FOCUS ON HOMELESSNESS IN LOS ANGELES COUNTY:

Aligning Hospitals, Health Systems, and Other Stakeholders to Identify and Implement Effective, Scalable Solutions

MAY 2024

LA PARTNERSHIP

COMMUNITIES LIFTING COMMUNITIES®

HOSPITAL ASSOCIATION of Southern California

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EXECUTIVE SUMMARY

Rising homelessness in California is a statewide challenge, as well as in Los Angeles County and other primarily urban areas throughout the state. The alarming and rapidly growing number of people experiencing homelessness (PEH) and the additional operational and economic costs related to caring for unhoused patients in hospital emergency departments (EDs) has resulted in challenging and unsustainable impacts for many hospitals and health systems.

In 2021, consensus emerged among Los Angeles County Health Assessment and Action Partnership (LA Partnership) collaborative members that homelessness is a shared and regulatory issue for hospitals. The collaborative selected this topic as its health priority area. The LA Partnership consists of more than 30 nonprofit hospitals, health systems, public health departments, and community partners. Communities Lifting Communities (CLC) conducted key informant interviews with LA Partnership member hospitals, the Los Angeles County Department of Public Health (LADPH), the Community Clinic Association of Los Angeles County (CCALAC), and other stakeholders in collaboration with the LA Partnership and the Center to Advance Community Health and Equity (CACHE), a fiscally sponsored program of the Public Health Institute. In addition, the homeless population ED utilization data was analyzed and Service Planning Areas (SPAs) in LA County with the highest concentrations of PEH were identified. The intent of this data collection and analysis was to identify communities where each hospital would have justification to align strategies across organizations in a portion of their defined service area.

This report examines and highlights current and planned hospital strategies for services, program supports, and investments to address homelessness in LA County. Opportunities for hospitals to collaborate to amplify and expand their impact, and potentially benefit other communities, are included as emerging best practices. Sample interventions offered by hospitals, and in some cases in alliance with other facilities and organizations, occur in three categories: **street medicine, recuperative care, and community health navigator programs**. There is also interest among LA Partnership members in **strategic data collection and analysis** and **best practice learning**. Affordable housing was also mentioned as a strategy implemented by several large health systems. Affordable housing does not fall within the scope and the range of commitment of resources that LA Partnership members have on behalf of their organizations and therefore, is not discussed in this report.

The challenges and opportunities that were identified by hospitals to support collaboration across competitive lines and align operational strategies to meet the demands of addressing homelessness are presented. The metrics and opportunities for alignment for health care leaders and stakeholders across the community provider, hospital, and public sector levels are discussed. Moving forward, LA Partnership colleagues will pursue an incremental approach to meet with hospital leaders to secure approval to proceed with a formal design of aligned strategies in the programmatic areas and identified subregions that allows hospitals and communities to build on collaboration.

GLOSSARY OF TERMS AND ACRONYMS

CACHE: Center to Advance Community Health and Equity, a fiscally sponsored program of the Public Health Institute. CACHE provided data analysis and consultation from January 2021 to October 2023

CES: Coordinated entry system

CHISs: Community health implementation strategies

CHN: Community health navigator

CHNAs: Community health needs assessments

CHW: Community health worker

CLC: Communities Lifting Communities is an affiliate 501(c)(3) nonprofit organization of the Hospital Association of Southern California and the backbone organization for the LA Partnership

CRCs: Community resource coordinators

ECM: Enhanced care management

ED: Emergency department

EHR: Electronic health record

FUSE: Frequent utilizer system engagement

HASC: Hospital Association of Southern California

HMIS: Homeless Management Information System

Homeless Navigators: Homeless navigators connect people experiencing homeless and families to the services, education, and resources they need, including food and basic necessities, key documents, transportation, job opportunities, health and mental health treatment, and both temporary shelter and permanent housing.

Homeless Patients: Reference to homeless patient encounters in the Department of Health Care Access and Information (HCAI) encounter database for any emergency department visit encounters coded with an ICD-10 diagnosis code of Z59.0, homelessness; Z59.01, sheltered homelessness; or Z59.02, unsheltered homelessness; or a zip code indicator, ZZZZZ/99999.

LACAHSA: LA County Affordable Housing Solutions Agency

LADPH: Los Angeles County Department of Public Health

LAHSA: Los Angeles Housing Services Authority

LA Partnership: Los Angeles County Community Health Assessment and Action Partnership

MCPs: Managed care plans

PEH: People experiencing homelessness

PSH: Permanent supportive housing

SDOH: Social determinants of health

SPAs: Service Planning Areas

SUD Navigators: Substance use disorder navigators

INTRODUCTION

The homelessness crisis in California continues to be a challenge for hospitals and the health care system, in general. In Southern California – as in other large, metropolitan areas throughout the state – many hospitals have additional costs associated with caring for people experiencing homelessness (PEH) and have difficulty finding available recuperative care beds and supportive housing post-discharge. In several cases, untreated mental illness and substance use disorders further compound the difficulty of meeting the medical (and other) needs of PEH.

The resulting operational and economic impact on hospitals and health systems has been both challenging and unsustainable. Engaging health care leadership and strengthening collaborative planning and investment among hospitals, public health agencies, and community stakeholders across competitive lines for a health priority and key community health improvement strategy will result in greater community impact.

Focus on Homelessness

The Los Angeles County Health Assessment and Action Partnership (LA Partnership) was established in 2016 to maximize the collective impact of community health activities in LA County. It pursues this goal by promoting best practices and alignment in community health needs assessments (CHNAs) and prevention-oriented implementation strategies among hospitals, public health agencies, and community partners. The LA Partnership is a collaborative of more than 30 nonprofit hospitals and health systems, public health departments, and community partners. LA Partnership collaborators are typically represented by community health and community benefit leaders. Members recognize that aligning their organizational priorities and strategic initiatives at the institutional level is a fundamental component of community health improvement work.

In October 2021, consensus emerged among members that homelessness is a shared and regulatory issue for hospitals, and it was selected as a health priority. Hospitals and health care systems are bearing an increasing financial burden for patients experiencing homelessness with more severe health conditions. Other entities outside hospitals also have the responsibility and potential capacity to respond. Hospital leaders agree that interventions and collaborations are needed both within hospitals and with community partners. The problem of homelessness requires coming together for the common good, commitment to aligning assets across sectors, strategically focusing on communities where health inequities are prevalent, and identifying opportunities for immediate collaboration.

In 2022, Communities Lifting Communities (CLC), the Hospital Association of Southern California (HASC), and the Center to Advance Community Health and Equity (CACHE), a fiscally sponsored program of the Public Health Institute, collaborated to conduct key informant interviews with 20 LA Partnership members to discuss locations, design, partners, timing, and other details about homeless services, activities, and investments at each hospital.

Based upon the interview results, data analysis of Community Health Needs Assessment (CHNAs), community health implementation strategies, SB 697 reports, and facilitated learning collaborative meetings, the team identified communities experiencing the greatest inequities where each hospital would have justification to align in a portion of their defined service area.

Sample interventions offered by hospitals, and in some cases in alliance with other facilities and organizations, occur in three categories: **street medicine, recuperative care, and community health navigator programs**. LA Partnership members are also interested in **strategic data collection and analysis** and **best practice learning**. (Affordable housing, as it is a leading driver of homelessness, was also mentioned as a strategy implemented by several large health systems. However, this area does not fall within the scope and commitment of resources of LA Partnership members and therefore is not discussed in this report.)

The goals of the LA Partnership homelessness initiative are to:

- Produce measurable, impactful solutions at scale. These range from near-term outcomes such as reducing preventable ED and inpatient utilization to long-term solutions, e.g., increasing the number of recuperative care beds and street medicine visits.
- Identify opportunities to engage other private sector stakeholders, such as financial institutions, large employers, and others, as co-investors.
- Position health care leaders as powerful advocates for local/regional policy development to assist in addressing the drivers of homelessness.

