Human Resources Administration
Department of Homeless Services
Department of Social Services

Pursuant to Local Law 114 of 2017 to amend the administrative code of the city of New York, in relation to requiring information on medical health services in shelters, the Department of Social Services respectfully submits the report below.

Those most at risk of homelessness are affected by high rates of poverty, family conflict and domestic violence, as well as poor health, including high rates of chronic disease and behavioral health diagnoses, coupled with low access to care. At DHS intake points, many clients arrive with a host of complex and interrelated challenges, but have one thing in common: a lack of safe and affordable permanent housing. The contents of this report describe medical services for individuals experiencing homelessness and should be viewed against the backdrop of the many services HRA and DHS provide to address social and structural determinants of health and homelessness. By working to prevent homelessness, bring people in from the streets 24/7, rehouse those persons who become homeless, and transform the approach to providing shelter that has been used over nearly 40 years, we are impacting the health of low-income New Yorkers beyond the provision of direct medical services.

This said, as a result of the 90-day review in 2016, DHS has implemented a series of reforms, including improvements in how DHS delivers and ensures health care for those seeking or residing in shelter. The improvements, for example, include adding appropriately licensed and experienced clinical and professional staff to the DHS Medical Director's office. These individuals assist the Medical Director in designing evidence-based standards of care, planning and implementing newly-expanded program monitoring and oversight, and conducting evaluations of existing programs and services.

Further, consistent with City and State laws governing the right to shelter and the Americans with Disabilities Act, reasonable accommodations are made available to all clients either at the same shelter or via transfer to a more suitable facility upon demonstration of need.

As part of the 90-day review that in 2016, a variety of reforms have taken place including, but not limited to the following:

- Revised the hospital and nursing home referral process to shelter, created an electronic referral form, and trained all shelters and hospitals in the revised process and new form.
- Planning for the development of a health data system to collect clinical health information from clinic providers and ensure that clients' clinical information and needs are available to DHS providers.
- Enhanced the clinical assessments of self-reported history and conditions 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.
- Use 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 service providers.
- Revising program monitoring and quality management tools and systems, including regular data analysis and ad hoc site visits by appropriately trained and skilled DHS staff.
- Collaborating with Providers of Health Care for Homeless in New York City and hospitals to create a seamless system of care for homeless clients, capitalizing on existing care systems in

New York City and using assessment shelters as points of clinical assessment and coordination of care, and health and wellness promotion.

- Developed comprehensive food and nutrition standards and procedures to ensure access to safe and nutritious food.
- Developing care coordination and health promotion protocols and curriculum to increase client self-sufficiency and reduce inappropriate acute care utilization.
- Targeting services for emerging new trends in the single adult population (persons 50 or older and 18 to 24): more effective targeting promotes our prevention and rehousing efforts. DHS's ability to respond to emerging trends in the single adult population allows us to better serve our clients and more quickly move them to independence through targeted supports.
- Implementing a more effective aftercare program: using the critical time intervention as a model, the City has enhanced aftercare services for rehoused clients.
- Providing assistance to obtain federal disability benefits: The City has dedicated services to focus on enrolling shelter residents on SSI/SSD to increase income and promote rehousing.
- Developing and revising medical and mental health standards for the screening at intake and comprehensive assessments in the assessment shelters to ensure that such assessments are completed, clients who need them are transferred to program shelters, and needed data are entered into the DHS client database to ensure that clients' clinical information and needs are available to DHS clinical providers in shelters.
- We are also focusing on evaluating a group of persons experiencing homelessness who are high utilizers of healthcare services and have significant health and/or behavioral health conditions, to design interventions and better coordinate their care and services, including facilitating their transition to appropriate housing and services, and working closely with hospitals and other medical providers.
- Developed standards of care for behavioral health care with implementation underway on-site at shelters, and strengthened linkage with medical providers in the community.

High-quality transitional housing is far more than just a room to sleep in or a roof over one's head. At these sites, we work in partnership with experienced not-for-profit social service providers whose dedicated staff connect clients every day with robust wraparound resources including case management, housing placement assistance, health and mental health services, and employment counseling on site. Cost covers far more than just rent—services, staffing, security, administrative costs and overhead are all included in the contract value.

