

LOS ANGELES COUNTY



Driving Transformative Change in Los Angeles County Initial Steps and Future Plans

Chief Executive Office



Prepared for
County Board of Supervisors

APRIL
2016

*The greatest danger in times of turbulence is not the turbulence
– it is to act with yesterday's logic.*

Peter Drucker

Meeting Challenges Differently

It has become commonplace to describe today's public sector environment as increasingly uncertain, complex, turbulent and even chaotic. As noted by Peters and Savorie, "the policy environment is marked by an accelerated rate of change."¹ At the simplest level, this can be attributed to an unrelenting rate of social and technological change and the realization that the "old rules" do not work. Consider for example, the policy debates and the often emotional search for agreement that have emerged within the last decade:

- Access to affordable health care including access to mental health treatment;
- Individual and societal consequences of income inequality and a call for a livable wage;
- Scrutiny of law enforcement techniques and the call for community based policing;
- Prevention and amelioration of homelessness; and
- Investments in information technology, public education, and social services.²

These challenges (and many more) occurred while government at all levels – federal, state, local – had to contend with the Great Recession (2008-2014) and the accompanying fiscal limitations on programs and services.

¹Peters, B. and Savoie (Eds). (2001). *Government in the 21st Century: Revitalizing the Public Service*. Montreal: McGill-Queens University Press.

² In a prescient 1989 book, Peter Vaill foresaw an extended era of "permanent white water," where emergent challenges and changing public expectations would affect every major aspect of the economic, political, and social spheres of society; accordingly, all sectors would need to rethink their ways of doing business (Vaill, Peter. 1989. *Managing as a Performing Art*. San Francisco: Jossey Bass.

It is expected, however, that even during a robust economic recovery, both existing demands and the constant appearance of new needs will challenge our organizations, while the combined resource dollars will remain constrained relative to what is needed.³ As a result, there is an emerging consensus among academicians, public administrators, and elected officials that government will need to do "business" better, differently. Simply stated, government leaders will need to increase their organizational capacity. For many government agencies this will require deep introspection of their current structures, processes, and even individual role responsibilities as they try to meet the expectations of their constituents.

This report highlights some of the bold actions taken by the Los Angeles County Board of Supervisors – actions aimed at meeting our local challenges.⁴ Additionally, this report provides a policy and operational agenda – based on Board discussions – for the next year.

Response from the Board of Supervisors

As noted in several Chief Executive Office (CEO) reports issued during 2015, the Board of Supervisors has forcefully adopted an expansive policy-oriented agenda aimed at resolving some of the most challenging and long standing issues confronting the County:

- Streamlining and integrating access for those needing multiple, high quality and comprehensive health services through the

³ See, for example, IBM Center for the Business of Government, Special Report Series, *Six Trends Driving Change in Government*, 2013.

⁴ A separate reference notebook accompanying this report contains materials related to Board actions during 2015, including motions, reports, and correspondence. It should be noted that in several areas, such as child protection and homelessness, the County is the provider of last resort.

integration of the Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH) into a single Health Agency;

- Enhancing the County’s child safety network by adopting and implementing the 65 recommendations of the County’s Blue Ribbon Commission on Child Protection, including the establishment of an Office of Child Protection responsible for “leading a broad partnership that implements meaningful solutions to improve the lives of children and families;”⁵
- Responding to and reducing the incidence of homelessness among the County’s vulnerable populations, including the development of a comprehensive, multi-faceted plan; and
- Diversion of low level criminal offenders from County jails and new efforts to reduce jail violence.

Additionally, the Board has introduced and adopted motions on child sex trafficking, cross-departmental information sharing, performance accountability and outcome measurement, and Pay-For-Success.

The Implications for County Governance

Given the scope of the issues undertaken, the depth of analysis needed to gain a deep understanding, and the intensity of debate between stakeholders and within the Board, the Board approved changes to the existing County governance model, establishing a more flexible and adaptive organization positioned to quickly respond to a dynamic environment.⁶ Three of the

⁵ Office of Child Protection, Mission Statement

⁶ In the CEO’s July 15, 2015 County Governance Report, it was stated that the 2007 internal governance structure

most significant aspects of the change have now become apparent:

- The Board has held an increasing number of policy debates thereby increasing public understanding of the complexity of the issues and transparency regarding policy decisions, next steps, and resource allocation;
- The CEO has become the focal point for implementing Board policies. This has included the best practice of (a) identifying an organizational expert to lead each initiative; (b) pulling together multiple departments to leverage their professional knowledge and skills; and (c) obtaining high involvement, public participation and on-going feedback throughout the process; and
- The County organization has developed an overlapping, unified approach to policy development, strategy, and implementation with identified role accountability at each level. There is growing awareness throughout the organization that the Board, CEO, and Departments are working collaboratively to produce synergistic results and that Departments need to adopt a similar framework when the delivery of programs and services require Department-to-Department coordination.

In January 2016, the Board approved a major reorganization of the CEO to (a) solidify the office as a budget-strategy making hub supporting the Board’s priorities; (b) place greater emphasis on the strategic use of

had become “excessively hierarchical, and resulted in administrative and bureaucratic delays, moving governance toward a tighter control model. Consequently, the Board offices were increasingly buffeted from content experts housed within departments and lacked a “sufficiently active role in setting policy on important County issues.”

information technology and accountability for strategic asset management; and (c) increase the internal “nimbleness” of the office to quickly respond to emergent demands by the Board.⁷

The Cultural Shift Imperative⁸

From the beginning, the Board understood that success in driving large-scale, transformative change was inextricably linked to a parallel change in County culture – the need to breakdown the traditional hierarchy and strong bureaucratic silos as the primary operating structure. As summarized by the CEO in the January 2016 reorganization report:

“The Board has envisioned a new County culture, characterized by cross-boundary collaboration, increased dialogue and communication, quick and effective responses to emergent needs, and a willingness to rethink how work is organized, while delivering high quality performance. The Board’s envisioned culture incorporates:

- *Policy agenda that is issue-oriented;*
- *Analysis that is multi viewpoint-oriented;*
- *Accountability that is outcome-oriented;*
- *Decision-making that is transparency-oriented; and*
- *Implementation that is integrated and network-oriented.”*

⁷ For example, at the beginning of 2015, the Board identified child protection, health integration, jail oversight as priority initiatives and ordered the CEO to set in motion the steps required to resolve. As the year progressed, the homeless crisis emerged as needing immediate action; the CEO organization had the ability to respond in a timely matter, thereby establishing the County as the regional leader.

⁸ Organization culture refers to the assumptions, beliefs, and values on how to succeed in an organization, thereby signaling how work is to be done and how employees should interact with each other. Culture is often described as the most powerful social determinant or behavior.

Thus, contained in nearly all motions requiring multi-department action(s), there are unequivocal guidelines describing behavioral expectations. The Board’s own language fall into four general domains:⁹

- Set 1: flexible management structures and streamlined governance;
- Set 2: increased communication;
- Set 3: enhanced transparency, promoting information sharing and accountability; and
- Set 4: inter-departmental partnering, and partnering with community agencies.

It is important to note that the County’s managerial leadership has adopted this approach and the County can now point to evidence of the benefits of working within four of these domains to address extremely complex issues. The four examples are illustrative:

1. **Operationalizing the Office of Child Protection.** Using the Board motion as a backdrop, the initiative team leader brought together 12 Department Heads (ranging from the Director of Children and Family Services to the Librarian) to develop the initial vision, mission, and value statements and subsequently, to help tease out the initial goals and strategies. Throughout, the process was informed by public convenings in supervisorial districts to obtain both a better understanding of community dissatisfaction with the existing systems and direct input on priority needs. Currently, many initial recommendations have been implemented and a longer-term strategic plan is nearing adoption;
2. **Securing Agreement on Information Sharing.** For many years, information sharing between departments/across domains (even when focused on the same

⁹ Each set contains the actual words from different Board motions.

client needing multiple services) was limited by claims of confidentiality and/or mismatched information systems. This year, 12 County Counsel attorneys and 7 Departments (DPH, DHS, DMH, District Attorney, Sheriff, Probation, and the Department of Public Social Services (DPSS) developed a County Protocol to assist the Department of Children and Family Services (DCFS) during the investigative process. Work has begun on creating an electronic portal to expedite access to this information. This protocol has received statewide recognition for its innovative approach;

3. **Leadership on Homelessness.** The explosion of the homeless population demonstrated the ability of the new governance process to respond quickly to an urgent situation. Sequentially, the Board debated and passed a series of policy motions, the CEO choose an initiative team leader and provided staff support, and multiple County Departments offered initial input, innovative ideas, and support for responding to the situation. Then, in large part, due to the swift response, the County's ad hoc initiative team developed a series of briefing papers and initiated a powerful cross-sectional coalition of cities, nonprofits, and volunteer groups to attend issue-oriented, solution-driven convenings. As a result, the County plan has received widespread accolades and implementation has been initiated. The County is now positioned to be a national leader in addressing homelessness through integrated services and cross-section collaborations; and
4. **Establishing the Office of Diversion and Re-entry.** Recognizing that involvement in

the criminal justice system cannot address mental illness and substance abuse issues, the Board articulated a strategic vision to address this long-standing, and growing problem. In response, several Departments, including the District Attorney's Office, Sheriff, DMH and DHS have begun diverting individuals from the criminal justice system into mental health and substance intervention treatment programs. Moreover, these Departments and community partners are working to implement a more standardized diversion assessment tool to better identify and divert those at risk of homelessness.

In summary, the decisions by the Board to: (a) address some of society's most difficult challenges in a meaningful way; (b) restructure the governance process to increase policy analysis and debate; (c) align the CEO to create a more nimble, strategic Department capable of supporting Board actions; and (d) initiate the cultural changes required to achieve success at the operational level has built a foundation for a more effective and efficient organization. Indeed, based on the 2015 achievements, the Board and CEO are formulating an equally ambitious agenda for 2016.

The Preliminary 2016 Agenda

In 2015, this Board turned its attention to key areas – areas identified as the priorities amongst multiple and conflicting priorities. In 2016, more work remains to be done. This work requires the Board's policy setting focus, the CEO's strategic coordination function, and County Departments' and private sector's implementation efforts. What follows is a high-level overview of 2016 priorities.

Critical Issues

Sustainability: This Board has adopted several motions related to sustainability to support County initiatives related to energy, water efficiency, conservation, and environmental stewardship. In 2016, focused attention will be given to these initiatives and other Board policies driving County sustainability efforts.

Economic Development: This Board has adopted several motions driving policy related to economic development. The Board's vision of economic development falls along a broad continuum ranging from attracting, retaining, and supporting businesses to financially empowering residents to gain more control over their economic future. The balance of 2016 will reflect focused efforts to implement Board policy governing the area of economic development.

Homelessness: The Board has adopted the 47 recommendations promulgated by the Homelessness Initiative. The remainder of 2016 will evidence sustained focus on implementation of the 12 homeless recommendations identified as Tier I recommendations.

The Probation Department: As the Probation Department rebuilds its executive team, the County continues to confront the challenges posed in serving the AB 109 population and minors in our juvenile justice system. 2016 requires the County to rethink the way the County addresses the needs of both of these populations.

Other Key Issues

In addition to the critical issues identified above, in 2016 several key issues will be addressed.

Oversight of 2015 Initiatives: The CEO will continue to monitor implementation of three of

the 2015 Board priorities: Sheriff's Department, Health Care Integration, and Child Protection. Implementation on each of these initiatives is well underway.

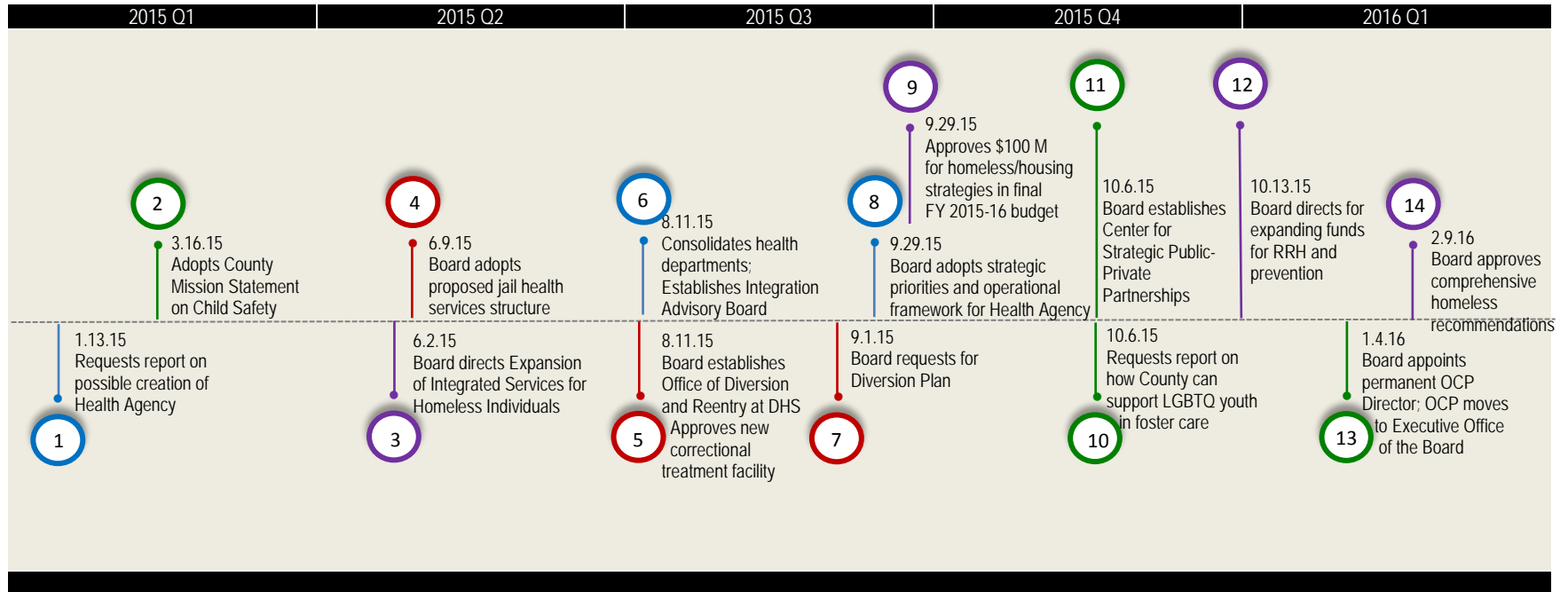
Strategic Planning and Measurement: As the Board continues to drive policy focused on addressing our most challenging social problems, and the Departments continue to work to meet their respective and diverse core missions, the CEO needs a mechanism to ensure that the efforts of County Departments are aligned with Board priorities in a way that increases the County's chances of successfully impacting the lives of children, adults, families and business of Los Angeles County. That mechanism is a strategic plan that incorporates measurement to track both performance and outcomes.

Open Data: As the Board, CEO and County Departments work together to drive meaningful change in the lives of residents and those requiring County services, the County must continue to embrace transparency as a basic way of doing business. 2016 will see greater efforts at making data available for the public, policy makers, and other interested persons.



County of Los Angeles
AD HOC INITIATIVES

TIMELINE OF AD HOC INITIATIVES



Board motions and actions for the following initiatives:

- Child Protection
- Health Integration
- Homeless Initiative
- Sheriff's Department Initiative (Diversion, Reentry, and Mental Health)



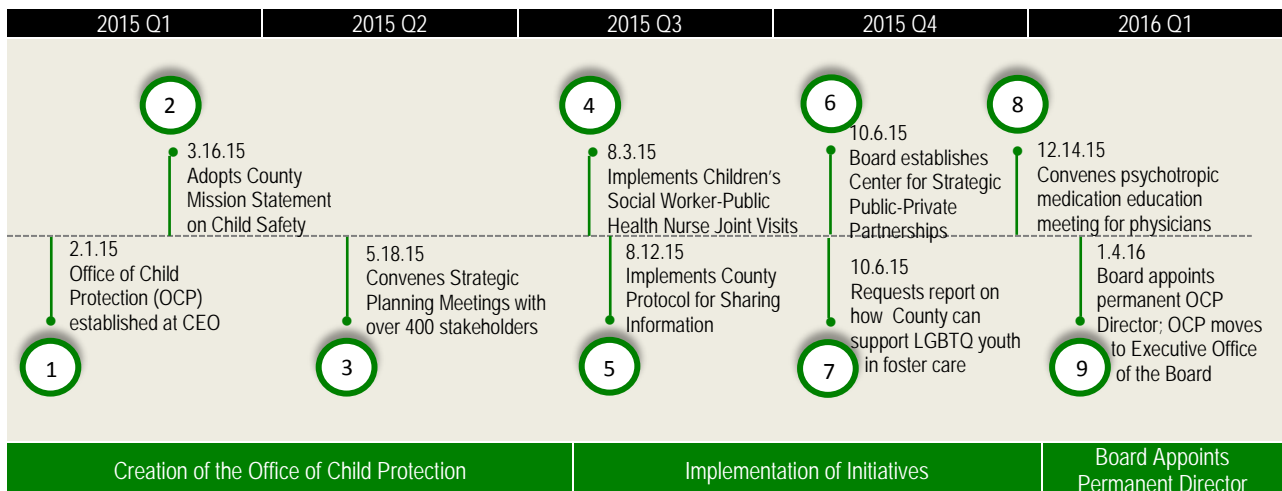
County of Los Angeles
AD HOC INITIATIVES

CHILD PROTECTION

Topic	Document	Date
Establish Office of Child Protection	1. Board Motion - Adopt the Recommendations in the Final Report of the Blue Ribbon Commission for Child Protection and Establish a Transition Team to Monitor and Implement Recommendations (Establish the Office of Child Protection)	6/10/14
	2. Board Correspondence - County Mission Statement on Child Safety	3/13/15
Implementation of Initiatives	3. Board Correspondence - Leveraging the County's Health System to Prevent Child Abuse and Neglect	4/13/15
	4. Board Correspondence - Protecting Commercially Sexually Exploited Children: Countywide Single Coordinated Entity, Unified Operational Model, Safe House Program	8/11/15
	5. Correspondence – Los Angeles County Protocol for Sharing Information When Investigating Reports of Suspected Child Abuse/Neglect or Making Detention Determinations	8/12/15
	6. Board Correspondence - Options for Establishing a Philanthropy Liaison in the Office of Child Protection	9/23/15
	7. Board Motion - Establish Center for Strategic Public-Private Partnerships	10/6/15
	8. Board Motion - Supporting LGBTQ Youth in Foster Care	10/6/15
	9. Board Correspondence - Supporting LGBTQ Youth in Foster Care	12/7/15
	10. Board Correspondence - Progress Update on the Blue Ribbon Commission for Child Protection Recommendations	12/16/15

- Information Available on County Office of Child Protection Website at: <http://priorities.lacounty.gov/childprotection/>
- Board Correspondence may be searched by title and date at: <http://portal.lacounty.gov/wps/portal/bc>

CHILD PROTECTION TIMELINE



9 Final Motion

AGN. NO. S-1

MOTION BY SUPERVISOR GLORIA MOLINA and SUPERVISOR MARK RIDLEY-THOMAS

June 10, 2014

Adopt the Recommendations in the Final Report of the Blue Ribbon Commission for Child Protection and Establish a Transition Team to Monitor Implementation of the Recommendations

After nine months of investigation and public hearings, the Blue Ribbon Commission on Child Protection has issued its report along with recommendations that will lead the effort to reform the child protection system. The recommendations are feasible, practical and will improve child safety.

Accomplishing structural reform within the child protection system will steer the County of Los Angeles into a new era of providing services that will embrace a child-centered philosophy. Fundamental changes to department policies, increased training, investigations of referrals regarding child abuse and neglect, and increased oversight are critical to child protection and reforming the system to better serve children and ultimately reduce child fatalities.

Achieving a paradigm shift in the child protection system is a long-term proposition. Exactly one year ago this month, the Board of Supervisors voted to create the Blue Ribbon Commission for Child Protection. The Commission was tasked with conducting a review of previously delayed or failed efforts to implement reforms and provide recommendations for a feasible plan of action to expeditiously implement much

MOTION

Molina _____

Ridley-Thomas _____

Yaroslavsky _____

Antonovich _____

Knabe _____

needed reforms.

In April, the Commission released a report containing over 40 recommendations for reform. The most unique recommendation is to create the Office of Child Protection to ensure far greater independent monitoring of child protection services among all the County departments that provide child protection services. These recommendations reflect a thoughtful and comprehensive analysis of over 700 prior Board-approved recommendations, witness testimony made available to the Commission from leaders in the child welfare field and stakeholders, review of child fatality case reports, and review of best practices in the field of child welfare.

The Board of Supervisors has a fundamental role in implementing the recommendations of the Blue Ribbon Commission for Child Protection. Only the Board of Supervisors can ensure that these recommendations, which cross a wide array of County departments, are implemented in a timely and effective manner.

Implementation of the recommendations—which cannot be achieved solely by the departments—requires the restoration of long-term integrity to child protection services. Implementation of the recommendations requires partnering by the Board of Supervisors.

I, THEREFORE, MOVE THAT THE BOARD OF SUPERVISORS:

1. Adopt the recommendations in the final report of the Blue Ribbon Commission for Child Protection *with further CEO analysis on the cost and timeframes.*
2. *The Board of Supervisors establish the Office of Child Protection (OCP) as a separate entity that reports directly to the Board of Supervisors. The OCP will be housed within the Board of Supervisors Executive Office.*
3. *The Board of Supervisors immediately undertake an executive search for the Director of the OCP. The Transition Team should work with the Board*

of Supervisors to provide input as to job description, desired qualities and experience for the Director of OCP. The Board of Supervisors will interview candidates and select the Director of OCP.

4. *The Transition Team be requested to make recommendations to the Board of Supervisors as to size and scope of the OCP, with the final determination to be made by the Board of Supervisors.*
5. Establish a Transition Team to monitor implementation of the recommendations, upon adoption by the Board, contained in the Commission's report of April 2014.
6. The Transition Team should be comprised of **9** members:
 - a. Five (5) members chosen by the Board of Supervisors; and,
 - b. ***One (1) representatives from the Blue Ribbon Commission for Child Protection;*** and,
 - c. A representative from Juvenile Court; and,
 - d. A representative from the Chief Executive Office; and,
 - e. ***A representative from the Children's Commission.***
7. Direct the CEO and other relevant County departments who provide child protection services to collaborate with the Transition Team to prioritize implementation of the recommendations.
8. ***Recommend to the Transition Team an assessment of Medical Hubs and Public Health Nurse programs to identify each Hub's strengths and weaknesses and recommend a plan for immediate implementation to meet the needs of each geographic area.***
9. Request that the Transition Team provide formal advice to the Board regarding recommendations for child safety, until the new, overarching Office of Child Protection is created to act as a unified coordinating entity.

10. *Prior to implementation of any the Blue Ribbon Commission recommendations, the Chief Executive Office will work with all relevant County departments, the Transition Team and/or OCP to determine cost of implementation and identify a source of funding for Board of Supervisors approval and execution. Chief Executive Office and relevant departments are also to identify savings within their departments and could offset any of these costs.*
11. Once created, the Office of Child Protection is to establish a critical pathway for the provision of child protection services in the County of Los Angeles, including but not limited to, developing one Countywide strategic plan, defining program outcomes and measures of success, streamlining of processes for greater efficiency, along with a timeline of major milestones.
12. Request that the Transition Team report back to the Board of Supervisors each month, beginning August 5, 2014, on the status of implementing the recommendations, and request that the Chair of the Board place this matter as a set item on the regular agenda.

MR/sf



County of Los Angeles CHIEF EXECUTIVE OFFICE

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
<http://ceo.lacounty.gov>

SACHI A. HAMAI
Interim Chief Executive Officer

March 16, 2015

To: Mayor Michael D. Antonovich
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe

From: Sachi A. Hamai 
Interim Chief Executive Officer

Board of Supervisors
HILDA L. SOLIS
First District

MARK RIDLEY-THOMAS
Second District

SHEILA KUEHL
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

RESPONSE TO BOARD MOTION ON DEVELOPING A PROPOSED MISSION STATEMENT ON CHILD SAFETY

On April 18, 2014, the Blue Ribbon Commission on Child Protection (BRC) issued its final report – *The Road to Safety for Our Children*. The Board adopted the recommendations on June 10, 2014. The BRC report included recommendations on preventing child abuse, protecting abused children from further abuse, and on child well-being. One of the BRC recommendations spoke to the need to articulate a countywide mission to prioritize and improve child safety. The rationale behind articulating this mission is to serve as a guiding principle for County department heads and other top level managers and as a critical message to everyone working in the child protection system that child protection is a priority. Articulating a mission to prioritize and improve child safety involves three milestones: 1) Establish and operationalize the Office of Child Protection; 2) Adopt a County mission statement on child safety; and 3) Adopt, implement and monitor a data driven, child-centered strategic plan. The Board has established and operationalized the Office of Child Protection (OCP). On January 13, 2015, this Board unanimously passed a motion introduced by Supervisor Kuehl directing the development of a County mission statement on child safety consistent with the BRC recommendations.

The County already has a strong mission statement that serves as the foundation of its work - *To enrich lives through effective and caring service*. A mission statement specific to child safety flows from the County's foundational mission statement and emphasizes the Board's commitment to ensuring the safety and well-being of its children. We also developed a mission statement for the OCP illustrating how the County mission on child safety will be fulfilled. The illustration below depicts the relationship of these three mission statements to each other.

"To Enrich Lives Through Effective And Caring Service"

**Please Conserve Paper – This Document and Copies are Two-Sided
Intra-County Correspondence Sent Electronically Only**



Stakeholder Input Process: Department Heads and Essential Partners

The OCP engaged a variety of stakeholders to help develop the proposed County mission statement on child safety. Before conducting stakeholder meetings, the OCP compiled and reviewed the mission statements of 36 County departments and one commission, paying particular attention to those Departments that impact child safety and well-being. Within five weeks, the OCP held five separate stakeholder meetings to seek input on what a County mission statement should include. The first three stakeholder meetings were held with County department heads and/or their designees. Participating departments included: Chief Executive Office, Child Support, Children and Family Services, District Attorney, Health Services, Library, Office of Education, Mental Health, Parks and Recreation, Probation, Public Health, Public Social Services, and Sheriff. One-hour meetings were held on February 3, 10, and 24, 2015. Several departments sent multiple representatives so that as many as 24 County representatives participated in the three meetings.

During the department head meetings, we discussed the meaning of child safety and whether any proposed statement on child safety should begin and end with child safety. This group readily agreed that the proposed mission statement must emphasize child safety, but not focus on child safety alone. This sentiment is consistent with the BRC's final report.

During the meetings, each attendee developed a proposed mission statement on child safety and then worked within a small group to reach consensus on a group mission statement. The group statements were shared with all other groups and a discussion

ensued about the attributes of each statement. After the discussion, participants identified those statements that resonated most strongly with them. There was broad support for the idea that after a child's safety needs are addressed, the County must do more. Broadly supported themes that emerged from these three sessions included: "protect," "well-being," "leadership," "partnership," and "champion."

Recognizing that the work of child protection and child welfare involves numerous private partners, the OCP held two meetings to seek input from private stakeholders also vested in the safety of our children. Each meeting lasted approximately two-and-a-half hours. The first meeting was held in the City of Lancaster on March 6, 2015 and the second meeting was held in South Los Angeles on March 9, 2015. Through these meetings, we were able to secure input from 81 additional stakeholders, including community-based organizations, County-contracted service providers, school districts, relative caregivers, advocates, and the health care and faith-based communities. We followed the same statement development and discussion process used during the department head meetings. Again, there was broad support for the idea that after a child's safety needs are addressed, the County must do more. Broadly supported themes that emerged from these meetings included: "children," "support families," "safety," "collaboration," "effective," and "partnership."

The OCP paid close attention to the nuanced differences in tone, and themes reflected in the statements produced during each of the stakeholder meetings. Certain proposals for a County mission on child safety seemed more appropriate for the OCP mission statement and vice-versa. Other proposals included important concepts and themes which would be too limiting if included in a mission statement, and, therefore, far more appropriate as a stand-alone value. Yet, other statements were very specific and would be better suited as a strategy under the joint strategic plan that the OCP will be developing. In order to provide a broad view of the how each piece works together, below you will find: 1) a proposed County mission statement on child safety, 2) a proposed mission statement for the OCP, and 3) value statements for the OCP.

Proposed Mission Statements: County Safety Statement and OCP Statement

Preamble to the County Mission Statement on Child Safety:

The safety and well-being of all of our children is of highest priority in the County. Consequently, County departments and agencies will work together as a team to provide the highest quality services to children and families. Broad community input and support is also critical to this mission. The County has established the Office of Child Protection to ensure the County achieves its child safety mission.

Proposed Countywide Mission Statement on Child Safety:

***Protect our children, support our families and
 champion their success***

Proposed Office of Child Protection Mission Statement:

The proposed OCP mission statement was designed to complement the countywide safety mission statement by explaining how it would be accomplished.

***Leading a broad partnership that implements
 meaningful solutions to improve the lives of our
 children and families***

In this context, a “broad partnership” is defined as County departments working together, as well as with other diverse stakeholders within the community.

Proposed Values for the County Mission on Child Safety:

Value	Value Statement
Integrity	We do the right thing for our children and families, listening to their voices, and placing their needs at the center of our policies and actions.
Data Driven Planning	We strategically use data to inform planning, activities, and decision making.
Integrated Service Delivery	We facilitate inter-agency collaboration to ensure that County departments both work together and with other diverse stakeholders. Towards this end, joint planning and budgeting is a necessary part of this collaborative process.
Child Centered and Family Focused	We consider the impact of policy implementation through the eyes of our children and families, and are committed to supporting a continuum of care that is both preventative and provides long-term support.
Transparency	We readily share information about our processes, activities, and decision making.
Community Engagement	We actively engage the community as real partners about the best ways to protect children and support their families in the cultural context of each community.
Advocacy	We seek to influence national, State, and local policy decisions, program development, and resource allocation to promote continuous improvement of the child protection system and better child protection outcomes.
Innovation	We constantly challenge ourselves and partners to advance best practices and seek new solutions for improving child protection, establishing Los Angeles County as a national model.

Conclusion

The OCP submits for your consideration the proposed mission and value statements listed above. Although this Board requested a single statement, the stakeholder process also enabled us to secure input on a mission statement for the OCP. In addition, the OCP mission and values statements are the pre-cursor to the joint strategic planning process – another BRC recommendation. Upon adoption of the proposed mission statements, the OCP will next turn its attention to the joint strategic planning process. Stakeholder groups will be involved in this process, as OCP seeks to build a “new partnership” moving forward. Survey results from the stakeholder meetings held in Lancaster and South Los Angeles reflect general satisfaction with the mission statement input process and a desire to participate in a future joint strategic planning process.

If you have any questions or need additional information, please contact Fesia Davenport at (213) 974-1186, or via email at fdavenport@ceo.lacounty.gov.

SAH:FAD
CDM:AM:ljp

c: Executive Office, Board of Supervisors
County Counsel
Child Support Services
Children and Family Services
Parks and Recreation
Probation
Public Health
Sheriff



SACHI A. HAMAI
Interim Chief Executive Officer

County of Los Angeles

CHIEF EXECUTIVE OFFICE

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
<http://ceo.lacounty.gov>

Board of Supervisors
HILDA L. SOLIS
First District

MARK RIDLEY-THOMAS
Second District

SHEILA KUEHL
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

April 13, 2015

To: Mayor Michael D. Antonovich
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe

From: Sachi A. Hamai
Interim Chief Executive Officer

LEVERAGING THE COUNTY'S HEALTH SYSTEM TO PREVENT CHILD ABUSE AND NEGLECT

Background

In its final report entitled, *The Road to Safety for Our Children*, the Blue Ribbon Commission on Child Protection (BRCCP) made several recommendations related to child safety and health services. The first recommendation called for the County to pair a Public Health Nurse (PHN) with a Children's Social Worker (CSW), when conducting a child abuse or neglect investigation for all children from birth at least until age one. The second recommendation called for the County to refer to the medical hub all detained children, and all other children under age one being investigated by the Department of Children and Family Services (DCFS). While the BRCCP indicated children under the age of one, the County expanded the age group to all children under 24 months of age. The third recommendation called for an assessment of the strengths and weaknesses of the medical hubs.

DHS Medical Hub Augmentation Plan

On January 9, 2015, the Department of Health Services (DHS) submitted a report of its assessment of the County's Medical Hub Clinics (medical hubs). DHS determined that additional resources would be required in order to: provide higher quality of service, reduce wait times, and increase the number of examinations conducted at the medical hubs. DHS recommended allocating \$1,998,363 of its existing resources to enhance staffing resources at the six County-run medical hubs.

"To Enrich Lives Through Effective And Caring Service"

**Please Conserve Paper – This Document and Copies are Two-Sided
Intra-County Correspondence Sent Electronically Only**

Joint Visit Conceptual Design by Chief Executive Office

On January 12, 2015, the Chief Executive Office (CEO) issued a report proposing a conceptual design of how PHNs could be paired with CSWs to conduct joint visits. The report also identified various tasks requiring completion and identified resources needed to implement the joint visit initiative. Finally, the CEO report recommended a phased in approach starting with one medical hub (Martin Luther King, Jr. Outpatient Center) and two DCFS Regional Offices (Compton and Vermont Corridor) rather than a simultaneous countywide roll-out.

Board's Motion Regarding Implementation

On January 13, 2015, this Board approved a motion introduced by Supervisor Mark Ridley-Thomas and Supervisor Sheila Kuehl directing the Interim Chief Executive Officer and Directors of DCFS, DHS, Mental Health and Public Health to:

1. Implement the recommendations, per the CEO's report dated January 12, 2015, for the actionable items related to pairing a PHN and a CSW when conducting abuse and neglect investigations for all children under 24 months of age;
2. Report back in 90 days on the milestones, performance outcomes, operational changes and additional board actions, including an update on the medical hub augmentation and its impact on appointment wait times and functionality of the medical hubs;
3. Finalize policy and recommendations regarding the provision of screenings of newly detained children, including coordination with existing initial comprehensive medical exams; and
4. Report back in the CEO's Recommended Fiscal Year 2015-16 Budget with an assessment of budget and operational changes needed to implement the recommendations.

The Office of Child Protection (OCP) submits this implementation plan for Phase I of the joint visit plan in response to the Board's January 13, 2015 motion. The plan is attached as Attachment I and has a July 1, 2015 launch date. The OCP has worked with the CEO, and DCFS, DHS, Public Health, Mental Health, and County Counsel to develop a workable plan. This report identifies milestones, performance outcomes, operational changes, and an update on the medical hub augmentation.

Each Supervisor
April 13, 2015
Page 3

The screening of newly detained children at each medical hub, as opposed to non-detained children subject to an investigation, will be addressed after Phase I of the CSW-PHN Joint Visit Initiative launches. It is important to note, however, that detained children are seen at medical hubs as DCFS policy requires that detained children be seen at a medical hub within certain timeframes. Finally, the CEO will issue a separate report which includes an assessment of budget and operational changes needed to implement the recommendations necessary to implement the CSW-PHN joint visit initiative.

If you have any questions, please contact Fesia Davenport at (213) 974-1186, or by email at fdavenport@ceo.lacounty.gov.

SAH:FD
VD:ljp

Attachment (1)

c: Executive Office, Board of Supervisors
Children and Family Services
County Counsel
Health Services
Mental Health
Public Health

This page left intentionally blank.

Leveraging the County's Health System to Prevent Child Abuse and Neglect

Executive Summary

The countywide CSW-PHN joint visit initiative will be rolled out in phases. Phase I will involve the Martin Luther King, Jr. Outpatient Medical Center (MLK Hub) and Compton and Vermont Corridor DCFS regional offices and will launch on July 1, 2015. On that date, recently hired DCFS PHNs will begin training and joint visits will commence later in the month. The July 1, 2015 launch date assumes the existence of several material factors identified in the table below:

Factor	Implementation Milestones and Next Steps	Status*
Hub Augmentation and Capacity	• DHS must hire staff to augment hubs placing an emphasis on the MLK Hub	IP
	• MLK Hub will offer expanded hours and ensure sufficient capacity exists to meet the increased demand for medical screenings	R
	• DMH will co-locate staff at the MLK Hub	IP
	• The DHS Nurse Advice Line will be operational	R
Adequate Space	• DMH staff co-located at the MLK hub must have space and equipment	IP
	• MLK hub space must be configured to enable DMH Medi-Cal certification**	IP
Adequate Staff Resources	• Hiring must be completed by all Departments and staff in place	IP
Procedures for Pairing CSW-PHN	• DCFS and DPH must finalize policies and forms necessary to implement operational changes including the PHN Assessment Tool and the joint visit protocol	IP
Operational Changes	• Streamlined PHN referral form must be finalized by DCFS and DHS	IP
	• Changes to e-mHub must be operational to accept the PHN referral form	IP
Training Staff	• Training Units from DCFS and DPH must finalize a joint training plan and curriculum to include: didactic training, hands-on training, and shadowing	IP

*Status: IP – In Progress; R – Ready to Launch; **Important but launch not contingent upon this factor

In addition, data collection metrics and tracking systems are needed to monitor and analyze results from Phase I and inform adjustments required to improve the process in subsequent phases. A preliminary list of metrics to measure safety, operational efficiency and effectiveness, and desired outcomes has been identified, and an electronic tracking system to capture most of this data is under development by DCFS.

The conceptual design of the joint visit initiative recommended that five PHNs be hired to launch Phase I – two for the Compton regional office and three for the Vermont Corridor office. After working closely with the PHN workgroups, uncovering more details about the logistics and timing of the referral process, and working on various staffing solutions, DCFS management recommends that the number of additional PHNs for the Phase I offices be increased as fully explained in Section III of this report. The OCP supports this request. In addition, DCFS has agreed to fund six additional Medical Case Workers, one for each hub, to assist DHS with the current workload at the Medical Hubs with an emphasis on responding to the needs of children and families referred to the hub through this joint visit initiative as fully explained in Section I of this report.

Lessons learned from Phase I will help to make the staffing projections closer to the actual need, and will enable each phase of the roll out to occur quicker than the phase that preceded it.

Phase I Planning Efforts Since January 2015 Board Motion

The OCP has worked closely with DCFS, DHS, DMH, DPH, and the Service Employees International Union (SEIU) representing PHNs and CSWs to ensure that all essential factors are in place before the launch date. The CEO's Office previously established the CSW-PHN Joint Visit Executive Leadership Committee. This committee consisted of executive managers and Directors from DCFS, DHS, DMH, DPH and helped to develop the conceptual design of the joint visit initiative presented in the CEO's January 12, 2015 Board report. The OCP met with the committee on March 3, 2015 to obtain an update on progress made since the Board issued its directive to take all actionable steps to implement the joint visit initiative.

After the Board's January 13, 2015 motion directing the CEO and other involved Departments with implementing all actionable items, DCFS established three implementation workgroups. These workgroups were established to begin the process of converting the joint visit conceptual design into practice. The workgroups are:

CSW-PHN Pairing: This workgroup was established to address all operational issues and identified implementation barriers to the conceptual design.

Policy & Training: This workgroup was established to address all policy and training issues associated with the joint visit initiative. The group is also charged with developing a workable training plan that equips PHNs and CSWs to team with each other during the joint visit, yet maintain an appropriate amount of independence to perform their separate functions.

Data & Measures: This workgroup was established to focus on the type of data needed to capture both operational and programmatic information that will help us determine whether the joint visit model as implemented is effective and supports the desired safety and health related outcomes.

On February 19, 2015, DCFS held a meeting with PHNs and a subsequent meeting with the SEIU management representing the PHNs. During those meetings, PHNs raised a number of questions regarding the joint visit initiative. The OCP has worked with SEIU, DCFS and DPH to prepare solutions and responses to the questions. While answers to some questions remain under consideration, none of the remaining questions pose a barrier to implementation. DCFS and SEIU must hold another meeting with staff to share the responses to the questions and also share the final plan for the Phase I roll-out before implementation. In addition, the OCP met with the workgroups, management from the involved Departments, SEIU Representatives, Nursing Directors from DHS and DPH, and County Counsel on March 10, 17, 20, 24, and 27 to obtain material updates, advice, and legal counsel to support the OCP's coordination of the planning efforts of all involved departments.

To aid understanding, this report provides updates and identifies next steps in the context of the following areas:

I. Medical Hub Augmentation and Capacity – This section provides an update on the Medical Hub expansion. This section also focuses on efforts to position the MLK Hub for Phase I of the joint visit initiative.

- II. Co-located Mental Health Services** – This section provides an update on the progress DMH has made in its plan to provide co-located mental health services at the MLK Hub.
- III. Public Health Nurses (PHNs) Staffing** – This section provides an update on the progress DCFS has made in developing a staffing and hiring plan to ensure sufficient resources for the Phase I DCFS regional offices.
- IV. Implementation Concerns and Solutions** – This section provides an update on concerns raised by Public Health Nurses and the solutions developed to address those concerns.
- V. CSW-PHN Joint Visit Policy, Training and Operations** – This section describes the major policy, procedural, and operational changes required to implement the joint visit initiative.
- VI. Measures and Outcomes** – This section describes the metrics to be measured and outcomes we seek to improve as a result of the joint visit initiative.

I. Medical Hub Augmentation and Capacity

Space

Hub space enhancements are in the planning stages at the MLK Hub. For MLK, DHS has determined that the existing Hub space will accommodate the Phase I joint visit initiative for the time being. On February 3, 2015, Supervisor Mark Ridley-Thomas introduced a motion that was approved by the Board to assess the feasibility of relocating the Hub to another MLK campus location. In the Board motion, the location was specified and a new building to accommodate the more collaborative and integrated vision for hub services is currently being planned. The preliminary timeline to construct the new building is approximately two years.

Space enhancements are also in the planning stages at the Harbor-UCLA Hub. At Harbor-UCLA, DHS has been working on a plan to relocate the Hub from two trailers on campus to a larger space. The Harbor Hub staff and hospital leadership are determining the correct clinic layout and working to minimize the structural modifications required to improve the space. DHS is working to propose a funding strategy for these renovations.

Hub enhancements for the Olive View Hub have been completed. Staff at the Olive View Hub moved into their new space in the hospital on January 26, 2015. The Hub now has four exam rooms compared to two previously, as well as more space for co-located DCFS and DMH staff.