Emergency Department Encounters by Population Identified as Experiencing Homelessness

The rapidly growing number of people experiencing homelessness (PEH), and the additional operational and economic costs related to caring for unhoused patients in EDs, has resulted in challenging and unsustainable impacts.

The number of Southern California hospital encounters by PEH was acquired through filtering the California Department of Health Care Access and Information (HCAI) encounter database via the SpeedTrack application for 2016 to 2022 for any ED visits coded with either the:
- ICD-10 diagnosis code of Z59.0, homelessness; Z59.01, sheltered homelessness; ornZ59.02, unsheltered homelessness; or
- Zip code indicator ZZZZZ/99999.

Table 1 below displays ED encounters by the patient population identified as "homeless" for treatment and release in HASC region hospitals in Los Angeles, Orange, Riverside, San Bernardino, Santa Barbara, and Ventura counties from 2016 to 2022. The data show an increasing trend of ED encounters by PEH, from a total of 41,032 visits in 2016 to 143,454 visits as of 2022. LA County leads all HASC counties with a significantly large increase in ED encounters from 2016 to 2022. However, all counties in the HASC region experienced the largest spike in visits from 2018 to 2019. Also, while homeless patient ED encounters slightly decreased from 2019 to 2021 in LA and Orange counties, the other counties are still seeing increases. The overall volume across the HASC region is approximately 102,422 more homeless encounters in the ED in 2022 than in 2016.

Table 1: ED Encounters by Population Identified as Homeless by County

County	2016	2017	2018	2019	2020	2021	2022
Los Angeles	26,063	31,958	40,196	93,636	92,856	90,786	89,611
Orange	6,641	8,729	8,979	19,354	17,887	15,683	16,095
Riverside	2,799	3,270	4,247	10,919	10,650	10,680	12,694
San Bernardino	2,691	3,684	4,525	12,852	14,109	14,212	15,851
Santa Barbara	1,277	1,486	1,685	3,665	4,381	4,636	4,900
Ventura	1,561	2,029	2,073	3,615	3,912	4,105	4,303
HASC Region	**41,032**	**51,156**	**61,705**	**144,041**	**143,795**	**140,102**	**143,454**

DATA COLLECTION AND ANALYSIS

CACHE's role in the LA Partnership homelessness initiative from January 2021 to October 2023 was to support CLC with facilitating partner engagement in key informant interviews, data collection and analysis, and to serve as a subject matter expert. CACHE reviewed publicly available documents such as community health needs assessments (CHNAs), community health implementation strategies (CHISs), and SB 697 reports for relevant information about area hospitals' current and planned strategies for services, program support and investments to address homelessness.

Key Informant Interviews

CLC and CACHE conducted key informant interviews with 20 LA Partnership member hospitals and health systems to obtain additional, more specific information from the individual facilities (refer to Interview Questions, Appendix A). Interviewees responded to questions on data collection and analysis to assess needs and coordinate services and supports for PEH; the types of services and activities each hospital has in place to address homelessness, along with their location and timing; names of organizations they partner with, and their measurable objectives.

"A major part of our effort to date has been inventorying what the hospitals are currently doing to address health inequities and homelessness," said Jonathan Schreiber, vice president of community engagement, Cedars-Sinai. "Knowing what programs and services are already out there and in what areas helps us determine whether there are opportunities for the hospitals to collaborate and amplify their impact.

"As a group, we're focused on identifying innovative and effective programs and services in specific areas that could potentially benefit other communities as well. Understanding what community programs are being provided by other facilities in their area helps hospitals eliminate siloed activity and promotes collaboration."

The interviews sought to identify current and planned homeless services and activities that presented opportunities for alignment in at least two specific neighborhoods and/or with a minimum of two health care organizations. Participants were asked what data is collected and which sources provide information needed to assess the needs and coordinate services and supports for PEH. Identified data collection sources are as follows:

- Hospital-encounter data comes from electronic health records (EHRs).
- Public-sector data comes from HMIS and the Department of Mental Health.
- EDs collect SDOH, psychological, and SB1152 data.
- National data comes from the National Health Care for the Homeless Council (NHCHC), Housing and Urban Development (HUD), County Health Rankings & Roadmaps, and the Healthy Places Index.

Data Collection and Analysis Recommendations

Hospitals and health systems are centering equity in their collection, review, and reporting of their organization's unhoused patient data to assess if their data gathering and use practices are equitable and inform improvement strategies and organizational policies. The following recommendations are additional opportunities for hospitals to improve their equity-centering efforts in collecting, reviewing, and reporting PEH data.

Centering Equity in Data Collection
- Data is collected on unhoused patient demographics and other identities, with emphasis on self-identification and self-reporting.
- Data is collected on unhoused patients' SDOH, using ICD-10-CM Z Codes and categories including homelessness, inadequate housing, housing instability, lack of adequate food, transportation, and financial insecurity.[1]
- Data is collected on SB 1152 requirements.
- Data is collected on the number of unhoused patients placed in a sheltered environment after an ED visit or hospital admission.
- Data is collected on the number of patients who stay connected to care and improve their health status.

Centering Equity in Data Review
- Health care providers are trained on best practices for reviewing data about race, ethnicity, other identities, and SDOH.
- Health care providers review race and ethnicity data and compare it to local point-in-time counts and Homeless Management Information System (HMIS) data to ensure providing equitable access to services.

Centering Equity in Data Reporting
- Unhoused patient and SDOH data is communicated to leadership, staff, board members, and the community with full transparency on a regular basis.
- Unhoused patient and SDOH data is used to inform equity improvement strategies and organizational policy.

Employing a data-informed strategy for hospitals to address health inequities and homelessness can prompt them to focus on the operational impact of programs and services they currently provide, rather than just viewing them as community benefit expenditures. Findings showed hospitals are challenged with a lack of access to HMIS and other county program data systems to know where patients are enrolled and beds are available.

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[1] "Improving The Collection of Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes," cms.gov

To date, the hospital and health systems' approach in HASC's Los Angeles region has been siloed and fragmented. The LA Partnership endeavors to plan and implement a collaborative approach to finding effective, scalable solutions to better serve unsheltered patients while alleviating the financial and logistical strain of homelessness on their EDs. Any collaboration faces challenges, including disparate data sources used, competition within markets, funding requirements, differing leadership priorities, and regulatory obstacles. We are taking an incremental approach to building a collaborative strategy, taking advantage of immediate opportunities to build momentum and visibility, and expanding on those early successes over the coming year.

Homeless Population Emergency Department Utilization Among Interviewed Hospitals

RFor the 20 hospitals that participated in the key informant interviews, the total number of homeless patients utilizing the ED increased from 5,914 in 2016 to 13,700 in 2022 (Table 2). Each individual patient is identified through a unique, randomly generated identifier. The number of PEH encounters in Southern California hospitals was acquired through filtering the HCAI encounter database via the SpeedTrack application for 2016 to 2022 for any ED visits coded with either:

- An ICD-10 diagnosis code of Z59.0, homelessness; Z59.01, sheltered homelessness; or Z59.02, unsheltered homelessness; or
- A zip code indicator, ZZZZZ/99999.

Overall, identified homeless patients averaged nearly three ED visits per year. The top 25 homeless patients who utilized the ED averaged 106 visits in 2022. This list of patients will vary by year, although there is some year-over-year consistency. The individual with the greatest number of ED encounters had 86 encounters over the course of five years.