As we transform a haphazard shelter system decades in the making, we are ending the use of all stop-gap measures citywide, including phasing out the approximately 19-year-old cluster program and the use of commercial hotel locations, which dates back on and off to the 1960s, while opening new high-quality sites that more effectively address our clients' unique needs—this includes high-quality shelters that are focused on supporting the needs of specific populations by provide targeted services/programs, including employed/employable New Yorkers, seniors, LGBTQ young persons, New Yorkers experiencing mental health challenges, veterans, etc. As we implement *Turning the Tide*, the City's five-year plan to transform a shelter system that has built up in a haphazard way over decades, we will be ending the use of the cluster program citywide.

When a New Yorker in need presents at an Assessment Site, staff work to identify what the individual's needs are and which program shelter would best facilitate the client's transition to housing permanency, including:

- General
- Employment
- Mental Health
- Substance Use
- Young Adults
- LGBTQ
- Older Populations
- Veterans

As per New York State regulations 18 NYCRR Part 491.4: "The operator shall not accept, except on an emergency basis, not retain any person who: (1) Causes danger to himself or others or interferes with the care and comfort of other residents; (2) Is in need of a social, religious, cultural or dietary regimen that cannot or will not be met by the facility; (3) Is in need of a level of medical, mental health, or nursing care that cannot be rendered safely and effectively by approved community resources; (4) Is incapable of ambulation on stairs without personal assistance unless such a person can be assigned a room on a floor with ground level egress; or (5) Is under 18 years of age."

There are no shelter programs, Safe Havens, or Drop in Centers (DIC) that have medical services appropriate for clients with medical or disabling conditions that fall within the absolute exclusion criteria detailed on pages 6-7 of the DHS Institutional Referral Procedure. There are no medical or respite shelters in the DHS shelter system.

Medical Services Providers at Assessment sites:

In addition to the initiatives listed above, we are also enhancing our provision of medical services at DHS intake and assessment facilities. Recognizing there is no one-size-fits-all solution to the citywide challenge of homelessness, we remain focused on continually strengthening our assessments of each individual and household's unique needs so that we can most effectively provide New Yorkers experiencing homelessness with the services and supports that would help them stabilize their lives, including connecting them with medical care in the community and developing strong linkages between shelter facilities and community-based service providers, organizations, and sister City Agencies.

By further developing and revising medical and mental health standards for the delivery of services at families with children (FWC) intake and single adult assessment shelters, we are improving the ways in which our clients are placed in appropriate shelters as well as ensuring they are connected to care.

To that end, last year, we issued a request for proposal (RFP) seeking qualified medical providers to deliver enhanced medical and behavioral health services at DHS intake and assessment facilities. Last year, we awarded those contracts to enhance our front-door evaluations of each client and the factors that may have contributed to their homelessness, including at:

- 30th Street Intake Facility (provider: Care for the Homeless)
- Bedford Atlantic Assessment Facility (provider: NYU-Langone, formerly Lutheran)
- PATH Family Intake (provider: The Floating Hospital)

We expect the service providers at these medical clinics to

- assess the medical and behavioral health needs of New Yorkers seeking shelter from the City upon arrival at assessment shelters;

- communicate with their outside medical providers, if any—and, if none, help connect clients with off-site medical care or other healthcare services within the community;
- perform or refer for recommended health screenings, including preventive health screening;
- provide care coordination and health promotion/health coaching; and
- communicate with hospitals about overall policies, practices, and systems, as well as regarding specific households' needs, including coordinating care and liaising with hospital Emergency Department and in-patient unit staff on clients' behalf and provide crisis prevention and intervention.

In addition, the medical services providers are helpful in determining if an individual is medically appropriate for shelter. Should an individual be determined inappropriate for shelter, shelter and clinical staff will coordinate with hospitals for needed medical services.

Following the medical and behavioral health evaluation, shelter staff will identify and prioritize clients who are in need of immediate medical or psychiatric evaluation or episodic care for clients who do not wish to access community services and care coordinators will ensure individuals are promptly connected to community-based medical and behavioral health service providers as recommended by the evaluations.