Staff

On January 13, 2015, this Board directed the CEO to add 14 new positions to the DHS budget to augment staffing levels at all six DHS medical hubs. CEO has granted DHS hiring authority to fill the positions during the current budget year. The 14 items will be added in DHS' FY 2015-16 Recommended Budget and effective July 1, 2015. Of the 14 items, four are allocated to the MLK Hub as follows. Of these four positions, candidates for two positions (Senior Physician and Nurse Practitioner) have been identified. For the remaining two positions (Financial Services Worker and Medical Case Worker) there is not an existing

Leveraging the County's Health System to Prevent Child Abuse and Neglect

list for these items, meaning an exam must be prepared. The timeline for filling these positions is as follows:

- By April 30, 2015 – Exams posted for Medical Case Worker II and Financial Services Worker,
- By May 31, 2015 – Interviews will be completed,
- By June 15, 2015 – Employment offers will be extended, and
- By July 15, 2015 – Appointed candidates will commence work at the hubs.

In order to expedite the hiring for the MLK Hub, by April 10, 2015, DHS will post a transfer opportunity notice for existing Medical Case Workers who may be interested in transferring to the MLK Hub.

In order to support expansion of capacity at the medical hubs and handle the work created by the joint visit initiative, DCFS will supplement the Medical Case Workers at each hub by funding six additional Medical Case Workers – one allocated to each hub. This will result in two Medical Case Workers at the MLK hub. Medical Case Workers will provide care coordination and link children with needed resources to address issues identified by hub providers. For example, Medical Case Workers may follow-up with DCFS, a Regional Center, and/or the child's school for a child with developmental issues. These positions will work closely with the DCFS PHN and CSW to form a case management team, to ensure that services are coordinated and duplication of effort is avoided. The Medical Case Worker will also work to ensure that children and their families receive follow-up appointments and increase the likelihood that parents attend follow-up appointments by contacting the family if an appointment is missed.

Cost: The full cost (i.e. salary and employee benefits) for six Medical Case Worker II items is \$416,000. CEO has given DHS authority to hire during this budget year. DHS will request in Final Changes that the six permanent Medical Caseworker II items be added to its FY 2015-16 budget.

In addition, DHS is recruiting to fill three daytime Registered Nurse II positions to staff an advice line as fully described below. No new position has been added to the DHS budget to provide the advice line service.

Operational Changes

Nurse Advice Line

DHS has installed a new telephone line for a Nurse Advice Line at the LAC+USC Medical Center. This telephone line will be staffed twenty-four hours a day, seven days a week by DHS Registered Nurses. In addition to serving caregivers, patients and CSWs, the Nurse Advice Line will be available for DCFS PHNs to contact, if they have a question or are seeking advice to assist them during a joint visit. In instances when a nurse is assisting another caller or is otherwise temporarily unavailable, the PHN will be able to leave a voicemail message and have his or her call returned by the DHS nurse within two hours. The outgoing voicemail message will note that if the caller is unable to wait two hours for a return call, the child should be brought to the closest emergency room or urgent care for evaluation.

Expansion of MLK Hub Hours

DHS has developed a staffing plan that will enable the MLK Hub to extend hours from 5:00 pm to 7:00 pm. Extended hours will be implemented before the Phase I launch date. DHS will continually assess the demand once Phase I begins, and will extend hours of operation to 8:00 pm if necessary. For situations

that require a child to be seen at the Hub after extended hours or on weekends, the child and parent will be referred to LAC+USC Medical Hub.

Streamlined Hub Referral Form

DHS and DCFS are working together to define any changes needed to the existing hub referral form in order to streamline the form for PHN use. They have also developed the technical requirements for a change that will need to be made to the e-mHub system to recognize and accept the streamlined referral form. The work to operationalize these changes is underway and expected to be completed by June 30, 2015.

Next Steps

- Hire all staff ensuring that MLK Hub staff are hired before launch date;
- Operationalize the Nurse Advice Line in advance of the launch date
- Extend hub hours and give notice to all Phase I involved Departments
- Finalize and test the streamlined e-mHub referral form
- Implement changes to the e-mHub system that will enable use of streamlined referral form

II. Co-located Mental Health Services at the MLK Hub

DHS identified the need for children and families served at the Medical Hubs to have onsite access to crisis intervention and a bridge of mental health services, until a family is connected with a mental health provider in the family's community. To address this need at the Medical Hubs and for the Phase I roll-out at the MLK Hub, DHS has worked with DMH to co-locate DMH staff at the hubs including the MLK Hub. The components of co-location include: 1) space and equipment; 2) staff, 3) training, and 4) Medi-Cal certification.

Space

On January 13, 2015 and February 12, 2015, DMH visited LAC+USC Medical Hub facility to learn more about the day to day operation of mental health staff in the medical setting. DMH has been in discussion with DCFS and DHS regarding the needs of co-located mental health staff at the MLK Hub. On February 18, 2015, the Departments discussed the space needs for the co-location of mental health staff at the Medical Hub. After the meeting, DHS provided DMH an approximate number of children and youth referred and general reasons for referral to the medical hub. DMH invited DHS to participate in the interview process of the mental health co-located clinicians. DMH is currently collaborating with DHS on developing a guideline and an agreed upon process for those children and youth who will be receiving mental health services at the hubs.

DMH anticipates being able to bill Medicaid for some of the specialty mental health services its staff will provide to the children and youth referred to the Medical Hub. DMH will work to obtain Medi-Cal certification of the hubs in order to bill for these services. Certification means that the space allows a billing Medi-Cal provider to provide a patient with services and that visit is able to draw down reimbursement from Medicaid. The space must meet the Federal and State Criteria for a space where a

certified provider is able to work. The certification will be done by DMH based on a set of standard elements that must be in the clinical setting. The certification process can take three to six months from the date of the certification request. However, both billable and non-billable services can be provided during the certification process. Panic buttons are required at the point service delivery begins. This is a Department and Union requirement.

Staff

On January 13, 2015, this Board authorized DMH to hire six Psychiatric Social Workers and one supervisor to augment services at the Medical Hubs. On March 2, 2015, DMH hired a Mental Health Clinical Supervisor who will monitor and manage the work of the Psychiatric Social Workers. The recruitment for these social workers is ongoing. Fifteen candidates have been interviewed thus far and DMH intends to make selections and extend offers before June 30, 2015.

Cost: The cost (i.e. salary and employee benefits) of the six Psychiatric Social Worker items and the Mental Health Clinical Supervisors is 825,000. DMH will request in Final Changes that that these permanent items be added to its FY 2015-16 budget. DMH has current authority to hire to fill the six social worker positions. The source of funding, additional costs and potential for revenue offset is discussed in the CEO's report on the Recommended Budget for FY 2015-16.

Training

DMH will train its staff in several areas to ensure that the newly hired Psychiatric Social Workers are prepared to provide effective services. The social workers will be trained in several areas including, screening and assessment, essential DMH data systems, trauma, crisis assessment, documentation, and screening tools. The training dates have yet to be determined but will occur with a sufficient amount of lead time to allow staff at the MLK Hub to absorb the training before the launch date.

Next Steps

- Timely install necessary computers equipment at each hub
- Commence the Medi-Cal certification process
- Hire all staff ensuring that MLK Hub is staffed before launch date
- Train all staff ensuring that MLK Hub staff is trained before launch

III. Public Health Nurses Staffing and Staffing Plan

Staff

Conceptual Methodology

The conceptual design of Phase I identified a need for five additional PHNs to handle the increased number of joint visits - two assigned to the DCFS Compton Office and three assigned to its Vermont Corridor Office. The conceptual design recommended that Emergency Response PHN units be established. This is a sound plan in that this replicates the Emergency Response model used for CSWs.

Leveraging the County's Health System to Prevent Child Abuse and Neglect

The estimated need for five additional PHNs was based on data provided by DCFS reflecting the number of referrals for FY 2013-14 involving children under two years of age. The DCFS data reflected the following FY 2013-14 data on referrals involving children under two:

- 6,345 referrals received by the Phase I offices,
- 1,750 of the 6,345 referrals involved a child under two,
- 111 (7%) of the 1,750 referrals involving a child under two received a joint visit, and
- 1,639 (93%) of the 1,750 referrals of a child under two did not receive a joint visit.

The conceptual design recommended five additional PHNs for the Phase I offices to meet the need. Please refer to the CEO's original report dated January 12, 2015 for a detailed analysis of the projected need. The conceptual design does not appear to account for, among other things, the additional 453 referrals received during nights and weekends that are handled by the Emergency Response Command Post for families in the catchment area of the Phase I Offices. For this and other reasons identified below, OCP supports the recommendation that the staffing levels for Phase I be increased.

Determination of Additional Need

The conceptual design called for the creation of an Emergency Response (ER) PHN Unit. The success of this model depends on having a sufficient number of PHNs available day in and day out to conduct visits and to also have time in the office to complete follow-up and link families to services. After analyzing the data and comparing it to the realities of everyday practice with workgroup members, it appears that the initial estimated need for five PHNs seems appropriate as a mathematical proposition, but too conservative to implement a staffing plan.

A review and assessment of the data is the starting point of the staffing analysis. Next, logistical and operational issues must inform a staffing plan – a plan which, in this case, points to a need for additional PHNs. This DCFS staffing plan must address the following:

- 1) The need for PHNs (like CSWs) to have days when they are not conducting investigations (i.e. being on rotation) allowing them time in the office to conduct follow-up and link families to services;
- 2) The need to have PHNs available to respond to referrals received after hours and weekends; and
- 3) The need to have an adequate number of PHNs available during those times where referrals are received simultaneously rather than in a series.

As such, DCFS recommends that the five PHN items approved by the Board be supplemented with nine additional PHNs assigned to the Phase I offices; plus six additional PHNs assigned to the DCFS Emergency Response Command Post (ERCP) operation (to handle nights and weekends); plus two PHN Supervisors to manage the new PHNs in the Phase I Regional offices and ERCP. The OCP supports this recommendation echoing the sentiments contained in the conceptual design – the true need will be unknown until Phase I is implemented and PHNs and CSWs start conducting joint visits. If during implementation it turns out that Phase I Offices are overstaffed, this positions DCFS to roll out Phase II sooner because trained staff can be redirected to Phase II Offices. The revised PHN staffing request is identified below.

Leveraging the County's Health System to Prevent Child Abuse and Neglect

Revised PHN Staffing Request

Table 1: PHN Staffing Plan

	Regional Office (Regular Hours)		Weekend/Afterhours	Total
	Compton	Vermont	ERCPC	
Total PHN Need	9	7	6	22
PHN Transfers Into Phase I Offices	1	1	0	2
Pre-approved PHN Items	2	3	0	5
New PHN Ask	6	3	6	15*

* (22 PHNs need - 2 transferred PHNs - 5 Pre-approved new hires = need for 15 additional PHNs)

Table 2: PHN Supervisor Staffing Plan

	Regional Office (Regular Hours)		Weekend/Afterhours	Total
	Compton	Vermont	ERCPC	
Total PHNS Need	1	1	3	5
PHNS Transfers Into Phase I Offices	1	1	0	2
Pre-approved PHNS	.50	.50	0	1
New PHNS Ask	n/a	n/a	2	2*

*(5 PHN Supervisors needed – 2 transferred supervisors – 1 pre-approved new hire = need for 2 additional supervisors)

PHNs assigned to ERCPC for evenings, nights and weekends will support additional phases of the roll out of the joint visit initiative.

Once Phase I launches, much learning, tracking and adapting will occur. DCFS and DPH will gain a better understanding of what the actual need for PHNs will be. The learning from Phase I will be used to adjust or “true-up” the number of PHNs needed in Phase I offices and the ERCPC as well as inform staffing needs for future phases of the joint visit initiative. If Phase I lessons learned reveal that Phase I has been over-resourced, then DCFS will determine the appropriate need and redirect PHN resources to Phase II offices.

Cost:

Previously approved costs – 6 staff, \$965,000

- Five PHN and one PHN Supervisor item was previously approved for the Phase I Offices.
- The cost of the salary and benefits for these six items is \$965,000.

Additional items requested – 17 staff, \$2.75M

- Fifteen additional PHN items and two additional PHN Supervisor items requested.
- The cost of the salary and employee benefits for the 15 additional PHNs is \$2.4M and \$350k for the two additional PHN Supervisors.

Existing staff – 4 staff, \$666k

- DCFS intends to devote four existing staff to the Phase I at a cost of \$666,000 for salary and employee benefits.

Total staff devoted to Phase I and costs – 27 staff, \$4.4M

- The total number of all staff (existing and new items) devoted to Phase I of the joint visit initiative is 27.

Leveraging the County's Health System to Prevent Child Abuse and Neglect

- The total cost of the salary and employee benefits of all staff working on the joint visit initiative for Phase I and the ERCP is \$4.4M.

CEO will provide DCFS with ordinance items for this current budget year and for FY 2015-16. DCFS will ask that the permanent items be added to its budget once the total number of needed PHNs and PHN Supervisors is determined.

PHN and PHN Supervisor Staffing Plan

Table 3: Regional Office PHN Staffing Plan

Shift/Hours	Regional Office (Regular Hours)		Total
	Compton	Vermont	
Day (M-T) 7:00 am – 5:30 pm	5	4	9*
Day (T-F) 7:00 am – 5:30 pm	4	3	7*
Total			16

* One supervisor assigned to each Phase I Regional Office.

Table 4: ERCP PHN Staffing Plan

Shift/Hours	Emergency Response Command Post	Total
Day (F-M) 7:00 am – 5:30 pm	2*	2
Swing 1 (W-Sat) 4:00 pm – 2:30 am	2*	2
Swing 2 (Sat – Tu) 4:00pm – 2:30 am	2*	2
Total		6

* One supervisor per shift. Each supervisor will be assigned additional duties to ensure they are fully engaged.

Hiring Plan and Hiring Timeline

The OCP has been working with DCFS and DPH to coordinate efforts to implement a hiring plan and timeline. DCFS currently does not have a list of eligible PHN candidates from which it can hire PHNs. It takes approximately four months to promulgate a list. DPH has allowed DCFS to use DPH's recently promulgated list in order to expedite the hiring process. DCFS will use the DPH list to invite PHN candidates to apply for the PHN positions allocated to this joint visit initiative. Candidates hired from this list will conduct joint visits and form the PHN – ER units as envisioned in the conceptual design. In order to launch Phase I in July, the additional PHNs should be hired by no later than June 30, 2015. The milestones for the DCFS PHN hiring plan are listed below:

- By April 10, 2015 DCFS issued canvass letter,
- By April 20, 2015 DCFS will begin the interview process,
- By May 10, 2015, DCFS will make final selection of candidates, and
- By June 30, 2015, PHNs are hired and assigned to DCFS regional offices or ERCP.

Next Steps

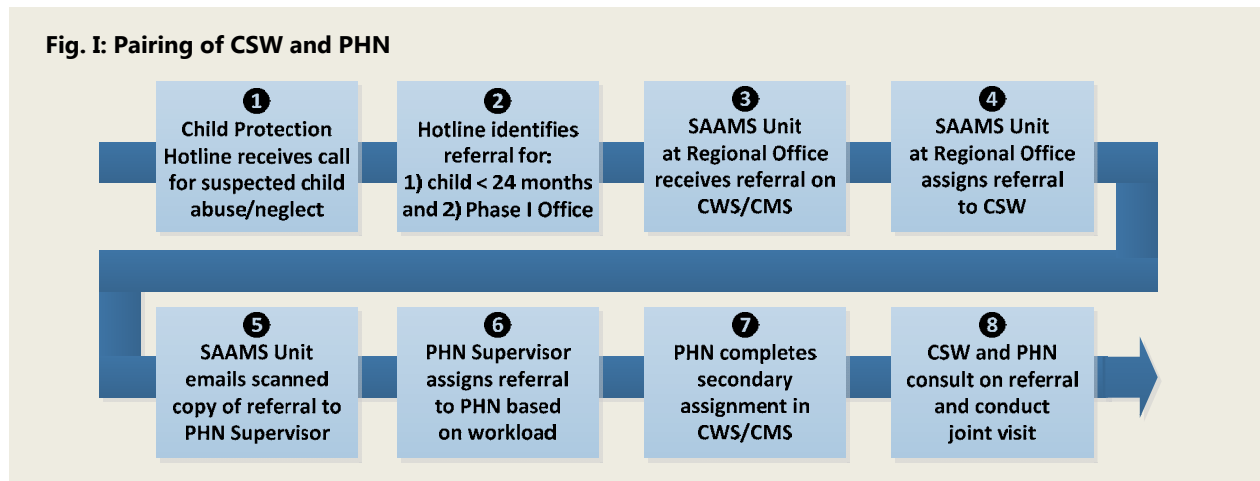
- Implement PHN hiring plan for PHNs and PHN Supervisors
- Solicit volunteers to serve as Lead Workers to mentor ER PHN Units
- Solicit volunteers to supervise the ER PHN Units

IV. Implementation Concerns and Solutions

The OCP has convened meetings with DCFS, DHS, DPH, and SEIU to work through identified implementation challenges in the following areas: 1) Operational issues associated with pairing PHNs and CSWs; and 2) Policy/Training.

CSW-PHN Pairing Protocol

Figure I on the next page provides a high level overview of a proposed conceptual design for assigning PHNs and CSWs to referrals and then pairing them for a joint visit.



On February 19, 2015, DCFS held a meeting with PHNs regarding the joint visit initiative and the Phase I roll out. Out of that meeting came various concerns identified by PHN staff and SEIU. The questions that came out of that meeting generally fall into the seven categories identified in Table 5.

Table 5: Issues and Concerns

Issue	Concern
1. Scope of Practice	Ensuring proposed PHN duties under this initiative fall within their scope of practice and thereby are in compliance with the Nurse Practices Act
2. Process and Procedure	Identifying processes in the conceptual design that pose implementation challenges or that will have unintended consequences
3. Policy/Training	Identifying which PHNs will be trained and topics to include in the training
4. Hub Capacity	Assessing whether Hubs will have capacity to handle increased visits
5. Staffing Phase I	Assessing whether 5 additional PHN staff represented a realistic estimate
6. Technological Support	Identifying need for technological support for PHNs in the field conducting joint visits
7. Single Administration	Identifying the County entity appropriate for single administration of the PHN program

DCFS, DPH and DHS have developed solutions to many of the issues and questions posed by staff. For other issues, solutions are being developed. Other issues are outside the scope of this joint visit initiative

as they are more appropriate for bargaining between the County and labor. With respect to all pending issues, the OCP will continue to meet with DCFS, DPH and SEIU to identify solutions. Once solutions or responses have been developed for the identified barriers and concerns, DCFS and DPH will hold another staff meeting with PHNs, PHN Supervisors and CSWs to respond to their questions and share the progress made to date.

Next Steps

- Present the pairing protocol to the DCFS-SEIU labor meeting
- Hold follow-up meeting with PHN and PHN Supervisors to share plans to address issues and share final plan for the Phase I roll-out.

V. Policy and Training

Several policies and forms needed to implement Phase I are currently under development and review. The OCP intends to reconvene the policy workgroups to finalize the policies. Once finalized, the policies must be presented to SEIU representing CSWs before implementation. At or around the same time, DCFS and DPH must also preview the joint visit initiative with stakeholders including: the Dependency courts, attorneys representing parents and children, and community medical providers.

Policy

Work on developing the policies necessary for the joint visit initiative is well underway. The DCFS Policy Unit, in collaboration with DCFS regional staff from the Phase I Offices, and Public Health Nurses drafted a proposed policy document titled, *PHN and CSW Joint Visit on Emergency Response Referrals for Children Under 24 Months of Age*. Once finalized and approved, this FYI will serve as the policy basis of the joint visit initiative. A policy workgroup has been established to vet the document. The workgroup consists of both DCFS and DPH PHNs, SEIU, and the DCFS Policy and Training Unit.

The FYI, among other things, informs staff about the purposes of the joint visit initiative; that Phase I is limited to the Compton and Vermont Corridor Regional Offices; provides direction on what must be done during a joint visit; and outlines the duties and responsibilities of the PHN and the CSW.

PHN Assessment Tool

The PHN Assessment Tool is a form under development that PHNs will use when conducting a joint visit. Recently, the OCP and DCFS sought input on the form from County Counsel and the Nurse Directors from DPH and DHS. Out of this discussion came a recommendation to revise the form to ensure that a PHN's assessment will remain a clinical observation rather than a medical diagnosis. The Nursing Directors have indicated that the proposed PHN Assessment Tool does not call for the PHN to engage in activity that is beyond a PHN's scope of practice.

Next Steps

- Finalize the FYI and present the document to CSWs
- Finalize PHN Assessment Tool
- Communicate plan to stakeholders

Training

A comprehensive training plan is being developed to ensure that Public Health Nurses have the requisite skills to determine whether a child should be referred to the MLK Hub or other appropriate safety related action. The plan is being developed through a collaborative effort between the DCFS and DPH Training units. The Policy/Training Workgroup will re-convene in April to finalize the training plan.

The training plan incorporates a multi-level approach: didactic training, hands-on training, and shadowing. PHNs will be allowed to shadow Emergency Response CSWs in order to gain a better understanding of the type of work they do. Then PHNs will be sent to training. Training modules will take five days to complete and will include lectures, computer-based tutorials, information guides, and simulations. DCFS plans to train all newly hired PHNs, all PHNs in the Phase I offices and all PHN Supervisors in the Phase I offices. Each training cohort will consist of 24 participants. The training curriculum is divided into two components: didactic and practicum.

Table 6: Training Curriculum Components

Didactic	Practicum
<ul style="list-style-type: none"> ▪ Core Practice Model Overview ▪ PHN/CSW Roles and Responsibilities ▪ Emergency Response (ER) Overview & Legal Authority ▪ Procedures for Conducting Joint Visits ▪ Field Safety Considerations ▪ Child Abuse Identification & Reporting Laws ▪ Medical/Health Documentation (including CWS/CMS contact entry) 	<ul style="list-style-type: none"> ▪ Scenario simulations where PHNs and CSWs will be able to gain an overall understanding of the joint visit process for the specific target population. ▪ Simulations will enable PHNs and CSWs to get insight into the type of skills that are necessary as well as obtain a perspective on what circumstances can be present during a joint visit.

Next Steps

- DCFS and DPH finalizing training manual and curriculum.
- Develop schedule to allow PHNs to shadow Emergency Response CSWs
- Develop training schedule for newly hired and existing PHNs assigned to Phase I Offices

VI. Measures and Outcomes

To understand the impact that Phase I has on the safety and well-being of children under 24 months, tracking various process and outcome measures is critical. Moreover, the results from Phase I will inform the adjustments required to achieve better results in subsequent phases. A data workgroup has been established. The Data Workgroup was tasked with creating the workflow process to capture data elements to be tracked and monitored during Phase I. Performance will be tracked during implementation of Phase I to ensure that services are provided to children and families; and to inform policy decisions that will impact future phases of the CSW-PHN Joint Visit Initiative as County-wide rollout continues. Most of the data elements are to be documented in CWS/CMS, and monthly activity reports (trends, impact) will be run to measure performance during Phase I.

Leveraging the County’s Health System to Prevent Child Abuse and Neglect

A preliminary list of data elements that will be tracked and monitored during implementation of Phase I have been identified and categorized into three types of outcomes: (1) process; (2) child welfare; (3) health. These outcomes pertain only to those referrals that received a CSW-PHN pairing during the investigation.

Table 7: Performance and Outcomes Measures

Activity	Measure
Referrals Assigned to CSW and PHN	<ol style="list-style-type: none"> 1. Total number of referrals that paired a CSW and PHN <ul style="list-style-type: none"> ▪ By time period (traditional business hours; afterhours) ▪ By referral type (Immediate Response, 5-day, etc.) ▪ By child’s age (less than 24 months (focus child); siblings over 24 months) ▪ Type of allegation
Joint Visits	<ol style="list-style-type: none"> 2. Total number of visits conducted by PHNs <ul style="list-style-type: none"> ▪ Number of initial visits that a CSW and PHN conducted together ▪ Number of initial visits conducted separately ▪ Number of joint visits conducted jointly 3. Number of children assessed by PHN (by age)
Hub Referrals by PHN	<ol style="list-style-type: none"> 4. Number of Hub referrals by PHN for medical screening <ul style="list-style-type: none"> ▪ Number of Hub referral refusals (by parents) 5. Number of children screened at Medical Hub (by age) 6. Number of days that Hub screening occurred after joint CSW-PHN visit
Hub Appointment Management	<ol style="list-style-type: none"> 7. Total number of appointments 8. Number of Hub appointment failures (by parents) <ul style="list-style-type: none"> ▪ Number of appointments rescheduled <ul style="list-style-type: none"> – Number of times rescheduled: 1, 2, 3, etc. – Reasons for rescheduling (parent request vs. Hub requests) ▪ Number of children that were not scheduled for an appointment within 72 hours of joint visit and the reasons (parent request vs. Hub unable to accommodate) ▪ Number of families that required (and received) transportation assistance
Child Welfare Related	<p><i>The following require a comparison of the baseline with Phase I outcomes by regional office</i></p> <ol style="list-style-type: none"> 9. Number of detentions 10. Impacts on ER referral closure timelines. Information on referrals open > than 30 days <ul style="list-style-type: none"> ▪ Number of children who required a Hub exam ▪ Number of children who received a Hub exam within 72 hours of joint CSW-PHN visit ▪ Impact of #8 above on referral closures (< 30 days vs. > 30 days) 11. Number of children returning to the system 12. Number of children with recurrence of maltreatment 13. Number of child fatalities, if any
Linkage with Health Care and Supportive Services	<ol style="list-style-type: none"> 14. Number of PHN-generated community referrals 15. Number of children who were referred to services as a result of PHN-generated referrals <ul style="list-style-type: none"> ▪ Number who received/obtained services ▪ Number who were deemed ineligible by agency ▪ Number who declined services 16. Number of families already connected with Home Visitation and other community-based specialty (resource) services at the time of the referral 17. Number of families with an existing Medical Home (and at time of referral/case closure) <ul style="list-style-type: none"> ▪ Number with no identified Medical Home at time of referral ▪ Number with private provider as Medical Home at time of referral ▪ Number with DHS as Medical Home at time of referral

More work is required to identify additional measures indicative of health related outcomes for children. The OCP has reached out to DHS and to the Children’s Data Network to help identify meaningful health

related measures that can be tracked through this joint visit initiative. As roll-out continues, data collection will improve and the metrics and outcomes initially chosen to be measured will likely change.

Next Steps

- Determine how to track requests for medical records and impact on disposition
- Continue to work on identifying health related outcomes and measures

Conclusion

Since January, much planning and work has taken already place to implement the CSW-PHN joint visit initiative. Each Department is working to implement its hiring plan, and the workgroups continue to meet to finalize policies, procedures and work through other logistical details. The Departments continue to work together to address intra-departmental operational changes. The OCP will provide a pre-implementation report on or before June 15, 2015 to keep this Board apprised of progress being made. The CEO will issue a separate report assessing the budget and operational changes, including personnel and capital improvements needed to implement the recommendations outlined in the Board reports issued by DHS on January 9, 2015 and CEO on January 12, 2015.



County of Los Angeles CHIEF EXECUTIVE OFFICE

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
<http://ceo.lacounty.gov>

SACHI A. HAMAI
Chief Executive Officer

Board of Supervisors
HILDA L. SOLIS
First District

MARK RIDLEY-THOMAS
Second District

SHEILA KUEHL
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

October 16, 2015

To: Supervisor Michael D. Antonovich, Mayor
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe

From Sachi A. Hamai
Chief Executive Officer

PROTECTING COMMERCIALY SEXUALLY EXPLOITED CHILDREN: COUNTYWIDE SINGLE COORDINATED ENTITY, UNIFIED OPERATIONAL MODEL, AND SAFE HOUSE PROGRAM

On April 14, 2015, May 12, 2015, and June 16, 2015, this Board adopted five motions related to Commercial Sexual Exploitation of Children (CSEC). Each motion was directed towards the Chief Executive Office (CEO) and/or other relevant departments. The specifics of each motion are summarized in the table below.

Board Sponsor(s)	Motion Directives
Ridley-Thomas and Solis (adopted 4/14/15)	Report back during Budget Deliberations on the feasibility of using \$6,738,000 of Healthier Communities, Stronger Families, Thriving Children (HST) funds from the CEO's Budget to the Provisional Financing uses Budget and report back on the following: <ul style="list-style-type: none"> • The feasibility of using the funds to offset \$300,000 in ongoing net county costs related to the CSEC STAR Court; • Services, programming interventions, and recovery solutions for CSEC, including a CSEC court in the dependency court; and • Recommendations related to dedicated staffing and evaluation tools and resources that track the magnitude of sexually exploited children with the County.
Solis and Knabe (adopted 05/12/15)	<ul style="list-style-type: none"> • Assess the feasibility of developing a safe facility for CSEC.
Ridley-Thomas and Antonovich (adopted 6/16/15)	Analyze the feasibility of creating a single entity responsible for, among other things, all countywide efforts related to human trafficking. This coordinating body would be responsible for, among other things:

"To Enrich Lives Through Effective And Caring Service"

**Please Conserve Paper – This Document and Copies are Two-Sided
Intra-County Correspondence Sent Electronically Only**

Board Sponsor(s)	Motion Directives
	<ul style="list-style-type: none"> • Developing and maintaining an informational and research database; • Developing a CSEC informational website; • Overseeing expansion of the County's First Responder Protocol; • Implementation of the County's SB 855 Plan; • Assessing training needs and recommend training solutions; • Assessing and evaluating County programs to determine if resources are appropriately allocated to avoid redundancy; • Reviewing and evaluating proposed initiatives; • Identifying funding streams; and • Developing a CSEC strategic plan.
Knabe and Solis (adopted 6/16/15)	<ul style="list-style-type: none"> • Assess the feasibility of creating a unified operational model to administer and oversee programs and services exclusively for victims of child sex trafficking.
Knabe (adopted 6/16/15)	<p>Explore options to refresh, rebrand, and expand the Safe house program to additional County facilities and to include CSEC. Specifically, the motion directed the CEO with a plan and timeframe to:</p> <ul style="list-style-type: none"> • Outreach to the public to educate them about the Safe House Program; • Train necessary employees to identify warning signs of CSEC and what should be done when a CSEC is identified; and • Implement expansion of the Safe House Program to include Sheriff's stations, hospitals, community health clinics, certain County offices and facilities.

With the exception of the May 12, 2015 motion related to a safe facility, each motion was referred back to its primary sponsor then consolidated and incorporated into a single motion introduced by Supervisors Ridley-Thomas and Antonovich and adopted by the Board on June 30, 2015. The June 30, 2015 motion directed the CEO to review all motions collectively and when appropriate issue recommendations on the feasibility, structure, implementation, planning, and necessary staffing levels. The report related to the Board's May 12, 2015 motion related to a safe facility for CSEC will be issued by the Department of Children and Family Services (DCFS) and other County Departments and is expected in mid-November 2015. This report addresses the motions originally introduced on June 16, 2015 and incorporated into the June 30, 2015 motion. Recommendations related to possible uses of the HST fund will be included in a companion report issued simultaneous to this report.

The CEO has worked closely with the Office of Child Protection (OCP), DCFS, Fire, Probation, Sheriff, and Public Health to develop recommendations responsive to these CSEC related motions. The recommendations are discussed in Attachment I and are summarized in the table below.

Motion	Summary of Recommendations
Single Coordinated Entity	<ol style="list-style-type: none"> 1. Collapse the CSEC Steering Committee and the CSEC Action Team and fold both into the newly established CSEC Integrated Leadership Team responsible for implementing the objectives identified in the Board's June 16, 2015 motion. 2. Identify the following Departments as standing members of the newly established CSEC Integrated Leadership Team: DCFS, Probation, Sheriff, Mental Health, DPSS, Public Health, Health Services, District Attorney and Public Defender, Alternate Public Defender, and Panel Attorneys. 3. Designate DCFS, Probation, and Sheriff, as co-leads of the CSEC Integrated Leadership Team collectively responsible for ensuring that a Countywide, CSEC-focused strategic plan which encapsulates the Board's identified objectives, is developed, implemented and monitored. 4. Designate the OCP as the County's decision maker on operational CSEC issues when an impasse is reached that threatens efforts to impede progress on implementing the Countywide strategic plan for CSEC and/ or unify the Countywide CSEC operational model. 5. In order to ensure a sustained effort and follow-through, require DCFS, Sheriff and Probation to dedicate at least one full-time equivalent to work on operational CSEC issues with their respective Departments and an additional .5 FTE to the CSEC Integrated Leadership Team and other CSEC efforts (attend planning meetings, write reports, prepare presentations, track data, etc.). 6. If not otherwise prohibited by its grant, Sheriff should add both DCFS and Probation to its Task Force leadership team and should be added to the SB 855 Executive Committee. 7. For the first year of its existence of the CSEC Integrated Leadership Team, require the team to meet, at least monthly, with the initial meeting occurring no more than 30 days after the Board adopts these recommendations. 8. Further require the CSEC Leadership Team to jointly issue regular written reports (every four months) on its activities and progress on implementation of its strategic plan.
Unified Operational Model	<ol style="list-style-type: none"> 1. Adopt the SB 855 plan as the County's foundational unified operational model. 2. Within 30 days of its initial meeting, require the CSEC Integrated Leadership Team to convene a meeting with relevant Departments and stakeholders to begin work on a Countywide CSEC strategic plan that addresses the entire continuum – from prevention to support - using the Action Team's plan as a foundation.
Safe House Program	<ol style="list-style-type: none"> 1. Identify the population that the rebranded program should serve. 2. Rename the program the "Safe Place Program" and determine whether a new name and logo are desirable and appropriate. 3. Develop a public awareness campaign that uses public service announcements, signage, literature, posters, and social media (including a

Motion	Summary of Recommendations
	website). 4. Require all County Departments to post, on their website, a link to the County's informational CSEC site. 5. Conduct a readiness assessment of which County Departments should participate in early roll-out of the re-branded program.

If you have any questions or require any additional information, please contact Fesia Davenport at (213) 974-1186, or by email at fdavenport@ceo.lacounty.gov.

SAH:JJ:FD:ljp

Attachment

- c: Executive Office, Board of Supervisors
- County Counsel
- District Attorney
- Sheriff
- Alternate Public Defender
- Children and Family Services
- Health Services
- Mental Health
- Probation
- Public Defender
- Public Health
- Public Social Services

Executive Summary

This report is divided into four sections. The first section discusses options for establishing a single, countywide, coordinating body to manage, coordinate, and monitor the County's many CSEC initiatives and conclude that no one County Department could effectively serve as the single coordinating entity. The second section discusses options for a unified operational model and recommends that the County's SB 855 plan serve as the foundation of the County's unified operational approach to serving CSEC. The third section discusses options for establishing a Countywide Safe House Program for CSEC and recommends that phased-in approach to the implementation of this initiative. The final section provides a general timeline for a single coordinating entity comprised of DCFS, Probation and Sheriff to begin the work of implementing the approaches and programs contemplated by the Board's CSEC motions.

Countywide CSEC Coordinating Body

The June 16th and June 30th motions both include the term "human trafficking." Human trafficking and child sex trafficking are different yet related concepts with the former definition being broader than the latter. Specifically, human trafficking includes, but is not limited to, child sex trafficking and is defined by the United States Immigration and Customs Enforcement as:

The recruitment, harboring, transportation, provision or obtaining of a person for labor or services, through the use of force, fraud or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage or slavery.

The definition of child sex trafficking is narrower and is generally used to describe a commercial enterprise where minor children are induced by coercion, fraud, duress, and/or deception to engage in and perform sexual acts in exchange for money or some other form of compensation.

The CEO sought clarification the primary sponsor's office to clarify that the intent of this motion was to focus on child sex trafficking and not human trafficking. As such, this memo focuses on child sex trafficking, the commercial sexual exploitation of children (CSEC) for purposes of providing options for a Countywide coordinating entity devoted to CSEC.

Discussion

Although it is feasible to create an entity to coordinate the County's activities related to CSEC it is not advisable to do so since there are several, existing, County-sponsored groups working on CSEC that could meet the Board's objectives. One of these groups could be repurposed and called the CSEC Integrated Leadership Team (Leadership Team). The existing CSEC initiatives include:

Countywide Coordinating Entity, Unified Operational Model, and Safe House Program for Commercially Sexually Exploited Children

- The SB 855 Steering Committee;
- CSEC Task Force;
- The Los Angeles County Human Trafficking Task Force;
- The CSEC Action Team; and
- The District Attorney’s Office (DAO) collaborative efforts related to diversion.

A profile of each collaborative is included in Table 1 below:

Table 1

County Effort	Date	Members	Purpose
SB 855 Steering Committee	2014	20 departments and partners including DCFS and Probation	To investigate suspected child abuse and make placement decisions when a child is suspected or identified as being sexually exploited.
CSEC Task Force	2012	7 departments including DCFS, Probation and Sheriff	To examine and track the CSEC population, make recommendations to address the needs of these youth and eliminate their recruitment into the abusive life of sex trafficking.
Human Trafficking Taskforce	2015	5 departments and partners including Sheriff, District Attorney, and DCFS, a community based network	To address and attack the problem of human trafficking (including sex trafficking) through a regionalized law enforcement, social services, and community-based organizational approach.
CSEC Action Team	2014	7 departments and stakeholders including DCFS, Probation, and the California Child Welfare Council CSEC Action Team managed by the CEO	To develop a comprehensive county-wide strategic plan to address CSEC, to implement the CSEC strategic plan (working with and through other departments and stakeholders), and implement the plan’s objectives.
District Attorney’s First Step Diversion Program	2014	5 County Departments and community based organizations including the DAO, Sheriff, Probation and DCFS	To provide girls and boys ages 12-17, who are arrested for sex-related crimes, with the opportunity to complete a year-long program (that provides counseling, medical and social services) in exchange for clearing original charges.

The Leadership Team should be comprised of a broad number of child serving County Departments and other CSEC serving entities, but not be so large as to render the group unwieldy and therefore ineffective. The Leadership Team would be responsible for, among other things:

- Accomplishing the deliverables identified in the Board’s June 16, 2015 motion;
- Regularly convening the Leadership Team members to share information and learning;
- Track progress on County CSEC initiatives;
- Identify and remove policy and operational barriers to effective coordination and service delivery; and

- Keep the Board apprised of the effectiveness of the County's CSEC initiatives.

Because the Leadership Team would be tasked with accomplishing the specific deliverables identified in the June 16, 2015 motion, a designated decision-maker would be advisable in order to manage projects involving multiple departments, and make final decisions when an impasse among the departments, or differing approaches to problem solving threaten to impede progress.

Of the five collaborative groups identified above, three of them merit serious consideration for being designated as the single Countywide CSEC coordinating entity. Those three collaboratives are: The SB 855 Steering Committee (Steering Committee), The Los Angeles County Human Trafficking Taskforce (Task Force); and the Los Angeles County Action Team (Action Team). A description of the purpose and work of each group is listed below. These three stand out among all others because of the scope of their work and/or the breadth of their membership. The relative strengths and weaknesses of each of the three entities in terms of being designated as the County's coordinating entity are summarized in Table 3 below.

SB 855 Steering Committee

The SB 855 Steering Committee is focused on child sex trafficking or youth at risk of becoming CSEC. The steering committee was established in 2014 in response to the passage of Senate Bill 855 (SB 855) in 2014. This legislation:

- Clarified that CSEC fall under the jurisdiction of the child welfare system as victims of child abuse and neglect pursuant to State law;
- Created a statewide CSEC program to be led by each county's child welfare agency to serve CSEC through a multidisciplinary team approach; and
- Provided funding for various interventions and services (including training, data collection, protocol development, certain types of staffing, supplemental foster care rate payments).

As required by SB 855, the County formed a multi-disciplinary CSEC steering committee to create a plan to serve CSEC victims using a multidisciplinary team approach and to oversee the delivery of CSEC services. SB 855 requires that the team be led by the each county's human services department (in the case of Los Angeles County it is DCFS), and include representatives from county probation, county mental health, county public health, and the juvenile court. The legislation designates as optional participation from other organizations such as law enforcement, survivors, and advocates. The County's Steering Committee is comprised of the Departments and entities identified in Table 2 below. DCFS is the County's lead as required by SB 855.

Table 2

Law Enforcement/ Law Related	Law Enforcement/ Law Related	Social & Health Services	Education and Advocacy
County Sheriff	Probation	Children and Family Services	Los Angeles Unified School District (LAUSD)
Los Angeles Police Department	Alternate Public Defender	Public Health (DPH)	Educational Advocates
Long Beach Police Department	Public Defender	Public Social Services	Placement Representatives
Children’s Law Center	District Attorney	Mental Health	Survivor Advocates
Los Angeles Dependency Lawyers	County Counsel		
Juvenile Court	Panel Attorneys		
Los Angeles City Attorney			

The purpose of the Steering Committee is to develop and implement a multi-disciplinary, County-wide protocol for delivering services to CSEC. A fuller discussion of this approach can be found in the next section of this report. The Steering Committee submitted a plan to the State outlining the County’s approach to CSEC. The plan calls for an array of services and interventions, including:

- Increasing awareness and training;
- Advocacy Services;
- CSEC oriented Court Services;
- Specialized Placements; and
- Incidental Supports.

The appeal of the Steering Committee is its:

1. Exclusive focus on child sex trafficking victims;
2. The existence of an operational protocol ready for Countywide roll-out;
3. Existence of a screening protocol (see unified operational model discussion below);
and
4. Multi-disciplinary approach born out of a social services model.

The limitations of the Steering Committee is the lack of a clear path outlining how all of the County’s various CSEC efforts (not all are mentioned in this report) will be coordinated and will work together. Put another way, there is no single document that pulls together all components of County CSEC efforts clearly delineating roles, responsibilities, relationships and resources along the entire CSEC continuum (i.e. prevention, protection, integrated service delivery, post-intervention supports). To that end, the Steering Committee’s approach appears to be deep in the area of integrated service delivery and supports and less so in the other areas of the continuum. Finally, as currently configured the Steering Committee is a committee of equals. There is no obvious protocol to resolve issues when they arise. These issues were raised by the Office of Child Protection (OCP) in a meeting with representatives from DCFS and Probation. While there was not uniform agreement on what the OCP sees as limitations

of the Steering Committee's approach, there was agreement that adequate resources are necessary and that having a third-party to decide issues would be helpful.

Los Angeles County Human Trafficking Taskforce

The Sheriff's Department is creating and building out a task force to combat human trafficking called the Los Angeles County Human Trafficking Task Force (Task Force). The Task Force is comprised of several agencies under the joint leadership of: the Sheriff's Department, CAST (Coalition To Abolish Slavery) - a community based organization experienced in servicing victims of sex trafficking, and the United States Attorney's Office. The Task Force has three major goals:

- Identify victims of human trafficking;
- Provide victim-centered services to identified victims; and
- Investigate cases of alleged human trafficking and supporting prosecution of traffickers.

