

Addressing the Challenge of Homeless Patient Discharges

Symposium Report

*Presented by the Los Angeles County District Attorney's Office,
the Los Angeles City Attorney's Office and
the Hospital Association of Southern California*



“It is our duty to provide patients who are homeless and mentally ill with resources, including healthcare and social services to ensure they get the help they need. The members of our homeless community deserve to be treated with the same humanity, dignity and respect that all of us would expect if we were in that situation.”
– Jackie Lacey, Los Angeles County District Attorney

“Every patient, whether housed or homeless, deserves the kind of medical care that we all want for our loved ones. Mission-driven, collective leadership on homeless patient discharge issues is essential to reaching this goal.”
– Mike Feuer, Los Angeles City Attorney

“There is no one organization, there is no one silo that can tackle the issue of homelessness alone. Homelessness is one of the greatest challenges of our time. Effectively caring for these most vulnerable individuals requires unprecedented collaboration.”
– George W. Greene, President and CEO of the Hospital Association of Southern California

For additional information, please visit the Los Angeles City Attorney's website:
<https://www.lacityattorney.org/homelessness>

Executive Summary

On November 5, 2018, at the California Endowment, the Los Angeles City Attorney’s Office, the Los Angeles County District Attorney’s Office and the Hospital Association of Southern California (HASC) brought together health care providers, social service agencies, and other community experts at a Symposium to discuss the challenge of homeless patient discharges and identify collaborative solutions to ensure that safe and supportive discharge from medical care is available to all Los Angeles residents, whether housed or homeless.

As the presentations and audience exchanges shared at the Symposium made clear, bridging the gap for homeless patients between hospital stays and supportive housing demands broad collaboration and the creative and efficient use of resources.

It is clear that our healthcare community and government leaders are committed to the ethical discharge of homeless patients while dealing with the many difficult issues that this patient population poses.

Going forward, our organizations are committed to continued collaboration to ensure that homeless individuals in Los Angeles can access a high quality of care and safe discharge from medical settings. We also hope that some of the Symposium’s key lessons and ideas for future action, outlined in this report, will serve as a springboard for further engagement and progress on the critical issue of homeless patient discharge planning among the broadest possible group of stakeholders.

Jackie Lacey
Los Angeles County District Attorney

Mike Feuer
Los Angeles City Attorney

George W. Greene
President and CEO of the Hospital Association of Southern California



Panel One: Identifying Challenges in Homeless Patient Discharges

Moderator: George Greene, President, Hospital Association of Southern California

Panelists: **Nikola Alenkin**, PhD, LCSW (Adjunct Faculty, College of Health and Human Services, Department of Social Work, California State University-Los Angeles and Supervisory Social Worker at the Greater Los Angeles Healthcare System, Department of Veterans Affairs); **Moshe Arnold** (Vice President of Financial Operations, Premier B.H., Inc.); **Charmaine Dorsey**, MSW, LCSW (Director, Utilization Management and Social Services Support, Los Angeles Department of Health Services); **Alicia Macklin**, Esq. (Hooper, Lundy & Bookman P.C.)

The Symposium's first panel analyzed the challenges faced by Los Angeles area hospitals, skilled nursing facilities, and other facilities in ensuring that homeless patients are discharged from all medical facilities to safe and supportive housing. It also explored solutions to move policy forward, offering examples of concrete advances toward improved discharge planning policies and medical respite options for homeless individuals.

Charmaine Dorsey discussed the importance of incorporating the expertise of those working on the front lines with homeless people in formulating responses to discharge planning—and listening to the preferences of homeless individuals, respecting their choices, and discussing the options available to each. **Homeless individuals, like everyone, want to be in familiar places where they feel a sense of belonging and know people; Dorsey highlighted how important it is to account for such preferences, as long as homeless individuals have the capacity to make good decisions for themselves.** She also emphasized the need for policy advocacy on homeless patient discharge issues that integrates subject-matter expertise and the experiences of homeless individuals from the outset, and emphasized that engaging new avenues for funding and policy wins is key to making progress in this area.

