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Los Angeles City and County Health Service Coordination for People Experiencing Homelessness

RAPID RESPONSE LANDSCAPE ANALYSIS

PRESENTED BY
PEOPLE'S HEALTH SOLUTIONS
COMMISSIONED BY UNITED
WAY OF GREATER LOS ANGELES



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About this Report

This report is a result of a collaborative effort between United Way of Greater Los Angeles (UWGLA), Los Angeles City Administrative Office (CAO), and People's Health Solutions. In response to a 2020 Los Angeles City Council motion calling for a deeper investigation into health service delivery for unhoused Angelenos within City limits, UWGLA and CAO came together to commission a third-party analysis to better understand: (1) the conditions behind the 1964 elimination of the City's health department, (2) the scope, scale, and design of Los Angeles County's health and mental health services and (3) health/mental service coordination with the City and other entities.

Over the past several months, People's Health Solutions has undertaken this analysis funded by UWGLA, in partnership with key City and County informants, advocates with lived experience, and experts in the provision of health/mental health services to the unhoused community.

Thank you to key Informants and interviewees from:

- Los Angeles County Department of Health Services
- Los Angeles County Department of Mental Health
- Los Angeles County Department of Public Health
- Los Angeles Homeless Services Authority
- Los Angeles Office of the City Administrator
- Los Angeles Fire Department
- City Council and County Supervisor Offices
- University of Southern California and University of California Los Angeles
- Numerous health, mental health, and homeless service organizations

We would like to acknowledge the focus group participants whose lived experience and expertise as advocates for our unhoused neighbors informed our narrative, and Dorothy Edwards of Corporation for Supportive Housing *Speak Up!* for her leadership in group co-facilitation. We are thankful for the numerous contributions at all stages of Steering Committee members: Etsemaye P. Agonafer, MD, MPH, MS; Dorothy Edwards; Caroline Rivas, MSW; Norma Stoker-Mtume, MHS, MA, MFT; and Lucien Wulsin, JD. We also honor the wisdom and compassion of the late Dr. Erylene Piper-Mandy, a mentor who taught the centrality of uplifting community history in mental health.

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Executive Summary

Background

What we call “homelessness” can be experienced in many different ways: from having to leave home to flee violence, to housing instability following a disabling health condition or economic hardship or loss of family, to being unsheltered on the streets. Reflective of this, we used terminology throughout our report that was as specific as possible to the situation being described, rather than using one term such as “people experiencing homelessness.” Recognizing that no one term fits all contexts is important to humanizing this issue.

There are an estimated 66,436 people in Los Angeles County (“County”) experiencing homelessness, and of these individuals two-thirds (41,290) reside in the City of Los Angeles (“City”) (LAHSA, 2020c). Loss of jobs and income coinciding with the COVID-19 pandemic are forecasted to continue to contribute to loss of housing and housing instability (Flaming et al., 2021), while at the same time, legacies of racism and gender discrimination continue to drive inequitable health outcomes (California Department of Public Health, 2020; O’Neill, 2020b).

The magnitude of the housing crisis, and inequities in health outcomes, underscore the need for efficient and equitable coordination of services for unhoused Angelenos. To this end, a 2020 LA City Council motion calling for an investigation of City and County health service coordination offered an opportunity to identify service gaps, barriers, and opportunities. United Way of Greater Los Angeles further expanded the scope of inquiry and commissioned People’s Health Solutions to implement a rapid analysis.

This rapid-response landscape analysis was undertaken with the aim of identifying potential solutions for improving City and County coordination of health and mental health services for people experiencing homelessness in the City. As safety net health and mental health services are provided by the County and coordinated at the Service Planning Area (SPA) level, it is difficult to tease out service gaps, barriers, and opportunities relevant only to the City. For this reason, overall health and mental health service findings and recommendations are relevant to the County, and those for enhancing service planning and coordination are applicable to the City and County.

Evaluation Design and Methods

This landscape analysis was conducted from mid-May through early July 2021 and involved a qualitative, sequential mixed-method approach including a document review, ten key informant interviews, a focus group with six advocates who have lived experience of being unsheltered and navigating health services in the City, and three case spotlights. Five categories were used as a framework to guide inquiry for all evaluation activities: (1) health and mental health system design, (2) health and mental health system scope and scale, (3) leadership and coordination, (4) communication and client engagement, and (5) data sharing and outcomes measurement.

A five-person steering committee representing diverse sectors was convened throughout the course of the project. Key informant interviews and the focus group were transcribed, coded, and analyzed using a blended “framework” and “constant comparison” approach.

The specific focus of this report is health and mental health safety net programs directly operated or contracted by the County or City, and therefore managed Medi-Cal programs fall outside the scope. We define mental health services as an umbrella term for mental and behavioral health services, the latter being inclusive of substance use disorder treatment.

Results

Historical Milestones Shaping the Health Service Landscape

The health and mental health landscape for people experiencing or vulnerable to homelessness in the City of LA has been shaped by policies, cultures, events, and structures over many decades.

Drivers of Inequities in Housing Status in the City

Decades of policies and structures such as redlining and eminent domain, clearance of units on Skid Row in the 1960s, and a rapid rise in mass incarceration from the 1970s onward, have shaped inequities we see today in housing and health outcomes. De-institutionalization, without adequate investment in community mental health systems, meant that many people with serious mental health conditions wound up unsheltered on the streets. These factors, combined with economic downturn and national cuts to social welfare programs, led to an exponential rise in homelessness by the early 1980s. Cycles of hospitalization, re-institutionalization in prisons/jails, and unsheltered homelessness persist to this day.

Role of City/County in Public Health and Indigent Care

In the early 1960s, health care for people in LA who were uninsured or of limited means was provided primarily through LA County General Hospital (Eastman Martin, 1979). In 1935, the [California Welfare & Institutions Code \(WIC\) § 17000](#) delegated Counties as the “provider of last resort” of health and mental health care for those not served by state or private institutions. For public health services such as disease control or environmental health, the LA City Health Department and County Department of Public Health provided very similar basic local public health services required by State law.

In 1972, in a push toward greater efficiency and integration, all County health functions were consolidated into a single department, the Department of Health Services (DHS) (Cousineau & Tranquada, 2007). Department of Mental Health (DMH) later split from DHS in 1978, and Department of Public Health (DPH) in turn split in 2006 (Sewell, 2015). The County Health Departments are currently separate but unified under the coordinating entity Alliance for Health Integration, which replaced the Health Agency in February 2020 (J. Baucum, personal communication, July 27, 2021).



City-County Health Department Merger for Public Health Services

In 1964, the City made the decision to eliminate its health department to reduce a double tax burden on City taxpayers (Delgadillo, 2005). The City and County concluded that most services the City Health Department was providing would either continue under the County Health Departments or be transferred to other departments within the City (Hufford, 1966).

In the early 1960s, basic public health services provided by the City included health statistics, communicable disease control, laboratory services, health education, maternal and child health services, and environmental health services. In addition, the City Health Department provided some chronic disease programs and mental health services. These very limited health service functions were administered separately from indigent health services of the County Departments of Hospitals and Mental Health (Hufford, 1966)

The 1964 City/County Health Agreement applies specifically to enforcement of municipal codes related to “public health and sanitation” and not to indigent health and mental health care, which in accordance with WIC §17000 had always been the responsibility of the County.

In January 1964, an ordinance was delivered to the County Board of Supervisors that acted as a formal notice to the County that the City was transferring its responsibility to provide health services within the City to the County as of July 1964 (Hufford, 1996). The City adopted the County’s Health Code as its ordinance and entered into an Agreement with the County establishing terms of enforcement of [LA County Health Code § 11.1](#) within the City (City of Los Angeles & County of Los Angeles, 1964) (**Appendix A**).

As expressed in [LA City Municipal Code \(LAMC\) Chapter III](#), any provisions of County Health Code that were substantially similar to LAMC have been “construed as restatements and continuations of existing law,” and in the case of any conflicts, provision of LAMC prevails over County code.

The City maintains control over the adoption of ordinances relating to public health within the City. Amendments may be made to the LAMC to authorize enforcement within the City by the County of new ordinances relating to public health and sanitation, pursuant to the aforementioned Agreement. Changes to the County Health Code are [routinely reviewed for incorporation](#) into LAMC by the City to confirm they express the will and intentions of City Council, and they may be expressly adopted or not adopted.

Transition to Housing First Model

When the first federal legislation addressing homelessness was passed in 1987, the dominant paradigm was “Housing Readiness,” a philosophy whereby a person was expected to achieve milestones of recovery before being able to access housing. This began to shift in the 1990s onward to “Housing First,” which involves providing permanent housing without the requirement of sobriety. From 2009 to 2016, federal and state laws recognized and committed funding to Housing First as a best practice and established the continuum of care (CoC) and coordinated entry system (CES).

In 2016, SB 1380 defined core components of Housing First that state-funded programs would need to adopt. Among these are support services for engagement and problem-solving; harm reduction approaches and connection to substance use treatment; and housing to “accommodate disabilities” and “promote health, community, and independence.”

Health System Design

Health and mental health services are delivered to unsheltered residents in the City of LA through a web of County services that work in coordination with Los Angeles Homeless Services Authority (LAHSA) — the lead agency for the HUD-funded Greater LA CoC — and to a very limited extent the City.

LAHSA operates as a joint power of authority of the City and County.

DHS, DMH, and DPH are each exclusively responsible for a portion of the Medi-Cal benefit. DPH is responsible for safety net substance use treatment and prevention services; DHS for health services; and DMH for mental health services for those with serious mental health conditions. These departments also coordinate with the Department of Public Social Services (DPSS). The City directly operates a limited scope of health, mental health, and public health programming predominantly through its Fire Department (LAFD) and Police Department (LAPD) emergency response teams and through the Unified Homeless Response Center (UHRC), whose programs include a new street medicine pilot with LA County USC Medical Center to provide mobile health and mental health services in East LA.

Services and programs operated and/or funded by the County or City and frequently used by people who are unsheltered can be grouped into five buckets mirroring a person's journey through the health and mental health system: (1) health care coverage, (2) outreach and engagement, (3) transition and diversion, (4) direct health services, and (5) supportive housing.

Leadership and Coordination

The structure of authority for planning health and mental health services predominantly falls under the Alliance for Health Integration (formerly Health Agency) and Board of Supervisors (BoS) at the County level. Some services, like mobile outreach and crisis intervention, are offered by the County in coordination with the City and LAHSA. The role of the City and Mayor's Office is largely limited to the duties of its emergency response agencies, since the 1964 City-County Health Agreement transferred responsibility for performing services to enforce ordinances "related to public health and sanitation" to the County. The County had always been responsible for delivering safety net health and mental health care to its residents.

Historically, the City has been responsible for housing and maintaining physical structures for public health service provision, as seen for example in the creation of emergency shelters within Recreation and Parks facilities and maintenance of screening and vaccination facilities since the onset of the COVID-19 pandemic. The County provides health services within these physical plants.

On February 9, 2016, the City Council and County Board of Supervisors, respectively, adopted two separate homeless response strategies developed through shared planning sessions. The resulting City Proposition HHH focused on production of supportive and affordable housing units (City of Los Angeles, 2021b). County Measure H funded health and mental health services,



*An example of what can be achieved through bridging silos under a common vision is presented in **NYC Case Spotlight Part 2: Veterans Administration Bridging Silos under a Common Vision.***

HEALTH/BEHAVIORAL HEALTH SERVICES FOR UNHOUSED ANGELENOS

Services and programs operated and/or funded by the County/City and utilized by unhoused residents frequently

KEY AGENCIES AND DEPARTMENTS

Mental Health (DMH)

Public Health (DPH) - SAPC

Health Services (DHS) - HFH, ODR

Public Social Services (DPSS)

CITY OF LA

Fire (LAFD)

Police (LAPD)

Unified Homeless Response Center

LA HOMELESS
SERVICES AUTHORITY

P Pilot program
starting in 2021

HEALTHCARE COVERAGE	<ul style="list-style-type: none"> Medi-Cal My Health LA (MHLA)
OUTREACH AND ENGAGEMENT	<ul style="list-style-type: none"> Homelessness Engagement Team (HET) Housing for Health Multidisciplinary Teams (MDTs) Homeless Outreach and Mobile Engagement (HOME) Psychiatric Mobile Response Team (PMRT) TAY Drop-In Centers Health Navigators Veterans Peer Access Network (VPAN) SOBER Unit Advanced Provider Response Unit (APRU) Systemwide Mental Assessment Response Team (SMART)
TRANSITION AND DIVERSION	<ul style="list-style-type: none"> ODR Housing Program (Pre-Release) WPC Re-Entry Program (Pre- and Post-Release) Court Liaison Program (CLP)
DIRECT HEALTH SERVICES	<ul style="list-style-type: none"> Ambulatory Care Network (ACN) Sobering Center (Skid Row) Naloxone Access points (NAPs) HFH "Street Medicine Team" P Mental Health Full Service Partnership (FSP) Assisted Outpatient Treatment for LA (AOT-LA) Alternative Crisis Services (Enriched Residential Services, Urgent Care Centers) Integrated Mobile Health Team (IMHT) Drug Med-Cal Organized Delivery System (DMC-ODS) Sobering Center (MRT Behavioral Health Center) P Overdose Education and Naloxone Distribution (OEND) USC Street Medicine Team for Unhoused Angelenos P Therapeutic Transportation (TT) P
SUPPORTIVE HOUSING	<ul style="list-style-type: none"> PSH, RRH, Interim Housing (City/County/HUD Funded) Housing for Health: PSH, Enhanced Residential Care, Stabilization Housing, Recuperative Housing ODR Housing Program Continuum of Care, Homeless Section 8, Interim Housing Recovery Bridge Housing (RBH)

case management, rental and housing subsidies, and emergency and affordable housing (County of Los Angeles, 2021). Supportive services in City-funded permanent supportive housing units are paid for by Measure H.

COVID-19 led to establishment of common planning forums and a command structure based at LAHSA and inclusive of but not limited to the County Health Departments and Chief Executive Office; and City Mayor's Office and Chief Administrative Office (Marston 2020b). The City and County implemented largely parallel response efforts. The City was predominantly responsible for physical plants such as emergency shelters and testing and vaccination sites, whereas the County focused on direct health service provision. There was nonetheless unprecedented collaboration between County, LAHSA, and service agencies, in particular culturally-specific organizations and federally qualified health centers, to bridge silos and allocate responsibility where each could have the most efficient impact.

Health System Scope and Scale: Service Gaps

Seven service gaps arose thematically from our key informant interviews and focus group as key areas where needs outstrip capacity with regard to funding, service delivery models, and/or personnel.

1. Permanent supportive housing
2. Medication for addiction treatment (MAT) for substance use conditions
3. Mobile clinical medical homes
4. Health care navigation and advocacy
5. Targeted programs for people in transition (hospital and jail settings)
6. Law enforcement collaborations and diversion programs (e.g., psychiatric mobile crisis)
7. Culturally-specific services

These gaps illustrate areas in which needs outstrip capacity with regard to funding, service delivery models, and personnel.

Health System Scope and Scale: Barriers to Meeting Need

The following arose thematically from our key informant interviews and focus group as primary barriers to the health system's capacity to serve residents who are unsheltered or experiencing housing instability to the degree that is expected of the City and County.

- 1. Affordable, interim, and permanent supportive housing:** Lack of housing was named by all participants as the greatest barrier to the health system's capacity to provide people with the safety and stability to heal and engage in ongoing services.
- 2. Funding and service delivery silos:** Silos between funding streams and between public agencies create barriers to combining housing, social service, and health service resources to create programs that meet people's whole health needs.

*These service gaps **mirror some of those identified in a recent needs assessment on mental health service needs in LA County** commissioned by the Health Agency prior to establishment of the Alliance for Health Integration (Mercer, 2019).*

- 3. Mobility of unsheltered residents and clean-up efforts:** Housing instability and mobility represent barriers to residents engaging with health services in an ongoing manner and to providers in ensuring continuity of care. Mobility was described as an important factor to take into account in service design around City encampment clean-up efforts, with participants citing a need for County collaboration to provide proactive mobile medical outreach and engagement.
- 4. Lack of fit of health service design to unsheltered residents:** Key characteristics that participants said made health and mental health services more effective were low-barrier access, relationship-building, mobile medicine, and Housing First and harm reduction models.
- 5. Racism:** Racist beliefs and practices among health care providers contribute to inequitable health outcomes. Focus group participants spoke at length about the feeling of being treated as a source of profit and of having avoided medical care due to fear of inappropriate treatment and harm.
- 6. Stigma and public misconception:** Various stigmas toward unsheltered neighbors have contributed to a culture of NIMBYism (“Not in My Back Yard”) and barriers to health care and housing. While Housing First and harm reduction models have proven highly effective, stigma toward addiction and MAT are barriers to dissemination.

*In our **NYC Case Spotlight**
Part 1: Proactive Outreach
through 311, we explore how
New York City implemented
a unified service access point
through its 311 system and
HOME-STAT teams.*

*Our **Spotlights** on **Venice**
Family Clinic and **Homeless**
Health Care Los Angeles in
turn demonstrate
how mobile medicine,
relationship-building, and
low-barrier entry form
pillars to effective models for
engaging our unsheltered
neighbors in health services.*

Engagement and Communication

Traditional media such as billboards, telephone hotlines, websites, and social media were the most common vehicles named by key informants as a means of communicating about health services to unsheltered residents. However, advocates with lived experience said that they had the greatest success learning about and accessing health services through referrals from hospitals or service providers outside of the health care sector, such as DPSS.

Participants emphasized the relative utility of direct engagement through mobile units or peers and access to low-barrier service entry points. Examples named were Drop-In Centers, Recovery Intake Centers, and Safe Consumption sites. Some specifically mentioned the role of multilingual *promotores* who deliver health education in diverse community settings.

Key informants voiced a desire for staff of those municipal agencies that unsheltered residents frequently interact with, such as public libraries and Recreation and Parks, to be empowered to help facilitate access to housing and health services. They identified the need for a unified health service access line or database searchable by service providers.

Data Sharing and Outcomes Measurement

Sharing of client-level information across City, County, and LAHSA is limited, in part due to silos and lack of shared information systems, and in part due to federal restrictions for sharing of personal health information. County departments including DHS, DPH, DMH, Sheriff, Probation, DPSS, and Department of Children and Family Services (DCFS) have the capability to match clients on unique identifiers. These same identifiers are used in the LAHSA Homeless Management Information System (HMIS), making it possible to also match data on those who are engaged with both LAHSA and County departments.

It is possible in real time for LAHSA and County staff to respectively access very limited profile information in each other's systems. LAHSA may for example view limited information on shared clients in DHS, DMH, and DPSS via the County Information Hub. The County in turn may view limited read-only information in HMIS, such as whether a client is seeking housing. Multiple key informants discussed how because these agencies have grown so large, and are often serving the exact same individuals, a more centralized platform could promote coordination and efficiency.

At the program level, key informants described opportunities for two-way City/County sharing of public health trends and patterns at the neighborhood level. Participants discussed the potential to achieve more positive results for unsheltered residents by shifting from a focus on program activities to collective health outcomes across communities served.

Recommendations

City of Los Angeles

- **Formal Oversight and Evaluation of Health Service Delivery:** The City should review County Health Codes and make recommendations to the County to amend its Codes to address emerging public health needs.
 - LA City Health Commission can oversee and evaluate the 1964 City-Council Agreement with official authority and resources. The Commission's role and County's responsibility to report to the Commission should be clearly stated in the Agreement as an amendment.
 - The Health Commission, through community engagement, could also conduct an annual evaluation of whether the safety net health and mental health needs of all Angelenos are met.
- **Further Research on City-County Health Coordination:** Investigate how other cities without their own health departments coordinate health services for unhoused residents (e.g., Seattle-King County Public Health and [Health Care for the Homeless Network](#)).
 - Review of similar agreements in these cities may provide insight into precedents for what delineates City vs. County roles in public health and sanitation and processes for ongoing oversight and amendment of "evergreen" public health contracts.
- **Staff Training and Referral Tools:** City staff who interact with unsheltered residents — including staff at Council District offices, libraries, schools, parks, and recreation centers — could be offered trainings and resources for referring residents to housing and health services.

*LAHSA and County data is being used by California Policy Lab at UCLA for a variety of projects, including creation of **predictive analytics to help identify clients vulnerable to housing instability.***

A new DHS Homeless Prevention Unit** developed to help implement Measure H prevention strategies has been staffed to make use of these predictive analytics to **engage clients in need of additional supports.

*While the City Council holds authority to renew the 1964 City-County Agreement, **there is no official department or authority within the City** that manages the contract and evaluates adequacy and effectiveness of municipal code enforcement provided by the County.*

The Alliance for Health Integration (AHI) was created in February 2020 through a motion of the BoS to create a revised structure and shared priorities for its predecessor, the Health Agency. The AHI is embedded in all three County Health Departments as an implementation arm for all health integration work.

County of Los Angeles

- **Unified Health Promotion under Single Health Agency Entity:** While DPH, DHS, and DMH coordinate at the service level, planning is largely independent, posing a challenge to service coordination. Collaboration between County and City is also limited, resulting in multiple parallel programs that could potentially serve more people if streamlined.
 - An ideal structure may be one that allows the County Health Departments to operate even more collaboratively. The AHI could function as a cross-cutting unit working under coordination of DHS Housing for Health to provide health and mental health services to unhoused Angelenos.
 - Incentive structures that shift emphasis from service activities to results and community health outcomes could play a role in promoting service coordination.
- **Provision of Health Service Quality Measurement Data for the City:** The City needs access to quality assurance and improvement data from the County's health services within the City.
 - County health, social, and homeless services are organized by Service Planning Area (SPA) or Service Area (SA), which does not delineate the City from the rest of the SPA it is located in for data reporting purposes.
 - The first step to meaningful data sharing would be for the County to provide reports on outcome indicators specific to the City that could help the City understand whether residents' needs are being met.
 - Health quality measurement indicators data for the City could inform the aforementioned annual evaluation of indigent health and mental health needs of the City's residents.

City and County of Los Angeles

- **Streamlined Mobile Outreach and Medicine Programs:** Spikes in mortality due to Fentanyl overdose and support needed by City CARE and CARE+ teams who visit encampments for clean-ups create urgency to bring mobile medicine to scale.
 - Multiple efforts at City and County levels to pilot "mobile medicine" programs present opportunity for streamlining and collaboration.
 - City (311) and County (211) hotlines could be paired with triage and mobile response through a unified hotline modeled after HOME-STAT in New York City.
 - More planned coordination between County street medicine and City CARE teams could bolster health supports for unhoused Angelenos.

- **Law Enforcement Collaborations for Mental Health Crisis:** Mental health crises have evolved from being a mental health care issue to a law enforcement issue. This may be harmful to both the individual in need of clinical support and the officer who is called upon to respond.
 - More mobile crisis teams are needed so responsibility for responding to crises does not fall on LAPD/LAFD officers who are not clinicians.
 - City System-wide Mental Assessment Response Team (SMART) and County Psychiatric Mobile Response Team (PMRT) are promising models, but ability to respond is limited by funding and staffing. Therapeutic Transportation Pilot represents a promising new resource.
- **Targeted Programs for People in Transition:** People discharged from hospitals or released from jails are vulnerable to cycles of homelessness, and plans for their community re-entry should be in place prior to release.
 - Post-hospital transitions could be supported by more enriched residential care and complementary functional rehabilitation.
 - Programs to support the re-entry of justice-system-involved individuals could be brought to greater scale through multi-sector collaboration between County (e.g., DHS Office of Diversion and Re-Entry), LAHSA, City (e.g., GRYD Office), and community-based organizations.
- **Forums for Planning and Shared Vision:** Solutions to gaps and barriers identified in this landscape analysis remain confounded if those unified under the same mission are not incentivized to work together under a common vision. Key informants at the City and County revealed very similar attitudes and beliefs that they struggled to engage in safe and productive dialogue on collaborative approaches to service delivery.
 - There is an opportunity for City and County leadership and staff involved in health and mental health care delivery for people experiencing homelessness to engage in strategic planning or mediation aimed at conflict resolution or collaborative action.
 - While the County is not bound by law to adopt new Health Codes based on needs identified by the City Health Commission, shared forums for planning and evaluation would allow for dialogue around emerging needs of the City's unhoused residents. Emergent public health needs of City residents identified by key informants include COVID-19 testing, mitigation, and vaccine delivery; mobile medical and social support for residents in encampments; and law enforcement collaborations such as psychiatric mobile crisis support.

Disproportionate rates of police shootings among BIPOC, people with disabilities, and people with mental health conditions underscore the need for law enforcement collaborations and alternatives (Fuller et al., 2015; LA Times Staff, 2021; Perry & Carter-Long, 2016).

One example of a promising program for older adults transitioning from hospitals is Community Aging in Place – Advancing Better Living for Elders (CAPABLE), which teams a nurse, occupational therapist, and a handy worker to help older adults achieve safety and independence (Johns Hopkins School of Nursing, 2021).

Health inequities are driven by neighborhood segregation, mass incarceration, and unequal health care (Bailey et al., 2021). Collaborative action for change is urgently needed to invest in historically displaced communities and to elevate community voices and needs.

Whole Person Care program findings underscore the importance of equilateral power-sharing across City, County, LAHSA, and CBOs. "Expanding integrative models of care requires targeted and inclusive training, funding, shared planning [and] governance to prevent unintended consequences of [a] single-sector approach" (Agonafer et al., 2021).

- **Building Relationships through Accompaniment:** Navigators, community health workers, and advocates with lived experience meet clients where they are at, build trust and therapeutic rapport, and engage patients in journeys of healing and recovery.
 - A pilot program could evaluate the efficacy and cost-effectiveness of a model proposed by advocates where every client is paired with accompaniment.
 - Campaigns to distribute health information and resources should harness the power of peers and social networks as an alternative to traditional media and didactics.

Policy and System Level

- **Reducing Race and Gender Inequities in Health and Housing Status:** LA City and County should prioritize equity in health outcomes and housing status.
 - At the policy level, progress can be made by the City and County through participatory budgeting and urban planning practices.
 - At the system level, the City and County should prioritize investment in culturally-responsive services that fit the needs of unsheltered residents (low-barrier access, relationship-building, mobile medicine, Housing First and harm reduction models).
- **Strengthening Partnerships and Bridging Funding Silos:** Cross-sector partnerships and bridging of funding silos are needed to improve fit of service design to unsheltered residents by supporting movement toward a "no wrong door" system.
 - Organize cross-sector collaboration around groups highly vulnerable to homelessness, e.g., justice-involved individuals, survivors of intimate partner violence, runaway youth, people with co-occurring conditions.
 - Advocating for combined programs at the state and federal level could enable more flexible program design at City and County level.

Table of Contents



Table of Contents

About this Report	3
Executive Summary	4
Background	17
Evaluation Design	19
Evaluation Methods	20
Results	22
Milestones for Health Service Delivery	22
Health and Mental Health System Design	36
Engagement and Communication	48
Health System: Service Gaps	55
Health System: Barriers to Meeting Need	66
Leadership and Coordination	77
Data Sharing and Outcomes Measurement	88
Recommendations	91
City of Los Angeles	92
County of Los Angeles	93
City and County of Los Angeles	94
Policy and System Level	98
References	100
Spotlight on Homeless Health Care Los Angeles	112
Spotlight on Venice Family Clinic	114
NYC Case Spotlight Part 1: Proactive Outreach through 311	116
NYC Case Spotlight Part 2: Veterans Affairs	118
Appendix A: 1964 City-County Health Agreement	120
Appendix B: City-County Agreement Amendment	125

Background

There are an estimated 66,436 people in Los Angeles County (“County”) experiencing homelessness, and of these individuals approximately two-thirds (41,290) reside in the City of Los Angeles (City) (Los Angeles Homeless Services Authority, 2020c). California is home to half of all unsheltered people in the United States (113,660), and one out of four people experiencing homelessness do so in New York City or Los Angeles (Henry et al., 2021). Loss of jobs and income coinciding with the COVID-19 pandemic are forecasted to continue to contribute to loss of housing and housing instability (Flaming et al., 2021). At the same time, legacies of racism and gender discrimination continue to drive inequitable health outcomes (California Department of Public Health, 2020; O’Neill, 2020b, 2020a).

This rapid-response landscape analysis was undertaken with the aim of identifying potential solutions for improving coordination of safety net health and mental health services for people experiencing homelessness in the City. This comes at a time when unprecedented public interest, political will, and resources are available for system improvement across City and County departments charged with a common mandate of addressing the needs of this highly vulnerable population. Since the specific focus is health safety net programs directly operated or managed by the City and County, managed Medi-Cal programs fall outside the scope of this report.

What we call “homelessness” can be experienced in many different ways: from having to leave home to flee violence, to housing instability following a disabling health condition or economic hardship or loss of family, to being unsheltered. Reflective of this, we use terminology throughout this report that is as specific as possible to the situation being described. Recognizing that no one term fits all contexts is important to humanizing this issue. For the purpose of defining the overall population of focus, we employ the definition of “people experiencing homelessness” as individuals or families who lack a fixed, regular, and adequate nighttime residence or who face housing instability due to imminent loss of their primary nighttime residence or because they are fleeing or attempting to flee violence (Housing and Urban Development, 2021c).

At the state level, the California Department of Health Care Services (2021c) is preparing to implement California Advancing & Innovating Medi-Cal (CalAIM) in January 2022. This would serve to renew California’s expiring Section 1115 demonstration waiver (Medi-Cal 2020) and Section 1915(b) waiver (Specialty Mental Health Services) programs. Through a focus on social determinants of health, CalAIM would fund and integrate delivery of flexible “in-lieu-of services” (e.g., navigators, housing services, sobering centers, meals), care management, and jail transition (Department of Health Care Services, 2021a). While Section 1115 authorizes Medi-Cal managed care programs, opportunities should exist

for contracting and coordination with County Departments of Health Services and Public Health. Section 1915(b) in turn applies to people with serious mental health conditions, many of whom receive services from the County Department of Mental Health (Department of Health Care Services, 2021b).

These current events are illustrative of a public call for efficient and equitable coordination across City and County programs to ensure resources go directly to people in need of immediate housing and health assistance and to the community organizations who serve them. They also represent opportunities for coordination to address “upstream” social factors that affect housing stability and health and that contribute to cycles of hospitalization, incarceration, and homelessness.

A 2020 LA City Council motion calling for a deeper investigation into the coordination across the City and County of Los Angeles offers an opportunity for identifying opportunities to improve integration of public health services for people who are experiencing homelessness (O’Farrell et al., 2020). Specifically, the motion requests an initial report to better understand:

1. Why the City chose to eliminate its health department in 1964;
2. The design, scope, and scale of LA health and mental health services delivered by LA County to people experiencing homelessness in the City (including outreach, case management, and linkages to housing and social services); and
3. How these services are coordinated by the County, City, Los Angeles Homeless Services Authority (LAHSA), and other non-profit partners.

In this landscape analysis we address these requests, beginning with a review of **historical milestones** that shape what the health service landscape looks like, exploring the undercurrents that have driven inequitable health outcomes today. We then turn our attention to the current health care landscape, visualizing the **design** of the non-managed-care health and mental health system and reviewing existing means of **engagement and communication** with people who are unsheltered. Next, we explore the scope and scale of this system by identifying **service gaps** and **barriers to meeting the health needs** of people experiencing homelessness. We next turn our attention to **leadership and coordination** among the City, County, and LAHSA. At last, we review the limited systems and processes in place for **data sharing and outcomes measurement**.

Evaluation Design

We took a qualitative, sequential mixed-method approach to this rapid-response landscape analysis, which included a document review, key informant interviews, a focus group with advocates with lived experience, and case studies. The following five categories were used as a framework to guide objective inquiry for all evaluation activities:

1. Health and Mental Health System Design
2. Health and Mental Health System Scope and Scale
3. Leadership and Coordination
4. Communication and Client Engagement
5. Data Sharing and Outcomes Measurement

Table 1 (below) maps categories of inquiry to the associated methods. Documents represent an ideal means of obtaining historical data and a current snapshot of the health and mental health systems for the homeless. Earlier key informant interviews provided input and direction for the document review, and mid- to later interviews provided an opportunity for dialogue on ideal system design and perceptions of service and capacity gaps. Interviews were also an opportunity to learn about leadership and coordination, and processes for client communication, engagement, accountability, and performance improvement. Focus groups were a vehicle to elicit shared understanding from a diverse group of advocates about their experiences accessing and engaging in services, what they see as service and capacity gaps, and ideal system design. Case studies served to compare Los Angeles to another large city with different approaches to coordinating health and mental health services for unsheltered residents and to highlight promising local approaches that could be replicated.

Table 1: Crosswalk of Categories of inquiry and Methods

Category of Inquiry	Document Review	Interview	Focus Group	Case Studies
System design	✓			✓
System scope and scale (service gaps / barriers to meeting need)	✓	✓	✓	✓
Leadership and coordination	✓	✓	✓	✓
Communication and client engagement		✓	✓	
Data sharing and outcomes measurement		✓		

To support inclusivity and collaborative planning, our evaluation team assembled a Steering Committee of individuals from diverse sectors with rich historical knowledge and subject area expertise. The team was asked to provide guidance on questions, coach the evaluation team through any bottlenecks in information gathering, provide a validity check on coverage of key documents and informants, and assist with interpretation of findings.