For clients receiving specialty care (HIV, Hepatitis C, dialysis, etc.) who may have their own specialized care coordinators, the provider will also facilitate care coordination and continuity of care. Through establishing and maintaining contacts with providers in the neighborhood, the care coordinator will advocate for timely and adequate community-based services.

The assessments conducted by service providers at these medical clinics will also help shelter staff more effectively assist clients with accessing services and transitioning into permanent housing.

The City has made important progress transforming a haphazard shelter system decades in the making by investing in historically underfunded not-for-profit service provider partners and facilities to ensure those partners are appropriately funded to deliver the services our homeless neighbors depend on as they get back on their feet; addressing conditions that have built up over many years; implementing the NYPD Management Team to oversee shelter security citywide; and raising the bar for services that we provide our homeless neighbors, moving away from a one-size-fits-all strategy towards a people and community-based system that is response to families' and individuals' unique needs. This includes:

- Investing in historically underfunded facilities and providers will help us turn the tide, which is why we've dedicated unprecedented dollars (more than a quarter-billion new dollars annually) to modernizing the outdated rates that our vital provider partners had been receiving for years to ensure those partners are appropriately funded to deliver the services our homeless neighbors depend on as they get back on their feet, while expanding education-focused programs and increasing our social work staffing and mental health services, thanks to First Lady Chirlane McCray's ThriveNYC Initiative.

Outlined below is the information for Calendar Year (CY) 2018 solicited in Local Law 114 of 2017

1. The number of shelters, domestic violence shelters, and HASA facilities with on-site medical health services, as well as the total number of shelters, domestic violence shelters and HASA facilities

DHS and HRA conducted a survey with all of the shelter programs to collect information for on-site medical services which in addition to linkages connect clients to community-based services. A total of 97 DHS shelter program and 2 Domestic Violence shelter provided on-site medical health services (Table 1).

Table 1: Number of shelter programs and shelter programs with on-site medical health services, 2018

	Overall # of Shelter Programs	Number of shelter programs with on-site medical health services
Shelters Programs	**516**	**97**
Single adults	140	60
Safe haven facilities	19	11
Veterans short term housing/Criminal Justice Shelter[1]	3	3
Adult Families	24	5
Families with Children[2]	330	18
Domestic Violence Shelters [3]	**54**	**2**[4]
Domestic Violence Emergency Shelters	46	2
Domestic Violence Tier II shelters	8	0
HASA Facilities[5]	**176**	**0**

[1] Borden VTSH is set up as 2 different 'facility code/addresses' -this includes both. In addition, Porter Criminal Justice Shelter is included in this count.

[2] The original report from 2017, which has since been revised and resubmitted, Families with Children shelters did not include clusters they are included in this revised number; the 2018 Families with Children shelter count also includes clusters

[3] Operating under the New York State Domestic Violence Prevention Act, the Human Resources Administration works with a network of providers to provide support services for survivors of domestic violence and their children. The law requires counties to provide shelter and services to survivors of domestic violence and establishes funding for these programs. The New York State Office of Children and Family Services promulgated and maintains regulations as to the standards for the establishment and maintenance of residential and non-residential domestic violence programs, and authorizes the local department of social services with the responsibility for contractual arrangements with providers of domestic violence residential services. The HRA Tier II system, operates under the requirements of 18 NYCRR part 900 - OTDA regulations. These regulations require that the District not refer families in need of a level of medical, mental health, nursing care or other assistance that cannot be rendered safely and effectively by the facility, or that cannot be reasonably provided by the facility through the assistance of other community resources.

[4] Two domestic violence emergency shelters have two locations with two separate operational licenses and share onsite medical health services.

[5] Unlike many shelters for single adults, SRO emergency housing provides single adults enrolled in HASA a temporary private room to reside in. HASA clients receive ongoing case management and are assigned to a caseworker at one of our HASA centers, located in all 5 boroughs. With this implementation structure and privacy measures for SRO emergency housing, medical health services in this model are most efficiently achieved through case management, rather than on-site medical services.

