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A qualitative evaluation of Housing for Health in Los Angeles County

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ABSTRACT

Homelessness is a widespread and challenging social and public health problem across the United States. Homelessness exacerbates poor health, social, and economic functioning. Permanent supportive housing (PSH) is a housing program model that provides housing as well as a range of supportive services to address co-occurring physical, mental, and social needs. The Housing for Health (HFH) program is modeled on PSH and was launched by the Los Angeles County Department of Health Services in 2012 with the aim of providing permanent supportive housing to individuals experiencing homelessness identified as frequent users of health services. This study uses data from 14 qualitative interviews with senior leaders and nine focus groups with tenants and program staff to understand tenant experiences with HFH and non-HFH programs, as they relate to care coordination. We report linkages to care and social services, variations in care coordination intensity, and the impact of workforce issues on tenant experience. The findings from this study underscore the value of housing programs that promote care coordination across service delivery sectors, and that adopt person-centered approaches to care. Lessons learned from programs like HFH are relevant for many stakeholders that may become providers of housing, as incentivized by recent Medicaid expansions.

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Introduction

Homelessness is a widespread social and public health challenge across the United States (HUD, 2020). In Los Angeles County, homelessness has been increasing steadily, with almost 59,000 homeless individuals registered in 2019, a 12% increase from the previous year (HUD, 2020; Greater Los Angeles … 2019). Compared to the general population, individuals experiencing homelessness typically suffer worse health, social, and economic outcomes, including physical health problems, HIV/AIDS, substance use disorders, and serious mental illness (e.g. schizophrenia) (Baggett et al., 2018; Clemenzi-Allen et al., 2019; Corrigan et al., 2015; LACDPH., 2015; Riley et al., 2007). Many of these conditions are only treated through frequent use of emergency room care (Baggett et al., 2010; Rehman & Wolff, 2019). At the same time, homelessness may result from accumulated adverse socio-economic and health conditions. The combination of health and socio-economic problems may be challenging for individuals long after they have been housed (Schick et al., 2019), underscoring the cyclical and complicated nature of homelessness, and the need to conceptualize and address it as a multidimensional issue.

Permanent supportive housing (PSH) programs are best positioned to address these chronic problems and help formerly homeless individuals stabilize in housing (Schick et al., 2019). PSH is an intervention model that provides housing and a range of supportive services to address co-occurring physical, mental, and social needs (Tsemberis et al., 2004). PSH programs assign persons who experience homelessness and complex medical and social needs to one or more case workers, place them in subsidized affordable housing units, and provide a broad range of health and other social and income support services within the community.

An important component of PSH is care coordination across the broad range of health and social services provided. Increasingly recognized as effective and efficient, (Craig et al., 2011; Greenberg & Rosenheck, 2010; Karper et al., 2008) care coordination takes a systems approach to organizing resources, such as staffing, finances, treatment planning, and logistics to better address tenant needs (Bunger, 2010). Processes that facilitate care coordination include the establishment of referral pathways and protocols for the exchange of individual-level case data between providers within and across service organizations (Bruder et al., 2016). Barriers to care coordination often occur due to constraints placed on information sharing or incompatible electronic platforms (Allen et al., 2013).

Care coordination is vital to enhancing tenants' experiences with the PSH program overall, insofar as it facilitates person-centered service provision

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(Macnaughton et al., 2018). Person-centered care is responsive to individual preferences and needs, and continuously provides tailored support (Institute of Medicine (U.S.), 2001). In practice, inconsistencies in care coordination affect continuity of care, and may undermine trust between PSH tenants and service providers (Deeny et al., 2017). For example, there are parallel approaches to coordination, whereby housing and socio-medical services are provided separately, under shared agreements across providers and institutions, but with each provider working in isolation (Øvretveit, 2011). Recent evidence suggests that this approach, which means tenants have multiple points of contact for service provision, may be too overwhelming for some tenants (Palimaru et al., 2021). Conversely, integrated approaches to care coordination are characterized by information sharing among organizations and service providers, and coordination through a single point of contact (Boon et al., 2004; McHugo et al., 2004). Evidence suggests that PSH programs with better integrated care coordination are more likely to have significant impact on housing stability (Baxter et al., 2019; Collins et al., 2013; Pearson et al., 2009), health (Chung et al., 2018), quality of life (Gadermann et al., 2017), criminal justice outcomes (O'Campo et al., 2016), and public service costs (Larimer et al., 2009; Ly & Latimer, 2015; Martinez & Burt, 2006). Yet gaps remain in understanding how care coordination affects tenants' experiences with PSH programs, especially given documented variation in how PSH principles are implemented across settings, for example, by funding structure and service delivery (Rog et al., 2014; Schick et al., 2019; Tabol et al., 2010; Wiktorowicz et al., 2019).

