know, their—they've listed it, and also in the report from 2009, of the Healthcare for the Homeless, Respite Care Providers Network June 2009 Report Medical Respite Services for Homeless People. They've-they've laid out—obviously their facilities from across the country every, you know, most states have—have some facility, and, you know, there are—

there are best practices out there. Do you know with---throughout the country--

DANIEL TIETZ: [interposing] No, I don't know there.

CHAIRPERSON LEVIN: -does everybody see this as purely a—do—do the other systems look at this and say this is not a—a homelessness question. This is a health question, is—is—or how—I mean California has got, you know, it looks like over a dozen medical respite programs for homeless people. How—what model are they looking at?

DANIEL TIETZ: Well, I—as I noted in my testimony, we have a couple of facilities as well that essentially do this. I think that--

CHAIRPERSON LEVIN: [interposing] How many beds in those facilities?

DANIEL TIETZ: I don't know off hand. It's limited. It's very little.

CHAIRPERSON LEVIN: [interposing] It's limited. It's like, you know, less than 100.

DANIEL TIETZ: Yes, so I—I—it's a very—I think it's a very challenging circumstance in that again it's—you know, we aren't—DHS shelters are licensed care facilities. They're shelters--

CHAIRPERSON LEVIN: [interposing] In the-like in--

DANIEL TIETZ: --and—and I think that there's a—there is a—a limited opportunity to offer something in this regard in addition to what we already have, what we already do, and part of this conversation is happening with Health and Hospitals and with the Department of Health and Mental Hygiene on what that should look like, and where it should be.

CHAIRPERSON LEVIN: And it would—something like that does—like for instance BRC or Comunilife (sic) Program would those—are those under State Department of Health framework? Is the specific licensure for that type of facility or--?

DANIEL TIETZ: [interposing] Not that I know of. Those—those programs aren't licensed.

CHAIRPERSON LEVIN: Okay, so they're—they're—they're regular DHS programs that are utilizing Medicaid?

DANIEL TIETZ: Well, so I—I don't know—I don't know to what degree they may bill for some of their services. There's no billing in shelter. So—so for example you could have—it's conceivable that

you could have a licensed clinic connected to a shelter or to which, you know, the—the shelter refers that then bills Medicaid for those services, but it's not—it's not the service in shelter that's being billed to Medicaid.

CHAIRPERSON LEVIN: So, you know, I want to read something from the opening of—of that National Healthcare for Homeless Council Report. It says imagine—or this is the one from 2009 I believe. It says, Imagine a person who is homeless with a fractured leg who also suffers from a type of disease such as diabetes. This person leaves the emergency shelter early in the morning and wanders the street all day with no place to rest, take medication or bathe. He struggles to find a meal, a bathroom and a place to sit. Exhausted, weak and believing there's no other option, he seeks the nearest emergency room for support. Once discharged from the emergency room or after an in-patient stay at the hospital, he's back on the street where his health is again put at risk. Medical respite care offers him a safe, nurturing alternative environment from the rigors of the street in which he—in which to recover and

receive medical and nursing care while keeping him out of the emergency room and safe from harm. It's--

DANIEL TIETZ: [interposing] I suggest now you—you had in your opening remarks you noted that folks must leave the shelter during the day, which is not correct. So, folks don't actually have to leave shelter during the day.

CHAIRPERSON LEVIN: And that's—that's a new—that's new from--

DANIEL TIETZ: Yeah, I want—I—I don't know what the rule was before, but I—we made clear several months ago that there's no—there's no putting folks out during the day. Now, in single shelters, for example, in the, you know, dormitory settings, those—the dorms themselves have to be clean. So, if folks aren't put out of shelter they can—we just, you know, ask them to leave their rooms long enough for them to be cleaned, and they can remain in the shelter if they wish.

CHAIRPERSON LEVIN: Fair enough, but I think that it—it speaks to kind of that there are—there is a—a—a number of people within the shelter system, single adults and—and—and adults without—your parents without children and—and—and families.

There—there is a certain number that fall into this—fall into this set of circumstances where their medical needs are greater than really what would be—what is appropriate, and I—I'll ask about how we—how we define appropriate. But—but just from a—a practical perspective the—it—they fall into the category where there—it's not appropriate for them to be in a congregate setting, and that they have—whether—whether it's having to go to dialysis, chemotherapy. I mean nobody would think—no medical—nobody with any medical background, I would believe, would think that it's appropriate for somebody receiving chemotherapy or dialysis to then go home to a congregate setting where they're sleeping on a cot in a dormitory without any—without any privacy or anything like that. So do you have a sense of—I guess the first question is do you have a sense of how many people fall into that category within the shelter system? Like how many—do we know—I think the first quest is can we quantity those—the number of people that are I need in need of that type of service?

DANIEL TIETZ: We can—we can try. I'll say that it isn't—it mean it's self-evident it isn't

a tidy bright line between, you know, on this side of the line are folks who need more than we could provide, and then on the other side of the line not so much. So, it's very difficult to say from data today moment to moment there are folks in shelter who when they arrive, just to maybe use your example, they didn't have a broken leg, but now they do. And so, there are plenty of folks frankly in shelter who had some acute care service who were in shelter previously and returned to shelter, and can largely manage on their own with a modest level of assist— additional assistance from the shelter staff. There are other folks who come with far greater needs, and who as we know to a limited degree we say aren't appropriate for shelter and refer back to a hospital and other facility because we believe that the shelter doesn't have what they need in order to be adequately managed. I noted in the—for families with children and adult families they're in units, and so to the degree that they can be assisted via, you know, licensed Home Care, that can be actually offered to them in that instance. So we can arrange for that or their provider can arrange for that because Home Care will actually deliver services in

shelter. Where there a private unit. Home Care won't deliver services in shelter in congregate settings. So, in some instances we have moved individuals into those private units, but it's a—you can see the problem we'll have with that with regard to capacity. So there is limited capacity for this at present.

CHAIRPERSON LEVIN: Right. I think, you know, I—I—I don't know what level of conversation DHS has had with—with the—the legal help from—from NYLAG and, you know, that—that organization that's—that affiliation has been put together. But it's—it's—it's a consortium of groups including hospitals. So Montefiore, Memorial, Sloan Kettering and, you know, they've brought it to our attention that there is—there is this—there isn't this deep need for people with chronic, acute, post-acute healthcare that are not—should not be in—they--they should not be in their—in the hospital any longer. They—they really ought not be in the hospital. It's—it's a bad system for us to have extended stays because there's no other—there's no other place for these people to go. And so there's—I mean do—do you agree that there is—that there's a—a real need based on what we're

hearing from practitioners on the ground in our hospitals that they don't have—they don't have a place that they feel—they feel comfortable discharging people to. I mean is that—I mean is—do you agree that there is a need there?

DANIEL TIETZ: Right. So, as I said, yes, I—earlier that we recognize that there's a need, and that, as I said, we're working with our City partners for sure on—so how to meet that need and where best to meet it. I think there's a—there's a—a good argument to be made that it maybe ought not be met in DHS shelter, but in some other setting. So we—we're not disputing that there's a need, we're only working on to where best and how best to meet that need. And I'll note that State Regs—the State Department of Health requires all licensed facilities, and that includes hospitals and skilled nursing facilities, nursing homes, to do discharge planning for their clients, and that doesn't equal simply referring folks to DHS. They actually have to do more than that. So if somebody needs more than what can be provided in shelter, it is actually for that discharging facility to—to address that need. I think we can all agree that there is a gap in terms

of settings. So what—so if not hospital and if not shelter then where exactly, and so I think that's the challenge we're working on addressing.

CHAIRPERSON LEVIN: So in your testimony you said that in FY16 there were 1,843 referrals from the acute care hospitals for single males entering the shelter system and for the first time and—and 65 for nursing homes. Of those, 33 and 14 were inappropriate respectively. So--

DANIEL TIETZ: [interposing] A very—so a very modest number. We took most of them.

CHAIRPERSON LEVIN: Right and that's—so I don't know how to interpret that because I don't whether—I guess the first question is what is the definition of appropriate? Because, you know, does that mean that DHS is taking individuals into the general single adults--

DANIEL TIETZ: [interposing] It's in many disciplined, many disciplines.

CHAIRPERSON LEVIN: --system that they ought not be taking now?

DANIEL TIETZ: Well, I don't think the same way. I mean I'll just say that—that—that we're—as we noted in in—in the reforms going forward, we're

changing some of that system both to centralize it in the Medical Director's Office, and then to get I—Io would say more—a more detailed look at who's being referred. Many folks leaving—many of those folks leaving acute care hospitals don't need ongoing skilled care services. So, that's why most of them would have been taken. The same could probably be said for the referrals for nursing homes. In many instances, it was a matter of payment that the—the nursing home resident, the insurer, probably long-term care—managed care insurer has decided that that facility is no longer going to get payment for that person because they're not in need of skilled of care. So and--and probably in most of those instances, we took someone some because they were no longer in need of skilled are, and they could manage in shelter.

CHAIRPERSON LEVIN: But of—so of those referrals, the 1,843 referrals, if 1,810 of them were—DHS is saying yes it's an appropriate setting for a DHS congregate care facility for that individual, I can't imagine that none of those 18—1,810 people have—have debilitating diabetes, cancer,

renal failure. Certainly those conditions apply to some of those 1,810 people.

DANIEL TIETZ: Yeah, without looking at the details of each of them, I couldn't say, but I think what we could genuinely say is that upon review by DHS it was believed that they could be managed in shelter. So in—I—I'm fairly confident that in most every instance these are folks who could largely self-care or we could connect with the on-site or referral resources to manage them in shelter.

CHAIRPERSON LEVIN: I think that there needs to be a broader conversation with our healthcare providers. If we're hearing from Montefiore and Memorial Sloan Kettering that their cancer patients believe that this is not right, that they're not—it's—it's not—it's not—it's a—it's not a good practice to have—that some of their—some of their patients are being—are among those 1,810 people ae just in demand that, you know, they—they've—they're concerned enough from their perspective that they've brought it to our attention that there's a gap here. There's a gap in care.

DANIEL TIETZ: Yeah, as I noted--

CHAIRPERSON LEVIN: [interposing] A gap in the continuum of care.

DANIEL TIETZ: --as I noted, as I noted we're having, as part of these reforms that we've announced, as part of the new hiring in the Medical Director's Office, as part of the new systems, is a look at all of this.

CHAIRPERSON LEVIN: And I just—and I'll—I'll turn it over to my co-chair, but I just want to point out that in this—have—have you seen the—the 2000—the October 2016 report?

DANIEL TIETZ: No.

CHAIRPERSON LEVIN: Okay, and have you seen the—the June 2009 Report?

DANIEL TIETZ: From?

CHAIRPERSON LEVIN: From—it's—it's—it's from—it's Medical Respite Services for Homeless People, Practical Planning and Healthcare for Homeless, Respite Care Providers Network. This is a report that was June 2009?

DANIEL TIETZ: No.

CHAIRPERSON LEVIN: Okay. It's from—it's put out by National Healthcare for the Homeless Council. They're the—they're the—the ones that put

it out. They identify steps in planning a medical respite program. So they put out—this is Best Practices a National Program. They—in their report they identify every program in the United States, which identifies the two here in New York City, Comunilife and BRC, but also then identifies all the ones throughout the country, of which in California alone there are probably over a dozen. Those two are the only two in New York State, by the way. But they identify—so it's—it's—it's pretty clear-cut in terms of best practices here. First, identify the need, and when it's appropriate. Second, identify the stakeholders. Third, scope—define the scope of care and range of services. Fourth, identify a model. Fifth, design the program. Sixth, determine costs and identify funding sources. Seventh, market the program. Eighth, implement the program. Ninth, collect data and outcomes and tenth, continuously evaluate market and refine the program. And I think that—I think we need to—I think what would be great is if we start to really get going on the first two steps there, which is identify the need and identify the stakeholders. We should all be talking to one another. DHS should be talking to the hospitals,

should be talking to the advocates, should be talking to the New York City Council and this committee, and so that we kind of close the loop there on identifying the needs and identifying the stakeholders. So I think that will be a good place to start. With that, I'll turn it over to my colleague.

CHAIRPERSON JOHNSON: Thank you, Steve and thank you Dan and Dr. Laraque (sic) for being here. So you know, your testimony was very thorough and clearly DHS is doing quite a bit when it comes to trying to provide services, enacting some reforms, looking towards the future and trying to figure out how to best handle this—this difficult population. I don't want to—you know, today is not about—my goal for this hearing is not about hammering DHS and-and--

DANIEL TIETZ: [interposing] I'm pleased to hear it. [laughter]

CHAIRPERSON JOHNSON: It—it is more about I think trying to understand what the real plans are for the future, and how you all think you're going to be able to expand these type of services and better meet the needs of your clients and the most vulnerable New Yorkers who really need this help.

And so, just to go back to Chair Levin's point on the number of referrals from acute care hospitals and long-term care facilities, 1,843 referrals from acute care hospitals jut for single males. That's just that population entering the shelter system for the first time. Sixty-five from nursing homes. Of those, 33 and 14 are inappropriate respectively. It is hard for me to believe that with a 60 plus thousand population right now in the shelter system, and does that number include the—the street homeless?

DANIEL TIETZ: No, I think that's just in the shelter. That—that doesn't include the Safe Haven and Drop-in.

CHAIRPERSON JOHNSON: And how many people right now is the city estimating are Safe Haven, Drop-in and chronically street homeless?

DANIEL TIETZ: I don't have that number in front of me. It's—I-I—I-let me get it for you.

CHAIRPERSON JOHNSON: So, I would think, and--and I could be wrong here. I'm not the expert on this. I'm sure there are folks here that would have a good answer, advocates and healthcare providers, and folks that are actually doing street outreach, and have been contracted to do that type of

work. But a lot of the chronically street homeless not just—we're not even talking to you about mental health services, but a lot of the folks that are on the street are people that—who are refusing to go to shelter have very serious healthcare problems. I mean I'll give you one example. [coughs] On 9th Avenue in Hells Kitchen in my district, there is a gentleman who is confined to a wheelchair who is chronically street homeless, refuses to—to go into shelter, who on a very regular basis, if not daily, weekly, and Breaking Ground has gone out multiple times to try to work with him. His legs and feet are completely scabbed over. I mean it's very hard to even look at the condition that he's in, and he cuts himself and picks the scabs everyday and he's bleeding all over the place, and when they go out he--at this point he is, you know, not wanting to engage in services. For me I'm sort of thinking that's sort of a clear and present. He's a danger to himself and he should be probably against his will put in the hospital so he gets the care that he needs. But I think that's sort of one of many stories of people that are out there that are chronically street homeless that have very serious medical problems and

aren't getting the help that they need. And so, my question is you talked a little bit about supportive housing. You know, the Governor and the State Legislature still haven't signed the MOU. Hopefully, that happens pretty soon. Is the hope that if we're able to get supportive housing off the ground in a substantial way that the supportive housing is going to be a place where people can get some of these services or be connected to care? Is that one of the pieces of the puzzle?

DANIEL TIETZ: Oh, for sure. So in the Mayor's 15,000 units, that's across 15 years. You're going to see 1,000 units a year. We expect to make awards for the first 500 before the end of this calendar year. So there will be some scattered site awarded soon in the Mayor's Plan. It will definitely make a difference. It's certainly part of the equation. There are some folks whose—whose needs are, you know, too great to be managed in shelter or at—at—or too great to be managed in the community in private market apartment without any services. And so supportive housing is—is exactly what's needed here. In other instances, of course, we, you know, rapidly get folks permanent housing and then as I mentioned

earlier, Home Care Housekeeping Services because they don't need to be in—in acute care or a long-term care facility. They could actually manage in the community if given the right supports, and so—so some of the answer for the folks with substantial medical needs in particular is to frankly use our rental assistance, use the supports we have to quickly get them housing in which case they can then also obtain Home Care and other supports.