Evaluation Methods

Steering Committee

A five-person Steering Committee was convened prior to the start of the project to discuss milestones for historical context, review guiding questions, key informants, and provide input on selection of case studies (April 2021). They were again convened mid-process to provide input on the focus group and interview guides (May 2021) and in the reporting phase to provide interpretive feedback on findings (June 2021). The team included experts in health systems, mental health, housing and homelessness.

Key Informant Interviews

Ten one-hour key informant interviews were conducted in May and June 2021 with individuals representing public officials from the City, County, and LAHSA (n=5); homeless, health, and mental health service providers in the City of LA with County contracts (n=3); and subject area experts (e.g., former retired officials and advocates) (n=2).

A key informant interview guide was developed with input from the Steering Committee, with questions organized by categories of inquiry. Supplemental questions were included in initial interviews to inform the milestones and document review. Interviews were conducted via Zoom and participants were advised that no identifying information would be shared outside the landscape analysis team, to encourage individuals to share from their own personal perspectives as opposed to as representatives of any particular agency. Participants received a \$40 e-Gift card as a “thank you” directly following the interview.

Focus Groups

One focus group was conducted with a group of six individuals with lived experience of homelessness who had completed formal training as health advocates for unsheltered City residents. Participants were representative of families, unaccompanied adults, transition-age youth, LGBTQ+-identifying individuals, and those with former involvement in the criminal justice and behavioral health systems.

A focus group guide organized by categories of inquiry, and including exercises to support creative thinking and grounding, was developed with input from the senior advocate and Steering Committee to ensure appropriateness for people with lived experience. The 1.5-hour group was co-facilitated with a senior advocate via Zoom in May 2021.



Participants each took a brief anonymous demographic survey via Qualtrics. They self-identified gender as female (n=3), male, (n=2), and transmale (n=1), and race as Black or African American (n=4) and White/Caucasian (n=2). Ages were widely dispersed from 25-29 (n=1) to 30-39 (n=2) to 60-64 (n=3) ranges. All had experience being unhoused and navigating health and mental health services in the City, and all reported currently living in the City. They had served as health advocates for unsheltered residents for a range of 1 to 9 years. Participants each received \$100 for participating in the focus group directly prior to the start of the group.

Document Review

The document review was conducted by a team of two analysts between May and June 2021. The document review mainly focused on health and mental health system design, scope, and scale. Initial document review was conducted by examining pre-identified sources including, but not limited to, contracts, municipal codes, ordinances, peer-reviewed journal articles, program descriptions and eligibility criteria, meeting minutes, and reports to the City Council and County Board of Supervisors. Once the initial round of review was completed, the team interviewed several key personnel from departments of the City, County, and LAHSA to further inform the document review process and identify additional sources. Based on the information gathered through those personnel interviews, as well as from the key informant interviews and focus group, a second round of document review was conducted to complete the full picture.

Case Studies

Case studies were conducted in May and June 2021 by a doctor of international studies who specializes in ethnography and is a clinical therapist. Categories of inquiry were used as guides for field interviews. The first, a two-part Case Spotlight on health care delivery to unsheltered residents in New York City, was chosen after initial key informant interviews suggested it would offer insights into promising approaches from a system with more centralized governance. The second, developed near the conclusion of the analysis, was a series of two Spotlights on agencies that were explicitly named by multiple key informants as having exemplary service models that offer insights into “what it takes” to implement promising approaches identified in the analysis: Homeless Health Care Los Angeles and Venice Family Clinic. Interviewees, who included City public officials and service agency leadership, were offered the option to remain anonymous.

Analysis

The key informant interviews and focus group were transcribed in Otter.ai software and imported into Dedoose coding software for thematic analysis. We took a blended “framework” and “constant comparison” approach to analysis (see Pope et al., 2000, for a comparison), which involved identifying thematic content and sorting it into the five pre-identified policy categories. Given the rapid nature of the project, the evaluation team convened on a daily basis over two months to compare and contrast findings from key informant interviews, focus group, document review, and case studies. Key points of intersection were identified and used to organize the narrative for the report findings. The process was highly iterative, whereby interviews helped identify information “holes” in the document review, while documents triggered follow-up and probing questions for interviews.

More than a dozen background interviews were conducted to obtain documents for the review and to validate information gathered and obtain detail on themes as they arose in the focus group and interviews. These were validating and informational in nature, and no quotations were included in the results. Some key informants were re-contacted in the analysis phase to ask follow-up questions and to check the accuracy of how information they shared was presented.

Results

A note on definitions: Voices from numerous disciplines and cultures are reflected in this landscape analysis, so it was impossible to achieve consistency in terminology. We define *mental health services* as an umbrella term inclusive of mental and behavioral health. *Mental health condition* is defined as any condition affecting “a person’s thinking, feeling, mood or behavior, such as depression, anxiety, bipolar disorder, or schizophrenia” (Centers for Disease Control, 2021). *Substance use condition or disorder (SUD)* is defined as “a mental disorder that affects a person’s brain and behavior, leading to a person’s inability to control their use of substances such as legal or illegal drugs, alcohol, or medications” (National Institutes of Health, 2021). *Serious mental health condition* and *serious mental illness* (ages 18+) and *serious emotional disturbance* (under age 18) are used interchangeably to refer to a “mental, behavioral, or emotional disorder resulting in serious functional impairment” that “substantially interferes with one or more major life activities” (for adults) or “limits role or functioning in family, school, or community activities” (for children and youth under age 18) (Substance Abuse and Mental Health Services Administration, 2021a).

Milestones for Health Service Delivery

The landscape for health and mental health services delivery in the City of Los Angeles (LA) is shaped by policies, cultures, and structures over many decades. Focusing on the landscape in 1964, when the LA City and County Health Departments were merged, to the present day, we review a few of the historical milestones that shape the health and mental health service landscape for City residents who are unhoused or who are experiencing housing instability.

Racial Barriers to Healthy Living Environments (1960s and Prior)

It should be acknowledged first and foremost that Angelenos live on colonized land. The dynamic of exclusion that has played out in the Tongva Basin over centuries — and in the last century through policies of redlining and eminent domain — have contributed to barriers to health for black, indigenous, and other people of color (BIPOC). As Hernandez (2017) wrote in a history of incarceration in the City of LA, exclusion has also extended more generally to unhoused individuals, immigrants, LGBTQ+ people, and others falling outside the social norms defined by the culture and institutions of Anglo-American settlers.

The primary structure of exclusion in the City of LA over the past century has been incarceration. As Hernandez (2017) writes, “incarceration is a pillar in the structure of invasion and settler colonialism in the Tongva Basin” (p. 10). By the 1950s and 1960s, the City of LA had built the largest jail system in the United States, and “blacks comprised an ever-increasing share of the city’s incarcerated population” (Hernandez, 2017).

Other structures of exclusion have included redlining and eminent domain.

As the recent decision by the Honorable Judge David O. Carter lays out through deep historical context, homelessness is a product of racism (*LA Alliance for Human Rights, et al. V. City of Los Angeles, et al.*, 2021). The practice of redlining created a “state-sponsored system of segregation,” which denied lending, homeownership, and wealth accumulation to BIPOC (Rothstein, 2018). Structures of exclusion continued through eminent domain, which seized property predominantly from BIPOC to construct freeways and displaced families into segregated black/brown and racially heterogeneous neighborhoods such as South and East LA.

Highways maintain physical boundaries between under- and highly-resourced communities in the City, affecting access to and delivery of health and mental health services (Park et al., 2008). This is in part due to practices and policies of exclusion that affect mobility patterns, a theme arising in our analysis (see “Barriers” section on “Mobility of Unsheltered Residents and ‘Clean Up’ Efforts”). Highways also represent a health hazard to those who settle in close proximity to them (Malson & Blasi, 2020).

‘Rehabilitation’ and Clearance of Skid Row Units (1960s)

Prior to 1964, shelters and indigent care services were largely clustered in the Skid Row area of the City of LA (Moore Sheeley et al., 2021). **In 1956, the City began a program to “rehabilitate” Skid Row through clearance of older buildings** (Sibley, 1960; Stern, 1956). Many of the area’s small hotels did not meet fire and safety codes, and owners found demolition to be more cost-effective than repairs (Community Redevelopment Agency of the City of Los Angeles, 2005). Over the next decade, the number of buildings dropped from an estimated 15,000 to 7,500 (Sibley, 1960).

With the loss of half of the affordable housing provided by hotels, many of the residents of the Skid Row area became unsheltered (Community Redevelopment Agency of the City of Los Angeles, 2005). As BIPOC were overrepresented among those seeking relief and shelter in the City of LA (Moore Sheeley et al., 2021), it was predominantly BIPOC who were displaced.

A key informant who led an agency on Skid Row at the time recalled how single room occupancy (SRO) hotel rooms — once a source of “transient” housing for unhoused residents — were demolished in the 1960s to make way for commercial development downtown:

“Housing production dropped off markedly [and] we started to down-zone, so housing production got much more complex and challenging. We tore down a lot of the cheapest kinds of housing. [The] SROs that were downtown, [we] tore down almost all of those...And that’s a resource for people in Skid Row. A very modest footprint, shared bathrooms and everything...they were called transient hotels because they serve this population in fact. And at the time, the general relief amount that was being paid, \$220, \$135 of that was considered to be your rental subsidy, and that would, keep you in one of those rooms.”

The primary source of social assistance to people who were unsheltered or relying upon SRO hotels at the time was General Relief (GR) of \$221/month, distributed through the Unattached Men's Center (now the Office of DPSS) on Skid Row. This amount has been unchanged since 1978, and today it would take six people on GR to pay the rent of a one-bedroom apartment in the City.

As Wolch & Dear (1993), former co-directors of Los Angeles Homelessness Project, said in their historical account *Malign Neglect: Homelessness in an American City*, **the City and County were largely hands-off in making affordable housing a municipal priority at the time.**

"Los Angeles County is responsible for the health and welfare of its residents, but it had no state mandate to provide or protect affordable housing except in unincorporated areas of the county...[in] the City of Los Angeles, for its part...no one single City department with responsibility for housing existed until the 1990s [and] no direct efforts were made to preserve the most affordable units until a moratorium on SRO hotel demolitions in Skid Row was enacted" (p. 87).

Later in 1975, a redevelopment plan by the City called for stabilization of Skid Row, and in the 1980s, non-profit housing agencies began to purchase and renovate the hotels to increase affordable housing stock. The number of SRO units today is one thousand fewer than the 7,500 remaining in the late 1960s. Today there are "about 6,500 residential SRO units in the area, 2,500 of which have been acquired and repaired by such nonprofit entities. Many of them provide social services to the tenants. In addition, there are approximately 1,270 mission and 24 emergency shelter beds" (Community Redevelopment Agency of the City of Los Angeles, 2005, p. 3).

Role of City/County in Public Health and Indigent Care (1960s)

In the early 1960s, health care for people who were uninsured or of limited means was provided primarily through LA County General Hospital, which the Board of Supervisors renamed LA County University of Southern California Medical Center in 1968 (Eastman Martin, 1979).¹ In 1935, California Welfare & Institutions Code (WIC) § 17000 delegated indigent health care to Counties and stipulated "every county and every city shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions."

Public health functions such as sanitation and infectious disease control, provided by the City, remained largely separate from indigent health and mental health care functions of LA County Department of Health Services. However, "the lines between indigent health care and public health began to blur in the 1960s with the merger of the Los Angeles City Health Department into the County Health Department" (Cousineau & Tranquada, 2007; Harmon, 1968).

¹ Note: It wasn't until 1972, following the social uprisings in Watts that called attention to a lack of health care in South Los Angeles, that the LA County public hospital system expanded from its one General Hospital to include Martin Luther King Jr. Medical Center and Charles Drew University of Medicine and Science (Cousineau & Tranquada, 2007).

City/County Health Department Merger (1964)

In 1964, the City made the decision to eliminate its health department to reduce a double tax burden on City taxpayers (Delgadillo, 2005). The City and County concluded that most services the City Health Department was providing would either continue under the County Health Departments or be transferred to other departments within the City (Hufford, 1966).

The County identified eight City services that are not provided by the County (Hollinger, 1962):

1. *Local ordinance enforcement when provisions do not parallel County ordinance or state law,*
2. *Pre-placement physical examination and executive examination,*
3. *Physician services to parochial schools,*
4. *Mosquito abatement services,*
5. *Rodent control,*
6. *Housing surveys relating to urban renewal,*
7. *Certification of commercial swimming pool equipment maintenance men, and*
8. *Premature infant conferences*

The City transferred some of these programs to other departments and established a City-County Health Agreement for municipal health code enforcement.

Based on the [California Health and Safety Code \(HSC\) § 476 \(now § 101375\)](#), which authorizes Counties to contract with Cities to enforce public health and sanitation ordinances within Cities, the City enacted Ordinance No. 123,768 on January 29, 1963. The Ordinance was delivered to the County Board of Supervisors, a formal notice to the County that the City transferred its responsibility to provide health services within the City to the County as of July 1964 (Hufford, 1996). The City adopted the County's Health Code as its ordinance and entered into an Agreement with the County establishing terms of enforcement of the [County Public Health Code](#) within the City (City of Los Angeles & County of Los Angeles, 1964) (**Appendix A**). As expressed in [LA Municipal Code \(LAMC\) Chapter III Public Health Code](#), any provisions of County Health Code that were substantially similar to LAMC have been "construed as restatements and continuations of existing law," and in the case of any conflicts, provision of LAMC prevails over County code.

In adopting provisions of the County Public Health Code by ordinance, the City called upon the County Health Officer to "perform the services to enforce said ordinance in the City to the same extent as the County Public Health Code is enforced in unincorporated territory." The Agreement would appear to apply specifically to enforcement of municipal codes related to "public health and sanitation," and thus not to indigent health and mental health care, which in accordance with WIC § 17000 had always been the responsibility of the County. That the County maintains responsibility for indigent care holds even in the four cities in California that have maintained their own health departments (i.e., the Cities of Pasadena, Long Beach, Vernon, and Berkeley).

The City maintains control over the adoption of ordinances relating to public health within the City. Amendments may be made to the City Municipal Code to authorize enforcement within the City by the County of new ordinances relating to public health and sanitation, pursuant to the aforementioned Agreement. One example is “Draft Ordinance Amending Los Angeles Municipal Code to Authorize County Enforcement of Commercial Sex Venue Ordinance within the City” (Delgadillo, 2005). Changes to the County Health Code are reviewed for incorporation into LAMC by the City to confirm they express the will and intentions of City Council as to matters relating to public health, and they may be expressly adopted or not adopted.

In short, the City never had responsibility for indigent health and mental health care, and the ceding of public health authority to the County came with a condition for City oversight via the option to adopt County ordinances or not.

Key informants shared that, when the City eliminated its health department in 1964, there was at the same time a national public health climate aimed at achieving efficiencies in addressing public health challenges. “There were Polio and other issues [leading into the 1960s] where scale mattered,” they said. “I think it really phased into the idea that an entity that covered the entire County would be better equipped to deal with the kinds of solutions that were necessary to safeguard public health.”

Key informant observations that consolidation was a function of both tax and health program administration efficiency was echoed in a journal article that described how in parallel, the County was seeking to integrate the various county health services (“county departments of hospitals, public health, and mental health”), which merged into the Department of Health Services in 1972. While consolidation was achieved structurally, it proved difficult to achieve integration:

“Integration promised a rational system of health planning whereby the deployment of health services would be based on demographic data or health status. But this approach was overcome by the increasingly political nature of the county health care system. Individual supervisors focused on problems in their own jurisdictions, rather than in the larger system. Regional planning was increasingly organized according to the district boundaries of the 5-member County Board of Supervisors” (Cousineau & Tranquada, 2007).

Lanterman-Petris-Short Act and Deinstitutionalization (1967)

In the early 1960s, the State of California provided mental health services to people with serious mental health conditions through a system of state mental institutions. These institutions were toppled by the **Lanterman-Petris-Short (LPS) Act of 1967**, which regulated involuntary placement in mental health institutions, setting criteria for involuntary (5150) holds and calling for provision of mental health care in community settings. It contributed to ending “the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders” (State of California, 1967). The number of patients in California state hospitals had peaked in 1959 at 37,000, of which approximately 50 percent or 18,500 were civil commitments. This number decreased to 3,000 committed individuals by 1980 and to 793 by 2020 (Placzek, 2016; Services, 2020; The California Department of State Hospitals, 2016, 2018).

There were powerful contributors to deinstitutionalization. One was the widespread use of chlorpromazine, discovered in 1954 and the first in a class of antipsychotics. Another was the **Community Mental Health Centers Act of 1963**, which facilitated people’s transition from inpatient psychiatric hospitals out into communities (Placzek, 2016; Testa & West, 2010). Another was the **federal enactment of Medicaid/Medicare through amendments to the Social Security Act of 1965**, which funded community mental health centers (Torrey, 1998). This gave federal government an increasing role as “payer, insurer, and regulator” of mental health services (Frank, 2000). To maximize use of federal funds, states redesigned public mental health programs to shift away from state hospitals to community settings such as nursing homes (Frank, 2000).

Deinstitutionalization was intended to move people living with mental health conditions from unsafe and overly restrictive hospital settings into their communities. It nevertheless had the unintended effect of leaving many in unsafe situations on the streets. Studies indicate a shift whereby, without comprehensive treatment and facing compounding trauma, many people with severe mental health conditions were subject to arrest and criminal prosecution. The number of inmates in California prisons with mental health conditions rose sharply in the 1970s, as state mental health institutions emptied (Harcourt, 2011; Torrey, 1998).

In a July 2020 audit by the State of California, the County reported a shortage of required treatment beds. This audit also concluded that while standards of the LPS Act were largely met, California has not ensured adequate care for individuals with serious mental health conditions. For example, 7,400 people in LA County experienced five or more short-term involuntary holds from fiscal years 2015 to 2018, but in fiscal year 2018-19, only 9 percent of these individuals were enrolled in the most intensive and comprehensive community-based services available. Large numbers of individuals have been subject to multiple short-term holds, but have not received care in the community-based mental health system (Auditor of the State of California, 2020).

DHS/DMH/DPH Splits (1978)

Prior to 1978, LA County Department Health Services (DHS) had responsibility for the full spectrum of public health and mental health services. This changed when the **Department of Mental Health (DMH) was formed and split from DHS in 1978** amidst concerns that mental health funding was being diverted to hospitals. The **Department of Public Health (DPH) was later formed and split from DHS in 2006** amidst hospital budget deficits (Sewell, 2015). Rationale was that by creating separate entities, funding for services for our most vulnerable residents and for specific health safety net functions couldn't be shifted to other parts of the health system.

First (1978-1982) and Second (1991-2011) Waves of Health Service Realignment

As discussed previously, California has a complex health care delivery system that is unique in that counties are responsible for administering and financing the vast majority of public health and mental health services. This is a result of both the long-standing WIC § 17000 and a series of “realignments” of fiscal and programmatic responsibilities from the state to counties.

The late 1970s in Los Angeles were characterized by major cuts to health and social services, as the federal government shifted responsibility for social service programs to states. Budget cuts in LA County led to the closure of community-based health and mental health clinics, with low-income communities of color being particularly hard-hit (Wolch & Dear, 1993).

“South-central communities were most severely affected, along with other neighborhoods in the central districts of the county. Only nine basic health centers and four comprehensive health centers remained open for ambulatory patients, and services at the comprehensive centers was reduced,” wrote Wolch & Dear (1993). “These closures were especially painful for south-central residents because three area hospitals noted for providing care to poor African-Americans had already closed by 1984.”

At the state level in 1978, **Proposition 13 (also known as Jarvis-Gann Act)** decreased property taxes and imposed restrictions on the tax authority of state and local government. Property taxes were reduced by half (California Budget Project, 1997), and as a result, the majority of counties reduced mental health services (Talbot, 1979). DMH faced among the highest cuts of all County services during this time (Wolch & Dear, 1993). Gaps in the community mental health system in underserved communities, combined with a shortage of hospital beds, in turn became major drivers of housing instability and loss (Committee for Greater Los Angeles et al., 2020).

As a response to the outcome of Proposition 13, legislators introduced **Assembly Bill 8 (AB 8), the first “realignment” of state dollars to counties**, in 1979. Under AB 8, property tax became state tax, and the state realigned revenues back to counties. AB 8 also provided fiscal relief to partially make up for tax losses resulting from Proposition 13 (Legislative Analyst’s Office, 1996).

In 1982, in a second round of “realignment,” Medi-Cal dropped 250,000 medically indigent adults (MIAs) ages 21 to 64 and made counties responsible for their care. Between 1980 and 1989, the number of uninsured in California rose by 50%, and discharges for uninsured patients went down rapidly, reflecting serious access issues for people with limited income (Boston University School of Public Health, 1991; Reidy Kelch & California HealthCare Foundation, 2005).

Realignment Acts in 1991 and 2011 transferred or “realigned” additional fiscal and programmatic responsibilities from the state to the counties (Taylor, 2018). Among the dozens of programs included in realignment are Medi-Cal services for adults and children and county medically indigent adult (MIA) programs (California HealthCare Foundation et al., 2009).

Mass Incarceration and Criminalization of Homelessness (1970s to Present)

With weakening of the community mental health system, and hospital bed shortages, people were diverted from hospitals, to the streets, and often into jails, in an ongoing cycle. As a key informant said, “We just basically reinstitutionalized everybody, but in actual carceral situations, and so this picture of people with mental illness oscillating between incarceration and the most acute unsheltered homelessness has been the hallmark of California’s response to serious mental illness since the deinstitutionalization process in the 70s.”

By the mid-1970s, the 50-square-block area of Skid Row had become a “containment zone” where people who were unhoused or discharged from hospitals or jails went to access services. This created a centralized place for “arrests for minor drug offenses or crimes based on poverty (e.g., resting or sleeping on the sidewalk)” (LA Alliance for Human Rights, et al. V. City of Los Angeles, et al., 2021). A former leader of one of the first service agencies on Skid Row painted a picture of what health service access was like for the clients at this time. As one recalled:

“At that time you couldn’t lay down on the sidewalk. You had to find a place to sit up. [The] biggest shelter actually in those early days was not a shelter. It was one of the all-night theaters, that for \$1.25 you could sleep and watch the same — they played the same movie every night... and there were 800 people typically in that theater at night. What they were mostly doing was dealing with lesions on people’s feet that were caused by them being forced to sleep sitting up in chairs all night and the edema turning into gangrene in some cases. It was just awful. So it was on that basic level that they were, it was either that or ambulances picked people up and took them to County Hospital when things got bad enough. And so that was about the extent.”

By the 1980s, a lack of mental health services for justice-involved individuals, combined with the War on Drugs, drove up policing of drug users deepened racial inequities in health. “The new mental health system did not provide aftercare and follow up services for discharged patients or inmates, and accessible outpatient services for this population remained scarce,” and this “prejudicially impacted communities of color, who were subjected to increasing policing and surveillance as part of the war on drugs” (Moore Sheeley et al., 2021; Parsons, 2018).

Four decades later, arrests for minor offenses are still common among people who are unsheltered. The LAHSA Ad Hoc Committee on Black People Experiencing Homelessness (2018) reported that in 2017, “over 50% of all homeless person arrests were related to nonviolent offenses, including charges for failure to appear (22%), possession of a controlled substance (10%), violation of supervision (8%), petty theft/shoplifting (7%), and trespassing (6%)” (p. 25). In 2019, while Black people represented 9 percent of the population in LA County (U.S. Census Bureau, 2019), they represented 34 percent of people in the County experiencing homelessness (Los Angeles Homeless Services Authority, 2020c), and 30 percent of the population in County jails (Holliday et al., 2020). The same LAHSA Committee found that nearly two-thirds of single adults experiencing homelessness have past criminal justice system involvement, and the percent of Black families with children experiencing homelessness who are justice-involved (44%) is much higher than that of White families (29%). This points to inequities in the intergenerational component to the cycle of homelessness and incarceration, whereby “when one family member is incarcerated, particularly the primary wage earner or head of household, the entire family unit is at risk of homelessness” (p. 24).

First Federal Legislation Addressing Homelessness (1987)

The number of unsheltered residents rose exponentially in the 1980s in the City of LA due the aforementioned rise in mass incarceration, loss of manufacturing and motion industry jobs, drops in affordable housing stock, and cuts to social welfare programs (Wolch & Dear, 1993).

The **Stewart B. McKinney Homeless Assistance Act of 1987** (McKinney-Vento Homeless Assistance Act), is widely recognized as the first major federal response to homelessness. It provided funding for individuals and families with diverse needs, “from first-time emergency situations to long-term chronically homeless substance [users], people with severe and persistent mental illness, people with HIV/AIDS, and other disabling conditions” (Burt et al., 2002).

Temporary housing solutions as opposed to preventive measures was a mainstay of assistance programs for those experiencing housing instability in the 1980s. McKinney funding supplemented Emergency Food and Shelter Program and Emergency Shelter Grant funds and were targeted toward individuals who were currently or at imminent risk of being unsheltered. However, there was no requirement attached for “systematic planning” or development of comprehensive systems of housing, health, and mental health care (Burt et al., 2002).

The approach to service delivery taken in the 1980s is best described as a “Housing Readiness” model, which involves “preparing” individuals to gradually move toward independence and transition into housing incrementally. Thus, for example, housing resources could be accessed only subsequently to achieving sobriety from drugs or alcohol.

Beginnings of Housing First Approach in Los Angeles (Late 1980s - Early 1990s)

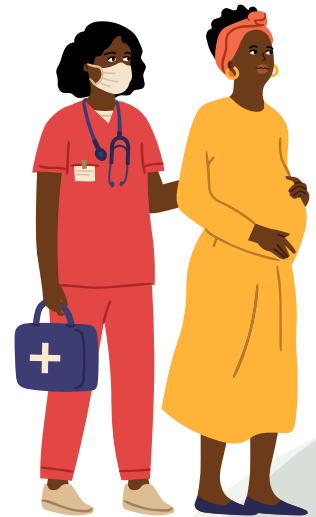
Alongside the faith-based missions that dominated service delivery on Skid Row in the late 1980s grew new types of organizations that began to provide shelter, health, and social services all under one roof. One of these was Los Angeles Men's Place (LAMP), described by a key informant who had worked at a different Skid Row agency at the time: *"Founder Mollie Lowry was just a remarkable person who just opened this place on Skid Row as kind of a Drop-In Center where her motto was 'to meet people where they are and then do whatever it takes for as long as it takes to help them get to a better place.'"* Another example was Downtown Women's Center (DWC), founded in 1978. Both supported the unique needs of people on Skid Row through a "whatever it takes" approach, meeting people where they were at and then accompanying them on their journeys. Health and mental health care were provided concurrently with housing to promote recovery and wellbeing.

The relationship-based approach taken by organizations like LAMP and DWC was formalized through a "Housing First" model, first piloted through [Pathways to Housing](#) in New York City in the 1980s (Tsemberis & Asmussen, 1999). "Housing First" turned the concept of "housing readiness" on its head by providing immediate access to permanent housing without the requirement of sobriety or recovery (Tsemberis et al., 2004). As one key informant said,

"The Housing First model does work, [where] you stabilize a patient without putting additional conditions on access to that housing. At least from my perspective, that's the usefulness or the greatness of Housing First, that you don't create additional barriers. [It wasn't] 'Oh, well, you should get your mental health addressed first, or your alcohol drug treatment first,' [but rather] 'stabilize them, get them into housing.' Once you do that, then of course, surround [them] with all the services that they might need. But get them in the house, because a lot of times with other services, that's the challenge. That if there's not a stability in their housing situation, the likelihood that they're going to be able to take full advantage of the other things that they need — mental health, SUD, primary medical care — it's going to be very small."

HUD Introduces Continuum of Care (CoC) (1996)

Continuums of Care, later codified as part of S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act (2009), were introduced by HUD in 1996. Continuum of Care (CoC) refers to the process by which communities throughout the United States organize to strategically plan and structure service systems for people experiencing or vulnerable to homelessness. Each community in turn submits a single comprehensive application to compete for funding for McKinney-Vento programs. CoC funds can today be used in five program areas: "permanent housing, transitional housing, supportive services only, HMIS, and, in some cases, homelessness prevention" (Housing and Urban Development, 2021a).



HUD classifies health and mental health as among those mainstream services that do not fall within the CoC. Other examples include Housing Choice Voucher Program (HCVP), Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI), and Temporary Assistance for Needy Families (TANF). As a national study on CoC found, HUD “urges communities to take maximum advantage of mainstream services,” but does not require their participation in CoC (Burt et al., 2002, p. xv). Greatest successes have been seen in “communities that recognize that mainstream agencies need to be seriously involved in broader-scale planning and coordination efforts,” and components to success named were “strong leadership in the homeless assistance system and a commitment from both mainstream agency leadership and homeless-specific program and service providers to work together” (Burt et al., 2002, p. xv).

Mental Health Services Act (MHSA) (2004)

The Mental Health Services Act (MHSA) was passed by California voters in 2004 through Proposition 63, which imposed a 1 percent tax on personal income in excess of \$1 million. **MHSA is significant because it provides counties with the largest amount of mental health care funding outside of Medi-Cal, with a focus on coordinated systems of care** (Los Angeles County Department of Mental Health, 2021b). It came in the wake of institutionalization as “an attempt to start building that community infrastructure with resources and a significant amount of funding, although not enough to make up for the loss,” as one key informant described.

MHSA provides funding to serve children living with serious emotional disturbance and adults and transition-age youth with serious mental health conditions, pursuant to [WIC § 5600.3](#). Counties are authorized to fund services and housing resources for people experiencing homelessness through four components: Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), and Capital Facilities and Technological needs (CFTN). This includes for example permanent supportive housing, full service partnership, navigators, and peer services (Department of Health Care Services, 2020).

Federal and State Support for Housing First Model (2009-2016)

Rigorous pilots of Housing First models in Los Angeles did not come until after Congress passed the [S. 896 HEARTH \(Homeless Emergency Assistance and Rapid Transition to Housing\) Act \(2009\)](#). **The HEARTH Act recognized Housing First as a best practice and committed federal funding to rapid re-housing programs. The California Legislature later passed [Senate Bill 1380 \(2016\)](#), which mandated state-funded housing programs to adopt the Housing First model.** It defined core components of Housing First that state-funded programs would need to adopt. Among these are support services emphasizing engagement and problem-solving; harm reduction approaches and connection to substance use services; and housing features to “accommodate disabilities” and “promote health and community and independence.”

The HEARTH Act, which reauthorized and amended the McKinney Vento Homeless Services Act, expanded the original HUD definition of homelessness from “an individual or family who lacks a fixed, regular, and adequate nighttime residence,” to include “people at imminent risk of homelessness, previously homeless people temporarily in institutional settings, unaccompanied youth and families with persistent housing instability, and people fleeing or attempting to flee domestic violence” (Leopold, 2019). It also codified into law the CoC process and established the coordinated entry system (CES), implemented in Los Angeles in 2017. CES

uses an algorithm to prioritize linkages to services among those who meet the expanded HUD definition of homeless. Adults and youth may enter the system through access/drop-in centers, crisis housing, and outreach teams, and families enter through Family Solutions Centers as [shown in this brochure](#).

The HEARTH Act also revised the Emergency Shelter Grants Program, renaming it the Emergency Solutions Program, to reflect “the change in the program’s focus from addressing the needs of homeless people in emergency or transitional shelters to assisting people to quickly regain stability in permanent housing after experiencing a housing crisis and/or homelessness” (Housing and Urban Development, 2021b). These changes are again illustrative of a movement away from “housing readiness” and primary investment in temporary housing to “housing first” and greater focus on flexible prevention and permanent housing solutions.

Housing First has proven to be an effective model for engaging people in mental health services (Gilmer et al., 2015), as well as shifting from crisis care to planned primary care and follow-up, “ensuring more appropriate use [of] health care resources” (Goering et al., 2014). In a decentralized CoC like LA, success of Housing First approaches rely upon “strong leadership and partnerships across departments, sectors, government and communities” (Goering et al., 2014). More details on the core components of the model can be found in this [Housing First Toolkit](#).

Affordable Care Act and Medicaid 1115 Waivers (2010)

The Affordable Care Act (ACA) was signed on March 23, 2010. Later that year, the State of California implemented the Medicaid Section 1115 waiver “Bridge to Reform” to prepare for the expansion of coverage expected under the ACA (Harbage & Ledford King, 2012). Under the ACA, California expanded Medi-Cal to cover adult citizens living under 138 percent of the federal poverty level. Of the three million Californians who remain uninsured, more than half are undocumented. Undocumented adults remain eligible for “restricted scope” Medi-Cal (primarily emergency and pregnancy-related services) (Insure the Uninsured Project, 2019). Health plans cannot deny coverage or impose cost barriers because of preexisting conditions (U.S. Department of Health and Human Services, 2021).

In 2015, DHHS approved the Medicaid 1115 waiver extension (also known as “Medi-Cal 2020”), which authorized funding for Whole Person Care (WPC) pilots (California Department of Health Care Services, 2016). WPC pilots allowed coordination of health, mental health, and social services, for people who are experiencing or vulnerable to homelessness, including individuals being released from institutions such as hospitals, rehabilitation facilities, and jails/prisons. **The waiver extension also brought about a Drug Medi-Cal Organization Delivery System (DMC-ODS) pilot to expand access to SUD treatment among Medi-Cal enrollees.** The pilot started with seven counties, including LA as an early adopter, and has expanded to 37 (Valentine et al., 2020).



