# HOMELESS POLICY DEPUTIES MEETING AGENDA

**MEETING WILL TAKE PLACE IN PERSON WITH A VIRTUAL OPTION**

**Date:** **Thursday, April 11, 2024**

**Time:** **2:00 PM**

**Location:** **Kenneth Hahn Hall of Administration**
500 West Temple St.,
Room 374-A
Los Angeles, CA 90012

For members of the public who wish to join virtually or over the phone, please see below:

**Microsoft Teams Link:** Click here to join the meeting

**Teleconference Number:** +1 323-776-6996,,562027719#

| | AGENDA ITEM | LEAD |
|---|---|---|
| I. | Welcome and Introductions | Amy Perkins, Third District |
| II. | The Integrated Care Model in Permanent Supportive Housing | Leepi Shimkhada, Deputy Director, Housing for Health, Department of Health Services<br><br>Maria Funk, Ph.D., Deputy Director, Housing and Job Development Division, Department of Mental Health<br><br>Sandy Song, MA, Section Manager, Adult Services, Department of Public Health<br><br>Julie DeRose, LMFT, Chief Program Officer, The People Concern |
| III. | Preventing Homelessness Promoting Health (PH)2 | Rhonda Higgins, Psy.D., Deputy Division Chief, Department of Mental Health<br><br>Ramona Casupang, LCSW, Mental Health Program Manager I, Department of Mental Health |

| | | |
|---|---|---|
| V. | In-Home Care Giving and The Interim Housing Outreach Program (IHOP) | Leepi Shimkhada, Deputy Director, Housing for Health, Department of Health Services<br><br>Heidi Behforouz, MD, Chief Medical Officer, Housing for Health, Department of Health Services<br><br>La Tina Jackson, LCSW, Deputy Director, Department of Mental Health<br><br>Sandy Song, MA, Section Manager, Adult Services, Department of Public Health |
| VI. | Items Recommended for Future Discussion | |
| VII. | Public Comment* | |

* Public Comment is limited to one minute. Those joining virtually interested in speaking should raise their hand on Microsoft Teams and unmute once called upon by the Chair. Those on their phones should press *5 to raise their hand and *6 to unmute.

**NEXT MEETING: APRIL 25, 2024**

# HOMELESS POLICY DEPUTIES MEETING

# APRIL 11, 2024

Health Services
LOS ANGELES COUNTY

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## Integrated Care Model in Permanent Supportive Housing

**LEEPI SHIMKHADA,** DEPUTY DIRECTOR, HOUSING FOR HEALTH, DEPARTMENT OF HEALTH SERVICES

**MARIA FUNK,** PH.D., DEPUTY DIRECTOR, HOUSING AND JOB DEVELOPMENT DIVISION, DEPARTMENT OF MENTAL HEALTH

**SANDY SONG,** MA, SECTION MANAGER, ADULT SERVICES, DEPARTMENT OF PUBLIC HEALTH

**JULIE DEROSE,** LMFT, CHIEF PROGRAM OFFICER, THE PEOPLE CONCERN

## Preventing Homelessness and Promoting Health

**RHONDA HIGGINS,** PSY.D., DEPUTY DIVISION CHIEF, DEPARTMENT OF MENTAL HEALTH

**RAMONA CASUPANG,** LCSW, MENTAL HEALTH PROGRAM MANAGER I. DEPARTMENT OF MENTAL HEALTH

## Interim Housing Outreach Program & In Home Caregiving

**LEEPI SHIMKHADA,** DEPUTY DIRECTOR, HOUSING FOR HEALTH, DEPARMENT OF HEALTH SERVICES

**HEIDI BEHFOROUZ,** MD, CHIEF MEDICAL OFFICER, HOUSING FOR HEALTH, DEPARTMENT OF HEALTH SERVICES

**LA TINA JACKSON,** LCSW, DEPUTY DIRECTOR, DEPARTMENT OF MENTAL HEALTH

**SANDY SONG,** MA, SECTION MANAGER, ADULT SERVICES, DEPARTMENT OF PUBLIC HEALTH

# INTEGRATED CARE MODEL IN PERMANENT SUPPORTIVE HOUSING: THE LA COUNTY MODEL

**Maria Funk,** Ph.D., Deputy Director, Housing and Job Development Division, Department of Mental Health

**Leepi Shimkhada,** MAPP, Deputy Director, Housing for Health, Department of Health Services

**Sandy Song,** MA, Section Manager, Adult Services, Department of Public Health

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Comprehensive services to tenants of PSH to achieve long-term stability and improved well-being

+

Ensures PSH tenants have access to Intensive Case Management Services, specialty mental health services, and substance use disorder services

→

# Integrated Care Model

# HISTORY OF THE INTEGRATED CARE MODEL IN LOS ANGELES COUNTY


Measure H: "Strategy D7" provide services and subsidies for Permanent Supportive Housing

**This is one of the widest reaching strategies that reaches across all 8 Service Planning Areas and several cities throughout LA County**

**DHS:** Intensive Case Management Services **(ICMS)**

**DMH:** Housing Supportive Services Program **(HSSP)**

**DPH-SAPC:** Client Engagement & Navigation Services **(CENS)**

# Benefits of Integrated Care

1. Reduced fragmentation of service providers lowers barriers to access, waste, and inefficiency while avoiding duplication and contradictory decisions.