For example, Los Angeles County supports numerous housing initiatives across several agencies. The Housing for Health (HFH) program was launched by the Los Angeles County Department of Health Services (DHS) in 2012 with the aim of providing permanent supportive housing to individuals experiencing homelessness and who are identified as frequent users of health services. HFH incorporates both PSH and Housing First principles (Chen, 2019), whereby housing does not require that potential tenants be sober or in treatment for substance use or mental health disorders. Furthermore, unlike non-HFH PSH programs, HFH manages a "flexible housing subsidy pool" which can support expenses incurred outside of the scope of typical care coordination or case management, such as moving costs and utility assistance. In practice, PSH programs occur on a continuum, with variation and overlap across programs, which places HFH at the service-intensive end. It is important to underscore that many PSH programs in Los Angeles County have been evolving towards the service-intensive end of this spectrum.

This study examines tenants' experiences across the PSH continuum (HFH and non-HFH), specifically as these experiences relate to approaches in care coordination. From 2016 to 2018, the Los Angeles County Department of Public Health (DPH) conducted a mixed-methods evaluation of HFH, comparing HFH to non-HFH PSH programs, to gauge its effectiveness and its impact on service utilization and outcomes in other service delivery sectors. Using qualitative data from this evaluation, the current study aims to understand from the perspective of multiple stakeholders, how and why variations in PSH approaches to care coordination (in this instance both HFH and non-HFH) impact tenants' housing experiences. The findings can potentially inform enhancements of housing programs and supportive services for persons experiencing homelessness.

Methods

Program description

HFH tenants typically qualify for local rental subsidy vouchers (funded with local tax dollars) or federal vouchers. Through its flexible housing subsidy pool, HFH streamlines the fragmented housing subsidy opportunities across federal, state, and local programs, thereby expediting the tenants' application process. Tenants who benefit from PSH services (HFH and non-HFH) are expected to pay 30% of their income (e.g., 30% of Supplemental Security Income) towards their rent. For tenants whose housing voucher does not fully cover the rent, HFH pays the difference, a process similar to that used for federal vouchers.

Both HFH and non-HFH programs tend to serve individuals who are high utilizers of emergency services. However, the essential distinction of the entry pathway to housing placement through HFH is that the referrals come directly from health providers via the Los Angeles County Department of Health Services (LAC DHS) within a coordinated outreach system that reduces duplication of services and includes the county's Coordinated Entry System (CES). Non-HFH referrals occur only through the CES. The CES is a core component of the housing resources and services network in Los Angeles, administered by the Los Angeles Homeless Services Authority and used by providers in all eight Service Planning Areas of Los Angeles County. The CES is designed to coordinate, centralize, and monitor client entry into homeless and housing services through one gateway, which captures any individual experiencing homelessness with a Service Prioritization Decision Assistance Tool (SPDAT) assessment and attendant acuity score.

HFH includes a comprehensive set of care coordination activities that are supported by a flexible housing subsidy pool, streamlined data systems and

administrative processes, and intensive case management services (ICMS). The flexible housing subsidy pool combines funding streams from LAC DHS, a nonprofit coordinating community-based partner, and property owners throughout the county (DHS, 2019). The centralized data system, known as Comprehensive Health Accompaniment Management Platform (CHAMP), has a dashboard that facilitates submission of referrals, creation of case notes and client profiles, permanent housing updates, and authorization forms (DHS, 2019). ICMS differs from traditional case management in that it follows a "whatever it takes" approach to meet tenant needs and help tenants become self-sufficient. ICMS begins at first contact with a client, and continues through intake and assessment, linkage to housing, move-in, and linkage to medical and social services (DHS, 2019). The HFH model, including its flexible housing subsidy pool and ICMS elements, has been adopted in at least two other counties in California, with some variation in approach to care coordination (Palimaru et al., 2021).

