

Feedback on Interim Housing Metrics and an Overview of the Interim Housing Outreach Program

Jasper Cooper, Director of Data Analytics and Evaluation, LA County DHS

La Tina Jackson, Deputy Director, LA County DMH

Bevin Kuhn, Deputy Chief Analytics Officer, LAHSA

Andy Perry, Principal Analyst & Lead Analytics Engineer, LA County CEO

Agenda

01 Reminder on Data Subcommittee Background and Approach

02 Incorporating Frontline Perspectives

03 Feedback on Interim Housing Metrics

Agencies and Personnel Supporting BSPC Recommendations

Agency	Personnel
	Molly Rysman
	Jasper Cooper
	Sam Matonik
	Monica Gudino
	Max Stevens*
	Andy Perry
	Dean Obermark
	Janey Rountree*
	Peter Casey
	Karen Law
	Tina Kim

Agency	Personnel
	Bevin Kuhn
	Saba Mwine-Chang
	John Cutone
	Alexandra Braboy
	Brooke Spellman**
	Lisa Benson
	Maria Funk
	La Tina Jackson
	Anil Thomas
	Aubree Lovelace
	Dan Mansfield
	Teresa Rivera
Karen Bernstein	

* Data Subcommittee Co-Chair

** HUD Technical Assistant

Our Role in Supporting the BPSC

For metrics developed by BPSC, we were asked to:

- 01 Validate whether data is already collected or could be
- 02 Determine the level at which data can be reported (e.g., site, provider, program, jurisdiction)
- 03 Recommend refinements to metrics
- 04 Explore feasibility of tracking referrals
- 05 Answer members' questions on terminology and conceptual framework

Our Approach to Providing Feedback

01

BPSC recommendations touch on different levels of performance management, impacting data availability. We produced a framework for these levels and mapped the BPSC recommendations to them.

02

We reviewed each recommendation, assessed level, data sources and feasibility.

03

Suggested alternatives to meet goals in short term, where possible. Where not possible, described challenges and potential future pathways.

04

Filled in gaps where we have additional, complementary measures.

05

North Star: what can we measure to understand this part of our system?

Performance Management

What question are we trying to answer?



KEY QUESTIONS

What should good services look like?

What should providers be doing?

Providers include contracted providers and government service providers.

How is a given provider performing on a given contract?

Recommend public reporting aggregated across providers until privacy concerns can be resolved.

How is a given system component (e.g., Interim Housing, Outreach) performing?

How well are the system components working together to reduce homelessness?

Important Caveats

01

Some BPSC recommendations cannot be measured systematically

02

In some cases, we recommended they be required in contracts but not tracked

03

However, others we recommended as system or contract performance indicators, even though data is not currently available and may be very hard to collect

04

We did not want lack of current availability to prevent measurement

05

In some cases, making data available will take significant planning, coordination, and resources

06

Cannot all be solved through data integration: some "data problems" require new program design, changes to workflows, and IT solutions

Incorporating Frontline Perspectives

Incorporating Frontline Perspective

What We Heard

- An ask to recognize our fallibility: No matter how careful the Data and BPSC committees are, the metric regime we craft will be imperfect.
- Realities on the ground for providers are stressful, potentially traumatic, and messy: They do not always map easily onto simple categories.
- A plea for flexibility as a core feature of provider-facing KPIs

Potential Framework

- Fallibility
 - Revisit metrics regularly; modify those that aren't working
 - Confirm that actions have intended effects
 - Identify and limit unintended consequences (e.g., perverse incentives)
- Flexibility
 - Use data as a compass
 - Grant administrators work proactively with providers to manage performance and hold themselves accountable to shared goals
 - Response to performance issues is to “turn the wheel” and keep going
 - Minimize use of data as a grade
 - Oversight bodies respond to performance data after the fact using the tools at their disposal (hearings, motions)
 - Response to performance issues tends to be punitive, introducing more overhead, and/or more metrics

Feedback on Interim Housing Metrics

Reminder: Original BPSC IH Metrics

01	Utilization	Are our investments fully leveraged to provide care?	5 metrics focused on occupancy, length of stay, and demographics
02	Needed Services	Needed Health, Behavioral Health, and Social Services	21 metrics focused on care referrals and income programs
03	Quality of Assistance	Are participants receiving quality assistance to prepare for permanent housing?	3 metrics focusing on assessment and document readiness
04	Housing Outcomes	Are participants experiencing positive housing outcomes?	5 metrics focused on exits to permanent destinations and demographics

How to read the report back table

01

Original BPSC metrics are sorted into the performance levels and rationale provided under "level justification". Under each level, original categorization is preserved

02

We describe data source, smallest geographic unit of reporting, and current vs. future data availability / feasibility

03

Wording edits flagged as substantive, non-substantive, or no edit and rationale provided under "edit justification"

04

To ease communication and planning, we suggest consolidating certain metrics. Consolidating is not meant to suggest that fewer things be measured. For completeness, we also recommend splitting or adding metrics.

Utilization

Are our investments fully leveraged to provide care?

01

Utilization

Original Recommendations

1

Interim housing maintains at least x% occupancy

2

Length of stay disaggregation, among active participants: Percentage of interim housing participants, disaggregated by stays of 90 days or less; 91 days - six months; six months - one year; one year - two years; over two years

3

Length of stay disaggregation, among exits: Percentage of interim housing participants who exited within the past quarter, disaggregated by stays of 90 days or less; 91 days - six months; six months - one year; one year - two years; over two years

4

Demographic disaggregation: Percentage of interim housing participants, disaggregated by race, ethnicity and gender

01 Utilization

Edits

1 Interim housing maintains at least x% occupancy

Length of stay disaggregation, among active participants: Percentage of interim housing participants, disaggregated by stays of 90 days or less; 91 days - six months; six months - one year; one year - two years; over two years

2

Length of stay disaggregation, among exits: Percentage of interim housing participants who exited within the past quarter, disaggregated by stays of 90 days or less; 91 days - six months; six months - one year; one year - two years; over two years

3

Demographic disaggregation: Percentage of interim housing participants, disaggregated by race, ethnicity and gender

4



1 Interim housing maintains at least x% occupancy (aggregated across all sites)

2 Interim housing maintains at least x% occupancy (site-level)



3 Average length of stay (LOS) in interim housing ~~disaggregation, among active participants:~~ ~~Percentage of interim housing participants,~~ disaggregated by active and exited participants as well as by LOS time bins ~~stays of 90 days or less; 91 days - six months; six months - one year; one year - two years; over two years~~



4 *Demographic disaggregation:* Percentage of interim housing participants, disaggregated by race, ethnicity and gender

How can we measure UTILIZATION?

Performance management level

- Most of these metrics suggested as system component indicators – reflect key elements of countywide coordination
- Added occupancy at site-level as contract performance indicator

Current Availability

- All metrics available for individual funders, but cannot yet be integrated into a single metric

Potential Future State

- 1-2 year effort to integrate data systems across funders to provide automatically updated, combined metrics

Geographic disaggregation

- Available now at site level, SPA, SD, CD, City

Needed Health, Behavioral Health and Social Services

Are participants receiving quality services?