2. Shared accountability improves ownership of client care and outcomes.

3. The integration of community social care with health care has been shown to improve outcomes and control costs.

4. Organizational bottlenecks are alleviated, which otherwise would put pressure on existing services and hinder a coordinated response to client needs.

5. Integration encourages a comprehensive approach to patient care, which is more likely to address health inequalities.

# CHALLENGES OF INTEGRATED MODELS

- Lack of coordination can result in duplication of services
- Unclear delineation between provider roles
- Conflicting and/or contradictory care plan and goals
- Providers specialization and difficulty seeing the bigger picture
- Poor communication between data systems around care coordination
- Difficulty implementing documented care plan
- Differences in relationships/working styles between providers

***Maruthappu, M., Hasan, A., & Zeltner, T. (2015). Enablers and Barriers in Implementing Integrated Care. *Health Systems & Reform*, *1*(4), 250–256. https://doi.org/10.1080/23288604.2015.1077301

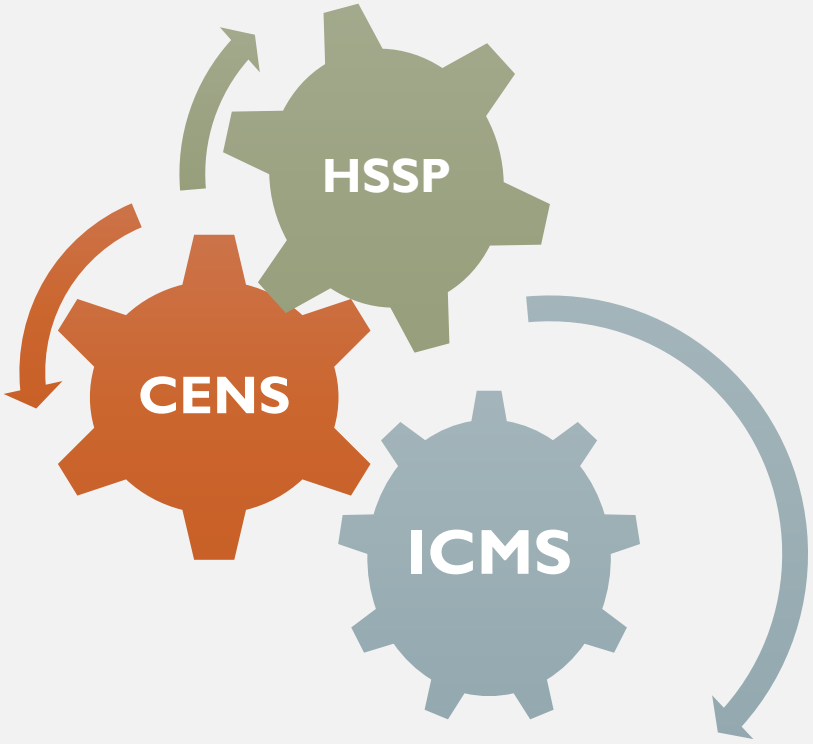
# ENSURING QUALITY INTEGRATED SERVICES

DHS, DMH, and DPH use Project-Based housing pipeline to track new development occupancy dates

Service providers will be identified for each development to ensure accessibility to services

When possible, we will contract with the same agency to provide two or more services