Emergency SRO /Family Provider Sites	**161**	**0**
Emergency Transitional Provider Sites	15	0

Note: These are shelter programs that were active as of December 31 of the reporting year

2. A description of the medical health services in each intake center

Families with children enter DHS shelter through the central intake center called the Prevention Assistance and Temporary Housing (PATH) center. All new families that report a health issue at intake (e.g., feeling sick) and those with specific medical needs, such as pregnant women, families with infants or who have a member with an acute medical condition or recent hospitalization are seen by the clinical provider at PATH, The Floating Hospital. The on-site clinician conducts a health screening and offers necessary urgent care, referrals as needed, and health education, and coordinates with the client's existing health care providers as needed. Once in shelter, clients are encouraged to and assisted in seeking care from their primary care physicians or a local clinic of their choice. Pregnant women and mothers with infants who are eligible are referred to the NYC DOHMH Nurse Family Partnership and Newborn Home Visiting Programs.

For single adults, services include medical and behavioral assessments (history and physical) and care as well as relevant infectious disease screening tests. For many of these individuals, entry into the DHS system may be the first contact they have with the health care system in several years. As such, clinical providers at assessment shelters conduct a comprehensive medical and a brief psychiatric assessment, followed by, as needed, a comprehensive behavioral health assessment. Assessments are conducted within five to ten days of the client's arrival. The medical history and physical includes routine laboratory testing and selected preventive care, such as referrals for Pap smears or mammograms. The physical examination is followed by screening for selected communicable or infectious diseases, such as tuberculosis and HIV. At shelters without on-site healthcare, clients are able to take advantage of a clinic close to their assigned shelter through linkage agreements.

If a client remains in the shelter system beyond the initial assessment period, the client may receive medical and psychiatric care, onsite, if available, or via linkage, as appropriate. At shelters with on-site clinics, medical providers can complete medical histories and physical examinations for clients referred to them by shelter staff and may provide primary and episodic care as well as mental health services. Specifically, onsite medical providers provide the following services: physical examinations; episodic care and first aid; limited ongoing primary care, as needed; monitoring of chronic diseases; medication administration, management, and supervised self-administration for select clients; and referrals to specialty medical care.

For adult families, self-assessments are conducted at intake centers where individuals respond to questions posed from staff. Clinical assessments are not conducted by a clinician at these sites.

HRA's Office of Domestic Violence provides oversight for the 24-hour NYC domestic violence hotline which serves as one of the contact points for the domestic violence shelter system, but also provides safety planning and referrals. Safe Horizon, a private not-for-profit social service agency and DV service provider, is the City contracted provider operating the hotline.

Upon arrival at a domestic violence shelter, as required by State mandate a caseworker will conduct the Client Assessment within 48 hours of arrival. As a part of the client assessment process, the following medical and mental health questions are asked:

- Do you consider yourself or your children in good health? Yes or No
    - If no, explain medical problem
- Have you or your child (ren) ever been hospitalized? If yes, please explain.
- Have you or your child (ren) ever received psychiatric treatment or counseling? If yes, please explain.
- Is anyone in the family currently in treatment (Yes) or (N0)?
- If yes, Name of Psychiatrist, phone#, Treatment schedule, List of medications,
- Is anyone pregnant (Yes) or (N0).
    - If yes, who and expected date of delivery?
    - If yes, receiving prenatal care (Yes) or (N0)? Where?
    - Any complications with the pregnancy (Yes) or (N0), Explain
- We also ask the following Drug /Alcohol History:
    - Does client have a history of alcohol or substance abuse? (Yes) or (N0)
    - Has client ever been in detox or rehab? (Yes) or (N0)
- Is client currently in treatment? (Yes) or (N0) If yes, where? Address / Counselor's name, telephone phone.

Depending upon the responses, referrals are made. In every case there is on-going case management at the shelter.