The Task Force has victim-centered, collaborative protocols and approaches to combat human trafficking including child sex trafficking. Training, community outreach, and raising awareness are critical components of the Task Force's plan. The Task Force has four subcommittees: Law Enforcement, Training and Outreach, Victim Service Providers, and Administration. The Task Force has also identified five objectives. They are:

1. Establish a sustainable and multidisciplinary, collaborative Task Force responding to victims of all forms of human trafficking;
2. Make data-driven decisions based on a shared understanding of human trafficking problem within Los Angeles County;
3. Identify victims of all forms of human trafficking through collaborative efforts supported by the Task Force training, investigation, and outreach;
4. Conduct effective trafficking investigations leading to successful prosecutions of cases at the state and federal level; and
5. Support a comprehensive array of victim services which meet the individualized needs of victims of all forms of human trafficking.

The Sheriff's Department has assigned dedicated staff to the Task Force and intends to add more regardless of whether it receives a federal grant to combat human trafficking. The Sheriff's Department plans to conduct an evaluation to measure the effectiveness of its proposed strategies, processes, performance and impact/outcomes.

The appeal of the Task Force is its:

1. Intent to use dedicated staff for both line operations and administration;
2. Focus on addressing the demand for CSEC; and
3. Decision to complete an evaluation by an independent party.

In terms of potentially designating the Task Force as the entity coordinating Countywide CSEC initiatives, other considerations must be addressed. The State Legislature and the California Department of Social Services has issued a clear mandate that CSEC are victims not criminals, should not be arrested, and should be provided the range of services offered by each county's child welfare agency. Cities and counties are slowly moving away from a law enforcement approach to serving this population.

By definition the Sheriff's Department is a law enforcement agency. As such, their status as a law enforcement agency seems to place them in conflict with the direction that the State is moving. Also, the Task Force will not focus exclusively on CSEC. Rather its efforts will be divided among other human trafficking populations. Finally, consideration must be given to the fact that the Task Force's efforts will be funded by a time-limited grant.

These issues were raised in a meeting between OCP, the Sheriff, and the Sheriff's staff working on the Task Force and merit further discussion. The Sheriff's Department does not believe that these considerations should prevent them from serving as the single coordinating entity as the Department has changed and continues to change its approach to CSEC. Should the Board elect to designate the Sheriff's Department as the County's coordinating entity for all CSEC initiatives, the Sheriff's Department has committed to taking all necessary steps to successfully carry out the charge and manage the perception issue raised by having a law enforcement agency serve as the face of the County when serving this vulnerable population.

Los Angeles County CSEC Action Team

The County's CSEC Action team was established after the State mandated that each County establish a team to develop a strategic plan to address CSEC and to implement those plans. The action team was assisted by a consultant procured by Probation and was comprised of DCFS, Probation, DPSS, DMH, District Attorney's Office, and CAST. DCFS and Probation co-led this action team and the CEO provided limited project management support. The Action Team developed a strategic plan consisting of four major focus areas:

1. Service Delivery;
2. Placement Resources;
3. Awareness and Outreach; and
4. Multi-System Data Collection and Sharing.

For each focus area goals and objectives were identified. One deliverable out of that strategic plan was the County's First Responder Protocol currently operational in two areas of the County. The Action Team still exists informally, but its focus has been diverted away from implementation of the strategic plan and towards Board motions specifically related to CSEC. The appeal of the Action Team is its comprehensive approach to CSEC and development of a framework for how CSEC objectives would be accomplished and sequenced. The appeal of the Action Team is:

Countywide Coordinating Entity, Unified Operational Model, and Safe House Program for Commercially Sexually Exploited Children

1. Fairly comprehensive approach, from the victim’s perspective, to address CSEC; and
2. Concrete and identified steps outlined to move the plan forward.

One challenge of the Action Team was the uneven levels of dedicated staffing resources from various County Departments. For example, DCFS was able to dedicate staff to the Action Team, but the dedicated staff was not full-time and was not at the appropriate level when considering the workload associated with CSEC. Probation’s ability to dedicate staff to CSEC has been the driving force behind CSEC in the County. But as this population moves to child welfare, DCFS must dedicate adequate administrative resources.

The Office of Child Protection discussed the staffing resources issue with both DCFS and Probation. DCFS represented that the Department was in the process of designating a full-time Assistant Regional Administrator to coordinate the Department’s work around CSEC. In addition, as caseloads have decreased, the Department is in a better position than it was previously. The Department intends to dedicate between 6 and 12 social workers to work on CSEC exclusively complementing the work of existing Children’s Social Worker’s.

Table 3

Existing CSEC Entity	Reasons Supporting Designation As Countywide Coordinating Entity	Reasons Supporting Non-Designation as Countywide Entity
SB 855 Steering Committee	<ul style="list-style-type: none"> • Exclusive focus on child sex trafficking victims, • Protocol in place and operational, • Multi-disciplinary approach borne out of a social services approach 	<ul style="list-style-type: none"> • Approach is deep (for services) but not wide (e.g. does not address demand). • Lacks neutral decision maker
Trafficking Task Force	<ul style="list-style-type: none"> • Dedicated/ing staff focused on administration, and line operations; • Focus on addressing demand for CSEC; • Planned two-part evaluation 	<ul style="list-style-type: none"> • Law enforcement agency as the face of County CSEC efforts results in inconsistent messaging, • Non-exclusive focus on CSEC, • Sustainability after grant expires, and • Lacks neutral decision maker.
CSEC Action Team	<ul style="list-style-type: none"> • Broader approach to addressing CSEC Countywide found in strategic plan • Inclusiveness of key County Departments 	<ul style="list-style-type: none"> • Lack of dedicated staffing at appropriate level

Conclusion and Recommendations

Based on the foregoing analysis it appears that the no single CSEC focused entity is poised to adequately cover the entire continuum to combat CSEC – yet this is exactly what CSEC victims need and the County should be doing. The continuum includes:

- Prevention;
- Protection;
- Placement;
- Treatment; and
- Support.

An approach that treats and supports victims without adequately addressing demand is less than ideal and the reverse is also true – a focus on the demand for CSEC without addressing treatment and support is equally undesirable. None of the entities identified above can adequately cover the entire continuum and there appears to be overlap and duplication between the planned or current activities of the Steering Committee, Task Force, and Action Team. Based on the foregoing, the CEO recommends that the Board take the following action:

1. Collapse the CSEC Steering Committee and the CSEC Action Team and fold both into the newly established CSEC Integrated Leadership Team responsible for implementing the objectives identified in the Board's June 16, 2015 motion.
2. Identify the following Departments as standing members of the newly established CSEC Integrated Leadership Team: DCFS, Probation, Sheriff, Mental Health, DPSS, Public Health, Health Services, District Attorney and Public Defender and the Alternate Public Defender.
3. Designate DCFS, Probation, and Sheriff, as co-leads of the CSEC Integrated Leadership Team collectively responsible for ensuring that a County-wide, CSEC-focused strategic plan which encapsulates the Board's identified objectives, is developed, implemented and monitored.
4. Designate the Office of Child Protection as the County's decision maker on operational CSEC issues when an impasse is reached that threatens efforts to impede progress on implementing the County-wide strategic plan for CSEC and/ or unify the County-wide CSEC operational model.
5. In order to ensure a sustained effort and follow-through, require DCFS, Sheriff and Probation to dedicate at least one FTE to work on operational CSEC issues with their respective Departments and an additional .5 FTE to the CSEC Integrated Leadership Team and other CSEC efforts (attend planning meetings, write reports, prepare presentations, etc.).

6. If not otherwise prohibited by its grant, Sheriff should add both DCFS and Probation to its Task Force leadership team.
7. For the first year of its existence of the CSEC Integrated Leadership Team, require the team to meet, at least monthly, with the initial meeting occurring no more than 30 days after the Board adopts these recommendations.
8. Further require the CSEC Leadership Team to jointly issue regular written reports (every four months) on its activities and progress on implementation of its strategic plan.

Unified Operational Model

Discussion

A unified operational model can take various forms. In a County the size of Los Angeles, appropriate levels of uniformity and coordination are essential components of any unified operational approach. County departments, partners, stakeholders, and others need a shared understanding of CSEC, and a clear understanding of everyone's role and responsibility in combatting CSEC. Essential components of a unified operational model include: 1) An agreed-upon, multi-departmental screening or assessment tool that will identify CSEC or youth at risk of CSEC; 2) A protocol that delineates the roles and responsibilities of each stakeholder in the CSEC continuum; and 3) Standardized communication channels must be established.

DCFS, DPH, Probation, and the Children's Law Center have agreed to use a screening tool developed by a private, non-profit organization. Plans to train on this tool are currently underway. In addition both Health Services and Public Health have developed screening protocols and/or assessment protocols. The protocols remain in draft phase and have yet to be finalized.

In June 2015, DCFS submitted a plan to the California Department of Social Services (State) describing how Los Angeles County would operationalize its plan to address the needs of CSEC. DCFS submitted the plan, as opposed to Probation or Sheriff, because SB 855 requires that the County's human services agency be the lead on any plan to implement SB 855 and receive State funding. In Los Angeles County, and with regard to CSEC, DCFS is the County's health and human services agency. The plan describes the County's vision to provide comprehensive services to the CSEC. Highlights of the plan are summarized in Table 4 below. The State will use the plan to identify the amount of funding Los Angeles County will receive from the State's CSEC program. The plan was developed as a result of a collaborative process involving the stakeholders identified in Table 1 above.

The plan describes the County’s current and future operational approaches to CSEC case management and service delivery. The future approach involves expanding and building upon the existing approach and has two major components: 1) Expansion of the County’s existing First Responder Protocol; and 2) Establishing a CSEC court in the dependency court (currently CSEC court exists in the delinquency court only). A central component of these approaches is a focus on coordination and integration among County departments and partners emanating from a victim-centered orientation.

Table 4

	Partners	Goals and Deliverables
First Responder Protocol	DCFS, Probation, DHS, Survivors/Advocates, Law Enforcement	<p><i>A multi-disciplinary team is assembled within 90 minutes of receiving a call giving notice of the recovery of a CSEC youth.</i></p> <ul style="list-style-type: none"> • Avoid arrest and divert CSEC to child welfare system • Engage youth immediately and intensively • Connect youth with experienced CSEC advocate • Coordinate case planning at earliest possible point • Develop safety plan including housing options • Ensure comprehensive medical evaluation
Dependency CSEC Court	DCFS, DMH, DPH, Children’s Law Center, survivor advocates, education advocates, and caregivers, and others as appropriate.	<p><i>Modeled on the existing CSEC court in delinquency. This court would monitor and direct each youth’s case plan to ensure that coordinated services are provided timely, and appropriately.</i></p> <ul style="list-style-type: none"> • Case planning and case management • Ensure youth have 24/7 access to a member of their MDT • Monitor youth’s progress and condition in placement to reduce run-away behavior • Increase gender sensitivity when necessary • Uncover and address underlying needs • Provide comprehensive mental health treatment • Assist with building self-esteem • Build upon existing resiliency factors

In addition to the screening/assessment tools and the operational protocols listed above, three other Departments are playing very important roles in the County’s efforts to combat CSEC: Health Services, Public Social Services, and Mental Health. Table 5 below summarizes the efforts of each department.

Table 5

Department	CSEC Efforts	Purpose
Health Services	Developed a draft assessment and intervention protocol for DHS staff.	To identify children involved or at risk for CSEC and to provide comprehensive care including treatment of acute medical issues, pregnancy prevention and care, treatment and care of sexually transmitted infections, mental health services. Health Services’ goal is to: prevent at risk children from entering CSEC, to prevent re-entry into CSEC for those involved, and to mitigate the mental, physical, and emotional impact of CSEC.

Countywide Coordinating Entity, Unified Operational Model, and Safe House Program for Commercially Sexually Exploited Children

Health Services	Developed a proposal to provide Countywide 24/7 medical/mental health services to recovered CSEC	To provide comprehensive medical services to recovered CSEC.
Mental Health	Training of contracted providers	Mental health has identified mental health contracted providers in each SPA who have been trained to identify CSEC.
Public Health	Developed a draft protocol for improving identification of and response to CSEC	Increase awareness and identification of CSEC encountered by DPH Programs and provide guidance on screening, and appropriate treatment and referral.
Public Social Services	CSEC Awareness Campaign among hotels/motels providing emergency shelter services to County recipients of General Relief	Raise awareness among DPSS contracted providers regarding child sex trafficking sex; securing commitments from contracted providers to disallow usage of their facilities for sex trafficking; posting of anti-sex trafficking posters in visible areas of the contracted providers; agreement with contracted providers to allow local law enforcement to inspect their registers, and other activities.

Conclusion and Recommendations

A unified operational model to CSEC requires uniformity, coordination of design and effort, and regular and ongoing communication. The County has many of the operational components in place for an operational model, but those components require coordination and ongoing communication to unify the Countywide operational model. Based on the foregoing, the CEO makes the following recommendations:

1. Adopt the SB 855 plan as the foundation for the County’s unified operational model.
2. Within 30 days of its initial meeting, require the CSEC Integrated Leadership Team to convene a meeting with relevant Departments and stakeholders to begin work on a Countywide CSEC strategic plan that addresses the entire continuum – from prevention to support - using the Action Team’s plan as a foundation.

Safe House Program

Discussion

In 1997, the current Safe House Program was implemented in Los Angeles County, mainly in Fire stations, as a way to provide a temporary haven for any child or adult facing a potentially threatening situation and needed a safe place. A few years later, the County implemented the Safe Surrender Program, which gave parents or guardians the choice to legally and safely surrender their babies at any hospital or fire station in Los Angeles County. While the Safe Surrender Baby Program has experienced high levels of success and visibility, the Safe House Program has not. It is feasible to refresh, rebrand, and expand the current Safe House Program to include CSEC. In order to successfully rebrand this program, the target population should be redirected to CSEC and other vulnerable youth. The term “Safe House” program has a specific meaning in the world of sex trafficking, therefore, the program should be named

something different while retaining the safety connotation. The CEO recommends that the program be renamed the "Safe Place Program." The conceptual design of a rebranded program should be operationalized by the CSEC Integrated Leadership Team as outlined below.

Phase I: Program Re-Design and Planning

1. Identify the population that the rebranded program should serve.
2. Determine whether a new name and logo are appropriate.
3. Develop a public awareness campaign that uses public service announcements, signage, literature, posters, and social media (including a website).
4. Require all County Departments to post, on their website, a link to the County's informational CSEC site.
5. Conduct a readiness assessment of which County Departments and/or community agencies should participate in early roll-out of the re-branded program.

Phase II: Roll-Out

Include the following departments in the initial roll-out of the rebranded Safe House Program: Fire Department, Children and Family Services, Probation, Public Social Services, and Sheriff. Early implementation would include the following actions for each Department:

- Prominently display the Safe Place logo, signage and literature;
- Include the safe house link on the Department's website;
- Train staff on signs of CSEC activity; and
- Train personnel on the steps to take when a CSEC seeks sanctuary in a Department's designated safe house facility.

After a reasonable implementation period, the CSEC Leadership Team should review the rebranded program, solicit feedback from each participating department, and make necessary adjustments before including other County departments or other entities such as: public libraries, hospitals, and clinics, and other non-county facilities.

Timeline for Early Efforts of Integrated Leadership Team

Below is a proposed timeline for the major activities under each of the three areas discussed above. These timelines are provided to show how the CSEC Integrated Leadership Team could spend its initial months:

Action Item	Nov	Dec	Jan	Feb	Mar	Apr
<p><i>Conduct the Inaugural Meeting of the CSEC Leadership Team</i></p> <p>Identify the current state of CSEC efforts: roles, responsibilities, relationships and resources from all CSEC related bodies. Identify and eliminate redundancy.</p>	→					
<p><i>Develop Strategic Plan</i></p> <p>Start work on a County-wide CSEC Strategic Plan which includes timelines for all deliverables identified in the Board's June 16, 2015 motion – including plan to roll out the SB 855 multi-disciplinary approach, and First Responder Protocol.</p>			→			
<p><i>SB 855 Implementation</i></p> <p>Continue work of implementing SB 855. Compare services and interventions (actual and planned) with those of other initiatives, identify and eliminate redundancy when appropriate.</p>						→
<p><i>Human Trafficking Implementation</i></p> <p>Continue the work of the Human Trafficking Task Force. Compare services and interventions (actual and planned) with those of other initiatives, identify and eliminate redundancy when appropriate.</p>	→					
<p><i>Safe Place Program</i></p> <p>Develop plan to rebrand and redesign the program.</p>			→			



County of Los Angeles
CHIEF EXECUTIVE OFFICE
Office of Child Protection

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 726, Los Angeles, California 90012
(213) 974-1186
<http://ceo.lacounty.gov>

SACHI A. HAMAI
Interim Chief Executive Officer

FESIA DAVENPORT
Interim Director

August 12, 2015

Board of Supervisors
HILDA L. SOLIS
First District


MARK RIDLEY-THOMAS
Second District

SHEILA KUEHL
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

TO: Philip L. Browning, Department of Children and Family Services
Cynthia A. Harding, Department of Public Health
Mitchell H. Katz, M.D., Department of Health Services
Jackie Lacey, Office of the District Attorney
Jim McDonnell, Sheriff's Department
Jerry Powers, Probation Department
Marvin J. Southard, D.S.W., Department of Mental Health
Sheryl L. Spiller, Department of Public Social Services

FROM: Fesia A. Davenport 
Interim Director, Office of Child Protection

**LOS ANGELES COUNTY PROTOCOL FOR SHARING INFORMATION WHEN
INVESTIGATING REPORTS OF SUSPECTED CHILD ABUSE/NEGLECT OR
MAKING DETENTION DETERMINATIONS**

As you know, the Office of Child Protection (OCP) has worked with each of your departments to finalize the attached protocol governing the sharing of confidential information for the purposes of investigating reports of suspected child abuse or neglect, or for the Department of Children and Family Services (DCFS) in making a detention determination. This protocol allows for the information to be shared through a two-person child abuse multidisciplinary team in person, telephonically, by facsimile, or electronically. Upon completing a thorough analysis of existing laws, County Counsel has determined that the sharing of this information is authorized by Welfare and Institutions Code Section 18961.7 for these purposes in order for workers to make appropriate and immediate decisions.

With this protocol finalized, DCFS emergency response workers, dependency investigators, other social workers involved in conducting investigations or making detention determinations, and their supervisors can receive information on individuals

"To Enrich Lives Through Effective And Caring Service"

***Please Conserve Paper – This Document and Copies are Two-Sided
Intra-County Correspondence Sent Electronically Only***

suspected of child abuse or neglect, or others residing in the home, if it is pertinent to the investigation. The information that can be shared for these purposes from other County departments is listed in Attachment A. This is information that can be shared within a two-person child abuse multidisciplinary team or your current multidisciplinary team process. Within the multidisciplinary team, all members can share relevant information with each other.

The OCP will be partnering with the Chief Information Office to create a new mechanism for electronically sharing this information using the two-person multidisciplinary team process. This mechanism will allow for expedited access to this important information, for better and more thorough child abuse investigations, and will include appropriate controls to protect the information. Once the new mechanism is completed, trainings will offered on how to access the information through the electronic system. This should greatly improve the ease and timeliness in which workers are able to access this critical information.

If you have any questions, please contact me, or your staff may contact Carrie Miller at cmiller@ceo.lacounty.gov. For any legal questions, you can contact the County Counsel attorney who advises your department.

Attachments (2)

FAD:CDM:ljp

c: Chief Executive Office
County Counsel
Chief Information Office

Data Elements to be Shared Electronically for Suspected Child Abuse or Neglect

Dept.	Data to be Shared
DHS	<ul style="list-style-type: none"> - Trauma-related injuries - Current psychotropic and opiate medications - Hospitalizations or emergency room visits within the last year
DPH	<ul style="list-style-type: none"> - Not receiving services from a SAPC contracted provider
DMH	<ul style="list-style-type: none"> - History of serious mental health illness - Recent hospitalization for psychiatric reasons - Forensic mental health history - Co-occurring disorder with substance abuse - Substance abuse (without another mental disorder) - Borderline or antisocial personality disorder diagnosis - Mental health episodes within the last year of: <ul style="list-style-type: none"> o Paranoia o Depression o Schizophrenia o Bi-polar o Delusions - Current participation level in treatment
DPSS	<ul style="list-style-type: none"> - Homelessness/housing instability - Domestic violence involvement - Substance abuse history
DA	<ul style="list-style-type: none"> - Penal Code violations related to the following areas: - Crimes against children under the age of 18 - Crimes relating to concealment of a child from a legal custodian or deprivation of child custody - Possession, sale, or distribution of pornography depicting an individual under the age of 18 - Employment of a minor in pornography or performing a prohibited act
Sheriff	<ul style="list-style-type: none"> - Case and charge information - Temporary restraining orders - Homelessness - Registered sex offender - Parole status - County warrant information - History of violent crimes - Non-violent crimes within the last 5 years <ul style="list-style-type: none"> o Filed arrests
Probation	<ul style="list-style-type: none"> - Homelessness - Substance abuse - Criminal history - Convictions of crimes against children - Current sex offender registrant (290 status) - Arson offender - Felony convictions when supervised by LA County Probation - Serious and violent offenses - Domestic violence - Currently active on Probation - Offense type - Location of current supervision - Inactive cases within the last 5 years

**LOS ANGELES COUNTY PROTOCOL
GOVERNING INFORMATION SHARING BY THE LOS ANGELES COUNTY CHILD
ABUSE MULTIDISCIPLINARY PERSONNEL TEAM CONVENED PURSUANT TO
WELFARE AND INSTITUTIONS CODE SECTION 18961.7**

The State Legislature has long recognized that the exchange of otherwise confidential information relevant to child abuse and neglect maintained by county departments is essential to the protection of children who are known or suspected of being abused or neglected. It therefore enacted laws allowing for the formation of child abuse multidisciplinary personnel teams comprised of individuals who are trained in the prevention, identification, or treatment of child abuse in order to allow information that would otherwise be confidential to be shared within the confines of the team for the safety and protection of at risk children within the County and preventing harm to these children.

The purpose in developing this protocol is consistent with the State Legislature's intent expressed in Welfare and Institutions Code section 16500 "*that all children are entitled to be safe and free from abuse and neglect.*"

At the same time, the County and each of the agencies participating in this protocol acknowledge that the information to be exchanged under this protocol is confidential and they are committed to preserving and maintaining the confidentiality of such information by limiting the disclosure of such information to that which has been determined to be generally relevant to the prevention, identification, or treatment of child abuse, by preventing the unauthorized access to or disclosure of such information, and by ensuring safeguards are in place to protect the confidentiality and security of such information.

1.0 Purpose of this Protocol

- 1.1 This protocol is drafted and implemented in accordance with Welfare and Institutions Code section 18961.7. The sharing of confidential information pursuant to this protocol is intended to allow Participating Agencies to investigate reports of suspected child abuse or neglect made pursuant to Sections 11160, 11166, or 11166.05 of the Penal Code, or for the purpose of child welfare agencies making a detention determination. This protocol is also intended to ensure that confidential information gathered by the team is not disclosed in violation of State or federal law.
- 1.2 This protocol is specifically intended to apply to the sharing of confidential information by teams established under Welfare and Institutions Code section 18961.7, which authorizes a two-person child abuse multidisciplinary team. Information sharing pursuant to this protocol is intended to allow provider agencies to investigate reports of suspected child abuse or neglect made pursuant to statutorily referenced

mandated reporter provisions¹ or for the purpose of child welfare agencies making a detention determination. This protocol also applies to investigations of non-mandated reports of child abuse if the sharing of information is done to make a child welfare detention determination.

- 1.3 Multidisciplinary personnel teams are also authorized under other provisions of State law, including but not limited to Welfare and Institutions Code sections 830², 10850.1³ and 18964⁴. Team members are encouraged to form multidisciplinary teams as permitted by these additional statutes to share relevant information to the extent permitted by these laws.

2.0 Definitions

- 2.1 Unless otherwise indicated, the terms used in this protocol shall have the same meaning as in Welfare and Institutions Code section 18961.7.

3.0 Participating Agencies

- 3.1 The provider agencies participating (Participating Agencies) in this protocol are:

The Los Angeles County Office of Child Protection (OCP)

The County of Los Angeles Department of Children and Family Services (DCFS)

The Los Angeles County Office of the District Attorney (DA)

The County of Los Angeles Department of Health Services (DHS)

The County of Los Angeles Department of Mental Health (DMH)

The Los Angeles County Probation Department (Probation)

The County of Los Angeles Department of Public Health (DPH)

The County of Los Angeles Department of Public Social Services (DPSS)

The Los Angeles County Sheriff's Department (LASD)

¹ Penal Code § 11160 (health provider mandated reporter), 11166 (general mandated reported), or 11166.05 (reporting of emotional damage).

² This statute addresses three person multidisciplinary personnel teams.

³ This statute permits the sharing of confidential records of federally funded public social services by members of multidisciplinary personnel teams.

⁴ This statute allows a multidisciplinary personnel team to deem other persons to be members of that multidisciplinary personnel team.

4.0 Establishment of the Multidisciplinary Personnel Team

- 4.1 A child abuse multidisciplinary personnel team is established, pursuant to Welfare and Institutions Code section 18961.7, for the County of Los Angeles.
- 4.2 The multidisciplinary personnel team established pursuant to Welfare and Institutions Code section 18961.7 consists of a minimum of any **two** child abuse multidisciplinary personnel team members described in Section 5.0.

5.0 Members of the Multidisciplinary Personnel Team

- 5.1 To maximize the rapid and effective sharing of information for the protection of children, the Participating Agencies have each designated at least one qualified person to serve as the administrative member of the multidisciplinary personnel team.
- 5.2 The members designated by the Participating Agencies to serve as a member of the multidisciplinary personnel team specified in Section 4.0 are listed on Attachment A.
- 5.3 The multidisciplinary personnel team may also include additional persons meeting the criteria set forth in Welfare and Institutions Code section 18961.7 and whose access is authorized by their respective agencies.
- 5.4 The director of each Participating Agency may change and/or increase his or her agency's designated members by transmitting a written notice, from the director or the director's designee, to the directors of each Participating Agency and to each person referenced in Section 5.2. The information contained in the written notice shall be incorporated into this protocol through a revised Attachment A.

6.0 Training and Qualifications

- 6.1 All members of the multidisciplinary personnel team shall be trained in the prevention, identification, or treatment of child abuse and neglect cases and be persons who are qualified to provide a broad range of services related to child abuse. The multidisciplinary personnel team may include any or all of those categories of persons listed in Welfare and Institutions Code section 18961.7(b)(1).
- 6.2 DCFS is the child protective agency for the County of Los Angeles. DCFS has determined, in consultation with the other Participating Agencies, the following regarding training for membership in the multidisciplinary personnel team:
 - 6.2.1 DCFS shall develop a training curriculum regarding the prevention, identification, or treatment of child abuse and neglect cases and make this training available to all potential members of the multidisciplinary personnel team.

6.2.2 The training curriculum shall be made accessible via an e-learning platform and each member's participation shall be tracked in the County of Los Angeles learning management system (aka SABA or The Learning Net). Upon completion of the training, trainees will be required to electronically indicate their understanding and agreement to the confidentiality of the data sharing process. Lastly, the e-learning will be readily available at all times, via SABA, for newly appointed multidisciplinary team members and for any subsequent refresher training, as necessary or required to ensure compliance with any statutory or regulatory requirements.

6.2.3 In addition to the above training curriculum, if deemed appropriate, a specific confidentiality training shall be developed for Social Workers assigned to Emergency Response units, Dependency Investigations units, and their respective supervisors regarding the confidentiality and security of the accessed information and how to appropriately access and use the accessed confidential information.

6.3 The items listed in the preceding section are not intended to describe the only way in which a person may meet the training requirements for membership in the multidisciplinary personnel team. It is intended to identify one agreed-upon way in which the training and qualifications may be satisfied. Members of the multidisciplinary personnel team have discretion on a case-by-case basis to determine whether an individual meets the training and qualification requirements.

7.0 Purpose of Information Sharing Under WIC section 18961.7(a)

7.1 The sharing of confidential information pursuant to this protocol is intended to allow Participating Agencies to investigate reports of suspected child abuse or neglect made pursuant to Sections 11160, 11166, or 11166.05 of the Penal Code, or for the purpose of child welfare agencies making a detention determination.

7.2 Making a detention determination is fact intensive. Such a decision requires both a broad and detailed understanding not only of the child who is the subject of an allegation of child abuse or neglect, but also of the members of that child's family, both nuclear and extended, as well as the members of that child's household. A decision to remove a child from his or her home should not be made when available services would prevent the need for removal. Conversely, when a decision is made to remove a child from his or her home, Welfare and Institutions Code section 319(d)(1) requires the juvenile court to make a determination, on the record, referencing the social worker's report or other evidence relied

upon, as to whether reasonable efforts were made to prevent or eliminate the need for removal of the child from his or her home. For these reasons, a legally sound detention determination unavoidably requires exchange and consideration of both broad and detailed information regarding, at a minimum, the service needs of the child, his or her family members and household members; the services available to the child, his or her family members and household members; the services already received by the child, his or her family members and household members; and the benefit, or lack of benefit, derived from the services received by the child, his or her family members and household members. For this reason, Welfare and Institutions Code section 18961.7 authorizes the broad and detailed exchange of information, and this protocol is intended to bring about the full exchange of information permitted under Section 18961.7.

- 7.3 The agencies who may exchange information pursuant to this protocol include, at a minimum, each agency listed in Welfare and Institutions Code section 18961.7(b)(2).
- 7.4 Each of the Participating Agencies listed in this protocol is a provider agency within the meaning of Welfare and Institutions Code section 18961.7(b)(2) and therefore may engage in the sharing of confidential information that is generally relevant to the prevention, identification, or treatment of child abuse, pursuant to this protocol.

8.0 Information that May be Disclosed and Exchanged among Members of the Multidisciplinary Personnel Team

- 8.1 The members of the multidisciplinary personnel team may disclose to and exchange with one another information and writings that relate to any incident of child abuse or neglect that a member of the multidisciplinary personnel team possessing that information or writing reasonably believes is generally relevant to the prevention, identification, or treatment of child abuse.
 - 8.1.1 Welfare and Institutions Code section 18961.7(c)(1) and this protocol require only that the information and writings relate to "any" incident of child abuse. It need not relate to the specific report of suspected child abuse or neglect which led the multidisciplinary personnel team to meet.
 - 8.1.2 The information and writings must be reasonably believed to be "generally" relevant to the prevention, identification, or treatment of child abuse. It need not be specifically or directly relevant to the prevention, identification, or treatment of child abuse in a particular instance.
 - 8.1.3 The State Legislature, in requiring that the information and writings be "relevant," set a low threshold. To illustrate, the

California Evidence Code defines relevant evidence as evidence, including evidence relevant to the credibility of a witness, "having *any* tendency in reason to prove or disprove any disputed fact that is of consequence" in making the determination. (See Evidence Code section 210.)

- 8.2 In developing this protocol, the County convened a group composed of representatives from each of the Participating Agencies, including persons designated under Section 5.0 above. The members of that group considered, in light of their training and experience, what categories of information are generally relevant to the prevention, identification, or treatment of child abuse. As a result, the items of information listed on Attachment B, at a minimum, were identified as being generally relevant to the prevention, identification, or treatment of child abuse.
- 8.3 The categories identified in Attachment B may be modified by the multidisciplinary personnel team referenced in Section 5.2 by updating Attachment B.
- 8.4 Absent facts to indicate that, in a specific instance, one or more of the items of information listed on Attachment B, is not generally relevant to the prevention, identification, or treatment of child abuse in a specific instance, the items of information listed on Attachment B are generally relevant and the members of the multidisciplinary personnel team may disclose to and exchange with one another those items of information, whether verbally or in writing.
- 8.5 The categories of information identified in Attachment B. are categories of information the Participating Agencies agree to share electronically through the Data System referenced in Section 13.0. This information is not, however, the only information that may be shared through a multidisciplinary team or under this Protocol. Any information may be shared that is generally relevant to the prevention, identification, or treatment of child abuse, as more fully discussed in Sections 8.1, 8.1.1, 8.1.2, and 8.1.3.
- 8.6 The Probation Department may share Criminal Offender Record Information (CORI) provided such sharing is permitted under State law, and since Welfare and Institutions Code section 18961.7 permits the sharing of information among Participating Agencies, the Probation Department may share CORI information in a manner consistent with Welfare and Institutions Code section 18961.7 and this Protocol.
- 8.7 "Protected health information," as defined in the federal Health Insurance Portability and Accountability Act of 1996, commonly called HIPAA,

may be shared in a manner consistent with Welfare and Institutions Code section 18961.7 and this Protocol, pursuant to 45 Code of Federal Regulations (C.F.R.) section 164.512, subdivisions (a) and (b).

9.0 How Information Will Be Shared By Members of the Multidisciplinary Personnel Team

- 9.1 Information and writings may be shared in person.
- 9.2 Information and writings may be shared telephonically.
- 9.3 Information and writings may be shared by facsimile.
- 9.4 Information and writings may be shared electronically.

9.4.1 When the County of Los Angeles' Data System referenced in Section 13.0 is functionally capable of ensuring that the accessing of information and writings is consistent with Welfare and Institutions Code section 18961.7 and this protocol, then the electronic sharing of information and writings may be accomplished through the use of the Data System, or any other appropriate electronic means when the Participating Agencies have established sufficient privacy and security controls to ensure no unauthorized access occurs.

10.0 When Information May be Shared

- 10.1 The information and writings which may be shared pursuant to Welfare and Institutions Code section 18961.7 and this protocol may be shared for a 30-day period following a report of suspected child abuse or neglect.
- 10.2 The information and writings which may be shared pursuant to Welfare and Institutions Code section 18961.7 and pursuant to this protocol may be shared for a period of time longer than 30 days following a report of suspected child abuse or neglect if documented good cause exists.
- 10.3 To establish good cause, the members of the multidisciplinary personnel team will discuss, among themselves, the exchange of information and writings beyond the 30-day period and whether they reasonably believe that good cause exists to support the sharing of information and writings longer than 30 days. They shall discuss the specific child abuse or neglect referral for which the information sharing may need to extend past 30 days. They shall also discuss the facts which the multidisciplinary personnel team believes to be good cause for the sharing of information and writings longer than the 30-day period. Then they shall discuss whether they believe good cause exists to support sharing beyond the 30-day time period.

- 10.4 If the members of the multidisciplinary personnel team believe good cause exists to support sharing beyond the 30-day time period, the basis for this conclusion shall be documented. As an example, DCFS will document the reason for good cause in the Child Welfare Services/Case Management System (CWS/CMS) Contact Notebook.
- 10.5 Any discussion relative to the disclosure or exchange of the information or writings during a team meeting is confidential, except to the extent that disclosure is required or permitted by law.

11.0 Child Abuse Multidisciplinary Team Meetings

- 11.1 Members of the multidisciplinary team identified in Section 5.2 will meet periodically for the purpose of (1) quality assurance, (2) ensuring the continued relevancy of all identified data sharing elements, (3) ensuring adherence to the protocols, (4) reviewing privacy and security issues, and (5) modifying as needed any provisions of this protocol to ensure compliance with State and federal laws.

12.0 Ensuring Confidentiality

- 12.1 Each Participating Agency shall make a determination regarding the specific information which will be available for multidisciplinary personnel team access.
- 12.2 No confidential information or writings shall be disclosed to persons who are not members of the multidisciplinary personnel team except to the extent required or permitted under applicable law.
- 12.3 Every member of the multidisciplinary personnel team who receives information or records regarding children and families in his or her capacity as a member of the team shall be under the same privacy and confidentiality obligations and subject to the same confidentiality penalties as the person disclosing or providing the information or records. The information or records obtained shall be maintained in a manner that ensures the maximum protection of privacy and confidentiality rights.
- 12.4 Information and records communicated or provided to the team members by all providers and agencies, as well as information and records created in the course of a child abuse or neglect investigation, shall be deemed private and confidential and shall be protected from discovery and disclosure by all applicable statutory and common law protections. Existing civil and criminal penalties shall apply to the inappropriate disclosure of information held by the team members.

13.0 Data System Access Control and Authorization

- 13.1 An electronic data system (Data System) will be developed to facilitate sharing of information under this Protocol.
- 13.2 Participating Agencies shall develop uniform written policies and procedures that include security and privacy awareness training that addresses purpose, scope, roles, and responsibilities to facilitate the secure access to the Data System.
- 13.3 All persons accessing the Data System developed for this protocol, must sign a confidentiality statement that includes, at a minimum, General Use, Security Safeguards, Acceptable Use, and Enforcement Policies. The confidentiality statement must be signed by any individual prior to access. The confidentiality statement must be renewed annually.
- 13.4 The Data System shall support “Roles” for all users, which define levels of access. Access levels shall be based on the types of individual information that these users need to perform their job functions.

14.0 Data System Security and Privacy Training

Each Participating Agency shall ensure all multidisciplinary personnel team members who have access to confidential information under this protocol are trained on how to access the information and how to protect the privacy and security of the information received.

15.0 General Information Security Safeguards and Controls

- 15.1 Participating Agencies shall adhere to Board of Supervisors (Board) Information Technology (IT) Security Policies #6.100 to 6.112 and Information Management Policy #6.200, including without limitation other applicable Board policies.
- 15.2 Participating Agencies shall employ security controls that meet applicable federal and State standards so that the information and data being transmitted shall not introduce any viruses, worms, unauthorized cookies, Trojans, malicious software, or malware into the Data System.
- 15.3 Participating Agencies shall take reasonable steps to ensure information is complete, accurate, and up-to-date to the extent necessary for the person’s or entity’s intended purposes and has not been altered or destroyed in an unauthorized manner.
- 15.4 The Data System shall be protected with reasonable administrative, technical, and physical safeguards to ensure data confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure.

- 15.5 The Data System shall use role-based access controls for all user authentication, enforcing the principle of least privilege.
- 15.6 The Data System shall display a warning banner stating that data is confidential, the system is logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.
- 15.7 The Data System shall provide an automatic timeout requiring re-authentication of the user session after no more than (20) minutes of inactivity.
- 15.8 Any data transmissions outside the Data System's secure internal networks must be encrypted using FIPS 140-2 certified algorithm, which is 128-bit or higher, such as AES.
- 15.9 Any remote access to the Data System shall be via two-factor authentication.
- 15.10 The Data System shall be protected by a comprehensive intrusion detection and prevention solution in the network and workstations, at the minimum.

16.0 Data System Auditability

- 16.1 The Data System shall audit when a person logs onto the system, including failed logons.
- 16.2 The Data System access logs shall include, but not be limited to, the following types of information: data modification, creation, and deletion.
- 16.3 System logs shall contain sufficient information to establish what events occurred, when the events occurred (time and date), the sources of the events, the outcomes of the events, and provide the capability to include additional, more detailed information in the audit records for audit events identified by type, location, or subject.
- 16.4 Data System log data shall be archived for at least (3) years after occurrence.
- 16.5 All Data System and audit log entries must have a timestamp that includes date and time utilizing a central time source.
- 16.6 All audit logs are deemed confidential, unless otherwise required by law and shall be secured accordingly.

17.0 Data System Authentication

- 17.1 The Data System will implement unique user names for accessing confidential information. Usernames must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the system. Passwords must be changed at least every (90) days, preferably every (60) days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:
- (i) Upper case letters (A-Z)
 - (ii) Lower case letters (a-z)
 - (iii) Arabic numerals (0-9)
 - (iv) Non-alphanumeric characters (punctuation symbols)
- 17.2 The use of multi-factor authentication will be considered when personal identifiable information (PII) and/or personal health information (PHI) is being accessed.
- 17.3 The Data System shall prevent access after (5) failed logon attempts.

18.0 Amending this Protocol

- 18.1 This protocol may be amended only by written agreement of each of the Participating Agencies.

19.0 Term and Termination of this Protocol

- 19.1 This protocol shall become binding upon a Participating Agency at the time the protocol is signed by the director of that Participating Agency.
- 19.2 Upon execution, this protocol shall remain in full force and effect unless otherwise terminated.
- 19.3 Any Participating Agency may terminate its participation in this protocol by sending an advanced written 30-day notice to the directors of the other Participating Agencies indicating intent to terminate participation in this protocol.


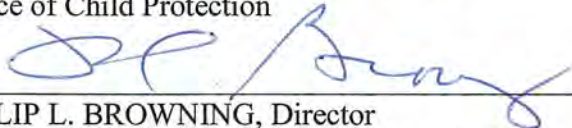
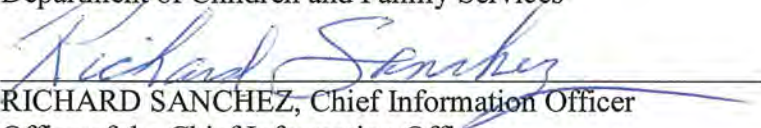

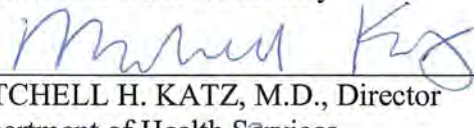
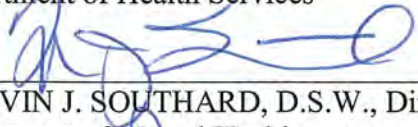
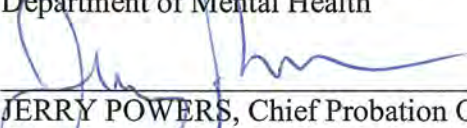
20.0 Implementation and Oversight

- 20.1 The OCP will also provide oversight and coordination of activities under this Protocol and the development and implementation that supports this protocol, in addition to serving as a Participating Agency.
- 20.2 The Chief Information Office (CIO) will assist in the development and implementation of any system that supports this protocol.

21.0 Signature and Distribution

- 21.1 This protocol may be executed in one or more counterparts; all counterparts shall be deemed to constitute one document and shall have the same force and effects as if all signatures had been obtained on one document. Further, a faxed or other form of electronic signature shall have the same force and effect as an original signature.
- 21.2 A copy of these protocols shall be distributed to each Participating Agency and to all persons who participate in the multidisciplinary personnel team, as is required pursuant to Welfare and Institutions Code section 18961.7(e).

The signatures below reflect the agreement of the following agencies to the terms of this Protocol.