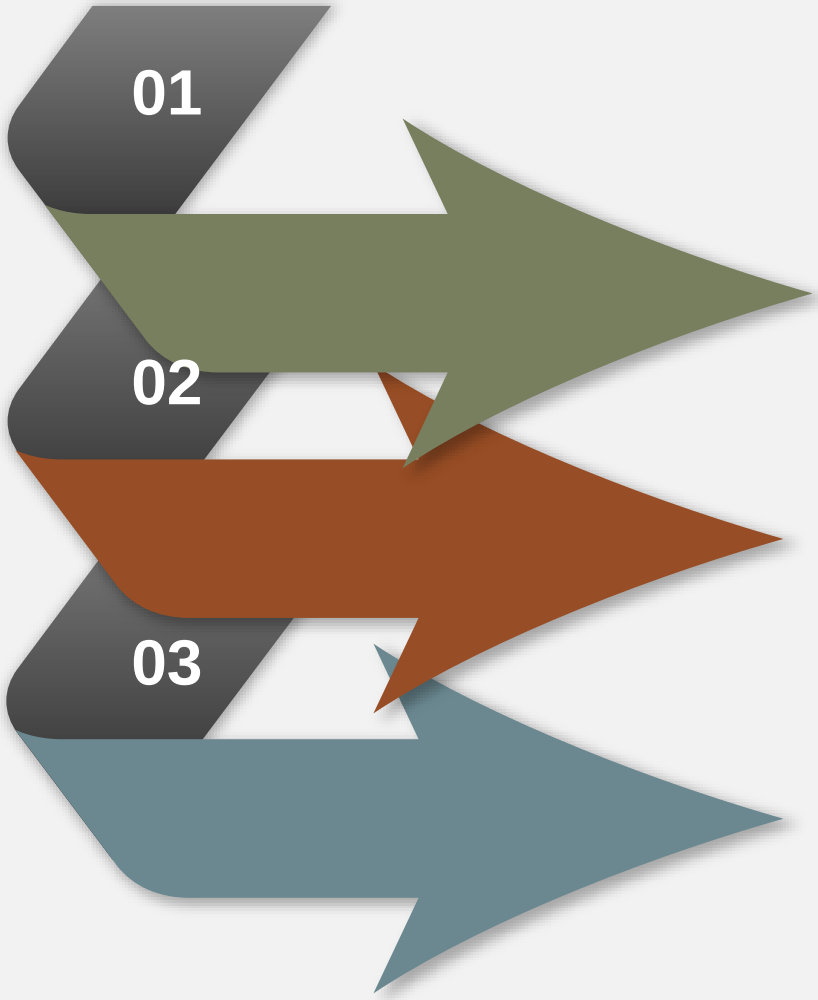
DHS, DMH, and DPH administrative staff meet regularly and have joint provider meetings to facilitate integration of partners



# CURRENT PERMANENT SUPPORTIVE HOUSING (PSH) PIPELINE

| Fiscal Year (FY) | Total Units | PSH Units |
|---|---|---|
| FY 23-24 | 4,567 | 2,910 |
| FY 24-25 | 4,693 | 3,258 |
| FY 25-26 | 3,191 | 2,329 |
| FY 26-27 | 1,462 | 864 |
| FY 27-28 | 302 | 196 |
| TBD | 1,220 | 839 |
| **Grand Total** | **15,435** | **10,396** |

# BEST PRACTICES




## Housing First

Connect people experiencing homelessness to permanent housing without preconditions or barriers to entry

## Harm Reduction

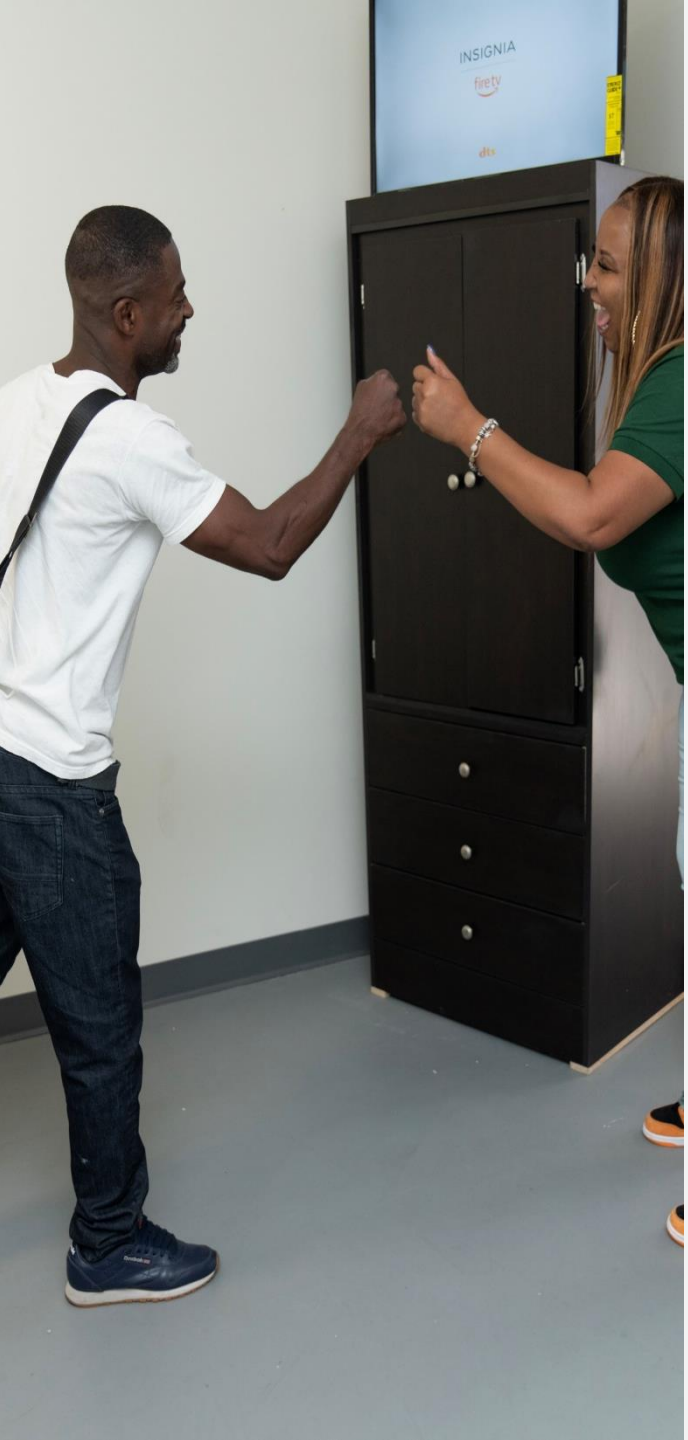
Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use