One advantage of HFH is that most tenants experience case manager continuity between program screening and during housing. Once housed, HFH requires that case managers meet with each tenant at least monthly (i.e., managed at high acuity level), for the first three years, then they automatically step down in acuity and continue to be managed at low acuity level (DHS, 2019). For tenants who destabilize after the three-year period, DHS reviews their case and they may resume high acuity case management (DHS, 2019). Tenants can be allocated housing units at either a project-based site (i.e., an entire building with tenants who are part of the same or similar housing programs, that hosts some services on site, including case management) or a scattered site (i.e., units in regular residential buildings where tenants live among tenants who are not necessarily recipients of housing vouchers or permanent supportive services).

Under HFH, services provided on site include health clinics and wellness programs, life skills classes, self-improvement and nutrition courses, group therapy, and in-home care. Program case managers also facilitate tenant access to additional off-site services, such as transportation to food banks, specialist care, support groups, legal counseling, and recreational activities. HFH tenants residing in scattered site units typically travel from their housing units to an organization's main offices in order to receive services such as those noted above. However, case managers make regular home visits, and in-home supportive services can be provided to those residing off-site as well.

Participants in non-HFH on-site projects also receive on-site services, but generally support is more limited compared to HFH sites, even when the need for support may be comparable. Off-site services, such as access to specialist care, are facilitated by a case manager when the tenant requests it, and access may depend on individual circumstances and eligibility. Similar to HFH, non-HFH tenants in scattered sites must travel to receive most services. Non-HFH PSH programs do not require monthly meetings between tenants and case managers.

Participant recruitment

We recruited participants separately for in-depth interviews (with senior leaders only) and focus groups (with tenants and program staff, such as case and program managers). Purposive sampling was used for the 14 in-depth interviews and convenience sampling for recruiting four program staff ($N = 29$) and five tenant ($N = 42$) focus groups.

Senior leaders and program staff were eligible to participate if they were in senior leadership, administrative (program managers) or provider (case manager) roles within the county's agencies that provide permanent supportive housing programming or agencies in related sectors, such as public health and social services. Administrative and provider participants had to have worked in HFH or non-HFH programs for at least 6 months. Tenants were individuals who had experienced homelessness and were eligible to participate if they were current HFH or non-HFH PSH tenants, 18 years of age or older, and had been living in permanent supportive housing for at least six months.

Interview participants were sampled from a known list of leaders within relevant county agencies. This list was supplemented with recommendations from HFH partners, who identified key senior administrators in the arena of homeless and related services. Focus group recruitment of program staff and tenants was assisted by HFH and non-HFH program administrators. Focus group recruitment occurred at both project-based and scattered sites. The housing sites were purposefully selected to ensure diversity (i.e., HFH and non-HFH, geographic spread throughout the county, with services provided by different agencies). Program staff were recruited through informational meetings, descriptive fliers and email communications. Tenants were recruited through informational meetings, fliers posted in common housing areas, and direct referrals from program and case managers.

All recruitment, data collection, and analytic procedures were approved by the DPH/DHS Institutional Review Board (IRB #2017-08-702). We obtained oral consent by reading aloud the study's consent form detailing the objective of the study, and associated risks and benefits, and providing a printed copy to all participants. Professional participants did not

Table 1. Sample questions from our interview and focus groups protocols.