Proposition HHH, Measure H (2016) and No Place Like Home (2018)

On July 2, 2015, the City initiated its **Ad Hoc Committee on Homelessness and Poverty**, which was later made into a standing committee to develop a strategic plan for reducing homelessness (Wesson et al., 2015). Responding in part to the creation of the Committee, and direction from the Mayor's Office, the City Administrative Office launched planning efforts for a [Comprehensive Homeless Strategy](#), approved on February 9, 2016. As the City stated, the Strategy reflects:

“the collaborative efforts of the City Council, its Homelessness and Poverty Committee, The Office of the Mayor, City Departments, the Los Angeles Homeless Services Authority, the County of Los Angeles, homeless service providers and the public. It is meant to be a comprehensive approach to address short- and long-term homelessness issues and is adopted in tandem with the Homeless Initiative approved concurrently by the County of Los Angeles Board of Supervisors” (City of Los Angeles, 2016).

Concurrently in 2015, the Board of Supervisors established the **LA County Homeless Initiative** (County of Los Angeles, 2021). The [Action Plan](#) laid out six strategies for preventing and addressing homelessness, including case management and other health and social services, and encouraged cities to partner in implementation (Los Angeles County Chief Executive Office, 2016).

City Proposition HHH (passed in 2016) and **County Measure H** (passed in 2017) provided critical resources for implementing the City Strategy and County Initiative. City Proposition HHH focused on production of supportive and affordable housing units (City of Los Angeles, 2021b). County Measure H funded health and mental health services, case management, rental and housing subsidies, and emergency and affordable housing (County of Los Angeles, 2021). Supportive services in City-funded permanent supportive housing units are paid for by Measure H.

The No Place Like Home (NPLH) Act of 2018 (SB 1206) dedicated up to \$2 billion in bond proceeds to invest in the development of permanent supportive housing for persons who are in need of mental health services and are experiencing or vulnerable to homelessness. The program employs low-barrier tenant selection practices that prioritize these individuals and offer flexible, voluntary, and individualized support services. Los Angeles County Development Agency proposed construction of 60 projects in Fiscal Year 2019, including 1,970 NPLH units. DMH will provide supportive services to the tenants in the NPLH-funded units, monitor provision of services, and approve eligible tenants (Los Angeles County Development Agency, 2021).

Passage of SB 1152 Hospital Discharge Process (2018)

Amid reports of “dumping” of hospital patients with serious health and mental health conditions on the streets, **SB 1152 was enacted in California in September 2018. SB 1152 amended California Health and Safety Code § 1262.5 to include a hospital discharge process.** The Act requires that all patients receive an “individual discharge plan” that helps them prepare for return to the community by connecting them “with available community resources, treatment, shelter, and other supportive services.” Hospitals are in turn required to discharge people without a home to “a social services agency, nonprofit social services provider, or governmental service provider that has agreed to accept [the] patient, if he or she has agreed.” While people may also be discharged to an alternative destination, in accordance with their preferences, hospitals are required to give priority to “identifying a sheltered destination with supportive services.”

COVID-19 Sheds Light on Health Inequities (2020 – Present)

The City and County of LA declared a state of emergency from COVID-19 in March 2020, in the wake of Executive and Public Health Orders that directed all Californians to stay home. **By the end of July 2020, COVID-19 was the fifth leading cause of mortality among people experiencing homelessness and the second leading cause among the population overall in LA County, with 35 unsheltered people among those who died** (Los Angeles County Department of Public Health, Center for Health Impact Evaluation, 2021). Its health effects were most far-reaching when one considered constraints on the capacity of the health systems (King et al., 2020); inequitable spread among communities of color and LGBTQ+ people (LA County DPH, Chief Science Office, 2020; O'Neill, 2020b); and projections that job and income loss will continue to drive housing instability (Flaming et al., 2021).

An LA County DPH summary report ([updated weekly here](#)) shows that as of August 9, 2021, there have been 7,996 total cases of COVID-19 among “people experiencing homelessness” in LA County, with 218 confirmed deaths (peak seen from late November 2020 through January 2021).

COVID-19 has spread along fault-lines of our most vulnerable, disproportionately impacting people in neighborhoods with high rates of poverty, people of color, and those identifying as LGBTQ+. These same groups have also seen a disproportionate share of unemployment and evictions, meaning experiences of housing instability or losing one’s home has also been inequitable. Since the start of the pandemic, morbidity and mortality have been disproportionately high among people experiencing homelessness who identify as male (64% of cases and 84% of deaths), Hispanic/Latino (44% of cases and 50% of deaths), or Black/African American (25% of cases and 24% of deaths) (Los Angeles County Department of Public Health, 2021b). A survey conducted by KFF Vaccine Monitor from December 2020 through January 2021 found that a larger share of LGBTQ+ as compared to non-LGBTQ+ adults reported job loss and negative impacts on their mental health (Dawson et al., 2021). And a report by DPH found that in April 2020, people who lived in areas with high rates of poverty had three times the rate of mortality from COVID-19 compared to communities with very low poverty levels (Los Angeles County Department of Public Health, Chief Science Office, 2020).

The pandemic has led to unprecedented coordination between the County, LAHSA, non-profit agencies, and federally-qualified health centers (FQHCs). It has also exposed barriers to coordination with the City. **Lessons learned from COVID-19 about City-County Coordination continue in the “Leadership and Coordination” section of our report.**



Health and Mental Health System Design

Health and mental health care are delivered to people experiencing homelessness in the City of Los Angeles through a web of County services that work in parallel and in coordination with LAHSA — the lead agency for the HUD-funded Greater Los Angeles Continuum of Care (CoC) — and to a more limited extent the City.

The County Alliance for Health Integration (AHI), which replaced the County Health Agency, implements cross-cutting work of the Department of Health Services (DHS), Department of Public Health (DPH) and Department of Mental Health (DMH), which are each exclusively responsible for a portion of the Medi-Cal benefit. DPH is responsible for safety net substance use treatment and prevention services; DHS for health services; and DMH for mental health services for those with serious mental health conditions. These departments also coordinate with Public Social Services (DPSS), which administers CalWORKS, CalFresh, General Relief (GR), and Medi-Cal enrollment.

Medi-Cal is the primary payer for health and mental health services for individuals and families in LA who have low incomes. The County is responsible for the delivery system organization and in many cases the direct provision of Medi-Cal-funded services through DMH, DHS, and DPH. For mental health services, Mental Health Services Act (MHSA) provides the greatest amount of funding second to Medi-Cal, and DMH is responsible for its administration for children and adults who meet medical necessity or Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) criteria for Medi-Cal Specialty Mental Health Services. DPH is in turn responsible for outpatient services and residential services (pregnant and postpartum women only) for children and adults who meet medical necessity or EPSDT criteria for Drug Medi-Cal Substance Use Disorder Services.

It is notable that while not within the scope of this report, Medi-Cal managed care is responsible for mental health services for people with low income who do not meet medical necessity or EPSDT criteria for Medi-Cal Specialty Mental Health Services (the so-called “mild to moderate” mental health services). Medi-Cal managed care is also responsible for prescription drugs.

In this section we summarize the role that these key agencies, including the County and its various departments, play in the delivery of health and mental health care to people in the City who are unhoused. We then describe how (through what major programs and entities) these services are delivered, focusing on those services that are most frequently used by residents who are unhoused. Service delivery is grouped into five buckets mirroring a person’s journey through the health and mental health system: health care coverage; outreach and engagement; transition and diversion; direct health services; and interim and permanent supportive housing.

Key Agencies and Departments

Department of Health Services (DHS) is responsible for the primary medical care portion of the Medi-Cal benefit through its 19 health centers, four hospitals, and network of community partner clinics. DHS also provides health services to youth in the juvenile justice system and specialized medical services to children in foster care (Los Angeles County Department of Health Services, 2021a). Health services for people who are experiencing or vulnerable to homelessness are offered via two divisions: Housing for Health (HFH) and Office of Diversion and Reentry (ODR). HFH was established in 2012 to reduce preventable hospital and emergency room use by providing permanent supportive housing (PSH) for people with complex health and mental health needs (Hunter et al., 2017). The division employs a Housing First approach, coordinating an array of clinical services, enriched residential care, interim housing, a sobering center, and street-based

HEALTH/BEHAVIORAL HEALTH SERVICES FOR UNHOUSED ANGELENOS

Services and programs operated and/or funded by the County/City and utilized by unhoused residents frequently

KEY AGENCIES AND DEPARTMENTS

Mental Health (DMH)

Public Health (DPH) - SAPC

Health Services (DHS) - HFH, ODR

Public Social Services (DPSS)

CITY OF LA

Fire (LAFD)

Police (LAPD)

Unified Homeless Response Center

LA HOMELESS
SERVICES AUTHORITY

P Pilot program
starting in 2021

HEALTHCARE COVERAGE

Medi-Cal

My Health LA (MHLA)

OUTREACH AND ENGAGEMENT

Homelessness Engagement Team (HET)

Housing for Health Multidisciplinary Teams (MDTs)

Homeless Outreach and Mobile Engagement (HOME)

Psychiatric Mobile Response Team (PMRT)

TAY Drop-In Centers

Health Navigators

Veterans Peer Access Network (VPAN)

SOBER Unit

Advanced Provider Response Unit (APRU)

Systemwide Mental Assessment Response Team (SMART)

TRANSITION AND DIVERSION

ODR Housing Program (Pre-Release)

WPC Re-Entry Program (Pre- and Post-Release)

Court Liaison Program (CLP)

DIRECT HEALTH SERVICES

Ambulatory Care Network (ACN)

Sobering Center (Skid Row)

Naloxone Access points (NAPs)

HFH "Street Medicine Team" **P**

Mental Health Full Service Partnership (FSP)

Assisted Outpatient Treatment for LA (AOT-LA)

Alternative Crisis Services (Enriched Residential Services, Urgent Care Centers)

Integrated Mobile Health Team (IMHT)

Drug Med-Cal Organized Delivery System (DMC-ODS)

Sobering Center (MRT Behavioral Health Center) **P**

Overdose Education and Naloxone Distribution (OEND)

USC Street Medicine Team for Unhoused Angelenos **P**

Therapeutic Transportation (TT) **P**

SUPPORTIVE HOUSING

PSH, RRH, Interim Housing (City/County/HUD Funded)

Housing for Health: PSH, Enhanced Residential Care,
Stabilization Housing, Recuperative Housing

ODR Housing Program

Continuum of Care, Homeless Section 8, Interim Housing

Recovery Bridge Housing (RBH)



engagement through multidisciplinary teams (MDTs). Benefits advocacy is provided through the Countywide Benefits Entitlement Services Team, and the division recently partnered with Department of Mental Health and California Policy Lab to create a Homeless Prevention Unit.

Department of Mental Health (DMH) operates mental health programs at more than 85 sites and provides services via contract programs and DMH staff at approximately 300 sites co-located with other County departments, schools, courts and other organizations (Los Angeles County Department of Mental Health, 2021).

Department of Public Health (DPH) has as its mission to “protect health, prevent disease, and promote health and well-being” for people in LA County (Los Angeles County Department of Public Health, 2021a). It promotes public health through diverse means including safe drinking water, vaccinations, communicable disease testing, and health behavior change campaigns. DPH is also responsible for population health surveillance, including tracking of both general and COVID-19 morbidity and mortality trends (Los Angeles County Department of Public Health, Center for Health Impact Evaluation, 2021). The bulk of services provided by DPH to unsheltered people are through its Substance Abuse Prevention and Control (SAPC) division, responsible for provision of safety net substance use disorder (SUD) prevention and treatment services to those who are eligible for Medi-Cal or lack health insurance. SAPC contracts with more than 150 community-based organizations (CBOs) for substance use prevention and treatment services (Los Angeles County Department of Public Health, Substance Abuse Prevention and Control, 2020b).

Department of Public Social Services (DPSS) provides cash assistance, food and nutrition, access to health care, job resources, and various community services for low-income families throughout the County. Cash assistance programs offered to people experiencing homelessness include CalWORKs and General Relief (GR). DPSS also offers nutrition (CalFresh) and health care assistance (Medi-Cal) to qualifying families and individuals.

Los Angeles Homeless Services Authority (LAHSA), as lead administrative agency of the CoC, coordinates housing and services for families and individuals experiencing homelessness. LAHSA oversees the Coordinated Entry System (CES) to coordinate and manage resources and services through the housing crisis response system. LAHSA also deploys Homelessness Engagement Teams (HET) and coordinates countywide homeless outreach efforts.

City of Los Angeles Fire Department (LAFD) is the City’s leading first-responder agency for health and mental health crisis. An analysis of LAFD calls for service in 2018 revealed that LAFD responded to calls for people experiencing homelessness at a rate of 1,135 calls per 1,000 unsheltered residents, or 14 times the rate of the housed population in the City (Abramson et al., 2019). Since the onset of COVID-19, LAFD launched dedicated homeless testing sites in Skid Row and rerouted Sobriety Emergency Response (SOBER) Units to provide care at the DHS Sobering Center on Skid Row for COVID-19-positive homeless individuals in need of safe quarantine (Sanko & Eckstein, 2021).

City of Los Angeles Police Department (LAPD), as part of City's Enhanced Comprehensive Homeless Strategy, works with LAHSA and the Los Angeles Bureau of Sanitation (LASAN) to provide homeless outreach through its Homeless Outreach and Proactive Engagement (HOPE) teams (Llewellyn, Jr., 2020). LAPD also runs Systemwide Mental Assessment Response Teams (SMART) to "help uniformed officers effectively respond to and link people in crisis to appropriate mental health services" (Los Angeles Police Department, 2021). In 2019, the department began distributing Narcan to respond to opioid overdoses. Resources Enhancement Services Enforcement Team (RESET), out of Central Division, responds to calls for services, code enforcement, outreach, and assistance to LASAN staff in the Skid Row area (Beck, 2018).

Health and Mental Health Services

Healthcare Coverage/Benefits

The most common means by which people who have low incomes access safety net health and mental health benefits is through Medi-Cal. The County's My Health LA is an alternative option for people who do not meet eligibility criteria for full-scale Medi-Cal, such as those who are undocumented. It covers both primary health and mental health care for people with "mild to moderate" conditions not meeting criteria for a serious mental health condition. People with full-scale Medi-Cal coverage or MHLA membership who have serious conditions are also eligible for DMH-funded mental health services and SAPC-funded SUD services (Los Angeles County Department of Health Services, 2021c; Los Angeles County Department of Public Health, Substance Abuse Prevention and Control, 2020a).

Department of Public Social Services (DPSS) leads Medi-Cal and MHLA enrollment for the County. When a person signs up for one of the cash assistance programs at DPSS, they are connected to various health and social services, including Medi-Cal or My Health LA (MHLA) (Los Angeles County Department of Public Social Services, 2021).

Outreach and Engagement

People may seek health services directly via a variety of access points: from a brick and mortar hospital, clinic, or drop-in center; mobile outreach or medical units; through a social service organization that offers a warm hand-off; or from a social service organization that has a co-located clinic or dedicated health staff. (Specific means by which people who are unsheltered access health and mental health services, and feedback on ideal means of engagement, are discussed in-depth in the "Engagement and Communication" section.)

For housing resources, City/County residents can theoretically go to any service provider contracted by LAHSA to be triaged into the HUD-funded housing service CoC through the CES. As there are not sufficient services to meet demand, entry is based on acuity of need as determined by the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT).

Access and Walk-In Centers provide health and mental health services without appointments, and program offerings and eligibility differ according to an agency's individual contracts with DMH or DHS (e.g., a child mental health agency might only serve transition-age youth with serious mental health conditions).

Under the Homeless Initiative Strategy E6, **mobile outreach and engagement** have been serving as a main strategy to connect unsheltered residents to housing resources, health, and mental health services (Funk et al., 2018; Los Angeles County Chief Executive Office, 2016). One can think of mobile teams as moving in intensity from street outreach focused primarily on housing linkages; to street outreach with an emphasis on crisis intervention or urgent health or mental health care and referral; to a full-fledge "mobile medical home" or street medicine teams that provide full-scope medical care on-site. Teams take both proactive (maintaining regular presence and building relationships) and reactive (responding to calls for services) approaches.

From Outreach and Engagement to Street Medicine

Wide range of street engagement teams funded/operated by the City/County and LAHSA

KEY AGENCIES AND DEPARTMENTS

Mental Health (DMH)

Public Health (DPH) - SAPC

Health Services (DHS) - HFH, ODR

Public Social Services (DPSS)

CITY OF LA

Fire (LAFD)

Police (LAPD)

Unified Homeless Response Center

LA HOMELESS
SERVICES AUTHORITY

P Pilot program
starting in 2021

Assessment/
Housing Referral

Warm Hand-Off to
Health Provider

Crisis Intervention/
Urgent Care

Full-Scope
Medical Care

Homeless Engagement Team (HET)

Multidisciplinary Teams (MDTs)

Homeless Outreach and Engagement (HOME)

Psychiatric Mobile Response Team (PMRT)

Sobriety Emergency Response (SOBER) Unit

Systemwide Mental Assessment
Response Team (SMART)

Advance Provider Response Unit (APRU)

USC Street Medicine Team for Unhoused Angelenos P

Therapeutic Transportation (TT) P

Housing for Health Street Medicine Team P

Mobile outreach and engagement are being employed by LAHSA through its Homeless Engagement Teams (HET), DMH through its Homeless Outreach and Mobile Engagement (HOME) Teams, and DHS through its 70+ MDTs deployed throughout the County.

- **LAHSA Homeless Engagement Teams (HET)** are generalist units that perform regular and proactive outreach to build trusting relationships with unsheltered residents and ultimately connect them to appropriate housing, health, and mental health services.
- **DHS Housing for Health (HFH) Multidisciplinary Teams (MDTs)** are composed of specialists from five different disciplines including physical health, mental health, substance use, generalist support, and peer support. Often, these teams work with clients with co-occurring health and mental health conditions. The MDTs respond to calls for residents who are unsheltered with the goal of building relationships and connecting them to housing resources and health and mental health services.
- **DMH Homeless Outreach Mobile Engagement (HOME)** teams are specialist units that provide psychiatric support, outreach, and intensive case management to unsheltered residents who are living with serious mental health conditions.

Mobile crisis teams offer assessment and linkage to mental health services for people experiencing symptoms of acute mental health episodes such as bipolar mania, suicidality, or delusions requiring immediate attention. Contact information is provided via brochures available online from the County of LA Emergency Outreach Bureau, as seen [here](#) and [here](#). On the City side, calls to 911 for health or mental health crises are addressed according to the nature of the emergency. The City deploys ambulances, Fire Department paramedics, and/or Police Department officers to the site of the emergency accordingly.

- **DMH Psychiatric Mobile Response Teams (PMRT)** may be called to provide on-site [WIC § 5150](#) and [5585](#) evaluations. The PMRT are staffed by licensed mental health providers and they are deployed separately from law enforcement teams.
- **Los Angeles Fire Department** operates several Mobile Integrated Health (MIH) Units. LAFD launched its first MIH pilot unit, **Advanced Provider Response Unit (APRU)**, in 2016. APRU is an ambulance staffed by a nurse practitioner or physician assistant teamed up with a firefighter/paramedic. The team can treat people on-site or navigate them to alternative destinations, such as a mental health urgent care or a sobering center. Based on this success, LAFD continued to run MIHs in partnership with DHS HFH, Kaiser Permanente Southern California Medical Group, Cedars Sinai, Dignity Health, and Providence Health & Services between 2017 and 2019 (Sanko & Eckstein, 2021). The **Sobriety Emergency Response (SOBER) Unit** was established in 2017 to reduce excessive use of emergency medical services and emergency departments. The SOBER Unit transports individuals who are inebriated to a Sobering Center in Downtown Los Angeles, rather than to an emergency room (City of Los Angeles Chief Legislative Analyst, 2021).

- **Los Angeles Police Department** staffs a **Systemwide Mental Assessment Response Team (SMART)** team, which pairs DMH clinicians with law enforcement officers to respond to situations involving individuals who are at high risk of harming themselves or others. The County's Sheriff Department operates Mental Evaluation Teams (MET) — sheriffs working in plain clothes with DMH licensed clinical social workers using an unmarked emergency vehicle to provide “mental health support, field crisis intervention, and appropriate psychiatric placements” (Villanueva & Sherin, 2019, p. 10). The goal of MET is to avoid unnecessary incarcerations and hospitalizations of residents in mental health crises. MET works within [Los Angeles Sheriff's Department jurisdiction](#), which largely excludes the City.

Finally, there are **three pilot “mobile medicine” programs** being implemented separately by LAFD/DMH, the City's Unified Homeless Response Center, and DHS Housing for Health that are offering direct full-scope medical care on-site:

- In 2020, LAFD and DMH executed a memorandum of agreement (MOA) to implement a 12-month **Therapeutic Transportation (TT) Pilot** (“Therapeutic Van Pilot”). To respond to mental health crises reported to LAFD, the only options were to request an LAPD SMART team, or DMH PMRT, which have very limited capacity to respond in a timely manner. To respond to crises appropriately and effectively, the City agreed to pay \$2 million to the County for the TT Pilot within its jurisdiction. Under TT, mental health professionals from DMH respond to emergency calls “either independently or to an incident where a fire unit on scene requests their assistance, depending on the circumstances and level of reported injury or safety concerns” (City of Los Angeles Chief Legislative Analyst, 2021, p. 3). TT will provide clients with immediate therapeutic support from DMH staff, and they may be transported directly to an appropriate mental health facility by the DMH therapeutic transport teams, freeing LAPD and LAFD resources for other emergency calls. Four DMH teams will be deployed to five LAPD fire stations, based on LAFD's Tiered Dispatch system. Participating DMH mental health urgent care centers are LAC-USC, Martin L. King, Westside, Harbor-UCLA, and Olive View-UCLA Medical Center. Each TT team from DMH consists of a Clinical Driver, a Peer Support Specialist, and a Licensed Psychiatric Technician (LPT).
- The City's Unified Homeless Response Center (UHRC) is preparing to launch **“USC Street Medicine Team for Unhoused Angelenos”** at the time this analysis was concluded, in collaboration with LA County University of Southern California Medical Center, using \$1 million in federal HUD Community Development Block Grant funds. The team will focus on the East LA / Boyle Heights neighborhoods around the Medical Center, where there is a significant unsheltered population. Services offered by the team include primary care, mental health care, and SUD treatment (Tso, 2021).



- At the time this analysis was concluded, **DHS Housing for Health (HFH)** was awaiting final approval for four “**street medicine teams**” that will provide direct service in all service planning areas. The teams will be deployed on mobile units and include physicians, nurses, social workers, counselors, community health workers, psychiatrists, and a clinical pharmacist. They will augment the work of the MDTs, who provide clinical support to both the LAHSA HET and DMH HOME. The hope is that additional clinical support and supervision provided by the street medicine teams to the MDTs will help raise the intensity of mobile services that are being provided in the field, allowing for more higher-level triaging and treatment.

The City is responsible for maintenance of public areas owned or managed by the City, and the Department of Recreation and Parks is responsible for the parks and beaches that they own or manage. The Mayor’s Office, through its Unified Homelessness Response Center (UHRC), oversees mobile “clean-up” teams known as **CARE and CARE+**. The CARE teams implement smaller “spot” cleanings of public areas, whereas the CARE+ teams implement “comprehensive” noticed clean-ups that often include heavy equipment and require those individuals living in the space to temporarily relocate. Through CARE+, the City offers a mobile hygiene component through a partnership with the non-profit organization Urban Alchemy.

Finally, DMH employs **health navigators** through its Service Area Chief offices who are charged with responding to individuals who request mental health services and help them navigate into services. DMH has used the Pacific Clinics Training Institute’s (PCTI) Health Navigator Certification Training Program for training for the Department and contracted providers since 2012. Both DHS and DMH also employ trained community health workers with lived experience who in turn are often positioned on mobile outreach teams to coordinate assessments and ensure the person’s needs are met.

In 2010, DMH began the **Veterans Peer Access Network (VPAN)**, a peer-support program for veterans, service members, and their families. VPAN deploys trained Veteran and Military Family Peers who connect veterans to critical resources including housing, physical and mental health care, substance abuse treatment, job placement and legal services (Los Angeles County Department of Mental Health, 2021b).

Transition and Diversion

AB1152, enacted in California in September 2018, requires that patients receive a plan as part of the hospital discharge process connecting them “with available community resources, treatment, shelter, and other supportive services,” as discussed in the “Milestones” section. During this process, DHS, DMH, and LAHSA staff work with hospital discharge coordinators to ensure there are options for people who don’t have a home to return to and who qualify for one of their beds. As discussed in the “Interim and Permanent Supportive Housing” section, DHS funds housing teams who manage referrals from hospital staff to expedite linkages to interim housing and PSH. DHS MDTs then work alongside hospital staff to ensure follow-up once clients are discharged.

LA Municipal Codes (LAMC) describe standard operating protocols for public area cleaning through CARE and CARE+ and handling and storing of personal property. [LAMC § 56.11](#) “regulates storage of property on the City’s public right-of-way [including] sidewalks, alleys, and streets,” and [LAMC § 63.44](#) “regulates storage of property on the City’s public Parks and Beach Parks.” Goals are described as maintaining safe and sanitary conditions, accessibility to all members of the public, and preventing harm and promoting public health and safety. [LAMC § 41.18](#), amended in July 2021, further dictates where encampments cannot be established within the City. Based on the amended code, the City is in the process of developing a Citywide Street Engagement Strategy that “outlines the procedures that outreach teams generally follow in their everyday outreach efforts.” (Szabo, 2021, p.1)

Based on the success of the Sobering Center on Skid Row, a new sobering center will be created inside the Mark Ridley-Thomas Behavioral Health Center (formerly known as Martin Luther King Jr. Behavioral Health Center) in Willowbrook area. DPH SAPC will be overseeing the operation of the new Center. The center aims to “break the cycle of streets, emergency rooms, and jails,” and offers same-day access to substance use treatment and other services (Wilson, 2016). The Center will provide “intake, sleeping area, shower, separate facilities for men and women, limited medical services, light refreshments, and referral to substance use disorder treatment services, and linkages to housing and other social services” (Ferrer, 2020).

DMH has several linkage programs connecting clients from other County programs and systems facing immediate housing instability with mental and behavioral health services. **Court Liaison Program** co-locates mental health clinicians at 22 County courts for defendant outreach, service needs assessment, and development of diversion, alleviation of sentencing, and post-release plans (Los Angeles County Department of Mental Health, 2019).

DHS manages the **Whole Person Care Re-entry** pre-release program that targets Medi-Cal-eligible County jail inmates who are being released in 90 days. Pre-release care coordination teams provide comprehensive services including: engagement in jail, assessment and pre-release care planning, discharge planning, visits with physical and mental health providers to coordinate post-release clinical follow-up needs and care transitions, transportation, establishment of benefits such as Medi-Cal, housing navigation, connection to other supportive social services, and “warm hand offs” to a community-based re-entry team. Once the “warm hand-off” is completed, re-entry post-release care coordination teams continue to engage participants. The team continues outreach and engagement that was begun during the pre-release stage and supports the pre-release care plan. The team also provides peer mentor-ship through community health workers, including “home visits, health coaching, harm reduction, linkage and accompaniment to appointments with physical and mental health providers, transportation, benefits establishment, maintenance of benefits,” as well as other social service supports and navigation to permanent housing (Katz, 2017a).

Direct Health and Mental Health Services

DHS funds a range of health services through its **Ambulatory Care Network**. The network offers primary, urgent, surgical, and specialty care through its four comprehensive health centers, 20 health centers, four hospitals, and 230 My Health LA network of community partner clinics (Los Angeles County Department of Health Services, 2021a). Most of its locations are outside of the City boundaries, with the exception of three health centers (LAC+USC, H. Claude Hudson, and Hubert H. Humphrey Comprehensive Health Centers), a handful of community partner clinics, and one hospital (Harbor+UCLA).

DHS also operates **David L. Murphy Sobering Center** on Skid Row, with service delivery contracted to [Exodus Recovery](#). The Center opened in 2017 to divert intoxicated persons from emergency rooms or incarceration. The Center stays open for 24 hours, with a capacity of stabilizing 50 people at any given time (Ghaly, 2018). According to Exodus Recovery, the majority of Center’s patients are people who are transported by law enforcement, select emergency personnel, and homeless outreach teams. The LAFD SOBER Unit transported about 20 people per day to the Center prior to COVID-19 (A. Guggenheim, personal communication, June 23, 2021). The Center provides respite and personal hygiene resources, along with medical monitoring and assessment.

Overdose Prevention Program (OPP), also known as safe consumption sites, was established in the County to help prevent fatal overdoses. Los Angeles Community Health Project (LACHP) is the County's community partner that provides training and operates **Naloxone Access Points** in South LA, Hollywood, Echo Park, Silverlake, Westlake, and Pico Union areas. They provide overdose prevention and response training, Naloxone distribution and refills, overdose debrief counseling, and linkage to relevant services. In 2019, DHS ODR began the **Overdose Education and Naloxone Distribution (OEND)** program to provide overdose prevention education, Naloxone, and harm reduction supplies to individuals at risk of opioid overdose.

OEND also manages a Naloxone on release program in the County jails, which provides overdose prevention and response video training and access to Naloxone upon release from County jail.

DMH operates mental health programs in more than 85 sites and provides services via contract programs and DMH staff at approximately 300 sites co-located with other County departments, schools, courts and other organizations (Los Angeles County Department of Mental Health, 2021).

- **Intensive crisis services** are provided through its nine **psychiatric urgent care centers (UCC)** in the County (three within the City). UCCs are Medi-Cal certified and LPS-designated stabilization services that provide rapid access to mental health evaluation and assessment, crisis intervention, and medication support to divert patients from involuntary inpatient treatments. UCC services are focused on "stabilization and linkage to recovery-oriented community-based resources" (Los Angeles County Department of Mental Health, 2021b, p. 62). During FY 2019-20, about 11,000 UCC clients identified as homeless at the time of admission, making up 30 percent of all UCC clients (Los Angeles County Department of Mental Health, 2021b).
- **Full Service Partnership (FSP)** is a field-based program that provides intensive services for adults, transition-age youth, and older adults. FSP delivers clinical services (24/7 assessment and crisis services; counseling and psychotherapy; field-based services; integrated treatment for co-occurring mental health and substance abuse disorder; case management to provide linkages to services for employment, education, housing and physical health care) and nonclinical services (peer and parent support services; self-help and family support groups; wellness centers; respite care). In addition to providing intensive mental health and addiction treatment for those with co-occurring SUDs, FSP provides support with housing, employment, and education.
- The **Integrated Mobile Health Team (IMHT)** (to be integrated under FSP during FY 2021-22) was designed to provide health, mental health, and substance use services in the field to people experiencing homelessness who have co-occurring substance use disorders or chronic health conditions (Los Angeles County Department of Mental Health, 2021b).

FSP was described by one key informant as facilitating "hot handoffs," whereby FSP staff go out into the field with the HOME team to engage with the client until the HOME team begins to "fade away," allowing for the FSP team to provide mental health services on an ongoing basis.

Substance Abuse Prevention and Control (SAPC) program under DPH is responsible for SUD services for Medi-Cal eligible individuals, with LA being among those counties participating in California's **Drug Medi-Cal Organized Delivery System (DMC-ODS)** (Brassil et al., 2018). SAPC has more than 150 contracted community-based SUD service providers at more than 300 sites throughout the County. In FY 2014-2015, SAPC served 10,035 people who self-identified as experiencing homelessness, which accounts for 16.8% of all clients admitted to SUD treatment. Clients are referred to SUD services by homeless outreach teams, DPSS offices, Substance Abuse Service Helpline, Client Engagement and Navigation Services (CENS), or directly through providers. CENS are co-located to perform SUD screening and make referrals to treatment in settings including encampments, permanent supportive housing, County jails, and emergency rooms (Los Angeles County Department of Public Health, 2015).

Interim and Permanent Supportive Housing

Stable housing is essential to those seeking health and mental health resources. LA County established a Flexible Housing Subsidy Pool that provides permanent supportive housing and interim/crisis housing for people in recovery. DHS Housing for Health manages and coordinates the majority of permanent supportive housing (PSH) and provides health services in coordination with DMH, ODR, and DHS SAPC.

HFH takes referrals directly from DHS health providers within a coordinated outreach system (including CES), while other PSH referrals take place only through CES. HFH pairs intensive case management services (ICMS) with permanent housing and utilizes Comprehensive Health Accompaniment Management Platform (CHAMP) (Palimaru et al., 2021). People experiencing homelessness with at least two admissions for inpatient hospitalization and/or emergency-based services within the last year in LA County are qualified for HFH's PSH program. There are three types of PSH: tenant-based, which involves scattered-site, market-rate apartments; project-based, which is usually multiple units or an entire complex with case management on-site; and enriched residential care for adults and older adults who need assistance with their activities of daily living.

HFH provides short-term and temporary housing for people in need of ongoing medical care through various interim housing programs.

- **Recuperative Housing** provides medical services for those discharged from hospitals who do not have a home to return to and who need specialized medical care.
- **Stabilization Housing** provides temporary transitional housing for unsheltered individuals with chronic health conditions.