Nikola Alenkin and **Brian Wren** both discussed homeless populations with distinct needs, including homeless veterans and undocumented homeless individuals. Wren mentioned that anecdotal evidence suggests that undocumented homeless individuals may visit emergency rooms more often, perhaps because they lack access to institutional safety net programs, the funding for care they provide, and family support. He offered that **diversifying approaches to homeless health care is crucial to making sure all homeless individuals are served**, although identifying financial resources to serve undocumented homeless individuals remains a challenge. Alenkin discussed the challenges facing homeless veterans, who can struggle to stay housed in Los Angeles's expensive rental market and may face mental health issues particular to veterans requiring special treatment. Yet Alenkin also highlighted that, despite the growing number of homeless veterans in Los Angeles, and the housing affordability and availability issues they confront, **innovative and collaborative approaches led in part by the Veterans Administration have reduced the actual number of veterans living on the street here.**

The Greater Los Angeles VA Healthcare System has revitalized its West Los Angeles campus with the development of permanent supportive housing for homeless veterans through an enhanced use lease. It has also launched a safe parking program for veterans living in their cars or RVs, providing veterans with a safe place to park overnight and access to showers, hygiene resources, social services, and eventually, housing. Finally, it developed hospital-to-home and per-diem grant programs to veterans released from the hospital, which offer access to residences, case management, and clinical services.

Moshe Arnold discussed the importance of considering what kind of facility is most appropriate for homeless patients on discharge from hospital settings, noting that skilled nursing facilities (SNFs) can play a role, but that **for certain patients, longer-term options like assisted living, board and care facilities, or shelter options with more intensive mental health resources, like psychiatric facilities, may be most appropriate. Arnold stated that funding to support these options is critical, and currently lacking; currently, for instance, Medicaid does not fund assisted living, except through a limited waiver program.**

Finally, **Alicia Macklin** highlighted some of the challenges hospitals face in balancing their legal commitments under federal, state, and local laws with the operational realities of running their facilities and respecting patient choice. She suggested that growing homeless patient numbers and the declining availability of emergency department services can put hospitals at risk for violations, especially given uncertainty about how facilities are supposed to interpret and comply with regulatory requirements—including the newly established discharge requirements contained in SB 1152. Macklin also noted that **homeless patients may refuse to cooperate with discharge planning or refuse referrals to services and spots in shelters.** She emphasized that **while legal standards create obligations for hospitals on the front end, there is still a great need for more community funding and resources to ensure patients can be received and supported upon discharge from a medical setting.**

Key Themes

- ✓ Complex homeless patient populations require a diversity of programs and services; “one size fits all” is not an effective approach.
- ✓ The experiences and preferences of homeless individuals should be at the heart of solutions designed to improve homeless patient care and discharge planning.
- ✓ Crafting better policies requires creating opportunities for sharing experiences and best practices among stakeholders.
- ✓ Health care services stakeholders must also be willing to leverage their leadership positions to support innovative approaches to improving discharge processes, and to develop and strengthen a unified voice for advocacy.
- ✓ A clear need exists for increased public and private funding to support diverse options in homeless patient care and social services support.

Panel Two: Addressing Mental Health, Consent, and Conservatorship Issues Associated with Homeless Patient Discharges

Moderator: Jackie Lacey, Los Angeles County District Attorney

Panelists: **Connie Draxler** (Deputy Director, Los Angeles County Department of Mental Health, Public Guardian Operations); **Martin Hernandez**, LCSW (Director of Patients' Rights, Los Angeles County Department of Mental Health); **Sandy Jo MacArthur** (Mental Health Training Coordinator, Los Angeles County District Attorney's Office); **Luis R. Orozco**, LCSW (Supervisor, HOME, Los Angeles County Department of Mental Health)

Panel two highlighted the unique challenges homeless patients confront around mental illness and capacity issues, and pinpointed how stakeholders can seek support with the conservatorship process and through other methods to identify homeless mental health resources.

All panelists noted a recent demographic shift in local homeless populations, represented by an increase in the incidence of homeless individuals with acute mental illnesses, and an increase in the incidence of elderly homeless with dementia and other cognitive issues, making treatment options for mentally ill homeless individuals an especially relevant issue.

Martin Hernandez discussed the specific needs and rights of homeless individuals with mental illness. He emphasized that **patients control their own treatment, and always have the right to deny placement on discharge from a medical setting**. Still, Hernandez emphasized, there is much that hospitals and service providers can do to increase the likelihood that homeless patients with mental illness and cognitive deficits accept referrals and receive the treatment they need. For instance, **to help ensure continued care, discharge planning should begin on the day an individual enters the hospital. Additionally, hospital staff should work on making personal connections and building trust with patients, and ensure that discharge planning information is given in writing, in a language a patient understands**.

Panel participants also discussed the critical importance of record keeping and information sharing in improving care for mentally ill homeless patients, especially given that **a hospital stay presents a critical moment of opportunity for connecting patients with available ongoing supportive services**.