## Whatever it Takes

Whatever it Takes is a flexible approach to service delivery for people who are experiencing homelessness or are living in Permanent Supportive Housing and dealing with mental illness, chronic health conditions, and or substance use disorders

# COMMON GOALS

| | |
|---|---|
| Housing Retention | The common goal of helping people stay long-term in PSH is a critical foundational goal of all providers in this model |
| Promote Health | All partners working together are bound by a common goal of promoting health and behavioral health to improve long term quality of life outcomes |
| Life Skills | Support skill building so people can achieve their goals whether it is to become a volunteer, go back to school, find meaningful employment, etc. |
| Aging in Place | Provide people with long-term solutions so they have services and affordable housing as they age and not be reliant on long term care facilities |




# CORE FUNCTIONS OF PSH ICMS

- Intake and assessment
- Documentation (ID, verifications)
- Address immediate needs (food, clothing, etc.)
- Provide and facilitate transportation
- Connection to benefits (health, income, in home care)
- Support with completing housing paperwork
- Unit location assistance
- Move in assistance
- Housing retention

# CORE FUNCTIONS OF CLIENT ENGAGEMENT AND NAVIGATION SERVICES (CENS)

- Outreach and Engagement
- SUD Screening, Referral, and Linkage to Treatment
- Navigation for SUD Services
- At-Risk Services for SUD Prevention and Early Intervention, including educational sessions on harm reduction
- SUD Information/Education for Individuals and Agencies

# CORE FUNCTIONS OF HSSP

- Individual Therapy
- Group Therapy
- Medication Support
- Crisis Intervention – available 24/7 for crisis response and staffing includes staff that can write 5150 holds
- Referral and Linkage
- Support with managing mental health symptoms
- Support in recovery goals

# SYSTEM CHALLENGES

- Occupancy date delays of projects on the pipeline
- HSSP transitioning from Measure H funding to Mental Health Services Act funding
- System capacity of service providers to continue to expand services
- Documenting case conferencing in a common system
- Ongoing funding source
- Higher rates for all service types

# THE PEOPLE CONCERN
# THE INTEGRATED CARE MODEL IN PRACTICE:
# A CASE STUDY

**Julie DeRose,** Chief Programs Officer

The People Concern

# THE PEOPLE CONERN

**The People Concern empowers the most vulnerable among us to rebuild their lives.**

The People Concern was formed in 2016 in a merger of two trusted social service organizations based in Los Angeles County, **OPCC and Lamp Community**. Together, we have had more than fifty years of work in the community.

The People Concern is a leading provider of, and advocate for, evidence-based solutions to the multi-faceted challenges inherent in homelessness and domestic violence.

The People Concern believes no one should have to live on the street or in a violent household.. Our programs empower the most vulnerable among us to improve their quality of life – housed, healthy and safe – and become active participants in the community.

We also work to educate the broader community and improve public policy.

# ARLINGTON SQUARE

## BEFORE INTERGRATED SERVICES

- 2 Case managers only providers on site
- In first 6 months – 24 hospitalizations, most were psychiatric
- 2 incarcerations for Substance use
- 2 situations in which staff found individuals dead in apartment

# ARLINGTON SQUARE

## NOW

- We have integrated services at the building
- Housed HSSP on site – clinical and psychiatric
- CENS (client engagement and navigation services) on site weekly
- DHS HFH Nurse –doing psychoeducation around medical symptoms and connection to Primary Care Services.

# ARLINGTON SQUARE

## NOW

- Have psychiatrist on site weekly
- Have easier access to a psychiatrist which has increased interest in discussing medication
  - one client agreed to vivitrol
- One individual that was incarcerated due to his SPMH was transferred from Jail to hospital and discharged on injectable medication.
  - We now have capacity to ensure compliance

## Case Study/Examples

- 35 year old Caucasian female – Dually Diagnosed
- Placed in project – transitioned well
- Following period of stability, client experienced re-occurrence of use
- Co-location of intensive Case Management and Substance Abuse Outreach Services supported smooth and easy connection to treatment
- Has managed to stay housed for over 4 year but has needed full integrated services.