Table 2: ED Utilization by High-cost, High-need Homeless Patients

Hospital	2016	2017	2018	2019	2020	2021	2022
Total Homeless Utilizers	5,914	7,522	9,905	14,378	13,762	13,496	13,700
Total ED Visits	13,039	16,441	22,891	38,402	38,769	38,613	38,830
Average Visits Per Homeless Patient	2.2	2.2	2.3	2.7	2.8	2.9	2.8
ED Visits by Top 25 by Year	1,038	1,146	1,598	2,204	2,326	2,498	2,651
Average Visit Per Top 25 Patient	41.5	45.8	63.9	88.1	93.0	100.0	106.0

Among the 20 LA Partnership hospitals interviewed, homeless patient ED encounters are a small but growing fraction of the overall ED volume (refer to Table 3). With better coding and identification, the hospitals recorded that 1.2% of ED patients identified as homeless in 2016 and 3.6% in 2022.

Table 3: Homeless Emergency Department Encounters to Total Volume

|	2016	2017	2018	2019	2020	2021	2022
ED Visit Identified as Homeless	13,039	16,441	22,891	38,402	38,769	38,613	38,830
Total ED Visits	1,092,384	1,144,624	1,150,931	1,173,298	870,964	958,503	1,068,691
Identified Homeless as Share of Total ED Volume	1.2%	1.4%	2.0%	3.3%	4.5%	4.0%	3.6%

DETERMINING WHERE INEQUITIES ARE CONCENTRATED

In addition to obtaining information through key informant interviews, the team collected and analyzed data to identify sub-geographic areas in LA where health inequities and homelessness are concentrated. CACHE used the Vulnerable Footprint Population tool to assess census tracts in the Los Angeles County Service Planning Areas (SPAs) where LA Partnership hospitals are located. Poverty and high-school completion rates were used as indicators of SDOH that can accurately predict levels of homelessness in those communities. Utilizing this data, areas identified as having the highest concentrations of PEH and greatest inequities include:

- **SPA: 2 Panorama City**
- **SPA 4: Boyle Heights (Northwest), Convention Center area and Skid Row**
- **SPA 6: Compton**

The following diagram details the Los Angeles County SPA map, showing where the LA Partnership hospitals interviewed are located. **Seven hospitals are located in SPA 2, five in SPA 4, three in SPA 5, four in SPA 8 and one in SPA 7.** Most of the LA Partnership hospitals are located in SPAs 2 and 4, which are identified as having sub-geographic regions with the highest concentrations of PEH and the greatest need. Identifying strategies that hospitals in these subgeographic areas are currently undertaking can reveal how they might align efforts with other providers' activities.

Figure 1: LA Partnership hospitals interviewed on Los Angeles County SPA Map
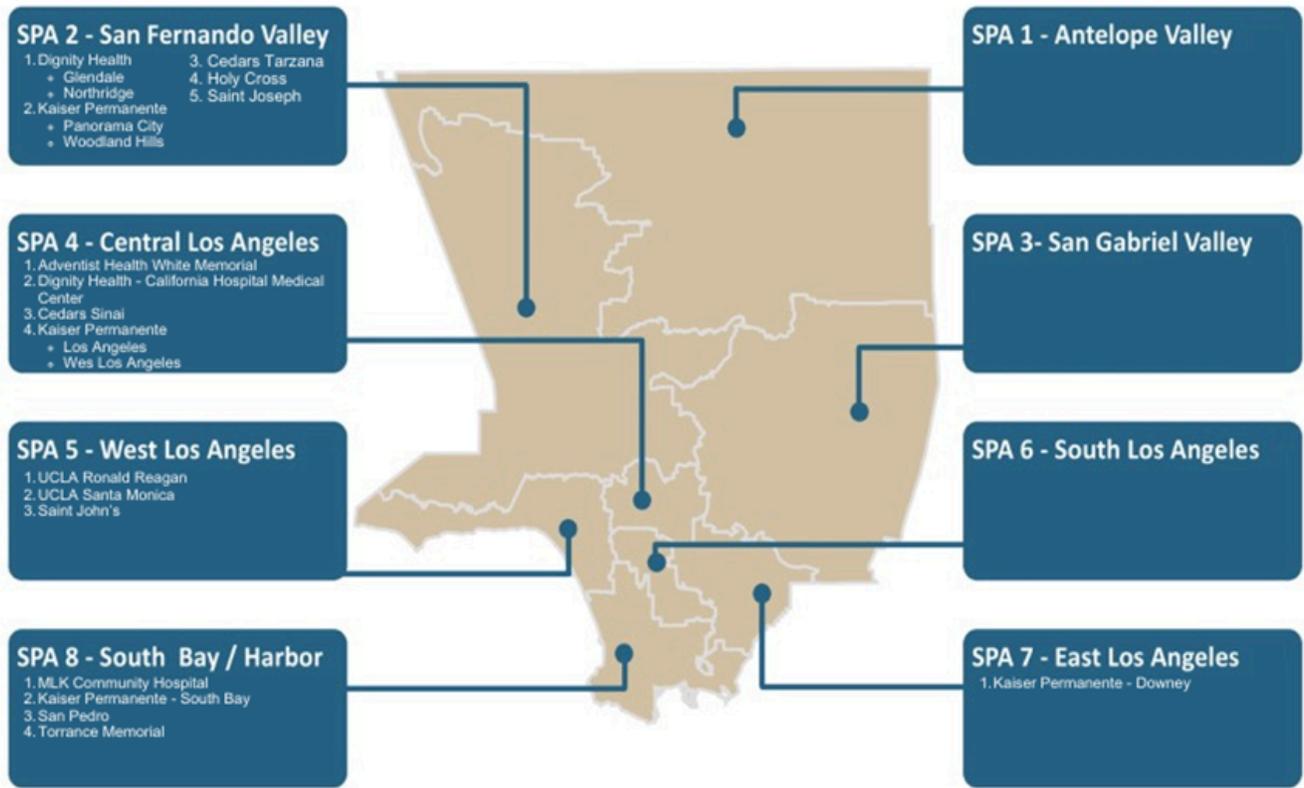
SAMPLE INTERVENTIONS IN PROGRESS

As this report demonstrates, some hospitals and health systems in LA County are taking individual actions or forming alliances to find ways to help relieve the impact of caring for ever-increasing numbers of unhoused patients. These individual and collaborative interventions generally occur in three categories: **street medicine, recuperative care, and community health navigator programs.** LA Partnership members also are interested in **strategic data collection and analysis** and **best practice learning.**

Street Medicine

Several hospitals have active **street medicine** programs or partnerships designed to bring medical care, behavioral health, substance use disorder, and social services directly to PEH in their lived environment. Four street medicine programs are presented:

UCLA Health Homeless Healthcare Collaborative

UCLA Health launched its Homeless Healthcare Collaborative in January 2022. Its mission is to promote greater health equity and improved clinical outcomes for PEH in Los Angeles and to improve access to and receipt of comprehensive, timely health care and social services. Through four mobile clinic vans, the collaborative meets patients where they are to increase accessibility to high-quality primary and urgent care services. UCLA Health has plans to launch two more vans during 2024, offering specialty care such as women's health, dermatology, and podiatry.

Mobile clinic staffing includes:
- Doctors, nurse practitioner (NP), physician assistant (PA), nurses, medical assistants
- Social workers, community health workers
- Medical students, residents, nurse practitioner students

Services include:
- Preventive care (vaccines, disease screenings)
- Urgent care services (laceration repair, skin infections)
- Chronic disease assessment and monitoring
- Medications
- Behavioral health care
- Specialty care referrals
- Coordination of care

Each van operates five days a week, with schedules staggered so at least one van is available every day of the week, since many medical clinics and other services are closed on weekends.

The UCLA Health caregivers can dispense medications straight from the vans, as well as administer vaccines. Additionally, point-of-care lab equipment in the vans allows them to perform advanced blood work, with results generated within 15 minutes. Attempts are made to follow up with every patient within two days.

In 2022, the first year of launching, they dispensed over 1,500 medications directly to patients, completed over 9,000 patient encounters, and delivered over 2,300 medical and psychiatric evaluations. The UCLA health system has seen a 7% reduction in unhoused patients[2] visiting UCLA health ED and a 32% reduction in repeat ED visits by high-risk patients seen by their team. In 2023, four full-time teams dispensed 5,597 medications and completed 13,609 patient encounters with over 4,700 medical evaluations. In addition, 696 Narcan boxes were distributed.

