Housing @ Risk Program

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The Bronx

- **1.4 million residents in the poorest urban county in the nation**
- **Median household income $34,000**
- **54% Hispanic, 37% African-American**
- **High burden of chronic disease**
- **Per capita health expenditures 22% higher than national average**
- **80% of health care costs paid by government payers**

Housing @ Risk Program

- H@RP was established in March 2009 in the Moses division.
- This program was designed to:
  - Provide highly coordinated health and housing support to patients who are homeless or unstably housed
  - Improve health outcomes
  - Reduce preventable Emergency Department visits and hospital admissions

H@RP Target Population

Homeless patients

- Sleeping in abandoned buildings, parks, subway, etc.
- Residing in a shelter or transitional residence

Unstably housed patients

- Couch Surfing
- Doubled-up
- No lease agreement
- Illegal room rentals

Potentially homeless patients

- Rental arrears
- At-risk of eviction
- Head of household has a chronic illness and may not be able to continue working

Unmet housing needs

- Needs accommodation due to medical condition
- Extensive housing repairs

Recently housed with history of homelessness

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How Does H@RP Work?

Alert System

Referrals

- Case Consultation
- Intensive Housing Support

Housing Clinic

Comunilife Respite

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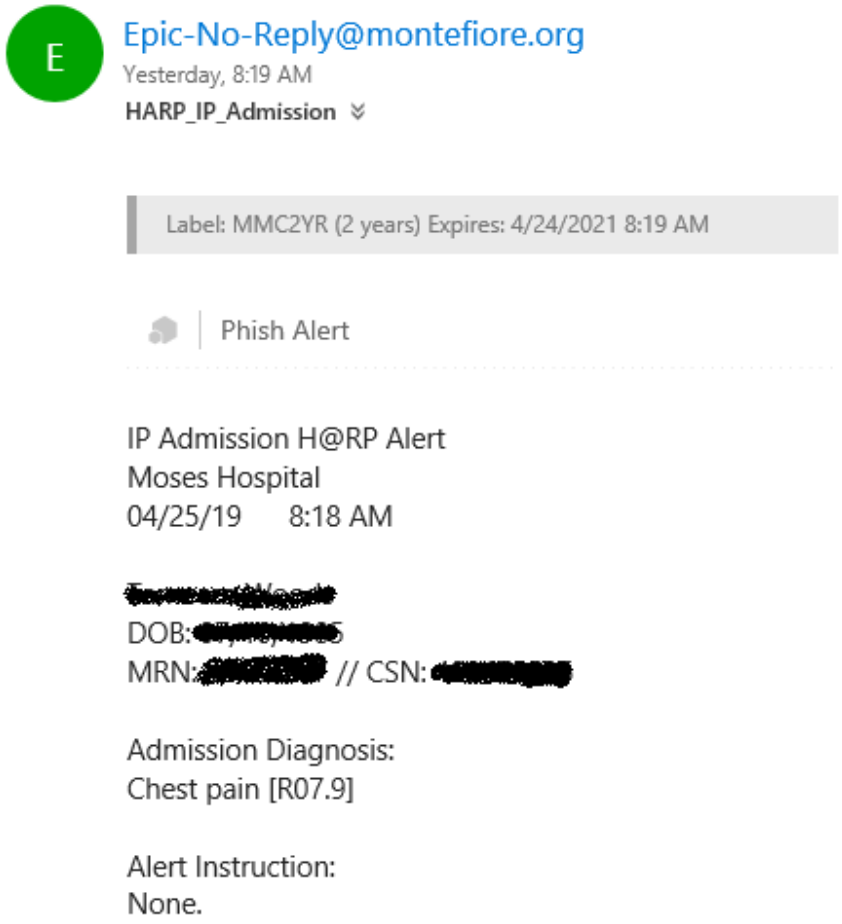

E

Epic-No-Reply@montefiore.org
Yesterday, 8:19 AM
HARP_IP_Admission

Label: MMC2YR (2 years) Expires: 4/24/2021 8:19 AM

Phish Alert

IP Admission H@RP Alert
Moses Hospital
04/25/19 8:18 AM

[redacted]
DOB:[redacted]
MRN:[redacted] // CSN:[redacted]

Admission Diagnosis:
Chest pain [R07.9]

Alert Instruction:
None.