Domain	Sample questions
Domain 1 Permanent Supportive Housing (PSH) Characteristics	In your opinion, what are the defining characteristics of PSH programs? *(senior leaders)* What do you think are the most important client-level outcomes that Permanent Supportive Housing programs seek to improve? *(senior leaders)*
Domain 2 Comparisons of PSH and Housing For Health (HFH) Model	In what ways, if any, does Housing for Health differ from other Permanent Supportive Housing programs? *(senior leaders)* Has anyone here worked with other permanent supportive housing programs besides Housing for Health? If so, have you noticed any differences? If so, can you share what those differences are? *(program staff)*
Domain 3 HFH Outcomes: Intended and Actual	What do you think are the client outcomes that Housing for Health seeks to affect or improve? *(senior leaders)* What do you see as the greatest impacts of the Housing for Health Program on client outcomes? (Probes: housing stability, health, health care utilization, family reunification, linkages to services, etc.) *(program staff)* What specific elements of the Housing for Health Program are impacting those outcomes? *(program staff)* How does your current situation compare to your situation before you got housing? *(tenants)* Since moving to the supportive housing location you're in now, have you noticed any changes in your health and well-being? If so, what has changed?*(tenant)* What, if anything, is it about your living situation that you think has led to these changes? *(tenant)* If you were not currently living in supportive housing, how would that affect you? In the short term? In the long term? *(tenant)*
Domain 4 HFH Linkages to and Impact on Other Sectors	How, if at all, does Housing for Health impact government agencies and service program staff in sectors outside of health care (e.g., criminal justice, social services, substance abuse, mental health)? *(senior leaders)* What are the most common client needs that require a referral to services outside of your agency? *(program staff)* What has been your experience working with referral program staff? (Probe: Are there any that you find to be particularly helpful/effective?) *(program staff)* What process do you follow to provide clients with linkages and referrals to services not available at your agency? *(program staff)* In addition to housing, what other services do you know of that are available to you? *(tenants)* What services have you participated in since you moved to your current location? *(tenants)* How did you decide what services you needed and/or which ones you would use? *(tenants)* How were you connected to those services? *(tenants)*

receive any incentive, but we offered $20 gift cards to tenant participants.

Data collection and analyses

We designed the interview and focus group protocols to elicit depth and perspective regarding tenant experience of PSH programs (HFH and non-HFH), the housing placement process, their current living situation, linkages to and utilization of supportive services, gaps in services, the role of the case manager(s), outcomes, and recommendations for improvement. Table 1 shows a sample of the questions from the interview and focus group protocols. (The full protocols are available upon request.) Interviews and focus groups were conducted by the two lead authors, who have extensive qualitative methods experience. The in-depth interviews were conducted by phone between October 2017 and January 2018. The nine focus groups were conducted between October and December 2017. Recruitment for tenant and case manager focus groups distinguished between HFH and non-HFH, such that there was no mixing of HFH and non-HFH participants. However, some case managers had experience with programs across the PSH continuum. Interviews lasted approximately 60 minutes, while focus groups were about 90 minutes long. All interviews and focus groups were fully audio-recorded and transcribed verbatim. Prior to each focus group, participants answered brief demographic surveys, including questions about age, gender, race/ethnicity, and education level. In addition, program staff offered information about their professional field, length of time working in PSH and/or HFH, where applicable. Tenants answered questions about total number of household members, and time spent housed in PSH or HFH program. No identifiable information was included in our notes, transcriptions, or surveys.

All transcripts were uploaded to Atlas.ti to facilitate data management, coding, analysis, and interpretation. Using a mix of inductive and deductive reasoning, the two lead authors worked with the larger research team to develop a codebook (Bernard & Ryan, 1998; MacQueen et al., 1998; Ryan & Bernard, 2003). Pre-identified domains based on the interview guides, as well as open and *in vivo* coding were used to establish categories and themes (Charmaz, 2006). Open coding refers to labeling interview content based on dimensions emerging from it (Charmaz, 2006). *In vivo* coding means assigning code labels using words or short phrases directly from the text (Charmaz, 2006). Coding was performed in multiple rounds, each consisting of at least two research team members coding the same content independently, then meeting to reconcile discrepancies and substantive differences of interpretation. The first and second authors also presented periodic updates to the

research team, eliciting feedback on coded content, code definitions, combining and splitting sub-codes, and coding rules. We analyzed the final output within and across groups, such as HFH vs non-HFH program staff and HFH vs non-HFH tenants.

Results

The interviewed leaders represented multi-sectoral agency administrators, funders, providers, and other leaders in public and private sectors. Table 2 shows focus group participant demographic characteristics. Among tenant participants, the mean age was 57 (range 28–71 years), 57% were male, one-third identified as Black/African American, one-third identified as White, and 20% as Hispanic/Latino. Sixty percent of tenants were in HFH programs, and 45% said they were in project-based sites. Among program staff, the mean age was 37 (range 24–60 years), 45% were male, 41% identified as Hispanic/Latino and 34% as White. One-quarter of program staff had experience with both HFH and non-HFH PSH programs, and more than one-third had experience working with tenants at both project-based and scatter sites. Some tenant participants ($n = 5$, 12%) were unable to describe the type of housing arrangement (project versus scatter) from which they benefitted.