For people involved in the criminal justice system, the Office of Diversion and Re-entry (ODR) under DHS provides the **ODR Housing Program** in partnership with the Superior Court. ODR Housing Program serves defendants experiencing homelessness who are living with a serious mental illness or SUD and are incarcerated in the County jail. The goal of the program is to reduce sentencing and divert the defendants to permanent supportive housing with intensive case management services (ICMS). ICMS providers act as a point of contact for the client's medical, mental health, and other supportive services (Katz, 2017b). Upon release from County jails, clients are referred into interim housing, and ultimately to PSH. PSH units for the program come from the Flexible Housing Subsidy Pool. Since the program launched in 2016, ODR Housing has served 3,385 clients (Ghaly, 2020; Los Angeles County Department of Health Services Office of Diversion and Reentry, 2021).

Since 2008, DMH has invested over \$900 million for capital development of PSH through California Housing Finance Agency, which administers the MHSA Housing Program and Special Needs Housing Program, and through LA County Development Authority, which administers the Mental Health Housing Program, Alternative Housing Program, and No Place Like Home. On the tenant-based subsidy side, DMH has 18 contracts with the City and County Housing Authorities for CoC and Housing Choice Voucher subsidies. DMH confirms the eligibility of all clients matches to these vouchers/certificates through the CES and makes referrals to the Housing Authorities for these federal subsidies. The department also provides housing navigation and retention-focused mental health services to the clients referred.

- For the **Enriched Residential Care (ERC)** Program, in addition to providing direct mental health services, DMH provides rent and personal and incidental funding for those who do not have an income. To strengthen the board and care system, DMH also pays an enhanced rate above the board and care rent of an average of \$1,000/month/client. DMH has an Interim Housing Program that they operate in collaboration with DHS and LAHSA at 19 shelter sites across the County.
- **Housing for Mental Health Program (HFMH)** provides subsidies that serve as an alternative to Housing Choice vouchers and are paired with FSP. Twenty percent of the HFMH subsidies are for people directly referred from the ODR. Once a person moves into PSH, DMH continues to provide services through FSP if the person is living with a serious mental health condition. All PSH recipients are eligible to receive ICMS through DHS. They are also eligible to receive assessment and linkage to SUD services through DPH.
- In collaboration with HFH, DMH began the **Prevent Homelessness Promote Health (PHsquared)** program to provide services to PSH and other residents vulnerable to becoming unhoused. A team of DMH and DHS staff provide “time-limited evidence-based practices and appropriate treatment modalities and interventions” with the goal of helping clients retain their housing (Los Angeles County Department of Mental Health, 2021b, p. 105).

DMH plans to implement a two-phase housing pilot project, **True Recovery Innovation Embraces Systems that Empower (TRIESTE)**, during FY 2021-24. Based on a community- and recovery-based service delivery model from Trieste, Italy, the pilot program will transition and provide services to unsheltered people living with serious mental health conditions through a no-barrier housing model (Los Angeles County Department of Mental Health, 2021b).

SAPC under DPH implements **Recovery Bridge Housing (RBH)**. RBH serves patients in need of concurrent treatment in outpatient, intensive outpatient, Opioid Treatment Program (OTP), or outpatient withdrawal management settings. RBH beds are available for 90 days within a calendar year for qualified patients. RBH units are abstinence-based peer-supported housing and unsheltered residents are prioritized given their higher risk for relapse without access to housing. If a patient self-identifies as experiencing homelessness, they are admitted to treatment and assessed using Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT). Coordinated Entry System (CES) lead agencies work with SUD providers to identify housing resources outside RBH if appropriate (Los Angeles County Department of Public Health, 2017).

Engagement and Communication

All key informants and focus group participants were asked how information about public health and mental health services are communicated by the City, LAHSA, County, and service providers to residents who are unhoused. Focus group participants were additionally asked how they found out about their options and navigated services in the past. Traditional media such as billboards, telephone hotlines, websites and social media were the most common vehicles named by key informants as a means of communicating about health services. However, nearly all participants mentioned a lack of unified health service access line or database searchable by service providers. They emphasized the relative utility of direct engagement through mobile units or peers and access to low-barrier service entry points such as Access and Drop-In Centers.

Lack of Unified Service Access Point

Navigating access points was described by advocates as a major challenge. They said it is difficult to know which provider to approach, given their insurance status or what types of client agencies are funded to serve. As a result, **people are often bounced between service providers:**

“Because of our insurance, they really couldn’t figure out how to make it billable. So they couldn’t give us the services they were offering. It was very frustrating. In the long-run my family, we got some services, but it wasn’t through a culturally-specific lens or what we would have chosen for the way that the family would have wanted to have therapy.”

*In our NYC Case Spotlight Part 1: Proactive Outreach through 311, we explore how New York City has implemented a unified service access point through its 311 system and HOME-STAT teams. Our **Spotlights on Venice Family Clinic and Homeless Health Care Los Angeles** in turn demonstrate how mobile medicine, relationship-building, and low-barrier entry form pillars to highly effective models for engaging unsheltered residents in health services.*



“I was in [agency name redacted] down on Skid Row, and there’s so much chaos going on there, that trying to find a doctor, trying to find a program, trying to find anything is very difficult, because it’s not in one place. And when you do try to reach out and try to find these places [there’s] a long waiting list. And a lot of times I’ve noticed that people when they do try to utilize these services, they get frustrated and they just give up because they’re not getting anywhere.”

Key informants said there is an expectation that people show up at the door of the correct type of provider depending upon their most immediate need. This is often due to silos between funding and contracting entities. As a result, people who have co-occurring health, mental health, and substance use conditions face challenges accessing care.

“We’re very siloed,” said a key informant who is a subject area expert. “The Department of Mental Health provision has largely been about mental health. And if you show up [under the influence], they can’t help you. Similarly, coming to your substance use treatment clinic...if you show up with an Axis II disorder or you’re in a [severe] psychotic crisis, [you] get nothing. They call the cops.”

There is **no one centralized or unified access line** that people can call to learn about available health or mental health services and to find out how to access them. Nor is there one centralized guide/map or resource database that service providers can search as an inventory or to provide information on resources available. People may call County (211) or City (311) telephone hotlines or one of the access hotlines operated by DMH/DPH/DHS or by community-based organizations themselves. Key informants noted that County hotlines have been expanded since the COVID-19 pandemic to deliver wellness information to the general public and to targeted groups (e.g., veterans, health workers).


Focus Group participants were aware of and had called 211 (County) for health information, but they described a number of instances of having trouble accessing services through these means. “When I utilized 211, it was always automated, made me mad, frustrated me,” said one. Another shared,

“I utilized the 211 for reaching out for some domestic violence support, and it didn’t lead to anywhere, just a bunch of questions. I probably spent 45 minutes on the phone with someone who was like ‘well just call back tomorrow.’ Just disclosing a lot of information that left me feeling vulnerable, and I didn’t have my own personal phone...so I didn’t call back the next day.”

One advocate said “warm handoffs” could improve the functionality of 211. “If you have connections through organizations, it’s much easier to navigate. But if you walk in on your own, or call 211, [it] does you no good if you can’t get the help once you get there,” they said. In our **NYC Case Spotlight Part 1: Proactive Outreach through 311**, we explore how New York City has implemented such a system through a 311 centralized dispatch.

Advocates with lived experience said they had the greatest success accessing care through **warm handoffs or referrals from hospitals following crisis situations**. The following excerpts describe how emergency rooms are an access point to services:

“When you get referred, it’s easier to get into these mental health places. Like [name redacted] just said, if you just walk in and try to sign up to get help, even if you’re going through the hardest of the hardest, sometimes [they] won’t [let you in]. With referrals from hospitals or organizations, it’s pretty much easier to get in.”



“When I was going through my crisis, there was a point in time where I was suicidal. The hospital usually connects you right away to any available services, even if you can’t find it, so once I got help from the hospital, I was already connected. That’s how I got my answers.”

Advocates with lived experience also described **success being referred in from public services outside of the formal health care service sector**:

“I was going to GR classes, [and] they offered Medi-Cal and that’s how I got on it. [That] was the biggest help. Even with me trying to find housing, it just so happened I went to a GR class and this guy had an application for [permanent supportive housing for transition-age youth]. And that’s how I did it. I [was] homeless, I barely even had a [thing] to eat. And I still showed up to the class for some reason...that Medi-Cal from GR really helped.”

Key informants described a **need for a decision map or database searchable by those who interface with and serve unsheltered neighbors** on a daily basis, such as those working in public library, community centers, and recreation and park settings:

“Council Offices want to know [how] to connect their homeless constituents to services the same way they do their other housed constituents...Who do they call? How do they connect? What services are available? And maybe it’s not every service available, but which services can Council Offices, or City staff, somebody at a library or park, or even LAPD [refer to]? What is the on-ramp for City staff to be able to make a connection for somebody that’s actually going to result in them getting some help? [Maybe it’s a] flow chart. Do they have this issue? Yes. Okay, call this number. Do they need this resource? No. Okay, but what about this? Yes, then call this number.”

A focus group participant who had trouble accessing care while unsheltered, and who now serves as a service navigator on Skid Row, made a similar observation, “there’s no one-stop place for any information, and I really feel that somebody should make that. A big network for any information on programs, doctors, you know, health facilities, which would make it easier for one person to just walk in, tell his problem, they tell him where to go.”

Direct Engagement through Mobile Units and Peers

Key informants and advocates alike said that an effective approach to reaching and engaging unsheltered neighbors is through mobile and peer outreach and engagement. They stressed the integral role of relationships in engagement and the value in tapping into strong social networks.

Mobile Outreach and Engagement

Advocates with lived experience said mobile outreach teams are essential to meeting people where they are at and building trusting relationships. This was described as particularly true among individuals who have faced structural barriers to health care, including communities of color and individuals who identify as LGBTQ+, and those who have experienced incarceration or hospitalization for mental health conditions. Mobile teams are often staffed with community health workers who can help with relationship-building and coordinating health assessments.

“A lot of individuals [who are unsheltered], they don’t trust anybody. Like, you don’t just go up [and] hand them a paper and say ‘can you sign this, I want to get you into X, Y, and Z.’ They’re not going to trust, you got to gain their trust. So, you know what my position was, I would you know, at least try to converse with the individual [until they] open up...and then later on, I could try to assist them in services they need.”

Mobile outreach teams were described as particularly essential in situations where someone is in an **acute mental health crisis** or has a serious mental health condition. Current options in the City for addressing an acute mental health emergency, such as an episode of psychosis, include presenting in person at a psychiatric clinic or hospital that has bed availability and accepts their insurance; calling 911; or calling the DMH Psychiatric Mobile Response Team (PMRT), who can provide on-site WIC § 5150 and 5585 evaluations. The PMRT are staffed by licensed mental health providers, and the average time from call received by DMH to PMRT arrival is 429 minutes or 7.15 hours. This can be higher during times when there is high call volume or during holidays.

For those living with serious mental health conditions who are not in an emergency situation, DMH HOME teams provide an opportunity to interface with licensed clinicians. The teams serve as an entry point to **DMH Full Service Partnership (FSP)**. Key informants said the intensive nature of the service make it a good match for someone who seeks support in multiple life domains.

“[The] HOME teams may be outreaching to someone and say ‘Oh, we want to refer this person or link them to an FSP.’ So, what we created is a system where [the] FSP [and] HOME team outreach the client together,” said one key informant. “So [it is] more than just a warm handoff, [they] really want a hot handoff...with the idea that HOME would then, you know, eventually fade away and then the FSP would continue to provide services ongoing.”

“A lot of individuals [who are unsheltered], they don’t trust anybody. Like, you don’t just go up [and] hand them a paper and say ‘can you sign this, I want to get you into X, Y, and Z.’ They’re not going to trust, you got to gain their trust. So, you know what my position was, I would you know, at least try to converse with the individual [until they] open up...and then later on, I could try to assist them in services they need.”

Peer Outreach and Engagement

The experience of being unsheltered or navigating a transitional period with scarce resources makes social networks invaluable. People are social beings, who naturally form networks of friends and family with whom to heal in community, to seek refuge in common experience, and to share resources. Focus group participants emphasized the value of health communication and behavior change campaigns that leverage social networks.

Peer outreach through community health workers and advocates was named by half of key informants and all focus group participants as a critical component of the LA CoC. There was recognition that the **roles of peers and licensed clinicians are interdependent**, as illustrated by excerpts from a behavioral health provider, County health official, and peer advocate, respectively:

"If there's going to be professionals, accompanying the professionals, having lived experience folks could be helpful. When I say lived experience, there's people who have experienced extreme levels of challenges with their mental health who have been through a process of stabilizing that could probably offer some tools, along with professionals."

"I think that peer-driven services are a critical component of the continuum of care. I think that they have their role, meaning particularly [for] outreach and engagement."

"[We need] to have sufficient capacity throughout the continuum, in terms of whether it's an inpatient psychiatric bed, or a community health worker who has lived experience that can help people through a difficult situation, and coordination between the two."

"If there's going to be professionals, accompanying the professionals, having lived experience folks could be helpful. When I say lived experience, there's people who have experienced extreme levels of challenges with their mental health who have been through a process of stabilizing that could probably offer some tools, along with professionals."

Peers were recognized as playing a critical role as trusted community health information messengers and direct players in the **response to Fentanyl exposure** that has driven a steep spike in mortality among people experiencing homelessness in recent months. Peers have the advantage of working through social networks to share information on harm reduction with those living with addiction and, when deployed on outreach teams, can engage those difficult to reach. A behavioral health provider discussed the role of peers in talking to residents about Naloxone, which is used to treat overdose, and the power of social networks in health intervention:

"It's education through folks who are trusted community messengers skilled at doing the work, often people with lived experience who can speak [with] them about their use patterns in a nonjudgmental way and just say 'you need to be aware of this risk, and here's Naloxone for you, and here's Naloxone for your friend for you, in the event [that] somebody has to give this to you, should you be in an overdose situation.' I think creating [the] mobile teams [and] having engagement occur with folks who are not a part of law enforcement [is key and] part of the broader national conversation [on effective approaches]."

A focus group participant similarly discussed the need to **invest in supportive community**:

“Supportive communities aren’t invested in. And what I mean by supportive communities is that if there’s a person who has someone that they go to, someone that they talk with, someone that they connect with [and] who they identify as social support, invest in those types of relationships. So that if these are my circle of people that I interact with, at least allow for my circle of people to have more resources and knowledge and experience. Invest in that body, to build out on their resources. To build their knowledge. So they can continue to support one another, but they don’t have to do it from a deficit model.”

Peers are also vital to engaging those vulnerable to homelessness during transition from 24-hour level-of-care settings back into housing in the community. One advocate described a model from Chicago featured at a recent community health worker conference:

“Right there at their bedside, while they were in the hospital, community health workers got them connected [to health and social services] and they would keep the relationship going... and so as people are being discharged, or as people are going through their assessment paperwork, there could be questions there that ask: ‘Would you like an advocate?’ And give some detail of what the advocate could do for them.”

Every focus group participant spoke at length about the roles of peer workers in their own lives and in the context of their current work as advocates. The following excerpts are illustrative of the value they saw in peer advocates and supportive community in general:

“At the end of the day, she said ‘thank you so much for going.’ [While] she got her procedure done, I stayed in the waiting room, and then came back with her in the taxi. She was grateful to have [the support]. ‘Each one teach[es] one,’ you know? It’s just things like that where we can help people at the lowest ends of their lives with some professional help.”

“An advocate is there to accompany the individual through the process of getting documentation fresh and to walk the path into health and housing that will be life-changing for that individual. Also, an advocate is a powerful tool because most advocates have experienced exactly what the person is now experiencing. This creates a personal bond and brings so much trust into the relationship.”

These excerpts point to the therapeutic value of peers walking the journey with their clients and of investing in social support networks to facilitate experiences of healing in community.



Access to Low-Barrier Service Entry points

Low-barrier access points provide opportunities for unsheltered residents to access services and for health promoters to engage with them in meaningful ways. Examples named by participants were Drop-in Centers, Recovery Intake Centers (“Sobering Centers”), and Safe Consumption sites. Specific examples named by key informants and focus group participants were Homeless Health Care Los Angeles, Salvation Army, St. Joseph’s Center, and Weingart Access Center.

“It’s a different system for providing services to the homeless, and I don’t think by and large we’re set up that way,” said a behavioral health service provider. “I think one type of service provider that is [a] Drop-in Center, where you come as you are, and all the services that you need [are] on-site. I think that those sites stand a greater likelihood of staying connected and linked to their homeless patients, as compared to a sort of normal brick and mortar facility.”

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Access and Drop-In Centers serve as places where people can walk in without an appointment for medical visits, obtain prescriptions, see a therapist, bring pets if they have them, and store belongings including their medications. These Centers offer an opportunity for service providers to engage with unsheltered neighbors and public health teams to offer programs (e.g., healing arts, support groups) through which to deliver health information and resources. Multiple key informants specifically mentioned the role of multilingual promotores who deliver health education in diverse community health center settings.

“We have promotores de salud that are part of our team. Who, you know, go out [and] do community presentations,” said a key informant who is among executive leadership at a large community behavioral health provider. “Normally non-health-related topics as a way of creating rapport with the community. Like helping your kids with homework...but inadvertently as a result of that, then we start getting into things like alcohol, drug issues, or mental health issues.”

For those living with or recovering from substance using conditions, other examples of low-barrier entry points include Recovery Intake Centers (“Sobering Centers”) and Safe Consumption sites. As a County public health official said,

“If you create a space where someone can go to receive monitoring for safe consumption, receive clean needles, if [needed], to prevent communicable disease — hepatitis, HIV — it’s also a chance to give folks food and nutrition advice. To potentially, through motivational interviewing, connect them to a whole range of services, whether it be primary care, substance use treatment, if they’re ready...it’s an opportunity for people to receive health care more broadly.”

Health System: Service Gaps

The following service gaps arose thematically from our key informant interviews and focus group as key service areas that are not yet at sufficient scale:

1. Permanent supportive housing;
2. Medication for addiction treatment (MAT) for substance use conditions;
3. Mobile clinical medical homes;
4. Health care navigation and peer advocacy;
5. Targeted programs for people in transition; and
6. Law enforcement collaboration and diversion programs; and culturally-specific services.

These gaps illustrate areas in which needs outstrip capacity with regard to funding, service delivery models, and personnel. They notably mirrored some of those demonstrated in a recent [needs assessment](#) on mental health service needs in LA County commissioned by the Health Agency prior to establishment of the new Alliance for Health Integration (AHI) (Mercer, 2019).

Gap 1. Permanent Supportive Housing (PSH)

Housing Authority of the City of Los Angeles (HACLA), Los Angeles County Development Authority (LACDA), Housing and Community Investment Department of Los Angeles (HCIDLA), Los Angeles Homeless Services Authority (LAHSA), Department of Health Services Housing for Health (DHS HFH), and Department of Mental Health (DMH) maintain a portfolio of permanent supportive housing (PSH) and affiliated supportive services, as described in the “Health and Mental Health System Design” section. HACLA specifically provides vouchers and housing portfolio, whereas health services for these City units are provided by the County health departments.

Subject area experts interviewed described leadership of DMH and DHS in providing PSH as a strength of the Los Angeles continuum of care (CoC). There was a sense that models exist that could be scaled with more adequate funding:

“The Department of Mental Health has been a major provider of permanent supportive housing services and acute services for people experiencing homelessness who have serious mental illness for a long time. They have held CoC contracts for a long time; they’re one of the oldest providers of PSH...and then the Mental Health Services Act funding came in and allowed them to do a significant amount of development of permanent supportive housing. So the efforts of the Department of Mental Health [have been] fairly robust.”

“Mitch Katz staffed a team that built the Office of Housing for Health within the Health Services Department, and it has done a really extraordinary job of building a portfolio of permanent supportive housing and affiliated supportive services for addressing the needs of highly vulnerable people experiencing homelessness. They have not been doing it that long on that scale...seven or eight years. But they have in that time built out a pretty sizable portfolio [and] have some really excellent practices, both from a contracting perspective and how to work with service providers.”

Focus Group participants said that access to PSH had changed their lives when they were navigating the health and mental health systems. One described it as a primary factor in breaking out of cycles of hospitalization, returning to the streets, and incarceration.

“I know that when I was fighting with the parole system, they didn’t have outstretched hands. They had outstretched handcuffs. It was do it this way, you know, or you’re going back to jail. But when I got into permanent supportive housing, things started to change,” said one advocate with lived experience. “I was one of the first people in permanent supportive housing. So it was all brand-new...so if there’s any doubt that it’s making an impact, that’s just false. I’ve seen so many people come from Skid Row [and it] totally changes their lives.”

Permanent supportive housing nevertheless arose as a universal theme as the greatest gap in the health and mental health system among people experiencing homelessness, since there are not sufficient PSH units to meet the demand. The effectiveness of service providers — be they street outreach, community mental health, or hospital staff — in health promotion is severely limited by the number of housing units available for clients/patients. As a public housing official pointed out, “[LAHSA] funded some hospital liaisons, and their effectiveness is only limited by [the] number of housing units available...they can’t house people.”

Gap 2. Medication for Addiction Treatment (MAT) for Substance Use Conditions

Half of key informants identified substance use disorder (SUD) treatment and specifically medication for addiction treatment (MAT) as a major gap in the behavioral health care system. MAT has proven highly effective in assisting people in recovery from opioid addiction as part of a comprehensive behavioral health intervention (National Institute on Drug Abuse, 2020). Key informants also described a need for greater distribution of medications to prevent mortality from Fentanyl overdose. Fentanyl is a synthetic opioid that can be mixed with other opioids and is up to 100 times stronger. It is driving recent spikes in mortality among unsheltered people in Los Angeles (Los Angeles County Department of Public Health, Center for Health Impact Evaluation, 2021).

Key informants discussed how bringing MAT to scale will require addressing stigma that exists around harm reduction models and recognizing effective alternatives and complements to 12-step program models that have dominated behavioral health for many decades (see “Barriers” section on “Stigma and Public Misconception”). As a former Skid Row health provider said,

“People [have] a very strong mindset [that] other recovery paths are inauthentic. Like somehow if you’re taking a medication that helps you reduce, you know, suppress cravings, you’re not doing it the right way, or you’re not following the steps. And that makes it inauthentic. To me I’d rather see this person able to go to work, right, thriving, reconnecting with their family, you know, I’m not connected to the steps.”

A County public official, when asked what factors (e.g., funding, personnel, service models) have prevented bringing SUD treatment to scale, pointed to the need for MAT and Naloxone funding, a larger clinical behavioral health workforce, and low-barrier access.



“Having been a part of a system transformation effort here in Los Angeles County, there is a desire for us to change things [and] I think we face challenges with sufficient funding. That’s number one. So you know, funding for just buying a whole lot of Naloxone. Funding for a range of treatment services -- withdrawal management is an incredibly scarce resource, those beds. In addition, [we] just don’t have enough workforce, and sufficient training [of] licensed professionals...Facilities like low-barrier kind of engagement centers, whether it’s a recovery intake center...alternatives to, you know, an emergency room. So it’s all of the above.”

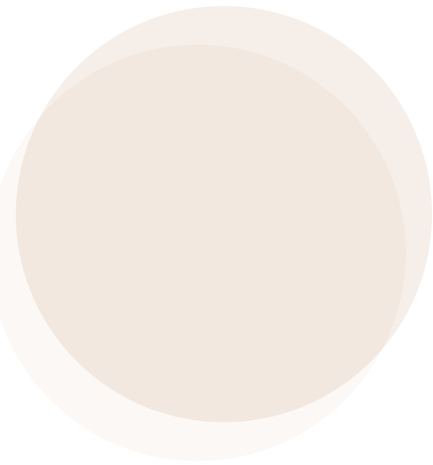
Key informants who were on leadership of health and behavioral health systems said other barriers to both offering and bringing SUD/MAT to scale are [federal rules](#) governing how they are administered and what processes clinicians must go through to obtain certification. As a behavioral health provider said, “We need to be able to take medications for addiction treatment out to the homeless patient population. But we have rules and regulations that are associated with using things like medications for addiction treatment that make it very prohibitive.” Federal rules include specialized training to become a buprenorphine-waivered (“X-waivered”) practitioner; annual caps to how many MAT prescriptions a clinician can extend; and how MAT figures into Medi-Cal reimbursement rates calculated for federally qualified health centers (Substance Abuse and Mental Health Services Administration, 2021b).

Significant spikes in mortality among people experiencing homelessness in Los Angeles in recent months have been driven by overdoses relating to exposure to the synthetic opioid Fentanyl. Key informants called for mass distribution of Naloxone, a medication for treating Fentanyl overdose, through drop-in centers and mobile units. As a County health official said,

“We are in the middle of a real emergency with opioid-related overdoses, particularly related to Fentanyl. [The] annual homeless mortality report demonstrated that very effectively. And there are a number of recommendations in there [being worked on by] a lot of different County partners and community-based organizations to try to grapple with this issue and this challenge for the community. I think the first thing is just kind of flooding the field, so-to-speak, with Naloxone. And that’s going to be done [through] DHS [multidisciplinary] outreach teams and LAHSA’s [homeless engagement teams].”

Ensuring that people at risk of exposure to Fentanyl have access to these medications in case of emergency is a harm reduction approach that can save lives.

There exists a revolving door between incarceration in prisons/jails in Los Angeles and living unsheltered on the streets, in particular given a long history of structural racism, criminalization of homelessness, and failures of deinstitutionalization. Nearly half of people who are incarcerated in the United



States have substance use conditions, but few receive treatment in jail settings. Given this, key informants said, there exists a particular need to coordinate prison and community-based treatment for behavioral health conditions.

Gap 3. Mobile Clinical “Medical Homes”

The topic of mobile street medicine was brought up by all 10 key informants and received the most frequent mentions. Key informants and focus group participants said there is a need for more full-scale “mobile medical homes” with licensed clinicians and pharmacists who can assess, counsel, treat, and fill prescriptions on-site.

“We do a lot of outreach to encampments. And then of course, these partnerships with shelter providers and homeless service providers, those are key. But we’ve been in the homeless health space for a long time. And so we have a lot of relationships, and we’ve got a [mobile] team that’s very committed to the population,” said one key informant. “The mobile has really become kind of a medical home because folks know that they can access it, they’ll see it...I mean, we have stories where folks that we met at a shelter clear on the other side of South LA were walking by with their cart, and saw us and said, “Oh, I need to refill on my medicine.” And they’ll come in.”

Providers in Los Angeles have ample experience outreaching unsheltered residents via mobile units and offering “warm handoffs” to brick-and-mortar health or mental health clinics. But key informants described a need to transition beyond a focus on outreach and referral:

“The thing that I don’t believe we really have transitioned fully to is homeless outreach teams that actually can deliver care. Meaning let’s go beyond just outreach and engagement. So that would mean that the homeless outreach team would have to be comprised of the various positions that are involved in the delivery of health services...So I think outreach teams are [an] effective model, [but] have to make the transition into delivering care out in the field.”

More than half of key informants brought up the value of “mobile medical homes” in delivering MAT to treat opioid use disorders and Naloxone to prevent mortality from Fentanyl overdose. As described in the last section, while federal regulations have created barriers to MAT delivery, COVID-19 loosened these restrictions some. And DHS recently received approvals that expand the County’s ability to deliver MAT through mobile units.

Through the leadership of its Overdose Education and Naloxone Distribution (OEND) program, DHS received approval to carry the MAT medication Suboxone onboard mobile units, so they can dispense it on-site as opposed to giving patients a prescription to walk to a pharmacy with. OEND also provides doses of Naloxone for MDT staff to carry to reverse Fentanyl overdose. Key informants said that while providing SUD services on the streets will require careful planning considering rules and regulations regarding these controlled substances, good models exist and there is evidence that this could have a substantial impact on mortality.

“Prescribe on the street, right? Deliver meds on the street,” said a subject matter expert from the homeless services sector. “If somebody has to go to a prescriber, or go to an institution to get their meds, [and] they have [a major] substance use disorder, and they’re in the throes of a massive, Axis II episode, I mean forget it. It’s just not going to happen. So thinking about the different ways that you could innovate on providing people what their needs are on the street...These are really complex situations [and] it feels like a need that is immediate. And if we did a good job, 10 years from now we would have sort of gotten through this crisis.”

As discussed in the “Design” section, four separate mobile medicine pilots are in various stages of implementation by the City and County. There are also excellent models and workflows already developed by community-based organizations for providing MAT and responding to overdose via mobile units, as described in our **Case Spotlight** on **Homeless Health Care Los Angeles**. All key informants described mobile medical homes as an approach that, if brought to scale, could have substantial impact in improving access to health care and saving lives.

Gap 4. Health Care Navigation and Peer Advocacy

Second to permanent supportive housing, the most common theme arising in our focus group was how being paired with a health care navigator or advocate is vital to transitioning off the streets and navigating the complex health and mental health system.

Navigators are responsible for steering people to appropriate housing and health services. They often work alongside community health workers who are coordinating assessment needs, to ensure that all options are available. “This creates a greater accountability for each person in these positions,” said one participant. An advocate in turn walks the path through the housing and health systems with the person for the longer long term.

“When you do build a rapport with an advocate [and] that relationship last years, the benefit, is just enormous...I haven’t had the handcuffs put on me since I met her. And that’s the difference between somebody who’s in it for the long-haul and somebody who isn’t. Because when I have problems, I can call her and it just worked out. But a lot of people don’t have family, they don’t have an advocate who’s really in their corner 24 hours a day. When they have that, the difference is monumental.”

There was a sense of these roles holding strong therapeutic value in and of themselves: Ultimately good health and mental health don’t come from medicine and therapy alone, but also trusting and persistent relationships, which focus group participants who were currently or had formerly served as navigators said are crucial to those who are unsheltered. They recommended that every person experiencing homelessness be linked to a navigator or advocate.

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“We could guide the individual from making appointments, to getting him to the hospital, to helping him with his paperwork while he’s at the hospital. As a matter of fact, [name redacted] had an individual that he escorted to the doctor early in the day. [It] makes it a lot easier, because you got a person that’s got a rapport, and you’re building it as you go through the system. You’re going through the system together. So you always have somebody in a sense to lean on. And a lot of times, that’s what we need in order to keep focus on doing what is necessary to get better on health.”

Focus group they said that navigators and advocates also played therapeutic roles in hospital settings, where participants had experienced beneficial outcomes from “bedside advocacy” and post-treatment planning.

“I think that every hospital or every agency should have a health care navigator. I know we have one at [homeless service agency name redacted]. And we work directly with [hospital name redacted] with bedside treatment and bedside advocacy. And it really works good. And they go from the hospital into housing, and that’s how it should be. We just don’t have many people that do that, though. We need more.”

Advocate roles were described as important to long-term continuity of service engagement given their role in building rapport and providing persistent accompaniment, given the high degree of staff turnover in health and homeless service organizations.

“The thing about that is that when somebody is getting hooked up into services, and they’re starting to get the paperwork filled out, and then they lose that person who’s advocating for them, they have to start over again...and pretty soon they just say, awww screw it and go back to the streets...they go back to what they know that’s more safe...it makes it more difficult for them to not know that there’s actually somebody there for them to get through. Because it can be really heartbreaking, you know, when you think that you’re making headway, and then all of a sudden that person that you was making headway with isn’t there anymore, and you don’t have anybody to turn to, it can devastate you. But the flip-side of that is when you do find somebody for the long-haul, your life can change. And an advocate can do that for you.”

Navigators were also seen as important to empowering and uplifting the voices of people who are in vulnerable situations and who may not be comfortable voicing what their needs are, given the power dynamic that may exist between clinicians/therapists and patients/clients.

“Navigating it is difficult. If you are successful in navigating [the health system], then you get the services that you need. When you are able to identify what the issue is that you’re having, it’s more than likely that you’ll be able to advocate and speak for yourself. But then there’s also those challenges of the way that practices are embedded right now. It’s a transition from the expert knowing what to do with you and telling you what you should do, and you being able to voice ‘this is what I need’ and having your actual need met.”



Gap 5. Targeted Programs for People in Transition

Focus group participants identified opportunities for engagement during periods of transition when people are vulnerable to homelessness. These include being released from jail settings, seeking safety in shelters or temporary housing as a result of intimate partner violence, and transitioning out of hospital and psychiatric emergency, inpatient, and 24-hour level-of-care settings. Participants described a need for targeted programs co-located within these settings to coordinate housing, health, and mental health care. The aim is to have services begun and supports in place before people transition back into the community.

For those in hospital settings, focus group participants described the benefits of co-located navigators and advocates for “bedside advocacy” and assisted transition into supportive housing (see “Peer Support and Outreach” and “Health Care Navigation and Peer Advocacy” sections). As leadership of a behavioral health system also observed,

“When patients come in through our hospital system, particularly our emergency department, then the emergency department is going to do its job, which is, you know, address the immediate health need. But the long-term health need of the patient is their housing situation and their other corresponding health and social service needs. So I think co-locating providers in the emergency department that can do that follow-up work with the patient out in the community is [a] very successful approach.”