Community partnerships are a key component of UCLA Health's Homeless Healthcare Collaborative, stretching from Santa Clarita to Lomita. They partner with a variety of different community and government based organizations to help identify people who need care. They also partner to help provide patient's wraparound services. The medical vans also provide care in different locations, including streets, encampments, shelters, tiny homes, and other interim housing sites.

For more information, visit Homeless Healthcare Collaborative, Los Angeles | UCLA Health.

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[2] UCLA Health, Homeless Healthcare Collaborative in Los Angeles: *Providing direct-in-community health care to unhoused adults and children.*(UCLA Health, 20..), https://www.uclahealth.org/programs/hhc.

MLK Community Healthcare Street Medicine Department

UIn South Los Angeles, MLK Community Healthcare (MLKCH) has developed a street medicine department and team to serve unhoused patients in their community. The interdisciplinary team consists of a medical director, nurse practitioner, nurse, social services, and street medicine manager, as well as two outreach coordinators with lived experience on the streets. The team regularly checks on former MLK Community Hospital patients who are unhoused. They refill prescriptions, provide wound care and substance use consultants, food, and water. They also provide housing navigation services and tenancy services under DHCS's California Advancing and Innovating Medi-Cal (CalAIM). In its first two years, the program has reduced PEH ED visits by 3% to 5% while also reducing extended hospital ED stays. [3]

Street medicine staffing includes:
- Doctor, NP, nurse
- Social worker
- Outreach coordinators

Services include:
- Post Discharge and continuity of care services
- Medications
- Behavioral health care
- Hospital consultations for PEH
- Coordination of care

As of January 2024, the MLKCH Street Medicine Department has served 482 patients with a total of 1,610 encounters, including 1,280 street rounds and 330 hospital consultations. Four hundred forty-two community members have also received outreach and harm reduction kits since August 2022. Patient demographics include an average age of 50 years; 52% Black or African American and 41% Hispanic or Latino; 80% speak English and 20% speak Spanish. Fifty-four percent of patients receive substance use treatment navigation and 13% have a severe mental health comorbidity.

MLK Community Healthcare Street Medicine

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[3] ABC7 Eyewitness News, *When the homeless can't get to a doctor, these professionals take medical training to the streets.* KABC Television, 2023, https://abc7.com/mlk-community-healthcare-abc7-solutions-homeless-homelessness/13905656

USC Street Medicine

According to the Street Medicine Institute, "Street medicine includes health and social services developed specifically to address the unique needs and circumstances of the unsheltered homeless delivered directly to them in their own environment."[4] The USC Street Medicine program allows the "streets to build the program." In 2023, there were four full-time teams that saw about 250 to 300 patients per team and had about 2,500 visits per team. This year, the team is comprised of five full-time teams and is on track to see over 1,200 unique patients and provide 10,000 visits throughout Los Angeles.

Services include:
- Urgent care/acute care
- Preventive care screening
- Diagnosis and management of chronic conditions
- Mental health diagnosis, treatment initiation and maintenance
- Medications
- Blood draw labs
- Medication-assisted therapy
- Point-of-care ultrasound
- Inpatient Consult Service
- Continuity of care from the hospital to the street

USC Street Medicine takes a holistic view of health, assisting with housing, food, insurance enrollment and financial resources, clean needle exchange, mail services, and clothing services.

The USC Street Medicine Inpatient consult service visits patients while admitted providing consultation based on knowledge of the streets, help with proper placement to avoid discharge to the street, and if the patient does go to the street, will follow up in the patient's environment to ensure a successful transition to outpatient care. Impacts of street medicine primary care when paired with a hospital-based consult service on hospital readmissions include a 75% reduction in hospital readmissions; a 37% reduction in hospital length of stay, from 12.5 days to 7.9 days, and a 38% success rate for housing placements.

Street medicine programs in California have grown from 27 to 61 in a year, with a great need for workforce development. As of October 2023, the Centers for Medicare & Medicaid Services (CMS) recognized a new Place of Service (POS) code, "27," for "Outreach Site/Street." CMS defines this site as "a non-permanent location on the street or found environment … where health professionals provide preventive, screening, diagnostic and/or treatment services to unsheltered homeless individuals." [5]

In March 2023, The California Street Medicine Landscape Survey and Report - California Health Care Foundation (chcf.org) was released, authored by Brett J. Feldman, MSPAS, PA-C; Corinne T. Feldman, MMS, PA-C; Alexis Coulourides Kogan, PhD; Sonali Saluja, MD, MPH, FACP, and Michael Cousineau, DrPH. The report was made possible by a grant from the California Health Care Foundation. This report includes recommendations to scale the street medicine care model in California to serve more PEH.

For more information, visit USC Street Medicine - Street Medicine.

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[4] Street Medicine Institute, About Us (streetmedicine.org)

[5] Centers for Medicare & Medicaid Services, New Place of Service (POS) Code 27 - "Outreach Site/Street" R12202CP | CMS October 2023

Healthcare in Action

Healthcare in Action's (HIA) mission is to improve the lives of PEH through quality holistic care. The vision is that all PEH have access to quality health care that addresses their mental and physical needs. HIA was founded in January 2022 and currently provides services in Los Angeles, Orange, San Bernardino, San Diego, San Mateo, and Riverside counties.

HIA takes a member-centered care coordination approach and practices street medicine by establishing rapport first, offering service and not judgment, building trust, planning together, and focusing on safety.

HIA's team structure for serving 200 patients:
- Care management supervisor
- Physician team leader
- Peer housing navigators
- Medical assistant clinical support partner
- Nurse practitioner/physician assistant
- Peer navigators/care management
- Additional clinical team members include a consulting psychiatrist, occupational therapist, behavioral health therapist, and RN/LVN for wound care and care delivery extension

Services include:
- Full scope primary care
- Clinical care management
- Mental health and substance use treatment
- Social work case management
- Housing navigation, including tenancy and deposit support
- Transportation to social services and other appointments
- Longitudinal care (e.g., care transitions, facilities, etc.)

The total number of patients served is over 6,000. In 2022, HIA housed 35 patients and in 2023 the number increased to 217. HIA has established clinical metrics and is collecting data on diagnosis and treatment of substance use disorders, diagnosis of mental illness, diagnosis and treatment of hypertension, ED visit and readmission rates, and patient experience through the net promoter score.

HIA street medicine services are funded by hospital and health system contracts, credentialed health plan partners and several municipal city contracts. HIA also seeks grants and contracts to both fund existing teams and scale-up new teams. For more information, visit Home (healthcareinaction.org).

"Investing in a mobile clinic for your street medicine program, for example, will have a direct savings impact on your overall budget and your emergency department," said Jim Tehan, Regional Director, Community Health, Providence Southern California. "That elevates your investment from just philanthropy and writing grants to meeting the strategic operational priorities of your organization. This is why it's so crucial to engage the C-suite leadership in any conversation about addressing homelessness."

Los Angeles County Street Medicine Coordination Workgroup

Convened by the Community Clinic Association of Los Angeles County (CCALAC), the workgroup aims to coordinate street medicine services among all providers in LA County to ensure linkages to specialty and direct care, medical homes, housing, and other supportive services. For more information, please visit LA County Street Medicine Coordination Workgroup - Community Clinic Association of Los Angeles County (ccalac.org)

Street Medicine Recommendations

Street medicine brings services out of the clinic and provides care directly on the street, in encampments, or from mobile vans, preventing medical conditions from deteriorating to the point of needing emergency care. Street medicine providers can usually provide the same primary care services on the street as in physical clinics. The following recommendations outline opportunities for hospitals and health care leaders to produce measurable, impactful street medicine solutions through co-investment opportunities, advocacy, ED operation improvements, and even a pilot program.