Across the leadership interviews and provider and tenant focus groups, nine main themes and dozens of subthemes were identified overall: movement towards Housing First model, characteristics of PSH, differences across PSH programs, distinct features of HFH, HFH added value, HFH-related tensions, HFH impact on tenant outcomes, barriers to housing stabilization and facilitators of housing stabilization. For the purpose of this analysis, however, we focus on the themes and subthemes that relate to the tenant experience with care coordination: linkages to care and social services, variations in care coordination intensity, and the impact of workforce issues on tenant experience.

Table 2. Focus group sample demographics.

Category	Program staff ($N = 29$)	Tenants ($N = 42$)
Age (mean, range)	37 (24–60 years)	57 (28–71 years)
Sex (*N*, %)		
Male	13 (45%)	24 (57%)
Female	13 (45%)	18 (43%)
Unknown	3 (10%)	–
Race/Ethnicity (*N*, %)		
Black/African American	5 (17%)	14 (33%)
White/Caucasian	10 (34%)	14 (33%)
Hispanic/Latino	12 (41%)	8 (19%)
Asian	–	2 (5%)
American Indian	–	2 (5%)
Unknown	2 (7%)	2 (5%)
Type of PSH		
Housing for Health (HFH)	12 (43%)	25 (60%)
Non-HFH	9 (32%)	17 (40%)
Both	7 (25%)	–
Housing Site		
Project-based	10 (36%)	19 (45%)
Scattered	8 (29%)	18 (43%)
Unknown	–	5 (12%)
Both	10 (36%)	–

Linkages to care and social services are better coordinated in HFH

An important advantage of PSH programs in general is that the services vouchers are connected to the individual in the program, rather than to a specific housing complex. This applies to both project-based and scattered site housing, although some project-based sites also have subsidies tied to units. In practice this means that services follow tenants as they move from one housing site to another. Along the PSH continuum of care, linkages to care are tailored based on comprehensive tenant screening, to ensure that each person is referred to the services that are best suited for their needs. As one interviewee put it, once individuals are accepted into a PSH or HFH program:

> […] they're additionally screened by their housing navigation staff to make sure we haven't missed anything because if somebody would much more benefit from a different type of programming, or housing, we wanna make sure we've attached them to anything that we possibly can that they're comfortable with. (I 1)

However, compared to non-HFH programs, leaders observed that HFH provides more care continuity across the trajectory of the housing stabilization process (from homeless, to housed, to stabilized) and across a comprehensive network of stakeholders (traversing multiple sectors, service agencies, and providers serving diverse client populations). In terms of tenant experience, even when service quality may be similar for both HFH and non-HFH tenants, HFH may be advantageous because it is less fragmented, as this leader described:

> I think those other [non-HFH] programs, though the level of services quality is the same, they may not be able to work with the client all the way from homelessness to housing. There may be a program that steps in in the beginning while they're homeless and then there's a new program that they get connected to for stabilization once they're housed. Both those types of models work. But I definitely think it's also nice for the client to have the continuity of services when they're working with one team from the beginning to the end. (I 2)

Another leader provided a slightly different point of view, suggesting that the HFH model does not offer more services than other PSH programs, and in fact, providers are often the same across PSH programs. However, HFH draws its strength from its care coordination approach, such as the service linkages across organizations:

> I don't know that the Housing for Health model offers any specific additional supportive services that are exclusively available. I think they're largely leveraging the linkages of that contractor, that that ICMS contractor is paying for. I think they [HFH] list a minimal set of standards that the partnership have, but to be honest that's true for any program and at this point the same providers are used for any program really, any Permanent Supportive Housing project or program. (I 5)

While still a work in progress, many leaders recognized that HFH is leading the way in streamlining documentation and reporting protocols across organizations. As one interviewee explained, centralized documentation and reporting of data as needed to the relevant departments means that the care coordination process is "more fluid and easier" (I 2).