Others expressed concern that even with “bedside advocacy” roles in place, a lack of transitional housing, residential care, and functional rehabilitation programs create barriers to effective transitional planning. As described in the “Milestones” section, the Lanterman-Petris-Short Act has ensured that people with serious mental health conditions receive care in the least restrictive setting possible. People leaving 5150 (72-hour, involuntary) holds often need continuing mental health services, and under SB 1152, hospitals are mandated to have comprehensive discharge plans. A lack of “step down” has nonetheless resulted in emergency departments filling up with individuals who don’t need hospital-based care, but have no place to be discharged to (Hospital Association of Southern California, 2021).

“Our hospital systems in LA County are really under a huge burden with both SB 1152 forcing them to create discharge plans, which is great, [but] also having nowhere to send somebody, especially who has significant health or mental health needs,” said a public housing official. “So what we need is better transitions of care. And what that means is a coherent discharge plan from Point A to Point Z...Point A being when you enter the hospital, Z being permanent supportive housing of some sort.”

For those with severe health or mental health conditions, multiple key informants described a need for more funding available through DHS and DMH allocated toward specialty transitional housing and enriched residential care programs (ERC). ERCs include Adult Residential Facilities (ARFs) and Residential Care Facilities

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for the Elderly (RCFEs) that are designed for people who need additional support with activities of daily living. These licensed residential facilities provide more intensive supports than project- or tenant-based housing.

Multiple key informants named ERC beds and functional rehabilitation programs as gaps in the health and mental health system that prevent successful transition from hospitals to the community. One described common experiences they see in hospitals in the City of LA:

“So as it stands now in the hospital, somebody comes in, I can send someone to various temporary places within the health care system or reach out [to] homeless services providers, hoping they’ll answer my phone call, and that they know me and look for [a] bed available. And especially if someone has severe health or mental health issues, they may not be appropriate for those homeless services settings, but they may be appropriate for a health care setting, which DHS and DMH can both fill those individual gaps themselves but have limited capacity. [I] think what I would like is more coherent transitions of care, with additional funding being allocated towards DMH and DHS specialty transitional housing for those folks who really have those specific needs.”

For those in jail settings, key informants saw a need for coordinated prison and community-based treatment for behavioral health conditions. Nearly half of people who are incarcerated have substance use conditions, but few receive treatment in jail settings. There is evidence that comprehensive substance use disorder and mental health services, begun in jail settings and continued as part of transitional planning, contributes to better health outcomes and more successful transitions back into the community.

“Particularly for those who are re-entering the community from jail settings, they may not have insurance established yet and need immediate intervention,” said a Case Study participant. “In this way, providing treatment on demand without any prerequisites is also very important, as well as linking them to services to help with stabilization, including insurance benefits, medical homes and field-based, wraparound case management support. The more linkage and support that can be done within the jails prior to an individual’s release, the more connected and strong foundation they have for their next step.”

Our **Spotlight on Homeless Health Care Los Angeles** illustrates how low-barrier access to SUD treatment including MAT can provide the flexible support needed by people with substance use conditions as they stabilize on a path to recovery. It is also illustrative of a successful model for SUD delivery to people re-entering the community from jail settings.

Gap 6. Law Enforcement Collaborations and Diversion Programs

Cycles of arrest and incarceration, returning to the streets, and hospitalization continue to drive race and gender inequities in incidence of homelessness and health outcomes. Key informants and focus group participants pointed to law enforcement collaborations and diversion programs as essential to breaking cycles of violence.

Key informants spoke of Psychiatric Mobile Response Teams (PMRT), who may be deployed in lieu of officers, and Systemwide Mental Assessment Response Teams (SMART), who are deployed in collaboration with officers, as promising approaches not yet brought to sufficient scale. As a County health official said of existing gaps in the system, “I think creating...mobile teams when it comes to mental health and having engagement occur with folks who are not a part of law enforcement. I think that’s part of the broader national conversation.”

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Focus group participants discussed how in many cases, people calling 911 in an emergency cannot be advised by the dispatch team as to whether SMART or officers without clinical accompaniment will respond. They said PMRT services exist at far too small a scale to respond to high demand. They also described how PMRT and SMART visits often lead to 72-hour holds, after which a person is released — failing to address the underlying health issue. They called for more proactive outreach through mobile units who can engage in a preventive manner (see “Client Engagement and Communication” section), as illustrated by this rich exchange between four advocates:

Participant 1: *“You’re not gonna get the services that you would hope you would get. What’s gonna happen with those guys is they’re gonna put you on a stretcher and take you away somewhere. They’re gonna just hold you for 72 hours, then let you go, and then this vicious cycle starts all over again.”*

Participant 2: *“And that don’t work. Isolating people when they’re having a mental struggle doesn’t work.”*

Participant 3: *“It makes it worse.”*

Participant 4: *“[These] teams are only really any good in a really, really high-crisis event. So when it comes to people who are on the streets who are struggling with their schizophrenia, their fears, their insecurities, their loneliness and depression, I think it would be awesome to have outreach teams to go out all the time and make direct communication, direct relationships with these folks.”*

An estimated 64 percent of people experiencing unsheltered homelessness in LA County have been involved in the criminal justice system (jail, prison, adult and juvenile probation, parole, and/or juvenile detention), according to a review using 2019 Greater LA Homeless Count Demographic Survey data (Gabriel et al., 2020). A recent study estimated that 30 percent (n=5,544) of people incarcerated in the County jail system are living with a serious mental health condition, and 61 percent were appropriate candidates for diversion (“redirection of eligible individuals with serious mental illness from traditional criminal justice processing into community-based services”) (Holliday et al., 2020). As DMH acknowledged in a

response to a motion from the Board of Supervisors, “many of their incarcerations could have been prevented entirely had they received needed treatment” (Sherin, 2019).

A few key informants mentioned the work of DHS Office of Diversion and Re-Entry (ODR) to divert people from jails during a mental health crisis. A behavioral health provider described a need for partnerships that:

“meet the patient through the door that they might be walking in. So if there’s innovative models that are working within that jail system, so that when a homeless patient gets picked up for whatever they’re doing in the community, but it’s law enforcement that intervenes, partnering with a health or social service provider that then can offer a solution that’s more from the health side, as opposed to the law enforcement side. So diversion programs that work that way, yes, law enforcement picks up the patient, but instead of putting them in jail, or sending them to prison, they link them to a health service provider. I think that those models are very effective.”

Others discussed the need for programs that release and provide support to people incarcerated as a result of behavior linked to mental health conditions. To this end, leadership of a large homeless services provider described their agency’s work with the ODR:

“The behavioral health work that’s going on there, where these are people who are incarcerated, they have a mental health diagnosis, and we are able to get them actually out of a jail and end their stay in incarceration. And that is promised by their willingness to stay med compliant. We provide housing, we do updates with the courts, and I think that’s an amazing intervention to ensure that people who really don’t belong in prison, you know, to be there in long stays in jail, when really, it’s their mental health that has caused the infraction. So I think that is really great work. And it is very much interdisciplinary on the legal side, on the mental health, behavioral health, and health side.”

Gap 7. Culturally-Specific Services

Lack of culturally-specific services, a dominant theme in our focus group, was described by advocates with lived experience as a major gap in serving communities of color and LGBTQ+ individuals. The focus group was concluded by asking participants to think about the question: “If the City or County could do one thing differently to improve health care for unsheltered neighbors, what would it be?” As one person stated, there is an overwhelming need for people to connect to healing in a manner that is culturally-relevant and trauma-informed:

“Address the root causes...I think of investing in people’s healing. So not making them have to go into facilities that have been designed in this watered-down type of westernized practices, but allow people to connect with what is healing for them [and] invest in them in doing that. Pay them to go and be invested in their mental health. Pay them to go and be able to invest in their health. Pay people so they don’t have to try

and work a bunch of jobs and they end up neglecting their health and their mental health... so much will be answered if you just allow people to address the root cause. People ain't got enough money. They've been traumatized by a [expletive redacted] up system. And they end up talking to themselves about it."

Key informants and advocates with lived experience described the promise of programs that offer health and mental health services from a culturally-specific lens and that are led by people from the communities served. One key informant pointed to a DMH innovation program that funded culturally-tailored interventions and imagined if such models were brought to greater scale:

"Organizations serving specific communities [were] called upon to apply [to offer] culturally-tailored interventions that would specifically target those who have generally been underrepresented, and those seeking mental health care and facing a lot of stigma. And so we applied because we'd had a history of serving the Latinx community," said leadership of a homeless service organization. "I believe that those models worked. I mean, the idea that you would target communities with great sensitivity to the trauma that they've experienced. For us, we hire only Spanish-speaking folks, it's required in that contract. So you can imagine what it would be like to have a Black project where you'd have Black people with mental health background training, psychiatry, and some cultural understanding and sensitivity, humility around what it's like to have mental illness undiagnosed or underreported."

A focus group participant in turn described the value of culturally-specific services:

"Already there's stigma, and many people who are severely mentally ill have run from their disease all their lives, having to be forced to take meds, and so some people, you know, are just out there living and struggling and dying, honestly. So the cultural sensitivity around racial trauma, around what it's like to be black and mentally ill in America and already have so many isms, including like, my goodness, I'm hearing voices right? Where do I go to say that, to share that? Mental illness is still so stigmatized in the black community, and again, a person who starts to feel paranoid and hearing voices and [who has] fear, anxiety, or suicidality, there's still very little space and place for that to be. And I think we've learned a lot, but I think we're still far behind."

The COVID-19 pandemic has laid bare the need to fund more culturally-specific health and mental health services. Key informants described how agencies embedded in neighborhoods with shared cultural and ethnic identities have played a central role in COVID-19 testing at encampment sites and pop-up vaccination events. They also pointed out how it is also due to many culturally-specific service providers vaccinating hundreds of thousands of people in California Healthy Places Index (HPI) high-health-need ZIP Codes that the City of LA is working toward achieving vaccine equity.



Health System: Barriers to Meeting Need

The following arose thematically from our key informant interviews and focus group as the primary barriers to the health system's capacity to serve people experiencing homelessness to the degree that is expected of Los Angeles (LA) City and County (herein the "City" and "County"). These barriers notably fell under four groupings of funding, service models, personnel gaps, and culture change:

1. Affordable, interim, and permanent supportive housing (funding);
2. Funding and service delivery silos (funding and service models);
3. Mobility of unsheltered residents and clean-up efforts (service models);
4. Fit of service design to unsheltered residents (service models and personnel gaps);
5. Racism (funding, service models, and culture change); and
6. Stigma and public misconception (culture change)

As a myriad of traumas and physical and emotional harms are incurred while unsheltered or facing housing instability (e.g., rape, arrest, harassment, disease exposure, food instability), housing is not only essential to intervention, but also the greatest form of prevention.

Barrier 1: Interim and Permanent Supportive Housing

Lack of interim and permanent supportive housing was named by all key informants and focus group participants as the greatest barrier to the health system's capacity to serve people experiencing homelessness. As a myriad of traumas and physical and emotional harms may be incurred while unsheltered or facing housing instability (e.g., rape, arrest, harassment, disease exposure, food instability), housing is not only essential to intervention, but also the greatest form of prevention.

"The problem is it doesn't really extend to people who aren't really sick yet," said a former Skid Row agency executive. "We have this coordinated entry system that is mandated by the feds and in LA operated by LAHSA, which prioritized people ultimately, in theory, by their likelihood of dying if left on the street...the idea is that, if you're really, really bad, then we give you first dibs on everything, which makes a certain amount of sense except that when you're only sheltering 25% of people in housing, many fewer than that, you're basically saying to people: Stay on the street for a couple of years until you're really screwed. And then we'll help you. But you have to serve a sentence of homelessness before we give you access to our housing and health system."

Key informants said that ensuring people are housed would also contribute to health and mental health care delivery that is less reactionary/episodic and more proactive/sustained:

"[Health care delivery to unsheltered residents] is episodic," said leadership of a large homeless health provider, who said their greatest challenge is locating their patients. "At what point are we going to say the only way we are going to deal with this effectively is if they have a

place to live? They're housed. And then we can do all the work: We can set up all the wraparound services. But there's so few of those projects compared to the number of folks who are experiencing homelessness that, I mean, the models are there. We know what works. It's just the failure [to] really build. And that's the City's job."

The metaphor of a Band-Aid was used to describe the provision of care to people without housing. "Prescribing" housing not only helps prevent compounding trauma, but also provides sanctuary and dignity for people to heal and stability to engage successfully in ongoing services and supports. "I think the health conditions are pretty acute," said leadership of a large health system. "Obviously they have a lot of chronic conditions, but those conditions are acute, you know, where people's blood sugar is really, really high. They have ulcers on their legs. There are just so many things that we see. We're providing a Band-Aid, when clearly what people need is stable housing."

Consensus was that the primary means of preventing physical and emotional trauma and harm, and for providers to effectively deliver health and mental health services, is by first helping people find safe and stable housing that is conducive to healing. "Folks should not be on the streets for so long," said a public housing official. "As soon as you can sort of build up a rapport, get them [expletive redacted] keys, get a roof [over their head], and continue the treatment once they're indoors. That is the one solution. And we have the capacity to do it, we just don't have the scale."

Barrier 2: Funding and Service Delivery Silos

Success in coordinating public health and mental health service delivery for special populations such as people experiencing homelessness was found to be shaped by the extent to which relevant funding streams are flexibly combined. As one key informant said, "figuring out the ways in which these federal programs could be linked together, it will force the bureaucracies to think about their intersectionality, and then it gets people at the local level working together."

Because HUD-funded homeless service provider networks (administered by LAHSA) are centered on housing and social support, there is reliance on agency-level coordination with health provider networks (administered by the County and funded by Medi-Cal, Medicare, MHSA, and SAMHSA) to offer housing, social, and health services as part of one integrated CoC. Thus, the concept of an integrated housing and health CoC is to some degree theoretical. LA was described by most key informants as having a decentralized CoC relying on proactive local collaboration.

"In Los Angeles, LAHSA is the lead applicant and HMIS provider, and on some level is the continuum of care in many people's minds," said a housing subject area expert. "I tend to want to refresh people's minds that the continuum is a collective body of folks that are facing this crisis. So on some level, it's all sorts of folks that [would] include the DMH, the DHS, and the DPH, each of which have a role and responsibility in

"We have, you know, 40 to 50 different contracts [and for] every different funding stream, there's a different contract number. We do a lot of our integrated medicine between our work with the DMH and DHS. It still feels like it's splintered, and there's more coordination that we can do,"



addressing the needs of people experiencing homelessness...HUD has worked to diminish barriers between federal silos, which are really true and significant barriers [and] ACA expansion provided access to federal reimbursement dollars through Medicaid...that gave Medi-Cal the capacity to bill for service provision that dealt with things like case management for [unsheltered residents and] provided a tremendous uptick in capacity. But I think you're absolutely right in identifying that [health care financing for people experiencing homelessness] goes through a different federal vertical [than HUD]."

Leadership of a behavioral health system described how these silos can prevent providers from working in flexible ways to address the holistic housing and health needs of unsheltered residents.

"[There is a] lack of resources to work in these innovative ways, meaning the hospital emergency department is paid to do hospital emergency department types of services. The health and social service provider is paid to do health and social services once the patient is linked. Meaning I do mental health services once the patient is already in my system. But there's not a lot of funding for us to work together in this fashion...things that might not be billable activities, someone has to be able to pay that cost. And a lot of times there's just not enough financial resources to work that way. Unless you have access to some sort of special private foundation funding or a funder that's interested in you working in an innovative fashion, meaning stop worrying about how you're going to get paid. Worry about doing the work that's needed."

As a result of funding silos, agencies seeking to provide comprehensive care to their clients often enter into numerous parallel contracts with different agencies and funding entities, each with their own client eligibility, performance specification, and reporting criteria.

"We have, you know, 40 to 50 different contracts [and for] every different funding stream, there's a different contract number. We do a lot of our integrated medicine between our work with the DMH and DHS. It still feels like it's splintered, and there's more coordination that we can do," said leadership of a culturally-specific homeless health care provider. "I think a lot of the times, it's funding streams. I think DHS and DMH have done a good job of making that process a little less cumbersome. But I think [providers] have a lot of funding streams with a lot of different requirements that vary from funder to funder."

Key informants discussed how these silos make mechanisms for the City, LAHSA, and County DMH/DHS/DPH to coordinate resources, with the mission of housing and optimizing the health of unsheltered neighbors, essential to creating a more integrated and efficient CoC.

“I was just in a meeting today with DMH, DHS, and LAHSA around interim housing,” said one key informant. “We have lots of coordination going on. I think the difficulty becomes on a micro level, that coordination and allocation of resources. Because if DMH is the only one who controls resources around housing for those who have severe mental health issues, [but] someone comes to the door of LAHSA and says ‘I need you to house me’ and LAHSA says ‘Well you have really severe paranoid schizophrenia, you need extra assistance, we need to get you into a DMH shelter’ but DMH says ‘well, we reserved all those beds for our clients, because there are not enough beds and too many clients,’ [that] presents a barrier to the system.”

Nearly all key informants, including service providers, identified DHS Housing for Health as playing an exemplary leadership role in coordinating across funding silos. As one noted,

“Housing for Health is a strong member of the continuum, they’re fully integrated, they have a seat on the CoC Board, and they are a major provider of permanent supportive housing and receive federal grants through the [HUD-funded] CoC. They are [also] a medical-billing provider... So that’s an instance of the County Health Agency [author’s note: replaced by the Alliance for Health Integration] building out an apparatus so that local service providers can bill for and receive funding for [a continuum of services]. But you know, the way that our federal government is set up is very silo-based.”

Key informants stated that Federal laws (e.g., ACA), State initiatives (e.g., Medicaid Section 1115 and 1915(b) waivers and future CalAIM), and County innovation programs that break down silos between housing, social, and health service funding will continue to play important roles in allowing for more efficient and equitable service delivery.

Barrier 3: Mobility of Unsheltered Residents and “Clean-Up” Efforts

Housing instability and mobility represent barriers to unsheltered residents engaging with services and to providers in ensuring continuity of health and mental health care over time. It is therefore an important factor to take into account in service design, particularly as it may relate to unintended consequences of City clean-ups of encampments.

“I think the difficulty is that people experiencing homelessness are so spread out..we [have] mobiles that go to the shelters. And so they’ve established kind of a medical home, to some extent, for folks who are at the same shelters or store their belongings at the same place,” said leadership of a homeless health provider. “But I think there is a significant percentage of folks experiencing homelessness that are at encampments, and I think those are particularly difficult. The penetration rate is much more difficult, the consistency rate, they’re

“Depending on the latest initiative to clean up an area or address some type of homeless encampment, it may cause someone to get moved or pushed into another area that makes it harder or more difficult for them to maintain that linkage that they may have with their mental health service provider if they’ve been able to establish one.”

constantly being forced to move by law enforcement, you know, their stuff is being thrown away, and they have to find a new place. It's really hard to keep up with them."

Three quarters of adults ages 25+ surveyed in the last homeless count resided in Los Angeles before becoming unsheltered, and 80 percent said they had been in the County for five or more years (Los Angeles Homeless Services Authority, 2020a). A study of people experiencing homelessness in Long Beach found that daily mobility patterns are less a function of access to transport, as is a popular belief, and more a function of space exclusion ("political struggles over the siting of shelters and the visible signs of homelessness and homeless people in the city") and conditions of service operation ("regulation of the use of city spaces — like the shelter during business hours") (Jocoy & Del Casino, 2010). In their study, unsheltered residents ranked health and mental health agencies number-one as the "most important place they need to go." Our key informants in turn described how instability of housing situations and space exclusion through the clearing of encampments force people to be mobile, making it difficult for them to achieve continuity of care despite its importance in their lives. For people with severe health conditions, they said, it may be difficult to remember prior service specifics or re-establish contact with service providers in prior locations of residence.

"In part it's just their housing situation," said leadership of one health care provider. "The instability of their housing situation. And depending how they're either being forced to move and relocate across the City, depending on, you know, the latest initiative to clean up an area or address some type of homeless encampment, it may cause someone to get moved or pushed into another area that makes it harder or more difficult for them to maintain that linkage that they may have with their mental health service provider if they've been able to establish one."

Service providers said challenges of mobility were particularly evident during COVID-19, in that they'd had difficulty tracking people to administer second doses of vaccines. As leadership of a large health and social service provider said,

"With the shelters, it's a little easier, because, [we're] able to go back. With the encampments, we have been able to do second shot, but, you know we get people to fill out and kind of make a commitment to meeting us in the same place. And, you know, what they'll say is, 'If the cops don't come and throw me out, I'll be here. If sanitation doesn't come and take all my stuff and ask me to move, I'll be here.' So it's been a difficult process. And you know, again, one shot of Pfizer, 50-60% immunity, is better than none."

As discussed in the "Design" section, the City is responsible for maintenance of public areas in compliance with LA Municipal Code (LAMC), implemented through efforts of its CARE and CARE+ teams. Amendments regulating personal property storage were made to LAMC in 2016 and 2018, respectively, "balancing the needs of the City's population, at all levels" (LAMC § 56.11) and to "prevent the misappropriation of Parks and Beach Parks for personal use" (LAMC § 63.44).

Concerns were expressed that while the spirit of clean-ups is to promote public health, they may also do harm if they trigger mental health crises, destabilize social networks, or exacerbate mobility. “One of the things that happens in encampments is, you know, people are social,” said a key informant. “Under whatever circumstances, they began to look after each other, and develop friendships and mutual support, and the system is hell-bent on destroying that, the one little thing that they managed to cobble together.”

For unsheltered residents with very limited social networks and resources, many of whom are fleeing violence, the experience of further loss in a time of great need is dehumanizing and can exacerbate crisis. As a focus group participant and survivor described, when the van she was living in was taken, she feared for her safety and it triggered a crisis. She said it was this loss – versus proactive outreach on the part of public health teams – that led her to seeking help, something that motivated her to later become an advocate:

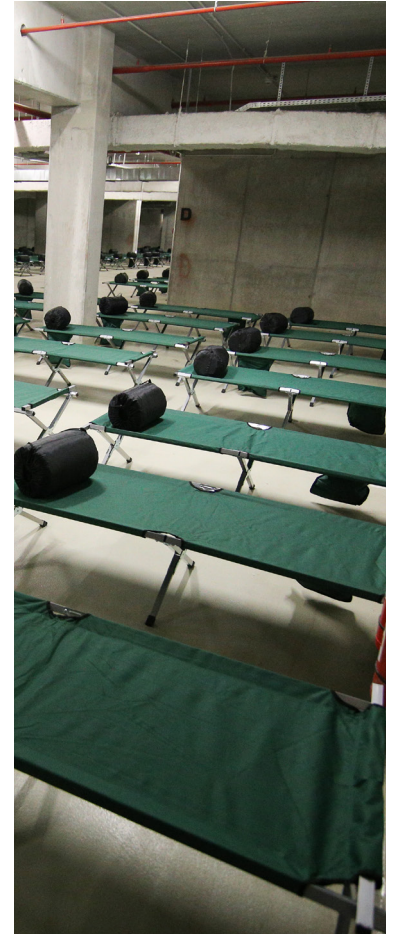
“I’d like to share that when I was homeless and I was having a mental health breakdown after my van was taken away and repossessed — I mean, towed away, whatever they call it,” said a focus group participant, “I became very suicidal, and I was gonna go kill myself. And all the times out there, I never — I don’t know what I’m trying to say. It’s just so sad that it has to get to that point before you feel like you can go seek help.”

Advocates and key informants suggested City and County CARE and CARE+ teams would benefit from greater support and coordination with DPH and DHS to deploy mobile teams to encampments proactively to bolster social supports, provide resources for maintaining hygiene and sanitation, engage people in health services, and establish relationships over time.

Barrier 4: Fit of Service Design to Unsheltered Residents

An overarching theme arising from narratives was that transforming health systems to achieve better health outcomes requires seeing and re-imagining the system from a “bottom-up” perspective. As a key informant who is former leader of a Skid Row agency said, “the fundamental problem with all of our systems is that hardly anybody ever takes the time to actually try to understand what the world looks like from the bottom. From that perspective. And it’s always been my mission in life to try to push systems [to] really understand what it looks like. Because otherwise, you’re just treating people as objects to be managed. And that’s morally wrong.”

Key components of what participants said makes for good fit of a health or



Key informants acknowledged how people often need same-day drop-in services that don't fit with the dominant medical paradigm, which requires advance appointments and referrals within specific networks.

mental health service provider to unsheltered residents were described in earlier sections and are illustrated in our Spotlights on Homeless Health Care Los Angeles and Venice Family Clinics, where the same themes arose organically. They include the importance of:

- Low-barrier access (see “Engagement and Communication” section on “Access to Low-Barrier Service Entrypoints”)
- Relationship-building (see “Gaps” section on “Health Care Navigation and Peer Advocacy” and “Engagement and Communication” section on “Direct Engagement through Mobile Units and Peers”)
- Mobile medicine (see “Gaps” section on “Mobile Clinical Medical Homes”)
- Housing First and harm reduction models (see “Milestones” section and below)

Key informants acknowledged how people often need same-day drop-in services that don't fit with the dominant medical paradigm, which requires advance appointments and referrals within specific networks. As one service provider explained, agencies offering walk-in services “stand a greater chance of staying connected and linked to their homeless patients, as compared to a sort of normal brick and mortar behavioral health service facility [that] operates on a scheduled basis [where you] have a therapy session once a week, [and] if you don't make that appointment, sorry, we'll see you next week. That just doesn't work [for] homeless individuals.”

Key informants and focus group participants also observed that the health care delivery system requires clients/patients to meet perceived basic standards that create comfort for providers, but pose barriers to access. One provider named expectations such as cleanliness and not carrying possessions. “There might not be facilities where you can safely leave your cart if you are trying to walk in and see your provider,” they said. “By and large, we're not set up, we're really not designed to serve the homeless population, which I think in itself could represent a barrier for either someone initially getting care or continuing with that care if you're not sensitive to that fact.”

Service delivery models that encourage relationship-building and trust were thought to support fit of service design to people experiencing homelessness. Advocates with lived experience said they had sought relationships with providers who were non-judgmental and who worked to establish trust. Key informants said that a lack of trust, as well as trauma related to negative experiences with service providers, was common among residents they serve who are unsheltered. They said this has created a paradox where unsheltered people have both an acute need for health services and an acute distrust of providers and systems that have harmed or failed them in the past.

Barrier 5: Racism

Key informants and focus group participants both described how racist beliefs and practices (e.g., differential diagnosis, treatment, and prescribing) among health care providers contribute to inequitable health outcomes. A specific theme arose around racial trauma and how, among people of color, trauma is often undiagnosed or can lead to misdiagnosis with mental illness. “Even in the mental health field, a lot of black people are being misdiagnosed because of the symptoms that may look like there’s something, when really it’s us navigating the trauma that we’ve experienced,” said an advocate with lived experience. “We’ll be given all kinds of diagnoses, when we just really need justice.”

As a key informant who is leadership of a large homeless service organization similarly stated, “There is a lot of racial trauma that I believe sometimes goes undiagnosed, because there’s not a lot of understanding of how race and trauma intersect in our [homeless services] sector. I think we’re trying to do more [and] certainly [there is] a lot of fear that people are living with around being unhoused and the overpolicing that has happened in the community.”

Focus group participants, the majority of whom identified as people of color, spoke at length about the feeling of being treated as a source of profit (e.g., being made to undergo unnecessary procedures) and of having avoided medical care due to fear of inappropriate treatment and harm. These experiences are highlighted by the following two-person exchange from our focus group:

Participant 1: *“It’s challenging to have [unsheltered neighbors] go and access care because of negative experiences [and] distrust, whether it be personal or the knowledge of the history. And I’m going to just explicitly say black people have an issue with the way stigma impacts us. We have an issue with the way that there’s been medical practices to purposefully cause harm and damage our reproductive systems and things like that. So yeah, for those reasons, there’s a lot of challenges with people saying ‘I’m gonna go in and be the test dummy.’”*

Participant 2: *“That’s something I go through every time I go to a doctor, because you never know if you’re going to get the right one, you know? You might get the right one that’s going to help you. But you also know, you got those out there that wants to do little types of experiments so they can be the first, you know? That’s one of my fears when I go to the doctor. And a lot of times, that might stop me from going to the doctor for a particular problem... The last one I had, he said something was wrong with my heart. Ended up nothing was wrong with my heart, [but] that was my fear all the time was, is this gonna be the right doctor? Is he gonna righteously be trying to help me?”*

“Even in the mental health field, a lot of black people are being misdiagnosed because of the symptoms that may look like there’s something, when really it’s us navigating the trauma that we’ve experienced.”



Key informant interviewees and focus group participants acknowledged how people of color are overrepresented in public (Medi-Cal) as opposed to private (marketplace) plans. They described what they saw as a disinvestment in health and homeless service facilities in communities of color. As leadership of a large multifaceted homeless service organization said:

“There is the quality of health care, right? So if you are on Medi-Cal and you are reliant upon the County systems, I mean, people of color have always known that those are the systems that the poor people get. You know? That we have access to because the City, the County, and the government has to make them available, but they don’t [have] to be the best or the highest quality. The lines don’t have to be short. [It’s] not always client- or customer- or patient-driven. So that is just something people of color know. That this is what is set aside for us. So I think when we just talk about what does health look like, what are the conceptualizations for people of color, of black people in the County...it hasn’t always been an uplifting experience. [It] is just how we’re treated when you are an impoverished person who has the Medi-Cal card.”

Participants described a need for equitable access to quality care, funding for culturally-specific services (see “Gaps” section on “Culturally-Specific Services”), and diversifying the health workforce to mirror the racial, ethnic, and language demographics of their neighborhoods.

“There’s some recent research [that] if you are a black person or, you know, even a mom, [if] she’s seen by a black doctors, she would be more likely to thrive as a result of being assigned a black doctors and her child [would have] better outcomes,” said a key informant. “All of that speaks to what is it about the training or the systemic racism in the way that black people are seen? We tend to be under diagnosed, we tend to not have the same amount of procedures. [We] see trends of unconscious bias that we seen in medical professionals that may somehow be addressed by just having people of the same race, ethnicity, or just commitment to providing quality care to people of color.”

Barrier 6: Stigma and Public Misconception

There is considerable public misconception that all people who are unsheltered have serious mental health conditions. While many have experienced trauma, often as a direct result of homelessness or housing instability, approximately one quarter of people experiencing homelessness in the Los Angeles CoC identify as having a mental health condition (Los Angeles Homeless Services Authority, 2020c). Of those, one key informant estimated only a fraction (e.g., 10%) may have conditions severe enough to qualify for DMH services.

“If you look at the data that we have, a quarter of the population have one or the other, serious mental illness or a significant substance use disorder, and about 10 or 11% have both,” said a key informant

from the housing sector. “[That] obviously is a significant minority among people experiencing homelessness, but it is the prevalent characteristic for the popular mythology. And in part for me, it’s because of availability bias. People remember those cases. [They] stand out in your memory, because their behavior is so, you know, disorderly and frightening.”

They continued, “It makes people feel scared, and they burn their way into people’s imagination, [but what the public] certainly never sees [is] the 18,000 people who are sleeping in their cars, and who bought the cheapest gym membership so they could shower in the morning, so they could get to work clean. You know, they’re not seeing those folks. But they do see the people who are in the grip of comorbid disorders.”

While the public image of an unsheltered individual may be someone with severe health and mental health conditions, the vast majority of unsheltered neighbors do not fit this stereotype. Key informants who are health and homeless service providers described how people coming through their doors are commonly seeking care for trauma relating to violence and abuse, recovery from substance use conditions, and medical care for conditions linked to the stress of living on the streets, such as dehydration, heart disease, diabetes, lesions, or untreated cancer. Of all adults ages 18+ surveyed in the 2020 Homeless Count, 33 percent reported an experience of domestic or intimate partner violence (Los Angeles Homeless Services Authority, 2020c).

Stereotypes have nonetheless contributed to a culture of NIMBYism (“Not In My Back Yard”) in the City of LA, leading to public calls for clean-ups in some neighborhoods and reducing landlords’ motivation to lease their units out as interim or affordable housing. There persists a harmful popular mythology of unhoused people as outsiders, as opposed to neighbors, in our communities. As leadership of a large behavioral health system pointed out,

“The last thing I would like to highlight is just the NIMBYism that still exists. Where it’s like we have innovative programs, but you know, the community still has a strong reaction to providing services to [unsheltered neighbors]. There’s been a process of trying to create these tiny homes [but] there’s still a lot of community reaction to that in terms of not wanting their community to be used for this purpose...instead of thinking that we’re addressing the problem, the community believes you are just increasing the number of homeless in my community, and I don’t like that.”

A County health official expressed a sense of concern and futility that fear of unsheltered individuals in communities in the City of LA had intensified since the pandemic, when they had hoped that communities would become more united.

“We were talking internally [that] we’d hoped that through this, we would have gained grace, and more compassion. But it seems like it’s, it’s people are tired, they want to come out, and they want to see the world different. Right? And the reality is we’re gonna have more homeless people and more people in need. And so just in terms of the amount of violence that we’re seeing, the amount of sort of forced movement of people, the rhetoric that is around now, in terms of, you know, cleaning up of whatever, it’s more aggressive now than it was before the pandemic. And it’s disturbing, right? I had hope that we would come out of this more unified.”

Key informants discussed a general stigma toward mental health care among those with past trauma related to their conditions (e.g., being arrested, forced to take medications, or placed on involuntary holds). They and focus group participants also described how mental health is particularly stigmatized in certain racial and ethnic groups, making cultural shame an additional barrier to services. One focus group participant reflected on the experience of stigma in his own life, when a family member told him not to access care. “Our own families might stop [us] from going, [by telling us] ‘there’s nothing wrong with you.

