Human Resources Administration
Department of Homeless Services
Department of Social Services

Outlined below is information for Calendar Year 2024 solicited in Local Law 114 of 2017

Introduction

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 services in shelters, the Department of Social Services (DSS) submits the calendar year (CY) 2024 report below.

Those most at risk of homelessness are affected by high rates of poverty, often compounded by family conflict, interpersonal violence, poor health – including high rates of chronic disease and behavioral health diagnoses, and limited access to high quality health care services.

This report describes medical conditions and services for individuals experiencing homelessness in shelters and on the street. It should be viewed against the backdrop of the many other services Human Resources Administration (HRA), Department of Homeless Services (DHS), and other City agencies provide to address social and structural determinants of health and homelessness.

DHS and HRA are committed to strengthening how medical services are accessed and provided for those experiencing unsheltered homelessness, who are entering shelter through intake, or who are currently residing in a shelter or safe haven. In alignment with City and State laws governing the right to shelter and the Americans with Disabilities Act, HRA/DHS provide reasonable accommodations to all clients upon demonstration of need.

As per New York State regulations 18 NYCRR Part 491.9(c): “A social services district shall not, without the approval of the office, place any person in a shelter for adults, a small-capacity shelter, or a shelter for adult families who: (1) has a mental or physical condition that makes such placement inappropriate or otherwise may cause danger to himself/herself or others; (2) requires services beyond those that the shelter is authorized to provide by law and regulation, and by an operational plan approved by the office; (3) is likely to substantially interfere with the health, safety, welfare, care or comfort of other residents; (4) is 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; (5) 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 the facility is equipped with an elevator; (6) has a generalized systemic communicable disease or a readily communicable local infection which cannot be properly isolated and quarantined in the facility.”

Please note that while shelters may be equipped with mental health services/supports and/or some may have qualified medical providers on site, shelters are not assisted living facilities, psychiatric centers, or medical institutions; as such, 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 and no shelters or Safe Havens have 24/7 healthcare. Access to medical care should not be predicated on homelessness or residence in a shelter. While onsite medical services provide key supports in some circumstances, referrals to community-based care that can continue after a family or individual moves to permanent housing are central to the DHS mission.

Shelter Medical Programs in 2024

In addition to having medical services available on-site at some shelters or by referral in all shelters, system-wide medical programs increase in availability in shelters were implemented or continued in 2024, including:

- Promoting connections to H+H Virtual Expresscare, a virtual urgent care service for DHS clients, regardless of insurance status
- Continuing Nurse Call Line so clients can speak to a nurse 24/7 and ask questions or request referrals to services
- Centralized care coordination provided by health staff in the DHS medical office
- Enhanced discharge planning to ensure a safe hospital discharge and coordinate entry to shelter directly from hospital
- Close collaboration with the public hospital system and providers of healthcare for the homeless
- Infectious disease response, infection control, and outbreak prevention, in partnership with the local health department

1. The total number of shelters and facilities with on-site medical services

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 performed a count of all the shelter programs and collected information about availability of on-site medical services. On-site medical services through co-located clinics, mobile health clinics, or contracted visiting medical provider. A total of 81 (14%) DHS shelters and 1(2%) Domestic Violence shelters report providing on-site medical health services in 2024 (Table 1).

Table 1: Number of shelter programs and shelter programs with on-site medical services, 2024

	Number of shelters	Number of shelters with on-site medical services[1]
DHS Shelters	**561**	**81**
Single adults	**171**	**43**
Streets[2]	**51**	**29**
Veterans short term housing/Criminal Justice Shelter	**1**	**1**
Adult Families	**14**	**4**
Families with Children	**324**	**4**
Domestic Violence Shelters	**54**	**1**
Domestic Violence Emergency Shelters	**42**	**0**
Domestic Violence Tier II shelters	**12**	**1**
HASA Facilities	**82**	**0**
Emergency SRO /Family Provider Sites	**69/12**	**0**
Emergency Transitional Provider Sites	**13**	**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