Signed:	 _____	Date: <u>7/1/2015</u>
	FESIA A. DAVENPORT, Interim Director Office of Child Protection	
Signed:	 _____	Date: <u>7/1/15</u>
	PHILIP L. BROWNING, Director Department of Children and Family Services	
Signed:	 _____	Date: <u>7-1-15</u>
	RICHARD SANCHEZ, Chief Information Officer Office of the Chief Information Officer	
Signed:	 _____	Date: <u>7-6-15</u>
	JACKIE LACEY, District Attorney Office of the District Attorney	
Signed:	 _____	Date: <u>7-8-15</u>
	MITCHELL H. KATZ, M.D., Director Department of Health Services	
Signed:	 _____	Date: <u>7/1/15</u>
	MARVIN J. SOUTHARD, D.S.W., Director Department of Mental Health	
Signed:	 _____	Date: <u>7/14/15</u>
	JERRY POWERS, Chief Probation Officer Probation Department	

Signed: Cynthia A. Harding Date: 7-2-15
CYNTHIA A. HARDING, Interim Director
Department of Public Health

Signed: Sheryl L. Spiller Date: 7/2/15
SHERYL L. SPILLER, Director
Department of Public Social Services

Signed: Jim McDonnell Date: 7-8-15
JIM MCDONNELL, Sheriff
Sheriff's Department

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

Thomas Fagan
THOMAS FAGAN
Principal Deputy County Counsel

APPROVED BY:
CHIEF EXECUTIVE OFFICE

Sachi A. Hamai
SACHI A. HAMAI
Interim Chief Executive Officer

Attachment A

Office of Child Protection

Carrie D. Miller, Ph.D.
Manager, Office of Child Protection
(213) 974-1478
cmiller@ceo.lacounty.gov

Department of Children and Family Services

Dawna Yokoyama
Deputy Director, DCFS Services Bureau II
(213) 351-5611
Yokoyd@dcfs.lacounty.gov

Office of the District Attorney

David Demerjian
Director, Bureau of Specialized Prosecutions
(213) 257-2271
DDemerjian@da.lacounty.gov

Joseph Esposito
Assistant District Attorney
(213) 257-2495
JEsposito@da.lacounty.gov

Department of Health Services

Aaron J. Miller, MD
Los Angeles County MLK Jr. Hub and High Desert Hub Clinics
(661) 524-6830
AMiller2@dhs.lacounty.gov

Department of Mental Health

G. Kaliah Salas, Psy.D.
Mental Health Clinical Program Head
(213) 739-5473
gsalas@dmh.lacounty.gov

Probation Department

Adam Long
Director, Juvenile Consultant, Field Services Division
(562) 940-2533 office
(323) 595-8000 cell
Adam.long@probation.lacounty.gov

Department of Public Health

Wesley Ford
Director, Substance Abuse Prevention and Control
(626) 299-4595
wford@dph.lacounty.gov

Department of Public Social Services

Jackie Mizell-Burt
Program Director, CalWORKs and GAIN Division Program Policy Section I
(562) 908-8447
JackieMizell-Burt@dpss.lacounty.gov

Lyric Nash
HSAIL, GR Special Projects and SSI Advocacy
(562) 908-6085
LyricNash@dpss.lacounty.gov

Sheriff Department

Scott R. Goodwin
Manager
(562) 754-2082
SRGoodwin@lasd.org

Attachment B

District Attorney:

- Penal Code violations related to the following areas:
 - o Crimes against children under the age of 18
 - o Crimes relating to concealment of a child from a legal custodian or deprivation of child custody
 - o Possession, sale, or distribution of pornography depicting an individual under the age of 18
 - o Employment of a minor in pornography or performing a prohibited act

Department of Health Services:

- Trauma-related injuries
- Current psychotropic and opiate medications
- Hospitalizations or emergency room visits within the last year

Department of Mental Health:

- History of serious mental health illness
- Recent hospitalization for psychiatric reasons
- Forensic mental health history
- Co-occurring disorder with substance abuse
- Substance abuse (without another mental disorder)
- Borderline or antisocial personality disorder diagnosis
- Mental health episodes within the last year of:
 - o Paranoia
 - o Depression
 - o Schizophrenia
 - o Bi-polar
 - o Delusions
- Current participation level in treatment

Probation Department:

- Homelessness
- Substance abuse
- Criminal history
 - o Convictions of crimes against children
 - o Current sex offender registrant (290 status)
 - o Arson offender
 - o Felony convictions when supervised by LA County Probation
 - Serious and violent offenses
 - Domestic violence
 - o Currently active on Probation
 - Offense type
 - Location of current supervision
 - o Inactive cases within the last 5 years

Department of Public Health:

- Not receiving services from a SAPC contracted provider

Department of Public Social Services:

- Homelessness/housing instability
- Domestic violence involvement
- Substance abuse history

Sheriff Department:

- Case and charge information
- Temporary restraining orders
- Homelessness
- Registered sex offender
- Parole status
- County warrant information
- History of violent crimes
- Non-violent crimes within the last 5 years
 - o Filed arrests



SACHI A. HAMAI
Interim Chief Executive Officer

County of Los Angeles CHIEF EXECUTIVE OFFICE

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
<http://ceo.lacounty.gov>

Board of Supervisors
HILDA L. SOLIS
First District

MARK RIDLEY-THOMAS
Second District

SHEILA KUEHL
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

September 23, 2015

To: Supervisor Michael D. Antonovich, Mayor
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe

From: Sachi A. Hamai 
Interim Chief Executive Officer

OPTIONS FOR ESTABLISHING A PHILANTHROPY LIAISON IN THE OFFICE OF CHILD PROTECTION

On June 16, 2015, this Board instructed the Interim Director of the Office of Child Protection (OCP) to work with the Interim Chief Executive Officer (CEO) to:

1. Collaborate with Southern California Grantmakers (SCG) to develop options for establishing a philanthropy liaison position within OCP, as well as necessary support for that position;
2. Identify funding for this initiative through a combination of philanthropic donations and County resources, with the County share from the Provisional Financing Unit (PFU) for implementing Blue Ribbon Commission recommendations; and
3. Report back to the Board within 60 days with estimated costs and timeframes for implementing said options and transfer the County share of funding.

The OCP has worked with the Southern California Grantmakers (SCG) to develop a plan responsive to the Board's motion and submits for your consideration the following proposal to establish a philanthropy liaison position within OCP.

"To Enrich Lives Through Effective And Caring Service"

**Please Conserve Paper – This Document and Copies are Two-Sided
Intra-County Correspondence Sent Electronically Only**

Background

The final report of the Blue Ribbon Commission on Child Protection (BRCCP) recommended that the County establish a closer working relationship with the philanthropic community to help improve the child protection system, noting that the Director of the OCP “. . . should reach out to the philanthropic community and build strategic partnerships to help improve the child protection system. . . The power of public-private partnerships has been under-utilized by the County to date and should be an important strategy for improving services.”¹

The recommendations presented by the BRCCP were widely supported by a coalition of private funders. These philanthropists have subsequently come together to form the Foster Care Funders Collaborative under the leadership of SCG, a regional association representing over 200 grantmakers that builds relationships between the private and public sectors and enhances the impact of individual and collaborative projects for the public good.

The SCG Funders Collaborative is specifically interested in identifying ways in which they can work with Los Angeles County to improve outcomes for our most vulnerable children and families. On June 1, 2015, the Board received a letter signed by Christine Essel, President and CEO of SCG, and Fred Ali, President and CEO of the Weingart Foundation, proposing that the Board consider establishing a philanthropy liaison within the OCP. Under this proposal, the salary of the liaison, as well as the salaries of support staff, would be equally funded by the County and philanthropy for three years. Should the Board elect to establish the philanthropy liaison as a permanent part of County government, after the three year period, all costs associated with the liaison would be borne by the County.

As described in the Board's June 16, 2015 motion, the Philanthropy Liaison would:

1. Facilitate ongoing cooperation and partnership between philanthropy and County agencies engaged with children and families, including: the Departments of Public Health, Mental Health, Health Services, Children and Family Services, Public Social Services, Sheriff, and Probation, as well as the Los Angeles Office of Education, First 5 LA, Los Angeles Homeless Services Authority, and various commissions;
2. Develop a shared agenda for joint initiatives to ensure the health and well-being of children within Los Angeles County;

¹ *The Road to Safety for Our Children*. Final Report of the Los Angeles County Blue Ribbon Commission on Child Protection. (Apr. 18, 2014. p. 13.)

3. Coordinate with LA n Sync and advocate for and work toward increased national philanthropic and federal funding support for Los Angeles County; and
4. Proactively link nonprofit leaders and organizations to the work of the OCP.

The OCP, working closely with SCG and philanthropic leadership (OCP-SCG workgroup), has developed options to establish, fund, and staff a philanthropic liaison position along with the requisite support staff.

I. Conceptual Design of the Center for Strategic Public-Private Partnerships

The philanthropy liaison and associated support staff would be housed in a newly created County organizational unit whose name signals its significance and distinct purpose in the County's organizational structure. The proposed name for the new unit is The Center for Strategic Public-Private Partnerships (Center or CSPP).

The Center should be housed in the OCP. This placement would be consistent with the Board's direction that the Center be housed within OCP and the focus of the SCG Funders Collaborative. If the Board determines that the Center should become a permanent part of County government the Board can explore, at that time, whether the Center should remain within the OCP, or be placed in another County office.

Based on a similar model established within the governmental structure of the City of Los Angeles, the County-SCG workgroup recommends that the new office be staffed by a total of three, full-time staff whose functional titles would be: Center Director; Associate Center Director; and Administrative Assistant. The Center Director and Administrative Assistant would be hired initially to establish the Center. The Associate Center Director would be hired last, after the Center is operational. The Associate Center Director and the Administrative Assistant would report to the Center Director who would, in turn, report to the OCP Director. The incumbent for each position would have several responsibilities including:

Center Director

- Work collaboratively with SCG, philanthropy, and nonprofits to plan, develop, and advance those initiatives that both the County and the philanthropic community agree upon and have the most potential to support the health and well-being of children in Los Angeles County and which otherwise align with County goals and efforts.

- Serve as a conduit for ongoing communication from philanthropy and the nonprofit sector to the County and vice-versa to aid mutual understanding, address shared concerns, and strengthen the County-philanthropy relationship.
- Link the philanthropy and nonprofit community to the work of the OCP to identify opportunities for value-added collaboration.
- Identify and work with similar local and federal efforts across the nation.

Associate Center Director

- Serve as project manager and implementer of County-SCG initiatives.
- Support the Center Director's efforts to enhance communication between the County and SCG and link philanthropy and nonprofits to the work of the County.
- Act as the County's liaison for LA n Sync.

Administrative Assistant

- Provide administrative and office support to the Center Director and Associate Center Director.
- Research and analyze philanthropic, federal, state, and other funding and partnering opportunities.
- Respond to inquiries from grantees, County departments, and other stakeholders.
- Prepare status reports, presentations, and other reports as necessary.
- Collect and analyze statistical data.
- Assist in the formulation, implementation, and administration of Center initiatives.

The Center will work closely with philanthropy, nonprofits and County Departments to identify existing initiatives and efforts, identify gaps in services and program delivery, and develop with the County those initiatives that will support the County's and philanthropy's shared mission of improving outcomes for our most vulnerable children and families. Within its three-year pilot period, and as soon as it is practical to do so, the CEO should assess the Center's effectiveness and make recommendations to the Board regarding whether the Center should be retained as a permanent part of the

County's organizational structure and whether the Center should remain within OCP or be more appropriately situated elsewhere within County government.

Recommendation

- Establish the Center within the OCP;
- Hire three full-time staff to conduct the work of the office; and
- Conduct an assessment of the Center's work as soon as it is practical to assist the Board in deciding whether the Center should become a permanent part of County government after the three-year pilot period expires.

II. Staffing Recommendation

Although the staffing discussion below focuses on the Center Director, it is equally applicable to the Associate Center Director position. The Administrative Assistant position should be a County employee.

OCP recommends hiring a consultant to serve as the Center Director. This option allows a broad search for a candidate outside of the County with demonstrated expertise in working with philanthropy and readily supports an initial time-limited employment arrangement. The Associate Center Director can be either a consultant or an existing County employee – a consultant is preferred. OCP will pursue the consultant option initially and seek to hire an employee only if no suitable consultant can be found. The Administrative Assistant should be an existing County employee.

The first step in the selection of a consultant is to develop a scope of work that clearly identifies the role, expected deliverables, and the pricing schedule. After a consultant has been interviewed and selected for the position, the County would enter into an agreement with the consultant which would delineate the role, responsibility, deliverables, and compensation of the consultant. A notice of an opportunity for a lateral transfer will be used to hire the Administrative Assistant.

Recommendation

- Hire a consultant to serve as the Center Director;
- Hire a consultant to serve as the Associate Center Director and seek a County employee only if no suitable consultant candidate can be found; and
- Hire an existing County employee (i.e., transfer) to serve as the Administrative Assistant.

III. Funding Options and Cost

In reviewing models of philanthropic offices in other jurisdictions, such as the City of Los Angeles and the State of Michigan, the OCP-SCG workgroup recommends that the County and philanthropy each contribute one-half of each position's base salary. The 50:50 ratio on the base salary would be applicable whether the Board elects to hire a consultant or temporarily transfer an existing County employee. The County would provide office space, computer equipment and other necessary support as deemed necessary and appropriate by the OCP Director. Table 1 shows the estimated cost contribution from the County and from SCG.

Table 1: Shared Cost for Consultant Team

Working Titles	Salary Range	Half of Cost Funded Each By County & Philanthropy	
		Minimum	Maximum
Center Director	\$125,000 - \$175,000	62,500	87,500
Associate Center Director	65,000 - 85,000	32,500	42,500
Administrative Assistant	48,000 - 60,000	24,000	30,000
Salary Subtotal	\$238,000 - \$320,000	\$119,000	\$160,000
Cost: training, convenings, printing, travel, publications	10,000	5,000	5,000
Total Cost	\$248,000 - \$330,000	\$124,000	\$165,000

Note: County will provide work space, supplies, office phone and other essential work implements.

Based on the responsibilities and desired characteristics of the Center Director, Associate Center Director, and Administrative Assistant, the OCP recommends that the salary range for each position be equivalent to the salary ranges identified in Table 1 above. However, actual salary placement within each range will depend on a number of factors including each candidate's qualifications, demonstrated skill level, and salary history.

The OCP has worked with the CEO's Compensation and Classification Division (Comp/Class) to discuss the proposed salary ranges for each position. For any position that will be filled by a County employee during the three-year pilot period, the Comp/Class Division recommends that the OCP submit a duty statement to enable Comp/Class to conduct an analysis of the proposed salary range. As such, no duty statement need be submitted for the Center Director since this position will be filled by a consultant. It is unlikely that a duty statement is needed for the Associate Center Director position since OCP will look to a consultant to fill this position. However, out of an abundance of precaution, OCP will submit a duty statement for the Associate Center Director. Finally, OCP will submit a duty statement for the Administrative Assistant position. In the unlikely event that CEO Comp/Class recommended salary range exceeds the proposed OCP salary range by more than 15 percent, OCP will provide notice to this Board and, barring instructions to do otherwise, will hire within the CEO Comp/Class recommended salary range.

SCG will be the fiscal agent for the philanthropy-supported costs of the Center. Per the Board's June 16, 2015 motion, the County's shared cost the PFU account established for the purpose of implementing the BRCCP recommendations will be used to support the Center during the initial implementation period. If the Board elects to make the Center a permanent part of County government, the OCP recommends that funding be shared by the County departments identified in the Board's June 16, 2015 motion, and other departments as appropriate.

Recommendation

- Hire all Center staff within the salary ranges proposed above;
- Should CEO Comp/Class recommend a higher salary range, hire within the recommended salary range after giving notice to the Board;
- Enter into a shared funding agreement with the SCG;
- Enter into consultant agreements for the Center Director and Associate Center Director positions; and
- Share funding costs among County Departments if the Center should become a permanent part of the County's structure.

IV. Timeframes for Staffing the Center for Strategic Public-Private Partnerships

OCP estimates that the Center can be operationalized within 90 days of receiving direction from the Board to do so. All Board offices will be invited to participate in the interviewing process for the Center Director. The list below identifies the necessary steps that must be taken and authority provided in order to operationalize the Center.

Next Steps

In order to proceed with establishing and operationalizing the Center, several tasks must be completed as follows:

- The Center must be established within the OCP;
- OCP must enter into a funding agreement with SCG for the purposes described in this report, not to exceed the maximum amount of the County's shared contribution for funding the salaries of the Center Director, Associate Center Director, and Administrative Assistant and other identified costs;
- The OCP may need authority to enter into a funding agreement with consultant(s) for the purposes described in this report, not to exceed the maximum amount of the County's shared contribution for funding the salaries of the Center Director, and/or the Associate Center Director;
- OCP will request ordinance authority to hire the Administrative Assistant;
- The CEO requires authority to move a sufficient amount of funding out of the PFU account to cover the County's share of cost; and

Within 90 days of hiring the Center Director, the OCP will submit a draft report to the Board identifying joint, preliminary, OCP-philanthropy initiatives to seek input and feedback on the proposed initiatives.

Each Supervisor
September 23, 2015
Page 9

If you have any questions on this report, please contact Fesia Davenport at (213) 974-1186, or by email at fdavenport@ceo.lacounty.gov.

SAH:FD

VD:ljp

- c: Executive Office, Board of Supervisors
- Children and Family Services
- County Counsel
- Community and Senior Services
- Child Support Services
- District Attorney
- Health Services
- Mental Health
- Parks and Recreation
- Probation
- Public Health
- Public Library
- Public Social Services
- Sheriff

MOTION BY SUPERVISORS HILDA L. SOLIS AND SHEILA KUEHL

October 6, 2015

The final report of the Blue Ribbon Commission on Child Protection (BRCCP) recommended that the County establish a closer working relationship with the philanthropic community to help improve the child protection system, noting that the Director of the OCP “. . . should reach out to the philanthropic community and build strategic partnerships to help improve the child protection system. . . . The power of public-private partnerships has been under-utilized by the County to date and should be an important strategy for improving services”.¹

The recommendations presented by the BRCCP were widely supported by the philanthropy community. A group of philanthropists have formed the Foster Care Funders Collaborative under the leadership of the Southern California Grantmakers (SCG), a regional association representing over 200 grantmakers that builds relationships between the private and public sectors and enhances the impact of individual and collaborative projects for the public good. The SCG’s Funders Collaborative is specifically interested in identifying ways in which they can work with

¹ *The Road to Safety for Our Children*. Final Report of the Los Angeles County Blue Ribbon Commission on Child Protection. (Apr. 18, 2014. p. 13.)

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

Los Angeles County to improve outcomes for our most vulnerable children and families.

On June 16, 2015, the Board of Supervisors directed the Interim Director of the Office of Child Protection (OCP), in consultation with the Interim Chief Executive Officer (CEO), to work with SCG to develop options for establishing a philanthropy liaison within the OCP, including estimated costs, timeframes, and the identification of funding through a combination of philanthropic and County resources. The goal of the philanthropy liaison office is to develop a collaborative relationship between the County and philanthropic community for the purpose of identifying and implementing joint projects to improve the outcomes of vulnerable children and their families.

On September 23, 2015, the CEO issued a report providing a conceptual design of the proposed philanthropy liaison office, staffing options for that office, as well as related costs, funding options, and timeframes.

WE, THEREFORE, MOVE that the Board of Supervisors approve the conceptual design for the office and direct the Interim CEO and the Interim Director of the OCP to:

1. Establish the Center for Strategic Public-Private Partnerships (Center) within the Office of Child Protection;
2. Staff the Center with no more than three County employees or three consultants, or an appropriate combination thereof, as recommended in the CEO's September 23, 2015 report, and at the respective base salaries not to exceed the amounts identified in the CEO's report; and as appropriate, based upon qualifications for the position;
3. Develop and execute an agreement with SCG to identify the County's and SCG's respective roles and responsibilities in jointly funding the costs of the Center staff who will perform the work of the Center;

4. Develop and execute the necessary agreements to procure the services of any consultants that will be hired to perform the work of the Center;
5. Request ordinance authority for any of the Center positions that will be filled by a County employee, if appropriate.
6. Appropriate the County's shared cost for the Center, for fiscal years 2015-16, and 2016-17 through the Provision Financing Uses designated for Blue Ribbon Commission Recommendations;
7. At the end of fiscal year 2015-16, or as soon as is practical to do so, and working closely with SCG, conduct an analysis to determine whether the Center's initiatives and efforts are supportive of vulnerable children and families and the effectiveness of its efforts.
8. If the analysis determines that the Center meets the needs of the County and philanthropy, develop a funding sustainability plan where the County's share of the Center's cost are shared among County Departments identified in the Board's June 16, 2015 motion.
9. Report back to the Board within 90 days with a status update on progress made in establishing and operationalizing the Center.

#

HLS:aa
SK:to



SACHI A. HAMAI
Chief Executive Officer

County of Los Angeles

CHIEF EXECUTIVE OFFICE

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
<http://ceo.lacounty.gov>

Board of Supervisors
HILDA L. SOLIS
First District

MARK RIDLEY-THOMAS
Second District

SHEILA KUEHL
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

December 7, 2015

To: Supervisor Michael D. Antonovich, Mayor
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe

From Sachi A. Hamai
Chief Executive Officer

SUPPORTING LGBTQ YOUTH IN FOSTER CARE

On October 6, 2015, this Board adopted a motion introduced by Supervisor Kuehl related to outcomes of lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth in the foster care system. The motion pointed out that LGBTQ youth in foster care have a higher than average number of foster care placements and a greater likelihood of being in a group home, hospitalized or homeless at some point in their lives. The motion directed that a Board report be issued within 60 days on the following action items:

1. Identify each County department currently serving LGBTQ youth and establish an inventory of LGBTQ-specific programs;
2. Review existing demographic data collection, intake, service planning and case review processes; and
3. Work with the Office of Child Protection (OCP) to submit recommendations no later than 180 days after the beginning of the contract period to the Board to consider for adoption.

The OCP has worked with the Chief Executive Office to identify and hire a consultant, Khush Cooper and Associates, using the delegated authority provided by the Board in its motion. The consultant's contract was fully executed on December 4, 2015. The consultant will commence services under the contract on January 4, 2016, due to the difficulty of scheduling all required introductory, level-setting meetings with various Departments during the upcoming holiday season.

"To Enrich Lives Through Effective And Caring Service"

**Please Conserve Paper – This Document and Copies are Two-Sided
Intra-County Correspondence Sent Electronically Only**

Each Supervisor
December 7, 2015
Page 2

The consultant will be working with the following Departments identified in the motion, in addition to other Departments deemed necessary or helpful by the consultant: Children and Family Services, Probation, Mental Health, Health Services, Public Social Services, Public Health, Community and Senior Services, Office of Education, and County Counsel. The consultant has developed a work plan with specific dates and milestones. Progress under the contract will be monitored by the OCP and a final report with recommendations will be issued before the expiration of the 180-day timeline stated in the Board's adopted motion.

If you have any questions, please contact Fesia Davenport at (213) 974-1186, or by email at fdavenport@ceo.lacounty.gov.

SAH:JJ
FAD:ljp

c: Executive Office, Board of Supervisors
County Counsel
Children and Family Services
Community and Senior Services
Health Services
Mental Health
Office of Education
Probation
Public Health
Public Social Services

LGBTQ.bm

"To Enrich Lives Through Effective And Caring Service"

**Please Conserve Paper – This Document and Copies are Two-Sided
Intra-County Correspondence Sent Electronically Only**

MOTION BY SUPERVISOR SHEILA KUEHL

October 6, 2015

SUPPORTING LGBTQ YOUTH IN FOSTER CARE

This Sunday, October 11, 2015 will mark the 27th anniversary of National Coming Out Day. Every year on this day, we celebrate and support those who come out as lesbian, gay, bisexual, transgender, or queer (LGBTQ) or as an ally for equality, to remind everyone of the great power of openness and visibility, and being honest about who we are. Every person who speaks up has the ability to change hearts and minds, and to create new advocates for equality.

Today, in honor of National Coming Out Day, I ask that my colleagues join me in speaking up for lesbian, gay, bisexual, transgender and questioning youth in the Los Angeles County child welfare system. These youth face unique challenges and barriers to finding positive outcomes and permanent homes—challenges stemming from discrimination due to their sexual orientation, gender identity and/or gender expression. Not only are LGBTQ youth overrepresented in the foster care population, there are also significant disparities in experience between LGBTQ youth and their non-LGBTQ counterparts. These disparities could be mitigated if we develop and utilize accurate data and enhanced training efforts to more fully address their needs, including identifying and remediating the effects of bullying and trauma.

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

As part of a five-year, federal grant awarded to the LGBT Center in Los Angeles, the Williams Institute at UCLA and Holarchy Consulting conducted a landmark study of 786 randomly sampled foster youth ages 12 to 21. The findings show that 19 percent—nearly one in five—foster youth in Los Angeles County identify as LGBTQ. This means that there are between 1.5 and 2 times more LGBTQ youth as a percentage of young people in foster care than outside foster care.

Given this overrepresentation of LGBTQ youth among foster children, it is even more problematic that there has been very little focus on this population. According to the Williams-Holarchy study, LGBTQ youth have a higher than average number of foster care placements and a greater likelihood of being in a group home, hospitalized or homeless at some point in their lives. More stable placements and stronger reunification efforts could lead to improved educational and permanency outcomes. Costly group home and hospital stays could be avoided with a more targeted approach in serving this unique population. While many of our departments have made very good efforts to develop specialized LGBTQ programs, now is the time for the County to systematically address the needs of LGBTQ youth in our child welfare system.

I, THEREFORE, MOVE that the Los Angeles County Board of Supervisors direct the Interim Office of Child Protection, in consultation with the Interim Chief Executive Officer and Departments of Children and Family Services (DCFS), Probation, Mental Health, Health, Public Social Services (DPSS), Public Health (DPH), Community and Senior Services (CSS), Office of Education, County Counsel and all other child and/or youth serving departments, to report back in 60 days on the following action items.

- Provide delegated authority of up to \$100,000 to hire an expert consultant to identify each County department currently serving LGBTQ youth in any capacity, and establish an inventory of LGBTQ-specific programs.

- For these departments, the consultant shall review existing demographic data collection, intake, service planning and case review processes to identify:
 - (1) improvements to providing culturally competent care and support;
 - (2) opportunities to add questions or information (in a culturally competent and sensitive manner) about sexual orientation, gender identity and discriminatory experiences to such data collection, intake, service planning and case review processes; and,
 - (3) identify training needs for department staff, as well as contractors (for example, DCFS Children's Social Workers and mental health providers, as well as foster and relative caregivers and parents) in order to raise the competency of those collecting this information or serving this population to do so confidentially, respectfully and accurately.
- The consultant shall work with the Office of Child Protection to submit recommendations no later than 180 days after the beginning of the contract period for the Board to consider for adoption.



SACHI A. HAMAI
Chief Executive Officer

County of Los Angeles CHIEF EXECUTIVE OFFICE

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
<http://ceo.lacounty.gov>

Board of Supervisors
HILDA L. SOLIS
First District

MARK RIDLEY-THOMAS
Second District

SHEILA KUEHL
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

December 16, 2015

To: Supervisor Hilda L. Solis, Chair
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: Sachi A. Hamai 
Chief Executive Officer

SECOND PROGRESS UPDATE ON THE BLUE RIBBON COMMISSION FOR CHILD PROTECTION RECOMMENDATIONS

On June 10, 2014, the Board of Supervisors adopted recommendations issued by the Blue Ribbon Commission on Child Protection (BRCCP) contained in its final report entitled "*The Road To Safety For Our Children.*" At the same time, the Board adopted an analysis of the BRCCP recommendations concurrently issued by the Chief Executive Office (CEO). Since June 2014, much effort and activity have taken place to move the BRCCP recommendations forward.

On June 30, 2015, the Office of Child Protection (OCP) submitted its initial report updating the Board on progress made in implementing the BRCCP Recommendations. This report provides similar and more current information. The OCP will issue its next report in March 2016 covering the period commencing November 2015 through February 2017.

In preparing this update, the OCP worked closely with several County departments and other organizations including the Departments of Children and Family Services, Health Services, Mental Health, Probation, Public Health, and Public Social Services, CEO, District Attorney, and First 5 L.A. All updates are through October 31, 2015 unless otherwise stated. Attachment I provides a report of activities completed or underway for each BRCCP recommendation listed.

"To Enrich Lives Through Effective And Caring Service"

**Please Conserve Paper – This Document and Copies are Two-Sided
Intra-County Correspondence Sent Electronically Only**

REPORT OVERVIEW

In the report, recommendations are categorized into the four domain areas: Prevention, Safety, Permanency, and Well-Being. In addition, a fifth category designated as “Global Impact,” was added to indicate a recommendation which materially impacts more than one domain area. The responses provided by Departments were reviewed by the OCP to determine the status of each project, ranging from “plan development in progress” to “implementation completed.” Table 1 below summarizes the status of all BRCCP recommendations by domain area. Most of the recommendations in the “plan development yet to begin” category are administrative in nature and will likely be folded into the OCP strategic plan.

OCTOBER 2015 STATUS

*Table 1:
 Status of BRCCP
 Recommendations
 by Domain Area*

DOMAIN AREA	Plan Development Yet to Begin	Plan Development in Progress	Plan Development Completed	Pre-Implementation Efforts Underway	Implementation in Progress	Implementation Completed	Total
Prevention	-	3	-	-	1	2	6
Safety	3	1	-	-	11	1	16
Permanency	1	1	-	1	3	3	9
Well-Being	1	2	-	1	4	-	8
Global Impact	1	3	-	-	7	6	17
County Administration	7	1	-	-	1	-	*9
Total	13	11	-	2	27	12	*65

*There are 66 recommendations, and the status for 65 recommendations are only shown as one will not be implemented.

PROGRESS FROM JUNE 2015

In comparison to the update provided last June, the status of 13 of the 65 BRCCP recommendations has changed. The status of 12 of these 13 recommendations has been promoted to “implementation in progress.” As of October 2015, a total of 27 recommendations are at the “implementation in progress” stage (see Table 2), by comparison, only 16 recommendations were at the “implementation in progress” stage in June 2015. Progress occurred primarily in recommendations related to E-SCARS, the Children’s Social Worker – Public Health Nurse Joint Visitation Initiative, and multi-departmental training. The total number of recommendations completed remains unchanged at 12.

Table 2: Change in Status of BRCCP Recommendations from June – October 2015

Status	Number of Recommendations (June 2015)	Change in Total (October 2015)	Revised Total (October 2015)
Planning Development Yet to Begin	15	-2	13
Plan Development in Progress	13	-2	11
Plan Completed	2	-2	-
Pre-Implementation Efforts Underway	7	-5	2
Implementation in Progress	16	+11	27
Implementation Completed	12	no change	12
Total	65	no change	65

Note: As progress is made in implementing the BRCCP recommendations, the number of recommendations at an early implementation stage will decrease, and the number of recommendations moving towards completion will increase.

If you have any questions, please contact Fesia Davenport at (213) 974-1186, or by email at fdavenport@ceo.lacounty.gov.

SAH:FD
VD:ljp

Attachment (1)

- c: Executive Office, Board of Supervisors
- County Counsel
- District Attorney
- Sheriff
- Child Support Services
- Children and Family Services
- Commission for Children and Families
- Community and Senior Services
- Health Services
- Inter-Agency Council on Child Abuse and Neglect
- Mental Health
- Parks and Recreation
- Probation
- Public Health
- Public Library
- Public Social Services

Update by the Office of Child Protection on the BRCCP Recommendations - October 2015

Recommendation	Entity	STATUS UPDATE					Comment	
		Planning Yet to Begin	Plan Development in Progress	Plan Developed	Pre-Implementation Efforts Underway	Implementation in Progress		Implementation Completed
1. PREVENTION 1.1 Oversee countywide prevention efforts.	OCP		✓					The OCP is working with First 5 LA, DPH and other agencies and entities to develop a countywide prevention plan. The plan will be developed in phases. Phase I will have a narrower focus than the overall plan. The conceptual design of Phase I focuses on identifying and addressing the reasons for referrals in high referral zip code areas in the County. Data is being gathered and analyzed to determine additional zip codes to include in Phase I. Meetings with DCFS Prevention and Aftercare Providers and community residents have been held or planned to better understand needs in these high referral areas. The plan will include strengthening communities and focusing on the five protective factors.
1.2 DPH and First 5 LA to jointly develop a comprehensive prevention plan to reduce the overall incidence of child abuse and neglect.	OCP, First 5 LA and DPH		✓					The OCP has taken the lead on this initiative working closely with First 5 LA and DPH. Additional departments and agencies have been added to the planning effort including DPSS, DCFS, members of the Children's Commission, L.A. Unified School District, and the Advancement Project. The prevention plan will focus on community based efforts aimed at strengthening communities, strengthening the five protective factors within families, and reforming the County's delivery of services which support and strengthen families. See also 1.1 above.
1.3 Prioritize access to Early Childhood Education learning programs for all children under the supervision of DCFS between ages 0 to 5.	DCFS						✓	DCFS has developed an automated Head Start Referral System. The system automatically searches for children who may be eligible for referral and allows DCFS social workers to electronically refer children to Head Start and other early childhood education (ECE) programs throughout Los Angeles County. The system was developed with the assistance of the Los Angeles County Office of Education Head Start Program, Long Beach Head Start, LAUSD, Child Care Resource Center, Options Resource and Referral agency, and organizations throughout the County. To date 7,000 children have been referred since the inception of the Head Start Referral System.
1.4 Pair a Public Health Nurse with a DCFS social worker in child abuse or neglect investigations of all children from birth to age two.	DCFS, DPH, DMH, DHS, CoCo, CEO/OCP						✓	This initiative will be implemented in phases. Joint visits under Phase commenced in August 2015 and includes the Martin Luther King, Jr. Medical Hub and the Compton and Vermont-Corridor DCFS Regional Offices. Joint visits are being conducted and referrals are being made to the Medical Hubs when appropriate. OCP and all involved departments will be issuing a report covering the first 90 days of Phase I. This data will be used to inform further roll out of this initiative to other areas of the County.

Update by the Office of Child Protection on the BRCCP Recommendations - October 2015

Recommendation	Entity	STATUS UPDATE					Comment
		Planning Yet to Begin	Plan Development in Progress	Plan Developed	Pre-Implementation Efforts Underway	Implementation in Progress	
1.5 DPH's evidence-based home visit service should be made available to all children under age one seen at a Medical Hub.			✓				<p>OCPC will work with DPH and DHS to ensure that medical hub staff are trained on home visitation programs in order to identify those families that may be eligible. The eligible population seen at the hubs will likely be small. As such, OCP will also incorporate the expansion of and access to home visitation services into its prevention plan.</p>
1.6 Conduct assessments of each medical hub to identify each hub's strengths and weaknesses.	DHS					✓	<p>The findings of the recommended medical hub assessment were issued by DHS on January 9, 2015 and adopted on January 13, 2015.</p>
<p>Agencies: County Counsel (CoCo), Departments of Children and Family Services (DCFS), Health Services (DHS), Mental Health (DMH), Public Health (DPH), Public Social Services (DPSS), District Attorney's Office (DAO), First 5 Los Angeles (First 5 LA), University Consortium for Children and Families (UCCF), Inter-Agency Council on Child Abuse and Neglect (ICAN), Service Employees International Union (SEIU)</p>							
2. SAFETY							
2.1 E-SCARS should be utilized fully by all relevant agencies and receive the necessary support to be well-maintained and enhanced.	DCFS, DA					✓	<p>The DAO has secured or is securing written agreements to ensure that E-SCARS is fully utilized and DCFS is working on enhancements to the E-SCARS system. Specifically, the DAO has established a new Memorandum of Understanding (MOU) with all relevant departments (DAO, Sheriff, and DCFS). The DAO is circulating and securing signatures for a Memorandum of Agreement (MOA) with law enforcement agencies within Los Angeles County. The MOU and MOA will reinforce the function and accountability of law enforcement, DCFS and DAO. Regarding E-SCARS, the Board previously approved the release of \$764,000 to DCFS for system enhancements and ongoing E-SCARS support and maintenance. DCFS continues with its redesign of the E-SCARS system, which will provide for a "High Risk" fatality flag and a "Child Fatality" flag. The redesign is expected to be fully operational by the Spring of 2017.</p>
2.2 Training of all levels of law enforcement must be enhanced to include sufficient initial and recurrent training on child abuse and E-SCARS.	DA					✓	<p>The DAO has completed the expansion of its E-SCARS unit. The DAO has appointed a prosecutor to serve as Deputy-in-Charge of the newly expanded unit and has hired three additional paralegals who will support the E-SCARS Unit. The Deputy-in-Charge will train law enforcement and prosecutors on using E-SCARS, including cross-reporting. With additional resources in place, an increase in DAO audits of E-SCARS is contemplated. In addition, the E-SCARS Unit can now fully focus on its oversight of response and information sharing by the involved agencies.</p>

Update by the Office of Child Protection on the BRCCP Recommendations - October 2015

Recommendation	Entity	STATUS UPDATE					Comment
		Planning Yet to Begin	Plan Development in Progress	Plan Developed	Pre-Implementation Efforts Underway	Implementation in Progress	
2.3 DCFS should create an adaptive training process for social workers and their supervisors that consists of a continuous learning environment akin to a teaching hospital. It should also conduct a job audit of social workers to determine what can be done differently or by others to address social worker workload.	DCFS					✓	In August 2013, DCFS implemented a new training program for new staff. The training is based on a teaching hospital model that involves simulation training. In August 2014, DCFS implemented mandatory training for its Supervising Social Workers. In 2009, DCFS conducted a job audit of clerical duties to determine which job functions should and could be performed by clerical staff. The audit was partially implemented. DCFS will revisit this job audit since policies, processes and procedures have changed since 2009.
2.4 Review research findings from Emily Putnam Hornstein, Ph.D and others on risk factors for children at risk of a child fatality due to abuse and neglect as well as data from the Interagency Council on Child Abuse and Neglect.	DCFS					✓	Dr. Putnam-Hornstein's work was reviewed and conversations were held between DCFS and Ms. Putnam-Hornstein regarding data and risk modeling. DCFS is an active participant in ICAN's workgroups and is familiar with their work. Also, DCFS currently monitors high risk cases associated with AB 109 releases, Sex Offender Registry, etc.
2.5 Using both case reviews and research findings, identify specific characteristics that distinguish children who have positive outcomes versus those who are subsequently severely injured or killed. Specifically identify key risk factors that are present in cases resulting in child fatalities.	DCFS					✓	DCFS Risk Management Division is currently updating their Critical Incident Fatality Tracking (CIFT) system which is used to capture trends related to critical incidents and fatalities.
2.6 Conduct a review of all child fatalities due to abuse and neglect within the past three years of children served in the Department of Health Services medical hub, DCFS, Probation, DPSS, by a DPH public health nurse or home visiting program or by a First 5 LA home visiting program.	OCP	✓					A single entity should collect and analyze this information in order to implement this recommendation. This recommendation should be considered as part of the BRCCP recommended commission study which will be part of the CEO's report on the governance structure.
2.7 Conduct a thorough review of all open cases in the above departments.	DCFS	✓					OCP must work with the relevant departments to develop a plan for the recommended review including identifying criteria for cases to be reviewed and what specifically should be reviewed in each case. Due to the large volume of cases that may be reviewed, a technological tool might be helpful in identifying cases to review.

Agencies: County Counsel (CoCo), Departments of Children and Family Services (DCFS), Health Services (DHS), Mental Health (DMH), Public Health (DPH), Public Social Services (DPSS), District Attorney's Office (DAO), First 5 Los Angeles (First 5 LA), University Consortium for Children and Families (UCCF), Inter-Agency Council on Child Abuse and Neglect (ICAN), Service Employees International Union (SEIU)

Update by the Office of Child Protection on the BRCCP Recommendations - October 2015

Recommendation	Entity	STATUS UPDATE					Comment
		Planning Yet to Begin	Plan Development in Progress	Plan Developed	Pre-Implementation Efforts Underway	Implementation in Progress	
2.8 Continually measure progress against measures of success identified (in Section III, p. 14).	OCF, DCFS, and potentially other departments and entities		✓			✓	This recommendation requires two levels of measurement - At the DCFS service delivery/youth outcomes level and at the Countywide systems outcomes level. DCFS monitors performance using a monthly STATS process against Federal, State, and County performance indicators. The OCP is working with the Children's Commission to develop a comprehensive set of outcomes measures that builds upon relevant information from other departments who also serve children within the other domains of the continuum, e.g. well-being.
2.9 Modify access to and delivery of key services including; health, mental health; domestic violence; substance abuse treatment; housing for adults; home visiting and prevention supports for children, youth and families. These services will need to be prioritized for those at highest risk of later fatalities.	DCFS					✓	This recommendation speaks to an overhaul of how numerous services are accessed and delivered. A substantive update cannot be provided for this recommendation until the OCP has finalized its strategic plan. Also, this recommendation will likely be impacted by other efforts in the County related to health integration and homelessness.
2.10 Equipped with specific case information and research findings that identify children at greater risk, proactively engage staff in the above serving departments to address risk factors immediately, thereby mitigating the likelihood of a child fatality.	DCFS					✓	DCFS staff regularly participate in DCFS training academy sessions which includes Lessons Learned to enhance critical thinking and help identify and improve practice around risk factors. As OCP initiatives related to multi-departmental safety training proceed, OCP will work with relevant departments in order to engage staff around identified risk factors.
2.11 Utilize a technological solution such as E-SCARS that crosses departments to ensure that information is shared and staff alerted when potentially fatal risk factors are present.	DCFS					✓	DCFS contracted with a vendor to develop a proof of concept for a risk modeling tool (i.e. data mining and analytical tool) that can be used for early identification and intervention in cases based on high risk levels. After validating the proof of concept, DCFS is developing a Statement of Work to procure services to develop a risk assessment tool. See also 2.13 and 2.14 below.
2.12 All Sheriff's deputies and local law enforcement agencies within the County of Los Angeles must cross-report every child abuse allegation to DCFS, as required by State law. In addition, it should be documented that a cross-report was made, for example, in a police report or law enforcement log.	DA					✓	The DAO continues to train all law enforcement agencies within the County of Los Angeles on E-SCARS cross-reporting. With the recent expansion of the E-SCARS Unit, the DAO can now provide recurring trainings to law enforcement agencies, as well as address any deficiencies in their data entry into E-SCARS.
2.13 The District Attorney's Office should increase its oversight of the law enforcement response and sharing of information, including cross-reporting between DCFS and law enforcement agencies, to ensure that each agency carries out its mandated investigative response.	DA					✓	The DAO has hired three additional paralegals to support the newly expanded E-SCARS unit. The paralegals will audit law enforcement responses to SCARS. They will monitor the timeliness of law enforcement responses and any follow up investigations. As a result, paralegals can seek to cure deficiencies and discrepancies in the SCARS, which will ensure that law enforcement leads an independent and parallel investigation to DCFS.