Original Recommendations

IH Outreach Program

- Number of consenting participants who are referred to the Interim Housing Outreach Program (IHOP; onsite health, mental health, and substance use services)
- Number of referred and consenting participants who are assessed for the Interim Housing Outreach Program eligibility
- At least 75% of IHOP-enrolled participants receive a baseline IHOP assessment within 30 days of referral
- At least 90% of IHOP-enrolled participants receive appropriate services (medical, occupational therapy and/or behavioral health) within 60 days of IHOP enrollment

Mental Health



- Number of referred, consenting interim housing participants referred to County-administered mental health services other than IHOP
- Number of referred, consenting interim housing participants receiving County-administered mental health services other than IHOP
- Number of referred, consenting interim housing participants referred to non-County-administered mental health services other than IHOP
- Number of referred, consenting interim housing participants receiving non-County-administered mental health services other than IHOP

Substance Use



- Number of referred, consenting interim housing participants referred to County-administered substance use services other than IHOP
- Number of referred, consenting interim housing participants receiving County-administered substance use services other than IHOP
- Number of referred, consenting interim housing participants referred to non-County-administered substance use services other than IHOP
- Number of referred, consenting interim housing participants receiving non-County-administered substance use services other than IHOP

Physical Health



- Number of interim housing participants who are referred to a primary care physician
- Number of referred and eligible interim housing participants who are connected or re-reconnected to a primary care physician
- Percentage of eligible interim housing participants who are enrolled in MediCal
- Percentage of eligible, consenting participants referred to high-acuity interim housing beds who are placed in high-acuity beds

Income



- Number of interim housing participants who are referred to programs or services intended to increase income (e.g., SDI, SSI, SSDI, general relief, CalWorks)
- Number of eligible, referred participants who obtain or increase income since enrollment in permanent supportive housing (e.g., SDI, SSI, SSDI, general relief, CalWorks)

PH referrals

- Percentage of interim housing participants, disaggregated by permanent housing referral status (e.g., are clients in the queue, matched, or housed through the time-limited subsidy, permanent supportive housing, or other appropriate permanent housing destination)

Workforce



- Number of interim housing participants who are referred to a workforce development program
- Number of eligible, referred interim housing participants who are connected to a County-administered workforce development program
- Number of eligible, referred permanent housing participants who are connected to a non-County-administered workforce development program

- Number of referred, consenting interim housing participants **referred** to non-County-administered and County-administered mental health services other than IHOP
- Number of referred, consenting interim housing participants **receiving** County-administered and non-County-administered mental health services other than IHOP
- Number of referred, consenting interim housing participants **referred** to County-administered and non-County-administered substance use services other than IHOP
- Number of referred, consenting interim housing participants **receiving** County-administered and non-County-administered substance use services other than IHOP
- Number of interim housing participants who are referred to a primary care physician
- Number of referred and eligible interim housing participants who are connected or re-connected to a primary care physician
- Number of interim housing participants who are referred to programs or services intended to increase income (e.g., SDI, SSI, SSDI, general relief, CalWorks)
- Number of eligible, referred participants who obtain or increase income since enrollment in permanent supportive housing (e.g., SDI, SSI, SSDI, general relief, CalWorks)
- Number of interim housing participants who are referred to a workforce development program
- Number of eligible, referred interim housing participants who are connected to a County-administered and non-County-administered workforce development program



1

Number of participants who are **referred** to a program intended to improve mental health, substance use, physical health, or income

2

Percentage of **referred participants who are eligible** to receive a program intended to improve mental health, substance use, physical health, or income

3

Percentage of referred, eligible, consenting participants receiving care through a program intended to improve mental health, substance use, physical health, or income

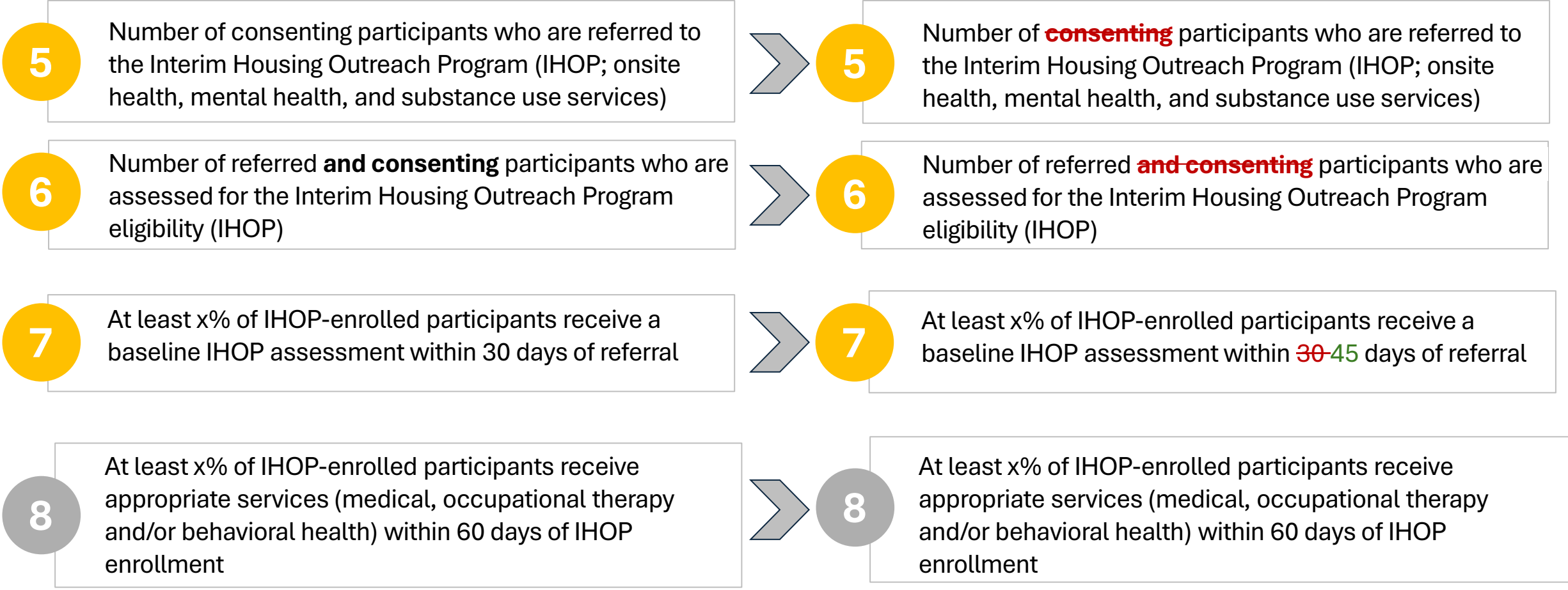
4

Number of participants receiving care through a program intended to improve mental health, substance use, physical health, income, or employment

■ BPSC Recommendation ■ No Edit ■ Consolidated

■ Substantive Edit ■ Add

02 Needed Services Edits



■ BPS Recommendation
 ■ No Edit
 ■ Non-Substantive Edit
 ■ Substantive Edit
 ■ Add

02

Needed Services

Edits

9

Percentage of eligible, consenting participants referred to high-acuity interim housing beds who are placed in high-acuity beds



9

Number of ~~Percentage of eligible, consenting~~ participants referred to a bed funded to serve high-acuity participants from a bed funded to serve low-acuity participants ~~higher-acuity interim housing beds who are placed in higher-acuity beds~~

10

Percentage of participants referred to a bed funded to serve high acuity participants from a bed funded to serve lower acuity participants who are **clinically-assessed as eligible** for that bed

11

Percentage of referred, eligible participants who were moved to a bed funded to serve high-acuity participants from a bed funded to serve lower acuity participants

12

Number of participants who move to a bed funded to serve high acuity participants from a bed funded to serve low acuity participants

13

Number of participants with **clinically-assessed high acuity needs** in beds funded to serve lower acuity needs **who receive appropriate care without moving beds**

14

Number of interim housing participants in beds **funded to serve high-acuity participants**

BPSC Recommendation No Edit Non-Substantive Edit Substantive Edit Add

02 Needed Services

Edits

10

Percentage of interim housing participants, disaggregated by permanent housing referral status (e.g., are clients in the queue, matched, or housed through the time-limited subsidy, permanent supportive housing, or other appropriate permanent housing destination)



15

Percentage of interim housing participants, disaggregated by permanent housing referral status (e.g., are clients in the queue, matched, or housed through the time-limited subsidy, permanent supportive housing, or other appropriate permanent housing destination)

11

Percentage of eligible interim housing participants who are enrolled in MediCal



16

Percentage of Eligible interim housing participants **who** are enrolled in MediCal

How can we measure if participants are receiving **NEEDED HEALTH, BEHAVIORAL HEALTH AND SOCIAL SERVICES?**

Performance management level

- PH referrals moved to system goal because it covers two system components. MediCal moved to required service. All other metrics at system component level.