Program staff noted that the first services they try to connect their tenants to typically include medical care, mental health care, and income benefits. As one participant explained,

> The first thing that we always focus on is their health, how they're connected. Making sure that they're going to be stable once they move in and they're connected so you don't have to worry about their health declining once they've moved in. (HFH Program Staff, FG-1)

Many tenants reported seeing doctors regularly and having fewer ER visits. HFH tenants reported improved physical and mental health, an overall sense of well-being, better nutrition, better sleeping patterns, higher energy levels, and a newfound ability to empathize and socialize with other people. Improvements in health were specifically mentioned by tenants with serious chronic conditions, as one tenant said: "I've improved a lot because I had lymphedema really bad when I came. Eventually I was able to get SSI so my physical improved, my mental improved, my financial improved. I'm doing better." (HFH Tenant, FG-3)

Care coordination intensity varied between HFH and non-HFH programs

A key difference between HFH and non-HFH programs was the intensity of the role assumed by case managers. In particular, the intensive case management services (ICMS) contracted through HFH were noted for having a lower caseload and for providing more time and attention to tenants and facilitating linkages to a broad range of desired services and supports. Program staff explained that HFH tenants are typically assigned a case manager who handles their administrative processing, housing situation, access to services, and generally advocates on behalf of the tenant whenever the need arises. HFH tenants are encouraged to meet with their case manager as often as necessary and case managers are required to make regular attempts to reengage with tenants with whom they have not interacted. HFH case managers reported that the frequency of meetings with tenants varied from once a week to once every couple of months to an "as-needed" basis. The intensive nature of case management under HFH facilitates the care coordination process, as noted by one leader:

> It's very intensive, time intensive. For example, with primary care visits or mental health visits the case managers accompany them [the tenants] to the visits and sit with them in the waiting room, talk with the doctors, with the psychiatrists, and then also do case conferencing with the team of different professionals to make sure that nothing falls through the cracks and they can problem solve together. So, I think it's like the level of intensity is a little bit higher with this project than the normal Permanent Supportive Housing. (I 6)

By contrast, non-HFH tenants reported having separate case workers for their housing services and their rehabilitation services respectively. Case management with non-HFH tenants was described as more fragmented and less prescriptive, especially between the services and housing components, and some case managers reported that tenants maintain little or no contact with them. Nevertheless, both HFH and non-HFH tenants explained that the care support and guidance they received from their case managers helped to remove a considerable amount of daily stress, such as having to organize transportation to see a doctor. The resulting peace of mind helped them better cope with pain and with managing their long-term conditions.

Many HFH tenants spoke positively about their case managers, crediting them with their survival, providing structure to daily life, and overall improvement in their quality of life. Case managers were generally perceived as extremely helpful and crucial to tenants' stabilization, and were described as kind, patient, resourceful, and having good listening skills. For most, the case manager serves as the first port of call for any issue or query they might have. Being assigned a case manager who was close to the tenant's age was perceived by some as a facilitator in their relationship. For example, one aging tenant said they connected better with the case manager who was closer in age, than to the younger interning case worker.

Some non-HFH tenants also noted that their case workers were very helpful and resourceful, including by identifying volunteer opportunities:

> If you approach staff here, they can make almost anything available to you. They have unlimited resources to point you in the right direction. And they will assist you. They'll go with you. I mean, you just have to open your mouth and ask. Yeah. It's all there. I

> haven't found anything that I've been in need of that it wasn't available. (Non-HFH Tenant, FG-9)

Across the PSH continuum, reported outcomes resulting from care coordination include being stabilized in the housing unit (housing retention), a decrease in detrimental behavior like substance use, improvement of overall physical and mental health, and community engagement, often through improved life skills, volunteering opportunities, and engagement with peer groups or tenant groups. In addition, low recidivism rates were mentioned for tenants previously involved in the justice system. Some unintended, but beneficial, outcomes are not tracked in the system but were shared informally by several interviewed leaders (e.g., reuniting tenants with their families).

Tenant experience may vary due to workforce issues and case manager turnover

Some leaders noted that, across PSH programs, tenant experience could vary in quality due to differences in level and quality of staffing. To address this variation, HFH requires that all case managers who are funded through HFH undergo a 10-month training program, followed by on-going in-service training. Some organizations focused on hiring staff who were caring and connected to the community in some way, but not professionally trained, while other organizations worked within a more hierarchical structure in which they hired a more highly trained and professionalized staff, and built-in mentorship and supervisory roles. As this interviewee from an HFH-funded organization described:

> Our teams are comprised of a Master's level and Bachelor's level staff and we have a program manager and they're all with a supervisor who's generally a licensed clinician. Then there'll be somebody in one of those positions who also has some kind of substance abuse experience or background. So I think our model tends to be a lot less grassroots and a lot more sophisticated in some ways because we're hiring licensed clinical social workers and licensed marriage and family therapists to supervise the staff working with you. (I 3)

Interviewed leaders mentioned that shortages of highly qualified case managers have become a significant issue for PSH programs across the County, underscored by a combination of factors, such as the unique high acuity needs of tenants with psychiatric and medical co-morbidities, the limited appeal of this type of work, burnout, the costs of behavioral health training, and slower board registration processes that may prevent hiring of social workers.