CHAIRPERSON JOHNSON: So, you know--

DANIEL TIETZ: [interposing] And I'll just note that, you know, of course, for folks who are on the street, huge challenges just to get them to come into a space for a meal or come into a space for a few hours to talk to someone. Without coming and not necessarily on the gentleman you mentioned, you know, it's not an unusual picture, and folks who are otherwise deemed confident and—and are free to make choices with which we disagree. And so, I, too, would like to see someone that you've just described in care and services. Under existing stat state and federal law, there are limitations to how much we can push on that without getting—without necessarily commenting on that particular case, you know, there

are folks who are—who are involuntarily taken to hospital emergency rooms with regularity and our—our—our greatest hope is that we can actually compel a hospitalization and then while they're in the hospital getting the treatment that's been ordered for them, you know, that—that a judge essentially imposes that we can quickly move to get them into housing rather than let them go back out. Now, some of that, you know, even with an order, you know, as a practical matter requires their cooperation but, you know, somebody is not going to stay in an apartment for example if they don't want to stay in an apartment. So it wouldn't matter who orders it. So our goal here is—is if you can get someone involuntarily hospitalized, is then to do all that we can to—to—you know, get them the services they need connected to housing, and then persuade them to remain in it.

CHAIRPERSON JOHNSON: I mean this may be an unpopular thing to say especially in front of—in front of the—in front of the advocates but, you know, there are many people on the street who—who I think should—and I know the police aren't allowed to actually ask for the order to involuntarily commit

them. It has to be from a relative or—or someone along those lines, but there are a lot of people that I see. I mean my district the Village, Chelsea, Hells Kitchen--the New York Times did a map. I have the most number of street homeless in the entire city of New York currently. I see them on my block that I live on. I see them on nearly every block in my district. A lot of these people I do not think are—and I don't want to sweeping generalizations, but are in a very bad state physically and mentally and I sort of think to myself how can this person be deemed that they're taken care of themselves in some ways. And I know it's a complicated tricky issue because we want to respect people's constitutional rights, but at the same time, there are instances where I'm wondering to myself how are these people not being compelled to be in the medical system and to try to get them stabilized in some way? So just a few questions and then I'm going to turn it over to my colleagues. The most recent number, by the way, that we have from the last census is approximately 2,700 people living on the streets. I think that number is actually very low. I think it's probably significantly higher than that. There's a bill in

the Council that Council Member Espinal has to actually do the whole count of different points during the year, not just during the cold months. So that we can actually see especially during the warm months what the population is. But—but what I wanted to—what I wanted to ask is how much money is spend on medical services annually for the homeless population?

DANIEL TIETZ: By—by DHS? I don't have a number in front of me, but we can get it for you.

CHAIRPERSON JOHNSON: And how is DHS working with to foster relationships between an individual's primary care providers if they have a primary care provide and, you know, to continue the individual's existing medical relationships?

DANIEL TIETZ: You just note that, you know, we do the—the -the street homeless count now quarterly. It was part of the 90-Day Review.

CHAIRPERSON JOHNSON: So was—when was the last one done?

DANIEL TIETZ: [off mic] I think it was last month. [on mic] I think it's last month I think.

CHAIRPERSON JOHNSON: And what was the number?

DANIEL TIETZ: I don't have the number in front of me, but we can get it for you.

CHAIRPERSON JOHNSON: Is there anyone here who has the number? I would like it.

DANIEL TIETZ: I just don't. I don't want—I don't want to misstate, but—so we—we can get it for you.

CHAIRPERSON JOHNSON: Okay. Regardless of what the number is?

DANIEL TIETZ: I'm sorry, ask your question again.

CHAIRPERSON JOHNSON: Regardless of what the number is, I think it's probably an inaccurate number, but I'm glad to know—I'm glad the survey is happening. It's just an imperfect way of--

DANIEL TIETZ: [interposing] Yeah, I don't know really think--

CHAIRPERSON JOHNSON: --of trying to capture homeless people--

DANIEL TIETZ: [interposing] I don't think anybody is going to dispute that—that it's a challenge to try and count street homeless. I think

we've—we've largely followed the guidance from HUD on this. So at least it's—so there's a consistent, you know, comparator from, you know, period to period.

CHAIRPERSON JOHNSON: So, the question was how is DHS working to foster relationships with an individual's primary care provider if they have one to continue to an individual's existing medical relationships?

DR. FABIENNE LARAQUE: Hi. Good morning. Thank you for your question. So, DHS has caseworkers and case managers and also staff on the provider's side that are supposed to fasten that link between the cure that they receive at the shelters and their primary care providers. If they have a primary are provider, then the preference is that they continue to be seen at their provider—primary care providers. And what we intend to do is to strengthen the scale coordination by enhancing those services and by also strengthening the exchange of information between what's going on in the shelters and the providers outside.

CHAIRPERSON JOHNSON: And Dr. Laraque, the—the question that Council Member that Chair Levin asked Dan about the two different reports that were

issued on medical respite care, have you had an opportunity to read those and look at those?

DR. FABIENNE LARAQUE: I have looked at them from homeless (sic) and respite care, and—and I understand that they can be successful. I don't think we're disputing the success of this care. I think what we are talking about is who should be responsible for the medical portion of the respite care.

CHAIRPERSON JOHNSON: And--and who should be responsible?

DANIEL TIETZ: Well, that's the problem we're working on.

CHAIRPERSON JOHNSON: Well, who should be responsible?

DANIEL TIETZ: I—I don't think we've—we've actually settled yet. I can—I could see arguments in various direction on this, but certainly, this is a conversation we're having with Health and Hospitals and with DOHMH.

CHAIRPERSON JOHNSON: So, DOHMH besides their STD clinics isn't really involved in providing direct healthcare in New York City. I mean they're a public health agency, but the department—

DANIEL TIETZ: [interposing] I'm not—I[m not suggesting that DOHMH be responsible for that part.

CHAIRPERSON JOHNSON: [interposing] Oh, no, I'm—I'm just—I'm just saying that, you know, it's—it's counterintuitive in some ways, but there are many other city agencies that provide more direct healthcare than DOHMH.

DANIEL TIETZ: And that's what I'm saying. I'm not suggesting that they would be the provider. So, really--

CHAIRPERSON JOHNSON: [interposing] Yep.

DANIEL TIETZ: --so really some agencies could be.

CHAIRPERSON JOHNSON: [interposing] No, I—I wasn't saying were.

DANIEL TIETZ: We're working closely with that just in terms of standards--

CHAIRPERSON JOHNSON: [interposing] The point--

DANIEL TIETZ: --and thinking about how services get delivered, et cetera. So this—I'm—I'm not suggesting that they would be that part.

CHAIRPERSON JOHNSON: I—I wasn't suggesting that you were suggesting that. [laughter] The point I was trying to make is that in this city where the Health and Hospitals Corporation is in not the best financial shape, and I am very scared of what is yet to come in the incoming administration on Medicaid dollars and on our Medicaid waiver and on HUD money, and a potential decrease in domestic spending and all of these things but, you know, there needs to be a plan. Like what is the plan? I mean I—I—your testimony was great, Dan, and—and I—I appreciate all that you guys are doing, but, you know, so we just--

DANIEL TIETZ: [interposing] Right, so here's the plan.

CHAIRPERSON JOHNSON: Hold on.

DANIEL TIETZ: Yeah.

CHAIRPERSON JOHNSON: We—we put this hearing off for a few months because Dr. Laraque was starting and we wanted to be respectful of letting here get up to speed, and to not call you in before you were able to come and talk about what the plan is and so you're here today. So I want to know what the plan is.

DANIEL TIETZ: Right. So in my testimony I—I listed some number of things that we're doing in terms of improving the services at—at DHS with regards to medical care. So that—that actually is a plan. It's there in that—in the testimony. I think central to that for our purposes and some of this we'll leave for Monday's hearing, but is to set standards, set requires in—in our request for proposals for self-pay providers to improve the oversight and the quality management of—of those services. We're investing a great deal of money both in the Medical Director's office in terms of new and qualified staff.

CHAIRPERSON JOHNSON: How many staff members?

DANIEL TIETZ: So the—the additional staff members, the additional funded positions now are five clinical positions in the office that will help to draft those standards and to do that oversight.

CHAIRPERSON JOHNSON: How many total people are in the office?

DANIEL TIETZ: There are—there eight heads now.

CHAIRPERSON JOHNSON: Eight people in the Chief Medical Officer's office?

DANIEL TIETZ: Yes, uh-huh.

CHAIRPERSON JOHNSON: Eight people for the whole system?

DANIEL TIETZ: Yes, but the—how the system works, and I—and, you know, there are improvements being made here as well is that we set standards in—in contracts, and then hold the providers to those standards. There will be performance deliverables and—and—and guidelines that will essentially enforced by the standards that and—that we set and that's the program administrators that essentially contract with providers to oversee. So we'll—we'll give those—those permanent administrators the power to—and the resources to, in fact, enforce the standards and—and conduct that oversight that was designed by this office. So, it's not as though the, you know, eight people in this officer are going to go from shelter to shelter in some, you know, every month or something. It's rather that the existing staff who are in the business of contract oversight are going to be given

the tools to monitor performance. So we're—we're creating that system that doesn't exist right now.

CHAIRPERSON JOHNSON: I mean that's helpful to hear, but it—it and again this is in no way to be disrespectful to the—to the hard work that you all are engaging in, and—and coming up with a further plan. But that seems kind of small ball to me. I mean that—that seems like piecemeal short-term stuff without a broader vision on how to figure this out, and—and I don't think this is an easy thing to figure out. So I'm not saying, you know, this is easy and how come you don't have a plan, but, you know, given the challenges of Health and Hospitals, given the—how—how high the shelter population is right now, given the number of people we're seeing on the streets now that's increased over the last three years, I mean we have to have some type of plan.

DANIEL TIETZ: Yeah, I'm—I'm just going to refer you back to my testimony because I think it's there.

CHAIRPERSON JOHNSON: Okay. So, what—what kind of services are offered for those who are terminally ill in the shelter system?

DANIEL TIETZ: Well, so in the—in the shelter system it would be limited because we would, of course, have an individual look at whether someone could be managed appropriately given their medical needs in shelter. To the degree that they couldn't, then they'd be referred to another—to another facility such as hospitals.

CHAIRPERSON JOHNSON: And dental and vision care? [background comments]

DR. FABIENNE LARAQUE: I think dental and vision care is provided to our contracted providers. If they have you, they fall in linkages not necessarily directly.

CHAIRPERSON JOHNSON: How many contracted providers are providing that type of care?

DR. FABIENNE LARAQUE: I don't know for that right now.

CHAIRPERSON JOHNSON: Well, we should know.

DR. FABIENNE LARAQUE: For that, well maybe in eight weeks or so taking the law. (sic) [background comments, pause]

CHAIRPERSON JOHNSON: So, we've been joined by Council Members Cornegy, Salamanca, Barron

and Eugene and Council Member Van Bramer was here earlier as well. Are there any colleagues that have— Oh, Council Member Grodenchik.

COUNCIL MEMBER GRODENCHIK: [off mic] Thank you. [on mic] Good morning everybody. It's often been said that many of the people in this city are one illness away from being homeless, and I—I believe that to be true to a large extent. Do you know what the percentage of people that are currently in the—in the shelter system in the city of New York who are there because of an illness who lost their apartment or, you know, were otherwise unable to be in a—a, you know, a residential household because of illness? Do you keep those kind of statistics?

DANIEL TIETZ: No.

COUNCIL MEMBER GRODENCHIK: Okay.

DANIEL TIETZ: And I'll note, however that in New York in part because the Medicaid program was expansive even before the Affordable Care Act expanded it yet further that that risk is much reduced here versus other places in the country. So the—the risk that you—that you site there, I'm not suggesting it, of course, doesn't ever happen, but—but—but there is extensive care in services here.

There's the Medicaid program, which covers the—the vast majority of folks who are in shelter. You know, it offers a lot

COUNCIL MEMBER GRODENCHIK: But if you're not working and you have no income, unless you have an extremely generous employer, and I'm wondering how many of those people slip form, you know-- Do you have—do we have a mechanism to prevent those people from becoming homeless? Do we—do we pay—do we have a—a certain amount of time that people are allotted to have their rent paid?

DANIEL TIETZ: Well, so as among the—the reforms that we've made including its rental assistance. So among the homelessness prevention efforts are—are pretty extensive in this regard including—including, if you will, one-time financial assistance to help folks not lose their housing. As I noted in my testimony, that's—that's pretty extensive. We prevented a great deal of homelessness in many—so the—the—the narrow question you're asking about the cause of their—their arrears, I may not know—I may not be able to draw out of our system data that could suggest that kind of narrow cause, but—but we could draw out the numbers that have been given

one-time assistance to pay arrears and to retain their homes—their housing.

COUNCIL MEMBER GRODENCHIK: I would appreciate that. The ramping up of medical staffing at DHS, do we have a cost for that yet?

DANIEL TIETZ: No.

COUNCIL MEMBER GRODENCHIK: No, and has—is there an allocated in the New York City Budget in the F17 Budget, or are you going to take money from another place and--

DANIEL TIETZ: It's self-funded.

COUNCIL MEMBER GRODENCHIK: It's self-funded through Medicaid?

DANIEL TIETZ: No, not it's self-funded. It's within our budget.

COUNCIL MEMBER GRODENCHIK: So it's already there. We—I would appreciate a cost on that, and jut to follow up maybe not directly on what Chair Johnson said, have we—has DHS ever considered having one entity to be in charge of all the medical care in the shelter system as opposed to--? I—I know that that there are many different providers that might be let me say more affordable that way for the City of

New York, and have you had any discussions along those lines?

DANIEL TIETZ: No, in part because of variability from, you know, community to community, neighborhood to neighborhood in terms of—of—of what's available, and which providers are there. So, you know, many folks actually come to shelter with some connection to a provider and other that they wish to keep. So we wouldn't want to—to ever fully replace it. Admittedly in some number of shelters we have, you know, contractors, subcontracted providers on site that can provide, as we noted in my testimony, you know, limited primary care referrals and—and basic care. But our goal is still to, in fact, you know, presuming folks aren't going to remain in shelter forever is to connect them a provider in the community. And again, most have insurance, usually Medicaid that makes that possible, and then to the degree that they needed free care, they could get free care from—from Health and Hospitals among other places. So, this remains a choice for folks in—in the absence of their having made a choice or having an existing provider will provide.

COUNCIL MEMBER GRODENCHIK: Thank you Mr. Tietz. Thank you, Mr. Chair.

CHAIRPERSON JOHNSON: Council Member Palma.

COUNCIL MEMBER PALMA: Thank you, Mr. Chair. Good—good morning, Dan. Good morning Dr. Laraque. I—I know that in these hearings we get—we—we tend to get a little anxious with the back and forth but I—I truly want you to understand that we want to get the information that we need to be able to be helpful to the Administration because we are partners, you know, in a partnership to make sure we deliver the best services that we can to the people of the City of New York, and I don't have to convince you of that because I know that you know that.

DANIEL TIETZ: Thank you.

COUNCIL MEMBER PALMA: And I—I want to—I want to get specifics in how—if you—if you know how many individuals that are being discharged from hospitals are actually being discharged from the hospital into the shelters, and—and both hospitals and nursing homes?

DANIEL TIETZ: Yes, so we have—we have some—some numbers. So I'm going to note that one of

the things that we found as part of the 90-Day Review is the inadequate data collection by the existing system in the Medical Director's Office. So, I'll note that we have better data on them than on others, which I frankly can't explain how that came to be for something we're changing. So we have—we have some—I don't have numbers that I cold give you right here, right here on men, women, families. If—if you were to break out, you know, families with children or adults and I don't have that. We can certainly try to pull that from the system that we have as present, and that we're changing.