An alert is triggered when:

Patients address states "undomiciled" or address of a shelter	They have a specific PCP who work with the homeless population	They have the undomiciled ICD 10 Code on their problem list (Z59.0)	They have the "undomiciled" flag	The H@RP Team manually enters the flag

Email alerts several key players:

ED and IP Social Workers & HARP Team

Inbasket and Email Alerts:

*When patient is registers in the ED

*Transferred to IP

*DC from IP

Referral Process

Referrals should be completed as soon as housing instability is identified

Complete referral and email to team

Include as much detail as you can

Depending on the situation and scheduling, HARP goal is to respond in a week

H@RP staff will assess referral and determine the level of support that can be provided.

Referrals will result in H@RP staff providing case consultation or accepting the patient onto the H@RP caseload for intense intervention.

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Assess Current Housing & Desired Housing

Housing Severity Levels

Level 1	Level 2	Level 3	Level 4
Stable	Unstable	Very Unstable	Extremely Unstable
No risk of instability	Could lose unit, but not immediately	Could lose unit quickly	Most unstable level of homelessness
This is permanent housing	**This is unstable, temporary housing**	**This is unstable housing that could be lost quickly, rendering someone Level 4 homeless**	**Someone has no shelter**
Patient has lease & can afford rent	Patient will have to move at some point into a stable unit they can afford and is suitable	Housing is usually controlled by someone else	Often sleeping is a public space
Someone living with family on a permanent basis	Open eviction case	There is not lease for patient	Staying at a church or places not suitable for living
May need to move if their circumstances change		Housing that is linked to program participation/transitional housing	Facilities like a drop-in center where there is no guarantee of a bed
		Court cases with eviction date	

Examples			
Supportive Housing	Renting a room	DV Shelter	Street
Apartment with permanent subsidy	Lack of future ability to pay rent	Shelter	Subway/Car
Affordable housing	Accruing rental arrears	Couch surfing	Park
Permanent Skilled Nursing Facility	Open/pending housing court case	Doubled up/squatting	Squatting in empty apartment or abandoned building
Permanent institutional placement	Patients' apartment is not suitable due to medical condition or mobility issues	Safe Haven	Church
Adult Home	Correctional Facility	3/4 or 1/2 House	Drop-in Center
Reunified with family	Foster care	Lost court eviction process	Hospital
Assisted living	State psych center	Marshall letter	
	Transitional Housing	Treatment facility	
	Unaddressed repair issues	Respite bed	
	Needs higher level of care		
	SRO		

For single adult shelter referrals: Please complete the referral form, send to DHS, and please CC the H@RP Team- Keona Serrano, Madeline Gotay & Deirdre Sekulic. H@RP Team will add patient to alert system.

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Outpatient Referral Process

1. Complete fillable H@RP referral form

2. E-mail referral form to H@RP team for review

Referral Form

Please FAX completed referral to: (718)325-9356

Patient Name:	**John Doe**	Current Address:	**123 Fairytale Lane, Bronx, NY 10467**
MRN#:	**12345678**	Current Phone:	**000-000-0000**
Patient DOB:	**11/4/1966**	Alt Contact Phone:	**000-000-0000**
Patient Age:	**53**	Referral Date:	**01/03/2020**
Preferred Language:	**English**		

(Please verify any data pulled from EPIC)

Medical Utilization History:

Number of ED Visits in the past 12 Months	**0**
Number of Hospital Admissions in the past 12 Months	**0**
Medical and Psychiatric Conditions (Problem list)	**Chronic Kidney Disease**

Relevant Community Providers: (PCP, HomeBase, Case Manager, Emergency Contact, Health Home, etc.)