Update by the Office of Child Protection on the BRCCP Recommendations - October 2015

Recommendation	Entity	STATUS UPDATE					Comment
		Planning Yet to Begin	Plan Development in Progress	Plan Developed	Pre-Implementation Efforts Underway	Implementation in Progress	
2.14 The County should develop an early warning system within E-SCARS to alert DCFS and law enforcement of high-risk allegations of abuse as early as possible. A convergence of high-risk factors would alert supervisors of high-risk situations and allow them to take appropriate action.	DA and DCFS						<p>The E-SCARS "High Risk Allegations" functionality will be incorporated in the 2015-16 redesign of E-SCARS, which is currently under development. The DAO will monitor the incorporation of the E-SCARS "High Risk Allegations" to safeguard that such an assessment tool does not conflict with crime charging or investigation standards. In addition, a "Child Fatality" flag will accompany a SCAR when a child fatality has occurred. This will alert all E-SCARS users to take action appropriate within their respective offices.</p> <p>Prior to submitting the SCAR, the DCFS supervisor will mark a newly created "High Alert" box if the referral meets either Child Fatality, Near Fatality, Critical Incidents, Abduction and Media Alert criteria. This process and functionality will be in addition to the current E-SCARS functionality.</p>
2.15 The Board should continue its active oversight of DCFS' strategic plan by adding a requirement for regular reporting of specific safety related outcomes, including recurrence of maltreatment within six months of a previous incident, maltreatment rates in out-of-home placement, and reentry into care within six months of a permanent placement.	OCP/DCFS		✓				<p>Once the OCP strategic plan is developed and Countywide outcome measures adopted, the OCP intends to conduct regular meetings with public and private members of the County's child protection network where data (including DCFS' data) will be regularly shared and discussed in order to assess whether children are safer, and how children and families are faring in the County's child protection network across the entire continuum of care.</p> <p>As a first step, OCP will incorporate into its strategic plan, specific roles (including work related to prevention) for child and family serving departments serving the same population as DCFS or those children and families at risk of coming to the attention of DCFS.</p>
2.16 The County can measurably and immediately improve child safety by requiring all departments to target resources and high quality services, including prevention services, toward children under the age of five.			✓				
<p>Agencies: County Counsel (CoCo), Departments of Children and Family Services (DCFS), Health Services (DHS), Mental Health (DMH), Public Health (DPH), Public Social Services (DPSS), First 5 Los Angeles (First 5 LA), University Consortium for Children and Families (UCCF), Inter-Agency Council on Child Abuse and Neglect (ICAN), Service Employees International Union (SEIU)</p>							
3. PERMANENCY							
3.1 A child's funding should be determined by the needs of the child, not whether placement is with a relative or a foster family. The CEO and DCFS should examine the County's ability to waive federal eligibility rules and its accompanying funding flexibility to strengthen support for children in out of home care.	DCFS, CEO/OCP						<p>The issue of a child's funding has been addressed. In March 2015, the County opted into the State Approved Relative Caregiver (ARC) Program for eligible relative caregivers. DCFS and DPSS launched the program on June 1, 2015. Relative caregivers started receiving payments in June. The process is ongoing and continuing.</p>

Update by the Office of Child Protection on the BRCCP Recommendations - October 2015

Recommendation	Entity	STATUS UPDATE					Comment		
		Planning Yet to Begin	Plan Development in Progress	Plan Developed	Pre-Implementation Efforts Underway	Implementation in Progress		Implementation Completed	
3.2 The County, through the Auditor-Controller and the CEO, should review the current mix of county licensing and supports for foster homes and approval and supports for kin, to assess the inconsistent performance and resource allocation, and to determine whether a more uniform streamlined system would be more effective. The Commission believes consideration of contracting out this process is warranted.	OCP, Auditor-Controller					✓		The State Department of Social Services (CDSS) will pre-empt the field relative to licensing and approval with the implementation of the Resource Family Approval Program. On October 15, 2015, CDSS issued written directives governing its Resource Family Approval Program. The purpose of this program "is to implement a unified, family-friendly, and child-centered resource family approval process to replace the existing multiple processes for licensing foster family homes and approving relatives and non-relative extended family members as foster care providers, and approving families for legal guardianship or adoption." Statewide implementation of this program is authorized for all California counties effective July 1, 2017. On the issue of supports for relative caregivers, please see 3.1 above and 3.5 below.	
3.3 DCFS should develop a computerized, real-time system to identify available and appropriate placements based on the specific needs of the child.	DCFS						✓	In August 2014, DCFS operationalized an enhanced Foster Care Search System (FCSS). Phase I of the FCSS has two major modules: 1. One component of the FCSS automates the formerly paper-based child placement process and provides a mobile application for workers and supervisors to confirm when a child has been placed in or removed from a bed - thereby providing more timely information as to bed availability. 2. Another component of the FCSS allows caregivers, group homes, and foster family agencies to manage their respective profiles. This module enables caregivers to review and verify home profiles, provide updates on home contact information; and enables FFAs to update their information online. Enhancement of the FCSS will be an ongoing process. See 3.1 above.	
3.4 The County and DCFS should utilize its Title IV-E waiver dollars to ensure parity of funding for children placed with kin to that of children placed in foster family settings.	DCFS							✓	See 3.1 above.
3.5 A child's services should be based on the needs of the child, not placement with a relative or a foster family. The CEO and DCFS should ensure that relative caregivers are more fully supported.	DCFS/CEO					✓			In order to better support relative caregivers, DCFS intends to contract out home assessment and supportive services for relatives. Proposed contracted relative caregiver service components include: orientations, procurement of necessary supplies and services, emergency needs, support groups and training, educational advocacy and legal assistance. DCFS is developing the Statement of Work.

Update by the Office of Child Protection on the BRCCP Recommendations - October 2015

Recommendation	Entity	STATUS UPDATE					Comment	
		Planning Yet to Begin	Plan Development in Progress	Plan Developed	Pre-Implementation Efforts Underway	Implementation in Progress		Implementation Completed
3.6 The Board should call for an independent analysis of non-relative foster family recruitment efforts in the County to determine how the system can be more efficient and effective. The analysis should use sound data to address a range of questions, including whether there are safe and appropriate homes in each SPA to meet the needs of foster youth.	DCFS					✓		The University of California Los Angeles recently issued a final report of its analysis of Los Angeles County's current process for recruiting resource parents. The report includes several recommendations to improve resource parent recruitment, retention, and for the placement of foster children. The recommendations require review and approval, and for approved recommendations, implementation plans. OCP will work DCFS, Children's Commission, and others, including philanthropy to begin the work of identifying and implementing the recommendations as appropriate.
3.7 DCFS should involve foster youth in the rating and assessment of foster homes.	DCFS						✓	DCFS has solicited and received input of foster youth in its rating and assessment of foster homes. The "Foster Youth Satisfaction Survey" was completed and posted on the DCFS website. Effective January 2015 during the annual re-evaluation and quality assurance review process of placement facilities, DCFS will interview a sample of placed children to obtain their input regarding the quality of care and services provided by a Foster Family Agency or Group Home. This survey is web-based, ongoing and results will be reported monthly.
3.8 The Board should require regular reporting on the frequency of missed monthly social worker visits, the wait times for children in offices or at the Command Post needing placement, the length of time for kin caregivers to be approved, and the number of foster homes recruited.	DCFS/OCP		✓					DCFS is developing a BRCCP data package which will include the information/data requested. The BRCCP data package will be placed on the SITE (i.e., DCFS intranet) so that it is easily accessible and available to staff. In addition to DCFS efforts, OCP intends to conduct regular meetings with stakeholders in the County's child protection network to share relevant data that will help inform stakeholders and improve outcomes for children and families.
3.9 The Board should establish specific benchmarks for improvement in the measures identified (in 2.15 and 3.8) and, as warranted. This should be done in collaboration with the CEO and DCFS.		✓						

Agencies: County Counsel (CoCo), Departments of Children and Family Services (DCFS), Health Services (DHS), Mental Health (DMH), Public Health (DPH), Public Social Services (DPSS), District Attorney's Office (DAO), First 5 Los Angeles (First 5 LA), University Consortium for Children and Families (UCCF), Inter-Agency Council on Child Abuse and Neglect (ICAN), Service Employees International Union (SEIU)

Update by the Office of Child Protection on the BRCCP Recommendations - October 2015

Recommendation	Entity	STATUS UPDATE					Comment	
		Planning Yet to Begin	Plan Development in Progress	Plan Developed	Pre-Implementation Efforts Underway	Implementation in Progress		Implementation Completed
4. WELL-BEING 4.1 The Board should issue a clear mandate that non-pharmacological interventions are best practice with children wherever feasible. The Board should work with the Juvenile Court to fully implement and measure compliance with this mandate.	DMH, Dependency Court, and OCP		✓					In November 2015, OCP will issue a report to the Board laying out Phase I of a comprehensive county-wide plan regarding psychotropic medication and foster/probation youth. The plan will address three major areas: 1) service delivery reform; 2) quality control and heightened monitoring; and 3) strengthening our administrative tools that drive our administrative processes and data analysis.
4.2 The County should establish mechanisms for cross-system education-related coordination, collaboration, and communication.	DCFS, Probation, Schools, OCP	✓						The County has a structure in place to address this recommendation - The Education Coordinating Council (ECC). The ECC has gone without a full-time director for some time and its meetings (and agenda) has been reduced to twice per year. The ECC Director has been hired and will begin work in November. The ECC Director will work with the ECC for the cross-system education-related coordination, collaboration and communication referenced in this recommendation.
4.3 The County should ensure that school stability and child safety are improved through Countywide expansion of the pilot program that has been proven effective in the Gloria Molina Foster Youth Education Program.	OCP, DCFS						✓	Expansion of this program will necessarily be impacted by the recent passage of the Legislation Control Funding Formula (LCFF). The County must partner with local school districts to leverage resources provided by the LCFF and ensure that there is no duplication of effort between this program and the LCFF. The Education Coordinating Council will be tasked with working with DCFS to determine how to best expand the program while simultaneously assessing how LCFF funds can be used to assist in this effort.
4.4 All children entering placement and children under age one whose cases are investigated by DCFS should be screened at a Medical Hub.	DCFS, DPH, DMH, DHS, CoCo, CEO/OCP						✓	The named Departments recently implemented Phase I of this initiative where children under investigation under age two (not one) are referred to a medical hub when medically necessary. Nurses were hired in July 2015 and joint visits began in August 2015. OCP will be issuing a status report and preliminary assessment to the Board in November which will cover the first 90 days of the project.
4.5 Children placed in out-of-home care or served by DCFS in their homes should have ongoing health care provided by physicians at the Medical Hubs.	DCFS, DHS					✓		In the BRCCP Final Report, this recommendation was paired with recommendation 4.4 above. This recommendation will be addressed once the nurse-social worker joint visit initiative is launched.

Agencies: County Counsel (CoCo), Departments of Children and Family Services (DCFS), Health Services (DHS), Mental Health (DMH), Public Health (DPH), Public Social Services (DPSS), District Attorney's Office (DAO), First 5 Los Angeles (First 5 LA), University Consortium for Children and Families (UCCF), Inter-Agency Council on Child Abuse and Neglect (ICAN), Service Employees International Union (SEIU)

Update by the Office of Child Protection on the BRCCP Recommendations - October 2015

Recommendation	Entity	STATUS UPDATE					Comment	
		Planning Yet to Begin	Plan Development in Progress	Plan Developed	Pre-Implementation Efforts Underway	Implementation in Progress		Implementation Completed
4.6 DPH must be held directly responsible for substance abuse treatment for high-risk teen mothers.	DPH		✓					DPH's grant from First 5 LA used to fund this program terminated June 30, 2015. This grant funded the co-located Substance Abuse Navigators at all DCFS Regional Offices to refer and link DCFS involved parents/caregivers, with children aged 0 – 5 years, to substance abuse treatment. DPH-SAPC will use Substance Abuse Prevention and Treatment (SAPT) Block Grant funding to extend funding through December 2015. Under the proposed program, services will be expanded to include more families by removing the child(ren)'s age restrictions and the expansion of services includes high risk teen mothers (aged 12 - 17 years) and pregnant teens. DCFS and DPH will work together to identify permanent funding for this program.
4.7 As part of performance-based contracting, mental health treatments for teens and transitioning youth must incorporate trauma-focused assessments and treatments, developmental status, ethnicity, sexual identity, and vulnerability to self-harming behaviors.	DMH					✓		The Department will be implementing a universal suicide risk assessment tool and will ensure these changes are made in conjunction with the self-harm category, the DSM 5 new diagnosis coding system (in which there are different information related to non-suicidal self-injury), and the ICD-10-CM (in which there are several diagnosis codes for self-harm which will allow for a valid secondary diagnosis). The revised forms will be released with a planned implementation date of October 1, 2015. Implementation of all revisions will allow for tracking of the responses through the EHR system. The self-harming behavior screening and assessment training was incorporated into the Psychiatric Diagnostic Training curriculum in July 2015; which occurs every three (3) months.
4.8 Children age five and under in the child welfare system must have access to age appropriate mental health services.	DMH						✓	Training is ongoing. The University Center for Excellence in Developmental Disabilities at Children's Hospital LA (UCEDD/CHLA) provided a summary report of participant data collected for the FY 2014-15 Birth to Five Core Training Series. UCEDD/CHLA provided training to clinicians in the DMH Provider Network through a contract with DMH. Another training contract with UCEDD/CHLA was approved. UCEDD staff will implement a Birth to Five Mental Health Core Training Series for FY 2015-16. The SOW requires specific learning objectives for each training session and submission of quarterly reports. During the summer period of June through August 2015, DMH Family and Community Partnerships, and CSOC staff provided a series of trainings on the ICARE Assessment Form for DMH Specialized Foster Care (SFC) and contract providers in Service Area 3 and for countywide Parent Child Interaction Therapy (PC IT) providers. A total of four trainings were conducted for a combined total of 82 participants.

Agencies: County Counsel (CoCo), Departments of Children and Family Services (DCFS), Health Services (DHS), Mental Health (DMH), Public Health (DPH), Public Social Services (DPSS), District Attorney's Office (DAO), First 5 Los Angeles (First 5 LA), University Consortium for Children and Families (UCCF), Inter-Agency Council on Child Abuse and Neglect (ICAN), Service Employees International Union (SEIU)

Update by the Office of Child Protection on the BRCCP Recommendations - October 2015

Recommendation	Entity	STATUS UPDATE					Comment
		Planning Yet to Begin	Plan Development in Progress	Plan Developed	Pre-Implementation Efforts Underway	Implementation in Progress	
5. GLOBAL IMPACT							
5.1 Oversee a Joint Strategic Planning Process to create a comprehensive, child-centered strategic plan that is data driven, informed by best practices, and connects all child welfare services in the County, and articulates measurable goals and time frames.	OCP		✓				OCP has begun the process to develop a countywide strategic plan. Between May 18, 2015 and June 11, 2015, the OCP held five stakeholder convenings (one in each Supervisorial district) involving over 400 county staff, contracted providers, schools, faith organizations, advocates, philanthropists and other community based organizations to solicit assistance in developing objectives that could potentially be included in the countywide strategic plan. Additional convenings were held for foster youth, relative caregivers, and foster parents.
5.2 Establish a Los Angeles County Office of Child Protection (OCP), with Countywide authority to coordinate, plan, and implement one unified child protection system.	OCP					✓	The Office of Child Protection was operationalized in February 2015.
5.3 Oversee implementation of the Commission's recommendations upon adoption by the Board.	OCP					✓	The OCP will oversee the implementation of the recommendations of the Blue Ribbon Commission.
5.4 In collaboration with the Board, identify the services currently provided by the Departments of Health Services, Children and Family Services, Public Health, Probation, Mental Health, Public Social Services, First 5 LA, the Los Angeles Office of Education, the Domestic Violence Council, and the Housing Authority of the County of Los Angeles deemed as crucial to ensuring child safety. The accompanying budget and staff resources also should be identified.	CEO						On October 20, 2014, a Board memo was issued by the CEO's Office providing the recommended information.
5.5 Departments and agencies closely involved in the identification, prevention, protection, and treatment of at-risk children should be mandated to participate in cross-training with DCFS employees. At a minimum, this interdisciplinary approach should include law enforcement, DMH, DHS, DPH, the	OCP/DCFS					✓	DCFS continues to offer and expand upon training in partnership with all of the agencies listed above. Additionally, OCP is working with DCFS, Probation, DMH and other partners (including law enforcement to implement multi-departmental training that includes training along with community partners.
5.6 DCFS, DMH, and DHS should train personnel, both in-house and in contract agencies, on how to most effectively work with the age 0-5 population, their families, and caretakers.	DCFS, DMH, DHS					✓	Training on the 0-5 population continues to be offered to DCFS staff and some of these trainings have been videotaped and made available to all DCFS staff electronically. Additionally, DCFS has partnered with San Diego Regional Training Academy/PCTWA who are working to complete and post online the eLearning on Trauma.
5.7 Greater disclosure, clarity, and inclusion should be a routine component of community engagement from planning to review of outcomes and allocation of resources.						✓	Since it was operationalized, the OCP has conducted no less than ten stakeholder convenings and participated in other non-OCP sponsored meetings related to child welfare in Los Angeles County. OCP believes that ongoing communication and community engagement is an essential key to unifying the child protection network in the county and models this behavior in its work. OCP will host regular meetings with stakeholders regarding topics of importance and relevance to child protection.

Agencies: County Counsel (CoCo), Departments of Children and Family Services (DCFS), Health Services (DHS), Mental Health (DMH), Public Health (DPH), Public Social Services (DPSS), District Attorney's Office (DAO), First 5 Los Angeles (First 5 LA), University Consortium for Children and Families (UCCF), Inter-Agency Council on Child Abuse and Neglect (ICAN), Service Employees International Union (SEIU)

Update by the Office of Child Protection on the BRCCP Recommendations - October 2015

Recommendation	Entity	STATUS UPDATE					Comment
		Planning Yet to Begin	Plan Development in Progress	Plan Developed	Pre-Implementation Efforts Underway	Implementation in Progress	
5.8 A first step is the re-establishment of community advisory councils that are attached directly to each DCFS Regional Office. These advisory councils would be co-chaired by the community and its respective Regional Office. In the past, SPA 6 effectively used this model in all three of its offices.	DCFS					✓	The DCFS Directors' Advisory Council members are helping to reestablish the DCFS Regional Advisory Councils. The Advisory Council has identified the re-establishment of local Community Advisory Councils as one of their three primary focus efforts. The Director's Advisory Council has agreed to act as liaisons to the various local councils; and being active in meetings at the local level when appropriate. On December 2014, Regional Offices began implementation of the enhancements to the Regional Community Advisory Councils and a monthly reporting process.
5.9 The Board should adopt clear outcome measures which should include those set forth above. (p. 14 of BRCCP report)	OCP		✓				OCP is working with the Children's Commission to develop outcome measures that includes, but is not limited to, DCFS-specific child safety measures. The idea is to establish other measurable outcomes that will help drive other domains with the continuum of care including prevention and well-being and that will implicate the work of other County departments.
5.10 The OCP should regularly assess the County's progress and report its findings directly to the Board. The findings should be reviewed regularly at Board meetings.	OCP					✓	The OCP will provide its first update on the BRCCP recommendations in June 2015. Once outcome measures are established, the OCP will regularly assess progress and report to the Board.
5.11 Establish and evaluate measurable outcomes as part of the annual planning and budget allocation process to facilitate constant improvement, generalize successful and discontinue unsatisfactory practices.	OCP	✓					Work is underway to develop measurable outcomes.
5.12 The UCCF should submit an annual report on outcomes that are aligned with the County's vision.	DCFS/OCP					✓	The UCCF submitted its 2013-14 report. A review and analysis of the report is warranted.
5.13 The Oversight Team must develop a dashboard to provide monthly report to the Board.	OCP					✓	The Transition Team developed a matrix to provide updates to the Board.
5.14 Capacity-building experts, including universities, should work with community-based organizations to enhance skills in grant application and administration, evidence-based practice, program design, and evaluation.	DCFS and other relevant departments					✓	On March 2, 2015 all the DCFS contractors were informed about an upcoming training that is offered by the Office of Small Business; the training was held on March 13, 2015. The trainings focused on assisting all attendees on how to successfully submit a proposal for a Request for Proposal. This recommendation, however, is larger than DCFS. DCFS should as much as possible focus on its core mission.

Agencies: County Counsel (CoCo), Departments of Children and Family Services (DCFS), Health Services (DHS), Mental Health (DMH), Public Health (DPH), Public Social Services (DPSS), District Attorney's Office (DAO), First 5 Los Angeles (First 5 LA), University Consortium for Children and Families (UCCF), Inter-Agency Council on Child Abuse and Neglect (ICAN), Service Employees International Union (SEIU)

Update by the Office of Child Protection on the BRCCP Recommendations - October 2015

Recommendation	Entity	STATUS UPDATE					Comment
		Planning Yet to Begin	Plan Development in Progress	Plan Developed	Pre-Implementation Efforts Underway	Implementation in Progress	
5.15 Performance-based contracting on agreed-upon outcome measures by DCF, other appropriate departments and the contracting agencies for children and families should be adopted, rewarding contracting agencies that achieve better results for the children they serve.	DCFS						DCFS plans to release solicitations consistent with this recommendation as early as the end of September 2015. Conversations have yet to be had with other child and family serving departments but there are plans to do so.
5.16 The County needs to develop a clear, multi-system data linkage and sharing plan that would operate as a single, coordinated system. (Include: DCF, DPSS, DMH, DPH, Probation, LACOE, and school districts at minimum. Also, partner with universities).	OCP		✓				The County has made progress in this area. OCP is currently working with County Counsel to finalize a multi-departmental data-sharing protocol. An automated tool will be developed to provide information to DCF's Emergency Response Social Workers investigating allegations of abuse or neglect. This is a very important first step in the development of a multi-system, data linkage and sharing plan.
5.17 The CEO and Juvenile Court should co-lead the creation of a Countywide confidentiality policy regarding a child's records and court proceedings to allow sharing of information across relevant departments, agencies, persons, and the Court to serve the needs of the child and increase the transparency of the system.	OCP					✓	The June 2014 CEO report indicated that California law already enables information sharing across relevant agencies and the Court for the purposes of coordinating services to best meet the needs of the child. The reports also mentioned the need for training County staff so that they understand the data sharing provisions and the various statutes that enable the sharing of data. This can be addressed in the efforts related to multi-departmental sharing.
<p>Agencies: County Counsel (CoCo), Departments of Children and Family Services (DCFS), Health Services (DHS), Mental Health (DMH), Public Health (DPH), District Attorney's Office (DAO), First 5 Los Angeles (First 5 LA), University Consortium for Children and Families (UCCF), Inter-Agency Council on Child Abuse and Neglect (ICAN), Service Employees International Union (SEIU)</p>							
6. COUNTY ADMINISTRATION							
6.1 A comprehensive service delivery system, including prevention programs that stop child maltreatments before it starts.	OCP		✓				This all encompassing recommendation speaks to an overhaul of how various services are provided. A substantive update cannot be provided for this recommendation until after the OCP has finalized the Countywide strategic plan.
6.2 All relevant County entities to work together and with the Community.	OCP					✓	This fundamental concept permeates much of the work of the OCP as it works with County departments, other governmental entities, contracted providers, faith based providers, philanthropy. This recommendation speaks to a continuous way of doing business together.
6.3 Joint strategic planning and blended funding streams.	OCP	✓					The strategic planning process is underway. When appropriate, funding streams will be blended when necessary, and otherwise permissible under appropriate statutory or regulatory authority.
6.4 Data-driven programs and evaluations.	OCP	✓					OCP recognizes the value and power of data. The OCP is committed to data driven decision making and recognizes that evaluations can help the County understand which programs, services, and interventions should be continued and which should be discontinued.
6.5 Have clear oversight and authority over financial and staffing resources from all relevant departments, as delegated by the Board.	OCP/CEO						Please see the analysis contained in the CEO's Board report dated June 10, 2014, which was adopted by the Board. On pages 10 - 14, the report outlines statutory barriers to transferring to OCP "oversight and authority" over various County departments. This recommendation was not adopted by the Board of Supervisors.

Update by the Office of Child Protection on the BRCCP Recommendations - October 2015

Recommendation	Entity	STATUS UPDATE					Comment
		Planning Yet to Begin	Plan Development in Progress	Plan Developed	Pre-Implementation Efforts Underway	Implementation in Progress	
6.6 Institute an annual Countywide budget review process that examines all proposed, present, and past resource allocations and align them with the goals of the Countywide strategic plan, as well as coordinate relevant funding streams from various departments.	OCP/CEO	✓					
6.7 Serve as the repository of and review all recommendations related to the protection of children. Oversee implementation of appropriate recommendations.	OCP	✓					
6.8 Review existing County commissions and, with the Board, streamline them, as appropriate.	OCP	✓					Defer to CEO's Governance Report (July 2015) and work with the CEO to assist in review.
6.9 ICAN should be removed from within DCFS and exist as an independent entity.	DCFS, OCP	✓					
6.10 An annual overview of the state of the field of child welfare, presented to the Board by external experts.	OCP	✓					

Agencies: County Counsel (CoCo), Departments of Children and Family Services (DCFS), Health Services (DHS), Mental Health (DMH), Public Health (DPH), Public Social Services (DPSS), District Attorney's Office (DAO), First 5 - Los Angeles (First 5 LA), University Consortium for Children and Families (UCCF), Inter-Agency Council on Child Abuse and Neglect (ICAN), Service Employees International Union (SEIU)



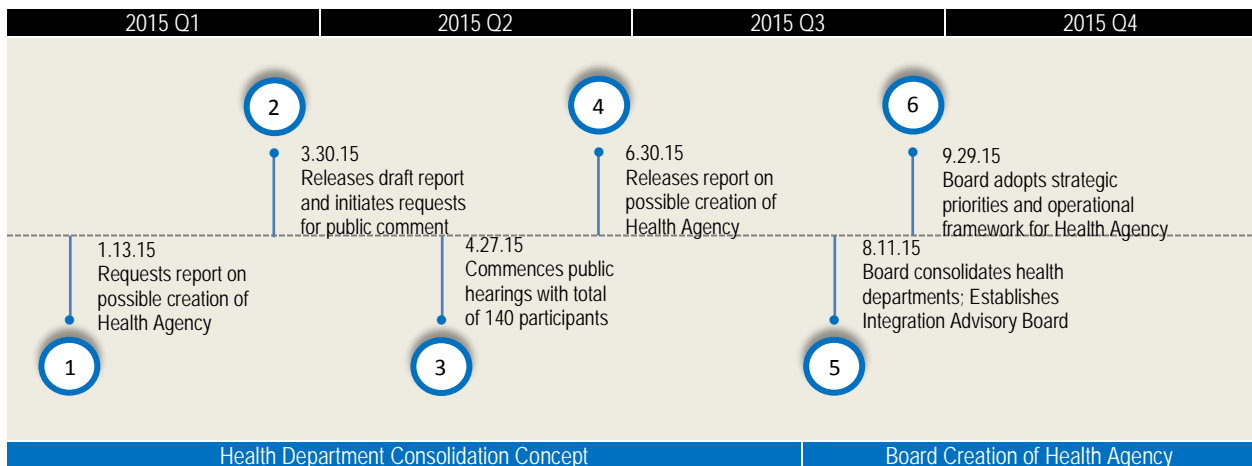
County of Los Angeles
AD HOC INITIATIVES

HEALTH INTEGRATION

Topic	Document	Date
Consolidation Concept	1. Board Motion - Consolidation of the Departments of Health Services, Public Health, and Mental Health	1/13/15
	2. Board Motion - Ensuring Quality Health and Mental Health Care Services in LA County Custody Facilities	3/3/15
	3. Board Correspondence - Final Report on Possible Creation of a Health Agency	6/30/15
Creation of Health Agency	4. Board Motion - Health Agency	8/11/15
	5. Board Letter - Approve the Strategic Priorities and Operational Framework for the Los Angeles County Health Agency – Approved	9/29/15

- Information Available on County Health Initiative Website at: <http://priorities.lacounty.gov/health/>
- Board Correspondence may be searched by title and date at: <http://portal.lacounty.gov/wps/portal/bc>

HEALTH INTEGRATION TIMELINE



**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND
MICHAEL D. ANTONOVICH**

MARCH 3, 2015

**Ensuring Quality Health and Mental Health Care Services in Los Angeles County
Custody Facilities**

On January 13, 2015, the Board of Supervisors (Board) passed a motion approving in concept the creation of a health agency and directed the Interim Chief Executive Officer (CEO), in collaboration with County Counsel, the directors of the Department of Human Resources, Department of Health Services (DHS), Department of Mental Health (DMH), Department of Public Health (DPH), and the Agricultural Commission, to report back in 60 days on the benefits, drawbacks, proposed structure, and implementation steps and timeframe. The motion directed the CEO to establish a stakeholder process to solicit input on the issues to be addressed in the report. To provide external stakeholders with sufficient time to review and provide input on a draft version of the report, it is prudent to extend the deadline for submitting a final version of the report to the Board.

The motion was also amended to consider including the Los Angeles County Sheriff's Department's (LASD) Medical Services Bureau in the health agency.

- MORE -

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND
MICHAEL D. ANTONOVICH
MARCH 3, 2015
PAGE 2**

Currently, health care services for County inmates are provided by four separate County departments: DHS, DMH, DPH, and LASD. Due to concerns surrounding the quality of health care provided within the jails, the motion asked for consideration of including jail health services in the health agency and how such a move might be structured and accomplished in light of the federal consent decree negotiations and the County Commission on Jail Violence's recommendations. It is critical that the extended timeline for gathering stakeholder input on the draft health agency report not hold up progress on taking immediate action to improve the quality of health care provided to inmates in the County jails.

WE THEREFORE MOVE THAT THE BOARD OF SUPERVISORS:

Direct the Interim Chief Executive Officer, in conjunction with County Counsel and the Directors of the Department of Human Resources, Health Services, Mental Health, Public Health, and the Sheriff's Department, to:

1. Extend the deadline for submission of the final report on the health agency, as outlined in the motion approved by the Board of Supervisors (Board) on January 13, 2015, to June 30, 2015, including a 45-day open comment period on a draft version of the report. The response to the Board on the movement of the Environmental Toxicology Lab, currently within the Agricultural Commission, to the Department of Public Health should still be governed by the original due date of March 13, 2015; and

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND
MICHAEL D. ANTONOVICH
MARCH 3, 2015
PAGE 3**

2. Report back to the Board in writing in 30 days summarizing the status of jail health services in Los Angeles County, including issues pertaining to physical health, mental health, and public health. The report should also outline a set of the proposed approaches and strategies to address these issues and improve the overall quality and delivery of the care provided.

###

(YV)

AMENDING MOTION BY SUPERVISOR MARK RIDLEY-THOMAS JANUARY 13, 2015

Consolidation of Sheriff Medical Services Bureau

I THEREFORE MOVE THAT THE BOARD OF SUPERVISORS include the Sheriff's Department in the working group discussions on health department consolidation and instruct the departments to include in the 60 day report back a recommendation on whether the Sheriff's Department Medical Services Bureau should be included in the consolidation, and if so, how it should be structured and accomplished.

####

YV

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

AMENDMENT TO AGENDA ITEM #2

Historically, the Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH) operated as a single department within our County. In response to a variety of factors and the need to establish distinct identities, the Board separated the three functions into three separate departments. While the decisions to separate the functions into three departments were appropriate at the time, evolving trends in health care delivery, policy, and reimbursement have changed. In the present and expected future health care environment, it would be better for the County to operate a single unified health ~~department~~ **agency** that encompasses all aspects of population and personal health.

By integrating DHS, DMH, and DPH, the County will be better positioned to provide high quality, comprehensive health-related services and programs to County residents. Additionally, a single combined health ~~department~~ **agency** would be best positioned organizationally to break down the bureaucratic barriers facing the County's patients, identify synergies between programs, streamline operations, optimize finances and align incentives so that all County staff work toward the goal of providing high-quality, patient-centered, cost-effective health services across the full continuum of

MOTION

- SOLIS _____
- RIDLEY-THOMAS _____
- KUEHL _____
- KNABE _____
- ANTONOVICH _____

health services. Additionally, consolidating the three departments should result in budgetary savings by sharing capital or administrative expenses, while yielding tangible benefits for patients in terms of service delivery enhancements.

Finally, it makes sense to also consolidate the environmental toxicology bureau functions currently performed by the Department of Agricultural Commissioner/Weights and Measures within the new consolidated health services ~~department~~ **agency**.

I, THEREFORE, MOVE that the Board of Supervisors:

1. Approve in concept the consolidation of DHS, DPH, and DMH into a single integrated ~~department~~ **agency**, including the assumption of the environmental toxicology bureau functions currently performed by the Agricultural Commissioner; and
2. Instruct the Chief Executive Officer, County Counsel and the Department of Human Resources, in conjunction with the Departments of Health Services, **Mental Health, Public Health, and Agricultural Commissioner/Weights and Measures** to report back within 60 days with a proposed structure ~~to that~~ **that might** accomplish ~~the~~ **such a** consolidation, as well as ~~proposed~~ **possible** implementation steps, ~~and a~~ time frame for achievement of the ~~consolidation~~ **agency, and the benefits as well as any drawbacks to this action. In addition the CEO should establish a stakeholder/public participation process to ensure that their input is considered in the report.**

#



County of Los Angeles CHIEF EXECUTIVE OFFICE

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
<http://ceo.lacounty.gov>

SACHI A. HAMAI
Interim Chief Executive Officer

June 30, 2015

To: Mayor Michael D. Antonovich
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knäbe

From: Sachi A. Hamai
Interim Chief Executive Officer

Board of Supervisors
HILDA L. SOLIS
First District

MARK RIDLEY-THOMAS
Second District

SHEILA KUEHL
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

FINAL REPORT ON POSSIBLE CREATION OF A HEALTH AGENCY (ITEM NO. 2, AGENDA OF JANUARY 13, 2015 AND ITEM NO. 2, AGENDA OF MARCH 3, 2015)

On January 13, 2015, the Board directed the Interim Chief Executive Officer, County Counsel and the Department of Human Resources, in conjunction with the Departments of Health Services (DMH), Mental Health (DMH), and Public Health (DPH), to report back in 60 days on the benefits, drawbacks, proposed structure, implementation steps, and timeframe for the creation of a single unified health agency. On March 3, 2015, the Board extended the deadline of the final report on the health agency to June 30, 2015. A draft version of this report was made public on March 30, 2015; formal public comment closed on May 29, 2015. Attached is the final report in response to this Board motion, having been revised based on input received during the public comment period.

While each has a unique mission and set of responsibilities, the ultimate goal of DHS, DMH, and DPH is to improve the health and well-being of all Los Angeles (LA) County residents across physical, behavioral, and population health. If created, a health agency would be responsible for leading, supporting, and promoting integration and enhancement of services and programs between the three Departments. An agency would support the full current scope and spectrum of activities and responsibilities of each Department. An agency is not intended to reduce service levels or programs, cut budgets, lay off staff, or cut contracts with private agencies/providers.

Key opportunities that the agency might assist the County in pursuing include:

- Improving health outcomes and reducing disparities
- Addressing major service gaps for specific vulnerable populations
- Bridging population and personal health
- Integrating services at the point of direct care delivery
- Streamlining access to care
- Using information technology to enable service and programmatic integration

"To Enrich Lives Through Effective And Caring Service"

**Please Conserve Paper – This Document and Copies are Two-Sided
Intra-County Correspondence Sent Electronically Only**

- Improving workforce education and training
- Strengthening the County's influence on health policy issues
- Improving use of space and facility planning
- Improving ancillary and administrative services/functions
- Maximizing revenue generation

An agency structure may have drawbacks. Risks and concerns that have been raised as part of the stakeholder process include the possibility that an agency may:

- Result in cuts to critical population health and mental health programs
- Add an increased degree of bureaucracy resulting in service/operations delays
- Require financial investment that would be funded from Departmental resources
- Lose focus on the full breadth of the Departments' current missions
- Lead to cultural friction that compromises integration efforts
- Place greater focus on the medical model at the expense of the recovery/resiliency model of care
- Disrupt existing programs and well-established client-provider relationships
- Distract County staff and community stakeholders from their ongoing work

The proposed agency structure takes into account the above risks and seeks to mitigate their likelihood of becoming a reality. Importantly, the Board chose to approve in concept an agency model in which each Department preserves a separately appropriated budget that can only be changed by the Board of Supervisors, rather than approving a merged model in which DHS, DMH, and DPH are consolidated into a single department.

To mitigate the risk of bureaucracy and administrative costs, agency staffing should be lean. Functions should not be duplicated between the Departments and agency. Units should be moved to the agency only when there is a clear, demonstrable added value of doing so in terms of service enhancements and efficiency gains. The report includes specific recommendations for units that could be positioned at the agency level over the short-term as well as recommendations for placement of agency-level individuals serving in strategic leadership roles in specific functional areas. Core administrative units, including human resources, information technology, finance, and contracting/procurement, among others, should not be immediately moved to the agency.

Many people felt that an agency was not necessary to achieve the benefits of integration, but rather such benefits could be achieved by the Departments working more collaboratively or through other non-agency structures. A summary of alternative non-agency models suggested by stakeholders include:

- Creation of a separate office, patterned after the Office of Child Protection, to help coordinate and lead integration-focused initiatives
- Realignment of Department functions without creation of an agency
- Creation of an agency focused only on clinical service delivery (i.e., excluding population health)
- Creation of a health and social services agency
- Creation of a health authority

The Board of Supervisors has three general options as to how it may choose to proceed. First, it may decide the current structure and organizational relationships of the Departments should be left unchanged, ceasing consideration of the agency and other models that would alter County organizational structure and Departmental relationships. Second, the Board may choose to proceed with creating an agency involving DHS, DMH, and DPH. Finally, the Board may choose to proceed with study and/or implementation of a different model, including those noted above.

If the Board chooses to proceed with creation of an agency, the County would adopt an ordinance formally approving the agency and specifying the reporting relationships between the agency and Departments. Additional recommended actions that should be taken if an agency is created include the need to:

- Appoint an agency director with the skills and temperament needed to be successful in the role
- Build a transparent, ongoing, and meaningful partnership with internal and external stakeholders
- Promote cultural competency in all health-related activities
- Establish an integrated strategic plan and a set of initial agency priorities
- Ensure accountability and oversight of the agency
- Regularly and publicly report on agency progress and impact
- Publish clear, concise data on Department budgets
- Publicly communicate changes in County organizational structure and programs
- Create opportunities to build relationships and trust among staff

The hope is that through this report, and the extensive internal and external stakeholder process that helped inform it, LA County leadership is well-positioned to determine the best path forward so that it may maximize opportunities for innovation and integration for the benefit of all LA County residents.

If you have any questions, please contact me, or your staff may contact Dr. Christina Ghaly at (213) 974-1160.

SAH:CRG:jp

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Health Services
Human Resources
Mental Health
Public Health



**Response to the Los Angeles County Board of Supervisors
Regarding Possible Creation of a Health Agency**

June 30, 2015

Table of Contents

Executive Summary.....	3
Introduction.....	5
Organizing LA County’s Health-Related Departments to Achieve Integration Goals	7
<i>An agency as an organizational structure</i>	10
<i>Non-agency alternatives</i>	11
Integration Opportunities	14
<i>Aligning resources and programs to improve health outcomes and reduce disparities</i>	14
<i>Addressing major service gaps for specific vulnerable populations</i>	16
<i>Bridging population and personal health</i>	22
<i>Integrating services at the point of care for those seeking care within the County</i>	24
<i>Streamlining access to care</i>	35
<i>Using information technology, data, and information exchange to enable service integration</i>	36
<i>Improving workforce education and training</i>	38
<i>Strengthening the County’s influence on health policy issues</i>	39
<i>Improving use of space and facility planning to improve access and reduce costs</i>	39
<i>Improving ancillary and administrative services and functions</i>	40
<i>Maximizing revenue generation</i>	42
Drawbacks and Risks of the Agency Model.....	45
<i>Concern regarding potential legal risks</i>	45
<i>Concern regarding potential human resource risks</i>	46
<i>Risk of history repeating itself: Fear of service/budget cuts and deprioritization of County functions</i>	47
<i>Risk of increased degree of bureaucracy</i>	50
<i>Risk that an agency may require financial investment for administrative positions</i>	52
<i>Risk that Departments may lose focus on the full breadth of their current missions</i>	52
<i>Risk that cultural differences may compromise integration efforts</i>	54
<i>Risk of medicalization of community-based mental health</i>	55
<i>Risk of disrupting existing service models and the staffing structures and partnerships they rely on</i>	56
<i>Risk agency planning may detract from the work of integration</i>	57
Proposed Structure	58
<i>Placement of specific responsibilities and functions within a health agency</i>	58
<i>The role of the Health Officer</i>	63
Possible Implementation Steps and Timeframe for Achievement of an Agency	64
<i>Legal and technical steps required to create an agency</i>	64
<i>Strategic/operational steps related to implementation of an agency</i>	64
Conclusion	72
Appendix I: Board Motion on Health Integration	74
Appendix II: Brief Overview of Process for Developing this Response to the Board	75
Appendix III: Overview of Department Responsibilities	78
Appendix IV: History of DHS, DMH, and DPH Organizational Structure	83
Appendix V: Structure of Health-Related Services in other Counties.....	84
Appendix VI: Principles as Approved by External Stakeholder Groups.....	89
Appendix VII: Public Comments.....	94
Appendix VIII: Summary of Findings from Facilitated Public Convenings.....	251

Executive Summary

On January 13, 2015, the Los Angeles (LA) County Board of Supervisors unanimously passed a motion approving in concept the creation of a single, integrated health agency with authority over the Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH). As requested in the Board motion, this report provides an overview of the types of integration-related opportunities that a health agency might pursue, the potential risks and drawbacks of a health agency, a proposed structure, and suggested implementation steps and timeline. The report was developed with significant input from a broad set of internal and external stakeholders across the health community.