Current Availability

- Referral / consent / eligibility currently not available.
- Receipt of most county programs (not income) available. Non-county programs more challenging (see below).

Potential Future State

- Tracking referrals, consents, eligibility will require additional factfinding and planning to upgrade and integrate data entry and integration – may require system changes.
- Mapping and progressive integration of non-County program data (e.g., street medicine) over next 1-5 years.

Geographic disaggregation

- Site level, SPA, SD, CD, City

Provide Quality Assistance

Are participants receiving quality assistance to prepare for permanent housing outcomes?

03

Quality of Assistance

Original Recommendations

1

At least x% of enrolled participants have completed a housing plan within 120 days of enrollment, with a goal of decreasing the number of days associated with this performance target over time

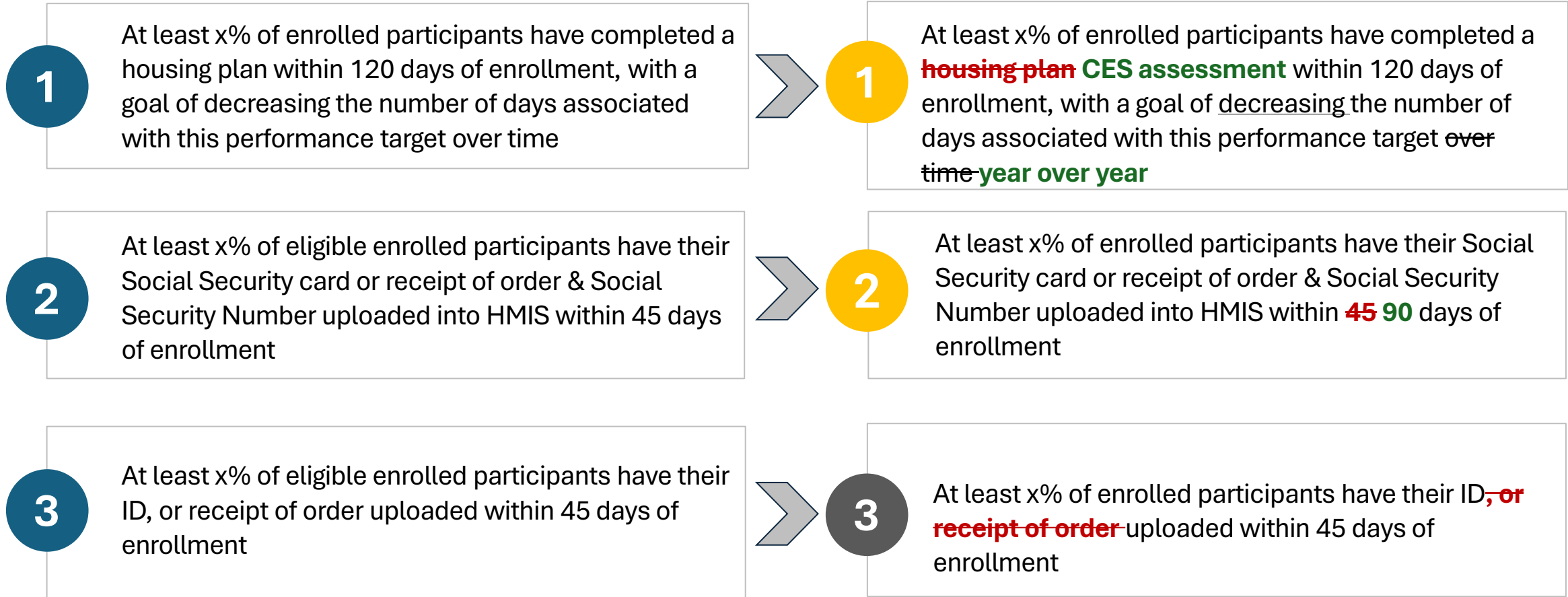
2

At least x% of eligible enrolled participants have their Social Security card or receipt of order & Social Security Number uploaded into HMIS within 45 days of enrollment

3

At least x% of eligible enrolled participants have their ID, or receipt of order uploaded within 45 days of enrollment

03 Quality of Assistance Edits



■ BPSC Recommendation
 ■ No Edit
 ■ Non-Substantive Edit
 ■ Substantive Edit
 ■ Add

How can we measure PROVIDING QUALITY ASSISTANCE

Performance management level

- All quality of assistance recommendations are at the contract performance indicator, because they reflect compliance with service delivery expectations.

Current Availability

- All metrics available for individual funders, but cannot yet be integrated into a single metric

Potential Future State

- 1-2 year effort to integrate data systems across funders to provide automatically updated, combined metrics

Geographic disaggregation

- Site level, SPA, SD, CD, City

Positive Housing Outcomes

Are participants experiencing positive housing outcomes?

04

Housing Outcomes

Original Recommendations

1

At least x% of participants exit to permanent housing destinations (with a breakdown of housing destinations, such as but not limited to, licensed residential care facilities, permanent supportive housing, time-limited subsidy)

2

Increase in percentage of participants exiting to permanent housing destinations over time

3

No more than x% of people are released to unknown, unsheltered, or locations “not acceptable for human habitation” (excluding transfers)

4

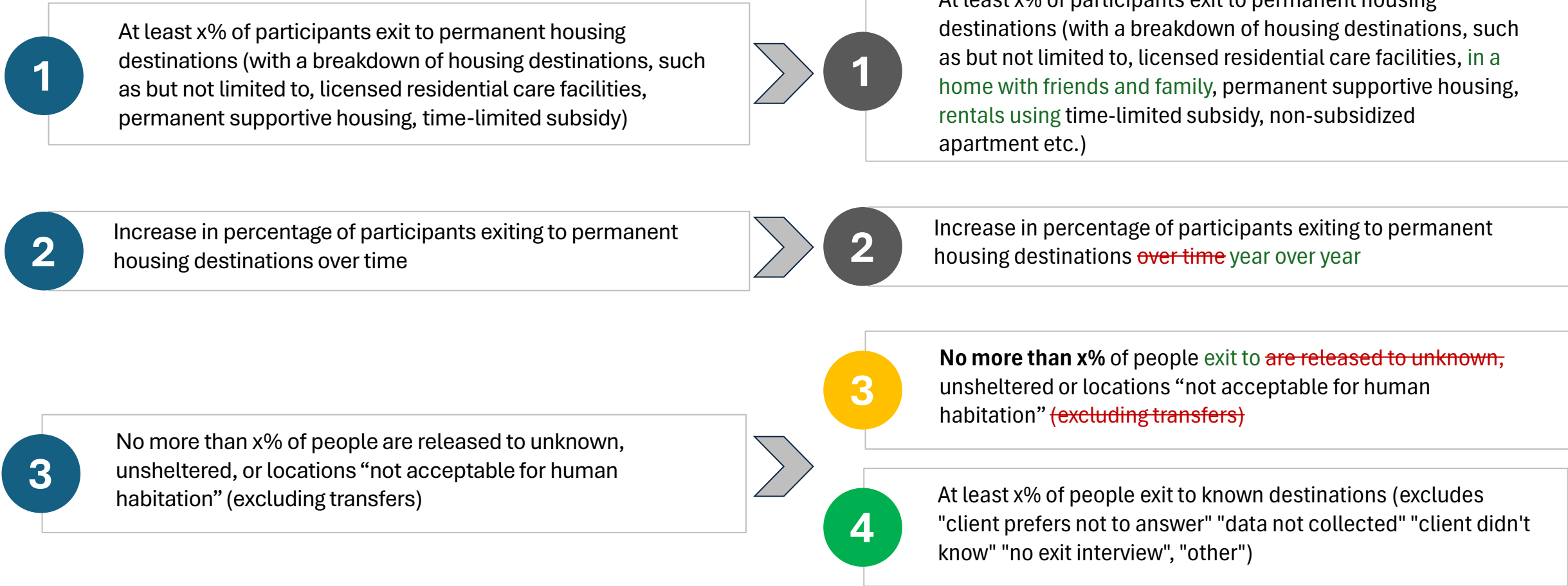
Decline in percentage of participants released to unknown locations over time