Sandy Jo MacArthur described the need for law enforcement officers, who interface frequently with homeless individuals, to continue to be trained in mental health issues and hospital admission standards. Historically, she explained, law enforcement officers were more likely to place mentally ill homeless people in jail than in hospitals, preventing individuals from receiving the intensive medical care they need. Through targeted training, however, officers have learned about the variety of factors that can lead to homelessness and how to effectively document the mental health and housing histories of homeless individuals. This information is critical, MacArthur noted, in order to effectively communicate with emergency room personnel why hospital admittance is necessary. **Luis Orozco** noted that while certain data privacy and security laws for safeguarding medical information (such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA)) place some important restrictions on sharing patient-specific data, these restrictions need not act as an obstacle to ensuring continuity of care. He emphasized **that community outreach workers and health care providers should be proactive about communicating with patients and each other to ensure that background health and housing information is available to help inform care and discharge planning decisions**.

The Los Angeles County Department of Mental Health (DMH) does outreach with the most severely at-risk individuals living on the streets, and tracks them closely. Because it can be challenging to execute a patient care plan for these individuals without access to their health histories, DMH works closely with community partners and builds long-term relationships with hospitals and health facilities to keep channels of communication open. Recently, this coordination paid off when DMH was able to help reconnect a homeless woman lacking mental competency who had been living on the streets for more than ten years with her family, after liaising with a health facility to obtain information on her background, and discovering that she had family members who were searching for her.

Finally, **Connie Draxler** discussed the conservatorship process handled by the Office of the Public Guardian, and the role it can play in ensuring that homeless patients with mental illness and cognitive impairments receive the care they need. A conservatorship requested pursuant to the Lanterman-Petris-Short Act, or an LPS conservatorship, requires that an individual have a grave disability due to mental health. Probate conservatorships do not require grave disability, but instead are used for individuals with dementia and other cognitive disorders, as well as victims of elder abuse. Critically, Draxler noted, **while conservatorships can offer an important bridge to housing and treatment for some, obtaining them is a difficult process and can take anywhere from between 40-120 days, depending on the type of conservatorship requested. For this reason, increased resources to assist mentally ill homeless individuals in accessing treatment and housing are an immediate need.**

Key Notes on Mental Health Resources for Homeless Individuals

- ✓ The Office of the Public Guardian handles conservatorships only for Los Angeles County residents, but residency can be established through multiple criteria. For instance, homeless individuals might fall under the Public Guardian’s jurisdiction by Medi-Cal code, which is county-dependent, or by reference to previous addresses or family location, or by demonstrating consistent transiency.
- ✓ **The Office of Patients’ Rights publishes a Patients’ Bill of Rights, but also does community outreach work through patients’ rights advocates and can be a resource not just for patients, but also for medical facilities.** For instance, if an individual experiencing homelessness refuses to leave a hospital or SNF setting despite no longer meeting medical criteria, hospital workers can ask the Office to deploy a patients’ rights advocate to sit with this individual and communicate discharge requirements. In this case, he or she is an advocate for both the patient and the skilled facility.
- ✓ **The Los Angeles Department of Mental Health (DMH) is also onboarding a number of new resources to assist mentally ill homeless patients.** For instance, DMH is in the process of moving to a new model of outreach to individuals experiencing homelessness called “search and serve,” which will enable DMH teams to identify individuals in need, make connections, and continue following those individuals to ensure continuity of care. DMH also has plans to open more crisis residential facilities, and may potentially pilot a bed-leasing program at SNFs to help meet demand.

Panel Three: Best Practices and Innovation in Homeless Patient Discharge Planning

Moderator: Mike Feuer, Los Angeles City Attorney

Panelists: **Elaine Batchlor**, M.D., MPH, CEO (Martin Luther King, Jr. Community Hospital (MLK)); **Molly Davies**, MSW (Vice President, Elder Abuse Prevention and Ombudsman Services, WISE & Healthy Aging); **Katie Hren**, MPH, LCSW (Cedars-Sinai Medical Center); **Edward Mariscal** (Manager, Long Term Care Program, Provider Engagement & Performance Management, Health Net, Inc.); **Jennifer Murray**, MSW, LCSW (Harbor-UCLA Medical Center)

“The fact that there is a paucity of resources doesn’t mean we don’t make an effort to coordinate services and connect patients to those services.” – Dr. Elaine Batchlor

In the third panel, discussion focused on national, state, and local legal requirements for homeless patient discharge, as well as affirmative best practices for homeless patient discharge planning and continued care.