COUNCIL MEMBER PALMA: I—I would appreciate that. If share that with—with the committee, and I—I would raise do you—do you think that you have better data on men because tend to have a more visible time connecting maybe—maybe to other family members or—or families with children or women being discharged and going to a friend's house before they go back to the shelter or--?

DANIEL TIETZ: I—I couldn't—I have no idea how that came to be. We—it is what we found, and I recognized, of course, quite promptly that that was inadequate and we're changing it.

COUNCIL MEMBER PALMA: Okay, I—in regards and I know that Chair Levin raised it in regards to making sure that we have all those stakeholders at the table. I—I think that—that is crucial to make sure that there's a direct communication with—with nursing home staff and hospital staff when we face, you know, when we face these individuals right, they need to know where they're coming from. Are they coming from permanent housing? Are they coming from the shelter? What's going to be—what's going to be the discharge plan? I think at that point, the city, DHS definitely needs to be part of that discussion. We know that when someone is in a safe haven, that there cannot be help for them—the reason—while they're in the hospital, but then there needs to be a plan when they discharge. They're probably—they're going got have permanent housing, right?

DANIEL TIETZ: Well, first as I noted, from number of folks, our, you know, particularly—so I'll just use your last example. So someone who—who has been street homeless and was being served by a Drop-In or a Safe Haven and then went to a hospital, our goal is to try and keep them there long enough to come up with an alternative plan for them. There is

no interest in returning them to the street or for that matter even—even to a shelter. It's like to get the—we want to take the opportunity while they're in care of—of working with them to get into appropriate permanent housing. In many instances that could be supportive housing, but to quickly—to keep them where they are long enough to be able to work with then to something permanent.

COUNCIL MEMBER PALMA: Right, and then in regards to the individuals who are—who are terminally ill or need further treatment but don't require that treatment suddenly, (sic) by staying in—in the hospital. Is there any discussions with HPD, NYCHA to have them as priorities to make sure then that part of the discharge plan is to identify a place for them to be helped individually so then they can continue their treatment.

DANIEL TIETZ: Yeah, there are priority populations for some number of housing options. I mean NYCHA certainly has a set of priority populations and works closely with us on that. We've also prioritized them for some other housing on our own. So for example some referrals to supportive

housing are prioritized for folks who have the most urgent need.

COUNCIL MEMBER PALMA: And—and then I would—I would just leave it with this, I again want to emphasize the need for the collaboration before discharge from nursing homes to hospitals. There are many individuals who may enter the—the—the hospital because of an illness and require them to go to re—to a rehab facility before they're sent home because they don't have anyone who takes care of them. These individuals may have a Section 8 voucher, or some sort of subsidy, and live on—on fixed incomes, right, which then are in danger of being taken away from the because of the requirements that the nursing homes have in terms of payments and this—that's how these individuals end up becoming homeless. So I—again the—the collaboration and—and the work that needs to be done among the stakeholders to make sure this population who fall into this category, right, continue to have their permanent housing and not end up in the shelter system. I think it's really crucial, and will definitely help alleviate a lot of the challenges that the DHS sees there.

DANIEL TIETZ: Yeah, we completely agree. I mean I'll note that—that when we say no, for example, to a nursing home for some—for some case or another, it isn't a flat no. It's the—here so what—who do you have? What is it that they need? We would prefer them not to be in shelter or we believe we can't serve them in shelter. But we can, you know, this is now, you know, they become part of the reforms and part of the—having combined DHS and HRA as here we can help with other rental assistance, with other—other resources to get them from—to—from that nursing home into an appropriate permanent housing that has no part of a—a stop in—in DHS.

COUNCIL MEMBER PALMA: So—so I'm glad to hear that, and I—and I look forward to continuing to work with the department to make sure, and with my colleague, Council Member Levin, and—and Johnson to make sure that we're truly partners to makings sure that we alleviate the challenges that are being faced.

CHAIRPERSON LEVIN: Thank you very much, Council Member Palma. Mr. Tietz, I just want to follow up on that for a second. How—how many instances are there of people going directly form a

hospital stay into permanent housing? How often does that happen?

DANIEL TIETZ: I don't that—the data in front of me, but we could certainly try and get it.

CHAIRPERSON LEVIN: I'm guessing it doesn't happen very much. Of the—of the—of the—so there would be—that would be of that university. You mentioned 1,844 men I mean and then there's women and families, but—but of--

DANIEL TIETZ: [interposing] Some of those is--

CHAIRPERSON LEVIN: --of those men, I imagine that it's a very low number that are actually skipping over the—just because I know how challenging it is to get into supportive housing. I mean we've tried to help constituents do this for ten years. It's not easy, and—and so, I imagine that—that just going right into that permanent housing from a hospital stay happen very infrequently.

DANIEL TIETZ: Yeah, that's right. So, I—I have no doubt that it is very infrequent. I think that's one of our goals in terms of changing how this works, which is so it's—it's—it's a different circumstance when someone is long-term care

because often times you can—you've got a longer lead in terms of planning. And I didn't—didn't wish to mislead. I'm not suggesting that all go from some other institution into supportive housing, just into some kind of affordable housing. So, maybe all they need is a private market apartment and—and Homecare or housekeeping assistance, which they can get, which we can arrange for as well, and they're fine. So it's not—it's not that everybody who's leaving some other—other, you know, licensed healthcare institution needs to go into supportive housing. I think the challenge particularly for hospitals and acute care settings is the lead time is far shorter. You don't—we don't—we don't have enough—enough time. They don't—we don't get enough notice, if you will, for someone that's—that's possibly never known to us before to actually plan with them on those discharges. So that's a real challenge.

CHAIRPERSON LEVIN: Right, I mean, but for affordable housing, supportive housing the same problem, which is the extreme shortage of units, and so I mean, you know, I just realistically like people sit on waiting lists for like ten years to get into a 202 apartment, and it's—it's—it's real—it's not—I—if—

if I wasn't clear before, I mean I—I believe strongly that there is a need for medical respite programs within the DHS system because there has to be a stop gap. Ideally, we could live in a—you know, we could say in a perfect world that people are going to straight from—from a hospital stay to an appropriate permanent housing setting, but realistically we all know that is an aspiration. It is not reflecting reality. So we do—we do need that—that place where people could be on a temporary basis that is—that is truly appropriate. Anyway, moving onto Council Member Gibson.

COUNCIL MEMBER GIBSON: Thank you very much. Good morning and thank you to our chairs. Thank you, Chair Levin and Chair Johnson, and good morning. Thank you for being here. I appreciate your presence, your detailed testimony and certainly the work you're doing on our partnership. Moving forward is extremely critical. So I just have a few questions, and I like Council Member Palma, Cabrera and Salamanca represent the Bronx where we have the PATH Center, which is the only intake for New York City's shelter system. So I wanted to ask--

DANIEL TIETZ: [interposing] For families—for families with children.

COUNCIL MEMBER GIBSON: For family and children, yes. Let me stand corrected, and now we have another Council Member joining us from the Bronx, Council Member Torres as well. I wanted to ask about the continuity of services for shelter families when they begin at PATH and they're assessed in terms of their health needs. There's an evaluation that is done, and during that time frame when they're determined to be eligible or not, and they move onto a Tier II or any other shelter, how is that healthcare continued as they're in the shelter system because on average many families are in our shelter system between eight months and a year. And so during that time what do we do to ensure that they are consistently getting healthcare as they're moving in the shelter system?

DANIEL TIETZ: So as I noted in my testimony at—at PATH at the Floating Hospital is the first opportunity. It's the outside clinical provider. There are handful of questions we ask some related to pregnancy, some related to communicable disease, if they've got insurance then there's—

there's, you know, additional offers in that regard. So—so if they have any of those four things that I noted, then they are automatically referred to the—the clinical provider at PATH to be seen. And then, of course, any others who wish to be seen can be seen by the Floating Hospital at PATH. From there, any number of things could happen. So if they have ongoing needs, and they don't have an existing provider, often times, the Floating Hospital will, in fact, make the connection. So then—then they may refer them to their own clinics. They may refer them to other clinics. They—they'll usually handle the initial referral. If they have existing providers the Floating Hospital will also offer to arrange. So they'll—they'll collaborate and coordinate with an existing provider that the family has. If while in shelter that family has a new need, has something come up?

COUNCIL MEMBER GIBSON: [interposing] Which is very likely.

DANIEL TIETZ: Yes, then the—the shelter provider's obligation is to connect them to services in the community, and again there's choice involved here. They could go to a provider that's—that's

known to them already. They can go to a provider that is—is already linked to their shelter provider on referral. So essentially they're—the shelter provider's obligation is to connect them to care and services if they don't have those care and services on site.

COUNCIL MEMBER GIBSON: Okay, and in terms of—now all of the shelter providers obviously have a contract with the city whether—whether it's DOHMH, DSS. How do you ensure that during their stay at a particular location the service providers are actually giving the level of healthcare needs that are essential for that particular family? So in terms of the ongoing conversation within that contract period, what types of—of reporting and information do you receive from the providers, and how is that relationship?

DANIEL TIETZ: It's a very sharp question, Council Member.

COUNCIL MEMBER GIBSON: I know my stuff. I have a lot of shelters in my district so I—I learn.

DANIEL TIETZ: I'm sure. So—so as I noted, among the reforms is this, which is we have upon coming in have some of the same concerns that

there wasn't enough oversight of the—of the existing relationships with—with contracted providers.

COUNCIL MEMBER GIBSON: Uh-huh.

DANIEL TIETZ: Now, in some instances the providers are directly contracted with DHS. So for example the Floating Hospital is contracted with DHS. It's on site at one of our own, you know, directly operated facilities, which is intake for families at PATH. In other instances, the providers are contracted with a shelter provider. So they're a subcontract, but because, you know, that—that they're on site at a shelter then, you know, it's the—the—deal isn't directly with DHS. Either way, our—our intention is to set standards that didn't previously exist, and then to carefully monitor their performance, and conduct oversight in the way—in the way that previously didn't exist. And so that's—that's in process now.

COUNCIL MEMBER GIBSON: Okay. So I just have two final questions. In the district I represent I have two single adult women shelters. One is for women that have a number of mental illnesses, and the other is the Franklin Avenue Women's Shelter. Both of those shelters, and I know

with the announcement several months ago that Commissioner Banks made about providers not telling clients that they have to leave by 9 o'clock because that's what was happening and come back by curfew. During the day and that eight-hour timeframe that many of those clients are out, you know, that's very critical, and I guess, you know, I want to understand in terms of the healthcare needs what we're doing with these particular clients, these single adults. Because if you travel to Franklin Avenue right now, if you go to my other location, which is in the West Bronx, you will see a number of clients languishing outside at any given time. Across the street from my office I have a park, and many of the residents that sit on my benches all day are not street homeless, but they're in a program, and I know that because I talk to them. And during the course of the day, they're there, but in the evening they leave because they have to make curfew. But the next day they're back again. So what many of us don't simply understand all the time is what are we doing with that time that clients are spending outside of the shelters as—as well as their medical needs? Like how

is that--in terms of oversight from the agency, how is that—that addressed?

DANIEL TIETZ: We'll certainly take a look at what you—at what you raised. I mean I'll note as I—as I did earlier that they're not required to leave shelter.

COUNCIL MEMBER GIBSON: Right.

DANIEL TIETZ: We only for the-for the dormitory setting we, of course, just have to clean them, but they don't have to leave the shelter entirely. We just need to be able to clean—clean each dorm during the day. So, we've also added programming, and as part of the 90-Day Review we recognized that there was a need for programming during the day. So, of course, folks need both, you know, to be engaged to—and, you know, Franklin is a—is a—an assessment shelter. So folks don't say long. So part of the purpose here for Franklin is to figure out so what is it folks need? What's going on with them, you know, in the medical sense and the mental health sense, social service—social services wide? What's—what's their housing circumstance? Where do they go from here? So part of that is to—is to be engaging folks, and so—so we've added that

programming as part of the 90-day—the 90-Day Review, and I would say that we're far from done with that. I think that we're still looking at—at what else we ought to be doing particularly with assessment shelters to—to quickly get folks what they need.

COUNCIL MEMBER GIBSON: Okay, great and I—I certainly inject myself in terms of helping you. I work with both of those providers of those shelters very closely because I want to make sure that while clients are outside, their time is productive. I don't want them languishing outside. I want them to have services, and in addition to health, many other services that the 90-Day Review was called for. So I appreciate that. My final question is another topic that I talk about all the time, and Commissioner Banks knows very well cluster and scatter sites. I don't like them. I am happy that we're phasing them out. I have a high concentration of cluster and scatter in the district I represent, and I'd love to know in terms of healthcare services these are families that are living traditional buildings. So there are no on-site services. How are we assessing the level of healthcare that this cluster and scatter site families are receiving.

DANIEL TIETZ: Well, so I want to draw a distinction between those two things. So what's being phased out are—are cluster shelters for families. So we--

COUNCIL MEMBER GIBSON: [interposing] In traditional buildings?

DANIEL TIETZ: Yes, that's right.

COUNCIL MEMBER GIBSON: Okay.

DANIEL TIETZ: So over the next couple of years we're—we're going to wind down those—those cluster shelters. To the greatest degree possible we prefer that the family stayed in place that they were given--

COUNCIL MEMBER GIBSON: [interposing] I do, too.

DANIEL TIETZ: --they were given leases. You know, in—in many of these buildings the shelter units, the cluster units are a minority of the building.

COUNCIL MEMBER GIBSON: Yes.

DANIEL TIETZ: And so, you know, one of the—one of the things we started with first in terms of the 90-Day Review and the improvements was in repairs. So the shelter repair squad has done

yeoman's work over the last year to quickly address violations, to make improvements especially in—in clusters, and those improvements aren't just for the families who are being sheltered and, you know, let's just say, you know, 10 out of 50 units, it's for all 50 units. So those—those—addressing those violations improved the housing of everybody in that building. So we'd prefer that they stay, and I think we're—we're getting actually some traction with that in terms of working with building owners to—to permit families to say, and giving them the rental assistance and other support they need to stay. So, of course, in those instances, you know, they're living in an apartment in the community. The—our goal here is to have, as with all folks in shelter, which is have the shelter provider connect them to healthcare and services, whatever they need. So, it could be Health Home if they've got some chronic illnesses. It could be a local clinic for just some primary care needs. It could be mental health, substance use related services, whatever they need. That's the obligation and ideally you're giving folks choices with regard to where they want to go for those services, and—and our—as I said earlier, part

of our task with—with folks who don't have health insurance is to connect them to health insurance. Often because they're low-income enough that's Medicaid. So our goal is to get folks that coverage and then connect them to services, and then they can take that wherever they would like to go with it, and our—our—our work is to help them with that. With—with regard to scatter sites, the scatter sites are supportive housing. I hear what you're saying. You know, do I think that there are better and worse supportive housing providers? Yes. That is certainly a—a goal of ours to improve oversight with regard to—to supportive housing. You know, the—as I noted earlier, before the end of the year, we expect that there'll be, you know, 500 additional units, scatter sites, supportive housing awarded—announced. But I think it's a valuable resource, and done right, serves folks who are in need, and who can generally do well in community settings with the right supports from well qualified and experienced providers.

COUNCIL MEMBER GIBSON: Okay, thank you very much, and I look forward to working with you even outside of the hearing. You guys know that I'm happy to help. I have lots of cluster in the

district I represent. So, I want to make sure we can return those apartments to affordable units, and also make sure that there's a continuity of healthcare services. So thank you so much, and thank you, Chair Levin.

CHAIRPERSON LEVIN: You're welcome.

COUNCIL MEMBER GIBSON: Thank you, Chair Johnson.