5

Demographic disaggregation: Percentage of interim housing exits, disaggregated by race, ethnicity and gender (with a breakdown by exit destination)

04 Housing Outcomes

Edits



- BPSC Recommendation
- No Edit
- Non-Substantive Edit
- Substantive Edit
- Add

04 Housing Outcomes

Edits



04

Housing Outcomes

Additions

7

Number of people who move into permanent housing as defined as exits to permanent destinations, moves into TLS, and moves into PSH.

8

Percentage of Participants who are document ready (i.e., have both their identification and social security card uploaded into HMIS)

9

Average days from IH enrollment to permanent housing move-in

How can we measure POSITIVE HOUSING OUTCOMES?

Performance management level

- Exits to any permanent destinations focus on performance of IH as system component, using exit destination flag.
- New metrics rely on move-in data from outside IH, so are system goals
- Reducing unknown or unfavorable exits are responsibility of providers so belong at contract indicator level

Current Availability

- All metrics available for individual funders, but cannot yet be integrated into a single metric

Potential Future State

- All metrics available for individual funders, but cannot yet be integrated into a single metric

Geographic disaggregation

- Site level, SPA, SD, CD, City

An aerial, isometric view of a city with various building shapes and heights. A solid blue horizontal band is superimposed over the middle of the image. The word "Questions?" is written in white, bold, sans-serif font, centered within the blue band.

Questions?



▶▶ Interim Housing Outreach Program

La Tina Jackson, LCSW

Deputy Director Countywide Engagement Division



LOS ANGELES COUNTY
**DEPARTMENT OF
MENTAL HEALTH**
hope. recovery. wellbeing.

▶▶ Our Role

- As mental health plan for Los Angeles County, DMH plays many roles in the in the homeless services space:
 - ◀ Direct Service Provider of Specialty Mental Health Treatment
 - ◀ Funder to Contract Agencies to Provide Specialty Mental Health Care
 - ◀ Funder to Contract Agencies for Community Bed Resources (interim housing and enriched residential care subsidies)
 - ◀ Funder to Contract Agencies for Specialty Mental Health Treatment Beds

▶▶ What is the Interim Housing Outreach Program (IHOP) ...

Not all interim housing is funded and structured to provide clinical supports to residents.

- IHOP expands service delivery by **bringing behavioral health, medical linkage, and care giving services to PEH with functional deficits due to their self care challenges, severe mental illness, or dysfunctional SUD in interim housing sites.**
- Our **primary goal is to stabilize residents via the provision of care and needed supports** at interim housing locations. Clients obtain treatment in the least restrictive environment possible, within the community.
- **If clients cannot be stabilized in their current location, they will be referred to facilities offering higher levels of care (acute and/or chronic).**
- The funding source for this program has specified eligibility requirements. **IHOP service recipients must have deficits with their activities of daily living (e.g. bathing, eating, transferring, cleaning etc.), need for specialty mental health treatment or substance use care.**

▶▶ What is the purpose of IHOP...

- The Interim Housing Outreach Program (IHOP) provides field-based, multidisciplinary teams (i.e. occupational therapist, mental health clinicians, psychiatrist, nurses, registered/certified substance use disorder counselors) **dedicated to serving people experiencing homelessness with complex health and behavioral health needs who are living in interim housing sites throughout LA County.**
- The program is **designed to address current gaps in behavioral health and physical health treatment in homeless services, support interim housing stability, aid transitions to permanent housing and prevent returns to homelessness.**
- IHOP teams serve all eight service areas (SA) in Los Angeles County and are comprised of staff from the Department of Mental Health (DMH), Department of Health Services Housing for Health (DHS-HFH), and Department of Public Health Substance Abuse Prevention & Control (DPH-SAPC) to address the full spectrum of client needs.

▶▶ IHOP Services

- **Mental Health Services:**

- ◁ Outreach/engagement
- ◁ Screening/assessment
- ◁ Psychiatric Medication & Administration
- ◁ Crisis intervention (including psychiatric hospitalization when deemed appropriate)
- ◁ Linkage to longitudinal care and consultation
- ◁ Transition to higher levels of care when deemed appropriate (e.g., residential care, crisis residential care)

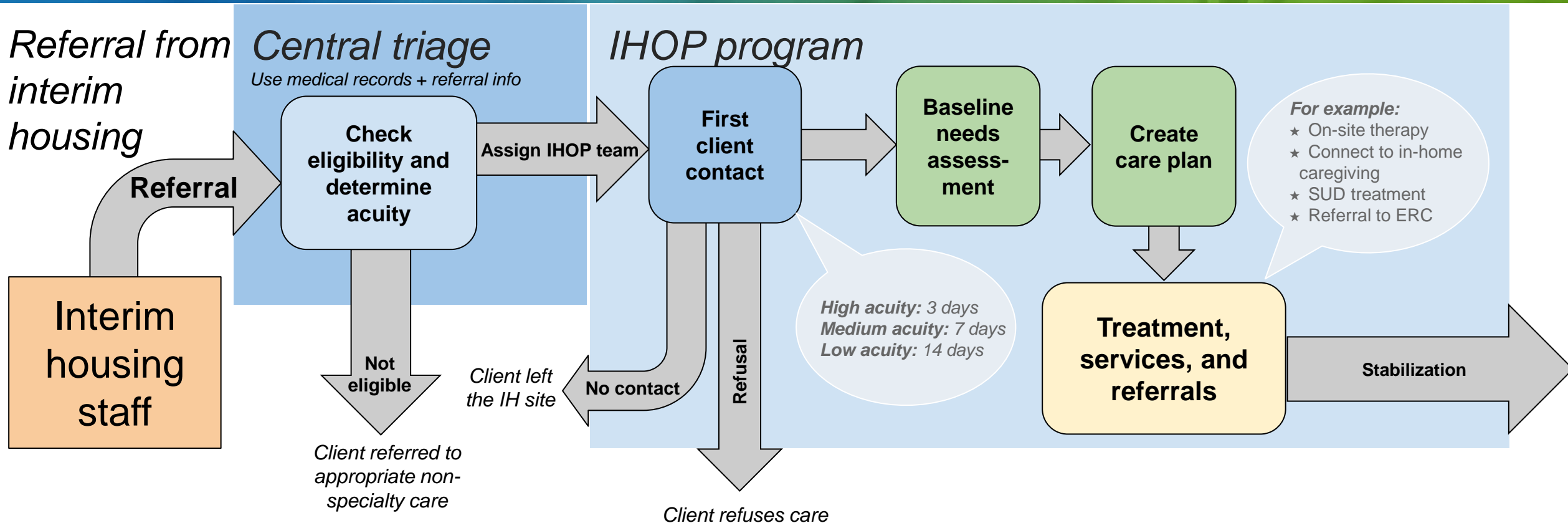
- **Health Services:**

- ◁ Functional assessment and support with essential life activities (aka activities of daily living and instrumental activities of daily living, (e.g. toileting, transferring, eating, and/or bathing, laundry, chores)
- ◁ Assignment of In-Home Care Giver (IHCG) services
- ◁ Connection to primary care and specialty health care
- ◁ Transition to higher levels of care when deemed appropriate (e.g. skilled nursing, residential care).