The legal requirements hospitals and other medical facilities must abide by include those established by SB 1152, a new state law, and section 41.60 of the Los Angeles Municipal Code. LAMC section 41.60 requires that hospitals and other health facilities (including skilled nursing facilities and interim care facilities) located within the City of Los Angeles secure “written consent” from homeless patients before transporting them to any location other than a patient’s residence, and requires that this consent be “knowingly, intelligently, and voluntarily” given. SB 1152 requires all hospitals across California to develop written homeless patient discharge policies, and to implement a number of safeguards and practices to help ensure that homeless patients are connected with community resources, supportive services, ongoing medical treatment, and shelter. Panelists additionally shared specific ideas on how to implement and improve on discharge practices based on models that are already being implemented in Los Angeles by leading hospitals.

Martin Luther King Jr. Community Hospital (MLK), a private, non-profit facility, has one of the most disadvantaged patient populations in Los Angeles, but currently employs a successful model for managing homeless patient care. MLK CEO **Dr. Elaine Batchlor** described the comprehensive policies and procedures the hospital has developed, and the specific guidance and direction it offers its staff, to guide homeless patient care.

MLK’s process begins with the identification of homeless patients immediately on admittance, and their assignment to case managers to guide their care. The hospital then conducts several assessments to document the array of needs homeless patients may present. Social workers and nurses are trained and certified to place individuals on psychiatric holds, if necessary. Care and discharge plans are created for homeless patients up front, and include options for follow-up medical appointments and placements. A homeless services team liaison communicates with homeless patients at MLK about this process, and also accompanies each patient on a “warm hand-off” to their post-discharge placement destination. Discharges typically happen during the daytime, and patients are sent with seasonally appropriate clothing and toiletry kits. If no placement can be identified, individuals stay in the Emergency Department until one can be arranged.

Katie Hren from Cedars-Sinai Medical Center discussed how the hospital, also a private, non-profit hospital without access to the same Los Angeles County resources public hospitals use, has implemented a model for homeless patients. Cedars found a catalyst for implementing a model specific to patients experiencing homelessness after finding that its emergency room was overwhelmed with these patients, who had no accessible alternative shelter. **Starting small, by creating internal champions for homeless patient care among staff, Cedars began investigating what role it could play within its broader community to care for homeless populations.** The hospital instituted local case conferencing sessions to involve community partners and health care providers in monitoring homeless patients in its care, and became an active member in community coalitions working on homelessness issues. When the hospital's own internal evaluations of high utilizers of emergency care at its facility demonstrated a need to implement more effective care plans for homeless patients, Cedars invested in community partnerships to assist the hospital in executing these plans, and communicated with its partners on what these care plans entailed and how the hospital could help to execute them.

Jennifer Murray spoke to how **a comprehensive model for the care and discharge of homeless patients at Harbor-UCLA, developed because it was the right thing to do, has also been economically advantageous for the hospital.** In October, 2016, Harbor-UCLA created an internal Homeless Task Force to help provide coordinated care for homeless patients. This team creates continuity of care throughout a homeless patient's stay at the hospital, and ensures successful placement after discharge. In its first year, the Task Force housed 267 patients (including in detox, interim, transitional, and permanent placements), resulting in savings to the hospital of \$5.7 million. In its second year, the Task Force housed 200 patients, saving the hospital \$4 million. Murray noted, however, that the costs savings of Harbor-UCLA's care and placement program for homeless patients are likely much greater, given the cost savings to additional public agencies that accrues once individuals are housed. In terms of cost effectiveness, other panelists commented that contracting for recuperative care and other placement beds is generally more efficient than having patients remain in emergency departments longer than is medically necessary.

Edward Mariscal and **Molly Davies** discussed additional resources available to assist individuals experiencing homelessness with the discharge process, through health care plan interventions and the oversight of Los Angeles County's long-term care ombudsman program, respectively. Mariscal described the data on homeless patient care that all health plans maintain, noting that this data is comprehensive and cuts across jurisdictions, providing a history that can be used to improve and implement successful care and discharge plans for homeless patients. He noted that **Health Net and all LA County Health Plans work often with community organizations and government service providers to solve critical problems in discharge planning, and can help send teams to work with hospital staff to communicate and implement discharge plans to directly assist homeless patients.** Mariscal discussed how hospitals, SNFs and medical facilities can get assistance in discharge planning by contacting Health Net's Long Term Care team (Public Programs Department) as early as possible and asking for assistance. Davies described how WISE & Healthy Aging helps facilities with transitioning clients from hospital to nursing home settings, by providing training and educational resources to hospitals and discharge planners. A key component of successful discharge, she noted, is beginning discharge planning the day a client arrives in a facility, whether a hospital or a skilled nursing facility.

Several of the panelists also offered to act as mentors to the relevant staff members for medical facilities, and provided contact information, below, for those interested in learning from their experiences.