Persons who are medically eligible for the HASA program must still apply for and be found eligible for cash assistance. All clients applying or recertifying for cash assistance who self-identify or appear to have a substance use history are referred for a substance use assessment by an on-site Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and are offered a referral for the appropriate treatment and/or harm reduction services as needed. We use an electronic instrument that is based upon the Addiction Severity Index that assesses client functioning with respect to substance use and treatment history as well as medical, mental health, employment, legal, and housing issues. It also includes a section to assess a client's motivation towards treatment and has decision support logic that helps the CASAC make determinations and standardizes determinations among CASACs. At intake, clients applying for HASA will submit lab results and or sign a HIPPA release so staff are able to access health records in order to confirm eligibility.

3. A description of the medical health services provided at drop-in centers and safe havens

Services at drop-in centers and safe havens include medical care, assessment services and referrals to clinical care.

All clients are provided a clinical assessment upon intake to a Drop-in or Safe Haven. Among the 22 Safe Havens and Drop-In Centers, all have clinical services on-site, save for one Safe Haven.

Safe Havens provide an immediate transitional housing alternative for chronic street homeless clients. The street outreach teams are the sole referral source and can place clients into a Safe Haven directly from the street. Safe Havens have flexible program requirements such as no curfew and generally have

smaller capacity. The program embraces housing first and harm reduction models. The primary goal is to bring clients off the streets into flexible settings with strong clinical supports to help clients transition to permanent housing. The staffing at Safe Havens is clinically rich. There are MSW level clinicians, CASAC certified staff and psychiatrists. The low client/staff ratio allows for more intensive work with each client.

4. A description of the medical health services provided to the unsheltered homeless population, including but not limited to the number of clients served by a provider under contract or similar agreement with the department to provide medical health services to the unsheltered homeless population, and the number of clients transported to the hospital

Outreach teams work from a harm reduction approach, building relationships with individuals who over time have historically rejected services. Outreach teams are also focused on the most vulnerable of those living outside to ensure they are safe and/or not at risk for injury or death. Outreach teams also perform crisis intervention assessments and work on placements to indoor settings through on-going case management and supportive services. This includes linking clients to medical benefits as they continue to work with these individuals throughout their journey. The outreach teams meet people "where they are" both literally and figuratively— whether that means conducting a medical or psychiatric evaluation on a street corner or sending an outreach worker who can speak to a client in his or her native language.

Central to the HOME-STAT effort, outreach teams continue to build the City's first-ever by-name list of individuals known to be homeless and residing on the streets, more effectively enabling the teams to directly and repeatedly engage New Yorkers in need where they are, continually offering supports and case management resources while developing the trust and relationships that will ultimately encourage these individuals to accept services and transition off the streets.

As this information is the most accurate real-time reflection of what outreach teams see on the ground every day, the City reports a summary of this by-name information on a quarterly basis as Local Law 217 of 2017 has required since September of 2018:

- As of the end of CYQ1 2018:
    - 1,710 HOME-STAT clients on the street (and other settings)
        - This refers to the total number of New Yorkers who are—
            - known to HOME-STAT outreach teams;
            - AND (2) confirmed to be experiencing unsheltered homelessness;
            - AND (3) currently being engaged by HOME-STAT outreach teams;
            - AND (4) included in the record, also known as the City's 'by-name list' of street homeless individuals
    - 1,720 prospective clients engaged by teams to assess living situations
- At the end of CYQ2 2018:
    - 1,600 HOME-STAT clients on the street (and other settings), as defined above
    - 2,100 prospective clients engaged by teams to assess living situations
- At the end of CYQ3 2018:
    - 1,500 HOME-STAT clients on the street (and other settings), as defined above
    - 2,680 prospective clients engaged by teams to assess living situations
- At the end of CYQ4 2018:
    - 1,600 HOME-STAT clients on the street (and other settings), as defined above

- 2,400 prospective clients engaged by teams to assess living situations

In calendar year 2018, 208 clients were transported to the hospital by outreach teams.

5. A list of the 10 most common medical health issues for adults living in shelters, as self-reported at intake/assessment, and the 10 most common medical health issues for children living in shelters, as self-reported at intake/assessment

The tables below outline the top 10 medical health conditions among adults in Adult Families, Single Adults, and Families with Children shelters. This is self-reported data at the time of application, when they arrive at the assessment or intake site, from every adult client that spent the night in an adult family, families with children or single adult shelter in 2018. In this data collection method, each client has the ability to report several health conditions and therefore these data are not de-duplicated. These counts include clients that turned 18 while in shelter during 2018. Asthma was the leading medical condition reported by adult in Families with Children and Adult Families shelter. Among adults in single adult shelters hypertension was the leading medical condition.