CHAIRPERSON LEVIN: Thank you very much, Council Member Gibson. Council Member Inez Barron of Brooklyn.

COUNCIL MEMBER BARRON: Thank you. I want to thank the Chairs for calling for this hearing, and thank the panel for coming. I represent the East New York section of Brooklyn, and to my knowledge we have 13—13 shelters, and four beds. I think that classification is the sites that are designated beds like Safe Haven.

DANIEL TIETZ: It is.

COUNCIL MEMBER BARRON: And any number of cluster sites. So, Community Board 5 is oversaturated with providing shelter for the homeless. We have been very vocal in expressing our displeasure in that regard, but we want to focus

today on the health of the individuals that are in the shelters. My colleague Vanessa Gibson asked the question that I was going to ask about oversight of the providers, particularly of those who are operating these cluster sites. And there's a particular provider whose name escapes me who was in the newspapers for how he was engaged in widespread ongoing fraud in terms of having people go to a place and getting stamped. Okay, you got the health services you're entitled, but they had not, in fact, gotten them. But he used the threat of displacing them to have their cooperation in that regard. So what type of measures are being put in place to make sure that that doesn't happen, and once those persons are found to have engaged in that, are they eliminated? Are they put out of the program or do they morph and get their cousins who now come behind and continue to operate those programs?

DANIEL TIETZ: Well, as I noted, we're— we're ending, of course, the Cluster Program over the next few years.

COUNCIL MEMBER BARRON: But I heard you say clusters for families. So, are--

DANIEL TIETZ: [interposing] No, there are--

COUNCIL MEMBER BARRON: --clusters only for families?

DANIEL TIETZ: Only for families.

COUNCIL MEMBER BARRON: Okay.

DANIEL TIETZ: Right there are no clusters for--families with children so there are no--

COUNCIL MEMBER BARRON: [interposing] Okay.

DANIEL TIETZ: --clusters for any other population. So, I—I think I know which provider you're referring to. That is—we—we have ended that relationship earlier this year with that provider, and—and are winding down those clusters. The—we are also moving quickly I'd say with some number of other cluster shelter providers to—to transition their units, you know, back to the affordable housing market. We have no interest in working with providers that are—are—are doing a poor job of sheltering folks. And so with the individual you're referring to we have no further business with him.

COUNCIL MEMBER BARRON: But is he banned? Is there a list that says, you know, X you cannot be—you can no longer be considered? Are you disqualified? Is there anything in place to prevent him--

DANIEL TIETZ: Yes.

COUNCIL MEMBER BARRON: --from coming into--

DANIEL TIETZ: So—so, you know, there's Vindex.

COUNCIL MEMBER BARRON: Okay.

DANIEL TIETZ: So he would get, I'm quite confident, poor remarks—poor remarks on a Vindex--

COUNCIL MEMBER BARRON: [interposing] Okay.

DANIEL TIETZ: --and then can't another City contract.

COUNCIL MEMBER BARRON: Okay and then the other question that I have is it gets to—again to the issue of fair share. We know that there is supposedly a formula, which has not been implemented appropriately, but as we're talking about the health needs of persons who are located in these shelters, is there any consideration of the geographic

obstacles that occur because there are no healthcare facilities nearby in the facility, and they're not provided on site. So is there any consideration? Is that being factored into how we're going to locate the services that we're going to provide?

DANIEL TIETZ: I think, you know, as you know, it's challenging staring a shelter for a whole host of reasons. You know, communities often don't want a homeless shelter. Our—our, you know, very clear and, you know, stated goals as a result of the 90-Day Review is that we must actually site purpose-built shelters because frankly the quality of services, the assistance that folks would get in such shelters is far better than they would get in other settings such as clusters or commercial hotels. No one here is saying that that's, it's, you know, are sheltering folks in—in commercial hotels is a good idea. But in the absence of other shelters to address the immediate need for folks who have nowhere else to go, then we're left to use those. So, it's challenging to site shelters. Our—our goal in every instance is to look carefully at the neighborhood, at the fair share issues that you raised, to the level of saturation at the proximity of community services

such as, you know, grocery stores, other community services at proximity and accessibility via transportation including transportation to things like health services. So these are all considerations. I—I'll note that in many instances we're pressing on shelter providers to—whose facilities may be a bit more isolated to provide anywhere—providing support for van services. So that if someone needs assistance getting to and support getting to appointments for example, it could be appointments for social services or mental health services or other health services, and we're saying here, we're going to give you the resources to make that happen.

COUNCIL MEMBER BARRON: And my final question I noticed in some of the literature that I was reading that when families come, they go to the Bronx to the PATH that there's a health questionnaire that they complete. What kind of assessment tool is there for individuals that may be coming into the system? [coughs]

DR. FABIENNE LARAQUE: Sorry, if—and the majority you mean singles I believe.

COUNCIL MEMBER BARRON: Yes.

DR. FABIENNE LARAQUE: So, actually those get a more extensive assessment compared to families. So they have a medical assessment, a mental health, and substance abuse assessment that is based and set on tools. (sic) And based on that, that is used to refer for services, and also to place them into single shelters.

COUNCIL MEMBER BARRON: Thank you. Thank you to the Chairs.

CHAIRPERSON LEVIN: Thank you very much Council Member Barron, Council Member Salamanca.

COUNCIL MEMBER SALAMANCA: Thank you, Mr. Chair, good morning. [coughs] So I represent the South Bronx. I know many of us have heard stories about families that are in the shelter system in a—in a borough, and they have to travel to another borough to take their children to school there, and it's my understanding that some families also have to travel long distance to see a primary care provider. What is DHS doing to ensure that families are within their boroughs where their children are going to school, and they have the healthcare providers there as well?

DANIEL TIETZ: Well, admittedly in a—in a system as large as ours [coughing] with limited

capacity, it—it is difficult to make—to make those arrangements work for all. Our goal certainly is to—is to shelter folks closest to their resources, and supports. So that could be family. It could be job. It could be their schools that their children are currently in. It—it could be their healthcare providers. When there's a particular need, you know, for someone to be close to a care provider, we make every effort to make transfers within the system to put them closer to their provider. You know, as I noted earlier the—to the degree that we are having challenges siting purpose-built shelter, and having greater capacity to make those transfers from within, then this is more difficult to do. But it frankly happens with great regularity that a family or an individual raises a particular need with regard to, you know, education or healthcare supports, and then we'll make the transfer.

COUNCIL MEMBER SALAMANCA: Does your agency have a percentage of families in which their children are going to school in other boroughs, or there are--

DANIEL TIETZ: [interposing] Yes.

COUNCIL MEMBER SALAMANCA: --there are providers in other boroughs?

DANIEL TIETZ: Yes, we can get you the data. I don't have it with me.

COUNCIL MEMBER SALAMANCA: Alright. In—in my council district I have many shelters, cluster sites, but two that really always come to mind I have the Living Room in Hunts Point that's run by Bronx Works is the only Drop-in Center in the Borough of the Bronx, and I also have the Pyramid as a safe haven where we're holding, well, not holding, but they're providing services for 75 single males. What I want to know is in terms of your contracted providers, these are—these sites for example Bronx Works with the Living Room and the Pyramid, what is your requirement for a healthcare provider, a contracted provider to—to be on site? How often do they need to be on site per week?

DANIEL TIETZ: Yeah, I don't—I'm afraid I don't know off hand the requirement in those particular contracts for their presence on site. I know that there is presence on site. I just don't know the--

COUNCIL MEMBER SALAMANCA: [interposing] And so, that's just in general. How often does DHS require a provider to have an on-site healthcare provider?

DANIEL TIETZ: Yeah, it's at least a few times a week. So I know then in other ones, and it—and again I can get you the specifics. But I know that there's a—there's a minimum requirement to be at least a few times per week of providing services on site. I'll note also though, that there—that so whether it's Bronx Works or it's BRC or it's another like Breaking Ground, it's another Safe Haven or Drop-in provider on—on staff. So daily on staff they have social workers, you know, MSWs. They've got clinical staff on—on-site. So there is certainly mental health sand substance use related services regularly. But I don't know—I don't know off hand those sites in terms of I think the medical care on site.

COUNCIL MEMBER SALAMANCA: Can you speak to me a little bit on the quality assurance component? How are—what quality—quality assurance methods are put in place to ensure that these

providers that are on site are actually providing good quality care? [background comments]

DR. FABIENNE LARAQUE: So one of the plans that we are going to implement is going to be a quality management program. I don't believe it exists at this point reporting as then mentioned before. It's actually pretty limited. So that's also why it's hard for us to know what is going on at this point, but--

COUNCIL MEMBER SALAMANCA: [interposing] Would—wouldn't you consider that a problem that you're not--

DR. FABIENNE LARAQUE: [interposing] Absolutely.

COUNCIL MEMBER SALAMANCA: --you're not monitoring the quality of care that these providers--

DR. FABIENNE LARAQUE: [interposing] Absolutely--

COUNCIL MEMBER SALAMANCA: --are giving our families.

DR. FABIENNE LARAQUE: --which is why we are staring this.

DANIEL TIETZ: Right, which is why we noted in the 90-Day Review that there is a gap here. Hence, we're making these changes.

COUNCIL MEMBER SALAMANCA: I—I—I—I'm—I find that unacceptable--

DR. FABIENNE LARAQUE: Absolutely.

COUNCIL MEMBER SALAMANCA: --that you are providing a healthcare program and services and there's no quality assurance.

DANIEL TIETZ: Right, we did, too, which is why we made or we're making the change.

COUNCIL MEMBER SALAMANCA: Aright and finally I just want to give you one of my experiences. I was able to get a gentleman from my community into the Bronx Works Living Room. He was there for a couple of weeks, and we made arrangements to get him into St. Vincent de Paul, a nursing home there. The nursing home required that he—his primary care provider or a provider fill out the necessary documents so that he can get into this nursing home. His sole provider three week went by, and his documents were still not filled out. So I called Bronx Works to follow up, and they said that there was a backlog. So I really hope that we can really

look into this quality assurance component, and to see what backlog there is in terms of getting these client' paperwork filled out so that we can get him into one of the service treatments such as a nursing home, which he was approved for, and they were holding a bed for him for. Thank you, Mr. Chair.

CHAIRPERSON LEVIN: Thank you very much, Council Member Salamanca. Council Member Ritchie Torres. [pause]

COUNCIL MEMBER TORRES: Thank you, Mr. Chairman. Good to see you, Den, as always. I guess I'll see you tomorrow--

DANIEL TIETZ: Yes.

COUNCIL MEMBER TORRES: --and announcement. I have been informed that that I have the highest concentration of cluster sites in the city, and so I'm curious to—I'm proud that the Mayor has a commitment to phasing it out over a three-year period.

DANIEL TIETZ: [off mic] Two years.

COUNCIL MEMBER TORRES: Two years? Okay, what's—what's the progress that's been made thus far?

DANIEL TIETZ: I don't have those numbers in front of me. I know we've—we've wound down several hundreds.

COUNCIL MEMBER TORRES: Yes.

DANIEL TIETZ: So, yes.

COUNCIL MEMBER TORRES: And in the place of cluster siting, I think the approach that you're taking is one of a master lease?

DANIEL TIETZ: Well, so there are a variety of things. Of course, for the families who are in the clusters, as I noted, we prefer to the greatest degree possible that they remain and—and – and obtain a lease themselves in those units. For others, we'll find permanent housing for them elsewhere. So our goal is to not move them into other shelter, but move them from those units to other permanent housing. In some instances, they'll be transferred from within. There are—there are some limited instances in which we're contemplating master leasing. So—so just for context it's a not—a not-for-profit. The lease is an entire property and provides and limited on-site and referral services for—for the folks who reside there. We've used that most notably with regards to single adults. So, for

example, veterans as well as to—to some adult families. I might be misremembering, but I don't know that we've used it yet with families with children. So our—our approach is mostly to—to get from those clusters if they're going to leave that cluster because they won't be renting the units that they're in with our assistance then to other permanent housing.

COUNCIL MEMBER TORRES: Do we know the number of people who are living in shelter units under a mater lease?

DANIEL TIETZ: I can get it. I don't have it before me.

COUNCIL MEMBER TORRES: Alright and are these units typically for those with mental health needs or a variety?

DANIEL TIETZ: Yeah, so I—I—it's—I would describe it as supportive housing light. So folks who aren't in need of genuine supportive housing, but—but, you know, and I'll use the veterans context maybe because it probably is most relevant. Where it may have been homeless at some length, it may have some mental health, substance use or other needs that could be manage in the community with modest on-site

and referral services from our not-for-profit providers. So, those are the kinds of folks we're thinking about in terms of the master leasing situations. If—if folks can—can manage in a private market apartment without any on-site services then we'll aim to do that with them rather than placing them in a master lease. So, we're—I think we're looking at the mater leasing as somewhere in between a private market apartment and supportive housing.

COUNCIL MEMBER TORRES: But obviously the need exceeds the supply of affordable housing. So I imagine that there are—there's a subset of the homeless population that might be best suited to supportive housing that you might have redirected for the master lease.

DANIEL TIETZ: Yeah, not—I wouldn't say that necessarily because the supportive housing is—is really for folks who have that level of need. It's—it's expensive, and three are plenty of New Yorkers who—who, as we noted earlier, who have been improved for supportive housing, but due to a lack of availability aren't in it. So, I would—I would be loathe to actually place someone in supportive

housing who didn't actually need that level of service.

COUNCIL MEMBER TORRES: So—so since—since the supply far exceeds the demand, where are those families? If—if there's an individual who needs supportive housing, where do they tend to be in the meantime? Where do you place them in the meantime?

DANIEL TIETZ: Well, and they're in shelter, and I think, you know, in some instances, they can be managed in private market apartments with additional services. So for example, homecare but, you know, often times then they're in shelter.

COUNCIL MEMBER TORRES: Is it comparable to the services that one would receive in supportive housing?

DANIEL TIETZ: You mean the shelter services?

COUNCIL MEMBER TORRES: Yes.

DANIEL TIETZ: Yes, so, I mean I guess we'll discuss in Monday's hearing, you know there are mental health shelters, for example, just to use the mental health population as an example that provide quite a bit of service.

COUNCIL MEMBER TORRES: Any dollar amounts that you—like how much are you investing in social services for shelters compared to supportive housing?

DANIEL TIETZ: Well, shelter is definitely more expensive. So our—our—the cost for us for an, you know, an average, you know, family staying in a shelter is $41,000 a year. That's more than we spend on supportive housing.

COUNCIL MEMBER TORRES: I have a question if—if the State has an initiative DSRIP, which is aimed at preventing avoidable—reducing the avoidable hospitalizations, then it would seem to me the neglect of the healthcare needs of those who are chronically homeless is one of the main drivers of repeat hospitalizations. So is there—is there collaboration between DHS and the public and private hospital system around proactively addressing the needs of the chronically homeless?

DANIEL TIETZ: Yes. So we're—as I noted in my testimony, we're having conversations certainly with Health and Hospitals in particular around our shared population so that the high need, high utilizers of Medicaid paid services particularly in—

in Health and Hospitals emergency rooms, but also in-patients that—and the folks who just go back and forth among the hospital emergency rooms or in-patients at the street shelter. And finding a way to—to target services to them to sort of break that loop, and figuring out where best to serve them and how best to serve them. So there's very active work on that as part of the reform.

COUNCIL MEMBER TORRES: And just one quick question about cultural confidence. If I'm setting aside tomorrow's announcement on LGBT youth in a DHS similar adult shelters, how do you see to it that I'm receiving culturally competent care, right, that addresses that my—

DANIEL TIETZ: So, in the last year or so, year and a half, HRA has trained virtually all of its staff, almost all 14,000 in a new curriculum on LBGTQI about cultural confidence, and how to serve the LGBTQI community. We're getting that training as well for DHS for both DHS' own staff and then for the contracted providers. Many of the contracted providers certainly the better providers already have some of this in their curriculum. So a bit of this will be mixing and matching among their existing

programs, and what we would like to see the content be. But I expect over the next year that that training will be completed among all of them.

