LOS ANGELES COUNTY
COMMUNITY HEALTH ASSESSMENT
AND ACTION PARTNERSHIP

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

OVERVIEW

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.

The Los Angeles County Community Health Assessment and Action Partnership (LA Partnership) – a collaborative of more than 30 nonprofit hospitals and health systems, public health departments and community partners – undertook research into current and planned hospital strategies for collaboration in services, program supports, and investments to address homelessness in LA County. A recently issued, 30-page report outlines the research findings, focusing on challenges inherent in collaboration across competitive lines, and opportunities to develop aligned operational strategies to meet the demands of addressing homelessness within the health care context. The report also focuses on the need to engage health care leadership and strengthen collaborative planning and investment among hospitals, public health agencies, and community stakeholders to gain greater community impact.

LA PARTNERSHIP HOMELESSNESS INITIATIVE GOALS

- 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.

MLK Community Healthcare Street Medicine

RESEARCH METHODOLOGY

The research process involved data collection and analysis using available documents such as community health needs assessments, community 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. In addition, key informant interviews were conducted with 20 LA Partnership member hospitals in five Los Angeles County Service Planning Areas (SPAs) to obtain additional, more specific information about individual hospitals' services and activities to address homelessness, the organizations they partner with, and their measurable results.

- The research process underscored the need to improve equity-centering efforts in collecting, reviewing and reporting data about persons experiencing homelessness (PEHs).
- 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.
- To date, hospitals and health systems in HASC's Los Angeles region have had no coordinated, collaborative approach to finding effective, scalable solutions to better serve unsheltered patients while alleviating the financial and logistical strain of homelessness on their emergency departments.

MLK Community Healthcare Street Medicine

RESULTS AND RECOMMENDATIONS

The report focused on three areas where hospitals 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 fell into three categories: **street medicine**, **recuperative care**, and **community health navigator programs**.

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. This study looked at three hospital mobile clinics and one community-based street medicine program.

Street Medicine Continued

- These clinics were staffed with interdisciplinary teams that included a combination of various provider types: physicians, nurse practitioners, physician assistants, nurses, medical assistants, social workers, community health workers, medical and nursing residents and students, and outreach coordinators.
- The services offered ranged by program, including primary care, preventive care (including vaccines), urgent care, chronic disease assessment and monitoring, medications, behavioral health, substance abuse treatment, blood draw labs, point-of-care ultrasound, inpatient hospital consultations, specialty care referrals, housing navigation, transportation to appointments, longitudinal care, and coordination of care.
- A key component of these programs involves partnerships with local agencies and community-based organizations.
- Street medicine providers can usually provide the same primary care services on the street as in physical clinics.
- Hospitals and health care leaders can produce measurable, impactful street medicine solutions through co-investment opportunities, advocacy, ED operation improvements, and even a pilot program.

Recuperative Care

Recuperative care (also known as medical respite) is a not-for-profit 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. 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 in their communities.

- While some LA Partnership hospitals are forced to contract for recuperative beds far from their communities, others struggle with finding available recuperative beds closer to home. Some facilities offer grants to help nonprofit organizations in LA County expand their recuperative care programs.
- Hospitals and health care leaders can advance recuperative care efforts through co-investment opportunities, partnerships, improving recuperative care services and advocacy.

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 health systems who have social care needs. Hospitals utilizing these programs use community health navigators (CHNs) or community resource coordinators (CRCs) to triage patients toward more sustainable support for social needs including behavioral health and supportive housing (temporary and ultimately permanent), as well as primary care medical homes.

- 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.
- There are opportunities to optimize direct referrals to Enhanced Care Management providers and Community Supports through the Department of Health Care Services CalAIM program.
- 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.

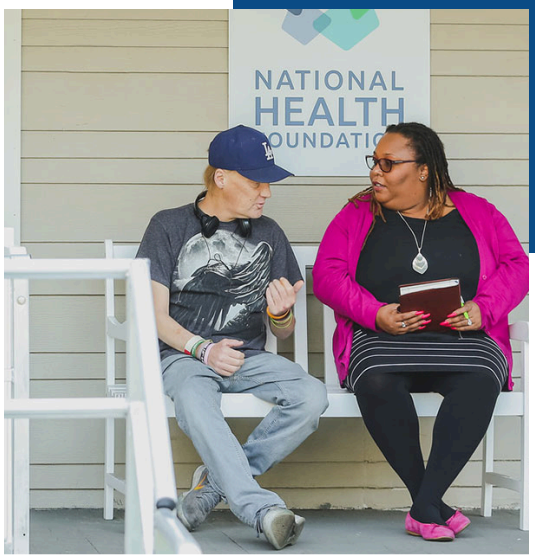
Opportunities for Collaboration

The report also lays out more robust recommendations for collaboration that include advancing care coordination, education, training and sharing best practices, co-investment, partnerships, and state and local advocacy.

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, the Los Angeles Homeless Services Authority (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.
- The report also offers recommendations for enhanced collaboration between area hospitals and LAHSA.



NHF Recuperative Care

OUR APPROACH MOVING FORWARD

- We will pursue an incremental approach that allows hospitals and communities to build on collaboration.
- We will enumerate and secure funding commitments leveraged among hospitals, public sector spending and philanthropy.
- LA Partnership members identified future areas of focus that could include strategic data collection and analysis and best practice learning.

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.

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