Name	Phone	Relationship
Jane Doe	**000-000-0000**	**Wife**

Current Housing Situation:

Current Housing Level: (See below for instructions)	**Level 2- Open/pending housing court case**
Description of Patients Housing Dilemma: (Reason for referral)	**Patient has an open housing court case for owing rental arrears. Patient owes $4,800 after losing employment due to current medical condition. Patient monthly rent is $1,200 a month. Patient does not have a rental subsidy. Patient lives alone.**
Specific Housing Needs & Accommodations: (lower floor, elevator, etc.)	**None**
Please explain any exhausted housing options the patient has applied for:	**HRA one-shot deal**
Please list desired housing (room rental, new apartment, supportive housing, housing subsidy, rental arrears paid, repairs advocacy)	**Housing Subsidy; Rental Arrears Paid**

Income and Entitlements: (Please enter dollar amounts)

Employment Wages	**$0**	Veterans Benefits	**$0**
Social Security Income	**$0**	Child Support	**$0**
Social Security Disability	**$0**	Retirement/Pension	**$0**
Public Assistance Cash	**$0**	Workers Comp/Unemployment	**$0**
SNAP Food Stamps	**$0**	Other:	**$0**
Non-Cash Benefits:	**No**		
Housing Voucher? Section 8 (HPD or NYCHA, LINC, FHEPS, CITY FHEPS, HUD VASH, etc.)	**No**	Medicaid CIN ID	**XYZ123456**
Medical Transportation	**No**	Medicare ID	

Instructions for H@RP Alert Textbox (if needed):

Referral Information: (Person completing this form)

Name: **Mary Jane**	Role/Specialty: **Care Manager**	Contact Phone & Email: **718-920-1234**

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Housing at Risk Program (H@RP) Clinic

Please join us **each Wednesday at 12:00 PM** for an interactive webinar to answer your questions about patients experiencing housing instability, provide case consultation and get suggestions about available resources.

Microsoft Teams Meeting

Join on your computer or mobile app
Click here to join the meeting
Or call-in (audio only)
+1 347-352-6762,,839870093#
Phone conference ID: 839 870 093#
Find a local number | Reset PIN

H@RP assists patients who are currently:

- Admitted into the hospital without a safe discharge plan
- Homeless; sleeping in abandoned buildings, parks, subways or public locations
- Residing in a shelter or transitional residence
- Accruing rental arrears or at risk of eviction
- In need of advocacy due to unaddressed housing repairs
- In need of a housing accommodation due to a medical condition
- Residing temporarily with family and friends or in an illegal room rental
- Housed with a history of chronic homelessness

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Types of H@RP Interventions

ASSIST PATIENTS WITH GETTING VITAL DOCUMENTS

ASSIST PATIENTS WITH GETTING INCOME FROM PA OR SSI/SSD

HOUSING SEARCH

PREVENTING EVICTION & HOMEBASE INITIATIVE

REPAIRS ADVOCACY

ONGOING COLLABORATION & CASE CONFERENCING

ADDRESSING PSYCHOSOCIAL STRESSORS

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H@RP 2022 Outcomes

- 165 cases
- 108 intensive caseload
- 56 case consultations
- Cases open for average 133 days
- Median age: 48
- Housing Status: 33.3% in rental arrears. 6.4% sheltered homeless
- 120 patients with no housing subsidy
- 77% of cases resolved

Comunilife Respite Program

Goal: Provide safe, appropriate level of care for individuals who are homeless or become unstably housed during a hospitalization, including patients who are unable to safely discharge to shelter.

Montefiore rents 4 beds from CBO

CBO provides case management support related to finding permanent housing

Montefiore H@RP remains involved to facilitate follow-up medical care

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Comunilife Program Requirements

PATIENT MUST BE INDEPENDENT IN ADL'S

PATIENT SHOULD HAVE A RESPITE DISCHARGE GOAL

PATIENT CAN BE IN A WHEELCHAIR BUT MUST BE ABLE TO INDEPENDENTLY TRANSFER

PATIENT CAN HAVE A SUBSTANCE ABUSE HISTORY AND RECENT USE BUT MUST BE ALREADY LINKED TO OUTPATIENT TREATMENT

ELIGIBLE CASES WILL BE INTERVIEWED VIA TELEPHONE BY THE COMUNILIFE STAFF

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Referring to Comunilife

Please complete referral found on intranet as soon as possible during the patient admission

Referrals should include: patients name and MRN number, along with a brief description of the case

All referrals should be emailed to Kareemah Benbow & Deirdre Sekulic. CC Corisha Sanders

Team will follow-up with CBO and then give determination to referral source.

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Respite Annual Report 2022

- 10 patients used an average of 2.8 beds for the year
- ROI 482%
- Clients discharged from respite to:
- Permanent housing 57%
- Shelter 14 %
- Higher level of care (SNF 14%)
- Reunited with family 14%

Contact Information

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