New York City Department of Homeless Services Intake Centers

Families with children

Families with children enter DHS shelter through the central intake center called the Prevention Assistance and Temporary Housing (PATH) center. Families that report a health issue at intake and those with specific medical needs (such as pregnant people, families with infants or who have a member with an acute medical condition or recent hospitalization) have the opportunity to access the clinic at PATH, which is operated by a Federally Qualified Health Center (FQHC). The clinic provides health screening, urgent care services, referrals, health education, and coordination with the client's

[1] This data is derived from a Point in Time (PIT) count conducted in Summer 2024 by the DSS Health Services Office
[2] Streets includes Safe Havens, Drop in Centers, and Stabilization Beds.

existing health care providers as needed. Pregnant people and those with infants who are eligible are referred to the NYC DOHMH Nurse Family Partnership and Newborn Home Visiting Programs.

Single adults

Single adults enter DHS shelter through a central Intake Center and then are placed in an Assessment Shelter for an average of 21 days. During this time, single adult clients are offered medical and behavioral assessments at onsite clinics operated by contracted medical providers, including medical history and physical, routine laboratory testing and infectious disease screening, urgent care and referrals for community care. Participation in medical services is voluntary. Medical visits are generally scheduled within five to ten days of the client's arrival to intake, with urgent care and telehealth services available on-demand as needed. Throughout 2024, Intake clinics have worked diligently – and continue to do so – to adapt and respond to the unique needs of new populations and client's entering New York City shelter system.

Adult families

For adult families going through intake, staff do an assessment using a self-report client questionnaire. Clinical assessments are not conducted by a clinician at adult family intake.

Human Resource Administration Domestic Violence Services

New York City's Domestic Violence (DV) shelter system is managed by the Human Resources Administration's (HRA) Domestic Violence Services (DVS) program, which oversees 54 shelters dedicated to supporting individuals and families affected by domestic violence. These shelters are designed to provide a safe and stable environment where clients can begin to address the trauma they have experienced, develop stronger coping skills, and work toward greater self-sufficiency. Entry into the DV shelter system is available through several channels, with the NYC Domestic Violence Hotline serving as the primary point of access. Through the hotline, survivors are connected with advocates who offer counseling, information, and guidance on available resources to help ensure the safety of survivors and their families.

The DV shelter system is committed to inclusivity, providing services to all victims of domestic violence regardless of race, creed, color, national origin, sexual orientation, gender identity or expression, military status, sex, marital status, disability, or immigration status. Within the residential programs, clients receive a comprehensive array of services, including individual counseling, advocacy, psycho-educational groups, and trauma-focused interventions. Additional support is available for childcare, benefit entitlement application assistance, financial development, workforce readiness, and connections to permanent housing. When requested, clients are also referred to appropriate community-based services that address their unique needs, such as employment assistance, legal services, medical care, and mental health support.

Upon arrival at a domestic violence shelter, as required by State mandate a client will be assessed within 48 hours of arrival and undergo an intake interview. While OCFS licensed Emergency DV shelters must

assess whether they can meet a residential client's physical and personal needs, including determining if a residential client requires a level of medical care that the shelter cannot safely provide, they are not required to provide on-site medical services as part of their core offerings. Emergency shelters may assist residents in accessing medical care in the community if needed. Medical services are not mandated to be provided on site in Office of Temporary and Disability Assistance (OTDA) Tier II DV shelters. OTDA regulations require that if a medical or mental health need is identified, referrals should be made to appropriate services in the community.

HIV/AIDS Services Administration

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). The CASACs are staffed within HRA's Customized Assistance Services (CAS) program and offer clients 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 HIPAA release, so staff are able to access health records in order to confirm eligibility.

3. Description of medical services provided at drop-in centers and safe havens

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

Safe Havens, Stabilization Beds, Welcome Centers and Drop-in Centers either have mental health, health and substance use services on site, or can make referrals to off-site services.

All placements to low-barrier street beds, including safe havens, stabilization beds and welcome centers are processed through the Joint Command Center (JCC). These low barrier beds do not have curfews and clients may be out of their beds for up to three days without losing such beds. Welcome Centers act as an assessment center for individuals experiencing street homelessness who are not well known to DHS or clients who have demonstrated that have been able to remain stable in previous transitional housing settings. Welcome Centers may refer clients to Safe Havens, Stabilization Beds, or the Adult Homeless System. Safe Havens are the most clinically intensive programs within the street portfolio. These sites are intended to serve the highest needs clients. Stabilization Beds are less clinically intensive and intended to serve clients with less intensive clinical needs.