COUNCIL MEMBER TORRES: And as far as connecting them to the mental health care, how do we ensure that that's culturally competent apart from the training of the HRA working role.

DANIEL TIETZ: So, right. So I think that that's a—a big part of our goal here in terms of this particular reform, which is to ensure that not just that it's—you know, in the kind of the services, if you will, linked like the-- provider has some connections that they have thoughtful referrals. That they—that those--that the services that they're connecting their clients to actually meet their individualized needs. A part of those individual—individualized service plans is to—is to examine just what it is they need, and how they can get it for them. So part of our training includes so what are the resources in the community that are in—in fact targeted to the LGBTQI community, and now do you make connections to them.

COUNCIL MEMBER TORRES: Thank you, Mr. Chairman.

CHAIRPERSON LEVIN: Thank you very much, Council Member Torres. So I just have a couple of more questions. We want to get to public testimony. WE do have to be out of the room by 1:00 p.m. So I'm just going to have a couple more questions for you. So I just wanted to—and I sound like a broken record here. So, does DHS consider individuals with serious chronic long-term health problems such as chemotherapy, dialysis, severe diabetes with issues around open wounds and—and things of that sort. Does DHS consider those conditions to be appropriate for the DHS support?

DANIEL TIETZ: So there isn't-there isn't a tidy one answer to that. I—you know, the—the referral process is genuine. Like we actually—they have to send us the detail in—in the system that we have, and then we review it. So there's no one answer. I would—in some instances where we have concern that they couldn't adequately be—be managed in the existing system, then we would reject them.

CHAIRPERSON LEVIN: And what happens to those people that are rejected

DANIEL TIETZ: Then they remain, I presume where they are. As I—as I noted earlier, in

some instances depending again, it's going to be very fact based. You know, if they're in a long-term care facility and what they really need is housing and most bit of service, that could potentially be provided by Home Care, we're—we're not going to do just a—a no and, you know, thank you, good-bye. This is here. They can't come here, but we're going to connect you to the right folks at HRA and DHS to help that person get the resources they need to get out of your facility and into the community. So that I don't—there's just been a tight—it's—it's very fact based. It will turn on—on the condition of the person that's in need--

CHAIRPERSON LEVIN: [interposing] And it's always the intent of this determination between the referring agency and DHS?

DANIEL TIETZ: [off mic] Go ahead.

DR. FABIENNE LARAQUE: Actually, yes. So, for example two days ago I was on the phone with a medical provider who—in a hospital who wanted to discharge a patient who we all thought wasn't appropriate, and I personally spoke to the hospital, and the hospital agreed to move the patient to a step down. So like you—you need for a few weeks or how

many time to have that patient become stronger. So, this discharge referral process is a two-way conversation between the hospitals and the medical officers. Our questions are very straightforward, and address whether their individual is able to take care of themselves.

CHAIRPERSON LEVIN: What if there's a disagreement?

DR. FABIENNE LARAQUE: If there is a disagreement, we—we will think the patient will not fare well in shelters, and if it's fine for them to be in--

CHAIRPERSON LEVIN: [interposing] Right, but only--

DR. FABIENNE LARAQUE: --shelters then we will tell the hospital that they have to look for a nursing home placement. We have placements at some other places.

CHAIRPERSON LEVIN: What about the other way around, which is that DHS is saying no that this is appropriate, and the—and the hospital referring is saying no it's not. The hospital--

DR. FABIENNE LARAQUE: [interposing] That—that doesn't really happen because the hospital--

CHAIRPERSON LEVIN: [interposing] There's only—but there's only 30—these are really, but there's 30 people are determined to be—

DANIEL TIETZ: [interposing] We—that's what you were asking then, Council Member. So you're asking if we think we should take them, and they don't want to send them to us?

CHAIRPERSON LEVIN: Correct.

DANIEL TIETZ: That never happens.

DR. FABIENNE LARAQUE: That doesn't happen. So the hospital initiates the process. They send over for all of the callers and they say hey a patient is ready for discharge, and then we say okay, let's look at the information, and see if we agree. If we agree, then 17,010 of those we agreed, but they were well enough to come to shelters because they are able to walk. They're able to take their medication. They're able to get on that.

CHAIRPERSON LEVIN: What about people who can't walk, they can't take any of the--

DR. FABIENNE LARAQUE: [interposing] We don't-

CHAIRPERSON LEVIN: --I mean people that won't—let me ask about what if they require medication that needs to be refrigerated? Is that—that would addressed--

DR. FABIENNE LARAQUE: [interposing] Yes, absolutely.

CHAIRPERSON LEVIN: --every single adult that would be addressed?

DR. FABIENNE LARAQUE: If they request—if they request a refrigerator, we will give it to them. If they request to be transferred some place with elevators we will try that. If they request an elevator because there are no wheelchair, we will--

CHAIRPERSON LEVIN: [interposing] Put a bed is accessible by a wheelchair because a single adult shelters, congregate facilities sleep on cots, is—are people able to get--

DR. FABIENNE LARAQUE: [interposing] They have a bed.

CHAIRPERSON LEVIN: --from a wheelchair to a cot?

DR. FABIENNE LARAQUE: Yes.

CHAIRPERSON LEVIN: Or if there's—I mean it—it—it—this one of the recommendations from one of the providers that we'll hearing from in ten minutes says that one of the challenges that they have is that people are—are not able to—that it's not an easy transition from a wheelchair to a low cot. So is—does—does DHS ensure that they have a bed that is accessible by a wheelchair?

DANIEL TIETZ: So we meet, as I noted in my testimony, we meet the requirements of the Americans with Disabilities Act in state and federal law with regards to—to reasonable accommodations. So if among those we can reasonably accommodate them, then we will.

CHAIRPERSON LEVIN: We've heard that single adults are bussed to Brooklyn in order to get a health screening. Is that correct?

DANIEL TIETZ: I would need more context.

CHAIRPERSON LEVIN: That when a single adult goes in the intake at 30th Street, their—a health screening is actually physical done in Brooklyn, they're bussed Brooklyn, is that correct?

DR. FABIENNE LARAQUE: So, yes. There is no clinic currently at the 30th Street Shelter, but

we are working on starting a clinic again at 30th Street Shelters.

CHAIRPERSON LEVIN: Because just if anybody doesn't know, 30th Street Shelter is literally in between NYU Hospital and Bellevue on side of the street and the other side of the street. So, they're—they're bussed—where—where are they bussed in Brooklyn?

DR. FABIENNE LARAQUE: Probably at that—the Atlantic Shelter, the assessment.

MALE SPEAKER: [off mic] Greenpoint

Green Point, or the Greenpoint Shelter.

CHAIRPERSON LEVIN: So BRC and Greenpoint?

MALE SPEAKER: [off mic] The Robert Clyman Shelter.

CHAIRPERSON LEVIN: Excuse me.

DANIEL TIETZ: Robert Clyman.

CHAIRPERSON LEVIN: Oh, I'm sorry, you're going to have to speak into the—into the—into the microphone.

DR. FABIENNE LARAQUE: It's the Robert Clyman Shelter.

CHAIRPERSON LEVIN: Okay. So, obviously that doesn't make a whole lot of sense. So that's going to be rectified soon.

DANIEL TIETZ: We're working on a—on a—an answer to that as part of the reforms for examining having a clinic on site at 30th Street.

CHAIRPERSON LEVIN: With adult families how many adult family shelters have on site medical health services?

DANIEL TIETZ: I—I don't off hand.

CHAIRPERSON LEVIN: In your testimony you spoke to--

DANIEL TIETZ: [interposing] Yeah.

CHAIRPERSON LEVIN: --a single adult and families, but adult families.

DANIEL TIETZ: Yeah, I don't know off-off hand. I would have to get it to you.

CHAIRPERSON LEVIN: And then is there medical services at that intake center?

DANIEL TIETZ: So that's co-located at 30th Street. So, no, not yet.

CHAIRPERSON LEVIN: Okay. So, I believe that we have a lot more work to do on this issue, and I look forward to working with—with you all to

advance the standard of care for individuals that are in great need of stable housing, and appropriate medical care. The—I think that one thing that we need to take away and keep in the front our minds is the health outcomes of people that homeless. They're so drastically worse than they are for the rest of us, and that's by every measure. And that is—those are—those are challenges that we can address, and we can have an impact, and we have an impact for improving people's lives, for improving their—the length of, you know, for extending the length of their life, or improving the quality of their life, and I really encourage DHS and HHC and Department of Health to work very closely with the provider community on policy that we can establish by a consensus that will advance these issues in a meaningful way, and I personally don't have a whole lot of patience. I want to see things done while we have the opportunity to do them. I don't want to wait for the state to act. I don't want to wait for the feds to act. We have it within our ability to act, and we should be doing everything with a—a—a great sense of urgency. Council Member Johnson.

CHAIRPERSON JOHNSON: Thank you for being here. I—I think there's a lot of work that we still have to do, and I think the questions that you heard today from the members of these two committees and the—I don't mean this in a—in an adversarial way. The questions that you weren't able to answer are important to us, and we hope to get answers to the questions that Council Members ask specifically about the different programs, and what the plans are. So we look forward to engaging and working together [coughs] and my hope is that we can actually come up with a plan that is going to serve the needs of the most vulnerable with the most difficult healthcare needs to get them the outcomes they need so that we don't see people dying at four times the rate that they're counterparts are who are not homeless. So I look forward to working together and having this conversation moving forward, and having the Council support any efforts that the department thinks will expedite this process in a meaningful way.

CHAIRPERSON LEVIN: Thanks.

DANIEL TIETZ: Thank you.

CHAIRPERSON LEVIN: And if you guys could leave staff here to hear public testimony that tends

to be very informative. Thank you very much. Okay, first panel Julie Brandfield of NYLAG; Li Yoon of NYLAG and Diedra Sedgwick (sp?) of Montefiore, and just for everybody to know, we're going to—we're going to have people on the clock for three minutes. If you have to speed read, if your testimony is a little longer, but we do have to be out of the room by 1 o'clock maybe give or take a couple minutes, but we want to keep it as close to 1 o'clock as possible. I think we have 13 people to testify in 35 minutes. So maybe 1:04 we're right on time. [pause] Go ahead. [pause] Press—press the button, and make sure the light is on.

JULIE BRANDFIELD: Thank you, Council Members Levin, Johnson, Co-chairs Johnson and Levin, and Council Members and everyone. Thank you and good afternoon. My name is Julie Brandfield, and I'm an attorney and Associate Director of Legal Health, a division of the New York Legal Assistance Group. In the interest of time, I'm going to refer you to my full printed testimony especially since Council Member Levin highlighted our work and our coalition, which is known as the Coalition for Housing and Health. It's a multi-disciplinary coalition of legal

groups, medical providers and housing advocates. First, I commend the bill your committees introduced in August for medically appropriate shelters for the medically frail. I'd like to move onto discussing my client's experience Demetrius Davis, who you referred to. Demetrius plainly illustrates the need to create shelters for the medically frail. His case arose at the same time the Coalition for Housing and Health was gaining momentum, and in essence became the face of the need within our group. Demetrius had been in the shelter system for over four years, and the city's help to find him permanent housing had been completely unsuccessful. In September of 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 was on drugs. No doubt because—because of his presentation. A few days later, he became so sick that he went to the emergency room, and where he was diagnosed as severely jaundiced, septic and having stage 3 pancreatic cancer. He was admitted immediately. I became involved when a social worker called to ask what type of housing was available for

homeless individuals who needed to start aggressive chemotherapy. The social worker knew returning to a 200-bed barrack style shelter was not appropriate. I explained that Demetrius feel into the category of medically homeless, too sick to be in the barrack style drop-in shelter, but no longer needing acute care hospitalization. He was exactly the person the Coalition for Housing and Health was advocating to help. As a stage 3 pancreatic patient, Demetrius was immune compromised and had at an increased risk of contracting infections. Therefore, in his doctor's own words it was "imperative that he have limited to no exposure to anyone with a communicable disease, and not—and—and be allowed accommodation in a separate room, an accommodation that would allow him to rest and space to convalesce. Despite being cleared for medically stable discharge on October 28, 2015, Demetrius remained hospitalized until January 19, 2016. That was only after a denied reasonable accommodation request I made to DHS [bell] for a private room shelter placement. Interventions at the City Council level and wait times to be visited in-patient by a homebased provider, and negotiations with the housing that had previously turned down

Demetrius until they agreed as an accommodation to offer him a second interview at which point he was accepted as a tenant, and received permanent housing. Over the course of those three months, I spent over 25 hours of attorney time advocating for Demetrius' housing rights, and that does not include the countless hours spent by his in-patient social worker and his power of attorney. The process was stripped of any dignity that an individual with cancer should have. DHS' response was that he should go to a nursing home. Demetrius felt intense pressure to leave the hospital, and he also had to accept a lower does of chemotherapy so that he would not be susceptible to hospital-borne illness. The effort to provide medically appropriate shelter to medically frail homeless individuals will directly and positively impact patients like Demetrius allowing them to be discharged from hospitals, be placed in a shelter environment where they can have care coordination, accessible—accessibility to beds at all times for rest and convalescence; easy access to medications and access to medical support staff; medically appropriate meals so their treatment plan can move forward in the—in the same aggressive means

it would for a patient who has a home. A system that is dependent on having a lawyer, advocate, savvy social worker and a caregiving team cannot be the answer. I am not sure Demetrius or those with similar situations would care what agency or branch of government was to provide an appropriate place for him to live, but he knew as well as we all do that the street and the hospital were not the answer. Demetrius knew he had become a part of the movement, and he had always hoped to testify publicly about the need, and unfortunately as Council Member Levin mentioned, he passed away recently is in his honor, and I thank you for the opportunity to share his story. Before I finish, I also want to add that I appreciate Council Member Grodenchik's question and comment that individuals are one ill—many individuals are one illness away from homelessness. I wish I could count the number of times myself and my colleagues have had to clients in the throes of eviction that there is cancer defense. The time it takes for SSI or SSD benefits to be approved often does not equal the numerous adjournment we can get for tenants so their evictions can be prevented. Even when we do, so often the benefit does not cover

the full rent, and eviction becomes impossible to prevent. Thank you.

CHAIRPERSON LEVIN: Thank you very much for your testimony.