- **Substance Use Disorders (SUD):**

- ◁ Outreach/engagement
- ◁ SUD information/education
- ◁ Screening and connection to SUD treatment
- ◁ Harm reduction services
- ◁ Overdose prevention
- ◁ Connection to withdrawal management
- ◁ Medication for addiction treatment
- ◁ Transition to higher levels of care when deemed appropriate (e.g. dedicated residential treatment beds).

▶▶ IHOP Workflow



Note: Refusal of care is common for people with severe mental illness and substance use disorders. Outreach & Engagement continue beyond initial refusal



**IHOP
SERVICE
DELIVERY
METRICS**



**INTERIM HOUSING
OUTREACH PROGRAM**

Interim Housing Outreach Program

3781

Number of Referrals

385

Referring Shelters

2477

IHOP Assessment

882

Currently Active Clients

688

Clients in Outreach

1017

Unique Clients Receiving Assessment for Activities of Daily Living Deficit

3139

Total Substance Use Services

460

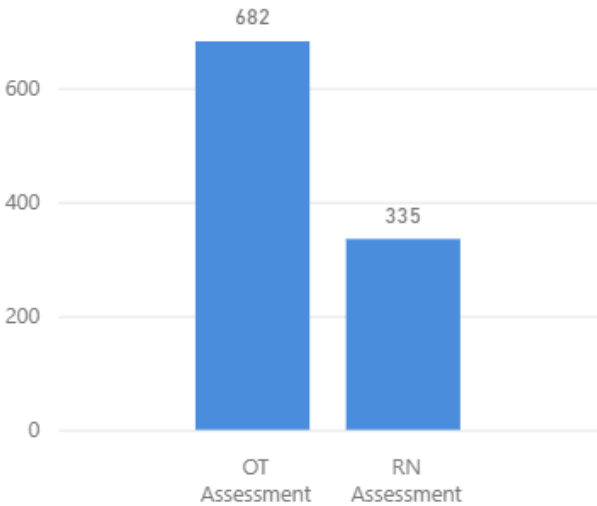
Unique Substance Use Service Clients

8681

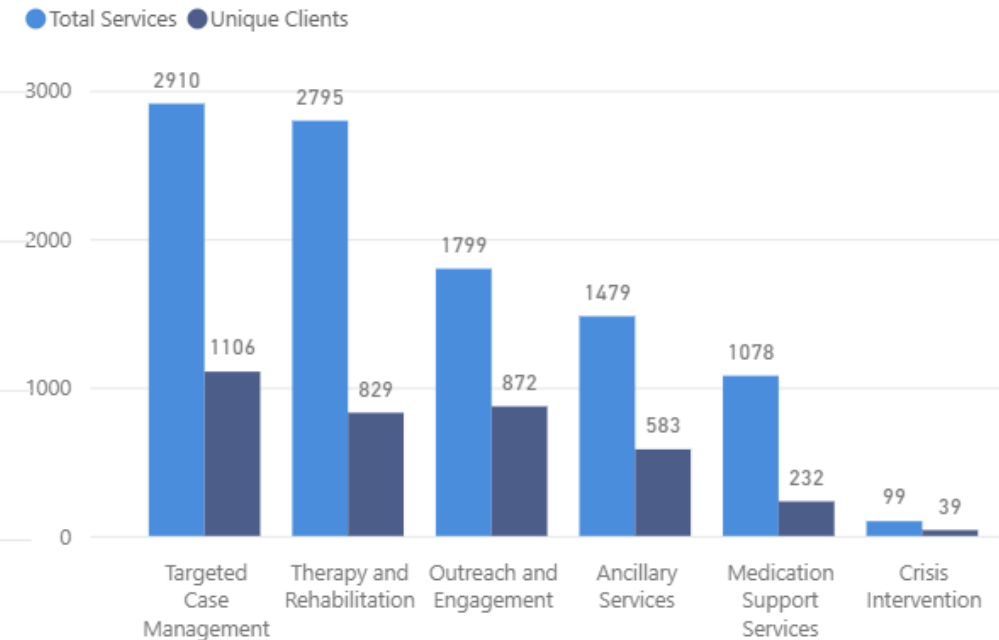
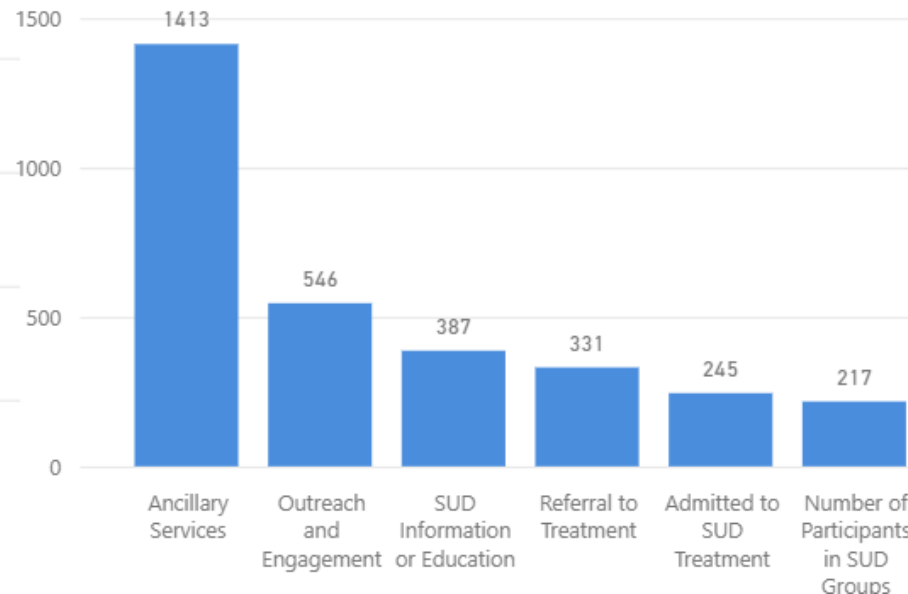
Total Specialty Mental Health Services