Key Themes and Ideas for Implementation

- ✓ **Discharge planning for homeless patients should start at the time of admission**
- ✓ **Hospitals and other facilities should not wait for the care of homeless patients to become a problem or for perfect solutions before taking action to implement discharge planning models;** proactive processes should be the goal.
- ✓ To make progress, we can redefine success as steps along the path to housing, giving weight to smaller tasks that move people forward on their paths to stability and housing.
- ✓ **Collaboration and partnerships are key to solving complex cases, and fragments in the housing and healthcare systems that homeless patients encounter must be addressed to fully serve them.** Improving homeless patient care requires participation from all kinds of facilities and stakeholders, and improved communication between healthcare providers, health plans, and people living on the streets.
- ✓ **Information-sharing resources for hospitals and other facilities seeking to place homeless patients exist.** Coordinated Entry System (CES), a “no wrong door system” for linking homeless patients to services, is the most well-known data platform, but other technology can fill gaps where CES is not available. For instance, health plans are working on a database of real-time patient data that collects historical, experiential, and social information on chronically homeless patients, which could be shared to improve discharge planning. Care Everywhere is another data-sharing program that enables hospitals to share case management notes on certain clients. One Degree, a part of Los Angeles County’s “Whole Person Care” program, is a repository for community resources, which requires agencies to set up individual profiles on a common platform care providers can access. Additionally, hospitals can include their own tools in electronic medical records for monitoring implementation of discharge plans. MLK, for instance, designed a drop-down menu in its admission system to flag issues specific to homeless patients.

Contact Information for Discharge Planning Mentors

The following individuals agreed to serve as mentors to peers at other healthcare facilities desiring assistance with implementing best discharge planning practices.

<p>Izette Aragon, MSW Martin Luther King, Jr. Community Hospital (MLK) 1680 E. 120th Street, Los Angeles, CA 90059 Tel.: (424) 338-8568 iaragon@mlkch.org</p>	<p>Molly Davies, LCSW, Vice President Elder Abuse Prevention & Ombudsman Services Wise & Healthy Aging Tel.: 310-394-9871 (ext. 431) mdavies@wiseandhealthyaging.org</p>	<p>Katie Hren, LCSW, MPH Clinical Social Worker, Dept. of Psychiatry and Behavioral Neurosciences, Cedars-Sinai 8730 Alden Drive, Thalians, Suite 3- 142, Los Angeles, CA 90048 Tel.: (310) 423-2875 kathryn.hren@cshs.org</p>
<p>Edward Mariscal, Manager, Long Term Care Program Provider Engagement & Performance Management, Health Net, Inc. 101 N. Brand Blvd., Suite 1500, Glendale, CA 91203 Tel.: (818) 543-9159 edward.mariscal@healthnet.com</p>	<p>Veronica Turner, MSW, LCSW, Clinical Social Worker Supervisor Harbor-UCLA Medical Center 1000 W. Carson St., Box 413, Torrance, CA 90509 Tel.: (310) 222-3278 veturner@dhs.lacounty.gov</p>	

Keynote Presentation: Improving Discharge, Ending Homelessness

Keynote Speaker: Joshua Bamberger, M.D., MPH, Associate Clinical Professor, Family and Community Medicine at UCSF, and Director of Health and Housing Initiatives at the Non-Profit Housing Association of Northern California



Dr. Bamberger began his keynote by describing a patient experiencing homelessness who was admitted to his emergency room with five admissions bands from other hospitals already attached to his wrist. The patient was a Vietnam veteran who had been battling alcoholism since being discharged from the Navy in the early 1970s. Ongoing alcoholism and a traumatic brain injury had led this patient to suffer from severe dementia. At the time of his discharge from the hospital, the patient refused a hand-off to a skilled nursing facility, and stated a preference to return to the streets and a familiar shelter. The patient was often too confused to make it to this shelter, but—lacking a rationale to conserve the patient, who assessments determined had been adequately fed, clothed, and still had enough capacity to make his own decisions—the hospital was forced to discharge him without any assurance he would receive appropriate continuing care.

Using this anecdote as a frame of reference, Dr. Bamberger went on to outline three potential discharge options based on models already implemented in other communities that might support patients like the one he described. **While not all housing models are directly applicable to the experience of homeless patients in Los Angeles, the goal, noted Dr. Bamberger, should be to recognize that housing is health.**

- The Barbara McInnis House, affiliated with the Boston Healthcare for the Homeless Program, was the first medical respite home in the nation, and now hosts 104 beds on the campus of Boston Medical

Center. Also a licensed skilled nursing facility, the McInnis House can bill Medicaid for nursing services at a higher rate of billing, which provides adequate Medicaid revenue to pay ongoing services for patients.