1. Join the Los Angeles County Street Medicine Coordination Workgroup
2. Identify co-investment opportunities to expand and strategically deploy street medicine teams in specific geographic areas experiencing the greatest inequities.
3. Advocate for optimal reimbursement for street medicine providers and visits, including direct access, with Medi-Cal managed care plans, the City of Los Angeles, and LA County.
4. Embed community health navigators in EDs and inpatient units to better coordinate comprehensive care for unhoused patients, enrollment in Medi-Cal and connections to street medicine teams, recuperative care, housing, and other services.
5. Embed an inpatient consult service in the hospital provided by the street medicine team which provides a consultation to the patient while admitted helping with proper placement and avoid discharging back to the streets, and if the patient does go to the street, the team follows up with patient's in their environment to ensure a successful transition to outpatient care.
6. Improve care coordination between street medicine teams and hospitals by developing a pilot program to offer telehealth consults, diagnostic imaging, advanced studies, and other services outside of the current street medicine scope.

Recuperative Care

To address the substantial cost and lack of availability of post-discharge beds for unhoused patients, several hospitals and health systems are acting on or developing plans to expand **recuperative care** (also known as medical respite) in their communities.

While some LA Partnership hospitals are forced to contract for recuperative beds far from their communities, such as Lancaster and Palmdale, others struggle with finding available recuperative care beds closer to home. Kaiser Permanente, Cedars-Sinai, Providence Health and Services, PIH Health, and other health systems provide grants to help nonprofit organizations in LA County expand their recuperative care programs.

For example, NHF received a grant in collaboration with Providence Southern California and the St. Joseph Community Partnership Fund to help build modular clinics for both primary and behavioral health services at the Arleta housing for older adults in the San Fernando Valley. Most of the funding is coming from the City of Los Angeles to help build the Arleta project which includes on-site direct medical care, nursing staff trained for the needs of older adults, meal programs, customized community activities, and staying connected with patients after they transfer to permanent housing. The Arleta Housing project is anticipated to open in spring 2024. The 43,000-square-foot facility will house 148 older adults experiencing homelessness until they are connected to permanent housing.

NHF Recuperative Care

Los Angeles Recuperative Care Learning Network

Since January 2021, the LARC Learning Network, composed of recuperative care providers, health plans, hospitals, and other organizations focused on recuperative care, came together in advance of CalAIM's January 2022 rollout. The Learning Network aims to build relationships and better understand and improve recuperative care services, with an emphasis on the contractual relationships and protocol surrounding Cal AIM and the newly implemented reimbursement of medical respite as an "in lieu of" service. For more information, please visit: Recuperative Care Forum Spurs Collaboration, Action

The LARC learning network is hosted by the National Institute for Medical Respite (NIMRC) and funded by Kaiser Permanente. The learning network consists of over 200 members and serves as an ongoing forum for stakeholders to address emerging issues. Recently, these have included establishing a presumptive eligibility referral process, evaluating a recuperative care bed availability real-time reporting resource, and piloting an activity of daily living (ADLs) in recuperative care project, which would increase access to recuperative care for PEH with ADL needs. These efforts, along with network participant goodwill, have strengthened and accelerated the medical respite rollout in Los Angeles.

Recuperative Care Recommendations

Recuperative care is a program that offers health care providers a safe place to discharge unhoused patients when they no longer require hospitalization but still need to heal from an illness or injury. The following recommendations are opportunities for hospitals and health care leaders to learn more about how to advance recuperative care efforts through co-investment opportunities, partnerships, improving recuperative care services, and advocacy.

1. Join the LA Recuperative Care Learning Network (LARC Learning Network), hosted by the National Institute for Medical Respite Care (NIMRC). For more information about the LARC learning network and how to join please contact Julia Gaines jgaines@nhchc.org.
2. Identify co-investment opportunities to expand recuperative care in specific geographic areas experiencing the greatest inequities.
3. Increase capacity for behavioral health, mental health, and substance use disorder services.
4. Expand capacity for supporting activities of daily living (ADLs) for PEH at recuperative care sites.
5. Advocate for transportation reimbursement for medical appointments from Medi-Cal managed care plans and other insurance.
6. Strengthen the transition from recuperative care to permanent supportive housing with CalAIM Enhanced Care Management (ECM) providers. As well as short-term post-hospitalization housing transitions from recuperative care.
7. Explore partnerships and service options with Federally Qualified Health Centers (FQHCs) and community-based organizations (CBOs) to expand primary care and support services.
8. Advocate for optimal reimbursement for recuperative care providers with Medi-Cal managed care plans, the City of Los Angeles, and LA County.

Community Health Navigator Programs

To help individuals get connected to more appropriate services and reduce the use of emergency services, many hospitals have launched social determinants of health (SDOH) programs to meet the needs of all patients visiting the hospital who have social care needs. Hospitals utilizing SDOH programs use community health navigators (CHNs) or community resource coordinators (CRCs) to triage patients toward more sustainable support through CBOs for social needs including behavioral health and supportive housing (temporary and ultimately permanent), as well as primary care medical homes. The two hospital programs that presented to the LA Partnership Collaborative were:

Cedars-Sinai

Cedars-Sinai engages in health system activities that directly impact basic needs and forms partnerships to provide help and community-based resources to PEH. On average, Cedars-Sinai has served nearly 4,000 unhoused patients yearly, 85% of whom have a behavioral health diagnosis. The average total material and labor costs per year are $80,000 and 12,000 hours, respectively.

To reduce the use of emergency services, Cedars-Sinai has introduced specialty patient navigator roles, called Community Resource Coordinators (CRC), in the ED that provide tailored support to vulnerable patient populations including unhoused and patients with substance use issues.

In August 2021 Cedars-Sinai launched the Community Connect Program, an SDOH program to meet the social care needs of all patients visiting the health system. This comprehensive SDOH approach includes a standardized SDOH assessment tool is available at every access point within the health system, an electronic referral platform, community partnerships, and a Community Health Worker (CHW) program.

Cedars-Sinai partners with FindHelp to implement an integrated electronic referral platform to tailor free or reduced-cost community service referrals to patients and enable bidirectional feedback tracking. A public-facing version of the platform is available for individuals to access at any time.

Under the Community Connect Program, CHWs have been integrated into many care teams across the health system. CHWs support patients by providing medical, social, and public benefit resource navigation to support their health related social care needs. These CHWs were initially funded through philanthropy and is now approved for operational funding for 10 positions.

Cedars-Sinai connects with community partners through targeted grantmaking, direct referral contracts, and informal navigation partnerships to appropriately meet the needs of individuals and provide necessary resources. Through these established community partnerships, an online direct referral pathway for case managers to Saban Community Clinic and Pacific Clinics for enhanced care management (ECM) services has been created to tap into CalAIM.

Cedars-Sinai's work reflects the importance of community partnerships and collaborations to address the challenges hospitals are facing in caring for the homeless population. Collective action is a necessity to provide PEH with the social service resources needed to support their behavioral health and housing assistance needs. Lastly, utilizing CRCs to triage patients to social services has helped ensure the transitional process for PEH is effective and sustainable.

California Hospital Medical Center (CHMC)

CHMC's Frequent Users System Engagement (FUSE) Program provides community-based case management for primary and behavioral health care and supportive housing to chronically homeless patients assessed as high-acuity. Those not eligible for the program are referred to partner community resources. FUSE has been in place for over 13 years and was an initial pilot through the Corporation of Supportive Housing (CSH).

FUSE's partner organizations include CommonSpirit, John Wesley Health Center (JWCH), and Housing Works. CHMC places a CHN on site to conduct outreach and referrals in the inpatient and emergency departments. Within CHMC, FUSE collaborates with care coordination teams, substance use disorder (SUD) navigators, and nursing teams. Social workers in the ED work closely with care coordination staff to determine a referral pathway. Individuals then receive an assessment, appointments for primary care at JWCH, and other necessary referrals. As of January 2023, FUSE had screened 2,583 patients, identified 39 as acute, and housed 33.