1740

Unique Specialty Mental Health Clients

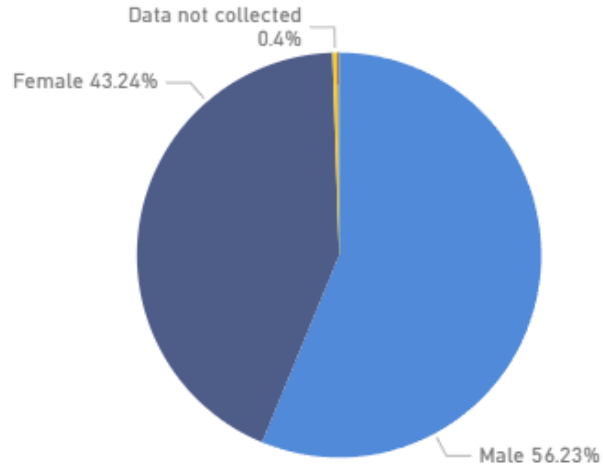


OT= Occupational Therapist
RN= Registered Nurse

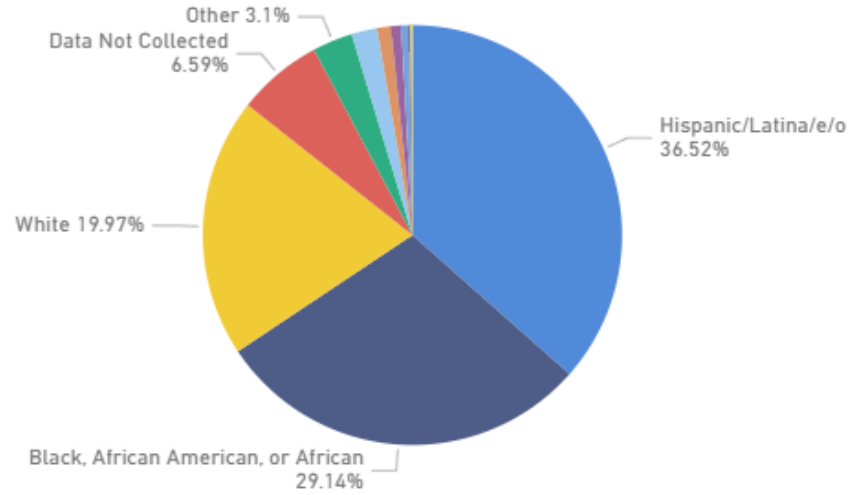


Demographics of Active IHOP Clients

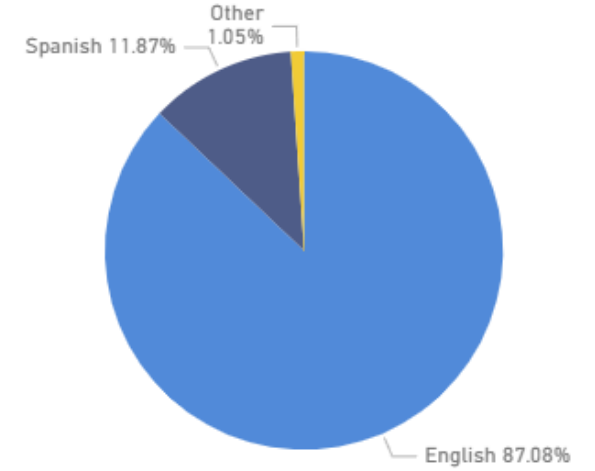
Active Clients by Gender



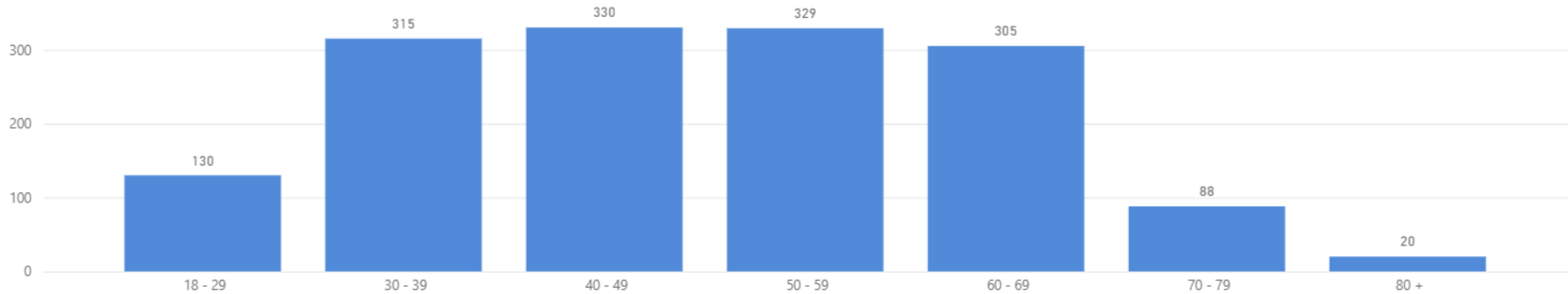
Active Clients by Race



Active Clients by Language