DEIDRE SEDGEWICK: Good afternoon. Thank you Chair Levin and Johnson for this opportunity. My name is Deidre Sedgwick(sic).I'm the Assistant Director of Social Work at Montefiore Medical Center in the Bronx, and I became responsible and over the past nine years to work on housing programs that Montefiore has created to address the health needs of homeless patients coming into hospital. We work with Dr. Gil who's here from Comunilife (sic) and Montefiore has a respite program, which I oversee that would contract for four beds annually with Dr. Gil. Over the past, we have developed that Montefiore system to alert us to homeless individuals in our ED can our Emergency Department, and unfortunately, we have found as well as the rest of the city an increase in our numbers. In the last year we found that 1,704 ED alters, and these are emails that go off to our shelter—social worker staff in the ED to alert us that there is somebody with a housing issue. These 1,700 alerts

they were crated by 930,000 (sic) people. It was up 11% from the previous year. So through our housing program and through the—our collaboration with the Bronx Housman Housing Consortium we've been working to identify community partners, and to go back to what I think it was Mr. Levin said earlier about how many people have we housed from a hospital. I can tell you how many Montefiore has had for a hospital. In the past maybe two—two years, we've actually housed 20 people not from hospitals. We have housed 20 people from moving them from the hospital to our Respite Program and working with the staff of the Respite Program to then move them on. We have done—my staff is a small staff, but we have 20 tiny applications, and I'm sure everybody in this room is aware of the lengthy process, and you cannot live in a hospital while you wait for supportive housing. And for the collaboration that we are working with, with patients with cancer diagnosis, it's often a disqualifier for supportive housing because what we're finding is the majority as—as you said earlier, it—it—cancer is a catastrophic illness, and if you're the head of household and you lose your income, your whole family is destabilized, and you—you can very

easily end up in a shelter. And unfortunately if that's your only illness is cancer, it doesn't qual— qualify you for the New York/New York Three, and I'm not sure if it's going to qualify you for New York/New York Four housing when it comes out. The results are now currently for street homelessness to get you in as a priority. Some of the issues that we've had with dis—discharging people safely, and a hospital never wants to discharge somebody that doesn't really need to be in shelter. In the last month I have sent two people to Respite, but they came in from the shelter. So they're actually DHS clients. [bell] They're not Montefiore clients. One of them is a young woman 38 years of age who has already gone through chemotherapy, and came in and got a double mastectomy and has drained. And, of course, we didn't want to send her back to her shelter, and we have her in respite until we can— hopefully she recovers. Another person is a shelter client that came in with chronic diabetes, and she has a chronic life ulcer that just won't heal in the shelter system. So we—we're fortunate at Montefiore to have respite, but it just proves that we need more step down, more respite care throughout the city.

We're contracted for four beds a months. I currently have seven people with Dr. Gil at Comunilife, and I have probably a waiting list of four more people that really need to get in, and housing—housing it's not just that—that it's a social determinant of housing, it's—it's life threatening. What we have found through our Transplant Center at Montefiore is you cannot get on a transplant list unless you are stably housed. So we have people with chronic end stage renal disease that could need a kidney transplant, and if we can't prove that they're stably housed if they're in the shelter system, they can't get on a list for transplant.

CHAIRPERSON LEVIN: Thank you. Sorry, who's—who—your contract is with Comunilife is that right, or is it an informal arrangement with Comunilife?

DEIDRE SEDGEWICK: No, we have—we have four-month contract, but Montefiore actually pays for the bed--

CHAIRPERSON LEVIN: Right.

DEIDRE SEDGEWICK: And it's a respite program with Comunilife that allows homecare services on site, allows visiting nurses on site. It's not—

it's not a licensed medical facility, and it's not part of DHS, and we—we have—we're fortunate enough to allow people to stay there. Montefiore will pay for them to stay there on a nighty rate until we can move them onto permanent housing.

CHAIRPERSON LEVIN: Okay, thank you.

LEAH YOON: Hi. Thank you, Chairman Levin and Johnson, Council Members. My name is Leah Yoon. I'm a staff member at NYLAG's Legal Health Division, and we're very grateful for this opportunity to talk about the medical health services at DHS Shelter System and specifically the amendment to the Administrative Code, the city of New York requiring information of the health services and shelters. So the amendment before you calls for a comprehensive report, and access to health services in the shelter system. However, while we commend the introduction of this amendment, the report itself does not address the fundamental issues for the medically homes. It alleges that there is no shelter system---

CHAIRPERSON LEVIN: [interposing] Can you speak a little bit closer. They're having trouble hearing over the live transfer. [pause]

LEAH YOON: The report itself does not address the fundamental issues for the medically homeless, which is that there is no shelter system in New York City providing adequate care for the fragile health commissions. Among the amendment's requests for information, we would like to focus specifically on the requirement for information on the number of individuals discharged from a hospital to a shelter. So the report will base its—the report is based on SPARCS(sic) which is a New York State Department of Health Statewide Planning and Research Cooperative System, and we do not think that the data from SPARCS will actually capture the plight of the medically homeless. Often times these individuals are street homeless when they enter the hospital, or they're in a single adult shelter, and lose their spot because of an extended hospitalization. And because discharge back to the street is not what I call a safe discharge. These patients remain hospitalized well beyond the point of their medically stable hard discharge. Similarly, patients remain hospitalized for extended stays when the shelter system is not—is not able to provide reasonable accommodations for these medically frail single adults, which in our—in

our experience is often the case. However, SPARCS does not collect data on the patient's reason for a length of stay in the hospital. Therefore, it would not be able to distinguish between a homeless person who can be discharged back to shelter when medically stable, and those who cannot be discharged even after becoming medically stable for a discharge because they have ongoing needs for medical attention that does not have to be addressed by the hospital. This gap in the shelter system means that there are always likely to be homeless patients stuck in hospitals. It also means that that SPARCS data would not reflect the small but vulnerable population. Secondly, there is the basic issue of accuracy of the data. Our research found that the data in SPARCS is only as good as what is put into it. But we have been told that the hospital staff frequently use a SPARCS homeless code 99 for anyone who does not provide a home address. Hence, a report created by the legislation on completion is likely to—likely to misrepresent the homeless population to their detriment. So our coalition actually crated a survey that requested information from legal hos-hospital partners. Twelve hospitals have responded [bell] to

our surveys, and at the completion of the survey hospitals reported having between one to three medically homeless patients that they were unable to discharge to shelter on a given day. These people were all medical stable, ready for discharge, but for the fact that the shelter would not accept them or accommodate them. These patients did need extensive medical—did not need medical—extensive medical care. All they needed was care coordination, private rooms or access to their bed at all times, medically appropriate meals, access to medication and medically support staff. The medically homeless is a relatively small [bell] population, but failing to address their critical needs, their health is put in jeopardy by unnecessarily lengthy stays in the hospital where they are susceptible to contracting hospital borne illness or where they may need to alter their treatment plan given their risk for infections when they're hospitalized. Thank you.

CHAIRPERSON LEVIN: Thank you very much to this panel. I just have one question. Julie, Mr. Davis was—he was determined to be—it was appropriate for him to be discharged to the shelter system, is that correct?

JULIE BRANDFIELD: Well, it--the doctor requested that he be—have a single room, and he didn't get that accommodation. So he was not the—he couldn't be accepted back into the shelter system because he—he couldn't be put into a single room.

CHAIRPERSON LEVIN: So according to Mr. Tietz's testimony, there's 1,843 discharges and the vast majority I mean like 98% were—were deemed appropriate. Is that in—is that consistent with what you're seeing, or are you seeing that—that a greater number are—are inappropriate for discharge back into the shelter system, or is it just a question of definition of appropriate?

JULIE BRANDFIELD: I would thank it's a question of definition. It's also a question of the hospital's at this point whether they continue to present these patients when they know that they're not going to be accepted. When we did our survey, there were 21 patients in total who were on the day that the hospitals filled out the survey--

CHAIRPERSON LEVIN: [interposing] On that one day?

JULIE BRANDFIELD: On that one day.

CHAIRPERSON LEVIN: Right. So, that doesn't jibe with the—with the idea that there are--

JULIE BRANDFIELD: [interposing] Not at all.

CHAIRPERSON LEVIN: --30 single males in a year--

JULIE BRANDFIELD: Right.

CHAIRPERSON LEVIN: --that are not appropriate to—to be discharged into the shelter system, and that does not jibe, right?

JULIE BRANDFIELD: No, it doesn't and I think, you know, our group would have many, many case examples that would contradict what we heard today.

DEIDRE SEDGEWICK: Well, I can tell from Montefiore it's—for us what people with that are on daily chemo or radiation, we've had patients go back to congregate settings that have STEM cell transplant for muscle melanoma and leukemia, and it's quite easy for us to—we don't get any pushback when they send in their shelter packet, and it goes in. The most pushback we get from a shelter packet going into DHS is that—that if the patient is on oxygen or if they're in a wheelchair because then we have to prove that they're able to transfer from bed to chair, and

they can do that in a hospital because the hospital bed is an appropriate size bed--

CHAIRPERSON LEVIN: Right.

DEIDRE SEDGEWICK: --but if you're transferring from a wheelchair into a small cot on the floor, it's very difficult.

CHAIRPERSON LEVIN: Thank you very much to this panel. We have [background comments]. Okay, actually never mind on that. We have the room past 1:00. They moved the other hearing. So I do thank you very much for your testimony. I look forward to working with you and this group in the future, and it's my hope, and I'm going to insist upon this that there's a close coordination between the work that you've been doing, you know, over the last year or two that you've been doing this in earnest, and the Department of Homeless Services and HHC and DOH and there needs to be—there needs to be a much closer relationship so that we can I think get on this here. Looking at those steps that it said, you know, it's identifying the need and then identifying the stakeholders. I think we—we—we're going to have to start at square one there. Thank you very much.

JULIE BRANDFIELD: Thank you.

CHAIRPERSON LEVIN: The next panel Dr. Rosa Gil, Comunilife; I'm sorry, Dr. Regina Olson—Olson, Care for the Homeless and Bobby Watts, Care for the Homeless. [pause]

DR. ROSA GIL: Good afternoon, Chairman—both Chairmen, Steve Levin and Johnson, and distinguished members of the City Council who are members of this committee, which is—these two committees are extremely important for the subject that is being discussed today. Comunilife, I'm the President and CEO of Comunilife, Inc., and our mission is to improve the quality of life for persons living with special needs particularly in the Hispanic community but, of course, in communities, the brother community in New York City, and we provide culturally competent services including mental health services and social services, and we also provide a continuum of supportive housing and affordable housing. Actually, we have over 1,600 units of supportive housing and affordable housing throughout the city of New York. I am delighted to be able to present testimony on the Medical Respite Program that we have developed jointly with Montefiore since 2011, and later on in 2012 the Bronx

Lebanon Hospital also approached Comunilife to be part of the rescue program. We have provided the Respite Program to over 96 patients that have discharged either from Montefiore or from Bronx Lebanon since we opened the Respite Program, and based on the discussion that we have had here before the Respite Program is just a short stay until a patient can recuperate and then we can place them in the appropriate housing venue. The population that we have served in the Respite Program are primarily men who are age 45 and—and older. They re Latinos. They are African-American and they come to us with multiple health, mental health and substance abuse issues, and highly unstable housing situations. And prior to their hospitalizations, some of us—these patients were living with families. Others were basically living on the street, and some others were living in—in the shelters. There Respite Program we offer comprehensive care coordination and document and documentation support, which is critical for the length of stay. If the patient does agree and there's sufficient documentation to be able to move them to the next level of care. It takes longer for them to move out of the Respite Program. We do

provide medication management. We provide three meals a day. We provide assistance with transportation to medical appointments, ongoing medical coordination with hospitals and coordinate today's nursing and medical facilities [bell] and assist them with housing search and transition to long-term care housing. We also work hard to create cognitive verification (sic) because in some cases that's what's important, and we make sure to have a— well, what we call checking that off because we want to be sure that two months, three months afterwards that there are continuing to be living independently, that they are not back in shelters or on—on the street. And the length of stay varies. It's between four weeks to twelve weeks in—in the program, and I—I believe that we-and this was one of the questions that I heard before in this testimony. For example of the 96 patients that we have served, 38 have been discharged to supportive housing. Some of them within our own system since we have 1,600 units of supportive housing, but obviously to other colleagues. We have discharged 19%, 38% to supportive housing, 19% to families, 12% to nursing homes, 8% to assisted living, 6% to independent

living, 4% to shelters, and 6% to rent the room, and 3% to substance abuse treatment facilities. I—I have to say to the committee that I am often called by other hospitals. Actually, I'm in discussion now with a hospital for Brooklyn who has really begged and asked for us to also help that Brooklyn Hospital to create their respite near their hospital, and even they're saying if you have extra beds in the Bronx, we are willing to provide the transportation to the patients to come to the Bronx. Although, we would prefer to develop this program in—in Brooklyn. I just wanted to—to say that I think it's extremely important to have medical services, too, in the shelters because we know what happens. I'm delighted that we're able to help with the Medial Respite Program. This is just not the total answer to this problem. I think that we have to create almost like a continuum of medical services for the homeless population in New York City, and I know that it doesn't have all the colleagues representing so I should here. Thank you very much for inviting me to present here.

CHAIRPERSON LEVIN: Thank you very much, Dr. Gil.

BOBBY WATTS: I'd like to say congratulations to Committee Chari Johnson, Committee Chair Levin and all the esteemed members of the City Council's Health Committee and General Welfare Committee for this important—important hearing. I'm going to—you have my prepared remarks. I'm going to truncate them. So I'm going to detour to say a few things that were not there, but were raised today, but first, I'm Bobby Watts, the Executive Director of Care for the Homeless, which is a federally qualified health center that specializes only in serving homeless people. We do that in clinics in—in 26 soup kitchens, shelters, drop-in centers in four boroughs. Ten of those sites are funded by DHS, not the clinics in all cases but the sites. So we were—we are very familiar with—with DHS regulations. We also operate a shelter under contract with DHS for 200 mentally ill and medically frail women in the Bronx. So I want to bring that perspective of working with homeless people and for 30 years as a health provider and also a shelter provider to say what you're doing is so important. What you're doing is important because you're saying City Council wants to have a say in setting the philosophy and the framework for

what should be the city's approach and stance to meeting the medical needs of homeless people in shelters and in New York City. Over the years the outlook of the administrations have changed. Some administrations have been very supportive of having clinics in shelters and medical services in shelters. Some have been actually very resistant even to the point of telling some providers they should return federal funding. I should point out that all of the clinics in family shelters are not funded by DHS. The federally qualified health centers use their grant and what they bill for Medicaid. So it's not costing the city or it's costing DHS anything, but it does do is that it prevents people from—it meets their healthcare needs very quickly so that they can—we prevent it from becoming catastrophic illness. It also when people are sick it keeps it from—their health conditions from deteriorating. One thing I will also point out is that Care for the Homeless for 12 years has been providing medical services to people on the street. It's been working with street outreach programs, began with the Bronx, with the Bronx Works Street Outreach Program where we sent first a nurse practitioner, and now a doctor on the

street providing care to people. Over the years, we have been very successful as part of that consortium that has resulted over a nine-year period in a 72% drop in street homelessness in the Bronx. Medical services reached some people who would not go into the shelter, but after the doctor treated them, they would come into our clinic and that became link for them to get other services and get housed. The last thing I will say is I share committee chair Levin's urgency about medical respite. It-it is heartbreaking the medical conditions of some people in shelters and shelters, many shelters even with the clinic were not designed to serve the medically frail people not from an architectural point of view, not from a staffing point of view, and we need to do that. With Dr. Gil, we are both on the Governor's Interagency Council on Homelessness. We are co-chairs of the health committee and that is the area that we are looking at OTDA [bell], with New York State DOH, and I am convinced that right now, there are many models that will work for medical respite, but according to the National Healthcare for the Homeless Council I'm glad you cited that. I'm former president of their board. So I'm truly honored.

Shelter is the most efficient place to—to provide medical respite. So there needs to be a number of ways including in shelters, and I think under existing licensure it can be done, and certainly there is an appetite to change the licensure if it's needed. But there is an urgency and a crying need. So thank you.

CHAIRPERSON JOHNSON: Thank you.

DR. REGINAL OLSON: Good afternoon. Thank you--

CHAIRPERSON JOHNSON: Just get--speak a little bit closer to the microphone. This is being webcast. So we have to get it.

