Recommendations

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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.

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.

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.

- 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.

> *"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).*

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.

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).

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).

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.