If created, a health agency would be responsible for leading, supporting, and promoting integration and enhancement of services and programs between DHS, DMH, and DPH for the benefit of all LA County residents. An agency would support the full scope and spectrum of activities and responsibilities of the three Departments. It is not intended to reduce service levels or programs, cut budgets, lay off staff, or cut contracts with private agencies/providers. Below are key integration opportunities the County ought to pursue that, if achieved, would yield significant benefits for the residents of LA County. The creation of an agency might assist in the pursuit of these goals.

1. Reduce health disparities by identifying and implementing interventions that address social determinants of health and improve access and utilization.
2. Address gaps in service delivery for at-risk, vulnerable populations, including but not limited to foster children and transitional aged youth, justice-involved populations, homeless individuals, and those in psychiatric crisis.
3. Enhance cross-linkage between population health and direct clinical care services.
4. Integrate direct care services for patients/clients/consumers that need physical, mental, substance abuse, and housing-related services and supports.
5. Streamline access to services and programs provided or funded by the County by creating a unique identifier and aligning referral, financial screening, and registration practices.
6. Use information technology to enhance access to information and coordinate management of shared clients and populations.
7. Educate and train the health care workforce to succeed in an integrated care environment.
8. Increase the County's ability to influence state and federal health policy issues.
9. Improve utilization of owned and leased buildings to enhance service delivery and lower costs.
10. Capture opportunities in pharmacy, ancillary services, contracting, purchasing, and human resources to improve the quality and efficiency of County services and the experience of those interacting with the system.
11. Generate additional revenue by increasing managed care contracts and strategically pursuing other revenue-maximization opportunities.

An agency structure may have drawbacks or disadvantages. Risks and concerns that have been raised as part of the stakeholder process include the possibility that an agency may:

1. Result in service and budget cuts to critical population health and mental health programs.
2. Add layers of bureaucracy that will result in delayed services/operations.
3. Require financial investment that would need to be funded within existing Departmental resources.
4. Prevent Departments from focusing on the full breadth of their current missions and scope of activities, the full set of clients/populations served, and the way in which services/programs are provided.
5. Aggravate cultural differences and distrust between the Departments, compromising efforts to work together.
6. Replace the recovery and resiliency models that are foundational to the community mental health system of care with a focus on a medical model of disease and treatment.
7. Disrupt existing, successful programs and well-established provider/agency relationships.

8. Distract Department staff and community stakeholders from their ongoing work enhancing programs/services.

The proposed agency structure takes into account the above risks and seeks to mitigate their likelihood of becoming a reality. First, the Board chose to approve in concept an agency model in which each Department preserves a separately appropriated budget that can only be changed by the Board of Supervisors, rather than approving a merged Department model in which DHS, DMH, and DPH are consolidated into a single department. Next, to mitigate the risk of bureaucracy and administrative costs, agency staffing should be lean. Functions should not be duplicated between the Departments and agency and units should only be moved to an agency level when there is a clear, demonstrable added value of doing so in terms of service enhancements and efficiency gains. Specific units (in full or in part) recommended for placement at an agency level are: data/planning, capital projects/space planning, government affairs, and consumer affairs/advocacy/ombudsman; a workforce training function should be considered. Core administrative functions (e.g., IT, HR, contracting, finance) should remain within the Departments. Individuals with strategic leadership positions in the following areas are also recommended: information technology, revenue maximization, service contracting/procurement, and human resources/employee relations; an individual charged with coordinating managed care strategy should be considered.

Many people felt that an agency was not necessary to achieve the benefits of integration, but rather such benefits could be achieved by the Departments working more collaboratively or through other non-agency structures. A summary of alternative non-agency models suggested by stakeholders include: creation of a separate office, patterned after the Office of Child Protection, to help coordinate and lead integration-focused initiatives; realignment of Department functions without creation of an agency; creation of an agency focused only on clinical service delivery (i.e., excluding population health); creation of a health and social services agency; and creation of a health authority.

At the Board's discretion, a health agency could be created by adopting a County ordinance formally approving the agency and specifying the reporting relationships between the agency and Departments. Beyond this, should the Board decide to create an agency, it should be carefully implemented in a way that mitigates the potential risks raised by stakeholders and that supports ongoing transparency and community engagement. Recommended actions include the need to:

1. Appoint an agency director with the skills and temperament needed to be successful in the role.
2. Establish and clearly communicate an integrated strategic plan and a set of initial agency priorities to which the agency director and Department heads are held accountable.
3. Build a transparent, ongoing, and meaningful partnership with internal and external stakeholders in which a broad set of community members, including patients/clients/consumers and their families, provide input into agency priorities/activities and raise ideas and concerns. Such engagement is critical in ensuring ongoing community participation in planning programs and initiatives and restoring trust and confidence among community members.
4. Promote cultural competency in all health-related activities.
5. Ensure accountability and oversight of the agency, potentially through empowerment of the existing Commissions.
6. Regularly and publicly report on agency progress, including indicators related to agency impact, encouraging public statements to be made by Department heads and community stakeholders as well as agency leadership.
7. Publish clear, concise data on Department budgets including sources and uses of various financing streams.
8. Clearly communicate any changes in County organizational structure or programs with the public.
9. Create opportunities to build relationships and trust among staff.

While each has a unique mission and set of responsibilities, the ultimate goal of the health-related Departments is to improve the health and well-being of all LA County residents, enhancing parity and equitable access to care and services across physical, behavioral, and population health. The hope is that through this report, and the extensive internal and external stakeholder process that helped inform it, LA County leadership is well-positioned to determine the best path forward so that it may maximize opportunities for innovation and integration for the benefit of all LA County residents.

Introduction

On January 13, 2015, the Los Angeles (LA) County Board of Supervisors unanimously approved in concept the creation of “a single, integrated agency” encompassing the Departments of Health Services, Mental Health, and Public Health¹, as well as the environmental toxicology bureau functions currently performed by the Agricultural Commissioner. The motion directed the Chief Executive Officer (CEO), County Counsel, and the Department of Human Resources (DHR), in conjunction with the Department of Health Services (DHS), the Department of Mental Health (DMH), the Department of Public Health (DPH), and Agricultural Commission to report back within 60 days on five issues: the benefits and drawbacks of the agency, proposed agency structure, possible implementation steps, and timeframe for achievement of the agency. The motion specifically requested a stakeholder/public participation process for soliciting broad input into the report.² Finally, the motion was also amended to include consideration for moving the Sheriff Medical Services Bureau (MSB) into the agency. This document will address issues pertaining to the organizational integration of DHS, DMH, and DPH, collectively referred to as the “Departments” in this report. The environmental toxicology lab was discussed in a separate report to the Board on March 31, 2015; on May 19, 2015, the Board voted unanimously to effectuate its transfer from the Agricultural Commissioner to the Department of Public Health by the end of the current fiscal year. Regarding health services provided to County jail inmates, on June 9, 2015, the Board voted unanimously to approve a single, integrated jail health services organizational structure, including the transition of jail health staff from the Department of Mental Health and Sheriff’s Department Medical Services Bureau to the Department of Health Services under the direction of a new Correctional Health Director. Issues pertaining to the environmental toxicology lab and jail health services will not be discussed further in this report.

Each of the three County health Departments strives, via a unique combination of policy, programmatic, regulatory, and direct care activities³, to enhance and promote the health of LA County residents, with “health” being defined in this report in its broadest, most comprehensive sense, emphasizing the physical, mental, social, and spiritual wellness of individuals and populations. This includes, where relevant, social services and programmatic supports that fall outside traditional definitions of health but that are needed to address social determinants and produce whole person wellness in all realms (e.g., entities focused on education, employment, community development, recreation, etc.). In meeting their common goal of enhancing health, the activities and responsibilities of the Departments are complementary. The specific niche for each Department (within the broad health care milieu) can be found in their mission statements, functional and operational structures, and strategic plans. The different responsibilities, activities, organizational identities, and assets of each should be viewed as the reason for there being so much value in working more closely together to address challenging issues. Beyond their overall focus on health, the Departments also share important similarities, including mission-driven County staff, a wide and complex network of community partnerships, an ethic of service and cultural proficiency, a commitment to evidence-based practices, and a focus on reducing health disparities among disadvantaged populations.

There was a strong and convincing rationale behind the re-establishment of an independent Department of Mental Health in 1978 and the creation of an independent Department of Public Health in 2006.⁴ The separations allowed each to develop a strong identity and reputation in their fields, to prioritize their work to achieve their missions, and to avoid program cuts that could occur in the setting of financial deficits. Internal and external stakeholders, including both those opposed to and in support of a health agency, applaud the wisdom of these historical separations.

The health-related needs of many individuals are fully met within the organizational structure of the current system. Many individuals receive excellent care and many populations benefit from the activities of each Department, including from successful integrated models of care provided in County-operated programs or as funded by the County. While

¹ Motion included in Appendix I.

² The process used to develop this report is included in Appendix II.

³ Please see an overview of the Departments’ responsibilities in Appendix III.

⁴ See Appendix IV for additional detail on the history of the Departments.

stakeholders highlighted these “pockets of success”, they also pointed to much larger areas where the system and its separate, largely siloed, efforts are not effectively serving individuals and populations. “It’s inefficient.” “Confusing.” “[Pieces of the system are] broken.” “We have many piecemeal processes that have failed to produce significant, lasting impact toward social change.” Individuals fall through the cracks and fail to get the services they need. Many individuals, including those that have been historically underserved, experience gaps in services and programs or remain entirely unserved, propagating deeply embedded disparities in access to care and health outcomes among specific populations. To address these deficiencies, the County must focus on ensuring that the totality of the County’s operated, managed, and/or funded health-related programs and services provide an integrated and high-quality approach to enhancing the health and wellness of all individuals and populations across LA County, not just those who are well-served by the current system. Success will depend on continuing a healthy duality of thinking: that is, the ability to maintain what is working well while instilling new integrated systems and practices to overcome the current gaps and meet the health needs of the most vulnerable populations.

There is broad agreement on the overall need to integrate services and programs across the different aspects of health, including mental, physical, and public health, and on integration as the best, most effective way to improve health outcomes and reduce disparities, particularly for the most disadvantaged and vulnerable County residents. However, there is strong disagreement on the best way to achieve this shared goal, on the question of whether or not organizational/structural changes to the County’s health-related Departments would help to advance integration, and, if organizational changes are needed, the form they should take.⁵ Those that favor the agency model believe it is the best way to achieve integration while maintaining independent departments and budgets able to fulfill the breadth of their current missions. Those hesitant or opposed to the agency model question whether a health agency is a necessary or even helpful step in the quest for better health outcomes, noting that more attention to cross-boundary collaboration and, in some cases, additional resources may produce the same outcomes. This report will focus primarily on the agency model proposed by the Board but will also note alternative ways that stakeholders felt integration goals could be achieved.

⁵ A summary of the structures used to organize health-related departments in other counties is included in Appendix V.

Organizing LA County's Health-Related Departments to Achieve Integration Goals

The US health care system is moving toward integration. The current siloes in which public health, mental health, and physical health operate, taking into account regulatory, financing, information management, and programmatic/service design, produce a fragmented system that fails to optimally serve all segments of the population. Integration is necessary to achieve sustainable and scalable improvements in health outcomes for individuals and populations across all racial, ethnic, cultural, and societal groups. The Affordable Care Act (ACA) is a major instigator of integration, noted to have "sweeping impacts on the provision of care for individuals with behavioral and physical health service needs who receive services in the public sector."⁶ Under the ACA and the state's ever-growing shift toward managed care, California has placed responsibility for treating mild to moderate mental illness on the local health plans which provide health services, rather than in the carve-out specialty mental health system. The trend toward managed care has also increased reliance on capitated payment models in which providers are taking on more financial risk while being held to increasingly stringent standards for timely access and quality. We therefore need delivery systems that can effectively and cost-efficiently manage a population that includes a large number of individuals with co-existing mental illness, substance use disorders, and/or multiple physical comorbidities. Federal regulations on mental health and substance abuse parity related to coverage have also raised the question of whether separate delivery systems and financing arrangements for these functions can produce equal outcomes for consumers.

Under managed care, financial incentives place increasing focus on the role of the delivery system in achieving health care's triple aim⁷, a goal that requires collaboration and integration across all of health's spheres: across the spectrum of clinical service delivery (e.g., mental health, physical health, substance abuse treatment) and within the components of each of these areas (e.g., community-based services vs. institutional-based services). It also encompasses areas outside of clinical service delivery, including for example the integration of population health and primary care.⁸ As one author noted, "a reformed system should integrate personal preventive and therapeutic care with public health and should include population-wide health initiatives. Coordinating personal medical care with population health will require a more structured system than has ever existed in the United States."⁹ This emphasis on integration is seen with Section 1115 Medicaid Waiver renewal discussions in California and approved waivers in other states that focus on the importance of integrating physical and behavioral health and on the delivery system's role and responsibility in achieving population health goals. Integration across the breadth of health's arenas is also the subject of numerous grants awarded by the Center for Medicare and Medicaid Innovation and of recently awarded State Innovation Models.

While the County must increase its efforts toward integration, there are several examples of programmatic/service integration initiatives already in place involving the Departments and partner organizations. Following are a few examples as provided by the three Departments:

1. **Center for Community Health (CCH); also known as the Leavey Center:** CCH is a health center that provides integrated primary care, mental health, dental, optometry, and substance use disorder services (via a contract with Homeless Healthcare Los Angeles) to low-income and homeless individuals on Skid Row. Partners include JWCH Institute, DHS, DMH, and DPH. CCH provides approximately 4,500 service encounters per month.¹⁰

⁶ Croft, B., (2013). "Care Integration in the Patient Protection and Affordable Care Act: Implications for Behavioral Health," *Administration and Policy in Mental Health*, 40(4). 258-63.

⁷ The health care triple aim: to improve overall health outcomes and population health; to improve quality and access and, as a result, experience of care; and to increase cost-effectiveness of care.

⁸ Institute of Medicine (2012), "Primary care and public health: Exploring integration to improve population health."

⁹ Chernichovsky, D, (2010). "Integrating public health and personal care in a reformed US health care system," *American Journal of Public Health*, 100(2). 205-11.

¹⁰ Data obtained from JWCH, June 2015.

2. **Co-Occurring Integrated Care Network (COIN):** The COIN program is a collaboration involving DPH, Probation, DMH, and other County partners and contracted providers to address the needs of Assembly Bill (AB) 109 Post release Supervised Persons (PSPs) who have a SUD, severe and persistent mental illness, and a high risk for relapse. Services offered include integrated SUD and mental health treatment services, medication assisted treatment, co-located probation supervision, and evidenced based programming. PSPs are referred by the Los Angeles County Superior Court, Division 83, for integrated co-occurring disorder services at the Antelope Valley Rehabilitation Center. Since implementation in March 2013, a total of 67 PSPs have enrolled in the COIN program and 65 were discharged, 75% of those with positive compliance (indicating they completed treatment or left treatment with satisfactory progress). Following discharge, COIN clients had a 56% decrease in homelessness and a 52% decrease in physical health problems.¹¹
3. **DMH co-locations in DHS facilities:** DHS-DMH co-locations place DMH staff on a full-time basis in DHS outpatient clinics to provide short-term evidenced-based early intervention services for adults suffering from depression and/or anxiety. The initial pilot at El Monte Comprehensive Health Center started in December 2010; seven sites currently have co-located staff. Approximately 175 unique clients across all sites were served each month in FY13-14. Aggregated outcomes for clients completing treatment are as follows for FY 2013-14: 65% positive change for individuals with depression and 57% positive change for individuals with anxiety.¹²
4. **Health Neighborhoods:** The DMH health neighborhood initiative is an effort to bring together regional providers across health, mental health, substance abuse, and community-based services to improve coordination of services in a specific community. Seven pilots are currently active: Boyle Heights, Central Long Beach, El Monte, Lancaster, MLK/Watts/Willowbrook, Pacoima, and Southeast Los Angeles.
5. **Integrated Mobile Health Team (IMHT):** IMHTs are integrated field-based teams led by mental health providers partnered with primary care providers, substance use disorder staff, and housing developers. This program assesses and provides services to homeless individuals with co-morbid mental health and physical health and/or substance use conditions who are chronically homeless and highly vulnerable. The teams have demonstrated improvements in mental health symptoms, use of alcohol, recovery from mental illness, physical health symptoms and signs (e.g., body mass index, blood pressure), and a decline in psychiatric hospitalizations and ED visits. Over the three years of the project, a total of 581 individuals were served by IMHTs.¹³
6. **MLK Psychiatric Urgent Care Center (UCC):** The UCC is a DMH facility that, through collaboration with DHS and DPH, provides primary care, mental health and substance use disorders treatment for frequent hospital emergency department utilizers. DMH contracts to provide urgent and outpatient mental health services. DHS provides primary care services, increasing access for clients with mental illness who prefer to seek medical care in a mental health setting. DPH contracts with Community Assessment Service Centers (CASC) to co-locate substance use disorder (SUD) counselors and provide assessment and referral to SUD treatment services. From July 1, 2014 to April 30, 2015, co-located SUD counselors at the MLK UCC have screened a total of 123 individuals and of those, referred 28 to SUD treatment.¹⁴

Successful examples of service integration are also often found in the systems of care that support HIV-positive individuals. From the beginning, the HIV community has insisted on providing integrated physical health, mental health, and substance

¹¹ Data obtained from DPH SAPC, June 2015.

¹² Data obtained from DMH and DHS, June 2015.

¹³ Data obtained from DMH, June 2015.

¹⁴ Data obtained from DPH SAPC, June 2015.

use treatment services to HIV-positive clients, a movement that was supported with categorical federal Ryan White Care Act and HIV Prevention funding and through the initiation of the local Ryan White Planning Council and the HIV Prevention Planning Committee, respectively.

These and other integration models are generally focused on small and/or specific populations or are present in only a certain facility, contracted entity, or region. While they should be applauded, they do not represent an integrated system of care for the residents of LA County, nor have these or other collaborative efforts by the Departments addressed striking disparities in health outcomes between different groups, including but not limited to racial and ethnic minorities and the needs of particular vulnerable populations that cross racial, ethnic, gender, and cultural lines. Similarly, the collective efforts of the Departments have failed to tackle or make substantial progress on what are considered major, intractable problems in the County: homelessness, psychiatric crises, health and mental health issues of children in the foster care system, and the needs of justice-involved populations. In both cases, this is because of a relative lack of focused attention on tackling social determinants that lie within the realm of the Departments' scope of work and because of a lack of successful, integrated programs having been implemented at scale across the County.

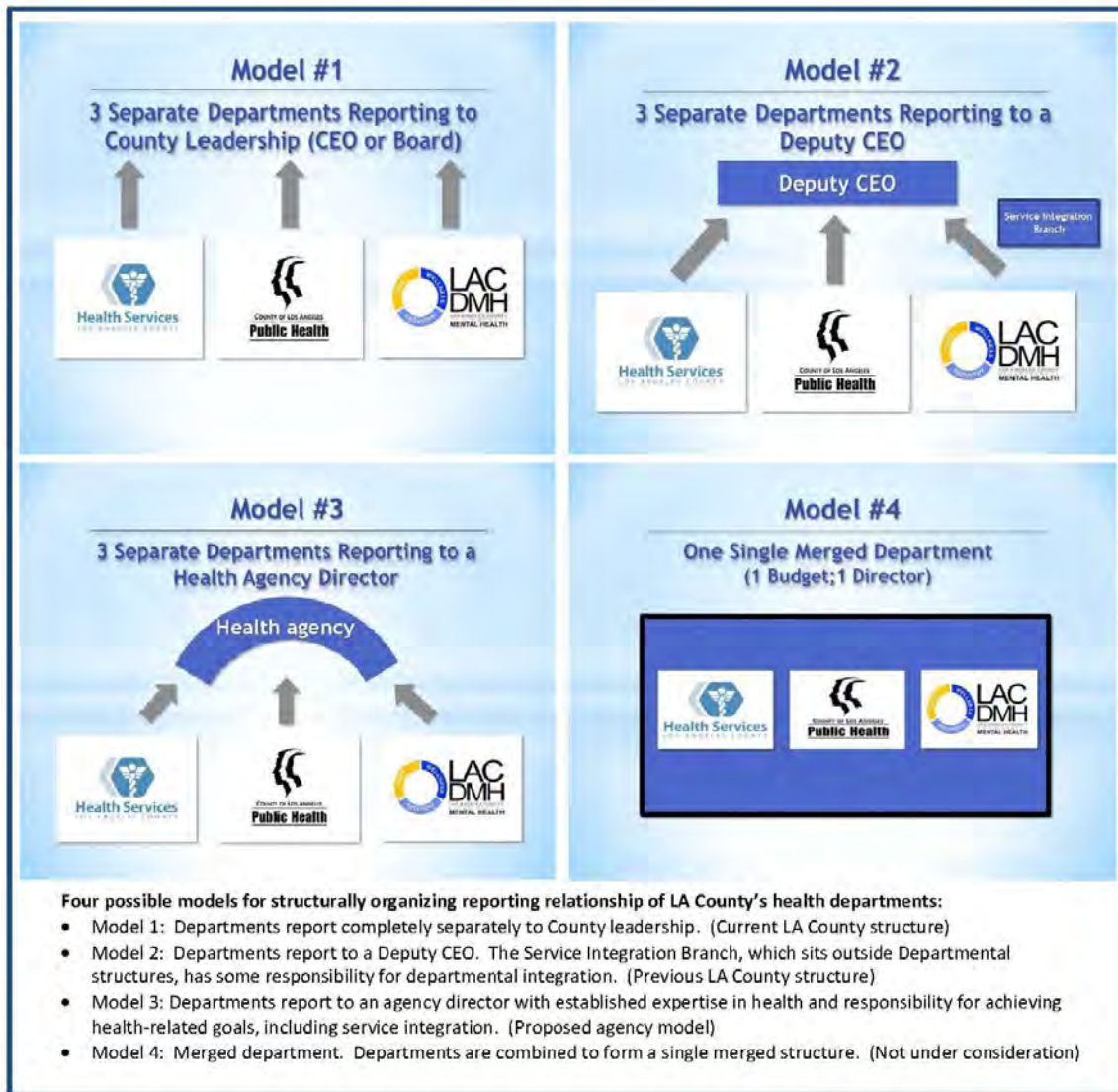
As noted in the introduction, virtually all stakeholders agree with the need to integrate activities (direct clinical services and programs extending beyond care delivery) across the three Departments. While many initially questioned the need for change, highlighting areas of success particularly within the contracted agency/provider community, this sentiment has shifted over the course of the months during which this report was drafted. A vast majority of stakeholders now generally acknowledge the need to make more rapid and robust progress in achieving scalable, sustainable programmatic changes within the broad Los Angeles County public sector system, including those services and programs directly operated by, managed by, or funded by the County. The area of greatest debate is no longer whether change is needed, but rather whether that change requires modification of the current organizational structure and governance in order to be maximally responsive to the evolving, more complex external environment. Further, if modifications are needed, there is debate on the best organizational structure and governance processes to employ in reaching the goals of integration.

The goal of any organizational change, including an agency as well as any other structural model put in place by the Board, would be to enhance services and programs for individuals and populations, and to increase the total capacity of the County's health-related Departments to serve the residents of LA County in a way that improves quality, customer experience, access to care, and health outcomes. The goal would be to lead and promote service integration where integration would benefit residents of LA County, done in a way that is responsive to the local needs and preferences of the region's diverse communities. Service cuts, staff layoffs, reductions to service contracts, or narrowing the scope of activity of the three Departments is not consistent with these goals and would not be pursued.

An emphasis on integration does not imply that all facets of each Department would benefit from integration-related activities. While the degree of overlap between the Departments is large, certain functions of each Department would not be relevant for integration. Examples include certain health protection programs and regulatory functions within DPH, certain highly specialized tertiary care clinical services within DHS, and the public guardian role within DMH, among others. Those areas that would not benefit from integration should continue to operate and evolve in their current Department. Similarly, any effort by the County to enhance focus on integration does not mean that the Departments should limit their scope of activities or center all of their energy and resources on those areas where their target populations overlap. To be successful, each Department must maintain a vibrant, strong presence across its full scope and spectrum of services. Whatever organizational structure is put in place should fully support the current responsibilities and activities of each Department.

An agency as an organizational structure

In its January 13th motion, the Board put forward a specific organizational model, a health agency, for further investigation and consideration. An agency is one of four general models the County could use to structure reporting relationships for its three health-related Departments, without making changes to the mission, scope of activity, or spectrum of services that each Department currently provides. Model #3, as seen in the box below, is the proposed agency model. Additional models proposed by stakeholders that would either a) implement a new structure without changing Departments’ reporting relationships, b) change the composition of the Departments themselves, or c) change relationships with other County departments or the Board of Supervisors, are included in the “Non-agency alternatives” section below.



Agencies are common in government at all levels and domains. They are characterized by direct reporting relationships between the agency and its component departments, with those departments maintaining their unique structure, mission, priorities, and appropriated budgets. The agency often serves as the strategic apex and central point of accountability for a set of organizations that occupy the same domain (e.g., health). Agencies characterize the structure and reporting relationship of both the State of California and the US government. With respect to California, the Department of Health

Care Services¹⁵ and the Department of Public Health both report, among other health and social service-related departments, to the California Secretary for Health and Human Services in an agency structure. Similarly, on the federal level, the Centers for Medicare and Medicaid Services and the Centers for Disease Control both report, among other health and social service-related departments, to the US Secretary for Health and Human Services in an agency structure.

Those who support an agency see organizational structure as an important enabler of integration and an agency as the right degree of organizational change, able to provide a cohesive and efficient means of building an organized and integrated approach to health and wellness that benefits all LA County residents while still empowering the Departments to focus on their unique roles and responsibilities. They believe that the County will be more likely to achieve the goals of integration if the Departments are led together than if they are led separately. They believe that without an accountable leader helping to set the vision, strategic priorities, policies, and performance objectives related to integration, ensuring coordination and alignment of individuals and groups related to each Department, and working through numerous operational obstacles in reaching scalable and sustainable solutions, most integration opportunities will not practically be achieved.

Notably, creation of an agency is not a merger in which three Departments would be combined into a single department with a single budget. The combination of DHS, DMH, and DPH in 1972 was a merger, with the now three Departments consolidated into one single department. The County has not previously employed an agency model in the organization of its health Departments. This is not a trivial distinction. First, departments have separately and individually appropriated budgets, with the Board of Supervisors having the sole power to increase or decrease department budgets. This serves as an important safeguard for ensuring that funds for mental health, public health, and physical health remain dedicated to those purposes. Second, while providing a structure to help people focus on a common set of priorities, attention and funding can be preserved for other issues. An agency focuses on areas of opportunity, on those places where there is potential for synergy that is not currently being realized. Finally, while cultural friction may naturally arise when inter-departmental teams begin working together in new ways (as it would under any structure/relationship in which a desire for greater integration brings together individuals and systems not accustomed to working together), the Departments and Department leadership are still in place, operating as a self-contained organization, and can maintain their unique identity and culture as long as the agency is not dominated by the agenda of one Department.

Non-agency alternatives

As noted above, a majority of stakeholders agree with the need for integration of services and programs, though they do not necessarily agree with the scope of integration that would be of value or the degree of overlap between the Departments. Despite a common support for service and programmatic integration, there are widely divergent views on whether or not structural changes are needed to achieve the opportunities for integration and, if they are, what type of structural change would be best.

Internal and external stakeholders often asserted that an agency is not needed to achieve integration-related goals, frequently stating “you don’t need an agency to do that.” On several occasions, they suggested alternative ways in which the County could support the goal of integration across the three Departments. Individuals supporting non-agency alternatives often believe that the County’s lack of progress on achieving integration opportunities is best attributed to a lack of available financial resources, rather than to more operational and strategic concerns, arguing that if only additional funds were available, the Departments would not be faced with the challenges they have in terms of service gaps, vulnerable populations, and lack of scaled and sustainable integration initiatives.

¹⁵ The Department of Health Care Services includes physical health, mental health, and substance abuse services in a merged department structure.

Regarding non-agency alternatives, several individuals believe that the current structure, Model 1 above, is optimal and that changes are not needed to the current organization of the County or its health Departments. They feel that integration goals can be achieved simply through greater collaborative effort by the Department heads. "The Departments can establish priorities and work together to achieve them." Some suggest that this collaborative effort could be enhanced if the Board of Supervisors set specific priorities for the Departments for which Department heads are held accountable.

Beyond the four general models in which the County could organize reporting relationships among its three health Departments, stakeholders often expressed a preference for an alternative structure. Provided below is a brief description of the main ideas raised during stakeholder discussions.

1. ***Create a separate entity outside of the Departments charged with interdepartmental coordination and integration.*** Several stakeholders suggested a model in which a separate office would be created, accountable directly to the Board of Supervisors, which would help to set strategic priorities and promote Departmental collaboration to achieve specific integration goals. The leader of this office and his/her team would not be directly responsible for Departmental functions or operations and would not have a direct reporting relationship with the Department heads. The leader's role would be one of coordination, alignment, and consensus-building. The proposed "Office for Healthcare Enhancement" follows this model, patterning itself after the County's Office of Child Protection (OCP) an entity under development in response to recommendations of the Blue Ribbon Commission on Child Protection (BRCCP). The OCP is charged with enhancing child safety across different County domains, in this case public safety (Probation), health (DHS, DMH, DPH), social services (DPSS), community services (Parks and Recreation, Public Library), etc. In a variant of this model, some individuals described a preference for a council leadership approach, rather than preferring a single appointed leader of the coordinating body. This council could be comprised of each of the three Department heads as well as other individuals, such as possibly Commission chairs, clients/consumers/patients, providers, labor, etc.
2. ***Change scope and alignment of current Departmental functions without creating an agency.*** A few stakeholders suggested fundamentally restructuring the Departments, including administrative, financial, and clinical elements. One proposal suggested the County should restructure the Departments into three new entities: one focusing on institutional care (hospitals, locked psychiatric beds, etc.), one focusing on community- and office-based clinical services (both behavioral and physical health), and one focusing on population health. A second proposal suggested the County should realign certain components of the current Departments, moving substance abuse treatment (with or without prevention), public health clinics, and non-clinic/community-based mental health responsibilities (i.e., mental health locked and unlocked placements) to DHS, leaving non-clinical service delivery public health functions within DPH and community-based mental health services within DMH. An agency would not be created in this arrangement.
3. ***Create agency focused on clinical service delivery only.*** Many stakeholders agreed with the concept of an agency that would bring together mental health, health services, substance abuse treatment (with or without prevention), and possibly DPH clinics/personal care services, but thought there was less value from including population health functions of DPH. They viewed the continued separation of core population health functions from a health agency as important to ensuring resources and attention continue to be dedicated to these activities and to recruiting population health experts to leadership roles, including notably the currently vacant DPH Director position. Some individuals felt there was a significant value to integrating those population health functions closely linked to clinical service delivery and suggested a variant in which those programmatic components (e.g., chronic disease prevention, maternal/child health, emergency preparedness, HIV/STD programs, etc.) also join the agency, leaving other areas of population health (e.g., environmental health, community education, regulatory activities) in a non-agency public health department. Some suggested that there could be a phased approach to realigning DPH

programs with an agency over time. The typical suggestion was starting with substance abuse treatment, moving to personal care/clinic services, and finally incorporating population health aspects of public health closely linked to physical or mental health services. In this model, all of DHS and DMH, in addition to portions of DPH, would move into an agency structure.

4. **Create agency but expand to include social services in addition to health functions.** Some stakeholders felt the creation of a health agency missed an opportunity to better coordinate and align all health and human/social service functions within the County. They questioned why the County was not considering inclusion of the Department of Public Social Services (DPSS), the Department of Children and Family Services (DCFS), Community and Senior Services (CSS), and homelessness programs located within the CEO.
5. **Create health authority.** Finally, several stakeholders suggested that rather than, or in addition to, a health agency, the County should consider establishing a health authority. A health authority is a public entity that has an autonomous or semi-autonomous governance structure to help achieve greater flexibility in such administrative tasks as contracting, procurement, hiring, etc. It operates to some extent independently from local government and associated regulations, being governed instead by a separate board, though often with some involvement of local government. A health authority model has been periodically considered by the County, most recently in 2004-05 but was ultimately rejected and has not been seriously considered since. There are multiple ways of structuring health authorities. Some contain only hospitals and/or clinics (e.g., Alameda Alliance for Health, New York Health and Hospitals Corporation) whereas some incorporate a broader set of health-related functions, including County roles in public health, mental health, and substance abuse in addition to hospital/clinic functions (e.g., Jackson Health Trust in Miami-Dade County, Denver Health).

Each of the options listed above, including the four organizational reporting models and the alternative models suggested by stakeholders, has potential risks, benefits, and ability to effect change under various circumstances and settings. Stakeholders however, do not agree about the specific risks and benefits of the agency and any particular non-agency alternative. They hold divergent views on the likelihood that a given model will be able to effectively establish and achieve a vision of integrated services, support collaboration, innovative problem-solving, and decision-making, or will have the capacity to work through operational issues to make progress on specific integration opportunities. Stakeholders further disagree on the extent to which any given model would be disruptive to existing Departmental operations, is inherently bureaucratic or hierarchical, is likely to produce greater or lesser non-value added forms of County process, and the degree to which cultural friction would result, among other factors.

The strategic choice before the Board regarding structure and governance is important and challenging given the lack of clear consensus among stakeholders. The question the Board must ultimately address is which model will be most effective in supporting the programmatic and operational changes required to build the County's capacity for integrated action. Regardless of the ultimate decision by the Board, the three Departments and relevant stakeholders must commit to making the structure work, specifically committing to a grass-roots, "bottom-up" approach to program/service design in a way that is responsive to the needs and preferences of unique populations and communities.

Integration Opportunities

This section will highlight major areas of opportunity for integration between DHS, DMH, and DPH and examples of specific projects that could be pursued within each area. The opportunities included here are broadly applicable across multiple populations but certainly must be tailored to meet the individual needs of the population served by a particular intervention. Progress in these areas would yield significant benefit for those served by the County. This section will not specify an operational or implementation plan for achieving each goal; this is the work that would be done through an agency over time and in active partnership with clients/consumers/patients, staff, and community stakeholders who have detailed knowledge of specific service gaps and local population needs. While the focus here is on work that could be done to improve services and programs to LA County's ten million residents, it should not be taken as a denial that good work has already taken place within and between the three Departments. Many individuals are well-served by the County and its contractors. Areas that are functioning well and meet the needs of individuals and populations should remain unchanged and would not be the focus of integration activities. Rather, the focus would be on those areas where there are gaps, where there are opportunities to improve, where individuals and populations are not well served.

Opportunities for service integration are classified into the following groups.

1. Aligning resources and programs to improve health outcomes and reduce disparities
2. Addressing major service gaps for vulnerable populations
3. Bridging population and personal health
4. Integrating services at the point of care for those seeking care within the County
5. Streamlining access to care
6. Using information technology, data, and information exchange to enable service integration
7. Improving workforce education and training
8. Strengthening the County's influence on health policy issues
9. Improving use of space and facility planning to improve access and reduce costs
10. Improving ancillary and administrative services and functions
11. Maximizing revenue generation

Aligning resources and programs to improve health outcomes and reduce disparities

Ethnic minorities have higher rates of chronic disease¹⁶ and mental distress,¹⁷ a higher incidence rate of HIV infection,¹⁸ and have more difficulty accessing mental and physical health services¹⁹ than their white compatriots. They experience higher infant mortality and a shorter overall life expectancy.²⁰ Data among Lesbian, Gay, Bisexual, Transgender, Queer and/or

¹⁶ a) Ogden CL, et al., (2014). "Prevalence of Childhood and Adult Obesity in the United States, 2011-2012." *JAMA*, 311(8), 806-814. b) CDC (2014). National Diabetes Statistics Report. c) Thom, T., et al., (2006). "Heart Disease and Stroke Statistics—2006 Update," *Circulation*, 113(6), e85–e151.

¹⁷ Blumberg SJ, et al., (2015). "Racial and ethnic disparities in men's use of mental health treatments." *NCHS data brief 206*. Hyattsville, MD: National Center for Health Statistics.

¹⁸ a) CDC, (2012). "Estimated HIV incidence among adults and adolescents in the United States, 2007–2010." *HIV Surveillance Supplemental Report*, 17(4). b) CDC NCHS (2014). "Health, United States."

¹⁹ a) Benjamin, LC, et al., (2015). "The Costs and Benefits of Reducing Racial-Ethnic Disparities in Mental Health Care." *Psychiatric Services*, 66(4), 389-396. b) Cohen RA et al., (2014). "Health insurance coverage: early release of estimates from the national health interview survey." CDC. c) AHRQ (2015), "2014 National Healthcare Quality and Disparities Report." d) The Commonwealth Fund (2006). "Health Care Quality Survey." e) NIH NIAAA, (2013). "Alcohol and the Hispanic Community."

²⁰ AHRQ (2015), "2014 National Healthcare Quality and Disparities Report."

Questioning (LGBTQ) point toward similar disparities in health risk factors and outcomes.²¹ The ultimate goal of the County's health-related Departments is to improve the health and well-being of all LA County residents, promoting equity for all individuals and populations regardless of a person's socio-economic status, background, beliefs, or disabilities, and enhancing parity of access to care and services across physical, behavioral, and population health. Accelerating progress toward these goals will help address the health disparities that unfortunately exist among many segments of LA County, including under-represented ethnic populations, LGBTQ individuals, and other culturally, medically, and socially diverse groups.

As an organizational structure, the agency can raise visibility into the unmet need of particular populations and identify interventions that will help to address gaps in care more effectively than any of the three Departments would be able to do alone. To be successful in achieving this, the County must focus on providing culturally and linguistically competent care in all its domains and must emphasize cross-discipline, integrated interventions that help to highlight and, when feasible, address the social determinants of health that are at the root of many of the evident disparities. An agency could play a strong role in spreading the lessons and practices of areas that perform well in this regard within each Department and foster the greater degree of programmatic collaboration needed within and across County departments and with external partners. This will need to bring the active involvement of external stakeholders who can quickly point out gaps in care and can provide early and objective notice of populations not benefiting from Department programs.

A variety of factors, many of which are mutable, contribute to health disparities: variable coverage for and access to services, the stigma of certain medical conditions, disjointed care delivery systems, inadequate or ineffective public messages, cultural and linguistic barriers, and a lack of attention to the social determinants of health which include enabling resources such as transportation, food, housing and education/job training. DPH has made significant progress in drawing attention to these issues through their work with other departments and their data briefs on these issues, e.g., DPH currently provides information and analysis about cross-over disparities (e.g., food or transportation access) and disparity "hot spots" in the County.²² DMH has also worked with a variety of community partners to advance the goal of addressing social determinants through the Health Neighborhood initiative. Still, more unified leadership could help better prioritize programmatic activities and guide investment by the local, state, and federal philanthropic community to help to advance achievements in addressing these factors.

In regards to stigma amelioration, service integration can help to reduce the impact of stigma of mental illness and substance abuse by providing individuals with more choices as to where they access needed services. An aligned approach can also more strategically connect public health awareness and prevention messaging to care delivery environments. Disparities are in part driven by the paradigm that has long separated components of health when the actual experience of the person who has needs in more than one health area is whole or unseparated. As one stakeholder said, under an integrated model, "LA County might become a leader in addressing health disparities and creating an effective bridge between what happens in the communities, in families, and what happens in the more intimate service settings." It can also help to drive the County toward a consistent and robust approach to cultural competency that focuses not simply on language and ethnicity, but rather recognizing the unique aspects of different cultures and how they relate to and engage with health services and programs.

²¹ a) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, Board on the Health of Select Populations, Institute of Medicine of the National Academies. *The health of lesbian, gay, bi- sexual, and transgender people: building a foundation for better understanding*. Washington, DC: National Academies Press; 2011. <https://www.ncbi.nlm.nih.gov/books/NBK64806>. b) Boehmer U, et al., (2007). "Overweight and obesity in sexual-minority women: evidence from population-based data." *Am J Public Health*,97(6), 1134-40.

²² These are accessible online through LA HealthDataNow! (<https://dqs.publichealth.lacounty.gov/>), the DPH Health Viewer (<http://publichealth.lacounty.gov/epi/HealthViewer.htm>), and through posted reports.

Addressing major service gaps for specific vulnerable populations

A key driver toward change is awareness that the County is not making sufficient progress in tackling some of the most important health issues for at-risk populations. These issues are rooted in the social and physical environments in which people live and cross racial, ethnic, cultural, and social lines. Addressing them requires a concerted effort with internal and external partners. Whereas many individuals have found excellent services and support from County-provided or funded programs, this success has not penetrated some of the more challenging and vulnerable groups: children in foster care, transitional age youth, children with serious emotion disturbances, incarcerated individuals, re-entry populations, individuals facing incarceration who may be candidates for diversion, homeless individuals, and those in crisis.

There are many reasons why it is challenging to effectively address the needs of these populations. First, solutions must involve not only DHS, DMH and DPH but at least one, and many times more than one, other County departments (e.g., DCFS, DPSS, Probation, Sheriff), and often require client/consumer/patient hand-offs between Departments. Since the agency will not organizationally encompass these other non-health departments, it will need to dedicate attention to making these partnerships effective. Second, financial investments and programs are often designed by Departments based on available categorical funding streams, each with established restrictions, without attention to other Departments' funding and activities. When collaborative and integrated service planning and provision do occur, they attempt to "fix" the problem with additional downstream interventions, seldom capitalizing on opportunities to alter upstream funding issues or affect initial program design. More funding, while always helpful, is often not essential to making improvements. Often, funds can be shifted, over time, from high-acuity, resource-intensive areas (e.g., locked inpatient psychiatric beds, incarceration) and used to support a greater, more client-centered, volume of lower acuity services (e.g., permanent supportive housing, crisis residential facilities) that are both lower cost and more clinically appropriate given an individual's long-term needs. Better integration across Departments would allow the County to approach these challenges as a broader health system issue rather than from the vantage point of independent Departments each focusing on their piece of the picture. This broad systems approach can allow for a different set of interventions and strategies to emerge that may prove more fruitful than the status quo. Success in this regard would have a spill-down effect across the County, including for populations that are not these highest risk groups. "Focus on the most difficult problems. If you solve system problems for the most disadvantaged, you end up helping everyone."