# Integrating Housing

## Integration of Services

- Staff provide intensive services
- Coordination of Mental Heath, Medical and Substance Abuse services on site integrates care
- Reduces barriers to housing stability
- Increases ability to keep individuals in best fit housing, increasing retention outcomes
- Increases effectiveness of services provided on site

# STAFF WEAR MULTIPLE HATS

# PREVENTING HOMELESSNESS & PROMOTING HEALTH (PH)$^2$

**Rhonda Higgins,** Psy.D., Deputy Division Chief, Department of Mental Health

**Ramona Casupang,** LCSW, Mental Health Program Manager I. Department of Mental Health

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# Prevent Homelessness Promote Health $(PH)^2$

- **$(PH)^2$** is a collaborative program between DMH and DHS Housing for Health
- **$(PH)^2$** provides field-based outreach and linkage services to assist previously homeless individuals and families experiencing untreated mental illness and/or complex medical conditions placing them in eminent risk for eviction and return to homelessness

# $(PH)^2$ SERVICES

- Housing Stabilization
- Mental Health Stabilization
- Communication with Property Managers
- Problem Solving Skills
- Psychiatric Crisis Intervention
- Conflict Resolution
- Short Term Case Management
- Harm Reduction
- Home Safety Assessment & Modifications
- Nursing Support for Chronic Disease Management
- Care Coordination and Transitions to Higher Levels of Care
- Creative Interventions As Deemed Appropriate


# PATHWAY TO SERVICES CREATIVE INTERVENTIONS

Resident Deemed At Risk For Eviction → ICMS Worker Refers to $(PH)^2$

Determine Primary Needs (health, mental/behavioral health) → $(PH)^2$ Team Assigned

Assess Residents Needs to Stabilize Their Living Situation → Provide Interventions As Appropriate

# IN HOME CARE GIVING SERVICES AND INTERIM HOUSING OUTREACH PROGRAM (IHOP)

**Leepi Shimkhada,** Deputy Director, Housing For Health, Department of Health Services

**Heidi Behforouz,** MD, Chief Medical Officer, Housing For Health, Department Of Health Services

**La Tina Jackson,** LCSW, Deputy Director, Department of Mental Health

**Sandy Song,** MA, Section Manager, Adult Services, Department of Public Health

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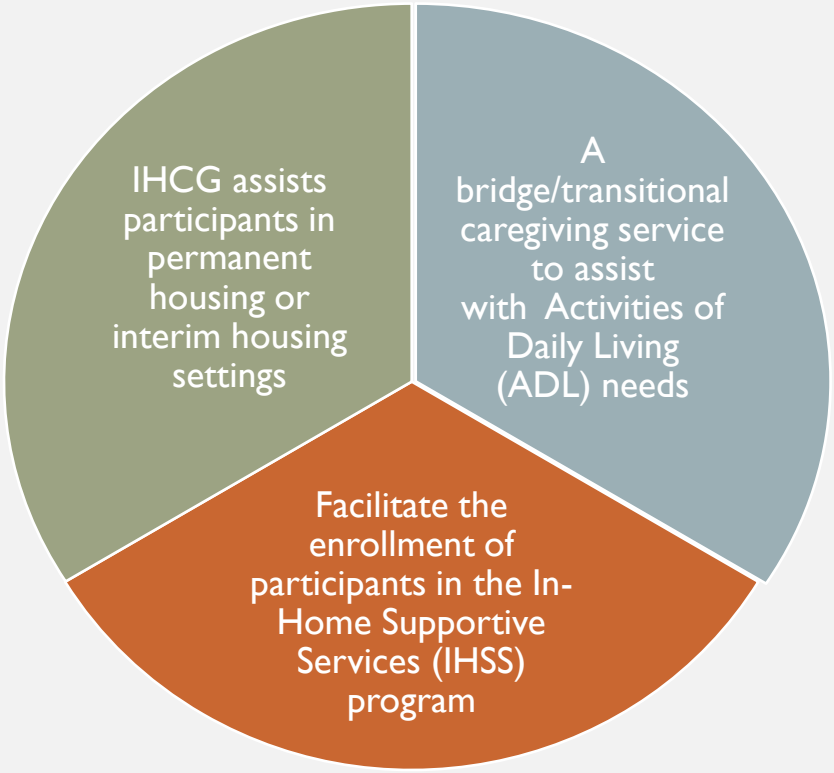
# IN-HOME CARE GIVING PROGRAM




Client-centered, compassionate, harm reduction, and trauma-informed care approaches in caregiving services

# COMMUNITY SUPPORTS
## Personal Care and Homemaker Services

- Personal Care and Homemaker Services (PCHS)- Services is a CalAIM Community Support program
- Funding for caregiving services for people in need assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)
- PCHS is the primary funding source for DHS' IHCG program
- The IHCG program and infrastructure has been operational for nine years

# HOUSING AND HOMELESS INCENTIVE PROGRAM (HHIP)

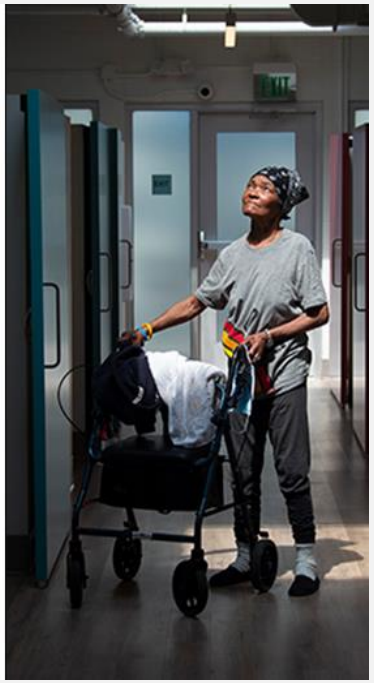
The Housing Homeless Incentive Program (HHIP), aimed at facilitating individuals' transition to community-based independent living arrangements.