Both HFH and non-HFH providers also brought up the issue of insufficient staffing, especially as needed to support high acuity tenants. Some described tenants acting out occasionally, even becoming physically violent toward staff. A few HFH providers pointed out that even when their case load balances high- and low-acuity tenants, the demanding nature of some cases can be such that even one complex tenant can disproportionately strain case manager workload. One non-HFH provider explained that PSH case managers are generally underpaid, while HFH providers spoke at length about the need for more staff support to help prevent burnout. They noted that there are not enough services/supports, particularly for dealing with substance abuse and mental health issues, which compounds an already stressful work environment. For tenant issues that they cannot address directly, they also experience barriers when attempting to refer clients to specialty care (i.e., mental health, behavioral health) as some partnering agencies are also overwhelmed and lack capacity (e.g., Department of Mental Health).

> I think it's very challenging because they're spread thin, DMH [Department of Mental Health]. We're spread thin. So it's difficult. It puts us in a very difficult situation. It's [name] and myself. Luckily we have interns that come in and provide some support. (Non-HFH Provider, FG-6)

Numerous HFH and non-HFH tenants complained about the effects of case manager turnover. They explained that it was particularly difficult, especially after they had opened up and established a trusting relationship with their initial case manager, to have to get to know and trust someone else. A tenant reported having had 5 case managers in two years. One participant explained:

> Because of our unique disabilities here, it could take a while for the trust to build up to the social worker. And just as you're starting to get comfortable, they're gone. And you have to start all over again. (Non-HFH Tenant, FG-9)

Another explained that turnover is particularly painful when tenants attach themselves strongly to their case manager and then experience a sense of abandonment: "It's like why do I open up? Because we be really opening up telling them some personal stuff that hurts to even talk about and then have to keep on doing it over and over." (HFH Tenant, FG-7)

Discussion

Using multiple stakeholder perspectives, this study contributes to the literature on the effectiveness of PSH models, specifically focusing on approaches to care coordination, and illustrating how and why PSH programs (HFH versus non-HFH) affect tenants' housing experiences and outcomes. Overall, this study shows that there are components of strength in HFH that better facilitate service provision, coordination

and utilization by tenants compared to non-HFH programs, such as flexible funding, ICMS, continuity of care, and centralized in-take and reporting. However, HFH and non-HFH programs share a set of systemic challenges, including the complex, time-consuming nature of working with high acuity clients, undersupplied mental health services, case manager turnover, and staff shortages, which may undermine some of the benefits of the HFH approach. The findings could help inform the design of meaningful enhancements to housing programs and supportive services.

First, worth noting is that the HFH program itself evolved within the timeframe of this study. For example, whereas initially HFH had focused more specifically on engaging and housing individuals who were high utilizers of medical services, it soon broadened the target population to include more highly functioning individuals. As noted by some senior leaders during the interviews, the distinction between HFH and non-HFH programs on the PSH continuum became less clear, as some non-HFH programs were setting their care coordination and funding standards by the HFH program and the Housing First approach, i.e. house people first, then provide intensive support and access to services. However, among PSH programs there is significant variation in capacity and available staffing resources, which can modify program effectiveness and tenants' housing experiences. This supports concerns expressed elsewhere about the inconsistent implementation of Housing First and possible lack of fidelity (Chen, 2019; Rog et al., 2014; Tabol et al., 2010).