- Fort Lyon is a clean and sober living facility located 200 miles outside of Denver, run by the Colorado Coalition for the Homeless. It houses 250 individuals, who are free to stay as long as they want to. The facility's remote location provides a geographic barrier to alcohol, until patients gain the sobriety and skills necessary to move into one of the permanent supportive housing units the Coalition sets aside for patients leaving Fort Lyon.
- The Oaks is a long-term supportive housing facility in Ottawa, Canada, which runs a Managed Alcohol Program designed to stabilize participants' alcoholism by medically regulating the administration of alcohol to residents.

Dr. Bamberger highlighted how morbidity outcomes for homeless individuals with medical and mental health needs improve with the provision of housing and targeted wrap-around medical and social services. As an example, he described a study that tracked the survival rates of housed and unsheltered persons diagnosed with HIV/AIDS between 2002 and 2006. All of the study's participants had the same access to life-saving antiretroviral medications, but the study's unsheltered population died at the same rate as those diagnosed with HIV/AIDS did before antiretrovirals were brought to market.

Dr. Bamberger also outlined a study in which high-utilizers of emergency medicine were randomly assigned to receive either housing, or usual care and discharge from the hospital. Patients were monitored for utilization costs for three years, and resulting data revealed that, for those housed, utilization costs were more than halved over three years. For those not housed, costs initially increased before later falling, but in part because this un-housed control group experienced increased morbidity rates. In this instance, the outcomes of both the experimental and control groups support the argument that housing is health.

If the evidence on this point is so clear, what is standing in the way of improving access to housing and care for homeless patients? Dr. Bamberger highlighted pervasive issues and myths that play a role in preventing progress, including: persistent bias against homeless individuals and misconceptions about the factors that lead to homelessness; the fact that regions which provide good services for homeless populations end up inundated with growing homeless populations as a result; the unfortunate ban on using Medicaid funding for shelter; NIMBYism; and attitudes about equity and resource allocation that might prevent communities from aggressively moving to end homelessness. To combat these barriers, **Dr. Bamberger suggested providing a strong moral narrative to directly combat common arguments that impede progress towards shelter for all, and focusing on campaigns to target discrete segments of homeless populations first (such as veterans and the elderly) to galvanize support and facilitate targeted fundraising.**

Dr. Bamberger ended his keynote with a call to action, suggesting that by utilizing capitated healthcare systems, community benefit obligation dollars, and Medicaid waivers in creative ways, communities can fund the diversity of housing options that are critical to end the humanitarian crisis facing homeless individuals. For instance, Dr. Bamberger mentioned that recently, six hospital facilities in Portland, Oregon pooled their community benefit obligation funds, funds the IRS requires non-profit hospitals to charitably expend to maintain their tax status, to purchase 345 new units of permanent, supportive housing with a \$21.5 million investment. He also noted that Kaiser hospitals are increasingly focused on leveraging their community benefit obligation funds in this way.

Panel Four: Highlighting Programs and Resources to Assist Hospitals and Skilled Nursing Facilities with Homeless Patient Discharge

Moderator: Phil Ansell, Director, Los Angeles County Homeless Initiative

Panelists: **Libby Boyce** (Director of Access, Referral and Engagement, Housing for Health Program, Los Angeles County Department of Health Services); **Kelly Bruno** (President and CEO, National Health Foundation); **Clemens Hong** (Director of Whole Person Care Los Angeles, Los Angeles County Department of Health Services); **Marina Genchev** (Manager, Single Adult Systems Integration, Los Angeles Homeless Services Authority (LAHSA)); **Shari Weaver** (South Bay Director, Coordinated Entry System, Harbor Interfaith Services)

“We have a crisis of homelessness. People are living and sleeping in places where no human being in one of the richest societies in history should ever have to live and sleep. At the same time, we have an extraordinary movement emerging across Los Angeles County to prevent that homelessness.” – Phil Ansell

Participants in the fourth and final Symposium panel discussed new funding for homeless housing initiatives, and identified resources available to hospitals and SNFs to assist in ensuring the legal and humane discharge of homeless patients from medical facilities.