FUSE leverages CalAIM to braid funds to support interim/permanent supportive housing (PSH) placements and move-in costs. However, managed care providers (MCPs) do not have a standardized procedure across LA County, resulting in confusion about roles and responsibilities. No interim housing funds are being offered. Currently, CommonSpirit is exploring additional funding streams and looking for opportunities to expand the FUSE program into other markets. The housing navigation team will soon include an outreach worker and recently added a housing navigator to support FUSE client support and engagement.

Despite challenges in seeking and securing funding streams to expand FUSE, the program offers a model for leveraging community partnerships and for more health systems to collaborate. In a similar way to Cedars-Sinai and its CRCs, CHMC utilizes CHNs, care coordination teams, SUD navigators, nursing teams, and social workers to conduct outreach and referrals. This approach ensures an effective and sustainable referral pathway for PEH to transition to interim housing and social services support.

Community Health Navigator Program Recommendations

One method to reduce unhoused patients' use of emergency services for non-urgent matters while ensuring they can access basic needs is to triage them toward community-based resources through CHNs or CRCs within hospital EDs. Community health workers with lived experience are critically important to connect with PEH.

1. Identify co-investment opportunities to expand and strategically organize CHN teams in specific geographic areas experiencing the greatest inequities.
2. Share emerging best practices to optimize direct referrals to ECM providers through CalAIM.
3. Identify and share training curriculum and presentations for hospital staff on homeless systems of care and the ROI for hospital based CHNs.
4. Explore opportunities for workforce development for direct service providers and hospital staff who have lived experience or want to serve PEH.

Hospital Staff Education and Training Recommendations

There is also a need for training on social needs screening, assessments, and generally an increase of knowledge for hospitals and staff to optimize housing navigation, with the possibility of scaling what is working well in areas with the greatest need.

1. Explore the feasibility of developing a shared housing navigation curriculum and training model for hospital staff that will cover
   a. Navigation within the hospital/health system
   b. Housing providers and services
2. Develop a community resource directory for PEH that is updated regularly with current information for referrals and improved connectivity.
3. Develop a platform for hospitals/health systems to share their systems process (e.g., CommonSpirit training model).
4. Create career growth opportunities through sustainable programming that supports direct service providers and staff with lived experience.
   a. Opportunity to train community health workers to be ED homeless navigators and CRCs.

Metrics for Consideration

Below are several metrics for consideration to define and measure the success of the collaboration or strategy. These metrics are categorized at the community provider, hospital, and public sector levels.

Community Provider Level	• Expanded number of community partners working in coordination with hospitals • Expanded housing navigation and tenancy services through CalAIM • Increased community capacity to address needs of PEH, e.g., mental health, substance use treatment • Expanded scope of services provided outside hospitals • Coordination at community level • Increased housing placements
Hospital Level	• Reduced ED utilization for PEH participating in community resource navigator, street medicine, and recuperative care programs • Reduced severity and acuity of health conditions seen in PEH • Reduced length of hospital stay and reduced readmissions for PEH
Public Sector Level	• Public sector engagement regarding joint action or aligned policy and advocacy • Increased public sector investments in hospitals addressing the issue of homelessness and health equity • Funding from private philanthropy leveraged by hospital commitments • Funding from Managed Care Plans to create synergy with hospital investments and interventions

POLICY AND ADVOCACY

Policy advocacy plays a vital role in addressing homelessness and mitigating the challenges hospitals are facing by supporting policy efforts to address the physical health, mental health, housing status, and social needs of a diverse and complex population of PEH and those at risk. At the same time, demand for youth and adult mental health services and ED discharge to psychiatric care are at an all-time high.[6]

State Policy Priorities

As of, March 20, 2024, California voters passed Proposition 1 which imposes strict requirements on counties to spend on housing and drug treatment problems to tackle the state's homelessness.[7] This measure would issue about $6.38 billion in bonds to build 4,350 housing units, half of which will be reserved for veterans, and add 6,800 mental health and addiction treatment beds.[8] It would also amend the Mental Health Services Act (MHSA) (a 1% tax on personal income over $1 million), allowing reliable funds to be utilized to help individuals with substance abuse, not just those with mental illness.[9] Proposition 1 marks the first update to the state's mental health system in 20 years, and many supporters argue this proposition will help combat the state's deteriorating homelessness crisis.[10]

More than 170,000 Californians are unhoused, the majority live unsheltered on the streets.[11] In addition to mental health and addiction disorders among PEH, research shows that the root cause of homelessness in California is income loss and lack of affordable housing.[12] Everyone In is a community movement advocating for affordable and supportive housing across LA County to end homelessness. Everyone In was strongly behind the passing of California SB679, the LA County Regional Housing Finance Act of 2022, which established the LA County Affordable Housing Solutions Agency (LACAHSA). SB679's purpose is to increase the supply of affordable housing in LA County by providing for significantly enhanced funding and technical assistance for renter protections, affordable housing preservation, and new affordable housing

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[6] Cal Matters, 2024 Voter Guide, Prop 1 (2024), https://calmatters.org/california-voter-guide-2024/prop-1-mental-health/?gad_source=1&gclid=EAIaIQobChMI_cz0haTZhQMVhS2tBh0sWw2-EAAYASAAEgJUyfD_BwE#h-polling-data

[7] KCRA, Associated Press News, *California voters pass Proposition 1, requiring counties to spend on programs to tackle homelessness* (March 20, 2024), https://www.kcra.com/article/california-prop-1-passes/60259887

[8] *Ibid.*

[9] California Budget & Policy Center. *Understanding Proposition 1* (January 2024), https://calbudgetcenter.org/resources/qa-understanding-california-prop-1/

[10] Cal Matters, 2024 Voter Guide, Prop 1 (2024), https://calmatters.org/california-voter-guide-2024/prop-1-mental-health/?gad_source=1&gclid=EAIaIQobChMI_cz0haTZhQMVhS2tBh0sWw2-EAAYASAAEgJUyfD_BwE#h-polling-data

[11] *Ibid.*

[12] *Ibid.*

production.[13]Everyone In's next steps are to fully staff the agency so it can launch and get a measure on the 2024 ballot to fund its work long term.[14]

Local Policy Priorities

The Measure United to House LA (Measure ULA) bill also passed in 2022. It establishes a one-time 4% to 5.5% tax on all property sales of $5 million or more to fund new affordable housing, homeless prevention for seniors, and legal representation for renters facing illegal eviction. Despite various lawsuits by opposing parties, Everyone In is advocating for implementation of this bill. [15]

> *Everyone In* has a history of local policy victories:
> - **Measure J:** Worked with a coalition to get this bill passed. It reallocates 10% of LA County's taxes for alternatives to incarceration, including affordable housing, education, and mental health care.[16]
> - **Measure H:** Assisted in ensuring Measure H's quarter-cent sales tax was successfully implemented. It has led to the first dedicated funding source for homeless services and short-term housing in the city of Los Angeles, generating roughly $350 million a year. [17]
> - **Proposition HHH:** Ensured officials continue following through on this bond to measure after it passed in 2016. HHH has since funded 8,800-plus new units of affordable housing — and counting — across the city of Los Angeles.[18]
> - **222 Pledge:** Pressured nine LA city councilmembers to each develop 222 units of supportive housing, resulting in about 2,000 new units of housing. [19]

Los Angeles City Budget Advocacy

Mayor Karen Bass has proposed investing $1.3 billion in homelessness services for 2024, a 10% increase from 2023. Of this budget, $150 million is expected to go directly to Measure ULA programs to end homelessness and support those who are at risk. Additional funding from the budget is expected to be used to buy hotels or motels for renovation to housing. The city will also seek other properties to renovate and use for sheltering PEH and for substance abuse treatment beds.[20]