DR. REGINA OLSON: 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 Chief Medical Officer of Care for the Homeless and a Board Certified Internist and Pediatrician, I am painfully aware of the importance of providing comprehensive healthcare to this most vulnerable group. As you're aware, homelessness in New York City has reached the highest level since the Great Depression. The

September estimates of over 60,000 homeless individuals with 24,000 children have been 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 one-stop shopping model of support in place is needed to address the addiction, behavioral health conditions and medical conditions in the homeless population. This model can address ongoing overlapping conditions and prevent the frequent decompensation resulting in this population being a high utilizer of expensive acute care services. The high cost associated with the lack of care coordination for this population has been documented. In a public study of homeless patients discharged from Bellevue Hospital 70% were readmitted within a 30-day period. The lack of effective coordination speaks for itself. Unfortunately, there are many stories I've witnessed that can illustrate the different paradigm for homeless individuals and their healthcare. Due to their social circumstances, healthcare is not the top priority for most homeless individuals until a situation becomes urgent. They

live with discomfort, disability and pain often unnecessarily. I'll tell you a story about a 47-year-old woman I saw. She came to one of our clinics because of a draining ulcer. Review of her chart did indicate that she had seizure disorder due to domestic violence induced head trauma, was on medication. In asking her about her current medication needs, she said she usually waits until she has a seizure, then she goes to the emergency room and receives medication at that point. Lack of access really precluded her ability to have a proactive approach to her medical care. Engaging her care in the clinic setting enabled her to have better care coordination, and to decrease emergency room visits. Accessible, which usually means on-site care, can reduce acute care interventions dramatically. Most homeless people in shelters are families with children. The tragic life long effects of early childhood adversity have been well documented in 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 a traumatic period may have many chronic conditions, have retention diabetes and depression. Among them are outcomes [bell] 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 support. Attached to my testimony are the top conditions presenting for evaluation in the clinic operated by Healthcare for the Homeless in the past year.

CHAIRPERSON JOHNSON: Thank you to the three of you for your—no, no, stay, please—for your testimony today. Extraordinarily helpful and thanks for being patient, and—and staying to—so that we could hear your testimony. Dr. Olson, the statistic that you had mentioned in your testimony a published study of homeless patients discharged from Bellevue Hospital, 70% were readmitted within 30 days. That is like a not surprising, but shocking number, and—and that in many ways speaks to me, and then you said

a lack of effective coordination seeing the result. That like screams failure to me, that it's an outright failure of the system. If the is the readmission rate, clearly people are not getting connected to the care that they need, and I mean it's not just horrible for the individual, inhumane in many ways, but it's horrible for the system and for the finances of the system, and creating a greater strain on the system. And so, if you could just talk a little bit more about that, or any—all of you, if you'd like.

DR. REGINA OLSON: We can talk about and we also have—have resources in the audience who are intimately familiar with the—with the information. I—I think what this looked at is, you know, what happens with individuals who present for an emergency room evaluation and are admitted, and exactly what's been described that because of lack of respite care, the ability for individuals to effectively recuperate from conditions, which were appropriately treated in a hospital setting, makes their decompensation occur very frequently, and-and quickly following discharge. I mean part of this study also showed that—that another group of individuals who maybe didn't get

admitted again were—were re-evaluated in the emergency room, and there's a—a technicality that hospitals have developed for decreasing re-admission rates, called observation where people can come back and for a period of time not be readmitted officially, but be observed meaning that there is reimbursement for diagnostic services provided, but not the day rate in the hospital. I—I think it—it speaks for itself that there—you know, is—is a need for recuperation following acute illness, and a healthy person who has a pneumonia generally is going to be discharged after possibly three to five days of intravenous antibiotics and hydrations at home, and not go back to work immediately. And, you know, have tender loving care and maybe, you know, chicken soup, which is the equivalent of non-prescription normal saline for hydration, and—and have a period of time when they are not back to the baseline. And why somehow that recuperative period is denied to an entire population is—is confusing at best, and a significant disparity more commonly.

CHAIRPERSON JOHNSON: It's immoral.

BOBBY WATTS: I would also just like to add, you know, Dr. Kelly Doran,(sic) who wrote the

article that was cited is in the audience and is a great resource and—and colleague and friend to many of us, but you mentioned it's hard for the individuals, immoral. It's costly for the systems, it's bad for the systems, it's bad for the healthcare system. I also just want to say it's—it's bad for the shelter system. I'm putting on now my shelter operator hat. When you don't—when you have people who are sick, whose needs are not being met, who are going back and forth to the hospital or just decompensating, it's harder for them to complete their independent living plan. It's hard for them to get their 2010 Es (sic) finished, and—and then it's hard for them to move out into appropriate housing. So it lengthens the length of stay, the average length of stay in shelters. It makes it harder for the other residents if there is not appropriate on-site medical care for—for people. And it's not just—the last thing I'll say, it's not just people coming from the hospitals who get sick, you know, who don't get—don't get well, your every day resident in the shelter can start to decompensate, and they are not sick enough to be admitted to the hospital. So you need to—Respite can also address

that need, to get them—have a place where they can recuperate and get better so that you can prevent hospitalizations.

CHAIRPERSON LEVIN: I just have one question for this panel. If you were to—one thing that seems a little bit confusing to me is that there does not seem to be a great coordination between systems here, agencies and systems or systems as—as—as exemplified by our city agencies. How would you characterize qualitatively the coordination of systems, the medical system, the homeless system, and—and the provider system in general? How would you—you know, if you were to give it a grade, what kind of a grade would you give it.

DR. ROSA GIL: I think that this is a—a great concern where the systems are overwhelmed, Chairman Levin and I'm—but I would say, and my colleagues can agree or disagree with me, but I would say that in the last five years around the issue of homelessness I think I do rate the lack of coordination among agencies pretty high from our experiences, and I have seen every year getting a little bit more challenging. You know, whether they're waiting for the response from HRA or whether

it's a response from another city agency, and I would say, you know, in—in a range between 1 and 10, I would say that we are at 8 at least.

BOBBY WATTS: I—I don't want to be flip, but this is a—a huge problem, but it's not unique to this situation. We have problems of transfer of information within the healthcare system form one hospital from one shift to another from one institution to another, and from system to another. And this is one of the drivers of homelessness that causes homelessness and prevents it being solved quickly. I—people are working hard, and they need more resources to coordinate better, and the City Council can really help set the lead on—on both of those.

CHAIRPERSON LEVIN: Right. I mean I would say that in an ideal world somebody could go from a hospital stay into a supportive housing unit like, you know, in a matter of days. We don't live in an ideal world.

DR. REGINA OLSON: And also it's data transparency because the reality of the cost is not—and when the Sparks data was—was addressed earlier, which is perhaps the best database on a

hospitalization basis, but the—the real cost for increased length of stay is not being articulated in such a way that is making a compelling case from the Department of Health because there could be highly effective partnerships forged based on effective transitioning to more appropriate care level. $2,200 a day is an approximate cost for an acute care hospitalization versus about $200 for a skilled nursing home, and in the vicinity of 150 in—in a shelter residential supportive housing, and we didn't talk about Respite.

CHAIRPERSON LEVIN: Right.

DR. REGINA OLSON: So I mean that's a huge differential.

CHAIRPERSON LEVIN: Right.

DR. REGINA OLSON: And if people are being in—in extended length of stay environments for 7 to 10 days, we know how to add.

CHAIRPERSON LEVIN: It's all tax dollars, too. I mean whether it's city or state, whatever. It's—it's all—all the same.

DR. REGINA OLSON: But—but it's not being trans—translated from the Department--

CHAIRPERSON LEVIN: [interposing] Right.

DR. REGINA OLSON: --of Health to Homeless Services, and their—their budgetary silos are very distinct.

CHAIRPERSON LEVIN: Right. They ought not be. I mean again it's one, you know. I mean when we—when we look at the budget, we look at one budget. I mean we—we obviously break it down into agencies, and different categories within the agency and budget lines, but is—is at the end of the end of the day we have one city budget.

BOBBY WATTS: Which is why I think it's so important the City Council is addressing this issue.

CHAIRPERSON LEVIN: Thank you.

BOBBY WATTS: Really congratulations.

CHAIRPERSON JOHNSON: I—I don't want to get on a high horse here and—and pontificate. I just want to say I mean it's a total outrage. It's an outrage that we have 24,000 children in the shelter system. It's an outrage that we have 60,000 people that are homeless, and it's an outrage that we are not in many ways fulfilling our responsibility to those people once they have already fallen through the cracks or they're in incredibly despairing

situations that they're not getting the most basic are that they need to be able to recuperate, recover, and get back on their feet. And so, I'm really glad we are having this conversation, and hopefully it's going to invigorate the Council and the administration and city agencies to actually figure out a path forward so that it's not siloed, and that it's not hitting the lottery to get a respite bed in New York City. So thank you very much. Oh, Dr. Gil with that.

DR. ROSA GIL: Chairman Johnson, if I may say that it—it is ironic when there is such a transformation in the hospital healthcare system where we are expected to downsize by 25% of in-patient units within five years, and the question is what do we do with empty space, and what do we do to accommodate the needs of all the sister agencies in terms of utilizing? And this is part of that conversation between agencies in terms of policies. How—do we best address this issue knowing that there's another system that is downsizing that perhaps, you know, some of those beds can be converted in respite beds. I mean I'm just throwing

this out because I feel that the system is in the need of transformation in many, many other areas.

CHAIRPERSON JOHNSON: Are you talking specifically about Health and Hospitals or are you talking generally about hospitals in New York City.

DR. ROSA GIL: No, in gen—in general.

CHAIRPERSON JOHNSON: Are you talking about DSRIP?

DR. ROSA GIL: No, I'm talking about this incident specifically. For example, through the DSRIP program there's only one respite program that was approved, which in Upstate New York. The rest of the system in the hospital system did not approve any request for a respite bed. I did through the Health and Hospital Corporation, but that was not funded. But what I'm saying is not only HHC, the Bertrand (sic) Hospitals also are going down in terms of volume of beds. So there's also empty beds in Bertrand (sic) Hospital.

CHAIRPERSON JOHNSON: Look at—look at what Beth Israel is—is planning on doing on the East Side.

DR. ROSA GIL: Yes.

CHAIRPERSON JOHNSON: Significant downsizing. It's going to be a miniature hospital compared to what it is now.

DR. ROSA GIL: That's right.

CHAIRPERSON JOHNSON: And—and then just lastly on the—on the Health and Hospitals point, I mean I think we have the best public hospital system in the United States, and we're lucky to have the public hospitals we have. I am, you know, I'm not trying to be Chicken Little here, by—by my statements, but I am—I am deathly afraid of what is to come with the new administration that in—in a—and a right wing congress that is probably going to cut all public hospital funding and HUD funding and homelessness funding and HIV and AIDS funding even more. And so, given the dire financial shape that Health and Hospitals is in right now, to ask them or have an expectation that they could take this on in some way when they are currently doing it for Rikers Island and the Correction system, which is a huge effort for them, is I think a bit of a stretch. And so, if there is a way to use their resources while at the same time coordinate with the Department of Health and other providers to be providing these

services inside the shelter system themselves instead of bussing people from Brooklyn to Manhattan or all over the place, but make this a standard model across shelter sites. I think that's the way to go. Thank you very much.

CHAIRPERSON LEVIN: Thank you. The next panel is Beth Hofmeister from Legal Aid, Barbara Conanan of NYU Lutheran Family Health Centers and Miranda Van—I'm sorry, Van--

MALE SPEAKER: Doran.

CHAIRPERSON LEVIN: Van Doran from NYU Lutheran Medical—Community Medical. [pause] I apologize if I mangled everybody's name. [laughter]

BETH HOFMEISTER: Thank you, Chairs, so much for the opportunity to talk today. My name is Beth Hofmeister. I'm an attorney at the Legal Aid Society I our Homeless Rights Practice. I'm actually also here testifying on behalf of our client Coalition for the Homeless who Giselle Routhier, who's their Policy Director had to leave a little bit early. I have a feeling that some of what I might say might look—might be a little bit unpopular. I just want to remind everyone that Coalition for the Homeless is a monitor for the shelter system, and

that they've been around since 1981, when the right to shelter stated. Legal Aid has been around for 140 years, and during that time we have also brought pretty much all of the right to shelter litigation, and remain class counsel on behalf of everyone in the homeless shelters. So, we also at Legal Aid have a lot of other units such as the Health Law Unit, and— and frankly, you know, dozens and dozens of other ways that we interact with the homeless population on a daily basis. I think that I'm not going to speak directly to the testimony, but just add a couple of things. I think that there obviously are a lot of issues that are being addressed in this hearing. The three that I—I'm hearing the most about are certainly about the medical respite needs/the medical—medically homeless. Results of the component of shelter by actual accommodations under the ADA, you know, for people who maybe need things like 24-hour 7 day a week bed rest, but aren't going to necessarily need that forever or just need, you know, certainly, you know, access to a shelter that has an elevator because of their mobility issues or whatever it may be. And then also just access to healthcare generally. I'm going to start with the last one, and

just remind everyone, too, that, you know, a third of my adult clients are working full time. They may not need the level of medical care that we're talking about in this hearing. So that, you know, the phase of homelessness in New York City based upon the reasons that many people become homeless is very different. So I don't want us to kind of be jumping to the most extreme and assume that that is kind of the norm. I think there's obviously a significant—I mean my colleagues that spoke in the two panels before me articulated beautifully kind of what the issue is particularly with medically—the medical homelessness issue. But I just want to make sure that having—letting people have choices especially for their medical care within the community, I think is very important, and so I don't want to end up with a situation or a system that's obligated or required to be providing significant medical services when it may not be a need, and a lot of our clients prefer to either continue to be in healthcare in the communities from where they came, or they want to be not kind of having that tie to the shelter system for when they do eventually get out of shelter. That's not everyone, but that is a significant portion of

the clients that we work with. I do want to touch base and just—I have to mention that the Legal Aid Society along with Coalition for the Homeless and CIDNY, the Center for Independence for the Disabled, did sue DHS. We do have an ongoing lawsuit *Butler v. City of New York* pertains specifically to individuals with disabilities in shelter. So I can't truthfully speak in great detail about that lawsuit, but I did just want to address that we are in communication [bell] and conversations with them, certainly about the myriad of issues that exist related to, you know, reasonable accommodations that exist in shelter, and will hopefully be continuing to work on addressing those. In terms of the Medical Respite need, Coalition with Homeless and the Legal Aid Society feel very strongly that the DHS shelter system is not the place to be providing medical respite care, and realize that's probably not how a lot of people in the audience feel. Certainly, you know, based upon the kind of contact that particularly the staff at Coalition for the Homeless has with the shelter system, I don't think that recommendation should be taken lightly. We absolutely agree there's a significant need for there to be respite care. We

get the same phone calls that a lot of, you know, everyday we're getting reasonable accommodation phone calls, and issues where people are being release from hospitals, clients that we've been working with for a long time dealing with all of the issues that have been laid out here. But whether or not DHS is the location or the place that those should be housed, I think is something that we probably disagree on compared to a lot of what we've heard here. Is there a need for that? Absolutely, and is that need at a critical point? Absolutely. I think we have—we also have an obligation to maintain the right to shelter, which at this time is an incredibly difficult obligation because of the nature of how many people there in shelter and as Dan Tietz touched on, frankly, the availability of citing what is like actual appropriate shelter locations in the city, and that can't be understated. So, you know, I just—we are—are going to continue to make sure that every person who shows up at the door of an intake center is able to get access to a shelter bed. I just want to end by saying I also represent a lot of clients in shelter systems that are outside of DHS and HRA. When a homeless uses a particularly dear population

that's close to my heart, I'm one of the attorneys on that lawsuit as well, and let alone I have those HPD and other shelter systems. By having a medical respite system that deals with the medical homeless issue only in DHS or in DSS, we might be also losing the ability for clients to run those shelter systems to have access to them, and I—I—that is a problem I deal with every single day as it relates to things like vouchers, and for like runaway homeless youth don't have access to vouchers, for example. They can't get access to LINC. It's a serious issue that if we put a system in charge of something as important as medical—medical respite like in DHS, there will be people who will just by nature of the siloing even within the homeless shelter provision, who will be left out, and I don't think that that's okay. The testimony goes into more detail about that, but I'm happy to answer any questions.

[background comments, pause]

BARBARA CONANAN: Good afternoon.