Table 2. Top Ten Medical Conditions from Intake/Assessment for Adults in Adult Families Shelter in CY 2018

Rank	Medical Condition	n
1	Asthma	1,162
2	Hypertension	1,129
3	Diabetes	711
4	Arthritis/ other joint disease	541
5	Allergies (seasonal or medications)	339
6	Heart disease	297
7	Seizure disorder/epilepsy	207
8	Anemia	170
9	Hepatitis C	105
10	Renal Disease	87

Table 3. Top Ten Medical Conditions from Intake/Assessment for Single Adults in Shelter in CY 2018

Rank	Medical Condition	n
1	Hypertension	5,830
2	Asthma	4,153

3	Diabetes	3,370
4	Arthritis/ other joint disease	2,379
5	Heart disease	1,240
6	Seizure disorder/epilepsy	817
7	Allergies (seasonal or medications)	725
8	Hepatitis C	663
9	Anemia	406
10	HIV/ AIDS	383

Table 4. Top Ten Medical Conditions from Intake/Assessment for Adults in Families with Children Shelter in CY 2018

Rank	Medical Condition	n
1	Asthma	3,926
2	Hypertension	1,564
3	Diabetes	1,190
4	Allergies (seasonal or medications)	907
5	Anemia	710
6	Arthritis/ other joint disease	653
7	Heart disease	384
8	Cancer	166
9	Renal Disease	149
10	Obesity	137

Note: These counts include clients that turned 18 while in shelter during 2018

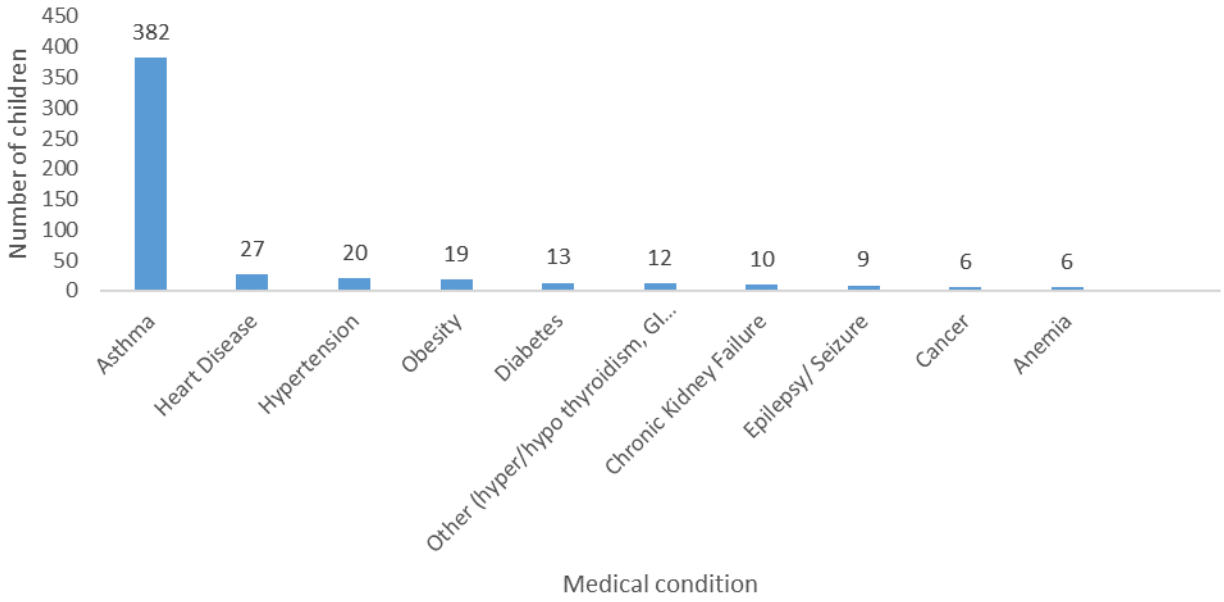
DHS Office of the Medical Director collects self-reported medical conditions for new families applying for shelter at the Families with Children (FWC) intake center (PATH) that report a health issue at intake (e.g., feeling sick or have a contagious condition) and also collects health information from returning families that have not previously completed the expanded health screening, if they presented to the clinic for another issue (e.g., pregnancy, recent hospitalization).