4. Description of medical services provided to the unsheltered homeless population

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 use a harm-reduction approach to build trusting relationships with unsheltered individuals who have historically rejected services. Outreach teams remain committed to revisiting, reengaging and monitoring our most vulnerable unsheltered clients, who may not be ready to accept services. In doing this, they help to ensure their safety and reduce the risk of injury or death, while continuing to discuss the services and resources available to them. Outreach teams also perform crisis intervention assessments and work on identifying appropriate placements through on-going case management and supportive services, including linking clients to medical benefits. The outreach teams meet people "where they are"— whether by conducting medical or psychiatric evaluations on the street or by connecting clients with an outreach worker who can speak to them in their native language.

Each of the street outreach teams have street medicine teams attached to them. These teams include a prescriber and a nurse who go into the field and attempt to connect individuals experiencing unsheltered homelessness to medical, mental health, and substance use services.

DHS also has Coordinated Behavior Health Taskforces (CBHT-3) which focus on some of the City's most vulnerable street homeless individuals. The CBHT brings together multiple City and State agencies to coordinate services for individuals suffering from complex combinations of street homelessness and mental illness.

DHS also has the Partnership Assistance for Transit Homelessness (PATH) and Subway Co-Response Outreach Teams (SCOUT) Programs which involve clinicians going into the field and offering mental health assessments to clients suffering from severe mental illness. Where appropriate, these clinicians will remove clients to hospitals for assessments.

As of the end of CYQ1 2024:

- 3,555 HOME-STAT/StreetSmart clients on the street (and other settings)[3]
- 766 prospective clients engaged by teams to assess living situations

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-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 know as the City's "by-name list" of street homeless individuals.

At the end of CYQ2 2024:

- 3,252 HOME-STAT/StreetSmart clients on the street (and other settings),
- 865 prospective clients engaged by teams to assess living situations

At the end of CYQ3 2024:

- 3,688 HOME-STAT/StreetSmart clients on the street (and other settings),
- 617 prospective clients engaged by teams to assess living situations

At the end of CYQ4 2024:

- 3,908 HOME-STAT/StreetSmart clients on the street (and other settings),
- 800 prospective clients engaged by teams to assess living situations

In calendar year 2024, 551*individuals were transported to the hospital by outreach teams.

**This data may include removals that were initiated pursuant to section 9.58 of the Mental Hygiene Law due to the ways in which this information was recorded. DSS is working to streamline the manner in which this information is reported for future submissions of this report. Additionally, the total quantity of removals initiated for calendar year 2024 pursuant to section 9.58 of the Mental Hygiene Law has been provided as required in DSS' report on Mental Health Services Provided in Shelters required pursuant to LL 115 of 2017.*

5. Ten most common self-reported medical health issues among adults and children at intake/assessment

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

Table 2 and Table 3 (below) display the top 10 self-reported medical conditions among adults in Adult Families, Single Adults, and Families with Children shelters. This self-reported data is collected 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 2024.

The same client may report several medical conditions, so these data are not mutually exclusive. These counts include clients that turned 18 while in shelter during 2024. Asthma was the leading medical condition reported by adults in Families with Children and Adult Families shelters. Among adults in single adult shelters, hypertension was the leading medical condition.

Table 2. Top ten self-reported medical conditions at intake/assessment for adults entering adult families shelters, January 1, 2024 – December 31, 2024

Rank	Medical Condition	N
1	Asthma	587
2	Hypertension/high blood pressure	583
3	Diabetes (Type 1/2/diet-controlled)	430
4	Back pain or herniated, slipped disc	282
5	Allergies (seasonal or medications)	249
6	Arthritis or other joint disease	232
7	High cholesterol	195
8	Other Serious Medical Condition	166
9	Heart/cardiac (CAD/MI/CHF/Afib)	164
10	Unable to climb stairs	138

Table 3. Top ten self-reported medical conditions at intake/assessment among single adults entering shelters, January 1, 2024 – December 31, 2024