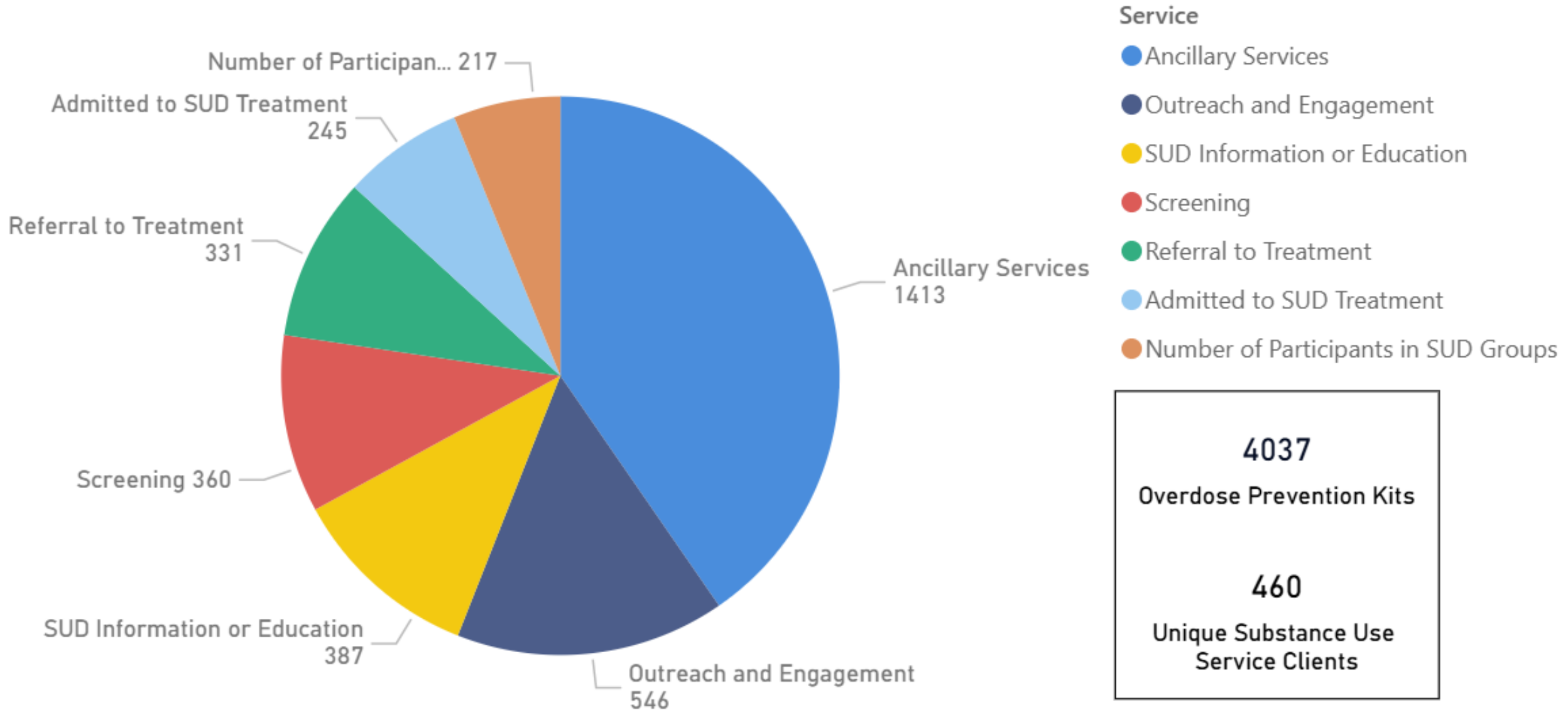


Active Clients by Age



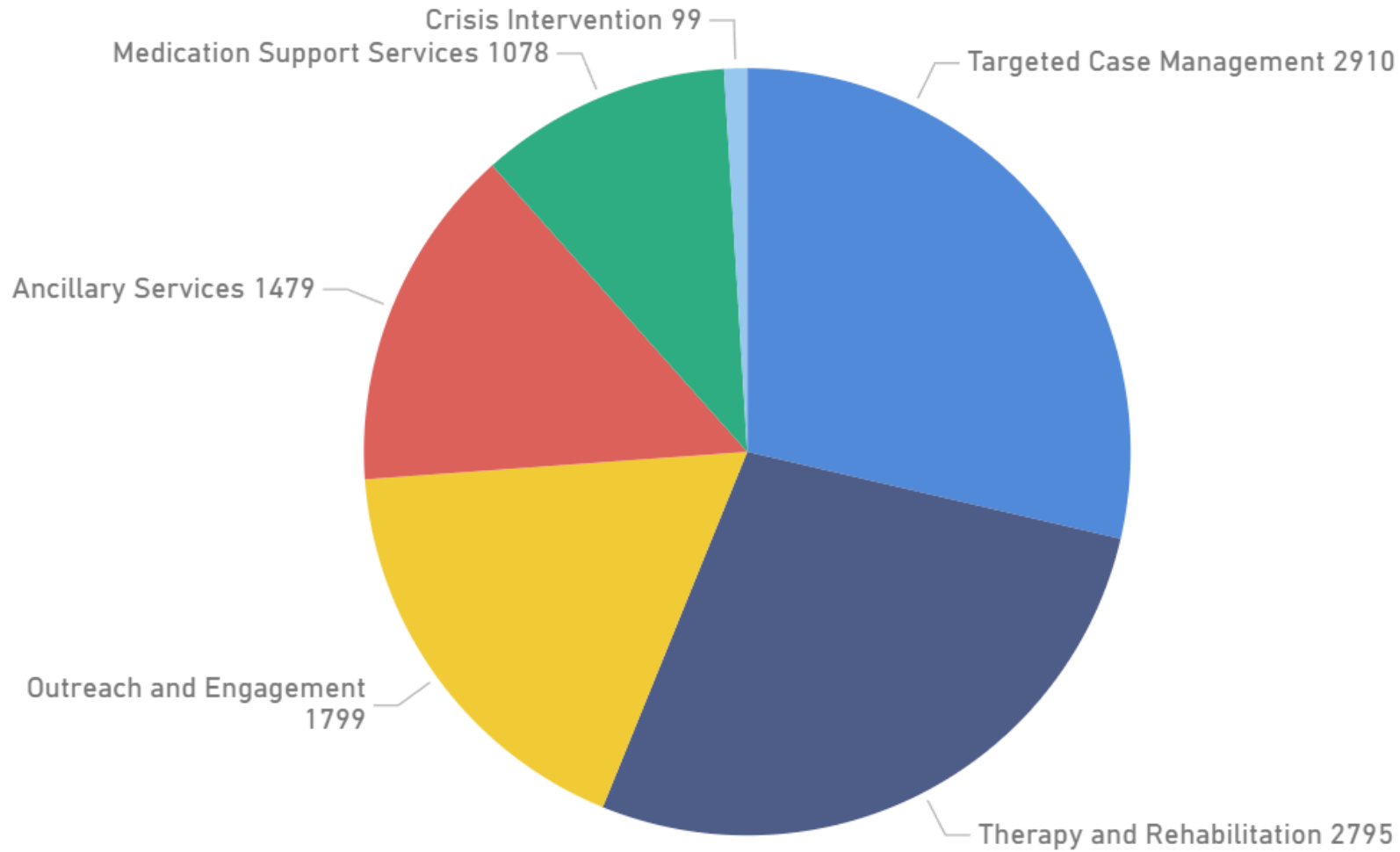


Substance Use Disorder (SUD) Treatment





Specialty Mental Health Services



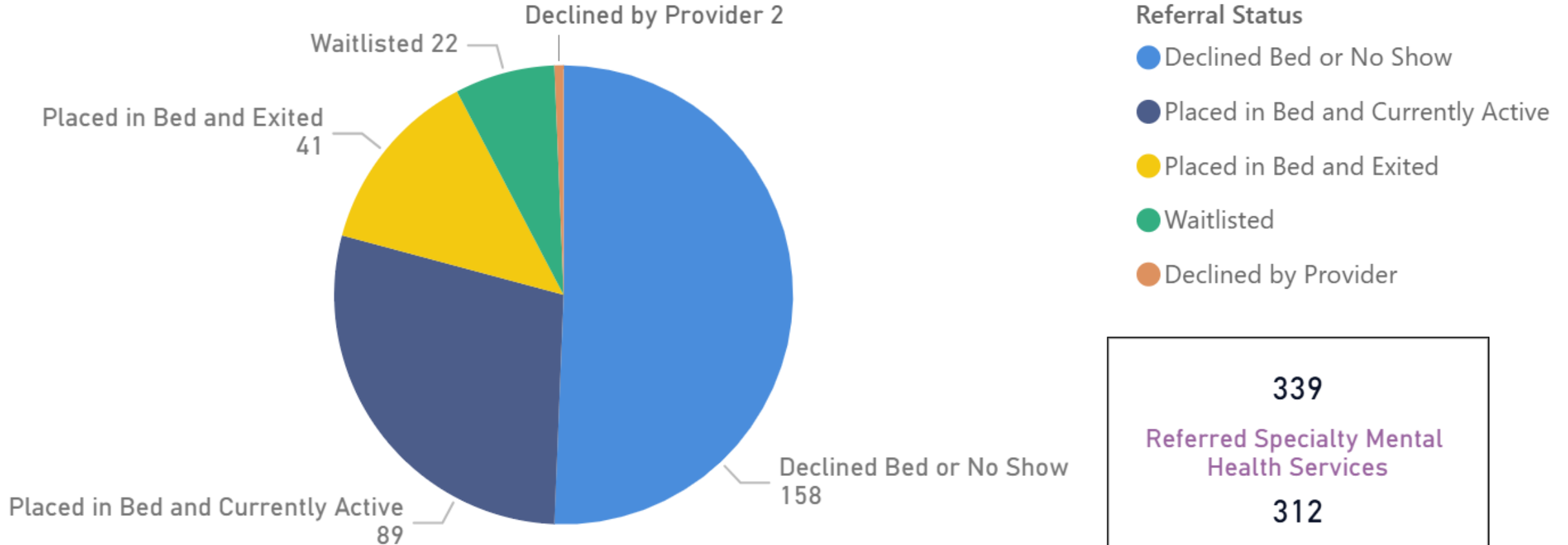
Service

- Targeted Case Management
- Therapy and Rehabilitation
- Outreach and Engagement
- Ancillary Services
- Medication Support Services
- Crisis Intervention