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[13] Track Bill, California SB679 *Los Angeles County: Affordable Housing,* State of California Authenticated Electronic Legal Material (2022), https://trackbill.com/bill/california-senate-bill-679-los-angeles-county-affordable-housing/2043581/

[14] Everyone In Powered by United Way, Key Policies (20..) https://everyoneinla.org/about-us/key-policies/

[15] *Ibid.*

[16] *Ibid.*

[17] *Ibid.*

[18] *Ibid.*

[19] *Ibid.*

[20] Associated Press News, *LA Mayor wants $1.3B for homeless crisis, hotels for housing* (April 17, 2023), https://appnews.com/article/los-angeles-homeless-crisis-mayor-karen-bass-billion-budget-3080bb1abdbbddfe0cfbff4eb28f64cc

Through the proposed budget, Mayor Bass has also launched her signature program, *Inside Safe*, in South Los Angeles. The program offers PEH motel rooms and a path to permanent housing and public services.[21]

Inside Safe supports the following five goals:
- Reduce loss of life on our streets
- Increase access to mental health and substance abuse treatment for those living in encampments.
- Eliminate street encampments.
- Promote long-term housing stability for PEH.
- Enhance the safety ang hygiene of neighborhoods for all residents, businesses, and neighbors.[22]

As a result of the substantial cost and lack of availability of post-discharge beds for unhoused patients, patients experiencing homelessness often are sent "home" from an ED or hospital visit without means for safe, sheltered healing. Expanding the supply of and access to affordable housing across housing types and locations is one strategy that could help secure permanent housing for the unhoused population and keep at-risk individuals in their homes. Therefore, supporting state, city, and local policy priorities that address the homelessness crisis could allow hospitals to see their PEH ED visits decrease, and improve the transitional care and post-discharge process for CRCs as well.

Hospital Collaboration on Homelessness Working Group / LA County

The Hospital Collaboration on Homelessness Working Group is convened by HASC with participants from Communities Lifting Communities, LAHSA, the LA County Homeless Initiative, and the Department of Health Services. The purpose of this group is to identify opportunities for collaboration, policy advocacy, and better understanding of the gaps in existing homeless services resources and access points in the continuum of care.

Initial findings identified a lack of resources, services, and shelter beds as a persistent issue. Hospitals lack access to real-time data on homeless services, shelters, and bed availability. There is no reliable means of transportation to safely transfer PEH from point A to point B. A universal data system that allows health providers to share information with one another would be beneficial, as many services are siloed, resulting in uncoordinated efforts.

Hospitals collaborating with LAHSA and the LA County Homeless Initiative:
- Create a shared language and provide basic education for hospital staff regarding what housing navigation looks like within the hospital system, housing providers and services, and community resources.

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[21] Los Angeles Mayor Karen Bass, *Inside Safe Effort Launched in South Los Angeles* (City of Los Angeles, 2023), https://mayor.lacity.gov/news/inside-safe-effort-launched-south-los-angeles#:~:text=Inside%20Safe%20supports%20the%20following.Eliminate%20street%20encapments

[22] *Ibid.*

- Consult with LAHSA, LA County leaders, and managed care plans to identify funding accountability and opportunities necessary for sustainability.
- Leverage Housing and Homelessness Incentive Program (HHIP), Enhanced Care Management (ECM) services, and other Community Supports through CalAIM and health plans.
- Encourage hospitals to attend the monthly LAHSA All SPA Hospital Meetings to understand service access and referral pathways, receive educational information and resources, and establish more efficient communication between LAHSA, hospitals, and homeless service providers.
- Explore opportunities to expand partnerships between coordinated entry system (CES) lead agencies, hospitals, and homeless service providers in specific service areas, and hold space for CES lead agency navigators, homeless workers, etc., in hospital spaces.

Recommendations for Collaboration Between Hospitals and LAHSA

The Los Angeles Homeless Services Authority (LAHSA) is a Los Angeles Continuum of Care lead agency that manages funding from federal, state, LA County, and City of Los Angeles sources to provide housing services to PEH and implement homeless initiative strategies in conjunction with nonprofit, city, and county agencies. LAHSA is a designated Homeless Management Information System (HMIS) lead and a management entity of the LA County Coordinated Entry System (CES). The following recommendations demonstrate ways hospitals can improve their collaboration with LAHSA.

- Encourage hospitals to attend the monthly LAHSA All SPA Hospital Meetings to understand service access and referral pathways, receive educational information and resources, and establish more efficient communication between LAHSA, hospitals, and homeless service providers.
- Explore opportunities to expand partnerships between CES lead agencies, hospitals, and homeless service providers in specific service areas, and hold space for CES lead agency navigators, homeless workers, etc., in hospitals.

OUR APPROACH MOVING FORWARD

We will pursue an incremental approach that allows hospitals and communities to build on collaboration. We will build consensus and define metrics within hospital regions for interventions and geographic partners. We will enumerate and secure funding commitments leveraged among hospitals, public sector spending, and philanthropy.

Funding commitments will be required from hospital partners for staffing and to leverage support from private philanthropy. Our approach to project design is incremental, recognizing that some decisions require more deliberation than others. This approach will enable us to build momentum and excitement over time. Two hospitals coming together in one neighborhood will create the opportunity for others across sectors to further scale and complement the efforts. In some cases, such collaborations will require adjustment of timing and location for selected activities and working with new partners. If we are to effectively address this immense challenge, it is time to link arms.

LA Partnership colleagues will meet with hospital leaders to secure approval to proceed with formal design of aligned strategies in the program areas and identified subregions. We look forward to discussing this collective approach to address homelessness and to gaining your participation.

"Homelessness is one of the most critical and challenging issues facing hospitals, health systems, and communities in our region," said Susan Harrington, President of CLC. "This initiative is an important step toward developing and implementing an effective, collaborative approach to meeting the needs of the unsheltered population. Much important work remains to be done but we have built a good foundation for the follow-up actions that need to be taken."

Advancing Health Equity in
Southern California Communities Initiative

Communities Lifting Communities (CLC), the community health improvement initiative and affiliate nonprofit 501(c)(3) organization of the Hospital Association of Southern California (HASC), supports hospitals, public health departments and other stakeholders to advance systems change and promote intercultural health equity through the effective use of data, prevention strategies, leadership, and partnerships.

CLC launched the Advancing Health Equity in Southern California Communities Initiative in 2021 to advance regional community health initiatives through a strategic, actionable community planning and investment framework. From 2021-2023, CLC and the Center to Advance Community Health and Equity (CACHE), a fiscally sponsored program of the Public Health Institute, partnered with the Los Angeles County Community Health Assessment and Action Partnership (LA Partnership) to identify opportunities for aligned action by hospitals and other affiliated organizations in LA County communities where health inequities and homelessness are concentrated.

For more information, contact Susan Harrington at sharrington@hasc.org.

ACKNOWLEDGEMENTS

We would like to thank the following organizations who provided input and time to make this report possible.