HHIP funding supports initiatives like the IHOP team, IHCG and unit acquisition strategies in LA County

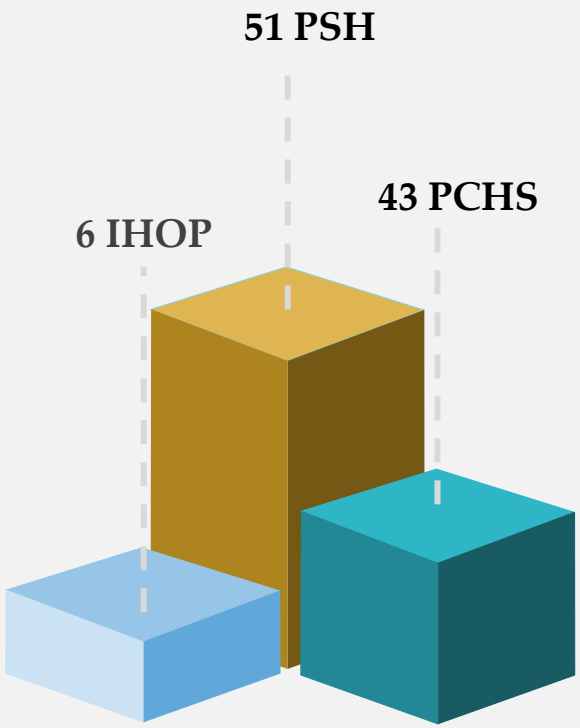
County of Los Angeles Homeless Initiative

L.A. Care HEALTH PLAN

health net



# Outcomes




- Serving 57 participants ( PSH + IHOP) in IHCG through HHIP funding
- 43 PCHS participants authorized through Managed Care plans within the last year
- All participants have applied for IHSS: some are approved and others awaiting approval
- Challenge: Identifying an appropriate IHSS worker for the participant

# IHCG SUCCESS

"Joe" joined the In Home Care Giving program in June 2022 after living in Permanent Supportive Housing since April 2019.

Initially, Joe showed positive progress, maintaining hygiene, a clean home, and daily activities. However, severe knee pain in late 2021 led to depression and increased alcohol use, worsening his diabetes symptoms.

By April 2022, Joe's condition deteriorated, leading to concerns from his Intensive Case Management Services provider. The HFH staff acted quickly to bring in a cleaning service and found him a caregiver through Jewish Family Services.

With these supports and Joe's resilience, things are looking up for Joe! He has improved significantly and has formed a strong bond with his caregiver.

# Interim Housing Outreach Program (IHOP)

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IHOP Update:

**Department of Health Services**
**Housing for Health**
**(DHS HFH)**


# IHOP
# A Collaborative Approach

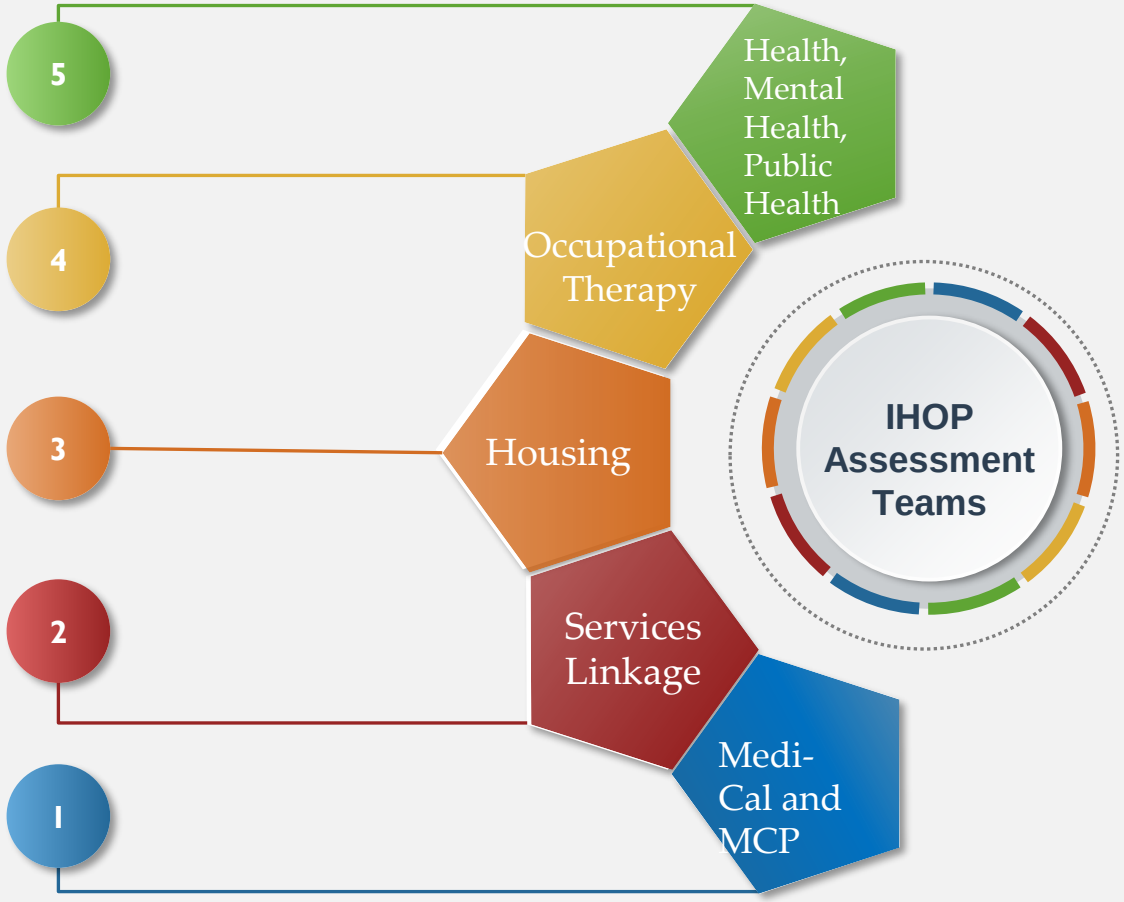
LA County Departments working together in collaboration

