

Overview Behavioral Health Programs & Housing for Health at NYC H+H

Agenda

- **Brief Overview of Behavioral Health Programs**
 - Extended Care Units (ECU)
- **Overview of Housing for Health**
 - Housing Engagement Location and Placement Services (HELPS)
 - Project ASAP

Behavioral Health

NYC Health + Hospitals provides a full spectrum of Behavioral Health treatment from inpatient to outpatient services



All outpatient behavioral health programs are accessed via each facility.

← **Care Management: Health Home, Health Home Plus, Critical Time Intervention, Complex Needs** →

Express Care by NYC Health and Hospital

■ Behavioral Health Conditions:

- Substance Use Disorders
- Anxiety
- Depression
- Stress
- Burnout
- Withdrawal
- Other emotional distress

■ Access to Express Care:

- Call 631-EXP-care (631-397-2273)
- Online - [NYC Health + Hospitals](#) "Talk to a Provider"

Vision: *Together, we will reduce homelessness and improve behavioral health outcomes through system change, innovation, and compassionate care.*

Housing First, Health Focused, Patient-Centered

- Trauma-informed, culturally competent care
- Prioritize permanent housing as a health intervention
- Patient-centered, coordinated services

Office of Behavioral Health Programs

- Complex Needs Program
- Domestic Violence Services
- Critical Time Intervention
- Addiction Services
- Bridge to Home
- **Extended Care Units**

What is an Extended Care Unit (ECU)?

- Approximately 4-month inpatient programs in which individuals are treated through a social learning model, which, in addition to medication management and psychotherapy, and,
- highlight the role of community-based learning (groups), and,
- behavioral reinforcement (rewards for prosocial behavior) to maneuver through challenges, stressors and other potentially anxiety provoking situations.
- The ECUs also offer enhanced clinical case management by applying for OMH supportive housing, benefits & entitlements, vital documents, and linkage to proper community support.

NYC H+H operates 3 ECUs:

- The Bellevue ECU opened March 2020
- Kings ECU opened in February 2023
- Elmhurst ECU opened in December 2024

The aims of the Extended Care Units are to:

- Reduce inpatient psychiatric hospitalizations
- Secure improved housing for individuals experiencing homelessness

Who do the ECU's serve?

- The ECUs serve adults with Severe and Persistent Mental Illness (SPMI). The most common diagnoses we treat on the ECUs are Schizophrenia, Schizoaffective Disorder, and Bipolar Disorder.
- The ECUs can admit individuals on a voluntary or involuntary legal status but whatever their legal status, the individual must **AGREE** to be admitted to the ECU.
- Homeless adults are a special population we serve on the ECUs, but a person does not have to be homeless to be eligible for the ECU.
- The ECUs only accept referrals from acute inpatient psychiatric units.

Inclusion / Exclusion for ECU

Candidates for the ECU are:

- typically showing a response to treatment but remain symptomatic despite treatment adherence
- engaged in treatment on the referring unit or at least show potential to do so
- have experienced multiple psychiatric admissions in their recent history.

Exclusion criteria for the ECU:

- a diagnosis that is likely to impair their ability to participate in unit programming (Neurocognitive Disorder, Intellectual Disability, Autism Spectrum Disorder, Traumatic Brain Injury, or another Neurologic Disorder)
- antisocial traits as primary driver of poor community tenure
- violent behavior or overtly sexual behavior that is likely to either compromise the therapeutic milieu
- a medical condition that cannot be safely managed outside of a medical psychiatry unit or an inpatient medical service

How to refer:

- H+H facilities can submit referrals by placing a consult order in EPIC and emailing Bellevue, Kings or Elmhurst with brief description of the patient's current clinical condition and the referral rationale, and contact information for the referring team members.
 - BHCECUREferrals@nychhc.org
 - KCHECUREferrals@nychhc.org
 - EHCECUREferrals@nychhc.org
- Non- H+H facilities can submit referral information and clinical documentation through the ECU referral portal: <https://innovations.nychhc.org/ecureferrals>

Contacts

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Housing for Health

Relationship between Housing and Health at H+H

- **In 2024, ~80,000 H+H patients (62,000 adults)** were homeless or marginally housed and over 50% were also DHS clients
- On average, patients experiencing homelessness visited the **ED 3x more often** than other patients
- Patients experiencing homelessness were more likely to have an inpatient visit and **stayed 4x longer** across their admissions

Housing for Health

H+H's Approach: Housing for Health

Connecting patients experiencing homelessness with housing supports and opportunities:

- Operate Medical Respite Beds
- Provide Housing Navigation Services
- Fund Case Management Services in Affordable Housing
- Dedicate NYC H+H Land for Affordable and Supportive Housing

Housing for Health has stably housed nearly 1500 patient households. Over half of these patients are housed in supportive housing.

99% of patients remain housed after one year.

Expediting this population into stable housing saves lives, improves health outcomes, and reduces the expensive emergency health care and in patient resources.