1740
Unique Specialty Mental
Health Clients

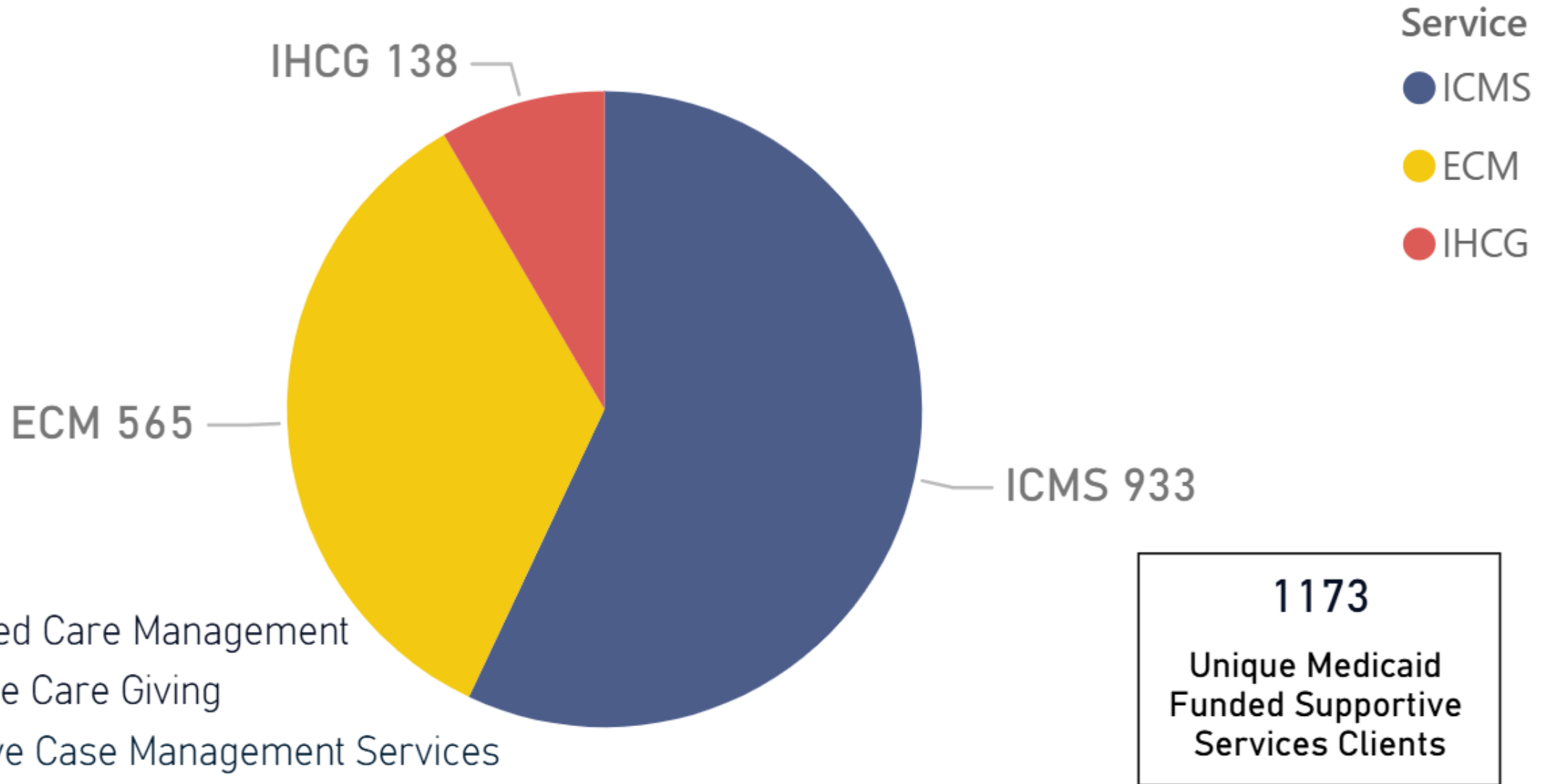


DMH Referrals to Beds Funded to Serve Higher-Acuity Participants

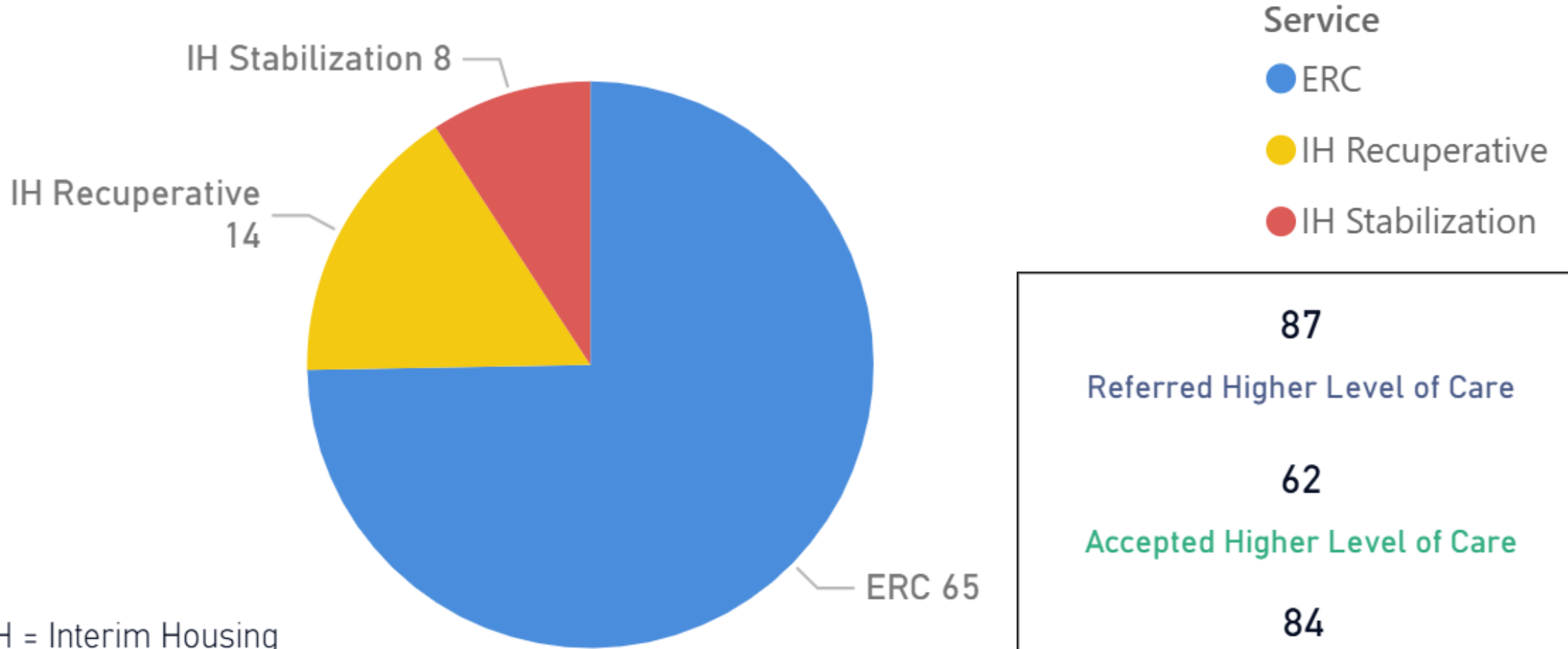




Medicaid Funded Supportive Services



DHS Referrals to Beds Funded to Serve Higher-Acuity Participants



IH = Interim Housing
ERC = Enriched Residential Care

87
Referred Higher Level of Care

62
Accepted Higher Level of Care

84
Unique Higher Level of Care Clients

Breakdown of Services Provided

Phase 1: Triage
(Referral Received)



Phase 2A - Outreach;
Phase 2B - Enrollment



Phase 3 (Needs Survey +
Baseline Assessment)



Phase 4 (Active,
Care Plan initiated)



Phase 5
(Discharge)

% Referrals Eligible for
IHOP

76.5%

Average Days From
Referral To First
Outreach

7.72

% Referrals Ineligible
for IHOP

18.9%

% Unable to Assess
Eligibility

4.62%

Time From Acuity To
First Outreach

Under Development

Avg # Days From
Consents to Needs
Assessment

4.6

Avg # Days To Baseline
Completion

44.2

% Active Clients With a
Baseline Completed

92.9%

Avg # Days From
Baseline to Active

7.7

Time From Referral to
Receipt of Services

Under Development

Avg # Days to Discharge

76.6

Avg # Days in Program

94.97

Questions?



LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.