You're just having a bad day.' When actually that person might be having a mental problem, a mental breakdown of some sort. [And] then you got to be fearful of what people will say, once they know, you know?"

Key informants acknowledged that while Housing First and harm reduction models have proven highly effective, there is stigma that will need to be overcome to achieve broader dissemination due to a dominance of "abstinence" models for both housing and recovery:

"So Housing First showed up 25 years ago, and the evidence starts to come forward that there's another way [and] it doesn't have to be [a] sobriety-based transitional models, we can do this other thing [and] it works better and cheaper," said a key informant who is a homeless services subject area expert. "But it took a long time, in part because of the kinds of dominant philosophies [of] parsing people into [are] they doing good, are they being good people? [The] sort of 'earning,' 'deserving,' the kind of language that is very harmful to addressing people as sort of whole people, was rife within our sector. And it took a lot of really good practice to get to the consciousness of Housing First and harm reduction and trauma-informed care. But we as a sector did adopt these approaches, and [we] became a learning sector. [We] transformed our behavior as a sector from folks who are very rigidly attached to moralistic models and sobriety-based models to a sector that says let's look at the evidence and let's work together [on the] evidence, let's try out new things, and then let's build on evidence that works."

Another key informant who is a leader of a behavioral health care system said there is also a lack of knowledge regarding how medications are used to treat mental health conditions in the same way that they are to treat somatic conditions such as infections, diabetes, or high blood pressure:

"Medications are a pretty sizable piece of the armamentarium of addressing just about every other health issue, but because the sector on substance use disorders has been so fundamentally locked around this single model, which is an abstinence-based model, it has resisted that kind of penetration of evidence-based practices that actually [show] harm reduction is a better model than abstinence models and that medication for addiction treatment [helps] reduce your cravings, reduce the impact of withdrawal...the kinds of things that we would ordinarily think of for management of chronic disease."

Leadership and Coordination

Structure of Authority

County Board of Supervisors

Los Angeles (LA) County ("County") represents a vast area that includes 88 municipalities, with three cities ([Long Beach](#), [Pasadena](#), and [Vernon](#)) having their own autonomous health departments and public health delivery systems. The County is governed by a five-member Board of Supervisors (BoS) that has both legislative and executive authority and who are elected by voters in their districts. The County BoS is "responsible for setting policies, enacting ordinances and adopting resolutions" and is "the largest and most complex" in the United States," governing more than 10 million people (County of Los Angeles Board of Supervisors, 2021).

Los Angeles County Alliance for Health Integration (formerly Health Agency)

The Alliance for Health Integration (AHI) was created in February 2020 through a [motion of Los Angeles County Board of Supervisors](#) in an effort to create a revised structure and shared priorities for its predecessor, the [LA County Health Agency](#). Its mission is to improve the health and wellbeing of LA County residents by aligning and efficiently implementing Board-approved prevention, treatment, and healing initiatives that require collaborative contributions of the three County Health Departments (DHS/DPH/DMH) (J. Baucum, personal communication, July 27, 2021).

Previous to the AHI, [LA County Health Agency](#) had been formed by the BoS in 2015 through adoption of an ordinance to re-integrate DHS, DPH, and DMH under one umbrella. The Agency's formation was intended to maintain the fiscal and programmatic independence of the three departments, while enhancing coordination of health-related activities, as is reflected in [LA County Municipal Code § 2.73](#). Based on a [memorandum](#) from former DHS Director Dr. Mitchell Katz, the Health Agency was also expected to control costs by "improving coordination of services, leveraging economies of scale, and decreasing administrative costs," and increase revenue by "taking advantage of available local, state, and federal funding streams" (Katz, 2015).

With the creation of the AHI in February 2020, the Board adopted the proposed framework and organization structure ([AHI Priority Plan](#)) to continue to build upon the integration and coordination work initiated by the Health Agency. Whereas "Health Agency" had been used to synonymously "equal" the three Health Departments, "AHI" signals cross-cutting work and shared spaces. The goal of AHI is to serve as an implementation arm of the Departments in order to meet adopted priorities. As such, the AHI is embedded in all three departments as an implementation arm for all health integration work (J. Baucum, personal communication, July 27, 2021).



City Council and Mayor's Office

The [City of Los Angeles](#) ("City") is governed by a [City Council](#) that enacts ordinances, and ordinances enacted by the Council are subject to veto or approval by the Mayor's Office (City of Los Angeles, 2021a). The Council in turn confirms or rejects appointments proposed by the Mayor. For example, the Mayor appoints the [City Administrative Officer](#) (CAO), who manages the City's budget and act as a financial advisor to the Mayor and City Council. CAO's appointment is subject to the Council's confirmation (City Administrative Officer, 2021b).

Mayor's Office of City Homelessness Initiatives

[Mayor's Office of City Homelessness Initiatives](#) (MOCHI) oversees the Mayor's strategies to serve unsheltered residents, including "the City's street strategy to address encampments, the development of interim housing citywide [and] the production and preservation of affordable and supportive housing [including] the Prop. HHH program" (Los Angeles Mayor's Office, 2021).

Los Angeles City Health Commission

To provide greater public health oversight, the City established the LA City Health Commission through The City of Los Angeles Health Protection Act (2014). Its purpose, as [stated in the ordinance](#), is to "determine the health needs of the people of the City of Los Angeles, determine whether those needs are being met, and to help determine the best and most cost-effective ways of meeting those needs" (p. 1). Initially, the Commission was tasked to review health service contracts with the County and report to the City Council on the effectiveness of service delivery. It was also tasked to evaluate the appropriateness of the 1964 City-County Agreement.

In its Action Plan for addressing homelessness (Los Angeles City Health Commission, 2020), the Commission urged adoption of recommendations to achieve eight strategies (pp. 2-11):

1. Continual expansion of **Housing for Health**;
2. Expansion of existing and creation of **Sobering Centers** in critical-need areas;
3. Increase access to sanitary public toilets through the **Mobile Pit Stop program**;
4. Reduce **Food Insecurity** by increasing Supplemental Nutrition Assistance Program (SNAP) enrollment and evaluating increase to General Relief (GR);
5. Monitor adoption of hospital **Discharge Planning** mandated by SB1152 and fund additional mobile medical outreach;
6. Increase **Affordable Housing** units;
7. Support current and new initiatives for addressing **Veteran Homelessness** (e.g., Veteran Peer Access Network, Safe Parking LA); and
8. Reduce use of **Heroin and Other Opioids** through increased access to Naloxone.

The Commission has not been appropriated any funding or staff to allow the Commission to meet the mission as originally laid out at its inception (H. Mandel, personal communication, June 27, 2021). The Commission operates with volunteer Commissioners and at times volunteer unpaid part-time research assistants and interns. There seems to be no direct or consistent channel of communication between the Commission and the County regarding the City-County Agreement.

Los Angeles Homeless Services Authority

LA County BoS and the Mayor and City Council established Los Angeles Homeless Services Authority (LAHSA) to administer the LA continuum of care (CoC). LAHSA was established in 1993 as a Joint Exercise of Powers Agreement between the City and County and converted to a permanent Joint Powers Authority in 2001. LAHSA has ten commissioners: five appointed by the Supervisors and five by the Mayor, with the confirmation of City Council. LAHSA coordinates and manages over \$869 million (FY2021 Q3) “in federal, state, county, and city funds for programs that provide shelter, housing, and services to people experiencing homelessness” (Los Angeles Homeless Services Authority, 2021).

Inter-Agency Health Service Coordination

During **outreach and engagement**, County and LAHSA staff complete the CES survey (VI-SPDAT) and enter individuals into the Homeless Management Information System (HMIS) to be linked to housing. **Housing matchers at DMH, DHS, and LAHSA coordinate closely to triage people to the most appropriate housing resources.** For example, LAHSA staff reach out to DMH and DHS when they have clients in need of referrals to specialty supportive housing. DMH and DHS in turn coordinate to triage people into interim and permanent supportive housing (PSH) units.

As part of a coordinated effort to provide PSH units as quickly as possible, at the end of 2019, LAHSA implemented **Housing Central Command (HCC)**. HCC is based on a crisis response model developed by U.S. Department of Housing and Urban Development (HUD) to help people find housing after natural disasters. The aim is to establish visibility of PSH inventory Countywide to expedite the move-in process. HCC is composed of the City/County agencies with PSH portfolio, such as DMH, DPH HFH, LA County Development Agency (LACDA), Housing and Community Investment Department of City of LA (HCIDLA), and Housing Authority of City of LA (HACLA). Other partners include MOCHI and LA County Department of Public Social Services (DPSS).

County, LAHSA, and City staff also coordinate to provide **direct outreach and care through mobile outreach teams**: LA Police Department (LAPD) officers partner with DMH staff to provide mobile crisis response through the City’s Systemwide Mental Health Assessment Response Teams (SMART). LA Fire Department (LAFD) partners with DHS HFH on the Advanced Provider Response Unit (APRU) and DPH on the Sobriety Emergency Response Unit (SOBER). At last, DHS Multidisciplinary Teams (MDT) partner with LAHSA Homeless Engagement Teams (HET) to provide a clinical service component to outreach.

While encampment “clean-up” is managed by the City Mayor’s Office CARE and CARE+ teams, LAHSA (“HET”), DHS (“MDT”), and DMH (“HOME”) units may coordinate to “identify, refer and link clients to integrated services as appropriate” (Los Angeles County Department of Mental Health, 2021b). However, the majority of health or mental health services that have complemented the work of CARE teams have been organized by the Mayor’s Office through voluntary partnerships such as UCLA Student Run Homeless Clinic. As described in the “Gaps” section of “Mobile Clinical Medical Homes,” the City is preparing to launch a new street medicine program, in partnership with LA County USC Medical Center, using federal Community Development Block Grant funds.

DPH began to coordinate with the City and LAHSA more recently as it gained a firmer footprint in the shelter space through **its Environmental Services Division and through the COVID-19 response**, described in the next section.

In addition to direct coordination on service teams, **County DMH/DPH/DHS and LAHSA have interfaced through regular staff trainings for co-education on service linkages and resource sharing.** These agencies also participate in and organize forums for community-based organizations. For example, DMH helps mental health providers navigate CoC housing and support services and resources through presentations at Service Area Leadership Team (SALT) and Underserved Cultural Community (UsCC) meetings. Leadership of the County Health Departments and LAHSA are also invited to present at City Council meetings.

Inter-Agency Strategic Planning

The City, County, and LAHSA participate in a variety of regular meetings designed for programmatic planning across entities. One example is the [Homeless Policy Deputies](#) Meetings, convened by the County Chief Executive Office (CEO) on Monday evenings and inclusive of all entities involved in the homeless response, including for example members of City Council, the CAO’s Office, County Alliance for Health Integration, and County Homeless Initiative.

MOCHI formed a **Unified Homeless Response Center (UHRC)** in April 2018 that provides physical space for City Departments (e.g., Police, Fire, Recreation and Parks, Sanitation, Transportation), LAHSA, and County DMH/DHS/DPH to work together. The vision is to unify City/County/LAHSA strategies for addressing homelessness in the City of LA under one task force. “Municipalities have very specific tools, [and] it’s all the physical infrastructure of the City and public safety,” one key informant stated. “But they’re not the full complement of what you need if you’re responding to homelessness. The Unified Homeless Response Center [is] a place to draw in some of the other County services that could be used to help inform how the City is deploying municipal services.” Key informants shared that outside of a few emergency situations, UHRC has struggled to gain traction with non-City entities.

As discussed in the “Milestones” section, the City and the County each launched strategic planning efforts to develop **comprehensive homeless strategies** in the lead-up to **Measures HHH (City) and H (County)**. These included establishment of what is now the [Homelessness and Poverty Committee](#) (City) and [LA County Homeless Initiative](#) (County). One key informant recalled, Planning efforts have largely been in parallel, with cross-pollination between the County, City, and LAHSA, to contribute to the plans of each other’s agencies and priorities of their respective governance.

COVID-19 Spurs Unprecedented Coordination, Exposes Gaps

In March 2020, as the City and County declared a state of emergency, California became the first state to receive FEMA approval to provide safe isolation rooms to unhoused residents. Project Roomkey, funded by the CARES Act and FEMA cost-sharing, was launched shortly thereafter and administered by localities (California Department of Social Services, 2020; Office of Governor Gavin Newsom, 2020). The County and LAHSA, together with hotel operators, co-administered **Project Roomkey** in Los Angeles to assist people who are unhoused and highly vulnerable to COVID-19 in finding shelter in hotel and motel rooms (Los Angeles Homeless Services Authority, 2020b; Los Angeles County, 2020). United Way of Greater Los Angeles in collaboration with California Community Foundation has since launched \$2.8 million in [Health Pathways Expansion](#) grants to support 16 community clinics and federally-qualified health centers in partnering with site operators to provide on-site health and mental health services to Project Roomkey residents.

Additional funding was in turn secured by the City through the LA Mayor’s Fund, Mayor’s Office, and donors for **Project Safe Haven**, which secured additional interim housing for survivors of intimate partner violence and their families. The City also funded **conversion of City recreation centers into emergency shelters, along with buses to bring people to shelters**. Shelters were staffed by City employees, DMH staff, and a contracted nurse registry company, GoRN, who provided staff for wellness screenings, temperature checks, and symptom monitoring.

“Both the City and County launched this series of planning sessions. And in the fall of 2015, there were dozens of these planning sessions that looked at elements of the homeless crisis, and they worked closely together. So [the] City were in those meetings, [the] County, service providers, lots of folks worked together. And they came up with their documents. They each wrote a book, you know, comprehensive homeless strategies. [They] were both passed on the same day. So there’s this massively heralded Tuesday in February of 2016 where they both met, not in a joint session, but in a coincidence session that adopted them on the same day, which was sort of a symbolically powerful moment.”



Establishment of Common Planning Forum

With the implementation of new programs during COVID-19, meetings between the City, County, LAHSA entities, and community-based organizations became more frequent and essential as staff sought to respond to the crisis and have their questions answered in real time. Among these are (now biweekly) meetings attended by all County Health Departments and Homeless Initiative's Office, City Council members, the CAO's Office, the Homeless Deputies, and LAHSA.

On June 23, 2020, LAHSA released a [COVID-19 response and recovery plan](#) developed in collaboration with the City and County, [first presented to the Board of Supervisors](#) on May 27, 2020 (Marston, 2020a). This plan recommended a recovery command structure wherein recovery efforts are "led by a collaborative team consisting of LAHSA, the CEO, DHS, DMH, and DPH, as well as the City of LA Mayor's Office and City Administrative Office" (Marston, 2020b).

Parallel City and County Response Efforts

The City and County implemented mostly parallel response efforts during COVID-19. The City was predominantly responsible for physical plants such as emergency shelters, testing and vaccination sites such as Dodger Stadium, whereas the County focused on direct health care provision.

Coronavirus Aid, Relief, and Economic Security (CARES) Act allowed HUD to develop a new formula to award Emergency Solutions Grant CARES Act funds (ESG-CV) to be used to "prevent, prepare for, and respond to the COVID-19 among individuals and families who are homeless or receiving homeless assistance" (Housing and Urban Development, 2021b). HUD allocated more than \$180 million for the City and \$70 million for the County. The County in turn gave a portion of their allocations to LAHSA for homeless prevention, interim housing resources during COVID-19 such as Project Roomkey, recovery rehousing for people transitioning out of Project Roomkey, and installation and operation of hygiene stations within its ESG service area (LA County excluding six cities: Los Angeles, Glendale, Pasadena, Pomona, and El Monte) (Hamai, 2020). Funding was allocated based on a formula, with the City and County receiving their own allocations without geographic overlap. Since the City and County received mutually-exclusive funding allocations for their own jurisdictions, there has not been meaningful collaboration between the two entities in spending down the ESG-CV funds.

A meta-narrative that arose was **City and County officials expressing the same reciprocal call for more meaningful collaboration** and concerns that the other was "defensive" and "confrontational," words used on both sides. The call for conflict resolution particularly arose around "wicked" problems such as set-up of emergency shelters at a time when little was still known about how the virus spreads. "The City really felt a lot of urgency to do something," said one key informant, who lamented that due to concerns over the safety of congregate settings, attempts by the City to have the County staff these shelters were partially met with resistance.



“DMH mental health providers [were] on-site, [which] helped people experiencing homelessness. It also gave a lot of peace of mind to the Recs and Parks people who [were] running the physical plants,” they continued. “[But] we had to hire a [outside consulting] nursing firm to check temperatures and to do wellness checks...and it was an [LAPD] police officer who would check people’s temperature when they were getting on the bus.”

A County official, too, recalled tension during this time. “The City often was not very happy about [County Health Departments] making recommendations in terms of bed spacing, quarantine, and isolation. It often becomes confrontational when it doesn’t have to,” they said. “There’s not like a spirit of ‘Hey, you know, could we do something together?’ And when we end up in the same place by accident, it gets a little tense...And I don’t exactly know why that is.”

Unprecedented Collaboration in COVID-19 Response

Key informant interviews revealed how the health and mental health response during COVID-19 generated new inter-agency collaboration, with a primary example being the implementation of **Project Roomkey**. This required what could be described as a Housing First model implemented through collaboration between LAHSA as the housing CoC administrator, the County Health Departments as public health safety net providers, and hotel/motel operators (Measure H Citizens’ Oversight Advisory Board, 2020). Initially, the County led the process of outreach to hotels, as well as negotiating and executing contracts. The County contracted with multiple hotels working with the State, LAHSA, and the Mayor’s Office. Once hotels were secured, the County worked closely with LAHSA to develop a master agreement outlining services, meal providers, and security support for these establishments. The City led the outreach effort to recruit hotels/motels within the City (City of Los Angeles Chief Legislative Analyst, 2020).

Based on the success of Project Roomkey, the State implemented a \$600 million grant project known as **Project Homekey**. Grants were made available to local public entities to purchase and rehabilitate housing, including hotels, motels, vacant apartment buildings, and other buildings and convert them into interim or permanent, long-term housing.

Key informants from DHS, DMH, and DPH attested to how Project Roomkey, Project Homekey, and Project Safe Haven spurred greater collaboration between County and LAHSA. County health officials said that while staff at DMH and DHS had coordinated closely to triage clients into housing prior to COVID-19, their staff had begun to coordinate more frequently with LAHSA.

“DMH uses the Housing for Health machinery for placement into interim housing and PSH [permanent supportive housing]. So we often function together in doing that work,” they said. “So if [name redacted] from Housing for Health got a call that seemed more DMH, he would transfer it over to DMH, and vice-versa...and now we’ve had to add LAHSA in with COVID. And I think it’s been really important because the LAHSA interim housing beds were a big black box to us...we’ve had to sort of move really



high-risk people to low-risk shelters because of COVID. [It's] engendered this sort of camaraderie that we haven't had before."

Other County health officials said that COVID-19 presented an opportunity for DPH to interface with LAHSA in a greater capacity than they had in the past with shelter inspections. As one said,

"They learned about isolation and quarantine, we learned about all the different types of shelter they provide and their housing strategies... and we had some difficult moments, you know, because putting in place isolation or quarantine orders or distancing requirements, we're reducing capacity...we were putting restrictions on things to keep people safe. And it, you know, just as it did in every part of almost everyone's life, you know, there was a sense of loss. [So] we had to learn from each other. But I think the benefit, the opportunity of this experience, was that we learned a lot about each other's services and expertise and we built relationships. And so I think a lot of things came together in very good ways that will be enduring."

Another example of new collaboration is **vaccination efforts**, which have required coordination within and between County DMH/DPH/DHS, LAHSA, homeless service agencies, and FQHCs, each offering what they are best equipped to do. This coordination is exemplified by the interlocking roles outlined in a [DHS presentation on COVID-19 vaccination for people who are unsheltered](#) (Los Angeles County Department of Health Services Housing for Health, 2021):

- **DPH Roles:** community engagement strategy, technical assistance, allocation of vaccine, outbreak management support
- **DHS Roles:** prioritizing sites, training community health workers, developing registration platform for unsheltered residents, storing and administering vaccine
- **DMH/LAHSA Roles:** data sharing to assist in planning, using HOME and HET teams to identify residents/staff interested in vaccine, orienting DHS and DPH to different locations where people are living unsheltered, community outreach and education
- **Homeless Service Agency Roles:** educating clients/staff on the vaccine, assisting in site set-up, developing COVID-19 mitigation protocols for staff following LA County DPH guidelines
- **FQHC Roles:** coordinating with DPH, DMH, DHS, and LAHSA to educate clients about vaccination events, provision of vaccines via clinics, mobile units, and pop-ups, using Akido app to report on COVID vaccination

DHS Housing for Health (HFH) was notably charged with all of the surveillance testing for COVID-19 for people who were unsheltered, and all of the infection control and containment across the shelter system (including LAHSA's shelters) and among those who are unsheltered. They also managed the quarantine and isolation centers for COVID-19 for the entire general population, including individuals who are unsheltered. They are currently the main facilitator of COVID-19 vaccine for people experiencing homelessness.



The response to the pandemic underscored the capability of DHS HFH to lead planning and coordination among the County health departments and LAHSA. Nearly all key informants spoke of the effectiveness of DHS HFH in serving unsheltered residents since its inception. Still, key informants emphasized how the “top-down” efforts of the County DHS/DPH/DMH and LAHSA to plan, allocate, and administer COVID-19 tests and vaccines could not have been successful without the “bottom-up” efforts of **culturally-specific organizations and FQHCs** in particular to engage residents in the neighborhoods they serve and repurpose their facilities and mobile units.

As one key informant pointed out, it is arguably because culturally-specific organizations banded together in a “whatever it takes” manner to collaborate, network, and share health information in their communities that the City of LA is progressing toward vaccine equity.

“Something like 78 percent of all the vaccines that were given — and we’ve given over 250,000 in South LA — were given to folks in HPI zip codes, you know, under-equity zip codes...we’re the highest vaccine equity provider in the state by percentage. I think one of the things we learned was that partnerships were critical. The partnerships with churches, the partnerships with community-based organizations, with elected officials. Labor, we were able to reach a lot of frontline workers through partnerships with County Federation of Labor and SEIU. So again, we had those partnerships already, but they kind of deepened. And there was [a] real, substantive, immediate benefit to them. Obviously they were in place in many ways, and there were new partnerships that developed as a result, [but] I think it was that foundation that allowed us to vaccinate so many folks, and particularly so many folks of color.”

Implementing a response in the most populous county in the United States — with vast demographic and cultural differences across regions — required these providers doing what many service providers learned to do well in a largely decentralized system: engaging their clients and other community organizations through vast webs of one-on-one relationships.

Lessons Learned

Value of Unified Response Structure

The COVID-19 response forced the City, County, LAHSA, and service providers to come together in regular meetings under a common response structure and to allocate responsibilities according to each entity’s strengths. This not only provided an opportunity to align delivery of services under the same entity, but also for each to become better acquainted of the other’s capabilities and to build relationships that could be sustained.

"Just because the City's not a health provider, there's sort of an assumption that [we] wouldn't do anything or can't contribute to the effort [to provide health services to unsheltered residents]. But I don't think that's true. We have facilities everywhere that people I think would love to open up. Council Offices before COVID were organizing Homeless Connect days... there are ways that the City would love to partner and that we can bring something to the table [to] increase the effectiveness of physical and behavioral health efforts by the County. We may not [have] a bunch of doctors, but we do have a lot of facilities, a lot of visibility, a lot of really good will on behalf of the Council Offices."

As a City representative said, there is interest on the part of municipal staff to learn how to help residents navigate and engage with the health and mental health system, since they are often among the people that residents bring these questions to. "There are so many City services that are frontline for people experiencing homelessness," they said, mentioning for example libraries and recreation and park spaces. "[Staff are] trying to learn how to navigate the system when they're not a social worker... [unsheltered residents] are asking them [for health resources] and people want to help. They want to do something, you know, so why not harness that?" They continued in expressing a hope that was reminiscent of roles the City had played prior to the dissolution of its health department in 1964.

Desire for Common Ground between City and County

A metanarrative that arose was a culture of "pointing fingers" where each player sought to assign responsibility to another player for shortcomings of the COVID-19 or homeless response at large. This has led to a climate characterized by silos, distrust, tension, and competition: the opposite of a climate that encourages knowledge-sharing and collaboration. As a housing official pointed out, "I think right now there's a lot of sort of blaming and 'whose fault is this?' rather than how can we empower the Health Agency [author note: replaced by the Alliance for Health Integration in February 2020] to take this on. It does seem like it's a moment of blaming, rather than embracing the work that needs to be done, the collective responsibility, [and] giving people the tools they need."

County, City, and LAHSA officials all expressed how they felt this distrust was in part symptomatic of highly decentralized structures of authority in LA. "There was a considerable body of distrust of municipalities and government among the folks who built the governing structures here," said one key informant. "You have a very strongly-divided City and County, [you] have a weak [system] in the City of LA so that the Mayor does not have the level of authority that the role carries in many other municipalities. And it just is a very challenging local governance environment and does not lend itself well to close collaboration."

A theme that arose organically in nearly all key informant interviews was frustration or concern over missed opportunities for the City and County to coordinate in their common mission of protecting public health and safety. As one key informant said,

"It's really, really hard [to] see how entrenched the distrust and sort of rivalry is between the County and the City. But we've had to sort of figure out how to work with each other. But I would say, not as well as I might have hoped around the COVID pandemic [in terms of] testing, people movement, shelter management, and vaccination. The City is doing its own thing. County is doing its own thing. And then when we bump into each other, we sort of talk, but it's often rancorous."

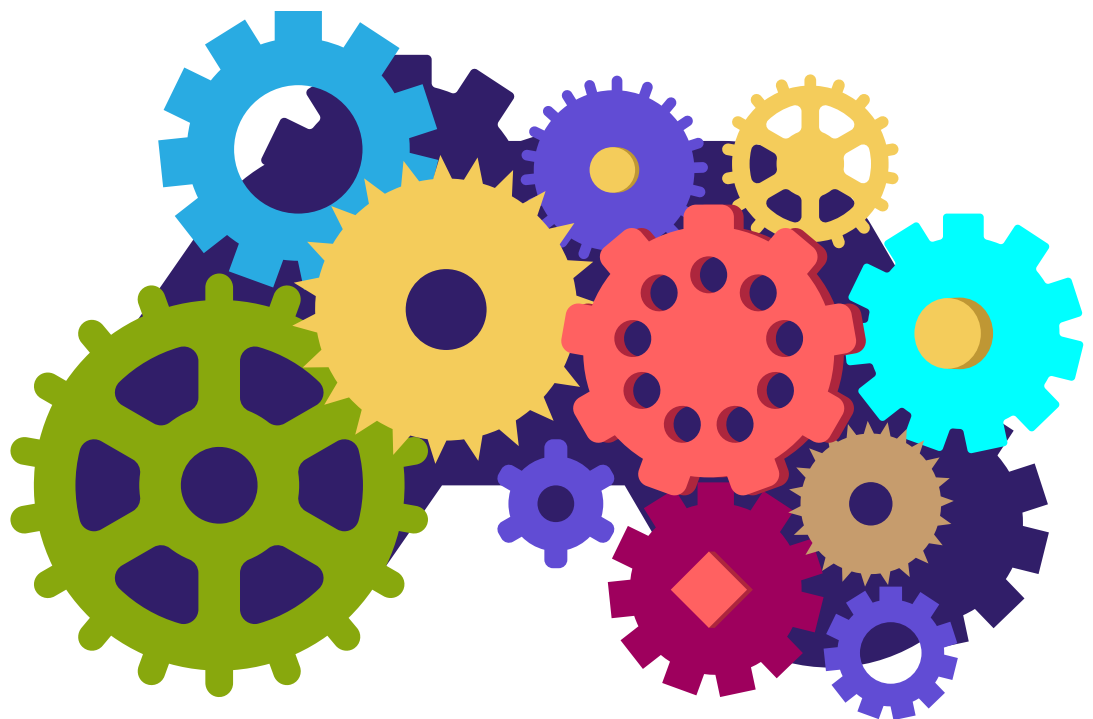
Bridging Silos under a Common Vision

Responding to an emergent and evolving public health crisis forced the County, LAHSA, and to some extent the City to combine their resources to achieve a common goal. Organized under a common vision and command center, each brought to the table their strengths, achieving what one key informant described as “being able to do macro work that applies to local areas.”

During COVID-19, federal restrictions for certain services (e.g., SUD treatment) were lowered and multiple agencies were able to use their funding to achieve the same goals. One public official described how the Project Roomkey not only helped acquaint County Health Departments with each other’s work, but also helped support the coordination of these departments with LAHSA.

“We tried to align the delivery of a broad range of healthcare services with the Project Roomkey sites, such that mental health services and substance use services were made available to folks who needed them in a timely fashion. So I think that sort of planning was helpful for us to get more acquainted with each other’s work and each other’s systems and all the nooks and crannies of how we have to do the work we do.”

One key informant drew a parallel to Housing and Urban Development Veterans Administration Supportive Housing program (HUD-VASH), whereby service providers in Los Angeles experienced a relaxing of certain restrictions, combined with an ability for multiple types of entities to use the same funds. This gave them enormous flexibility for collaborating to do “whatever it takes” to meet the health needs of unsheltered veterans. The promise of bridging silos in this way is discussed in **NYC Case Spotlight Part 2: VA Bridging Silos under a Common Vision.**



Data Sharing and Outcomes Measurement

Client Level

Sharing of client-level information across City, County, and LAHSA data warehouses is limited, in part due to silos and lack of shared information system, and in part due to federal restrictions for sharing of health information. LA County departments including DHS, DPH, DMH, Sheriff, Probation, DPSS, and DCFS have the capability to match clients on unique identifiers. These same identifiers are used in the LAHSA Homeless Management Information System (HMIS), making it possible to also match data on those who are engaged with both LAHSA and County departments.

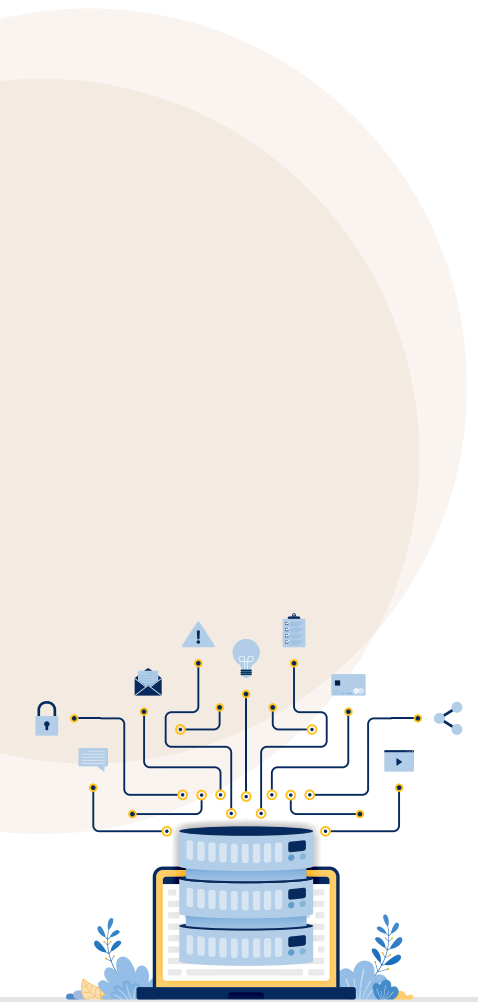
LAHSA and County data in its deidentified form (stripped of personal information) is being used by applied researchers at **California Policy Lab (CPL)** at UCLA for several ongoing projects, including creation of predictive analytics to identify clients vulnerable to housing instability (J. Rountree, personal communication, June 21, 2021).² The Economic Roundtable has also created predictive analytics to identify what types of clients would most benefit from additional outreach. All of CPL's projects are developed collaboratively with and sponsored by one or more County agencies. These projects have supported a shift from looking retrospectively at outcomes to identifying clients who would benefit from additional support in real time. As one key informant stated,

“LA County operates an integrated data system across all of their platforms. And they generate an enormous amount of data on individuals. So anytime you interact with DMH or DHS or welfare department [DPSS] or even the Sheriff, then that fact is recorded, and it makes it possible to look at people longitudinally. And so that data has been used [to] create predictive analytics looking at who's likely to have a bad outcome without an intervention, and then prioritize people on the front end. [So] that's an opportunity for more sort of real-time engagement as opposed to retrospective longitudinal outcomes.”

A new **DHS Homeless Prevention Unit** developed by DHS HFH in collaboration with DMH to implement Measure H prevention strategies has been staffed to make use of predictive analytics developed by CPL. The data will also have other uses, e.g., to describe aggregate service use patterns, diagnoses, and health outcomes of people served by LAHSA and the County.

The profile information that LAHSA and the County can access in each other's systems is very limited. LAHSA may for example view limited information on shared clients in DHS, DMH, and DPSS via the County Information Hub. The County in turn may view limited read-only information in HMIS, such as whether a client has a VI-SPDAT. Recently, AB 210 (Information Sharing for Homeless Adult and Family Multidisciplinary Teams) is allowing members of multidisciplinary teams to look up their clients' information in the County Homeless Information Portal.