Phil Ansell noted that the Los Angeles County Board of Supervisors and the Los Angeles City Council have approved comprehensive and complementary homeless strategies, supported by ballot initiatives which have directed large amounts of new funding to homeless housing efforts: Proposition HHH (\$1.2 billion) and Measure H (\$3.5 billion). This funding supports the Los Angeles County Homeless Initiative, which moved 7,500 homeless families and adults into permanent housing, and 13,500 unsheltered adults into interim housing, in just its first year. **Marina Genchev** discussed the Los Angeles Homeless Services Authority’s parallel efforts to house homeless residents of Los Angeles, through its use of the Coordinated Entry System (CES), a database that facilitates the coordination and management of resources to match people with permanent housing. **Through use of a vulnerability index, CES moves away from a ‘first-come, first-served’ model to focus on housing homeless individuals with the greatest need and most acute medical risks first.** The chronically homeless population in Los Angeles has decreased 18% since the advent of CES. **Shari Weaver** discussed how CES works in the South Bay, in coordination with the South Bay Coalition to end homelessness, where a United Way pilot program and five partner hospitals are collaborating on discharge planning to ensure that hospital staff and community social workers have access to data on homeless individuals and their interaction with county service providers. She noted that the program was so successful that the participating hospitals chose to continue to fund the program after the funding for the pilot program ended.

Libby Boyce discussed Housing for Health and its programs to serve homeless individuals who are frequent users of health care services. **One of Housing for Health’s priority areas is finding interim housing for individuals exiting institutions, and ideally, placement in permanent, long-term, affordable rental housing with access to intensive care management services that can link residents with the health and social services necessary to sustain independent living.** Housing for Health also offers interim housing, in the form of recuperative care housing with health and mental health services, as well as stabilization housing, which offers even more intensive wrap-around services, case management, and transportation. For individuals who are unable to remain stable in permanent housing without intensive care and supervision, board and care facilities may be an option. For this reason, Housing for Health is assisting board and cares in offering more substantial care for homeless individuals transitioning to these residential settings. It also supports a Benefit Entitlement Services Team, to assist homeless individuals in accessing supplemental security income and disability benefits

they are eligible to receive. Finally, Housing for Health runs over fifty multidisciplinary teams in Los Angeles County focused on health, mental health, substance abuse, and other issues, which, in addition to LAHSA homeless engagement teams they work with, serve as initial points of contact for assisting homeless individuals living on the street.

Clemens Hong introduced Whole Person Care, a five-year pilot program to bring together health and social service entities to develop the infrastructure, capacity, and capability to serve the most vulnerable Medi-Cal beneficiaries in Los Angeles County. Whole Person Care uses community health workers that have worked under the supervision of social workers to coordinate care, break down barriers, and build trust in ways traditional systems are not able to do. It funds the service components of Housing for Health, such as the initiative's intensive case management and recuperative care programs, as well as its support for board and care facilities. It also runs a substance abuse disorder engagement and support program, a hospital-facing program for high-risk homeless individuals with substance abuse disorders who are high-utilizers of emergency room services. **One of Whole Person Care's successes is using recovery coaches, many of whom have shared lived experiences with patients, to connect with patients and help them engage in treatment, stay motivated in their recovery efforts, and guide them to other services, including primary care.** Finally, Whole Person Care is funding a "transitions in care" program, a hospital-to-home transition program for a small subset of hospitals, as well as a new pilot program for wrap-around services that support homeless individuals in hospitals for extended periods of time as a result of a lack of beds in skilled nursing facilities.

Kelly Bruno described the National Health Foundation's non-profit approach to the provision of recuperative care services, including through its operation of a new, 62-bed facility in Pico Union built with community support. She noted the importance of involving residents from the beginning of the project by encouraging their participation in project planning and volunteer days at the build site, by hiring local residents to work on construction, and by thanking the community with a block party on the opening of the facility. **NHF's focus, said Bruno, is on humanizing the homeless experience by building residences that are comfortable, safe, and integrated into neighborhoods.** NHF also coordinates with county homeless resources, including by ensuring that all residents in buildings it operates are entered into CES.

Key Homeless Services Resources

- ✓ **LAHSA** publishes a CES access point directory, updated shelter list, and directory of shelter beds for individuals exiting institutions, as well as a list of community meetings focused on homeless health care issues. LAHSA is also developing an online portal to facilitate access to county beds by providing real-time online information about available beds that are open.
- ✓ **Housing for Health** operates a variety of housing facilities, from interim and recuperative care facilities to long-term supportive housing.
- ✓ **Whole Person Care** runs a number of community-based programs to help homeless individuals access health care and transition to interim and permanent housing settings, and offers social services support to conduct outreach to homeless individuals and connect them with services.

Moving Forward: Key Takeaways and Next Steps

While challenges remain to ensure that homeless patient discharge planning operates effectively, Los Angeles has a great opportunity to make real progress for homeless individuals through continued collaboration, conversation, and targeted interventions, while understanding the healthcare community's tremendous challenges in dealing with this population. Summarized here are a few global takeaways from the Symposium, as well as goals identified by participants eager to further this work.