CHAIRPERSON LEVIN: Speak close to the mic.

BARBARA CONANAN: Okay.

CHAIRPERSON LEVIN: Thank you.

BARBARA CONANAN: Good afternoon, Chairperson Levin, Chairperson Johnson, members of the General Welfare and Health Committees, members of the City Council, Department of Homeless Services, colleagues. Thank you for this opportunity to speak today. My name is Barbara Conanan and I am the Program Director of the NYU Lutheran Family Health Centers Community Program. The Community Medicine Program has provided medial and behavioral health services to homeless persons in New York City for 37 years. [pause/background noise] Okay. Prior to us being picked up and saved by NYU Lutheran when Saint Lutheran closed, we brought the model program helped to homeless street walk. (sic) And so, I—I also want to say in addition to providing services, I also belong to a group called New York City Providers of Homeless Health Care, which Bobby Watts belongs to and, you know, 12 other agencies. They all provide health and mental health services to homeless persons. I began my career as a nurse. I used to go to the streets, to the shelters to drop-in centers and at SRO hotels to provide healthcare services. So I was one of those pioneers, and so I traveled, one of the three nurses that would do outreach, and now

I'm really, really happy that the country has moved towards providing federal funding for healthcare for homeless people. However, not enough is—is done at this time. So agree and support the Council's bill that increases reporting and data collection unnecessary. However, this is only the first step to fully understand the scale of the problem and taking action. Today, I want to introduce you to my colleague Dr. Miranda Bundoran, a physician with the Community Medicine Program. She's a practitioner on the ground. [pause]

DR. MIRANDA BUNDORAN: Hi, thank you. I'm Miranda Bundoran. I'm an internist. I provide primary care at—on Wards Island that we serve two sites at, two men's shelters on Wards Island, and you have my written testimony so I'm going to truncate a little bit what I'm saying because of time. So, I really salute you for looking into this issue, and I'm happy to see that you recognize the—the issue of these medically homeless patients, and the fact that we need some better system to accommodate their needs. I see a lot of people who are either acutely or chronically ill. As you mentioned, people on dialysis, people getting chemotherapy, people who

just had surgery. I've had patients who just got a heart transplants the service of the shelter system. Just—you can't—you can't imagine a new—you think you can't be surprised, but then someone else gets a service even more surprising. So we really do need a better system [bell] to take care of those patients. There's another group of people that I just want to highlight very quickly, you've actually made reference to as well, people who are disabled. Whether they are in a wheelchair, blind, deaf—we have quite a number of those patients as well, and their needs are not always met. I have actually had more than one patient who is wheelchair bound, spinal cord injury patients when they go to take a shower there's a bench. They fall off onto the floor. Just simple things like that, which obviously they can be injured. It's humiliating—it's because it's a liability frankly for the shelter system, and it's just a necessary cost. It would be great to really know how many of those people are in the system, what their needs are, actually have them met. The second issue that I want to highlight was also discussed before, but it's the importance of better information share data exchange between the shelters, the

hospitals, you know, the shelter medical providers so that we're all on the same page. It could be TB information. People get moved around. They get TB tested like six times a year because I don't know that they already had a test. I can't get their results. Maybe we had a positive case. Things like that fall through the system—through the cracks. People come out of the emergency room and we don't know what their plan is so we can't help them implement it. We can't help them get to their appointments. I do a lot of work on people and then they transferred, and I can't follow up with them and we have abnormality that we can never follow up on. And then the last thing I think is really important is just looking at the physical infrastructure of the shelters and the health centers that are inside the shelters, and making sure that they're really up to standard, putting the money in to make sure that those clinics are actually adequate, they meet—you know, they're up to DOH standards, and that people can actually get the service that they need. There's a lot of other issues we've already talked about, a lot of them, but in—sort of to summarize what I said, we just—we need much better accommodations for these

people who are frail or sick. We need better information exchange and we really have to look at the physical infrastructure inside of the shelters. So again, I thank you so much for the opportunity to speak today, and for looking into this issue.

CHAIRPERSON LEVIN: Thank you very much. Thank you to this panel, and thank you very much not only for your advocacy, but obviously the work that you—that you're doing for individuals. All three of you is—that's—that's what it's really about is helping—helping these—these people with the—with the big challenges that they face in their lives. Thank you.

DR. MIRANDA BUNDORAN: Okay. [pause]

CHAIRPERSON LEVIN: Next panel Kelly Duran, NYU School of Medicine; Noah Berland, NYU School of Medicine and Luke Paolantonio, Immigrant Health and Canter Disparities. [pause] Just speak close to the mic because we've got to get it on the webcast.

NOAH BERLAND: Chairman Johnson and Chairman Levin, Council Members and staff, good morning and/or now afternoon 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 a first year medical student at New York University School of Medicine, and what brings me here today is a passion for ensuring that most—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. We chose this because overdose is the leading external cause of death for the—all shelter residents. To date, we have two verified unreported reversals (sic)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, at many of their meetings. On the general 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 and 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 the poverty of economic needs, they also have a poverty of time, and resident most—and most other resources. Shelter residents many of whom are employed don't have any flexibility missing work with erratic and often unpredictable schedules making visiting health centers with long—long waits almost impossible to access—to be accessed. As a medical student, I often saw how long patients would have to wait, and while I 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 in the wards and in the ED—ED, our most complicated discharges are always to a shelter. We would often keep patients in the hospital with a much higher level of care than they needed, at both greater expense to the city and a greater cost of freedom and

comfort to patients because coordinating a state discharge to a shelter is at times nearly impossible. Sometimes that barrier—barrier can be as simple as transportation, and the patient's mobility having a wheelchair or complex medication needs to just throw a monkey wrench into our carefully thought out and time discharges. It's hard to express how often problems like these have come up. These problems are a lack of servicer and facilities able to meet these relatively simple needs often would lead to the patient quickly returning to the hospital, to the Emergency Department frequently being admitted to the hospital not uncommonly with complications or worsening conditions due to inadequate treatment. Something that was simple had ballooned to a worse and more complex problem not too different from what other shelter—from what shelter residents who through deferred care get inadequate access to healthcare that—that meets their specific and unique needs. These unique problems are often lost to most physicians, nurses and care providers who rely on our social workers [bell] to navigate these processes and hurdlers, but the systems that presently exist are inefficient or are often purely in one direction from

the shelters to our programs further complicating the situation. Better communication and clear understanding of the accommodation of these shelters could improve outcomes, costs and discharge efficiency, and patient safety.

CHAIRPERSON LEVIN: Thank you very much.

KELLY DORAN: Hi. Thank you to the Chairs Levin and Johnson, and to the Council. My name is Kelly Doran. I'm an emergency physician at Bellevue Hospital—emergency physician. I work for NYU School of Medicine and I spend most of my time doing research on homelessness and other social determinants of health. And I actually was not going to testify today. So I will submit full written testimony later, but--

CHAIRPERSON LEVIN: Great.

KELLY DORAN: --I—I filled out an attendance card, and sine my name was invoked and my study is invoked, I will just say one—a few quick things. I wanted to mention the study that was mentioned about the readmission rate. That study was actually connect—conducted at a hospital in Connecticut. That study was not at Bellevue Hospital, just for the record. We did find that

there was a—a 30-day hospital inpatient readmission rate of 50% among patients who were homeless, that compared to readmission rates at the hospital among other Medicaid patients with closer to 20%, and when you included the hospital revisits including emergency department revisits, that 30-day revisit rate was 70%. I suspect that we see similar things in hospitals throughout New York City, but I haven't studied that. That paper was published in Medical Care in 2013. I would mention that what it did was it would lead us to develop a medical respite program in Connecticut, in New Have Connecticut given that compelling evidence and other evidence we compiled doing a systematic review of the evidence for the efficacy of medical respite programs, which was published in the Journal of Health Care for the poor and underserved. And we presented that information to the State Council in Connecticut, and ultimately they passed a bill to support a medical respite program in New Haven. So, there is a model for it. You know this revolving door between the hospital and the streets is real. I see it in my research, and in my experience as an emergency physician, and it's a big problem and I'm thankful to the committee for

pulling together this hearing, and I hope that good comes of it.

CHAIRPERSON LEVIN: Thank you very much. Thank you for your research, too.

LUKE PAOLANTONIO: [coughs] Good afternoon, everyone. My name is Luke Paolantonio, and I'm a community outreach worker at the Immigrant Health and Cancer Disparity Service at Memorial Sloan Kettering Cancer Center. So I really appreciate this opportunity to speak with you all about this really pressing issue. So as we all know, socio-economic factors are key determinants of cancer outcomes. In New York City, 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 showing that we are lucky to be practicing and working in New York City. We have a system that does not exclude based on a patient's ability to pay on immigration status. However, for all the good work that the system accomplishes, and all of the resources that go into supporting the system, we do doom it and our patients to poorer

outcomes by not supporting the socio-economic factors that make or break their treatment, the cure rates and their disease related quality of life. We are here today to speak specifically about the scourge of homelessness and insecure housing at it affects our most vulnerable populations. It's heartbreaking and totally unacceptable to treat a patient for cancer, and then have that patient leave his or here chemotherapy session to recuperate under a subway trestle. What are we actually doing for these individuals? We're exposing them to 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 the poor treatment outcome despite the availability of actual medical care. We need to do something about this. We need to ensure that there are designated and medically responsive shelter beds available for the medically frail, the unstably housed and the homeless. Eligible—eligibility for these beds should be determined by the patient's treating healthcare 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 like after chemotherapy to decrease the risk to the patient and to stem the expensive cycle of treatment and readmission. Our coalition has toured communal life, and—and we thought it as a successful model. We've toured the Living Room and the Pyramid, and the Safe Haven model are—are great examples. I think the Pyramid has empty single rooms that can be converted for the medically homeless to have respite. So it's again just channeling these resources that are out there. So thank you for your consideration of these vulnerable populations for whom we care, and who desperately need these services, and their health and also the fiscal health of the medical are system will benefit from the provision of—of this urgently needed housing.

CHAIRPERSON LEVIN: Thank you all very much for your testimony, for staying here and hearing all of the administration's testimony and—and response to our questions. I look forward to working with you in the coming months, and as I said earlier, you I have—I have a sense of urgency here, and I want

to see a real impact in the status quo. I mean honestly hearing your testimony makes me want to scream because I—I—I—I am viscerally angered by the status quo, and we can't really allow that to continue the way it did. Thank you. [pause] The last panel Wendy O'Shields and—from Safety Net Activists, and John Betts of Bronx Works. [pause] Go ahead.

WENDY O'SHIELDS: My name is Wendy O'Shields and I'm testifying as a Safety Net activist. Many times an ambulance is called for medical issues that might be easily—might be easily resolved [coughs] if medical staff were on site at DHS shelters. The cost of EMT runs taking residents to hospitals for minor illnesses could be greatly reduced. There is a definite need for medical staff on site during the evenings at DHS shelters. Possibly a general practitioner doctor, a physician's assistant and 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 an unscrupulous profit driven and Medicaid bilking small time operations immediately. Please compile a

list of your 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.

CHAIRPERSON LEVIN: Thank you very much, Ms. O'Shields.

JOHN BETTS: Chairman Johnson and Chairman Leven, Council Members and staff, good afternoon and thank you for the opportunity to speak about this proposed bill. My name is John Betts and I am the Program Director of the Living Room Drop-In Center and Safe Haven at Bronx Works. I currently oversee our 50-bed Safe Haven Transitional Shelter and the only drop-in center for homeless adults in the Bronx. Bronx Works is a large multi-service agency that has worked in the Bronx since 1972 and runs a number of programs. We currently provide a wide range of homeless services, and we are proud of our collaborative relationship with the Department of Homeless Services that has allowed us to provide innovative solutions, which have helped reduce street homeless in the Bronx by 88% between 2005 and 2015. Since we provide a continuum of care for homeless

individuals and families, 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 are clients face is an integral part of these services. We support this bill because it will serve as a vulner—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 hospital 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-year-old blind and homeless male who was chronically homeless and had been in and out of shelter for over two years. He was frequently hospitalized including six hospitalizations from his assigned shelter and another three times from the Bronx Works 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 readmissions to—and discharges to facilities incapable of meeting his needs. This was effectively a Band-Aid for larger issue. Further, there is a significant population of hospital homeless individuals who will circumvent the shelter system due to the breakdown in communication. During the nights of the Hope Count, the Bronx Health and Housing Consortium conducts a parallel count of homeless individuals staying a night in the hospital waiting rooms, hallways and emergency departments, and during this year's count, the Consortium counted 87 homeless individuals across nine Bronx hospital locations, which is nearly double the Hope Count number of people found on the street, and the majority of these individuals reported more than 10 emergency department visits in the past year. Since March 2016, the Bronx Works Homeless Outreach Team has engaged over 500 individuals in Bronx Hospital Emergency Departments, and transported over 120 to either shelter or a drop-in center. When hospitals

and shelters can collect—collaborate effectively [bell] and have the necessary resources we have had amazing successes in the partnership with Bronx Partners for Healthy Communities in Saint Barnabas Hospital, which was funded through Medicaid Redesign as part of DSRIP. We helped to transition a young 25-year-old man into his own Safe Haven room, and prior to his engagement and placement in the Safe Haven, he had 82 ED visits at St. Barnabas in 2015, and in the four months after his placement at the Safe Haven, he only visited the St. Barnabas Emergency Room two to three times. So, I think we can all see how important this is, and one of the easiest ways to begin a collaboration is to grant hospitals access to the Cares database of record. Right now there is no really effective way for DHS and hospitals to communicate because hospitals do not have access to—to the database to be able to see whether or not a person has a shelter of origin. And so we know that the best solution is permanent housing, but there's currently a gap in transitional housing options, and that's why we are in full support of this bill. Thank you. [background comments, pause]

CHAIRPERSON JOHNSON: Thank you both very much. I mean I know you weren't able, John, to read your entire testimony, and we appreciate the work you put into it, and we'll, of course, read it all. I mean the—the—the number—a few numbers that you gave are pretty staggering. One is the night of the Hope Count, double the number of people that were counted in the vicinity actually being in the hospital waiting, and it shows the—in many ways the deficiencies in the Hope Count, and actually getting an accurate number. I mean it's important that we do it because it gives us some sample size, but again I think the Hope Count very much undercounts the number of people that are homeless and needing care. And then, too, the 25-year-old individual who went from 82 ED visits to two, I mean, Steve, what were you saying the number is?

CHAIRPERSON LEVIN: I—I mean—if—if somebody could do the math and find out how much that saved the City of New York in terms of--

CHAIRPERSON JOHNSON: [interposing] Hundreds of thousands of dollars?

JOHN BETTS: Yes, yes, hundreds of thousands of dollars.

CHAIRPERSON JOHNSON: Hundreds of thousands, and that's one instance?

JOHN BETTS: Yes.

CHAIRPERSON JOHNSON: So, thank you for your testimony.

JOHN BETTS: Thank you.

CHAIRPERSON LEVIN: Thank you both for your testimony. Thank you.

CHAIRPERSON JOHNSON: So thank you all for coming today. We look forward to continuing this conversation with you. I'm grateful that my friend and colleague, Steven Levin, agreed to have this haring jointly to look at these issues. It's—and I don't say this in anyway to be critical of him, it's long overdue for us to be having this conversation. And so, I'm glad we did this today, and we look forward to working with all of you and the city to try to get something in place that will take care of the most vulnerable even in the homeless population who really, really need our help.

CHAIRPERSON LEVIN: And thank you to my friend and colleague, Corey Johnson for co-chairing the hearing, and I'll let you--

CHAIRPERSON JOHNSON: [interposing] And with that—

CHAIRPERSON LEVIN: --I'll let you gavel out.

CHAIRPERSON JOHNSON: --the hearing is adjourned. [gavel]

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date December 10, 2016