Rank	Medical Condition	N
1	Hypertension/high blood pressure	4,068
2	Asthma	2,907
3	Diabetes (Type 1/2/diet-controlled)	2,593
4	Other Serious Medical Condition	1,629
5	Back pain or herniated, slipped disc	1,522
6	Arthritis or other joint disease	1,499
7	Unable to climb stairs	1,220
8	High cholesterol	1,052
9	Heart/cardiac (CAD/MI/CHF/Afib)	978
10	Seizure disorder/epilepsy	616

Table 4. Top ten self-reported medical conditions at intake/assessment for adults in families with children shelters, January 1, 2024 – December 31, 2024

Rank	Medical Condition	N
1	Asthma	1,440
2	Hypertension/high blood pressure	762
3	Diabetes (Type 1/2/diet-controlled)	571
4	Allergies (seasonal or medications)	358
5	Other Serious Medical Condition	338
6	Back pain or herniated, slipped disc	327
7	Anemia	308
8	Pregnancy (high-risk/pre-term labor)	266
9	Arthritis or other joint disease	217
10	Unable to climb stairs	207

Note: These counts include clients that turned 18 while in shelter during 2024

The DSS Health Services Office/DHS Office of the Medical Director collects self-reported medical conditions from new families applying for shelter at the Families with Children (FWC) intake center (PATH) who are seen in the onsite clinic, including medical conditions among children in the family as reported by the head of household. Families seen at the PATH clinic includes those who report a health issue at intake (e.g., feeling sick or have a contagious condition) or those who present to the clinic for another issue (e.g., pregnancy, recent hospitalization).

The self-reported medical conditions among children seen at the PATH clinic in 2024 could not be reported because of a technical issue in the database where the information is reported and stored, however, year over year, the most commonly reported medical condition among children entering shelter is asthma. More cases of asthma are reported than of the other 9 conditions in the top 10 combined. In past years, approximately 20% of children assessed at PATH have reported at least one medical condition.

6. Ten most common medical issues among adults and children living in shelters

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 outline the 10 most common medical conditions among children (Table 5) and adults (Tables 6 and 7) living in shelter as reported by medical providers. In 2024, asthma was the leading medical condition reported among children and adults in the families with children assessment clinic at PATH, and hypertension was the leading medical condition reported by single adult assessment clinics.

Table 5. Ten most common medical conditions among children as reported by the medical provider at PATH, January 1, 2024 - December 31, 2024

Rank	Medical conditions
1	Asthma
2	Dermatitis
3	Anemia
4	Epilepsy and Seizures
5	Heart Disease
6	Diabetes
7	Hypertension
8	Sickle Cell disease
9	Gastro-esophageal reflux disease
10	Scoliosis

Note: includes developmental conditions

Table 6. Ten most common medical conditions among adults in in family with children shelters as reported by the medical provider at PATH, January 1, 2024 – December 31, 2024

Rank	Medical conditions
1	Asthma
2	Anemia
3	Hypertension
4	High Risk Pregnancy
5	Diabetes
6	Heart Disease
7	Epilepsy and Seizures
8	Obesity
9	Gastro-esophageal reflux disease
10	Cancer

Table 7. Ten most common medical conditions among single adults as reported by the medical providers at adult assessment shelters, January 1, 2024 – December 31, 2024

Rank	Medical Condition
1	Hypertension
2	Obesity
3	Diabetes
4	Asthma
5	Hyperlipidemia
6	Vitamin D Deficiency
7	Arthritis
8	Heart Disease
9	Gastro-esophageal reflux disease
10	Epilepsy and Seizures

7. Number entering shelter who self-report having been discharged from hospital to shelter

The number of individuals entering shelter who self-report having been "discharged" from a hospital to a shelter*

In 2024, 506 individuals entering shelter as single adults reported having been discharged from a hospital to shelter.

Table 8. Number of single adults entering shelter who self-reported having been discharged from a hospital to a shelter, January 1, 2024 – December 31, 2024

Please note in previous versions of this table, genders other than Men were captured in the Women category. For this year, we've included an 'Other/unknown' category.