- In 2018, data were collected for 2,936 children, of those, 423 children (14%) had at least one chronic medical condition. Asthma was the leading medical condition reported among children (Figure 1).

- In September 2018, DHS launched a revised version of the health screening via an enhanced data collection tool to collect additional information on medical conditions reported by the head of the household for each family member. Additional medical health conditions include epilepsy, seizure, anemia, hepatitis B, hepatitis C, HIV and others (includes hyperthyroidism, hypothyroidism, gastric illness, high cholesterol, arthritis, skin allergy, lupus). Therefore, these conditions are only reflected in the reporting for the period September to December 2018.

- Figure 1 shows the top 10 medical conditions among children as reported by the head of the household for each family member. Some children have more than one medical conditions.

Figure 1: Medical conditions among children as reported by the head of the household for each family member at families with children intake center, CY 2018 (N =423)[6]



Note: The data collection tool from Families with Children intake center was revised in September 2018 to collect additional medical conditions.

6. A list of the 10 most common medical health issues for adults living in shelters and the 10 most common medical health issues for children living in shelters, as reported by providers under contract or similar agreement with the department to provide medical services in shelter

Tables below outlines the 10 most common medical conditions among children (Table 5) and adults (Table 6) living in shelter as reported by the medical providers. Asthma and hypertension were the leading medical condition reported among children and adults, respectively.

Table 5: Ten most common medical conditions among children as reported by the medical provider at PATH, CY 2018

Rank	Medical conditions
1	Asthma
2	Eczema
3	Heart disease
4	Anemia
5	Seizure Disorder
6	Bronchitis

[6] Some children have more than one medical conditions.

7	Obesity
8	Sickle Cell Disease
9	Gastroesophageal reflux disorder
10	Hypothyroidism

Table 6: Ten most common medical conditions among adults as reported by the medical providers at assessment shelters, CY 2018

Rank	Medical Condition
1	Hypertension
2	Asthma
3	Diabetes
4	Overweight/Obese
5	Heart Disease
6	Arthritis
7	Anemia
8	Seizure disorder/epilepsy
9	Gastro-esophageal reflux disease
10	Back pain or herniated/slipped disc

7. The number of individuals new to the shelter system discharged from a hospital to a shelter

Reason for Homelessness – Single Adult* entrants in CY2018	Women		Men		Total	
Discharge from Hospital Medical Department	95	1.5%	291	1.5%	386	1.5%
Discharge from Hospital Psychiatric Department	157	2.6%	218	1.1%	374	1.4%

*Future reports will include datasets on discharges from a hospital to a shelter for FWC and Adult Families.

8. The number of individuals new to the shelter system discharged from a nursing home to a shelter

Reason for Homelessness – Single Adult* entrants in CY2018	Women		Men		Total	
Discharge from other, non-hospital facility/program[7]	296	4.8%	998	5.1%	1,294	5.0%

*Future reports will include datasets on discharges from a nursing home to a shelter for FWC and Adult Families.

9. Any metrics relevant to the provision of medical health services reported to the department by any entity providing such services

Please refer to the new overdose report and the annual mortality report submitted pursuant to LL225 of 2017 and LL63 of 2005, replaced by LL 7 of 2012, respectively.

10. No later than September 1, 2020 and every three years thereafter, the most frequent causes of hospitalizations, excluding HIV or AIDS, for homeless adults based on information available through SPARCS

These data will be available for future reporting as required by the local law.

[7] This category of data may encompass discharges from nursing homes to shelters, but it is not limited to that facility type; the category also includes discharges from other non-hospital facilities and programs. Due to current data collection methods, this data category is the best available to encompass discharges from nursing homes.