Critical supports during the assessment/stabilization process to ensure maximal function and safety for those with ADL deficits

Getting people connected to DHS' Housing Navigation services allow people to get document ready and assessed in CES or be referred for Enriched Residential Care if needed

Services include linkage to primary care (inc. mobile clinics), CBEST, mental health/SUD services

Linkage and referral to Medi-Cal, authorization for personal care and homemaker services and housing navigation services, ECM




Funded by the Homeless and Housing Incentive Program (HHIP)

# DHS IHOP LAUNCH

- DHS team comprised of 6 RNs and 6 OTs and 2 NPs and 8 support staff (EMT/LVN/MCW)
- DHS launched in November in SPA 4 with preliminary focus on clients with ADL deficits
  - Most clients are medium acuity; 30% are high acuity and require intensive care management
  - Will expand to those with functional deficits due to SMI/SUD issues when DMH/SAPC join
- Have received referrals from over 60 shelters; shelter staff refer clients electronically
- Monthly training/TA webinars for shelter staff
- 279 clients have been referred with 104 clients assessed in 32 shelters (25 SPA 4 shelters)
- Very few residents have needed referral to ERC (5) or RCC (4)
- 6 clients have been referred to IHCG and 5 have been assigned a care giver; we have decreased IHCG placement from 2-3 weeks to 1-2 days
- 34 people connected to ICMS housing navigators
- Working closely with MCPs on how to expedite direct access to medically necessary services/supplies, field-capable ECM providers, and PCHS/IHSS

# IHOP CASE STUDY

- "John" was referred by staff at a temporary winter shelter in SPA 1. Referral information indicted "fall risk" and incontinence issues. Upon evaluation, OT and RN determined that client had an overactive bladder? and neurological deficits that impacted his ambulation (possible Parkinson's given resting tremor and shuffling gait?) These neurological issues resulted in the client's inability to safely navigate the large shelter to get to the restroom in time. OT and RN also noted cognitive processing issues that led to his "damaging the washer" when he could not figure out how to use the machine to wash his soiled clothes. He also struggled to don/doff his clothes and put on his shoes.
- IHOP team determined the need for primary care and neurological work up and worked to reactivate his Medicaid and connect him to medical services. Recognizing that the winter shelter was not an ideal location, the IHOP team referred him to a recuperative care center (RCC). At first, the RCC declined the placement due to his ADL deficits; however, the IHOP team was able to secure an IHCG worker for 20 hours/week and he was admitted to the RCC the following day.
- Since placement in higher level of care, the client is doing well and has upcoming appointments with care providers to address his underlying neurological issues and receive PT/OT services for gait training and functional rehabilitation.

# IHOP CASE STUDY

- "Julie" resides in tiny home interim housing location with her small emotional support dog Cheddar. She was referred by IH staff requesting transfer to an ERC facility as client exhibited difficulty maintaining unit and caring for self.
- Client seen by IHOP RN and OT. Client reports losing her home and job during COVID and has had a hard time adjusting to her "new normal" which has exacerbated her mental health/depression. Client has uncontrolled diabetes and is not connected to a local PCP. Client reports that she has poor sleep due to noises of other residents and the train tracks that run behind her unit. She utilizes a walker for mobility due to chronic pain, weakness and poor balance as a result of old injury and sciatica. Client has difficulty remember to take her medications (for physical and mental health). Due to mobility and cognitive deficits, she has difficulty maintaining her unit, often misplacing medications and other needed items such as blood glucose monitor and BP machine. Her unit is also noted to have rotten and old food, presenting sanitation and safety concerns.
- Client was supported by IHOP team in getting connected to PCP and mental health care. She was referred to an ICMS for housing navigation. IHOP secured approval for 11 hours a week of IHCG for support in home maintenance (clutter, laundry, remote supervision for safety in showering/dressing), medication management (filling pill box, verbal cues to take, pharmacy refills/pick up), and scheduling and attendance support with medical appointments.
- Julie has not had to move to an ERC and is working hard with her ICMS to identify an ADA accessible, pet friendly PSH unit.