Adventist Health White Memorial
- Juan De La Cruz, President, Charitable Foundation
- Khathy Hoang, Philanthropy Operations Manager, Charitable Foundation
- Lila DiBella, BSN, RN, PHN, PCCN-K, Care Transitions Navigator-Clinical Supervisor, Grants
- Pia Banez, Project Manager, Behavioral Health Integration

Cedars-Sinai
- Katie Hren, LCSW, MPH, Associate Director, Community Connect, Office of Health Equity
- Erin Jackson-Ward, MPH, Director, Community Benefit Giving
- Cindy Levey, Executive Director, Community Benefit and Social Responsibility Systems
- Jonathan Schreiber, MSBA, MBA, MA Ed, Vice President, Community Engagement
- Emily Skehan, Senior Program Officer, Community Benefit Giving

Communities Lifting Communities
- Susan Harrington, President
- Karen Ochoa, Director of Health Equity Programs and Operations
- Darielle Green, MPP, Program Coordinator
- Iliana Covarrubias, Operations and Project Coordinator

County of Los Angeles, Department of Public Health
- Dr. Franklin Pratt, Chief, Physician Administration, Division of Medical and Dental Affairs, Los Angeles County Department of Public Health
- Alicia H. Chang, MD, MS, Regional Health Officer, Service Planning Areas 7 and 8, East and South Bay Region
- John M. Connolly, Chief Strategist, PhD, MS Ed
- Will Nicholas, PhD, MPH, MA, Director, Center for Health Impact Evaluation
- Gary Tsai, MD, Subdivision Director, Substance Abuse Prevention and Control

Dignity Health-California Hospital Medical Center and CommonSpirit Health
- Ashley Brand, System Director, Community Health, Integration and Housing, CommonSpirit Health
- Margaret Lynn Yonekura, MD, Director, Community Health, Dignity Health-California Hospital Medical Center
- Nicole Wilson, MSW, Project Manager, Community Homeless Health, CommonSpirit Health
- Barbara Gonzalez, Interim Director of Community health Outreach, California Hospital Medical Center

Healthcare in Action
- K. Grace Bell, Chief Operating Officer, Healthcare in Action

Hospital Association of Southern California
- Adena Tessler, Regional Vice President, Los Angeles Region

Kaiser Permanente, Southern California Region
- Sheri D. Bathurst, Community Health Manager, Kaiser Permanente Downey Medical Center
- Celia A. Brugman, Community Health Manager, Kaiser Permanente West Los Angeles Medical Center
- Mario P. Ceballos, Community Health Manager, Kaiser Permanente Los Angeles Medical Center
- Mehrnaz X. Davoudi, Manager, Evaluation and Measurement, Community Health, National Office
- Janae A. Oliver, Community Health Manager, Kaiser Permanente South Bay Medical Center
- Cody M. Ruedaflores, Manager, Community Benefit Programs, Community Health, Southern California Region Office
- Clara V. Steimberg, Community Health Manager, Kaiser Permanente Woodland Hills Medical Center and Ventura County
- Elizabeth D. Trombley, Senior Director, Community Health, Southern California Region Office
- Amy C. Wiese, Community Health Manager, Kaiser Permanente Panorama City Medical Center and Antelope Valley

MLK Community Healthcare
- Lauren Espy, MPH, Director of Community Programs, Community Benefits
- Jessica Nunez, LCSW, MPH, Social Services and Street Medicine Manager
- Jorge Reyno, MD, MHA, Senior Vice President of Population Health
- Sarat Varghese, MD, Medical Director

Providence Health & Services
- Megan McAninch-Jones, MSc, MBA, Executive Director, Community Investment Strategy and Evaluation, Community Partnership
- Anthony Ortiz-Luis, Director, Community Health Investment, Providence San Fernando Valley
- Justin Joe, Director, Community Health Investment, Providence South Bay and Westside
- Jim Tehan, Senior Director, Community Health Investment, Providence Los Angeles Service Area

UCLA Health
- Brian Zunner-Keating, MS, RN, Director, Homeless Healthcare Collaborative
- Catherine Weaver, MD, FAAEM, FACEP, Medical Director of UCLA Homeless Healthcare Collaborative

USC
- Brett J. Feldman, MSPAS, PA-C, Director and Co-founder, USC Street Medicine

Center to Advance Community Health and Equity (CACHE)
CLC would also like to thank our consulting partner colleagues at CACHE, who provided project design guidance, subject matter expertise and data analysis.
- Kevin Barnett, DrPH, MPH, MCP, Executive Director, Center to Advance Community Health and Equity, Principal Investigator, Public Health Institute
- Marisol Gomez, MPH, Research Associate
- Katherine Johnson, MPP, Deputy Director, Center to Advance Community Health & Equity Senior Program Advisor and Principal Investigator, Public Health Institute

Funders

CLC would like to thank our funders for this initiative.

- Adventist Health White Memorial
- Blue Shield of California Foundation
- California Community Foundation
- Cedars-Sinai
- Dignity Health
- Kaiser Permanente
- The California Endowment

APPENDIX A: KEY INFORMANT INTERVIEW SURVEY QUESTIONS

Key Informant Interview Objectives and Approach

To build a collaborative approach to addressing homelessness among hospitals, CACHE collected detailed information on current and planned strategies for services, program support, and investments. The starting point is a review of relevant information in publicly available documents such as community health needs assessments (CHNAs), implementation strategies (ISs), and SB697 reports.

Our key informant interviews (KIIs) will include both general questions and targeted follow-ups on strategies referenced in the publicly available documents. Information on current activities will focus on specific types of services/activities (the "**what**"), locations of services/activities (the "**where**"), the timing and duration of services/activities (the "**when**"), current partners (the "who"), and measurable objectives (the "**why**"). To ensure that we are forward thinking, we welcomed any details interviewees could provide on planned services/activities. This information will provide an entry point for the design of collaborative strategies that optimally leverage our and community partner assets. We will take an incremental approach to building a collaborative strategy, taking advantage of immediate opportunities to build momentum and visibility, and expanding on those early successes over the coming year.

Key Informant Interview Questions Framework

1. What data do you currently collect and analyze that provides the information needed to assess needs and coordinate services and supports for homeless populations? What sources provide this data?
2. What are current gaps in data collection, information and/or analytic support that hinder your ability to identify and coordinate services for homeless patients who visit your facility? California is developing a data exchange framework that will include data from hospitals and social services agencies. How might access to data on homelessness services support your efforts?
3. What are your most significant "pain points" in serving homeless populations?
4. Which neighborhoods near your facility would you identify as "hot spots," where homeless and housing insecurity are most concentrated?
5. In which of these neighborhoods do you currently provide services and supports for PEH or those at risk of homelessness?

Programmatic Areas

a) Intake, assessment and discharge/referral to short term shelter and care:
- medical respite programs
- homeless shelters
- transitional housing
- short-term affordable housing

b) Facilitate enrollment in Medi-Cal

c) Facilitate enrollment in other federal and state programs

d) Assign staff/contractors with appropriate expertise to assist in service navigation/care coordination in ED and/or community-based settings

e) Provide grants/in-kind support for CBOs serving homeless populations (including short-term shelter/care)

f) Food distribution
g) Engagement with key stakeholders in the community development community
h) Grants and/or investments to support housing or other needs for homeless populations
i) Advocacy for services and policies to increase affordable housing and associated services
j) Participate in Hospital Liaison Program
k) Other (please specify)

Survey Questions

Organization name and contact information

Please provide a brief overview of homeless services and activities in Los Angeles County.

Efforts to date in Los Angeles

1. **What** kinds of services and activities are provided? Please provide a brief description of the specific program elements for each service and activity.

2. **Where** are the services and activities provided, with location address(es)?

3. **Who** receives the services and is there a focus on youth; adults; women; seniors; families; Black. Indigenous and people of color (BIPOC); other?

4. **When** are services and activities provided, i.e., weekly, monthly, quarterly, certain days of the week or times of day?

5. **At what scale** are services and activities provided, i.e., number of clients or caseload?

Plans for 2022 and beyond

o **What** kinds of solutions are you planning, pursuing, or advocating for, in addition to your current activities?

o **Where** will the planned services and activities be provided, with location address(es)?

o **Who** will receive the services and is there a focus on youth; adults; women; seniors; families; Black, Indigenous and people of color (BIPOC); other?

o **When** will the planned services and activities be provided, i.e., weekly, monthly, quarterly, certain days of the week or times of day?

o **At what scale** will the planned services and activities be provided, i.e., number of clients or caseload?

o **What** are your most significant "pain points" in the delivery of services for homeless populations?

o Would you consider funding partnership opportunities at the grassroots or upstream levels?