Children in Foster Care and Transitional Aged Youth (TAY)

On any given day, LA County has 18,000 children in the foster care system and 13,000 being investigated for physical abuse, sexual abuse, or neglect. Although the Department of Children and Family Services (DCFS) is the lead agency, DHS, DMH and DPH also have roles in serving these children and their families. Studies of the recent deaths of children in the County reveal cracks that exist between investigative and support/care services. Deaths have often involved a breakdown in communication between the involved Departments and a lack of connection between what is happening in the child's home or community and the findings by providers in medical or mental health settings. The recent activities of the Blue Ribbon Commission have brought together many County departments to refine and redeploy resources around how public health nurses assess and refer children vulnerable to child abuse, how more seamless and continuous care can be provided to children in foster care, and how we support children who are difficult to place in safe and appropriate foster care because of age, medical, or behavioral health conditions. Particularly with the creation of the Office of Child Protection, a health agency can be a tremendous force in helping to coordinate the three health-related Departments in their activities related to child protection and foster children.

An additional opportunity under the agency model is in the implementation of whole person care for DCFS-involved children and youth. Despite improvements in services with the implementation of the Katie A. settlement agreement and

the Medical Hub Clinics, mental health and physical health services for children and youth in foster care, as well as non-health services such as employment/vocational training, educational and recreational supports, housing, etc., still operate on parallel tracks and are not well coordinated, leading to delays in care, poorer health outcomes, and unnecessary duplication of services. For example, DMH-contracted Multidisciplinary Assessment Team (MAT) providers conducting comprehensive assessments of newly detained children operate separately from the Medical Hub system, with minimal or no sharing of information between the systems despite that fact that it is permissible for such information to be shared. In addition, foster parents and relative caregivers are often challenged by the need to navigate different systems of care and by the sheer number of agencies and appointments to which they must bring children in their care. Providing greater opportunities for one-stop services and care coordination can help reduce the stresses on foster and relative caregivers and families.

TAY (often defined as those 16-25 years old, including but not limited to those who age out of the LA County child welfare and juvenile probation systems) face numerous challenges in attaining self-sufficiency and have been shown to have poorer outcomes than their peers in educational attainment, employment, housing stability, and mental health. Crossover youth with experience in both the child welfare and juvenile probation systems are at particularly high risk for incarceration, poverty, and high reliance on public benefits and services. County departments have developed goals and programs aimed at increasing TAY self-sufficiency; however, services are still fragmented. DHS, DMH and DPH each provide services that are highly relevant for this age group, including sexually transmitted infection and SUD prevention and treatment, care for chronic and acute medical conditions, mental health outpatient treatment and crisis intervention, and transitional and permanent supportive housing. There is a need for greater coordination of these services, improved information sharing, and much-needed consolidated care coordination/case management services, particularly for high-risk subgroups such as crossover youth and LGBTQ youth.

Re-entry and incarcerated populations

The re-entry population is a diverse group that includes those coming from the State prison system and the County jails. The former group is largely people returning to LA County after years of being away. The latter includes a wide spectrum, ranging from those who quickly cycle through jail to those who have served multi-year sentences. The diversity and unpredictability of when and from where (court, jail or a prison) people are released is a primary driver of the complexity of re-entry services: it is difficult to plan services for an individual when his/her re-entry date, time, and location are unknown and/or unreliable. This challenge is multiplied because the re-entry population has a need for services from all three of the County's health Departments as well as other County departments such as Probation and the Sheriff's Department. While difficult, intervening in this group is critical: people leaving jail and prison have a 12-fold higher likelihood of dying in the first two weeks following release than someone in the general population.²³ The County should be held accountable for narrowing this disparity. A shared approach to addressing the health needs of the re-entry population could enhance pre-release planning, making it easier for this at-risk population to access services without gaps or duplication.

One relative success in integrating care among re-entry populations has been the County's Assembly Bill (AB) 109 experience. Under the AB 109 effort, many County departments have come together to serve an at-risk and vulnerable re-entry population. With CEO support, the Departments have co-located staff, allowing them to work together and share responsibility in creating a system that coordinates care and ensures timely access for re-entry individuals, often able to successfully trouble-shoot very difficult cases. Although there is more work to do under the AB 109 program, such as a need to enhance housing and supportive services beyond the current 90-day transitional housing options available, the Departments have demonstrated the potential impact of working together to assist difficult populations.

²³ Binswanger, IA, et al, (2007). "Release from prison – a high risk of death for former inmates." *NEJM*, 356(2), 157-65.

Under a shared approach to re-entry service planning and coordination, there is an opportunity to create truly integrated and not just coordinated and co-located services. Currently, each Department has or is developing programs that target a specific subset of the re-entry population. These programs are mostly created independently from the other Departments. Stakeholders identified many opportunities to bring services together and provide more seamless service provision. As examples, DMH has a program targeting the mental health needs of formerly incarcerated women that would benefit from augmentation of onsite medical services. DHS is planning a transitions clinic at the MLK medical campus to link the sickest of the re-entry population coming out of the County jail system with continuity health services; existing campus mental health and substance abuse services are being leveraged to serve this population. More such programs could be created. Stakeholders also discussed the opportunity to create and use assessment and care coordination tools. Other potential areas of focus of a re-entry service planning effort include: developing shared metrics and jointly reporting progress toward these metrics, as has been done with AB 109, prioritizing greater in-reach of community mental health providers to work with inmates while in jail, and ensuring discharge of individuals with substance use disorders into treatment programs. Under the ACA, the largely male, low income re-entry population has gone from being majority uninsured to having near universal eligibility for coverage through Medicaid expansion. Given the federal funding that now follows these individuals, coordinated, integrated re-entry programs can be more easily prioritized and developed.

While a separate memo explores major issues in health services within the jails²⁴, it is worth noting here that stakeholders agreed that improving jail health services, particularly at the point of release, would have immense benefit when it comes to planning for re-entry services. Nurse and provider assessments, diagnostic studies, medication lists, labs, and problem lists should follow the individual into the community so their re-entry care plan can be appropriately informed. For example, if a person receives an MRI study in jail, the result should be shared with community providers thereby obviating the need for another study and improving the timeliness of getting the individual to the appropriate next step in care.

Jail Diversion

Over the past twenty years the number of people with mental illness and substance abuse incarcerated in jails has grown. In Los Angeles County's Twin Towers Correctional Facility, for example, the high observation housing (HOH) unit designated for inmates with serious mental illness or those actively suicidal had approximately 250 inmates two to three years ago; today, there are 500 to 550 inmates. The increase is due to a variety of trends, including societal and judicial considerations as well as a loss of community-based placements over the past two to three decades. Loss of these placements has meant more and more individuals with mental illness and/or substance abuse remain without treatment and support, often homeless and alone on the streets. Arrests and jail time for minor, non-public safety offenses (e.g., petty theft, public urination, public inebriation, trespassing, vandalism) have become commonplace for this population as law enforcement officers do not have alternative drop-off locations for such offenders.

Today in LA County's jail system, of the roughly 17,500 inmates, 20% have a serious mental illness, nearly all of whom have a co-occurring substance use disorder. A staggering 80% of the total inmate population is estimated to have a substance use disorder. Jails and prisons have replaced treatment programs and community placements. However, jails are an inadequate replacement: they are expensive and destabilizing environments for people with mental illness. They lack sufficient capacity and space to provide mental health and substance use treatment, leaving most inmates to cope with unaddressed mental health and substance use issues. Unsurprisingly, most of these issues fail to improve and often worsen rather than improve while in jail. While the County must work to simultaneously improve jail mental health and substance use services, there is a clear motivation to prevent offenders with serious mental illness or substance abuse issues who are

²⁴ [http://file.lacounty.gov/bc/q2_2015/cms1_229439.pdf#search="APPROVAL OF PROPOSED JAIL HEALTH SERVICES STRUCTURE"](http://file.lacounty.gov/bc/q2_2015/cms1_229439.pdf#search=)

not considered public safety risks from ending up in jail in the first place. These programs should, as much as possible, live in the community.

In a growing movement around the country, municipalities have looked for opportunities to divert non-violent mentally ill and substance abusing offenders into community-based programs where they can receive appropriate care in a therapeutic rather than destabilizing environment. LA County has begun to explore how jail diversion – both pre- and post-booking– can best be accomplished. DMH, DPH’s Substance Abuse Prevention and Control (SAPC), and LASD have been developing a diversion plan over the last year under the leadership of the County’s District Attorney. As this larger County diversion plan is being developed, meaningful efforts to divert offenders are beginning. An example of a pre-booking diversion project being developed is the use of DMH-contracted psychiatric UCCs to accept more people directly from law enforcement in lieu of bringing them to jails or the emergency room. An example of a post-booking diversion strategy is the effort between LASD, DMH and the courts to place misdemeanants incompetent to stand trial (MIST) offenders in community mental health placements rather than keep them in jail.

A whole-person approach is needed to accelerate the pace of progress toward a comprehensive and thoughtful jail diversion plan across LA County. The health-related Departments must be at the forefront of developing and implementing diversion strategies, working in partnership with social and public safety focused departments. The Departments have a key role in determining which sites are appropriate for diversion services, considering both community-based treatment programs as well as locked and unlocked placements. The diversion programs must continue to bring together the mental health treatment services, medical and counseling-based substance abuse interventions, and supportive housing services in a single location. Joint program planning, service integration, and funding prioritization among the health Departments, law enforcement, and the courts, is the only way diversion approaches will grow and have the large scale impact seen in other parts of the country. Although many diversion programs can be created today within our existing environment by building relationships and programs between departments, this build-as-you-can strategy may not lead to the comprehensive set of collaborative, integrated programs required to make the meaningful change within the jail population so that non-violent, mentally ill persons are no longer incarcerated. Coordinated action and leadership is needed to draw the best ideas from the collective Departments, identify ripe opportunities for both space and funding to create the programs and allow for more straightforward and streamlined partnership with the custody and court-related partners who must all ultimately work together to develop innovative diversion programs while preserving public safety.

Homelessness

There are over 40,000 homeless people in LA County, 25% of whom describe having a substance use disorder, nearly 30% describe having mental illness, nearly 20% who describe having a physical disability, and 10% who are under age 18. At least 2,000 chronically homeless individuals live within a 54 square block area in downtown Los Angeles known as Skid Row, the nation’s largest concentration of unsheltered homeless individuals. Each of LA County’s eight SPAs experienced a higher rate of homelessness in 2015 than in 2013.²⁵ A much larger number of individuals, 373,000 in 2011, report being homeless or marginally housed at some time in the past five years, with rates higher among African-American’s (14.8%) and Latinos (5.2%) than among whites (4.1%).²⁶ These individuals are frequent users of emergency services, ricocheting through County and private EDs, psychiatric EDs, medical and psychiatric inpatient units, the street, jails, residential substance abuse treatment, homeless shelters, and recuperative centers. Study after study in Los Angeles and the rest of the nation

²⁵ Above data is according to the Los Angeles County Homeless Services Authority biannual count of homeless individuals, there were 44,359 homeless individuals in LA County in January 2015. Full data available at www.lahsa.org.

²⁶ Los Angeles County Health Survey, 2011. Reflects those who reported being homeless or not having their own place to live or sleep in the past five years. Note the report documented a rate of 1.8% among Asian/Pacific Islanders but noted the value was not statistically significant.

indicate that greater coordination among health care providers and other systems can change this harmful and costly pattern of care.

To a large extent, persistent homelessness in LA County and the rest of the nation stems from lack of affordable housing and poor integration of critical services that homeless and low-income people need to lift themselves out of poverty. Health care plays a critical role given the clear connection between poor health and poverty. In looking at neighborhoods with high rates of homelessness, such as Skid Row, the evidence is overwhelming that the safety net has failed homeless people. Multiple health-related services are needed to effectively assist homeless people who are often struggling with complex and overlapping health issues. More common than not, homeless people have unmet physical health, mental health, and substance abuse treatment needs. For homeless people, treating the “whole person” is a critical component of their path toward survival, recovery, and residential stability.

Notwithstanding many efforts to provide greater coordination among the health Departments on the ground, the physical health, mental health, and substance treatment services remain largely distinct. While there is some coordination, successful programs benefit only a handful of patients each. Many community members are confused as to how to access health and housing services and how to interpret or use the myriads of forms each Department uses. It is common to hear “I don’t know how to get somebody into primary care” or “no matter what I’ve tried, I can’t access mental health services for my patient” in a way they want to receive care, or “there is no housing for people who are currently using substances”. This dysfunction has real consequences for people desperately trying to make a change in their lives. The fact that a case manager working with a homeless person has no clear path to assemble needed services across the spectrum of health programs, keeps that person homeless and revolving through the hospitals, jails, and streets, at great cost to that person’s health and the public’s finances. Given the natural dynamics of three separate health Departments in terms of philosophy, funding rules, accountability, program design, and housing-related priorities, it remains difficult to bring all the resources together that are necessary to make meaningful and course-changing interventions in the lives of homeless people.

Ending chronic homelessness starts with engaging people on the street and at the point of discharge from institutional care (e.g., hospitals, mental health facilities, jail). In order to be effective, outreach staff need to have a broad range of tangible resources at their disposal including access to detox and other substance abuse treatment services; crisis and on-going mental health services; urgent and primary care; and interim and permanent housing. This should also include supportive housing, which is widely viewed as key intervention for homeless people (and other populations exiting institutions such as jails, inpatient psychiatric facilities, and residential treatment). Supportive housing strives to provide a “whatever it takes” approach to helping residents recover and thrive, including access to a wide range of medical, social, and logistical supports. The three Departments hold the keys to all of these different types of housing services and resources. However, the reality is that the right combination of services is rarely available at the moment they are needed, or in the way that the individual prefers to receive them.

Many stakeholders commented that they felt existing funds could be better leveraged in an integrated model to solve this problem. A full spectrum of physical and behavioral health (including substance abuse) and housing services should be available to homeless individuals, implementing a true “no wrong door” approach in which chronically homeless individuals can be housed regardless of where or how they present. This would require finance staff to piece together full funding for services using a diverse set of different sources. As one example, individuals who require specialty mental health care are not able to access housing options, including permanent supportive housing with wrap-around case management services, using DMH’s resources unless they have an open case with DMH or its provider network based on interpretations of restrictions on the sources of funds. This common problem could be addressed in a two general ways: by creating new ways for people to engage in mental health care (e.g., via primary care co-locations) before they are housed in a way that may be acceptable to the patient, and by creating less restrictive shared housing and service entry criteria that rely on different mechanisms to verify an ability to use certain funding streams or by actually pooling funding behind the scenes.

The ACA, through for example expansion of the Drug Medi-Cal benefit and treatment of mild to moderate mental illness, presents a fresh opportunity to approach this problem in new ways, but opportunities exist to better integrate services even without these new funds.

Psychiatric emergency services

Overcrowding of psychiatric emergency service (PES) facilities is a longstanding problem, adversely affecting public and private hospitals and the individuals and families they serve. Beyond the human cost for the person in crisis, PES overcrowding also results in a greater risk of violence toward patients and staff and extended wait times for ambulances and law enforcement when ED staff members are not able to safely transfer individuals to ED care immediately after arrival. But more than this, it is a canary in the coal mine, reflective of deep societal problems, challenges in the health system's ability to fully meet the demand for health and often social services, and problems moving people efficiently between varying levels of care. It is often assumed that EDs and PESs, as well as LPS-designated²⁷ urgent care facilities, are filled past capacity because of a shortage of inpatient mental health beds in the County. While this is true on occasion, particularly for individuals with characteristics that make them difficult to accommodate, such as registered sex offenders, children, adolescents, pregnant women, individuals with comorbid medical issues, etc., it is not generally the case. On any given day, over half of DHS' 132 staffed inpatient psychiatric beds are filled with individuals who no longer require acute inpatient admission but for whom a placement deemed appropriate by the discharging physician is not available. A similar situation is prevalent in private EDs and inpatient psychiatric units. The cost of operating these inpatient beds is far higher than the cost of operating lower level of care placement options. Thus, the primary challenge is not a lack of funding but lack of an organized vision, and execution against this vision, for managing placement options across the full spectrum of an individual's acuity and clinical need.

Although the PES challenges are often thought of as an adult problem, the most challenging situations in the PES involve long stays for children or adolescents. The complexities of finding appropriate and available placements for children is a problem that impacts the entire County system of care, particularly given it involves a wider range of partners, including Regional Centers, DCFS, in addition to DHS, DMH, and private hospitals. For children with Serious Emotional Disturbances (SED), the many successful community-based services and the entire Children's System of Care efforts led by DMH in LA County can be augmented with more available crisis and acute services and better coordination among partners. Fairly recent changes in AB 3632, the erosion of Regional Center resources, as well as the lack of foster care placements capable of meeting the needs of children with SED has created a nexus of factors that leave children to cope with an acute crisis without many appropriate options. In many cases, these children can only find care in surrounding counties and only after waiting several days in County or private hospital EDs. Under a more coordinated, collaborative effort, the Departments could arrange for the necessary placements within the boundaries of LA County and also develop a strong legislative agenda to ensure future policy decisions enhance rather than further erode our ability to care for these children. The power garnered from working together on system design, legislative advocacy, and policy setting has potential to create new options and opportunities for children with SED and their families.

Multiple collaborative efforts have attempted to address the PES crisis for adults and children over the years. DMH has long co-located case workers in DHS inpatient psychiatric units in an effort to assist with discharge planning and placement options immediately after admission, freeing up beds for those in the PES. Still struggling with discharge delays, DHS and DMH have partnered more recently on an "all hands on deck" discharge approach which has yielded dramatic point-in-time results but has not proven sustainable. DMH has increased the level of engagement with law enforcement to link field personnel with mental health training and divert people whenever possible to non-ED settings. DMH has also opened

²⁷ LPS (Lanterman Petris Short) designation refers to the ability of a facility to accept patients on psychiatric holds.

additional urgent care facilities able to serve as alternative destinations for a portion of individuals who would otherwise be transported to the PES. DHS has also partnered to expand the capabilities of one such urgent care facility. DMH's new urgent care center in Sylmar opened in 2011 as a non-LPS designated facility and, as a result, was unable to play a role in decompressing the chronically overcrowded Olive View PES located down the street. After several years of discussing various possible solutions to this problem, DHS and DMH have agreed for DHS to assume responsibility for operating and staffing the locked portion of the urgent care center, a move which will allow the facility to begin serving people on involuntary holds 24/7. Despite these and other initiatives, the census in the three County PESs has remained at twice or even three times the facilities' physical capacity for years.

Much more can and should be done to accelerate the movement of patients through the continuum of care while maintaining activities and resources that serve a vital role in stabilizing the PES system (e.g., PMRT teams, allocation of IMD beds to private hospitals). Below are examples of steps that could be taken to address challenges in meeting the needs of individuals in psychiatric emergencies. In many cases, efforts in these areas are ongoing, but a renewed effort and innovative approaches in these areas could yield benefits.

1. DHS and DMH must develop a collective vision for managing psychiatric emergencies, focused on getting people to the right level of care at the right time. Individuals should not have to experience long waits in County or non-County facilities for acute services and, similarly, those ready for community-based placements should not be slated for or kept in more restrictive types of care. This philosophy should apply County-wide, to both public and private hospitals.
2. The resources and budgets of each Department's investment into acute services, as well as those outpatient services that support discharges from the acute system, should be made more transparent.
3. The Departments should continuously evaluate whether or not available resources are maximally matched by federal funds (via the Waiver and other mechanisms) and flexible enough to purchase services or placements which are new and innovative in their function and approach, such as greater use of acute diversion units and crisis residential beds.
4. The County should continuously engage with private facilities on new strategies to support acute psychiatric services. This includes making sure County investments in psychiatric services in non-County facilities are strategic and maximize the benefit for all those served by the County.
5. The County should improve audits of IMD utilization to determine whether there is an opportunity to reduce length of stay and thus reduce wait times for patients in inpatient psychiatric units.

Bridging population and personal health

The field of public health began to differentiate itself from clinical medicine in the early 20th century due in large part to the rise of the biomedical model of disease and a resulting devaluation of other approaches such as health education, community mobilization, and regulation. Underfunding and misaligned financial incentives also began to increasingly impair a close linkage between public health and clinical service delivery as they resulted in payment structures designed to reward treatment of disease rather than prevention of it, paying for volume rather than outcomes, and incentivizing specialty care and procedural interventions over primary care, preventive care, and health promotion activities. Despite this history, public health and direct clinical services have complementary functions and share a common goal of improving a population's health, though the former defines "population" to include persons who do not seek or receive clinical care.

While the medicalization of physical health care was critical to progress in diagnosing and treating disease, the devaluation of social determinants of health during that same period was to the detriment of individuals and the achievement of population health goals. When society began to again recognize the critical importance of social determinants in the late

20th century, it happened in the context of largely siloed public health and primary care expertise and infrastructure, limiting the feasibility of a coordinated and collaborative response. This is unfortunate. Most of the major challenges facing primary care providers involve factors that are not present in the clinic setting. According to a commonly cited statistic, only 10% of an individual's health is attributable to the care they receive, the remainder being determined by genetics, social circumstances, environmental exposure, and behavioral patterns.²⁸ Rising health care costs also underscore the importance of re-integration, given the important role of public health activities in achieving sustainable and cost-effective improvements in a population's health.

Public health and primary care integration efforts have shown to benefit individuals and populations. While DPH's activities should not be limited to those served within DHS and DMH, improved integration of direct clinical care and public health could enhance the capacity of both Departments to carry out their respective missions. This would be done by combining knowledge, resources, and skills, including leveraging DPH's strong ties at the community level to link those served in County facilities to community-based organizations and resources in areas such as prevention, health promotion, health education and management of chronic disease. Giving providers population-based information relevant to their practices could enhance their capacity to address behaviors and underlying causes of illness. At a very practical level, greater linkages could also ensure that individuals who screen positive to risk factors or disease in the community could have streamlined linkage to primary care, obstetric, behavioral health, or other appropriate clinical access points within a delivery system if they do not have an existing provider.

Increased access to health information technology (IT) serves as a powerful tool in linking public health and clinical service delivery. If desired, DPH could use the recent Electronic Health Record (EHR) implementations in DHS and DMH to monitor and learn about diseases or risk factors that cluster in low-income or vulnerable populations seen within the County, including but not limited to obesity, tobacco use, substance abuse, food security, prescription drug/opiate abuse, etc. Greater cross-linkage between public health and the mental and physical health delivery system could also help the County play a greater role in setting a vision for the County's overall health care delivery system, improving coordination and collaboration across providers of all types, and understanding gaps that specific entities, including both public and private providers, may be well-suited to fill. On a similar note, the County could play a stronger role in engaging with private health care organizations in reviewing policy and operational issues that affect the entire County.

Integration efforts might also promote the seamless and strategic linkage of patients in the delivery system to community-based services. As one stakeholder put it "the days where patients receive their health care within the walls of a clinic building or doctor's office are over. The community is an important army for health care service delivery that needs a deeper tie into primary, specialty, mental health and other care." This point is more and more recognized in the personal health realm as evidenced by the evolution of the patient-centered medical home (PCMH) model. The most evolved PCMH models have seamlessly linked individuals with community-based services (i.e., cooking courses, exercise opportunities, food and transportation access, health empowerment and self-efficacy programs, weight loss interventions, etc.), providing important connections that can address the root causes of disease.

Tighter integration between physical and public health also creates unique opportunities to strengthen programs that rely on both strong public health programs and clinic-based services. Needle exchange is one example. High rates of substance abuse threaten not just the health and well-being of those addicted, but also many who surround them. Needle and syringe exchange programs are one important mechanism for reducing the unnecessary spread of infectious diseases, with benefits for population health and a reduction in unnecessary utilization of costly health services. Through closer integration, individuals being served in County-operated or funded clinics who could benefit from needle exchange could be seamlessly referred and connected (e.g., via warm hand-offs or other mechanisms) with such services in the community.

²⁸ Schroeder, S (2007). "We can do better – Improving the health of the American people." *NEJM*, 357(12), 1221-1228. Adapted from McGinnis, JM, et al, (2002). "The case for more active policy attention to health promotion." *Health Affairs*, 21(2), 78-93.

Similarly, those who visit community-based needle exchange sites could be connected with clinical services and resources they need to enhance their overall health, including SUD treatment services.

While people support the linkage between primary care and population health in theory, many wondered whether greater integration between DHS, DMH, and DPH would hamper collaborative efforts between public health and health care providers outside of the County's directly operated network. There is no reason why this must be the case. If created, an agency's proper focus and mission should not be on the individuals served by DHS or DMH, but on the ten million residents in LA County. To the extent that greater partnership between the County's health-related Departments helps to inform and improve the population health activities within DPH, this would benefit providers and individuals across the County. Also, while partnerships should not be limited to DHS and DMH, collaborations between DHS, DMH, and DPH are critical precisely because they focus on underserved, disadvantaged populations: safety net beneficiaries are one of the groups most affected by the social determinants that many DPH programs rightly seek to address.

Integrating services at the point of care for those seeking care within the County

A commonly shared goal of all stakeholders, both internal and external, is that clinical services should be more completely and consistently integrated at the point of direct care delivery for individuals, including both children and adults, cared for within (or in clinics funded by) one or more County departments. This section focuses on how best to optimize care for this set of individuals, a challenge complicated by the fact that Medi-Cal and safety net providers for specialty mental health services are encompassed in one provider network whereas primary care services are provided by DHS, Federally Qualified Health Centers (FQHCs) and other independent practice groups and plans.

A frequently cited 2013 data analysis revealed that only ten percent of the total active DMH outpatient client population was empaneled to DHS directly-operated primary care clinics. People have suggested that this means there is relatively little overlap between the DHS and DMH population and thus little need to create a mechanism to prioritize clinical service integration activities across the Departments. This conclusion, however, is inaccurate. First, the 10% figure underestimates the overlap between DHS' empaneled population and DMH's active client base.²⁹ Second, the true population of overlap between DHS and DMH that is relevant for service integration extends far beyond the cross-over between DHS-empaneled patients and active DMH clients. It should also include: a) Active DMH clients who use any clinical service (e.g., inpatient, specialty care, substance abuse services, personal care public health services) provided or funded by DHS or DPH; many of these individuals enter the County system via community-based primary care services (through either the County-funded My Health LA Program³⁰ or by non-contracted community-based primary care providers) b) Active DMH clients with no stable source of primary care, many of whom rely on County or private EDs, psychiatric EDs, urgent care centers, and inpatient units for their comprehensive health-related needs c) Individuals with a serious mental illness or serious emotional disturbance who are seen within County or private hospitals/clinics but who are not actively engaged in the DMH system. All of these individuals may benefit from a connection with a resource able to provide integrated health services, obtained through either County or community-based resources, or a combination thereof. Certainly there are many active DMH clients with a stable source of high-quality physical and behavioral health care in private clinics and who do not use DHS or DPH direct clinical services; this should not be used as an argument to deprioritize the needs of often vulnerable individuals who are not so well-connected.

²⁹ Reasons for the underestimate include: 1) Data was pulled early in DHS' empanelment process. In 2013, ~ 250,000 patients were empaneled to DHS primary care clinics; today the figure is ~500,000. 2) The data match process is prone to error: since the Departments do not share a unique identifier, data matches are highly error-prone and tend to underestimate the true shared population.

³⁰ My Health LA funds primary care at contracted community clinics for up to 150,000 uninsured LA County residents.

Given high rates of mental illness and SUD among Medicaid populations³¹, the total population of individuals who could benefit from integrated health services across DHS, DMH, and DPH is likely high. Attention to these groups is important because those served within the County and in clinics funded by the County are some of the most disadvantaged, underserved, and overlooked populations in LA County. They are disproportionately low-income and may not be eligible for public insurance. They are members of underrepresented minorities or groups who have long suffered health disparities, discrimination, with poor (or no) access to care. Some portions of this population come to the attention of mainstream society only when they are in crisis, when they present a personal and public safety risk, when they over-use emergency services, or when they are identified as imposing high societal costs. They may be part of particularly vulnerable segments of society: recently incarcerated, children and transitional age youth, disabled, and/or homeless. There are many individuals within the County who would likely benefit from coordinated mental health, physical health, and often substance abuse treatment services. A failure by the County to well-serve these populations propagates and even risks increasing health disparities in LA County.

Much has been written about the different models through which care can be integrated in different populations. Integration activities range in intensity from simple care linkages to more complex care models utilizing a diversified and highly-trained workforce.³² Co-location, while often a core component of the model, is not in and of itself sufficient to bring about true service integration. The target population (including children and adults, specific ethnic/racial groups, those with various medical or psychiatric diagnoses, etc.), design, and health-related outcomes of these models vary substantially. Rather than summarizing this excellent body of literature³³, this section will focus on the overall opportunities and benefits for clients/consumers/patients in LA County. The specific opportunities to be pursued should depend on a number of factors including the needs and preferences of individuals, communities, and populations served, their degree of connectedness to the current system, comorbidities, etc. Local community place-based initiatives, including those operated by the County as well as community-based models developed and led by contracted agencies and providers, that have demonstrated success in serving the needs of a diverse set of individuals and populations, and evidence-based models of service delivery that support a range of different communities and that can be adapted in response to the voice and culture of individuals and their communities, should be prioritized for implementation, particularly if they can be brought to scale in a sustainable manner.

³¹ Rates of mental illness in Medicaid populations are over twice the rate as in the general population; among disabled Medicaid patients, mental illness prevalence is estimated to be approximately 50%. (Kronick, M (2009). "The faces of Medicaid III: Refining the portrait of people with multiple chronic conditions." *Center for Health Care Strategies, Inc.*)

Substance use disorders are estimated to affect approximately 13.6% of those newly eligible for Medicaid and approximately 11.9% of those previously eligible; (vs. a rate in the general population of 10.3%). (Mark, TL. et al. (2015). "National estimates of behavioral health conditions and their treatment among adults newly insured under the ACA." *Psychiatric Services*, 66(4), 426-429.)

³² Throughout this report, "workforce" refers to both County and non-County staff at private and/or contracted agencies and providers.

³³ While numerous publications exist, the following provide overviews of integration models, frameworks, and key success factors:

- a) Agency for Healthcare Research and Quality, "Integration of mental health/substance abuse and primary care," No 173, 2008.
- b) Institute for Healthcare Improvement and the Lewin Group, "Approaches to integrating physical health services into behavioral health organizations: a guide to resources, promising practices, and tools," prepared for CMS, 2012.
- c) The Kaiser Commission on Medicaid and the Uninsured, "Integrating physical and behavioral health care, promising Medicaid models," 2014.
- d) Millbank Memorial Fund, "Evolving models of behavioral health integration in primary care," 2010.
- e) National Council for Community Behavioral Healthcare, "Behavioral health/primary care integration models, competencies, and infrastructure," 2003.
- f) National Council for Community Behavioral Healthcare, "Behavioral health/primary care integration and the person-centered healthcare home," 2009.
- g) SAMHSA-HRSA, Center for Integrated Health Solutions, "A standard framework for levels of integrated healthcare," 2013.
SAMHSA-HRSA, Center for Integrated Health Solutions, "Advancing behavioral health integration within NCQA-recognized patient-centered medical homes," 2014.

Bi-directional co-location and integration of primary care and mental health services to enhance access to care

To the greatest extent possible, individuals should have the option to receive integrated primary care and mental health services, including both specialty and non-specialty services, in the location where they are most comfortable. There are two general forms this could take: co-locating and integrating primary care services in mental health settings and co-locating and integrating mental health services in primary care settings. Both models can apply equally to directly-operated and contracted clinic sites, though the implementation steps for each will obviously vary.

In co-located, integrated models, physical health services would be provided by nursing and/or provider-level staff who can tailor treatment approaches based on the individual's risk factors for physical illness, medical history, and readiness to engage with the health system. On the mental health side, the individual's level of impairment and scope of need for specialty vs. non-specialty mental health services will determine whether these services should be provided by members of the primary care medical team itself, with education and consultation provided by mental health staff, or by mental health staff directly. This co-location of services should not be limited to manage those with only mild to moderate mental illness. Primary care clinics across LA County are frequently used by those with serious mental illness and serious emotional disturbances, just as specialty mental health providers are used by those with physical health conditions. The goal is to effectively manage a full spectrum of services in a way that is responsive to the needs of the individual client. One summary of how this division of responsibility could work is provided in "Revised Four Quadrant Clinical Integration Model" as described by the Second Supervisorial District Empowerment Congress Mental Health Committee.³⁴ It presents a six-box matrix for how integrated services would be provided depending on an individual's physical health risk (high/low) and mental health risk (high/moderate/low), advocating that individuals at mild and moderate mental health risk can be successfully served in physical health settings by a combination of mental and physical health staff, in addition to mental health settings as is the commonly accepted practice. Despite the appeal of co-location, there is a sizeable gap between individual demand and what the system is currently able to provide.³⁵

Primary care services co-located and integrated into mental health settings: For over a decade, those with co-occurring serious mental illness have been known to die more than 25 years earlier than people without mental illness, with the majority of the excess mortality stemming from largely preventable and/or treatable medical conditions.³⁶ There are multiple explanations for this finding. First, individuals with mental illness have higher rates of clinical (e.g., smoking, obesity) and social (e.g., poverty, homelessness) factors than the general population. Second, individuals with mental illness may be uncomfortable or unwelcome in traditional medical settings, including primary care clinics. Individuals may also be fearful of new situations or may have had negative experiences in physical health clinics previously, in part due to the stigma associated with mental illness, because clients believe primary care providers look down on them, or because primary care providers do not have time to manage the concerns of mental health clients. Also, those with mental illness are frequently under-diagnosed and under-referred to primary care or specialty care services, despite their high risk for disease and the known physical effects of psychotropic medications. In the words of one stakeholder: "primary care just doesn't work for many [mental health] clients". Outcomes among children are equally disturbing.³⁷ Given the high stakes, taking time to strengthen and evolve the availability of primary care in mental health settings should be a high County priority. The operationalization of a sophisticated primary care-mental health integration model will take time to develop

³⁴ Second Supervisorial District Empowerment Congress Mental Health Committee, "Los Angeles County Mental Health Services 2014 White Paper," 2012.

³⁵ Blue Shield of California Foundation, "Exploring low-income Californians' needs and preferences for behavioral health care," 2015.

³⁶ Parks J, et al, (2006). "Morbidity and mortality in people with serious mental illness." National Assoc. of State Mental Health Directors.

³⁷ SED youth have higher rates of pregnancy and STDs, including HIV, than the general population, and experience higher rates of SUD and suicide. Youth with SED are also at higher risk for not graduating from high school, homelessness, illness, poverty, future unemployment, dependence on public systems, and arrest, many of which are associated with chronic diseases and premature mortality. (Davis, M., Vander Stoep, A. (1997). "The transition to adulthood among adolescents who have serious emotional disturbance." *Journal of Mental Health Administration*, 24(4), 400-427.

but is an important venture if we hope to reverse the decades-long trend of premature morbidity and mortality among those with mental illness.

Mental health services co-located and integrated into primary care settings: Partly due to the intense stigma of mental illness, many of those seen in the physical health system “fly under the radar” and don’t receive necessary mental health or substance abuse services, engaging only in the primary care (or other physical health) system where their less stigmatized medical illnesses are addressed but where their behavioral health issues are often undertreated. Even when an individual would accept treatment for mental illness, there are additional challenges in connecting them to care, both because of a failure by primary care providers to screen and refer both children and adults to mental health and failure of the system to translate that referral to a timely visit. Many individuals with mild or even moderate mental illness can be well-served by a medical home team if supported by the expertise and experience of mental health clinicians in identification, diagnosis, and treatment techniques, including use of recovery-based approaches. For other individuals, treatment by a mental health professional may be required, but could often still be performed in the physical health setting, enhancing access to and retention in care. These actions are currently being undertaken by DHS and DMH to some extent but could be accelerated.

DHS and DMH have attempted to address this need previously with a basic co-location model in which DMH placed a psychiatric social worker in certain DHS adult primary care sites, while recognizing that successful co-locations between DMH and community clinics and among pediatric populations should also be supported. While several sites have been in place for over three years, the volume of referrals has been lower than the suspected need in each clinic and providers have criticized the actual impact on access and linkage to care. There are many reasons for this, including a cumbersome referral system, resistance from primary care leadership and/or slow adoption by primary care providers in certain sites, and sub-optimal mechanisms for ensuring joint consultation and follow-up between providers. Some stakeholders pointed to successful examples of these DHS-DMH co-location efforts as evidence of what could be accomplished without an agency. Others argued that the challenges support the need for a new model to promote service integration.

Co-location can offer particular benefits to those with complex medical problems and disabilities. These individuals often require a broad mix of services including substance use treatment and mental health care but face unique challenges in navigating a complex array of physically separated services. One example where greater collaboration and integration could be specifically helpful is in meeting the needs of Traumatic Brain Injury (TBI) patients. TBI patients have a high prevalence and incidence of mental illness and substance use disorders, both prior to and following their injury.^{38,39,40} Given the nature of this group’s behavior, proper facilities and integrated models of care are needed to help manage their complex rehabilitative needs.

While critical, physical co-location is only one aspect of care integration. Clinics, including both directly-operated and contracted partners, could also be assisted in helping to evolve partnerships in a deeper and more deliberate way, such as the development of shared care plans, merged care management functions, etc.

³⁸ Model Systems Knowledge Translation Center abstract: “TBI Model System Collaborative Study of Amantadine for Post TBI Irritability and Aggression.” Accessed March 23, 2015 at: <http://www.msktc.org/projects/detail/1059>.

³⁹ Kolakowsky-Hayner, SA (1999). “Pre-injury substance abuse among persons with brain injury and persons with spinal cord injury.” *Brain Injury*, 13(8), 571–581.

⁴⁰ Ohio Valley Center for Brain Injury Prevention and Rehabilitation. (1997). “Substance use and abuse after brain injury; A programmer’s guide.”

Improved access to substance use services

Approximately 8.2% (21.6 million) of US residents aged 12 or older suffered from a SUD in the past year.⁴¹ These individuals tend to be heavy utilizers of health services, incurring between two and three times the total medical expenses as those without SUDs.⁴² Similar to the statistics for individuals with a mental health condition, individuals with a SUD die on average 26 years earlier than the general population due to modifiable risk factors and physical health problems related to their long-term substance use.⁴³ Also, despite frequent use of public and private EDs, psychiatric emergency services, urgent care clinics, and mental health facilities, very few admissions to SUD facilities result from referral from other health professionals⁴⁴, evidence of a disconnection between the health care system and the SUD delivery system. As a result, individuals with SUD fail to receive the well-documented benefits of SUD treatments, receive physical health care in isolation from their medical risk factors, and the County fails to achieve the cost savings that accrue when SUD services are effectively integrated or coordinated with other health care settings.

Recent legislative changes under the ACA and its renewed focus on the importance of parity present an unprecedented opportunity to end the past forty years of separate and unequal resources for the treatment of SUDs. Currently, the Substance Abuse and Mental Health Service Administration (SAMHSA) is considering changes to federal substance abuse confidentiality rules, in part due to their acknowledgment that the strict consent requirement of the Federal Substance Abuse law, commonly referred to as Part Two, makes it difficult for programs to participate in care coordination initiatives that facilitate the sharing of health information. These legislative efforts, combined with new knowledge from basic, clinical, and health services research over the past two decades, have set the stage for a new public health-oriented approach to managing SUDs with the same insurance options, healthcare team composition, clinical goals, and clinical methods analogous to those used to manage other chronic illnesses such as diabetes, asthma, or chronic pain.

Changes in SUD treatment models are much needed. Recent advancements in understanding the biopsychosocial basis of addiction has led to new models for treating SUD, including medical assisted therapies. However, these new models have not been widely incorporated into SUD treatment. For the most part, existing treatments for addiction are “program-centered” rather than “person-centered” – everyone gets the same care regardless of the type of addiction or coexisting medical and/or social problems. Because everyone essentially receives the same care, there has not been a movement to evaluate other influences including issues related to employment, legal or family issues, and medical/psychiatric problems that could affect the course of recovery. Previously, health coverage linked to SUD programmatic care has been time- or session-limited, and the financial limitations of health coverage have restricted the range of treatment components (tests, medications, therapies, family support services, etc.) available within any treatment program.

With the augmentation of the Drug Medi-Cal (DMC) benefit and the need to reestablish and augment the DMC provider network, the County should specifically explore opportunities to expand DHS’ and DMH’s clinic and workforce capacity to provide substance abuse services. A recent Medi-Cal managed care requirement for primary care providers to offer alcohol Screening, Brief Intervention, and Referral to Treatment (SBIRT) has drawn attention to substance abuse, but has not extended to actual treatment capacity. Currently, outpatient substance abuse services are primarily contracted out. DHS and DPH need to explore how substance abuse screening, counseling, and treatment might be offered within existing DHS primary care clinics or DMH mental health clinics, alongside contracted partners. This may be done through training DHS staff in how to manage SUD patients by employing more focused workforce models such as greater reliance on certified

⁴¹ SAMHSA. Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings. <http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf>

⁴² Thomas, MR, et al, (2005). “Prevalence of psychiatric disorders and costs of care among adult enrollees in a Medicaid HMO.” *Psychiatric Services*, 56(11), 1394-1401.

⁴³ Oregon Dept. of Human Services, Addiction and Mental Health Division (2008). “Measuring premature mortality among Oregonians.”

⁴⁴ According to an analysis of Los Angeles County Participant Reporting System (LACPRS) data in FY 13-14, only 1.4% % of admissions came directly from a health professional referral.

substance abuse counselors as DMH has been doing for a number of years. In this instance, the integration of certified SUD counselors into DHS clinics, as is already the case in DMH clinics, would complement the professionalization of the SUD workforce to create a healthcare workforce that is more similar across systems of care and whose training reflects the individualized needs of whole-person care.

While the role of psychosocial interventions and more recovery-focused approaches should be strengthened, advances in pharmacotherapy have also led to an increasingly medicalized model for delivering substance abuse treatment, including office-based pharmacologic treatment interventions such as Buprenorphine (Suboxone) for opiate addiction and Naltrexone for alcohol use disorder. These changes in the substance abuse field require a diversification of the SUD workforce to include more highly trained individuals, such as physicians, nurses, psychologists, and social workers. Greater use of these professionals within mental health and physical health settings would complement the services provided by SUD counselors and allow for the development of a system of care for substance abuse that can more comprehensively and efficiently meet the needs of persons with SUD. In the transition toward more integrated systems of care, the agency model will play an important role in ensuring that the level of professionals in substance abuse mirror those in physical and mental health in order to allow for more effective coordination and communication. As it expands capacity to provide substance abuse services, the County should pursue possible certification of DHS and DMH clinics as DMC providers. This would not only improve care for individuals using the County's delivery system, but would also help to support the overall success of the expanded DMC benefit in LA County by increasing access and network coverage. DMC certification would also allow the County to be reimbursed via DMC for office-based pharmacologic interventions and other services for which a dedicated revenue stream does not currently exist.