² Ongoing research projects at California Policy Lab include predicting single adult homelessness among current County clients; predicting family homelessness among CalWORKS enrollees; predicting homelessness among TAY who are involved with DCFS; analyzing SMI and SUD diagnoses among participants in street outreach services (in partnership with LAHSA and DMH); observing and describing both homelessness and service utilization patterns among DMH clients; testing the feasibility of predicting mortality among homeless individuals; understanding how well the VI-SPDAT and other triage tools predict vulnerability; and working with County agencies in a technical assistance capacity to improve observation and measurement of homelessness (J. Rountree, personal communication, June 21, 2021).



Inability to access enrollment information across entities has been a challenge for serving people who are unsheltered. While such information could ideally be supplied via an insurance card, unhoused people experience barriers to retaining or replacing IDs, such as cards being stolen with their belongings or not having an address to ship cards to. Those in a health or mental health crisis may not be able to recall the specifics of their plan. As a key informant said, with regard to how to improve client-level data sharing for unsheltered residents, without “knowing which managed care somebody is enrolled in, [a] case manager cannot even begin to get you benefits if they don’t know where to start. So enrollment data is the very first place to start.”

Client tracking remains largely a function occurring at the individual service organization level.

Providers enter and access client data in multiple separate City/County/LAHSa systems, and client tracking is “bottom-up” and unique to any one agency. Though still uncommon, tracking can occur through patient tracking systems (“registries”) that may integrate with electronic health records or electronic platforms that support care planning and collaborative workflows within and across agencies.

Program Level

At the City, County, and LAHSa program level, opportunities exist to enhance data sharing through **technology or forums that would allow for two-way sharing of public health trends and patterns at the neighborhood level.** As a key informant said, LAHSa and the County “have a lot of analyses that can [be] share[d] with [the City] that will inform their work,” and the City has analyses that can “sharpen [the County and LAHSa’s] work and make it more effective.” Patterns in drug overdose was used as an example. The County “talking with the City about the data and where they are seeing trends [in] different communities can inform the work that they do. And it could be a two-way street. [The City] may have datasets that could be valuable for [the County].”

Multiple key informants discussed how because agencies such as LAHSa, DMH, and DHS HFH have grown so large, and are often serving the exact same individuals and communities, a **centralized communication platform** could also help promote coordination and efficiency. This sentiment is reflected in the following excerpts from two different public administrators.

“All of those entities have grown so large now. [And] since we have no centralized data platform, each one of us uses our own data management system, each one of us stands up our own teams. That becomes a problem. Don’t get me wrong, money is still the problem. But the problem of [lack of funding] would be easier to handle [if] the coordination was stronger.”

“Every time we’ve tried to address the sort of coordination question, we always bump up against data sharing. [Each entity uses] different systems. I think it’s hard to follow a person through.”

Key informants said joint analysis of health outcomes and other service metrics between City and County officials could also be facilitated by **working toward common definitions and metrics**.

One key informant stated “we need to adopt common definitions” and explained,

“I think that the important thing that we don’t do and that we need to do is adopt the same metrics and the same language and the same definitions. While I think the County agencies and LAHSA have pretty similar definitions governed by HUD...private organizations and the City [don’t] have exactly the same definitions. Like if you even were just asking the agency ‘what is your definition of homelessness,’ you might get three different answers.”

Another used LAHSA and its contracts with outside agencies as examples of where metrics defined by other government programs may not fit what is most important or relevant to people who are unsheltered. “Each of those contracts has a certain set of metrics,” he said, “and if they don’t well-align with the metrics of the other programs,” the programs do not integrate well.

A final theme arising from interviews was the potential to **accelerate a reduction in homelessness by shifting from a focus on program activities to housing and health outcomes**. The effectiveness of **Brilliant Corners**, the agency that manages housing placements for the County’s Flexible Housing Subsidy Pool, were attributed to a focus on doing “whatever it takes” to achieve positive results for people with some of the greatest health needs.

“They’re effective because they manage for results,” said one key informant of these two agencies. “Brilliant Corners is really, really good at finding what housing there is [because] they get paid based on successful placements. Whereas everybody in the [continuum of care] gets paid for their activities. So you may have six different LAHSA outreach workers who encounter the same person, and they have six successful encounters. But the person is exactly the same person... basically I do my activity, then I throw them over to the next person. And there’s nobody responsible for the failure of that connection, which happens all the time...so what makes the Housing for Health thing work, I think, is that results [are] what they want. But there’s no reward for activity. And it took me a long time to learn this, but it’s really important not to confuse activity with accomplishment in whatever field you’re in.”

Recommendations



Recommendations

City of Los Angeles

Formal Oversight and Evaluation of Health Service Delivery

To respond to the immediate crisis of homelessness and public health issues in a timely manner, an alternative to the City having its own health department would be strengthening the City's oversight on the County's service delivery within the City. According to an analysis by the City Administrative Officer, establishing a new City health department could take up to two years (Santana, 2013).

While City Council holds authority to renew the 1964 City-County Agreement, there is no official department or authority within the City that manages the contract and evaluates adequacy and effectiveness of the services provided by the County. The City already has the Health Commission that was established in 2014 to review the 1964 City-County Agreement to ensure that the County provides quality services to meet the needs of the City's residents. After the initial investigation, the Commission has focused on advising the Mayor and the Council on public-health-related matters, rather than tracking the Agreement and its effectiveness.

The Health Commission can oversee and evaluate the 1964 City-Council Agreement and service delivery with official authority and resources. The Commission's role and the County's responsibility to report to the Commission should be clearly stated in the Agreement as an amendment. Through community engagement, the Commission could also conduct an annual evaluation of whether health needs of Angelenos are met.

Further Research on City-County Health Coordination

It would be beneficial to investigate how other cities without their own health departments coordinate health services for unhoused residents (e.g., Seattle-King County Public Health and Health Care for the Homeless Network). Review of similar agreements in these cities may provide insight into precedents for what delineates City vs. County roles in public health and sanitation and processes for ongoing oversight and amendment of so-called "evergreen" public health contracts that automatically renew on an annual basis.



Staff Training and Resource Tools

City staff who interact with unsheltered residents — including staff at Council District offices, libraries, schools, parks, and recreation centers — could be offered trainings and resources for referrals. Trainings would be most effective if paired with tools such as a unified access line or “map” of services, beyond a list of phone numbers. Under the City’s Enhanced Comprehensive Homeless Strategy (ECHS), a training course is being developed for “front desk staff who may interact directly with individuals seeking resources.” The training is currently supported by various City entities and LAHSA. However, the County’s Alliance for Health Integration could provide expertise in available health resources as an opportunity to break down silos of information sharing and build relationships across the various entities.

County of Los Angeles

Unified Health Promotion under Single Entity

Current budgets and funding mechanisms have positioned health care at the center of moving unsheltered residents into housing, with both DMH and DHS playing a substantial role in funding and managing large networks of interim and permanent supportive housing. This flips the dominant paradigm of homeless service providers as the referral entity for health care on its head, showing health providers can be successful in “prescribing” housing for health.

DPH, DHS, and DMH act independently, making it more difficult to coordinate services for unhoused Angelenos. The Alliance for Health Integration (AHI) was recently embedded in all three health departments as an implementation arm (described as “mini” departments) for all health integration work. In light of this, an ideal structure for health promotion for unsheltered Angelenos may be one that allows the AHI to operate under the guidance of a lead agency, e.g., with the AHI functioning as a unit with DHS Housing for Health as lead coordinator.



Provision of Health Service Quality Measurement Data for the City

The City does not have a way to measure quality or quantity of services provided by the County Health Departments. The County's health, social, and homeless services are organized by Service Planning Areas (SPAs) or Service Area (SA) for DMH, which does not delineate the City from the rest of the SPA it is located within for data reporting purposes.

For homeless services, LAHSA provides performance and outcome data for City-funded homeless outreach services, including the number of client contacts, engagements, services, and referrals offered, and other housing-related outcomes (Rysman, 2021). LAHSA also maintains data dashboards on Project Homekey (PHK), permanent housing placement, and older adults CES engagement and placement with capabilities to filter data for the City (Islam, 2021). Community and City-level data reporting during COVID-19 is a good example of data sharing between the City and DPH. DPH has been able to provide daily updates on cases and death rates by community and City, which expedited local responses to outbreaks.

The first step to meaningful data sharing would be for the County to provide regular reports on quality measurement indicators specific to the City that could help the City understand whether its residents' needs are being met. Key public health indicators should be chosen through cross-sector and inter-agency dialogue and deliberation.

City and County of Los Angeles

Streamlined Mobile Outreach and Medicine Programs

Mobile units are an effective approach to outreach, engagement, and health and mental health delivery to unsheltered residents. The COVID-19 pandemic has shone a light on how, working together, the City, County Alliance for Health Integration, and hundreds of CBOs could deploy mobile units to offer testing and vaccinate thousands of people on the streets and in shelters.

- At present, County and City mobile outreach and engagement teams tend to act independently, resulting in multiple parallel programs (e.g., three separate "mobile medicine" pilots) that could benefit from efficiencies if funding, staff, and volunteers were combined. This is a timely issue given recent spikes in mortality among people experiencing homelessness in the City have been attributed to overdoses relating to exposure to the synthetic opioid Fentanyl (Los Angeles County Department of Public Health, Center for Health Impact Evaluation, 2021). Good will on behalf of the County and City to pilot mobile medical homes represents a tremendous opportunity for collaboration to address the urgent need for overdose prevention. Multiple efforts to pilot new mobile medicine programs, such as the new DHS HFH "street medicine teams" and City Unified Homeless Response Center (UHRC) "USC Street Medicine Teams," could be streamlined.

The scaling of a mobile response represents an opportunity to contribute to the effectiveness of the City (311) and County (211) response systems. As our NYC Case Spotlight Part 1: Proactive Outreach through 311 illustrates, pairing triage and mobile response with such hotlines through a program like HOME-STAT could be part of a coordinated effort between the City and County to engage and link unsheltered residents to health, mental health, and housing resources.

- Another immediate need is more planned collaboration between DHS, DMH, and City CARE and CARE+ teams. With County support, City teams who visit encampments have an opportunity to foster neighborhood trust, provide critical resources, and help bolster people's social supports. More proactive outreach and engagement, occurring over a period of weeks, could help prevent the need for enforcement of encampment "clean-ups" or forced evacuation and mobility of people who are unsheltered, which can be traumatic when occurring with very short notice.

At present, there is no one unified response line to link residents to health and mental health services, but a unified 211/311 system could potentially serve this purpose. Recently the County of LA undertook an initiative to revamp the 211 system. They also announced the winners of a Tech Innovation Challenge that includes a new centralized portal to connect unsheltered residents with service providers, and a mobile app to improve access to public service data. Both would benefit from a human-centered design approach where voices of people with lived experience are involved at all stages from development to implementation.

Law Enforcement Collaborations for Mental Health Crisis

The City of Los Angeles Police Department (LAPD) and Fire Department (LAFD) are the frontline emergency health care responders when people call 911 seeking medical assistance or when someone is considered to be a threat to themselves or others and in need of mental health crisis support. Yet a mental health crisis requires skilled intervention from mental health clinicians.

People with mental health conditions may be skeptical of involving police in crisis situations, particularly if the outcome may be a jail hold. Additionally, there may be fears related to gun violence: Half of people killed by police are estimated to have some form of disability (Perry & Carter-Long, 2016), and people with untreated mental health conditions are 16 times more likely to be killed during a police encounter (Fuller et al., 2015). So too may people of color be fearful of seeking crisis services that involve law enforcement given their disproportionate representation in police shootings. An analysis of homicide records from the County medical examiner-coroner shows that "Black people make up less than 10% of L.A. County's population, yet they represent a 25% of law enforcement killings" (Los Angeles Times Staff, 2021).

There is a need to fund and staff more mobile health crisis teams so that the responsibility for responding to crises does not fall on LAPD and LAFD officers who are not licensed mental health clinicians. This includes collaborative responses where officers and mental health clinicians are deployed concurrently (e.g., City SMART teams) and responses where mental health crisis teams are deployed without officers (e.g., PMRT). Few resources for these teams exist and capacity to respond is very limited. The new LAFD and DMH Therapeutic Transportation pilot is an example of a promising initiative. There is also a need to embed social workers with specific expertise in responding to intimate partner violence within 911 response teams. This can help ensure that those who are fleeing violence, whether at home, in a shelter, or on the streets have the support they need to achieve housing stability and connection to health and mental health services.

"By dismantling the mental illness treatment system, we have turned mental health crisis from a medical issue into a police matter. This is patently unfair, illogical and is proving harmful both to the individual in desperate need of care and the officer who is forced to respond" (Treatment Advocacy Center, 2015).

CAPABLE teams a nurse, an occupational therapist, and a handy worker to help older adults with disability achieve safety and independence. Research on Medicaid cost savings of CAPABLE has revealed that “roughly \$3,000 in program costs yielded more than \$20,000 in savings in medical costs driven by reductions in both inpatient and outpatient expenditures” (Johns Hopkins School of Nursing, 2021; Ruiz et al., 2017).

Targeted Programs for People in Transition

More than 40 years after the Lanterman-Petris-Short Act, shortages of community mental health providers and hospital beds remain. A recent report by DMH responding to a motion from LA County Board of Supervisors to address the ongoing shortages encouraged stakeholders to “look at the whole system of mental health beds and services, including those that play a role prior, during, and after hospital stays” (Sherin, 2019).

For those transitioning out of hospital settings and into the community, a shortage of post-hospital enriched residential care (ERC) beds was named as a significant service gap by multiple key informants. In the shorter term, without funding for additional ERC beds, a functional rehabilitation program potentially led by DHS and/or DMH could offer a complementary solution. With such a program available, people could be stepped down to independent housing, with maximal support, to free up ERC beds for people who have more acute needs. Such a program might for example employ an evidence-based model known as [Community Aging in Place - Advancing Better Living for Elders](#) (CAPABLE).

Another group in transition who are highly vulnerable to cycles of homelessness are individuals involved in the justice system. There exists a revolving door between incarceration in prisons/jails and homelessness, in particular given a long history of structural racism, criminalization of homelessness, and failures of deinstitutionalization. Transitional programs funded by DHS Office of Diversion and Re-Entry (ODR) could potentially be brought to greater scale through multisector collaboration between County, LAHSA, City (e.g., Gang Reduction and Youth Development), and CBOs. About half of people who are incarcerated have substance use conditions, but few have access to treatment. There is evidence that comprehensive mental health services, including MAT, offered in jail settings and continued as part of transitional planning, contributes to recovery and successful transitions back into the community (National Institute on Drug Abuse, 2020).

Forums for Planning and Shared Vision

To some extent, it does not matter what improvements are made to engagement and communication, service delivery, or data sharing if the issue of collaboration is not faced head-on. Solutions to the gaps and barriers identified in this landscape analysis remain confounded if all those unified under the mission of health promotion for unhoused Angelenos are not incentivized to march in step and in the same direction by leaders who engage in cross-sector planning and coordination.

Key informants at the City and County revealed very similar attitudes and beliefs that, even in the wake of COVID-19, they struggled to engage in safe and productive dialogue on collaborative approaches to service delivery. Both said

greater coordination would be beneficial given their common missions, and the different resources they bring to the table, and sought more open and authentic communication. There is an opportunity for City and County leadership and staff involved in health care delivery to engage in strategic planning or mediation aimed at conflict resolution and collaborative action. Such efforts could help generate new insights by allowing for open sharing of different perspectives and encouraging integrated efforts among the diverse stakeholders involved in service coordination. This would also help build cultures of mental health to support the wellbeing and retention of staff.

Building Relationships through Accompaniment

Advocates envisioned a day when everyone experiencing homelessness are paired with a navigator, community health worker, or peer with lived experience. Such individuals have the capability to meet people where they are at, build trust and rapport over time, and accompany them in their journey through the health and behavioral health system.

People are social beings and heal in relationship and community to one another. Self-management and/or recovery from chronic diseases such as diabetes, acute injury or illness, and mental health conditions is often non-linear. Accompaniment can provide the emotional and spiritual support and encouragement needed as people navigate health care, recover, cope with anticipated setbacks, and eventually thrive.

- A pilot program to evaluate the efficacy and cost-effectiveness of scaling a model where all vulnerable unhoused residents are connected to a navigator, community health worker, or advocate could prove efficacious. An Institute to train and provide certification for these various roles could help bring such a model to scale. Accompaniment models have been effectively developed and brought to large scale in diverse local, state, and country settings by organizations such as Partners In Health, whose accompagnateur model has been used to surmount large-scale public health crises and epidemics through outreach and one-on-one relationship-building.
- Community health workers and advocates, many of whom are peers, play a vital role in disseminating health information and resources. Campaigns to address priority issues driving mortality among unhoused Angelenos, in particular Fentanyl overdose, should be driven by principles of social and behavioral science as to what factors influence health behavior change. This includes harnessing the power of social networks in behavioral health promotion to unhoused residents. Multilingual promotores can play a vital role in distribution of health information throughout peer networks and to those walking into Drop-In Centers.

Policy and System Level

Reducing Race and Gender Inequities in Health of Unhoused Angelenos

People of color and LGBTQ+ individuals are disproportionately represented among people experiencing homelessness due to a long history of structures and processes such as segregation, discrimination, and inequitable treatment as it relates to health and mental health care. So too has the health of these residents been disproportionately impacted by the COVID-19 pandemic.

LA City Council and Mayor's Offices should have race and gender equity in health among unhoused residents as an overarching goal. Research corroborates our landscape analysis findings that health inequities are driven by neighborhood segregation, mass incarceration, and unequal health care (Bailey et al., 2021). Collaborative action for transformative change is urgently needed to invest in historically displaced communities and elevate community voices, needs, and ideas.

At the policy level, progress can be made through participatory budgeting and urban planning practices. Data sharing across City and County, for example through asset-based community development mapping, could be used to identify strengths of low-income communities. Paired with participatory planning, this could be used to support what focus group participants described as "supportive community," a pillar to reducing health inequities and addressing upstream causes of homelessness (Williams & Cooper, 2009). In line with national trends, the City and County should require community engagement plans from all organizations accepting funding from them.

At the health system level, the City should prioritize investment in culturally-responsive services that fit the unique needs of unhoused Angelenos (low-barrier access, relationship-building, mobile medicine, Housing First and harm reduction models).

- The health care system in the City is built largely on a Western paradigm of addressing illness within a medical model. So too is the mental health system largely rooted in the Anglo-European perspective that built psychology/psychiatry as a medical discipline and that tends to focus on problematic behaviors (M. Moore, personal communication, June 3, 2021).
- Advocates in our focus group said that when they and clients have gone to health providers for help, it was often for a range of health, social, economic, political, and spiritual reasons. Health providers may fail to ask a person's goals and where they want to be. The provider, who is often in a place of power, may suggest a solution that a person doesn't want or need, or at worst does harm (Piper-Mandy, 2016).
- There is ample evidence that people of color served by agencies staffed and led by people of color experience better engagement, involvement in decision-making, and health outcomes (Huerto, 2020).

Strengthening Partnerships and Bridging Funding Silos

Achieving a more integrated, “no wrong door” system of care for unhoused Angelenos will require strengthening cross-sector partnerships and bridging funding silos that create barriers to delivering services in a way that fits the unique needs of unsheltered residents. Cross-sector collaborations could be organized around groups highly vulnerable to homelessness. Examples might include youth transitioning out of the foster system, veterans, intimate partner violence survivors, justice-system-involved individuals, and people with co-occurring health conditions.

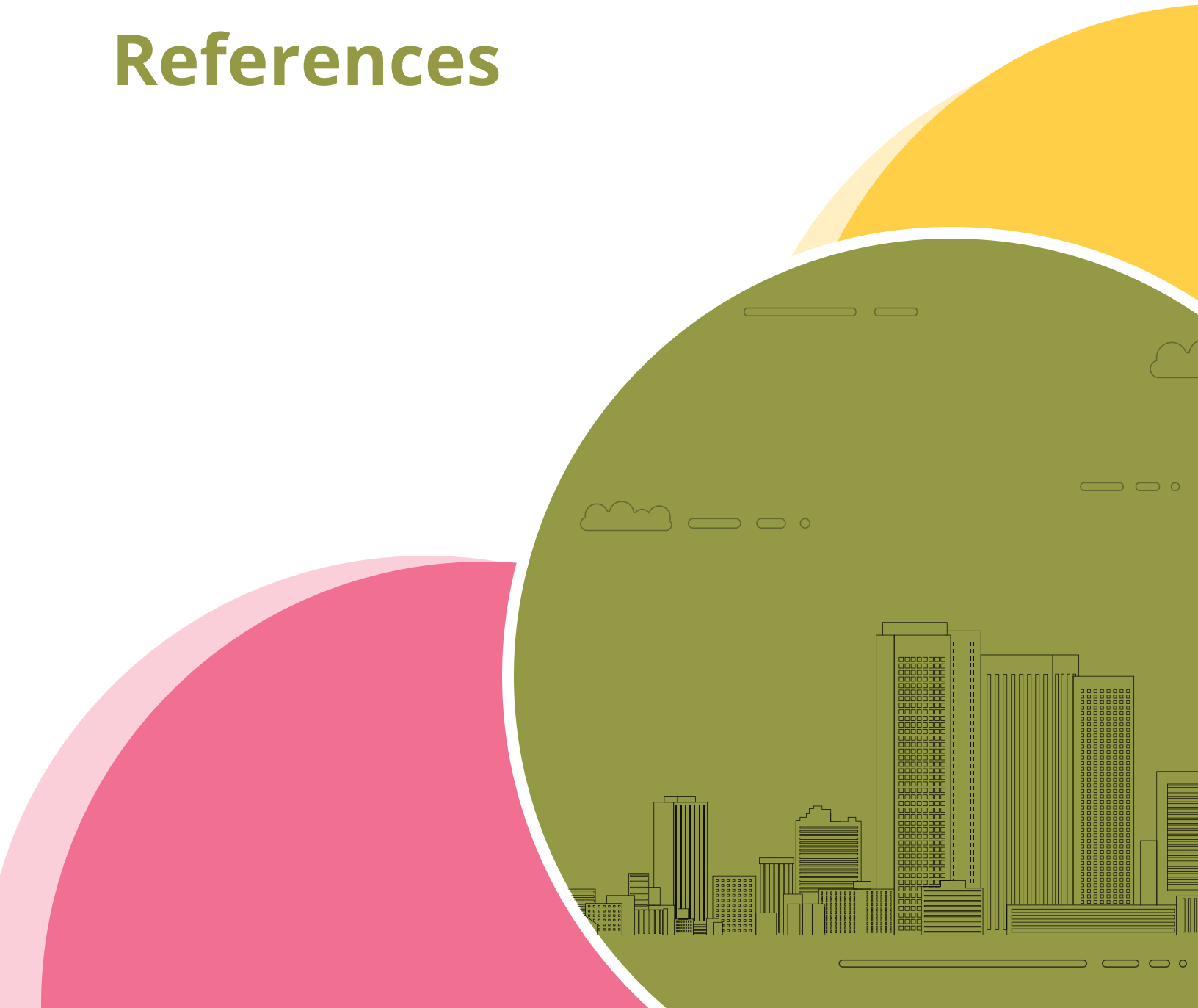
Undertaking unprecedented efforts to coordinate housing and health care, within the institutional constraints of numerous government silos, is a challenge that LA and other major U.S. cities hold in common.

A combination of “top-down” and “bottom-up” leadership of City/County, LAHSA, and community-based organizations (CBOs) has been achieved to some extent during COVID-19. Cross-sector collaboration of this nature was notably at the heart of the recent five-year Whole Person Care Los Angeles (WPC-LA) program implemented by LA DHS (Los Angeles County Department of Health Services, 2021b). This Medicaid Section 1115 Waiver program initiated cross-sector partnerships to provide coordinated health, mental health, and social services to vulnerable populations in LA County.

- Research suggests that CBOs who participated “valued new opportunities to expand their regional/partnership networks through work with multiple county departments, healthcare systems, and CBOs,” while recognizing drawbacks that came from their limited inclusion in design and implementation, such as a lack of incentive to break down silos or technologies for inter-agency referrals (Agonafer et al., 2021).
- Research on WPC LA informs future efforts to organize cross-sector partnerships for people experiencing homelessness by underscoring the importance of equilateral power-sharing across City/County, LAHSA, and CBOs. As the study concluded, “expanding these integrative models of care requires targeted and inclusive training, funding, shared planning, governance, and intentional program implementation to prevent unintended consequences of a siloed, single-sector approach” (Agonafer et al., 2021).

The ability of the City/County to flexibly fund such cross-sector collaboratives could be enhanced by advocating for combined programs at the state and federal level. Diminished barriers between funding silos, as achieved for example with HUD-VASH, could enable flexible use of funding with a focus on results and shared outcomes versus activities. CBOs specializing in health care for unsheltered residents have demonstrated promising approaches to coordination that could be disseminated with more flexible funding arrangements.

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Spotlights



Spotlight on Homeless Health Care Los Angeles

Since 1987, Homeless Health Care Los Angeles (HHCLA) has provided comprehensive services to unhoused residents on Skid Row. It serves as an example of a service model designed to meet the unique needs of people experiencing homelessness. HHCLA fills this need through low-threshold health and mental health programming with staff who are attuned to clients' needs.

HHCLA uses Housing First and harm reduction approaches that have been successful in building long-lasting relationships with clients. They have developed a gold-standard model for overdose prevention through low-barrier programs. Other services offered include placement in supportive housing, mental health care, assistance with pets, space for rest, and training and education on harm reduction to unhoused Angelenos and practitioners.

Community Partnerships. As a safety-net agency, HHCLA specializes in engagement and evaluation of individual medical needs usually after clients have been unsuccessful in navigating other health care systems. In addition, HHCLA helps with clients' health stabilization and linkage to medical providers or permanent medical homes for long-term care. In order to carry this mission, HHCLA coordinates with other health delivery agencies.

With funding from the City of LA / Mayor's Office, HHCLA has participated in Project IMPACT, which provides opportunities to individuals with criminal justice system involvement. The program provides wraparound legal, career, education, and behavioral health services. They work collaboratively through behavioral health staff embedded within County offices to provide housing and other resources within criminal justice settings such as courts and jails. Additionally, HHCLA coordinates services with other County agencies to assist with specific needs. For example, HHCLA communicates with DCFS on behalf of clients who are experiencing child custody issues.

Housing First and Harm Reduction. HHCLA applies Housing First principles. Clients are paired with case managers, and those who are offered housing do not have to satisfy substance treatment protocols (Tsemberis et al., 2004). Providing housing resources without any prerequisites for compliance with treatment protocols is an important step toward health stabilization. In order to help with housing placement, HHCLA also partners with housing navigation providers to support clients with finding market-rate units for rent.

HHCLA has a flexible funding model, using an array of funding sources to carry out its mission. In addition to government sources of funding HHCLA utilizes

significant private discretionary funds and foundation grants throughout its programs. The flexible-funding model allows for innovation and continuity of programming. Flexibility allows HHCLA to assist with transportation costs (e.g., Metro, Lyft, Uber), meal cards, and other items necessary for the health and mental health of participants. In addition, HHCLA offers psychiatric services that are not bound by insurance limits for appointment times. This allows for HHCLA's collaborating psychiatrists and clinicians to have extended or more frequent sessions with HHCLA's clients.

Low-Barrier Approaches. HHCLA delivers substance use disorder (SUD) / medication-assisted treatment (MAT) through low-threshold/low-barrier programming and harm reduction philosophical approach. They offer Drop-In services through the Center for Harm Reduction and the 24/7 hygiene center, Refresh Spot, which was co-founded with the City of LA.

HHCLA provides a MAT program for people who use opiates. In the context of MAT delivery, HHCLA has two medical providers and a nurse practitioner. They have developed and made available a MAT consultation line where callers are connected to MAT services. There is also a line for providers to call to seek guidance in assisting clients who are in need of Suboxone or Naltrexone, pharmaceuticals used in assisted treatment of opioid addiction. Furthermore, HHCLA makes readily available Naloxone to help reverse overdose.

HHCLA has been a pioneer in the syringe exchange movement and the Center operates a safe consumption site that in 2020 alone saved 1,000 lives. The medical team also provides health evaluation and wound care to those who are injecting drugs in order to reduce their risk of infection. Recently, with clients struggling with methamphetamine addiction, the HHCLA medical team has prescribed medications that may help curb cravings. The medical team has also begun prescribing long-acting injectables to support a drug user's severe and persistent mental health symptoms that are impacting their ability to change their substance use.

Mobile Medicine. HHCLA's multi-disciplinary, field-based mobile outreach team consists of a registered nurse or nurse practitioner, a mental health therapist, a case manager/substance use counselor, a peer outreach worker, and a part-time psychiatrist. This mobile outreach team meets individuals in encampments, streets, alleys, or parks. HHCLA's outreach teams have the capacity to provide a comprehensive set of field-based wraparound services for participants. They engage unhoused members of the community and triage interested individuals into programs.

Relationship-Building. An essential part of HHCLA is establishing and building relationships and cultivating connections with unhoused Angelenos. Instrumental in the mission of HHCLA is communicating compassion and a non-judgmental attitude, according to HHCLA Director, Mark Casanova, and Clinical Director, JoAnn Hemstreet, LCSW. The organization applies a client-centered approach, meeting people where they are at by providing support in the fulfillment of personalized goals. "Clients have not been asked what they want, but rather told what they need to do from family to friends to parole officers, judges and treatment providers," said Casanova. Casanova also said, "HHCLA tends to work mostly with clients that have not been successful in navigating services. It also works with people for life, and the staff tries to communicate that once they walk into the door of Homeless Health Care, they become a part of our family forever and know they can always come 'home' when they need to."

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Spotlight on Venice Family Clinic

Venice Family Clinic (VFC) was founded in 1970 by volunteer physicians Phillip Rossman and Mayer Davidson. The Clinic provides health and mental health services to mostly underserved communities in greater Los Angeles, including Venice, Santa Monica, Inglewood, Mar Vista, and Culver City. According to Elizabeth Forer, chief executive officer, the Clinic is “proud to offer quality comprehensive and primary care to underserved communities.”

A pioneer in providing services that “fit” the needs of people who are experiencing or are vulnerable to homelessness, VFC has established partnerships with numerous health and mental health organizations and adopted a Housing First approach. They offer low-barrier entry to services and mobile medicine, and they prioritize building relationships with community members through use of peer navigation.

The Clinic offers comprehensive wellness and education programs, including reproductive health, dental care and vision, chronic pain and stress management, obesity prevention, nutrition and exercise, HIV/AIDS prevention and treatment, and child development classes. The Clinic also offers integrative medicine, acupuncture, chiropractic services and osteopathic care.

Community Partnerships. Forer stressed the importance of growing in the community by establishing partnerships with other local specialized organizations, such as through an upcoming partnership with South Bay Family Health Care. Pivoting to meeting the needs of the community is central to the VFC philosophy. As an example, during the pandemic, VFC collaborated with numerous partner organizations including Food Forward to distribute free fresh and healthy food at its Santa Monica and Culver City sites with the philosophy that “food is medicine.”

Housing First and Harm Reduction Models. VFC has integrated addiction treatment into its primary care through Substance Use, Motivation and Medication Integrated Treatment (SUMMIT), designed to achieve abstinence from alcohol and opioids (Ober et al., 2017). The program takes a harm reduction philosophy that offer an alternative to traditional “step” programs, meeting clients where they are at, destigmatizing addiction, and working with them to choose the best options. This may include addiction counseling, therapy, case management, and/or groups. Clients are not turned away or asked to reschedule appointments for their level of sobriety, but rather are triaged to the most appropriate service. Case management plays a central role connecting patients with resources and making sure their basic needs are met, including guiding them to housing resources. VFC connects clients to housing in keeping with a Housing First philosophy, which is to offer housing without preconditions of health or mental health (Padgett et al., 2015).

Low-Barrier Access. In 2020, VFC provided comprehensive primary care to more than 27,000 people and had 128,775 patient visits. Sixty-four percent of the people who visited VFC in 2020 lived below the federal poverty line, and 16 percent were unhoused. Tending, in particular, to needs of families vulnerable to homelessness, VFC's newest mobile clinics are built in a way that allows staff to offer a mobile version of their comprehensive model of health care. The mobile clinic travels to shelters, transitional living programs, and access centers.

Mobile Medicine. Providing medicine on wheels since 1985, VFC has established itself as a pioneer in street medicine. VFC has nine street medicine teams. The multidisciplinary teams (MDT) covers Santa Monica, while the C3 (City, County, Community) medical teams do outreach in Santa Monica and Skid Row. For clients who wish to reduce substance use, the medical team provides medication assisted treatment (MAT), and the mobile VFC is equipped for this purpose.

Relationship-Building. Dr. Coley King, medical director of Homeless Health Care at VFC, stressed the importance of building trust with unhoused residents as a precondition for successful treatment and compliance with health care guidance (Lopez, 2020). According to Dr. Coley, most of patients experiencing homelessness suffer from chronic conditions that could become serious, if left untreated. Members of the street medicine team build trust with unhoused residents over time and, as requested, escort individuals to hospitals and clinics for care (Vice News Tonight, 2020). The street medicine team also delivers medication to clients where they are (King & Resser, 2020).