# IHOP CHALLENGES

- High demand with small team
- Protracted time from referral to assessment completion
- IHOP is an assessment/linkage program whereas many of these vulnerable clients (30%) need longitudinal intensive care management
  - Limited shelter capacity to provide ongoing care management support
  - Many clients are not connected to primary care or field-capable ECM services
- IHCG placement challenges
- PCP linkage given lack of timely PCP access/limited field-based ECM supports
- Data collection/analysis challenges as well as lack of uniform platform for cross-agency and agency-CBO care coordination
- Limited PSH

IHOP Updates:

# Department of Mental Health (DMH)

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# DMH IHOP Overview

- Outreach & Engagement
- Behavioral Health Assessment
- Medication Support
  - On-Site Medication Administration
  - Co-Occurring Addiction Treatment
- Individual and/or Group Rehabilitation
  - Individual and/or Group Therapy
  - Skills Building Sessions
  - Support Groups

# DMH IHOP Overview

- Bridge Treatment to the appropriate level of longitudinal care:
  - HOME or AOT
  - Full-Service Partnership
  - Outpatient Services
- Medication for Addiction Treatment
- Dedicated Psychiatric Crisis Support

# Updates Since November 2023

- Grant Funds Added to DMH Mid-Year Budget Adjustments December 2023
- DMH Received Authority to Hire March 7, 2024
- Hiring Will be Conducted In 3 Phases (March 7- December 31, 2024)
  - Phase 1 – Program Administration, Central Triage Unit Service Areas 4 & 6 Teams
  - Phase 2 – Regional Administrative Staff, Service Areas 1, 2, 3, 5, 7 & 8; Service Area 2 Regional Team
  - Phase 3 – Regional Teams – Service Areas 5, 7 and 8
- Identified An Independent Evaluator For the IHOP Program
- Identified A Care Management Technology Platform to be Shared by All 3 Health Agencies

# DMH IHOP LAUNCH – IN PROGRESS

- DMH component comprised of a Central Triage Team and 8 Regional multi-disciplinary teams 170 FTE:
- 279 clients have been referred with 104 clients assessed in 32 shelters (25 SPA 4 shelters)
- Very few residents have needed referral to ERC (5) or RCC (4)
- 6 clients have been referred to IHCG and 5 have been assigned a care giver; we have decreased IHCG placement from 2-3 weeks to 1-2 days
- 34 people connected to ICMS housing navigators
- Working closely with MCPs on how to expedite direct access to medically necessary services/supplies, field-capable ECM providers, and PCHS/IHSS

| 1 Supervising Psychiatrist | 10 Clinical Supervisors | Administrative Support |
|---|---|---|
| 2 Psychiatrist | 34 Psychiatric social Workers | 25 Administrative Staff |
| 6 Psychiatric Nurse Practitioners | 30 medical Case Workers | 1 Data Scientist |
| 1 Supervising Psychiatric Nurse | 8 Supervising Community Health Workers | |
| 10 Licensed Vocational Nurses | 40 Community Health Workers | |

# IHOP Update:

# Department of Public Health-
# Substance Abuse Prevention & Control
# (DPH-SAPC)

# DPH-SAPC IHOP Overview

**Substance Use Education**
- Individual
- Group
- specific curriculum focused on overdose and prevention for those at-risk of SUDs

**Harm-Reduction Support**
- Naloxone and Fentanyl Test Strips, Syringe Services


**Outpatient Substance Abuse Treatment**
- Individual
- Group

**Residential Substance Use Disorder Treatment**
- Dedicated beds to Co-Occurring Disorder population
- Supporting psychiatric social workers

**Medication Assisted Treatment and/or Ambulatory Withdrawal Management**
- Methadone

# DPH-SAPC IHOP Updates

- **November 2023:** Began supporting DHS in the SPA 4 pilot with in-kind Client Engagement and Navigation Services (CENS), on an as-needed basis
- **February 2024:** Received confirmation from DMH that CENS agencies can begin hiring and onboarding staff
- **February 2024:** CENS agencies in all SPAs were instructed to begin identifying, hiring, and onboarding staff for the IHOP team, with the goal of onboarding all staff by September 30, 2024
- As of **March 2024,** 10 individuals have been referred to the CENS
- **March 2024:** DMH/SAPC Departmental Service Order has been established

# THANK YOU!

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