Prior Residence – Single Adult entrants in 2024	**Women**		**Men**		**Other / unknown**		**Total**	
Hospital	147	1.6%	358	1.2%	1	0.0%	506	1.3%

*LL114 captures the number of single adults who self-report "discharge" from a hospital or medical facility as a reason for entering shelter. Because this information is self-reported, it may include but is not limited to those who have been formally/officially discharged from a hospital or medical facility by the institution. For example, the number above could include someone who reported "discharge" from a hospital or medical facility as a reason for entering shelter, but was not formally referred to shelter by the hospital: i.e. an individual visited and departed a hospital on their own, but called this a "discharge" or was discharged from a hospital to alternative housing before losing that housing and seeking shelter. Alternatively, the number could exclude someone who was, in fact, officially discharged and referred to shelter from a hospital or medical facility, and may have chosen to self-report a different "reason" for their homelessness and not disclose their discharge. This number does not represent the verified number of formal "discharges"/referrals from hospitals or similar institutions to shelter.

8. Number entering shelter who self-report having been discharged from nursing home to shelter

The number of individuals new to the shelter system who self-report having been "discharged" from a nursing home to a shelter*

In 2024, 53 individuals entering shelter as single adults reported having been discharged from a nursing home to a shelter.

Table 9. Number of single adults entering shelter who self-reported having been discharged from a nursing home to a shelter, January 1, 2024 – December 31, 2024

Please note in previous versions of this table, genders other than Men were captured in the Women category. For this year, we've included an 'Other/unknown' category.

Prior Residence – Single Adult entrants in 2024	**Women**		**Men**		**Other / unknown**		**Total**	
Nursing Home	13	0.1%	40	0.1%	0	0.0%	53	0.01%

*LL114 captures the number of single adults who self-report "discharge" from a hospital or medical facility/nursing home as a reason for entering shelter. Because this information is self-reported, it may include but is not limited to those who have been formally/officially discharged from a hospital or medical facility/nursing home by the institution. For example, the number above could include someone who reported "discharge" from a hospital or medical facility/nursing home as a reason for entering shelter, but was not formally referred to shelter by the hospital: i.e. an individual visited and departed a hospital on their own, but called this a "discharge" or was discharged from a hospital to alternative housing before losing that housing and seeking shelter. Alternatively, the number could exclude someone who was, in fact, officially discharged and referred to shelter from a hospital or medical facility/nursing home, and may have chosen to self-report a different "reason" for their homelessness and not disclose their discharge. This number does not represent the verified number of formal "discharges"/referrals from hospitals or similar institutions to shelter.

9. Metrics relevant to the provision of medical health services

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. Most frequent causes of hospitalizations for homeless adults (SPARCS)

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.

DHS shelter data is provided to Statewide Planning and Research Cooperative System (SPARCS) for matching annually, but reporting is delayed by one year due to the timing of the availability of the analytic dataset. The table below outlines the most frequent admitting diagnoses of hospitalizations for homeless adults in 2023 according to data from SPARCS. Diagnoses were identified using the Clinical Classifications Software Refined (CCSR) for ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) Diagnoses. In 2023, the top 3 admitting diagnoses were for behavioral health conditions.

Table 10. Ten most common admitting diagnoses for hospitalizations of adults experiencing homelessness who spent at least one night in a New York City Department of Homeless Services shelter, January 1, 2023 – December 31, 2023

Rank	Admitting Diagnosis
1	Alcohol-related disorders
2	Schizophrenia spectrum and other psychotic disorders
3	Other specified substance-related disorders
4	Nonspecific chest pain
5	Respiratory signs and symptoms
6	Skin and subcutaneous tissue infections
7	Abdominal pain and other digestive/abdomen signs and symptoms
8	Epilepsy; convulsions
9	Nervous system signs and symptoms
10	Musculoskeletal pain, not low back pain

Note: This publication was produced from raw data purchased from or provided by the New York State Department of Health (NYSDOH). However, the conclusions derived, calculations, and views expressed herein are those of the author(s) and do not reflect the conclusions or views of NYSDOH. NYSDOH, its employees, officers, and agents make no representation, warranty or guarantee as to the accuracy, completeness, currency, or suitability of the information provided here.