Housing Reduced Healthcare Utilization at H+H

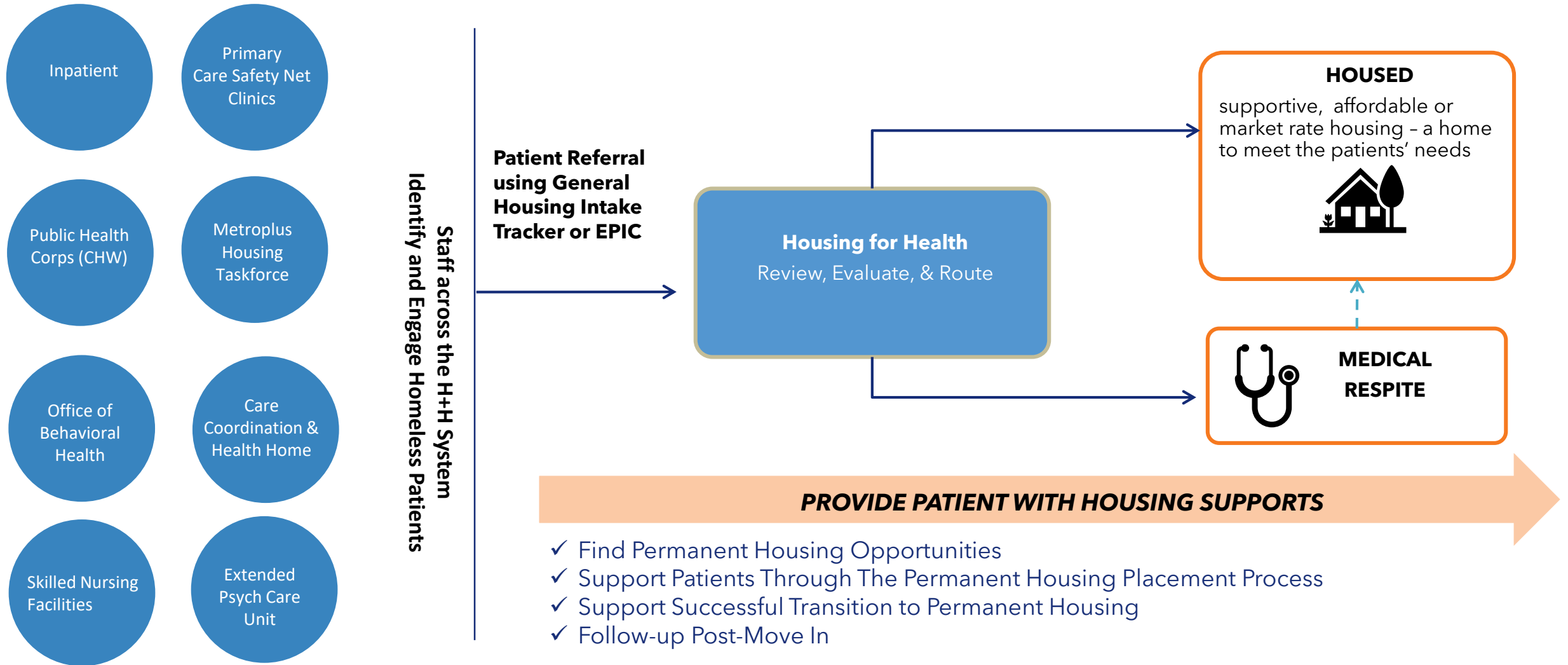
Housing for Health collaborated with MetroPlus Health (Medicaid Managed Care) to review healthcare utilization of approximately 200 mutual adult patients housed for at least 6 months between July 2019 to November 2023.

Patients housed in permanent housing demonstrated significant reductions in healthcare utilization, including:

- 32% reduction in ED visits
- 29% reduction in inpatient admissions
- 36% reduction in length of stay for medical admissions
- 46% reduction in length of stay for psychiatric admissions

Workflow to Identify, Engage, House Patients

Referrals come from across the system



NYC Health + Hospitals Housing for Health

Housing for Health (HfH) is NYC Health + Hospitals whole person care initiative to serve patients experiencing homelessness by connecting them to housing supports and permanent housing.

Through a partnership with our vendor **Coordinated Behavioral Care** NYC Health + Hospitals **Housing Engagement Location and Placement Services Program** provides one on one housing support to help patients experiencing homelessness move into permanent housing.

Our Housing Engagement Location Placement Services (HELPS) Partners are committed to a “whatever it takes” approach to get our patients housed.

- **Find Permanent Housing Opportunities**
- **Support Patients Through The Permanent Housing Placement Process**
 - Conduct housing assessments in the field
 - Complete housing packets and supportive housing applications
 - Facilitate Rent-ups
 - Coordinate with other stakeholders including shelter, H+H care teams, housing providers, and landlords
 - Monitor, track, and report housing progression
- **Support Successful Transition to Permanent Housing**
 - Respond to patients and property managers/owners
 - Ensure patient has supplies, necessities, and support upon move in
- **Follow-up Post-Move In**
 - Check in with tenant to identify needs and provide connection to care or services



In FY25, H+H Care Teams **referred over 1000** patients and the HELPS teams **placed over 400** patient households in permanent housing.

Project ASAP is Housing for Health's initiative to get more H+H patients approved for and accepted to supportive housing.

- Our strategy includes the following components:
 - **Mental Health Reports:** Provide patients access to HRA-approved clinical documentation required for supportive housing applications either through their provider or on-demand through Virtual ExpressCare
 - **Supportive Housing Applications:** Train care team members to complete supportive housing applications and utilize HELPS to complete applications for referred patients
 - **Housing Placement:** HELPS teams provide housing search and placement assistance into supportive housing units

Questions?

Follow up Contacts:

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