One clear distinction of HFH-funded programs, however, is a strong emphasis on care coordination with cross-sectoral linkages made to a broad array of functional and instrumental supports. These connections were likely facilitated by the lower case management ratio supported by the HFH approach, as well as the streamlined administrative protocols across organizations. Tenants are encouraged to engage with their assigned case worker(s) at least once a month, to identify and connect to a range of services from which they may benefit, including physical and mental health care, substance use treatment, transportation, employment, and income support. Intensive case management service staff are required to re-engage and maintain a relationship with tenants whenever possible. This requirement establishes accountability between the tenant and the program, reminds the tenant that support is available if they want it, while also bringing structure to the lives of individuals who may have not had any for a long time.

Tenants' experiences with care coordination across the PSH continuum were generally positive, especially the linkages to health services. However, we found agreement among leaders, program staff, and tenants with regard to the perceived better outcomes achieved by HFH, which include housing retention, a decrease in detrimental behavior like substance use, improvement of overall physical and mental health, and community engagement, often through life skills, volunteering, peer groups, or tenant groups. These findings complement previous evidence evaluating such outcomes quantitatively, and indicate that successfully achieving these outcomes depends on the nature of the care coordination approach (Baxter et al., 2019; Chung et al., 2018; Collins et al., 2013; Gadermann et al., 2017; Larimer et al., 2009; Ly & Latimer, 2015; Martinez & Burt, 2006; O'Campo et al., 2016; Pearson et al., 2009). For example, evidence suggests that successful PSH programs depend on case managers who can be the single point of contact for a client, addressing questions and referrals across the care continuum (Kerman et al., 2019).

Leaders and providers in this study commented on the importance of workforce quality to the tenant experience. This aligns with findings elsewhere that underscore the importance of training and promoting specialist qualifications among case managers (Souza et al., 2020). Broader system issues, such as workforce shortages, will require policy interventions at the federal and state level, and across sectors, such as education and health. Unique findings regarding the importance of the age match between case manager and tenant should be further investigated, as they are highly relevant to policy improvements.

Lessons learned from programs like HFH are relevant for many other stakeholders that may become providers of housing programs. For example, recent expansion in Medicaid coverage has made it appealing and feasible for healthcare systems to take on financial risk by funding and implementing housing programs for their highest service utilizers (Kuehn, 2019; Wilkins, 2015). As they do so, they ought to account for tenant experiences, such as the ones detailed in this study (e.g. the need for care coordination), while at the same time tailoring housing provision to suit constraints and opportunities in their own settings.

Limitations

Qualitative research has some general limitations. First, generalizability of our findings is hindered by the relatively small sample size and the fact that our participants come from a large urban area in southern California, so they may not be representative of experiences across the US. However, the team-based, systematic analysis of the data produced a coding process that was rigorous and mitigated potential biases in terms of content and focus. Also, the aim of qualitative inquiry is not to be generalizable but rather to gain a richer and more in-depth accounting of a particular phenomenon: in this case, the experiences and

observations of multiple stakeholders of PSH in Los Angeles County.

The study is also limited by the potential for self-selection bias as those who agreed to participate may be systematically different than those who did not participate. For instance, the participants represented in this report may, on average, be more social, more engaged, and/or have a stronger point of view than those not represented. In addition, while the in-person focus groups conducted in project-based housing sites proved to be an effective way to reach some tenants and program staff, this approach may have excluded others with specific challenges (e.g., tenants with functional disabilities, mental health concerns, or substance use issues) that limit mobility and/or preclude or discourage participation in tenant/communal meetings. Additional limitations include the fact that, because all data collection was conducted in English, the views of people with no or limited English proficiency are excluded.

Conclusion

The findings from this study point to the value of housing programs that promote linkages and care coordination across service delivery sectors, and that adopt approaches to care that not only put housing first, but importantly put the person first. Aspects of the HFH program can be implemented elsewhere: in particular, the principles of person-centered care, the recognition that housing stabilization is a product of both individual agency and self-determination, as well as supporting equitable access to a well-designed and connected network of services and supports. Housing programs would also benefit from focusing on integrated service coordination and the flexible subsidy housing approach.

Numerous provisions of the Affordable Care Act (e.g., Medicaid expansion, Medicaid Health Homes, Whole Person Care initiatives) support the types of care coordination and service integration efforts described here (DiPietro et al., 2014; Mechanic, 2012; Turk & Hudson, 2017). Local communities that are dedicated to addressing the needs of their homeless and recently housed populations can leverage these policies to advance programs like HFH that span across the public and private sector to increase housing stability and improve the health and well-being of all members of the community.

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