Key Takeaways

- **Great models for best practices in discharge planning abound in Los Angeles.**
 - MLK, Cedars, and Harbor-UCLA are already implementing homeless patient discharge programs that can serve as a model for other hospitals and facilities.
 - Los Angeles County's Department of Mental Health also publishes a Patients' Bill of Rights to help guide facilities in implementing policies and procedures that account for the rights, roles, and preferences of homeless individuals.
 - The Long-Term Care Ombudsman program offers additional oversight support and resources for handling discharge planning, from the perspective of both discharging *and* receiving facilities.
- **Discharge planning is for everyone, and does not need to be cost-intensive.**
 - Even hospitals and other facilities without lots of excess staff or access to funding can make efforts to staff and train dedicated homeless patient care teams and contacts, and take advantage of homeless services teams and coalitions supported by, e.g., Whole Person Care, or resource workers employed by health plans.
 - This work can also save hospitals and other medical facilities money by improving health outcomes and reducing morbidity, and chipping away at the 'revolving door' issue posed by high utilizers of emergency room services.
- **We have great tools for connecting homeless patients with community resources, but need more communication between hospitals, county and city agencies, and health care providers and community resources, where appropriate.**
 - Coordination and communication are key to ensuring homeless individuals can access community services and resources.
 - Utilizing data-sharing platforms including CES helps track homeless patients and capture their health and housing histories to better inform treatment and discharge planning.
 - LAHSA also has a list of resources on potential placements, and the Los Angeles City Attorney's Office has collated resources on discharge planning issues on its website, available at <https://www.lacityattorney.org/homelessness>.
- **The imperative to identify new sources of funding and make available abundant and varied new forms of supportive housing is clear.**
 - Private hospitals, the Office of the Public Guardian, Housing for Health, non-profits like NHF, and others are all bringing new housing options online, through bed leasing programs, rent subsidies and grant programs, direct investments in infrastructure, etc. New housing and homeless healthcare services in Los Angeles can also assist in addressing challenges.
 - Stakeholders must work together to identify new ways to improve the efficiency of housing expenditures, including through leveraging Measure HHH funds.

Goals for Future Progress

Short- and mid-term goals

- **Los Angeles District Attorney Jackie Lacey, Los Angeles City Attorney Mike Feuer, HASC, and other members of the community will continue to collaborate to address targeted issues with homeless patient care and discharge planning.**
- **Improve information for the benefit of hospitals, SNFs, and other facilities on how to access private, non-profit, local, state, and federal resources** to ensure homeless patients are discharged to locations best suited to address their needs.
 - Expand the current list of key departments and contacts from hospitals, SNFs, other health care facilities, non-profits, and appropriate governmental agencies.
 - Schedule regular quarterly meetings for governmental agencies, hospitals, and SNFs to address best practices, proposed solutions, and concerns of front-line discharge workers. These meetings can also introduce new and changing resources offered by LAHSA and other agencies.
 - LAHSA will create a system where health care providers can be alerted in real time to the available beds in Los Angeles County. According to LAHSA, this data set will be updated every morning and is expected to be available in early 2019.
 - Coordinate health and managed care plans around homeless patient discharge issues, and ensure avenues for involving them more directly in liaising with hospitals and medical facilities to serve the homeless patients they insure.
- **Develop a comprehensive database for information-sharing on homeless patient health and housing histories that can reach across silos to be available to all hospitals and providers.**
- **Work together to address community concerns, get community buy-in for housing facilities for the homeless, and develop innovative funding models to support new housing initiatives.** Inform communities about the need for this housing, and the specific populations that will be served in each location, such as shelters that primarily house homeless veterans or the elderly.
- **Develop a process for addressing the desire to increase the resources available to homeless patients, including those with acute psychiatric needs and substance abuse problems.**
 - For example, new detox facilities can be used to address immediate need for specialized substance abuse interventions, and pilot projects, like those seeking to secure beds at SNF facilities with special funding, can fill gaps and create new capacity.
 - We also need to identify potential new sources of funding for medical respite/ recuperative care beds, interim beds, and long term-housing opportunities through coordination with the private sector (e.g. private hospitals and the business community), non-profit and philanthropic resources, and the creative use of public funds.

Long-term goals

- **Improve and increase the supportive services available to all homeless patients.**
- **Increase the number of long-term supportive care facilities providing wrap-around medical and psychiatric treatment that are available to homeless patients.**