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NYC Case Spotlight Part 1: Proactive Outreach through 311

New York City (NYC) and Los Angeles (LA) County and City together represent less than 6 percent of the population in the United States (U.S.), but are home to 25 percent of people experiencing homelessness (Evans, Philips, Ruffini, 2019). In 2020, NYC's homeless population was 77,943 (McCarthy, 2021), and LA County and City counted 66,436 and 41,290, respectively (Los Angeles Homeless Services Authority, 2020). In both cities, proactive street outreach is critical to successfully providing health and mental health services to unsheltered residents.

City (MyLA311) and County-contracted (211LA) non-emergency call systems could play a role in active engagement and service triage for unsheltered Angelenos who are in need of health and housing services, using the New York City (NYC) 311 model as a promising approach.

Street outreach in NYC is conducted by Homeless Outreach & Mobile Engagement Street Action Teams (HOME-STAT) (New York City Mayor's Office of Operations, 2021). These teams are facilitated by a 311 number for unhoused residents and others who see residents in need of housing and other health and social services. Once the call is made, a service request file is created. Subsequently, outreach assistance is assigned to a pertinent agency or social service provider, who locates the person based on the information provided within an average of one hour (New York City Mayor's Office of Operations, 2021).

NYC is the only city in the U.S. to have a year-round "right to shelter" law that mandates the City provide shelter to all residents seeking it. For successful outreach, a low ratio between outreach workers and clients is important. Partly as a result of much greater funding and scale of mobile outreach services, NYC can deploy 1 outreach worker for every 8 unhoused residents, compared to 1 for every 33 in LA (NBC Los Angeles, 2019). LAHSA's general homeless service budget for 2020-21 was \$877.7 million (Los Angeles Homeless Services Authority, 2021). Notably, the Department of Homeless Services in NYC reported preliminary budget totals for FY2021 of \$2.7 billion (New York City Council Finance Division, 2020).

In Los Angeles, the coordinate entry system (CES) exists to triage and facilitate unhoused residents in gaining access to housing and support services. In 2019, Los Angeles Homeless Services Authority (LAHSA) received criticism from City Controller Ron Galperin, who found the CES ineffective in connecting unhoused residents with drug and mental health treatment and housing. The Controller specifically recommended a proactive outreach strategy; that LAHSA work with City and County partners to develop goals on outreach activities; the use of the statistical program "HomeSTAT" to assist with LAHSA's outreach goals; and geo-based mapping of LAHSA's street outreach activities (Galperin, 2019).

Another characteristic of mobile outreach teams in NYC that makes them successful is that housing and health functions on the team are integrated. In NYC, Department of Homeless Service teams conduct “joint outreach operations with community stakeholders and Agency partners, including the Department of Health and Mental Hygiene, the Parks Department, and the Department of Transportation as appropriate, to utilize each Agency’s expertise, engage more New Yorkers, and offer more supports” (New York City Department of Homeless Services, 2021).

Top priority for the integrated dispatch teams in NYC is engaging unsheltered residents and building trust. The service is available 24/7, 365 days per year. A central focus of HOME-STAT is the establishment of a by-name list of people experiencing unsheltered homelessness. Once contact is initiated, outreach teams continue engaging unsheltered residents in an ongoing manner until their needs are met (New York City Mayor’s Office of Operations, 2021).

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NYC Case Spotlight Part 2: VA Bridging Silos Under a Common Vision

The number of veterans experiencing homelessness in the United States (U.S.) is over 37,000, based on point-in-time estimates from January 2020 (Henry et al., 2021). Los Angeles (LA) ranked highest among all cities in terms of the number of veterans experiencing homelessness, at 3,681 (U.S. Department of Housing and Urban Development, 2021). LA City also had the highest percentage of homeless veterans who were unsheltered, at 76 percent (Henry et al., 2021, p. 63).

Point-in-time estimates reveal there were 685 homeless veterans in NYC in January 2020, and partly as a result of right-to-shelter laws, only three reported being unsheltered (U.S. Department of Housing and Urban Development, 2021). That said, the smaller number of veterans experiencing homelessness in NYC overall is in part due to the effects of the Housing and Urban Development Veterans Affairs Supportive Housing Continuum program (HUD-VASH). According to a recent assessment, veterans experiencing homelessness in NYC are rehoused within 90 days of entering HUD-VASH (New York City Department of Veterans' Services, 2021).

HUD-VASH is described as “a partnership between the Department of Veterans' Services and NYC Housing Authority that creates paths to permanent housing for disconnected veterans and their families” (New York City Department of Veterans' Services, 2021). The program was first established on a limited basis in 1992 for veterans with mental health conditions. Through Housing Choice vouchers, veterans experiencing homelessness are assisted with housing and integration into their communities. The expectation is that they contribute rent at 30 to 40 percent of their monthly income, which often is a disability payment (New York City Human Resources Administration Department of Social Services, 2021). In addition to housing vouchers, the veterans are provided case management services according to the Assertive Community Treatment Model (O'Connell et al., 2008). Given the success of the program in housing veterans across the country, the program may serve as prototype for housing non-veteran populations as well.

Under HUD-VASH, the Veterans Administration (VA) delivers direct services by conducting outreach to veterans who need assistance, connecting unhoused veterans with housing, health care, and employment services (U.S. Department of Veterans Affairs, Veterans Health Administration, 2021). To assist with

outreach, the VA employs formerly unsheltered veterans. The philosophy of VA outreach teams is: “Instead of the veteran having to come to the VA, we bring the VA to the community” (Denkmann, 2019). The teams focus on establishing connection with unsheltered veterans. According to Kevin Kincey, an outreach worker and formerly unsheltered veteran himself, “some veterans don’t trust, because they’ve been taken advantage of. The only thing you can do as a provider is show up when you say you will” (Denkmann, 2019).

According to a key informant, HUD-VASH in Los Angeles has built on the precedent of Housing First to reduce veteran homelessness and serves as an example of how combining federal funding streams and breaking down silos between housing and health can lead to more flexible solutions. He said that, for example, the program has driven “public housing agencies to do a better job of streamlining admission criteria, because there were relaxed criminal background screens.”

HUD-VASH may serve as example of an effective model to interrupt cycles of homelessness in LA through combined housing and health care funding and a Housing First approach, not just for veterans, but for other groups who are particularly vulnerable to homelessness.

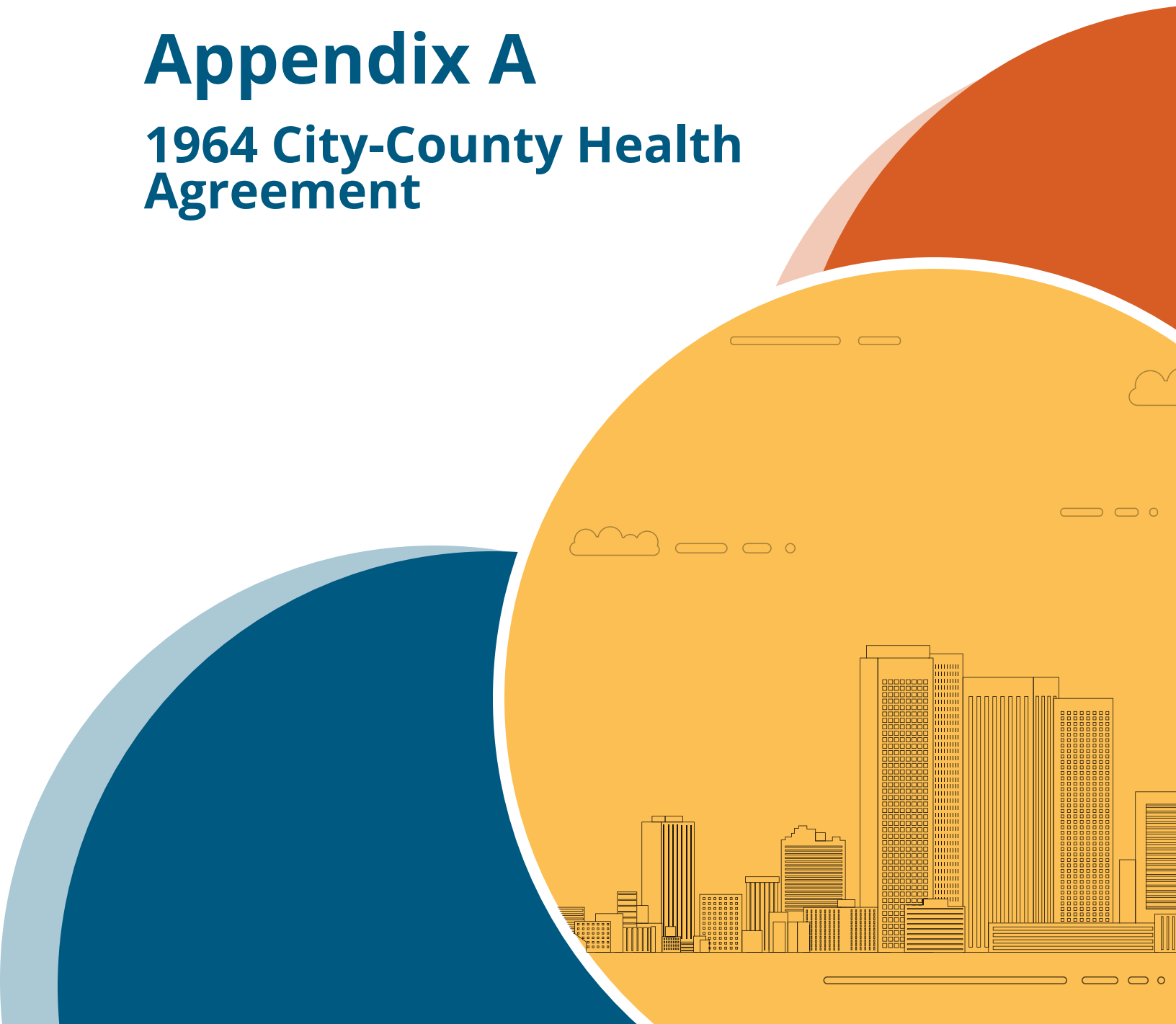
The key informant continued, “If you could do that with other federal agencies, you know get HHS to work with HUD on a plurality of individual standalone programs, [for example] a program between HHS’s substance use and mental health treatment areas and HUD CoC programs, that would be a real powerful benefit. It forces the federal apparatus that deals with substance use treatment and mental health treatment, which are different silos, to work together. This in turn would motivate the local modalities to work together [and] holds up a mirror and forces them to look at their requirements, what are the barriers...figuring out ways to combine their programs.”

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Appendix A

1964 City-County Health Agreement



AN AGREEMENT ESTABLISHING TERMS
FOR THE ENFORCEMENT BY THE
COUNTY IN THE CITY OF LOS ANGELES
OF THE COUNTY PUBLIC HEALTH CODE

An Agreement made and entered into this 18th day of JUNE, 1964, by and between the County of Los Angeles, State of California, hereinafter called the "County" and the City of Los Angeles, State of California, a municipal corporation, hereinafter called the "City."

WITNESSETH:

WHEREAS, Sections 480, 481 and 482 of the State Health and Safety Code authorize the Board of Supervisors of the County to contract with the City for the performance by the Health Officer and other employees of the County of any and all functions relating to the enforcement in the City of all ordinances thereof relating to public health and sanitation and the making of all inspections and the performance of all functions in connection therewith at cost;

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, it is hereby agreed as follows:

1. In the event the City, by ordinance, adopts the provisions of the County Public Health Code (County Ordinance No. 7583), the County Health Officer shall perform the services to enforce said ordinance in the City to the

same extent as the County Public Health Code is enforced in unincorporated territory, and shall issue the permits and collect the fees provided for in Section 750 of said County Public Health Code.

Said fees, and any other or additional fees provided for by the County by ordinance adopted pursuant to the provisions of Section 510 of the State Health and Safety Code, shall be retained by the County Health Officer for the benefit of the County as full compensation for the services performed by said Health Officer in the enforcement of said ordinance, except that any court time spent by County employees for the enforcement thereof shall be compensated for in accordance with the provisions below. In the event, and whenever said County Public Health Code is amended to change the amount or amounts of any of the aforesaid permit fees, the City shall amend its adopting ordinance to provide permit fees in the exact amount as those designated in the County ordinance as amended. The County shall notify the City in writing of any such amendment.

2. The City agrees to compensate the County for court time in the enforcement of such ordinances on the basis of the cost of performing said work as defined in Paragraph 5 hereof, reduced by the amount recovered by witness fees.

3. The County agrees to submit to the City during the life of this agreement periodic statements in duplicate for the services described in Paragraph 2 and rendered during the period covered, and the City agrees to pay the cost thereof within thirty (30) days after receipt of such billing. If the City desires monthly billing, it shall notify the County in writing, otherwise billing periods shall be fixed by the County.

4. Performance hereunder shall commence on the effective date of the City's adoption of the County Public Health Code, and shall remain in full force and effect to July 1, 1965. If this contract is not then terminated, it shall be deemed renewed without further action of the contracting parties from year to year. Either party hereto shall have the right to terminate this Agreement at the end of any fiscal year by giving written notice of such intention to so do, such notice to be given not less than thirty (30) days prior to the end of any fiscal year.

5. Costs shall include salaries of employees engaged in performing the services described in Paragraph 2, a prorated vacation and sick leave, supervision of such employees while so employed, the County Retirement Contribution and Workmen's Compensation Insurance Premiums on salaries, travelling expenses, supplies, plus a prorated of all indirect expenses. If the cost of providing such services changes, the City shall be notified of each such change in writing.

6. For the purpose of performing the functions provided for herein, the County shall furnish and supply all necessary labor, supervision, equipment, communication facilities and supplies necessary to maintain a level of service sufficient to adequately enforce the ordinances described herein and to protect the public health, safety and welfare.

7. Notwithstanding anything hereinbefore contained, it is agreed that in all instances where special supplies, stationery, notices, forms, and the like, which are different from those used by the County and must be issued in the name of said City, the same shall be supplied by the City at its own cost and expense.

8. The City shall not be called upon to assume any liability for the payment of any salaries, wages, or other compensation to any County personnel performing services hereunder for the City, or any liability of any kind other than that provided for in this Agreement. Nor shall the City be liable for compensation or indemnity to any County employee for injury or sickness arising out of his employment.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement the day and year first above written.

Attest:

CITY OF LOS ANGELES

WALTER C. PETERSON
City Clerk

By *Walter C. Peterson*
Deputy

By *[Signature]*
Mayor

Approved as to Form

ROGER ARNEBERGH, City Attorney

By *[Signature]*
Assistant

Attest:

COUNTY OF LOS ANGELES

GORDON T. NESVIG
Clerk of the Board
of Supervisors

By *Wendell Bernstein*
Deputy

By *[Signature]*
Chairman
Board of Supervisors

Approved as to Form

HAROLD W. KENNEDY, County Counsel

By *Gence W. Wahfield*
Assistant

APPROVED BY BOARD OF SUPERVISORS

JUN 16 1964

Gordon T. Nesvig
Gordon T. Nesvig
Clerk of the Board

Appendix B:

City-County Agreement Amendment



OFFICE OF THE CITY ATTORNEY
ROCKARD J. DELGADILLO
CITY ATTORNEY

REPORT NO. R 05-0075
FEB 28 2005

REPORT RE:

**DRAFT ORDINANCE AMENDING LOS ANGELES MUNICIPAL CODE
TO AUTHORIZE COUNTY ENFORCEMENT OF COMMERCIAL SEX
VENUE ORDINANCE WITHIN THE CITY AND DRAFT PROVISION
AMENDING CITY-COUNTY PUBLIC HEALTH AGREEMENT OF 1964
TO EXEMPT CITY FROM LIABILITY FOR THE COSTS OF COURT
TIME FOR THE ENFORCEMENT THEREOF**

The Honorable Members of the Arts, Parks, Health
and Aging Committee of the Los Angeles City
Council of the City of Los Angeles
Room 395, City Hall
200 North Spring Street
Los Angeles, California 90012

Council File No. 04-2229

Honorable Members:

This office has prepared and now transmits for your action the attached draft ordinance, approved as to form and legality. This draft ordinance amends the Los Angeles Municipal Code to authorize enforcement within the City by the County of Los Angeles ("County") of its Commercial Sex Venue (CSV) ordinance pursuant to the City-County Public Health Agreement of 1964 ("Agreement"). Attached as well is a draft provision amending the Agreement, approved as to form and legality. This draft provision would exempt the City from the obligation to compensate the County for the costs of court time of County personnel in the enforcement of its Commercial Sex Venue ordinance within the City.

Background

In its October 27, 2004 letter to you, the AIDS Coordinator's Office (ACO) recommended that the City Council request that we prepare an ordinance enabling the Los Angeles County Department of Health Services (DHS) to

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The Honorable Members of the Arts, Parks, Health
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Council of the City of Los Angeles
Page 2

enforce its CSV ordinance within the City of Los Angeles, subject to the resolution of the following three concerns: 1. The City's financial obligations under the Agreement; 2. City input on proposed regulation changes; and, 3. Notice to the City prior to closure of a CSV. On November 16, 2004, you requested that we assist the ACO in resolving these concerns with DHS. On January 26, 2005, those negotiations were concluded. On January 31, 2005, you requested that we prepare the ordinance for your committee.

Summary of Ordinance Provision

This ordinance amends Chapter 3, Section 31.00 of the Los Angeles Municipal Code to authorize enforcement within the City by the County of Los Angeles of its CSV ordinance pursuant to the City-County Public Health Agreement of 1964.

Summary of Agreement Provision

This provision amends the City-County Public Health Agreement of 1964 to exempt the City from liability to reimburse the County for the costs of court time in the enforcement of its Commercial Sex Venue ordinance within the City.

Discussion

Introduction

At the request of the Chief Legislative Analyst's Office, we provide in this section a more extensive discussion than is our normal practice because of the loss of institutional memory within the City over the last forty years on the matters involved. We begin with a brief history of the City's relationship with the County regarding the delivery of health services. Until 1964, the City had its own health department financed through a tax on City residents. This department delivered such services as vital statistics, laboratory services, communicable disease control, sanitation, health education, and maternal and child health through such programs as harbor rodent control, mosquito control, and milk inspections.

However, state law required that City residents also support the County's health department, even though that department delivered no services to City residents. Because of the distribution of assessed values throughout the County by 1963, this double tax burden meant that City taxpayers were both fully funding the City's health department and providing 40% of County health's budget despite receiving no services. In 1963, the City's effort to end this inequity through state legislation failed in part because of County opposition. As a result,

The Honorable Members of the Arts, Parks, Health
and Aging Committee of the Los Angeles City
Council of the City of Los Angeles
Page 3

the City decided to end this double burden by closing its own health department and transferring the delivery of most services to the County.

Pursuant to Ordinance No. 127,507 the City repealed the existing City Health Code (Chapter 3 of the Los Angeles Municipal Code [LAMC]) and adopted in lieu thereof most of the County's Health Code. Pursuant to Ordinance No. 127,508 the City moved those municipal health services it chose to retain to other portions of the LAMC. And pursuant to Ordinance No. 127,509 the City entered into an agreement with the County to deliver health services entitled An Agreement Establishing Terms For The Enforcement By The County In The City Of Los Angeles Of The County Public Health Code, ("City-County Public Health Agreement of 1964" or "Agreement"). Today, forty years later, the Agreement remains in effect, having been automatically renewed from year to year by its terms until one of the parties provides written notice to terminate. A copy of the Agreement is attached for your convenience.

The Ordinance Provision

The City did not assign its authority to deliver health services over to the County pursuant to the Agreement. Rather, the City contracted with the County to provide those services that the City determined should be delivered to City residents. The mechanism for doing so is for the City to incorporate into the Los Angeles Municipal Code those County health ordinances the City wishes enforced. Between the years 1964 and 1988, we have been unable to determine when the City might have adopted new county health ordinances. In 1988, however, following the County's reorganization of its code, the City did adopt most of those renumbered provisions pursuant to Ordinance No. 164,035 by enacting Section 31.00 of the LAMC. Ten years later, in 1998, the City adopted the County's newly-enacted restaurant grading scheme pursuant to Ordinance No. 171,930 by amending Section 31.00(a)(1) to add the current third paragraph.

The ordinance you have requested would amend Section 31.00(a)(1) to add a new fourth paragraph adopting the County's recently-enacted Commercial Sex Venue ordinance, thus authorizing the County's enforcement of it within the City. The ordinance would also reformat Section 31.00(a)(1) to enumerate each paragraph.

The Agreement Amendment Provision

The City is obligated under the Agreement to compensate the County for the costs of court time of County personnel enforcing its ordinances within the City. As a matter of risk management, it is prudent to consider the City's liability exposure pursuant to this provision with respect to the CSV ordinance. One

The Honorable Members of the Arts, Parks, Health
and Aging Committee of the Los Angeles City
Council of the City of Los Angeles
Page 4

factor is that all CSVs within the County are currently located within the City. A second is that the regulatory standards in this area are still evolving. A third is that while the City would be obligated to compensate the County for the costs of court time, it would be the County that would control all relevant aspects of any litigation.

A fourth factor concerns the meaning of the term "court time." A reasonable present-day construction of the term would be to read it narrowly as referring to the costs of the time spent by County personnel while testifying in court. However, that may not have been what was meant when the parties entered into the Agreement forty years ago. Unfortunately, the terms of the Agreement, itself, are unhelpful in determining what was intended. Paragraph 2 states that court time shall be based on "the cost of performing said work as defined in Paragraph 5 hereof, reduced by the amount recovered by witness fees." Paragraph 5 merely refers back to Paragraph 2: "Costs shall include salaries of employees engaged in performing the services described in Paragraph 2." While it may be argued that the reference in Paragraph 2 to witness fees supports a narrow construction of the term, it is not dispositive.

We looked next for other evidence as to what may have been meant by reviewing Council File No. 109,110, the forty-year old file concerning the City's transfer of health services to the County. The general tenor of much of the file also supports a narrow interpretation. Great attention was paid to the cost shifts involved in such a major transfer of City staff, supplies and buildings to the County. The County's concern about reimbursement for staff court time could be read in that light. For a transitional period, it might have been argued, the City should compensate the County for the court time spent by staff recently on the City payroll enforcing ordinances that had recently been enforced by the City, itself. However, there were no specific references to the issue, and the file is incomplete.

The one oblique reference we did find was in a later Council file, No. 85-0869-S6. In a May 2, 1988, letter to Councilwoman Ruth Galanter, Supervisor Deane Dana states that "[T]he contract between the City and the County [presumably referring to the Agreement] allows the County to bill the City for certain litigation expenses related to the public health services rendered." The Supervisor's reference to "certain litigation expenses" suggests that "court time" might have been intended to be read more broadly, to include, for example, the costs of County Counsel staff engaged in preparing and conducting litigation, and those of witnesses preparing to testify. This broader reading could expose the City to quite significant costs. The Supervisor's comment is unsupported by explanation, authority or reference to past practice, however.

The Honorable Members of the Arts, Parks, Health
and Aging Committee of the Los Angeles City
Council of the City of Los Angeles
Page 5

To resolve this issue with respect to the ordinance before you, the County has agreed to execute the attached Agreement amendment to exempt the City completely from any obligation to compensate the County for court time in the enforcement of the CSV ordinance.

Other Liability

The amendment would not shield the City from the normal costs of a lawsuit naming the City as a co-defendant along with the County. It is possible that such a suit may be filed, particularly in light of the two factors mentioned in the preceding section: that all CSVs within the County are currently located within the City, and the regulatory standards in this area of public health are still evolving.

Council Rule 38 Referral

A copy of the draft ordinance and Agreement amendment were sent, pursuant to Council Rule 38, to the Department on Disability, simultaneously with the transmittal of this letter to you. This office has asked the Department to make any comments about them directly to you at the time you consider this matter.

If you have any questions, please contact David Schulman at (213) 978-7758. Either he or another member of this office will be available when you consider this matter to answer any questions you may have.

Sincerely,

ROCKARD J. DELGADILLO, City Attorney

By 
TERREE A. BOWERS
Chief Deputy City Attorney

TAB:DS:vc
Transmittal

ORDINANCE NO. _____

An Ordinance amending Section 31.00 of the Los Angeles Municipal Code authorizing enforcement within the City by the County of Los Angeles of its Commercial Sex Venue ordinance pursuant to the City-County Public Health Agreement of 1964.

WHEREAS, on June 18, 1964, the City of Los Angeles ("City") and the County of Los Angeles ("County") entered into An Agreement Establishing Terms For The Enforcement By The County In The City Of Los Angeles Of The County Public Health Code ("Agreement" or "City-County Public Health Agreement of 1964"); and

WHEREAS, the Agreement remains in effect today forty years later, having been automatically renewed from year to year by its terms until one of the parties provides written notice to terminate; and

WHEREAS, by the terms of the Agreement the City contracted with the County to provide those services the City determined should be delivered to City residents; and

WHEREAS, the mechanism for doing so was for the City to adopt into the Los Angeles Municipal Code those County health ordinances the City wished enforced;

WHEREAS, on September 14, 2004, the County adopted an ordinance amending the County Code, Title 11 – Health and Safety, relating to bathhouses and similar commercial establishments, to redefine bathhouses and similar commercial establishments as commercial sex venues; requiring each of the venues to obtain a public health facility permit from the Health Officer as a condition of operation; and authorizing the Health Officer to initiate sanctions, including suspension or revocation of the permit, if the venue fails to comply with the regulations; and

WHEREAS, prior to the adoption of said ordinance, the County consulted with members of the community, including persons living with HIV and AIDS, the County Commission on HIV Health Services, and patrons and owners of venues that would be affected by the ordinance; and

WHEREAS, prior to the adoption of said ordinance, the County also invited comment from the City and in particular the City's AIDS Coordinator's Office; and

WHEREAS, in adopting said ordinance the County found that evidence exists that certain commercial establishments in the County allow, facilitate, and/or provide facilities for their patrons to engage in high risk sexual contact that poses a significant risk for the transmission of the human immunodeficiency virus (HIV) as well as other sexually transmitted diseases, and that such high risk sexual contact poses an unacceptable public health risk; and

WHEREAS, all venues that would be subject to the County ordinance are located within the City of Los Angeles; and

WHEREAS, following enactment of its ordinance the County sent a letter to the City requesting adoption of said ordinance so as to authorize County enforcement of said ordinance within the City pursuant to the City-County Public Health Agreement of 1964; and

WHEREAS, in its transmittal letter of October 27, 2004, the City AIDS Coordinator's Office recommended adoption of said ordinance subject to three concerns; and

WHEREAS, the City and the County then reached mutually agreed upon resolutions to all three concerns; and

WHEREAS, the Mayor's AIDS Leadership Council in its December 2003 white paper *HIV and AIDS in Los Angeles: 21st Century Challenges and Approaches: A Report to the Mayor and City Council of Los Angeles* recognized the importance of City and County collaboration on issues of HIV prevention; and

WHEREAS, in its white paper the Mayor's Council also noted that the City "must ensure that all of the residents of Los Angeles who are at high risk for HIV transmission have access to the prevention programs and services that may prevent HIV infection," including "the use of appropriate prevention messages . . . in sex clubs, bathhouses and other public sex venues;" and

WHEREAS, the U.S. Centers for Disease Control and Prevention has urged state and local jurisdictions to take appropriate steps to help lower the rate of new HIV infections in the United States, which has held steady at approximately 40,000 new infections annually for the past ten years;

NOW THEREFORE,

**THE PEOPLE OF THE CITY OF LOS ANGELES
DO ORDAIN AS FOLLOWS:**

Section 1. Section 31.00(a)(1) of the Los Angeles Municipal Code is reformatted to read:

Sec. 31.00. Health Regulations.**(a) Incorporation of County Code Provisions**

1. **(A)** The provisions of Division 1 of Title 11 of the Los Angeles County Code, entitled "Health Code," as amended to July 9, 1987, a copy of which is attached to Council File No. 86-1437 as Attachment "B" to the report of the City Attorney dated March 28, 1988, with the exception of Chapter 11.19 and Section 11.20.310 of Part 2 of Chapter 11.20 of Division 1 of said Title 11 fully express the will and intention of the Council of the City of Los Angeles as to those matters relating to public health which are contained therein, and are hereby adopted, except said Chapter 11.19 and Section 11.20.310 of Part 2 of Chapter 11.20, and are incorporated herein by reference.
- (B)** Chapter 11.19 and Section 11.20.310 of Part 2 of Chapter 11.20 of Division 1 (entitled "Health Code"), of Title 11 of the Los Angeles County Code, as amended to July 9, 1987, do not express the Council's will and intention and are expressly not adopted by the City of Los Angeles.
- (C)** The provisions of Sections 8.04.165, 8.04.225, 8.04.275, 8.04.337, 8.04.405, 8.04.405, 8.04.752, 8.04.755, 8.04.930 and 8.04.943 of Title 8 and the provisions of Chapter 11.11 of Title 11 of the Los Angeles County Code, as enacted by and referenced in Los Angeles County Ordinance 97-0071, effective January 16, 1998, fully express the will and intention of the Council of the City of Los Angeles as to those matters relating to public health which are contained therein, and are hereby adopted and are incorporated herein by reference. (Para. Added by Ord. 171,930, Eff. 4/3/98.)

Sec. 2. Section 31.00(a)(1) of the Los Angeles Municipal Code is further amended by adding the following paragraph:

- (D)** The provisions of Chapter 11.04 of Title 11 of the Los Angeles County Code, as enacted by and referenced in Los Angeles County Ordinance 2004-0050, effective October 14, 2004, fully express the will and intention of the Council of the City of Los Angeles as to those matters relating to public health that are contained therein, and are hereby adopted and are incorporated herein by reference.

Sec. 3. The City Clerk shall certify to the passage of this ordinance and have it published in accordance with Council policy, either in a daily newspaper circulated in the City of Los Angeles or by posting for ten days in three public places in the City of Los Angeles: one copy on the bulletin board located in the Main Street lobby to the City Hall; one copy on the bulletin board located at the ground level at the Los Angeles Street entrance to the Los Angeles Police Department; and one copy on the bulletin board located at the Temple Street entrance to the Los Angeles County Hall of Records.

I hereby certify that the foregoing ordinance was passed by the Council of the City of Los Angeles at its meeting of _____.

FRANK T. MARTINEZ, City Clerk

By _____ Deputy

Approved _____

Mayor

Approved as to Form and Legality

ROCKARD J. DELGADILLO, City Attorney

By David I. Schulman
DAVID I. SCHULMAN
Deputy City Attorney

Date 2/28/05

Council File No. 04-2229

**AMENDMENT TO CITY-COUNTY
PUBLIC HEALTH AGREEMENT OF 1964**

An Amendment made and entered into this ____ day of _____, 2004, by and between the County of Los Angeles, State of California, hereinafter called the "County" and the City of Los Angeles, State of California, a municipal corporation, hereinafter called the "City."

WITNESSETH:

WHEREAS, on the 18th day of June, 1964, the County and the City entered into An Agreement Establishing Terms For The Enforcement By The County In The City Of Los Angeles Of The County Public Health Code, hereinafter the "Agreement; and

WHEREAS, the Agreement remains in effect, having been automatically renewed from year to year by the terms of its provisions until such time as either the County or the City provides written notice to terminate; and

WHEREAS, the County has requested the City to adopt an ordinance pursuant to the Agreement authorizing enforcement within the City by the County of its Commercial Sex Venue ordinance, hereinafter "ordinance;" and

WHEREAS, said ordinance if adopted by the City would obligate the City pursuant to the Agreement to compensate the County for the costs of court time of County personnel in the enforcement of said ordinance; and

NOW THEREFORE, in consideration of continuing the comity that exists between the County and the City and the interest shared by the County and the City in implementing the ordinance, it is hereby agreed as follows:

Paragraph 2 of the Agreement is deleted in its entirety and replaced with the following:

2. The City agrees to compensate the County for court time in the enforcement of such ordinances on the basis of the cost of performing said work as defined in Paragraph 5 hereof, reduced by the amount recovered by witness fees. However, the County agrees to exempt the City from any and all obligations to compensate the County for the costs of court time of County personnel in the enforcement of the provisions of Chapter 11.04 of Title 11 of the Los Angeles County Code, as enacted by and referenced in Los Angeles County Ordinance 2004-0050, effective October 14, 2004.

IN WITNESS WHEREOF, the parties hereto have executed this
Amendment the day and year first above written.

Attest:

CITY OF LOS ANGELES

FRANK MARTINEZ
City Clerk

By _____
Deputy

By _____
JAMES K. HAHN, Mayor

Approved as to Form and Legality

ROCKARD J. DELGADILLO, City Attorney

By David I. Schuman
DAVID I. SCHULMAN
Deputy City Attorney

Attest:

COUNTY OF LOS ANGELES

By _____
THOMAS L. GARTHWAITE, MD, Director
Department of Health Services

Approved as to Form

RAY G. FORTNER, County Counsel

By _____
Deputy



peopleshealthsolutions.com

People's Health Solutions is a consulting team working to build healthy and sustainable communities. PHS helps health and human service organizations amplify their impact by understanding community needs; defining what it means to be successful; and showing results through data visualization and storytelling.



HomeForGoodLA.org

United Way of Greater Los Angeles's Home For Good Initiative unifies the community around a bold vision of ending homelessness in L.A. County, pioneers approaches, and coordinates across diverse, multi-sector coalitions to scale the most transformative, equitable solutions.