Improved access to quality substance abuse treatment will have positive downstream effects on overall population health goals, including both physical and mental health: just as it is difficult to remain healthy while hungry or homeless, managing disease and becoming healthy is near impossible while addicted. In addition, individualized approaches to illness management for individuals suffering from alcohol and other addictions will require close coordination across the Departments to sustain self-managed recovery – specifically, sobriety, personal health, and good social function. Transitioning individuals through a system of care that is coordinated with all other aspects of their health will allow providers to anticipate challenges and intervene promptly to help patients prevent relapses, reduce ED visits and hospitalizations, and improve health outcomes.

An additional advantage of having DHS and DMH provide directly operated SUD services is that the County becomes directly familiar with the practice, approaches and operational realities of delivering these services. This firsthand experience allows the County to be more knowledgeable and discerning purchasers of substance abuse contracted services and enhance the ability to design more accessible and integrated programs with its existing contractors as has been DMH's historical experience.

Beyond SUD network expansion, another potential benefit of greater linkage between substance abuse and primary care is a more coordinated strategy for managing prescription drug abuse. With the expansion of Medi-Cal, it is paramount for direct service providers such as DHS to remain vigilant around opiate diversion, misuse, and abuse. Bringing DPH contractor expertise and energy together with DHS providers might allow the County to improve approaches to preventing and managing opiate abuse and diversion. In turn, these improvements could be shared and adopted in contracted clinics.

Finally, greater collaboration could help to identify opportunities and mobilize resources to expand access to inpatient rehabilitation or residential services, particularly important with the expansion of the DMC benefit under the ACA. The Departments may also choose to prioritize creation of more novel approaches to detox, such as integrated sobering centers supported by physical and mental health, housing, and other social services. One program that could serve as an example for the County is the Restoration Center in San Antonio, TX. The Restoration Center is a detox and substance abuse treatment center that provides assistance to homeless individuals struggling with alcohol and drugs and those with severe

mental illness. The Restoration Center provides 48-hour inpatient psychiatric unit, residential detoxification, a sobering facility, injured prisoner programs, outpatient substance abuse treatment including intensive outpatient substance abuse counseling services, in-house recovery programs, linkage to housing, and job training. More than 18,000 people pass through the Restoration Center each year. The Center has saved the city of San Antonio more than \$10 million annually, largely from reducing the inappropriate use of emergency rooms, unnecessary hospitalization, and detention in jails and mental health facilities.⁴⁵ Other benefits include increased support for homeless populations and greater efficiency in the use of law enforcement.

The County should also leverage opportunities to influence Medicaid coverage regulations and design of opportunities in the upcoming Section 1115 Waiver (e.g., inclusion of sobering center services for uninsured individuals in the proposal for a merged Disproportionate Share Hospital / Safety Net Care Pool fund). The approval of California's DMC waiver, which would shift DMC financing to a per user per month capitated payment would also help to further incentivize novel approaches to managing this chronic disease and the high associated health and social costs.

While stakeholders voiced mixed views of the agency model itself, they were nearly unanimous in supporting any changes in the County that could improve support for a full continuum of SUD services based on medical need. Citing extremely low penetration rates at less than 20%⁴⁶, stakeholders commonly commented that "it certainly couldn't get any worse." Stakeholders cited the need for treatment on demand and simultaneous access to multidisciplinary services as "the only things that are proven to make a difference for real people in crisis." They pointed to screening and early intervention for both alcohol and other drugs, such as through use of SBIRT, as offering the best hope for changing the course of disease. "We treat substance abuse, a chronic brain disease, episodically in EDs, psychiatric EDs, and in jails, and then we wonder why it isn't working." As with the integration of mental and physical health, the County needs to develop an organized system of care for the management of SUD, a model that offers interventions for individuals across acuity levels and at different stages of willingness to engage in their recovery. Integrating all three service spheres - mental health, physical health, and substance abuse - into the same site would help each Department better connect individuals to the right service, at the right time, in the right place in a way that is efficient and person-centered. This does not imply that all individuals prefer to receive all of their health-related services at a single site; they do not. Individuals who prefer to maintain separate locations or providers for their disparate health services should continue to have this option available to them. As with all efforts to integrate and streamline access to services, the goal is to provide clients/consumers/patients with greater, and not more limited, degree of choice as to how they access programs.

Complex care programs

One of the most important opportunities could be to better align programs currently underway in each Department to help support and manage the most complex individuals within each service area. Although each Department's programs are distinct, they often share similar elements. These include: a) a focus on a specific population; b) use of specific demographic, clinical, or utilization characteristics to identify the target population; c) innovative uses of often non-licensed workforce members; d) services provided both within and beyond the four walls of a clinical setting; and e) often have complex financing sources that must be navigated.

Individuals with complex chronic injuries (e.g., spinal cord injuries) and diseases (e.g., HIV infection) may especially benefit from complex care programs provided in an integrated, collaborative manner. For example, individuals with HIV require a unique and complex set of services from a variety of health providers. Accessing such care is particularly complicated given

⁴⁵ <http://www.chcsbc.org/innovation/restoration-center/>; <http://kaiserhealthnews.org/news/san-antonio-model-mental-health-system/>

⁴⁶ Los Angeles County Participant Reporting System data, 2013. Los Angeles County DPH, Substance Abuse Prevention and Control.

the complexity of payer sources that individuals and their providers must navigate in providing this care, including services covered under Ryan White Care Act, the AIDS Drug Assistance Program, SAMHSA, and CDC-funded programs. These complicated payer sources are compounded by a fragmented provider system and the acute need for preventive and non-medical community-based interventions to address ongoing disparities in HIV incidence, access, and outcomes among specific populations (e.g., communities of color).

There are a variety of synergistic opportunities to align certain aspects of these programs:

1. **Program development:** A critical way in which to support the development of complex care management approaches is to lead the Departments to adopt a joint program design and implementation approach, including non-County partners and providers when appropriate to do so. The experience of Project 50, which DMH facilitated in 2007 with a goal of permanently housing fifty of Skid Row's most chronically homeless individuals, is a concrete example of a project that successfully engaged health and social service County departments for the benefit of individuals and the community. While a good example of integration, it will be important to build programs such as these to a much larger scale, a goal that takes substantial energy and coordination.
2. **Risk stratification and identification:** Currently each Department determines its own eligibility criteria for complex patient and high-utilizer programs, usually based on requirements of associated funding streams. Because the criteria are often similar but not overlapping, certain high-cost, high-need patients may qualify for a program with a certain set of benefits in one Department but not for a program with separate benefits in another. This makes it difficult and confusing for providers, inside and outside the County, to know how best to connect individuals with the services and programs they need. Departments should consider jointly determining where the overlap is in their respective populations and how to structure eligibility so the benefit is to the most complex individuals possible at the County, rather than Department, level without incurring fiscal liabilities and audit issues.
3. **Data/analytics:** These programs are often resource-intensive and thus require heightened scrutiny as to their performance and value. The Departments should synchronize their approaches to measurement and analysis (where there are opportunities to do so), reducing duplication of analytic activities, facilitating response to the varying needs of funders, and allowing for more robust program analysis which can inform which programs should be further supported and which may require alteration.
4. **Training:** Given high use of non-licensed clinical (e.g., community health workers) and non-clinical (e.g., analysts, epidemiologists) staff and the need for constant recruitment due to staff turnover, it could be valuable to centralize scarce but critical expertise and adopt a coordinated, efficient way for the Departments to train and educate the workforce. This may mean, for example, jointly partnering with labor- and community-based agencies expert in the use and training of certain personnel. In doing so, opportunities for those with lived experience should be maintained and expanded.

Apart from the needs of highly complex populations, individuals who use services in more than one Department would benefit from greater commonality in Departmental forms and electronic documentation tools (e.g., forms for registration, consent, and care planning, population registries, screening and discharge planning tools). Greater alignment in tools would allow for development of more efficient and transparent care management approaches, shared assessments of clinical quality, and would help County departments and community-based organizations to more consistently interact around specific individuals they share in common. Aligned documentation tools could also facilitate greater use and effectiveness of multi-disciplinary team meetings for high-risk populations including youth in foster care, re-entry populations, homeless individuals, and fragile elderly.

Integrated children's services

A majority of the content in this report applies equally to adults and children. Still, a number of stakeholders requested discussion of integration opportunities that are specific to children. There is no doubt that children across the County would benefit from a coordinated effort to integrate services and programs. While many integration opportunities apply to both adult and youth populations, opportunities for children are different in a few important ways: a) they must place greater focus on prevention and early intervention efforts alongside more traditional direct services; b) they must be collaborative with entities focused on children, particularly DCFS, the LA County Office of Education, and schools; and c) they must promote a broader agenda that prioritizes policy and legislative changes to promote overall child safety and well-being.

Many of the current successful children's services provided by the Departments can be enhanced through integration. For example, integration can promote service augmentation and close gaps for unique populations such as children and youth in foster care (CYIFC), TAY, youth in the juvenile justice system, children with serious emotional disturbances, children with co-occurring mental and physical health issues including some children in the California Children's Services (CCS) program, and children cared for by guardians without strong social supports and who themselves have multiple comorbidities and use multiple County services. Integration can also improve the coordination of the many preventative and early intervention services targeting children and their families around violence prevention, trauma avoidance (e.g., promoting bike helmets), obesity prevention, substance use prevention, and communicable disease prevention, to name a few.

The County has over 2.3 million children between 0-18 years of age.⁴⁷ The County's direct services touch the most vulnerable of these children while the prevention, protection, and safety messages touch a much larger number. In regards to direct services, the health-related Departments are uniquely positioned to provide comprehensive, convenient, and effective care to the most vulnerable children in LA County, either in traditional clinics or alternative settings such as school-based clinics, other community sites, or using home-based visit models. By joining forces, the Departments might provide a state-of-the-art model of trauma-informed health home services ideal for those in the foster care or juvenile detention systems. Most of the children touched by DCFS and/or juvenile detention come through the doors of DHS and DMH at some point. However, the disconnect between the DHS medical Hubs and the DMH-led mental health assessment and services programs represents a missed opportunity. By virtue of the recent Board of Supervisors-supported Hub augmentation promoted through the Blue Ribbon Commission on Child Protection, wherein DHS partnered with DCFS and DMH to augment existing medical services with co-located mental health and case management services, the County is beginning to put together this more comprehensive, continuity model for CYIFC. The Hub system, through its planned case management enhancements, hopes to build on its current capabilities to stretch into communities and schools that are vital to the success of these children.

For youth in the juvenile justice system, the recent effort to create a more scripted and robust aftercare planning process for youth in the juvenile camps can be leveraged to create a functional re-entry system for youth returning to their families and communities. For many youth, their time in the camps provides an opportunity to make certain life improvements and changes but consolidating these gains when they return to their communities can only occur with a more concerted, integrated, and coordinated effort. To do this well will require DHS, DMH, and DPH to work together to not only provide thoughtful, targeted aftercare planning but also to ensure seamless and coordinated implementation of these aftercare programs. A youth exiting a camp with diabetes and substance abuse problems, for example, should find services provided by DHS or a community-based provider connected to and coordinated with a SAPC-contracted provider. The chance to actually change the arc of this youth's life depends on services that are convenient, family-centered, and that work together, rather than in silos.

⁴⁷ US Census Bureau, 2013.

Over the past five years, the science of how trauma impacts overall development as well as mental and physical health has rapidly developed. We know that exposure to early trauma in the home or community creates hormonal surges that are unusually high in childhood, create abnormal neural white matter connections that are hard to interrupt and ultimately become a root cause of challenging behaviors and illness throughout life. These behaviors and illness put affected children at a distinct disadvantage in coping with life stressors and compromise their chances of succeeding in society. The frequent result is children who have difficulty in school, poor acquisition of life skills such as reading and basic arithmetic, high truancy rates, difficulty forming strong peer and adult relationships and, ultimately, missed educational opportunities to improve their life chances. DHS, DMH, and DPH should be among the leaders in working to turn the tide on the prevalence and the impact of childhood trauma and in the provision of trauma-informed care.⁴⁸ This will take many forms, such as violence prevention initiatives, identification of child abuse and neglect, efforts to reduce the rapid rise in opiate abuse among children, enhanced roles for school-based health centers, and collaboration with schools to ensure individualized education plans (IEPs) have the requisite behavioral and physical health services needed to support children and family, to name a few. The specific learning and expertise that the Departments have developed in trauma-informed care should be spread across one another in design of services for children. The Departments should become a visible and vocal County leader in determining not only how to integrate services currently siloed within DHS, DMH or DPH but to also ensure trauma-informed practices are implemented within these integrated services. The Departments should work with the County's Office of Child Protection, the broad LA County funding community, First 5 LA, as well as the rich array of community-based providers working hard, day-in and day-out for these children and families, to set a clear and strategic agenda that supports children already exposed to trauma and to lessen the future exposure to trauma so more children can develop into healthy and productive young adults free of the poisonous impact of surrounding stressors.

Although many other parts of this report relate to children, it is appropriate to mention a few that are most relevant to promoting health and wellness, especially for the most vulnerable. This includes the importance of information sharing across the Departments; figuring out how to efficiently share this information while maintaining compliance with all relevant regulatory safeguards will be key to the success of any service integration effort. Similarly, reducing the maze of interactions required for non-County entities to partner with the Departments will promote collaboration and effective program development so children and families can use their energy to become stronger rather than on navigating our currently disjointed system. The technology enhancements potentially available in a more integrated health system will certainly improve efforts to reduce duplication and ensure timeliness of care to the most vulnerable children and youth who move between institutions and placements and suffer the inefficiencies of poor coordination.

Expansion of the recovery and resiliency model into physical health care settings

The recovery model emphasizes an individual's capacity to change and gain control and meaning in their life through empowerment, hope, community, and attention to the whole person. Among children with SED, the resiliency model also emphasizes integrated systems of care (e.g., involving family, school, community agencies, etc.) to enhance a child's future opportunities. Both models rely on care being client-directed and incorporate a strong family focus where relevant. DMH's community mental health programs are centered around the concept of recovery and resilience, rather than on a "medical" model for treating mental illness. While often used in the mental health context, an emphasis on recovery and resilience should not be reserved only for specialty mental health populations. Housing programs (e.g., DHS' Housing for Health program), care models for those with uncurable chronic medical conditions, and many approaches to substance abuse treatment often employ a recovery philosophy with good results. Despite wide and growing recognition of the value of recovery-based approaches, use of the model could be expanded. For example, DHS could increase use of recovery

⁴⁸ It should be noted that DMH has already gained approval to devote \$91million to the furtherance of trauma-informed care through the Health Neighborhood Initiative using MHPA Innovations funds.

philosophies in managing individuals with chronic pain or chronic conditions, particularly those not well-served with available medical interventions. Individuals with diabetes, chronic pelvic or abdominal pain, arthritis, or headaches could benefit from a greater emphasis on recovery. An agency could help spread these practices across the Departments, making available additional treatment options based on an individual's level of commitment to engage and change.

Greater linkage to care by embedding primary care in DPH direct service clinics

When DPH became a separate department in 2006, it retained responsibility for operating direct clinical services such as STD screening and treatment, TB control, and immunization clinics. Both DHS and DPH acknowledge there was little coordination between these services and primary care prior to the separation. By embedding primary care in DPH clinics, LA County residents who rely on DPH clinics for certain focused services could have the option of accessing more comprehensive services at the time of their visit. Although STD, immunization, or family planning services might be the initial draw, co-locating a nurse or provider would help identify those with or at risk for chronic medical conditions, substance use disorders, domestic violence, or other potentially mutable conditions that benefit from early intervention.

For childhood immunization services, offering, but not requiring, well-child services could increase the number of school aged children who receive necessary anticipatory guidance, are screened for common chronic diseases prevalent in childhood, and are assessed for developmental or behavioral issues that can impede school success and achievement. Beyond the benefits in access and care quality, an additional advantage of this approach is the opportunity to enhance the system's funding by assisting with eligibility determination and enrollment for Medicaid, with linkage to the person's provider of choice either within or outside of DHS. Finally, there is an opportunity to better integrate mental health screening tools into both DHS and DPH pediatric clinics, actions that could help make important early interventions for at-risk children. Literature shows that most serious mental disorders begin early in life (50% by age 14 and 75% by age 24⁴⁹) but, unfortunately, less than half of children with such disorders receive treatment appropriate for their condition.⁵⁰ County clinics serve a number of children who are at high risk for behavioral health problems and who could qualify for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits through Medi-Cal but whom are not routinely and systematically screened. Implementation of standardized screening tools for mental illness could be an important way to identify and link individuals with the mental health services they need and are entitled to.

Tuberculosis (TB) services

Due to prompt intervention and intense case management by DPH's TB control program, TB rates are declining in the County. However, there are still a number of individuals undergoing community-based treatment for TB or who require ongoing surveillance by DPH. Inpatient and highly specialized outpatient care (e.g., pulmonary procedures) are provided by DHS as well as non-County hospitals and clinics, but providers in the different Departments are unable to easily and quickly exchange health information for care and treatment purposes. Advances in achieving a unique patient identifier, common medical record (or linked systems) would help, as would a greater level of joint care planning. DHS and DPH could also rely on one another's ancillary services (e.g., radiology) based on availability in certain locations with resulting cost-savings. Bringing together the housing efforts within DHS and DMH with the TB housing efforts of DPH might allow LA County to better serve homeless TB patients. Finally, better coordination between DPH's surveillance and control of TB within the jail

⁴⁹ Kessler RC, et al, (2005). "Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication." *Archives of General Psychiatry*, 62(6), 593-602

⁵⁰ Costello JV, et al, (2014). "Services for adolescents with psychiatric disorders: 12-month data from the National Comorbidity Survey – Adolescent." *Psychiatry Services*, 65(3), 359-366.

and DHS' inmate specialty health services could allow for a more efficient approach to the management of possible jail TB, including fewer unnecessary admissions to rule out TB, a costly evaluation in a hospital setting.

Streamlining access to care

While the clinical care in County facilities is often excellent, the process of getting connected to that care can be challenging. In many stakeholder sessions, individuals came forward describing satisfaction with the care they receive in the County and their anxiety or fear that the agency would disrupt the services they have come to rely on. Yet in listening to these stories, they frequently started with a description of how difficult it was for the individual to get established in care in the first place. They described weeks, months, and in some cases years, of being referred from place to place, both within the County system and between private and County providers, of having to fill out an overwhelming amount of paperwork, of having appointments cancelled without notice, of having their information not available when they went to the next site of care.

A great deal of time is spent discussing a “no wrong door” approach to accessing care and services. Despite the attention the topic receives, there are still a variety of doors to access County services/programs, many of them “wrong” or at least ineffective at linking people to the services they need in a client-centered, efficient manner. The redundancy and waste in the system is striking, as is the impact on customer satisfaction, retention in care, timely access to services, service coordination/rationalization, reimbursement, and ultimately, quality. While people acknowledge this current state and support the development of a coordinated, rational way for individuals to access the system, the operational barriers to making true headway on the issue are sizeable. “No one knows what services are available across the whole continuum, much less how to get your patients to access them. It’s a black hole.”

Screening tools; referral criteria, protocols, and tools; consents and authorizations; patient financial services policies and protocols; unique identifiers; registration and check-in procedures; and preferred points of entry to services are not aligned across Departments. Even if hypothetically consistent, which they are not, the duplication in these processes is tremendous, in large part because the Departments do not share a common identifier between one another so cannot tell in real-time when someone is known in another part of the County. DMH has access to the services provided in its network of care, but may have trouble matching those with DHS provider records. “You have no idea the number of times I had to fill out paperwork asking the same questions. Everywhere you go it’s the same thing. I have to start from scratch every time. Doesn’t anyone talk to each other?” Contracted service providers outside of mental health also lack a common identifier and often cannot easily refer individuals to one another. Despite being well-established in one Department’s system, that Department must first send them, either physically or virtually, for referral processing, or force individuals to start over by telling them to dial a 1-800 number to access mental health services or to go to emergency or walk-in sites to access physical health care. This creates unnecessary delays in care and is a source of immense aggravation for individuals.

The solution lies in streamlining and rationalizing the multiple different processes, beginning with identifying a particular need for a particular person and ending with an encounter appropriate to that person’s need. Common or at least consistent referral and financial screening processes and protocols and an ability to share demographic and basic financial information are essential. A critical piece of the puzzle is the establishment of either a unique identifier or Enterprise Master Patient Index (EMPI) able to be used across the system; this is already in the development in a way that is compliant with all relevant privacy laws. Without this, it will not be possible to fully capture opportunities in streamlining access to care. While it sounds straightforward, achieving this degree of alignment is immensely complicated, requiring numerous changes in IT systems, staff roles and workflows, and clinical practices. Some believe that because of the complexity of the

work required, without a single entity prioritizing the end goal, it will not be realistic for the County to accomplish the necessary steps.

Using information technology, data, and information exchange to enable service integration

Information technology (IT) is a key enabler of overall service integration goals and of efforts to enhance system access. The shared benefits of IT integration include the ability to enhance providers' access to information on individuals using services across Departments (thus improving service delivery and care coordination), eliminate redundant processes for those receiving services from more than one Department, and increase the ability of Departments to perform population-based analyses for program planning and evaluation.

Electronic Health Record (EHR) and Information Sharing: Many people have asserted that the optimal solution for LA County would be a single shared EHR using one unique identifier; operational efficiency, data quality, and customer experience can be optimized by having all parts of an organization use a single, shared EHR if the necessary functionality is there for all involved user organizations. However, there is not agreement that this is the only or best solution for LA County. A single EHR solution should only be considered if it can be established that the EHR can meet the differing needs of directly-operated sites and programs without compromising different documentation, reporting, and care delivery methods. Contracted providers would almost certainly not be users of the single EHR because most, if not all, have or will have their own EHRs; their data and operations will need to be integrated electronically. There is no scenario under which all data for all clients/consumers/patients seen in clinics operated or funded by the County will originate in a single EHR as long as there are contracted service providers as part of the County's health care delivery network.

There is consensus on the value of a single comprehensive longitudinal health record for LA County clients/consumers/patients. There is no consensus, however, regarding how this goal is best achieved. A great deal can be done without moving all of LA County health service delivery to a single EHR by using the data integration capabilities of existing County systems. By pursuing that less disruptive course as the starting place to build the comprehensive consumer health record, benefits are achieved in a shorter time and the County can then allow for very careful analysis of the functionality of the available EHR options and their ability to meet the needs of all Departments.

If the Departments do choose to progress to the use of a single system, patient/client privacy and security can be preserved: modern EHRs are architected in a manner that allows for tight control over privacy and security of Protected Health Information (PHI), segmenting data so it can only be accessed by an appropriate resource. Modern EHRs also maintain audit trails of all records accessed as well as the specific information viewed.

Each Department is at a different place in its own EHR process.

- **DHS:** DHS has completed implementation of its integrated enterprise EHR, a Cerner product (Millennium) referred to as ORCHID (Online Real-time Centralized Health Information Database) at three IT cluster sites representing over 75% of clinical volume within DHS. The remaining three sites are projected to be live by early 2016. Both Sheriff Medical Services Bureau and the Juvenile Court Health Services also use a version of Cerner Millennium that is customized for the custody environment. Cerner Hub, a tool that facilitates information sharing between Cerner systems, will be live and able to begin linking the Sheriff, Probation, and DHS systems by fall 2015.
- **DMH:** DMH has implemented the Netsmart Avatar behavioral health EHR at 122 of 143 directly-operated sites and four contracted sites. Netsmart is a niche mental health product, capable of performing clinical documentation

and claims/authorization functions required to fulfill DMH's role as the Medi-Cal Local Plan Administrator for specialty mental health, serving contracted legal entity providers and providers in the Fee-for-Service Medi-Cal network. DMH will soon pilot use of Netsmart's Care Connect module that exchanges referral information and continuity of care documents between participating systems, including those not using Netsmart products. These steps can enhance care coordination over what is in place in LA County today, but they are not the only available integration solutions for managing shared clients/consumers/patients. Netsmart has expressed a willingness to work with Cerner to integrate Avatar with the Cerner Hub so that clinical data, not just static documents, can be exchanged electronically between the two systems.

- **DPH:** DPH has been working with DHS since 2014 to explore the feasibility of adopting ORCHID as the EHR for its fourteen Public Health clinics, leveraging the County's contract with Cerner that was specifically written to facilitate the addition of additional County departments at the same preferred pricing level available to DHS. Due diligence performed to date has not identified any significant gaps that would prevent adoption of the ORCHID platform for clinical services. The Departments are working to resolve several technical and operational/design issues before finalizing a contract.

Despite the potential advantages of being on a shared EHR, given where DHS and DMH are in their respective implementations, it would not be prudent to disrupt either's ongoing implementation. The consequences of changing course would be expensive, and possibly hugely damaging to programs, services, client/consumer/patient confidence, and the good will of the County's contracted providers. If a diligent investigation into the advantages and disadvantages of converting to a single shared EHR confirms such a move is in the best interests of the County and its consumers, the transition would take several years to implement.⁵¹

While a single EHR solution capable of meeting each Department's clinical and administrative needs may be the best solution for directly-operated clinics, this would not directly address the need for information exchange with contracted community-based providers, each of whom have their own EHRs as noted above. To better integrate services for those who receive care outside of directly-operated County clinics, the County must continue its support for LANES (Los Angeles Network for Enhanced Services), the organization implementing a Health Information Exchange (HIE) collaboration between LA County stakeholders including the Community Clinic Association of Los Angeles County, LA Care Health Plan, and the Hospital Association of Southern California. The County must also continue development of an Enterprise Master Patient Index (EMPI) which can reconcile multiple unique identifiers used for the same individual and help ensure the correct person is identified regardless of how or where they receive services within the County. Progress on the EMPI and LANES initiatives is ongoing and should continue, regardless of the ultimate decision concerning the creation of an agency and shift to a single, integrated EHR. As important as they are, though, neither LANES nor a County EMPI would offer the County comparable functionality as would a single EHR. Beyond the potential for a single or linked EHR and single identifier, there are additional opportunities to leverage IT in a way that could enhance departmental operations, improve service levels, and reduce costs.

Applications (outside of the EHR): The three Departments currently use many different systems for a variety of common functions. The Departments could evaluate their collective library of applications to identify opportunities to consolidate currently unlike systems, with resulting cost reductions and improved alignment of processes, data, and reporting capabilities. Examples of areas to investigate include physician credentialing/master provider database, pharmacy benefit management, health care claims clearinghouses, referral management systems, active directory, and Picture Archiving and Communication Systems (PACS) that facilitate the movement of radiological studies across clinical environments. As longer

⁵¹ Per a Board motion approved on April 7, 2015, the CEO, CIO, County Counsel, and Departments are currently developing a report on the feasibility and potential impact of shifting to a single, integrated EHR. This report is due to the Board July 7th.

term opportunities, the Departments could consider an aligned approach to Personal Health Records, allowing individuals to utilize the same system for accessing personal health information across Departments. They could also consider a coordinated strategy for billing and cost-accounting systems. The Departments also each use several IT applications that are unique to the functions of their Department and would not be appropriate for convergence. These individual applications should continue to be supported regardless of work on shared tools.

Data Governance and Repositories: If DHS, DMH, and DPH are to effectively coordinate care and improve service delivery, there must be agreement on the meaning of data used across Departments; this is achieved through a process known as data governance. A joint data governance approach would lay the foundation for more effective use of data to meet County goals. There would also be significant value to the County of the Departments having a single health care data warehouse. Both DHS and DMH have invested in their respective data warehouse/repositories to address the much broader range of data becoming available with the implementation of their EHRs. DPH does not have a data warehouse or data analytic infrastructure but could establish data feeds into DHS' repository and build a Public Health data mart to expand its data reporting and analytic capabilities. Making these investments by leveraging existing infrastructure would be more cost-effective than making de novo investments. As with EHRs, data repositories can be structured to properly safeguard data privacy and security. If shared data repositories are developed, DHS, DMH and DPH will need to work with County Counsel to examine consent and data use guidelines to ensure compliance with all regulatory requirements.

Improving workforce education and training

A wonderful strength of the County health system is its rich and talented workforce. Some believe that through the direct actions taken by an agency and the indirect effects of an agency's effort to integrate care, an agency can support workforce education and training in ways that build staff capabilities, increase workforce satisfaction, and enhance recruitment and retention. Innovation in clinical service delivery and population health will not be successful without workforce education. Best or expected practices in workforce education could be established across the three Departments. Performance and quality improvement programs should be commonplace. Developing shared approaches and tools for improving performance on new or existing initiatives will help the County to efficiently alter programs, approaches, and front-line practices.⁵² In some cases, expanded roles or the creation of new/broader classifications may be needed, helping to diversify the workforce, support job ladders and create promotional opportunities. These in turn might help invigorate the County's workforce, with benefit for both those served and employed by the County. Finally, classifications that are currently underutilized within the County might find greater use if programs and duties were planned and structured in a coordinated way.

Workforce education opportunities can be increased with minimal investment simply by better leveraging the unique strengths and expertise already available in each Department. As an example, DMH could provide de-escalation training to some DHS and DPH staff. In other areas, new investments may need to be made, but doing so across all three Departments would be a more efficient use of available resources. For example, the County could benefit from potentially creating a County-wide Community Health Worker (CHW) institute that would support both County and community-based CHW efforts. Also, each Department is involved in customer-service training initiatives for front-line staff. While the services may be disparate, the intended customer (the public, client, consumer, patient) may be interacting with more than one Department. A common approach to basic customer service would enhance the consumer experience and likely lead to efficiencies in training resources over time.

⁵² Although the nature of the process improvement work across Departments may differ, the approaches may be similar and done in an integrated manner. Care should be taken, however, not to eliminate important differences between Departmental approaches.

Strengthening the County's influence on health policy issues

Due to its sheer size, LA County has a very visible role in shaping state and federal policy. However, efforts are often poorly aligned because the three Departments approach advocacy and policy differently. Policy and advocacy priorities should be set and advanced together. The stories of front line experience can be complimented by broader, population-focused data and trends. As one public health leader said, "we [DPH] would benefit by having DHS or DMH by our side when we are talking to city councils about an issue in their community because our sister Departments can tell the real life stories about patients who might be impacted by the areas we discuss."

At this moment in time, there are some obvious areas where collective action on a joint policy and advocacy agenda and approach would be applied. The current drug Medi-Cal provider certification process is being developed by the State; LA County has much to gain or lose depending on the direction the State takes. There is also ongoing conversation more locally about the built environment (e.g., parks, neighborhood design) and community development. Finally, a policy agency could include advocacy to rationalize the various financial incentives and financing streams that are often a barrier to greater service integration. In any of these instances, a louder and cohesive voice from the County's health agency could be more effective than DHS, DMH or DPH moving forward alone. A joint approach to policy and advocacy must still prioritize issues of importance to each Department, rather than solely focusing on those issues that are of concern across multiple areas.

Improving use of space and facility planning to improve access and reduce costs

As described in greater detail above, one important way in which services can be integrated at the point of care is through co-location. Co-location may have several advantages:

- It may offer individuals more choice in terms of where they receive care, allowing people to attend the type of facility or clinic in which they are most comfortable, expanding access to care and retention in care.
- If it is designed in a way that improves geographic access, this can result in improved customer experience and improved geographic coverage for managed care contracts.
- If a portion of clinical (e.g., nursing attendant, substance abuse counselor) or support staff (e.g., front desk staff, security) are shared, it can reduce administrative costs.
- It may provide an opportunity to diminish the stigma associated with the provision of mental health services - if the culture and service delivery provided by health facilities is embracing of those with mental illness.

Better integration of services, whether through co-location or other solutions, presents an opportunity to more effectively manage the County's inventory of County-owned and leased facilities, including clinical, administrative, and warehouse buildings. Each of the Departments currently faces several challenges with respect to their facilities. All three face capacity constraints and are looking to expand services in specific geographies. Each Department has several old County-owned buildings which have major deferred maintenance needs and will require substantial capital investment in order to provide safe and efficient work environments. Further, many buildings are not designed in a way that supports current operations and services. By managing space jointly at the agency level, the County could be more strategic in how it uses space, where it chooses to buy or lease new buildings, helping the County to avoid additional capital investments in new infrastructure. In thinking through specific space-related opportunities, it is important to keep in mind the different ways each Department conducts its business, unique regulatory requirements (e.g., OSHPD or Cal-OSHA) that must be met, the role of field-based staff, ADA accessibility, and the availability of parking, public transportation and support infrastructure.

Improving ancillary and administrative services and functions

Greater efficiencies in ancillary and administrative areas can improve service quality and an individual's experience with the system. Further, by reducing duplication and producing economies of scale, efficiencies in these areas can reduce costs over the long-term. While such potential cost savings are not the primary goal of an agency, they should be captured over time in order to allow funds to be redirected to clinical and population health programs. Considered briefly here are opportunities in pharmacy and non-pharmacy ancillaries (e.g., radiology), contracting/purchasing, and human resources.

Pharmacy and non-pharmacy ancillaries

There are several potential opportunities to improve integration of pharmacy services. The first is related to enhanced pharmacy access by allowing DMH uninsured clients to access DHS pharmacies. This may also result in savings since the DHS cost to refill a prescription is less than the fee paid to DMH's contracted pharmacies. Additionally, individuals seen at both DMH and DPH could potentially receive prescription refills by mail using DHS' Central Fill location.

Second, the Departments could benefit from implementation of an evidence-based unified drug formulary and prescribing protocols/practices. This would provide individuals with a more consistent experience and would reduce costs by increasing the use of generic medications and consolidating use on a smaller number of pharmaceuticals. DMH conforms its indigent formulary to the Medicaid formulary to prevent dual levels of care between insured and indigent clients. However, there may be savings possible by adopting different formulary practices; typical savings from such moves are 10-20% of non-reimbursed annual pharmacy expenditure.

Third, it may be possible to extend 340B pharmaceutical pricing to DMH's directly-operated clinics, typically accessing such pricing through DHS facilities' covered entity status. DHS hospitals and DPH clinics have access to 340B pricing already. It is not advisable to attempt to extend 340B pricing to contracted clinics given that it would require substantial disruption to existing service patterns. While there are several ways in which DMH's clinics may gain access to 340B pricing⁵³, it would be a long-term process, would require substantial administrative restructuring of DMH facilities and regulatory approvals, and would possibly impose new risks to DHS as the covered entity responsible for oversight and audit of the 340B program. The County should carefully investigate the estimated financial savings (currently estimated at \$2-3 million annually) and operational impact before embarking on this path.

Adopting a single or at least coordinated strategy for ancillary clinical and operational services outside of pharmacy can benefit clients/consumers/patients by improving service quality and helping to realize operational efficiencies and financial savings. Such efforts could be applied to clinical laboratory services, radiology, durable medical equipment, employee health services, home health services, and medical transportation. As an example, DPH currently provides a small amount of radiology professional services through a contract radiologist. DHS, with its larger radiology practices, may be able to provide this service for the same or lower cost and with fewer service interruptions. Also, DMH processes labs collected within its directly operated clinics at contract, non-County labs. Given the highly automated nature of most laboratory test processing, a DHS or DPH lab could provide the same processing at a net County savings.

⁵³ Four models for extending DMH 340B pricing: 1) Merged Location: DMH clinics and staff must be fully merged with and physically located within the "four walls" of a registered 340B hospital. 2) Child Site: Covered entities add "child site" locations (outpatient facilities located outside the four walls of the covered entity, subject to geographical limitations on distance between facilities). 3) Referral Relationship: A DHS hospital refers 340B-eligible patients, as needed, to DMH clinics for mental health treatment. The covered entity retains responsibility for the overall care of the referred patient and use of any 340B drugs dispensed. 4) FQHC Look-alike Status: FQHC "Look-Alikes" are eligible for 340b pricing but must meet federal regulatory requirements under Section 330 of Public Health Law, including the need to have a governing board made up of individuals currently being served by the health center.

Contracting, contract monitoring, and purchasing

In stakeholder sessions, some external entities who contract with multiple Departments shared hope that an agency would be able to reduce unnecessary duplication of auditing, reporting, and contract monitoring practices and better align currently conflicting programmatic requirements. Challenges in both of these areas contribute to confusion and unnecessary costs on the part of consumers and can serve as obstacles to delivery of efficient, high-quality services for consumers. Several of the County's current contracted partners expressed a desire for an aligned and accelerated contracting approach which took into account the full breadth of services purchased. As one contractor put it, "If the agency's only achievement was a single, coordinated RFP, reporting, and audit process for each of the three Departments, it would be worth it just for that." Other ways the Departments could work together include: 1) Developing future contract solicitations that could be used by any of the three Departments. 2) Consolidating similar contracts if programmatic alignment is strong and services are not tied to restricted dollars (e.g., MHSA); IT contracts are one area that may benefit given the specialized contracting expertise needed. 3) Expanding best practices across the Departments, including pursuing greater flexibility when contracting for proprietary services (e.g., maintenance contracts). 4) Exploring master agreements with similar terms and conditions but with options for different scopes of work and funding caps.

Changes should be made with caution to avoid unexpected adverse effects. As one contractor put it "From my perspective, things are fine. I've figured out how to navigate County ways. There may be advantages to the County of doing this, I don't know, but please don't let the agency make things worse for us."

Contract monitoring and program audits may also benefit from greater collaboration, for example by having contract monitors or program auditors assigned to administrative/insurance compliance for shared contractors across the agency. An in-depth review would highlight what agreements may benefit from shared monitoring functions and which may require specialized knowledge or skill sets to ensure compliance. Given that each Department raised concern about an inadequacy of resources for contract monitoring, moves to streamline contracting activities would help to make good use of scarce resources and may reduce the need to add additional contract auditor staff in the future.

Given the different state of each Department in their eCAPS roll-out and the different manner eCAPS is used to meet their organization's procurement needs, it would not be advisable to consolidate the Departments' purchasing functions at this time. There are opportunities, however, to optimize purchasing practices, such as by fully capturing manufacturer rebates and other cost saving mechanisms, extending use of University Health System Consortium (UHC) Novation Agreements⁵⁴, and sharing warehouse space and supply distribution infrastructure. The County also has the opportunity to leverage better pricing and standardized support through an enterprise approach to IT purchasing and contracting. Where the three Departments utilize common products or services, there is an opportunity to establish master or joint agreements that could be leveraged by each.

Human Resources (HR)

Creation of an agency could help improve HR operations and enhance consistency in several ways:

Exam planning and development: DHS, DMH and DPH utilize a number of the same or similar classifications where exam planning and administration is delegated to the Department-level. At present, collaboration is limited to requests to use an eligible list that resulted from another Department's exam. An integrated approach to exam administration for common

⁵⁴ UHC is a national healthcare consortium that competitively solicits bids for goods and services to leverage volume purchases to achieve low pricing and rebates to customers for future UHC purchases. DHS currently uses UHC for medical equipment and supply purchases. DPH indicates they currently use UHC only for certain medical commodities. DMH does not utilize UHC.

classifications could result in better exam planning and recruitment outreach and more efficient use of subject matter expertise and HR analysts, though this may not be appropriate for all classifications. For example, an agency could seek delegated authority from DHR to run exams for County-wide classifications (e.g., IT positions) for all three Departments, tailored to the specialized needs of health-related departments, while still coordinating with DHR on all master calendar exams. More broadly, an agency would be strategically positioned to develop classifications and job specifications closely tied to health care delivery. As an alternative view, some felt greater coordination on exams could result in worse outcomes for individual Departments (e.g., longer planning period, inability to attract appropriate staff, etc.).

Employee relations and risk management: There is significant overlap among staff classifications at DHS, DMH, and DPH. Consequently, the three Departments interact with many of the same unions via labor-management committees at the Department and County levels. Strategy-setting and engagement at the agency level would enhance each Department's ability to manage issues related to commonly represented classifications, employees, and functions. For instance, an agency initiative to engage represented employees in working to the top of clinical license would have greater impact than each Department pursuing separate strategies in union engagement.

Following are some additional examples of areas where greater collaboration would yield benefit on staff-related issues:

- DHS is adopting Safe and Just Culture principles to improve operations, risk management and performance management and could be scaled to include DMH and DPH.
- Departments could better align in how they manage performance improvement initiatives, including mechanisms for engaging front-line staff, middle-management and labor colleagues.
- Departmental approaches to employee wellness could be jointly pursued such as those exemplified by DPH.
- An agency might create greater opportunity to investigate and, when appropriate, advocate for a solution to classification-compensation issues, such as pay discrepancies between similar classes.
- DHS and DPH might implement a Staff Advisory Committee in the manner that DMH has done.

Maximizing revenue generation

There may be opportunities to generate additional revenue through more collaborative and integrated efforts between the three Departments. Following is a summary of potential opportunities for maximizing revenue. Each of these would need to be further evaluated before a definitive decision could be made as to the magnitude of the net benefit that could be achieved and the timeline over which each opportunity could be pursued.

Managed care contracting and billing: Managed care revenue contracting is in its infancy in the County outside of DMH's status as the Medi-Cal specialty mental health (SMH) plan under California's carve-out for SMH services in which it has responsibility for adult Medi-Cal clients with SMI or children with SED. In fulfilling this responsibility, DMH both contracts for and directly operates clinics providing the required services and also maintains a contract to provide SMH services to all plans participating in Cal Medi-Connect serving those who are dually eligible for both Medicare and Medi-Cal. Clients with mild to moderate mental illness (i.e., non-specialty mental health [NSMH] services) are managed through Medi-Cal's managed care two-plan model in LA County or through fee-for-service (FFS) Medi-Cal. DMH is beginning to consider developing contracts outside of the scope of the SMH carve-out, investigating opportunities to execute Medi-Cal contracts to provide treatment for NSMH services and for treatment of SMI/SED for non-Medi-Cal/non-indigent individuals. DHS holds two contracts with Medicaid managed care plans and eighteen contracts with other health plans, independent physician associations (IPAs), hospitals, and pharmacy benefits management companies, with one more in progress. At present, DPH's SAPC program provides services to behavioral health affiliates, LA Care, Health Net, and Molina, through its memorandum of understanding (MOU) with Care 1st and its agent Beacon Health Strategies. SUD services are provided to

these managed care plan participants that qualify and SUD services are reimbursed through the Drug Medi-Cal program. At present, DPH bills Medi-Cal for immunizations and is in the process of billing for TB Directly Observed Therapy (DOT), along with a pilot for public health nurse Targeted Case Management.

In the nearer term, while all three Departments bill private providers to different extents, opportunities remain to further support revenue generation through billing. While DPH has tried to utilize DHS billing infrastructure in the past, DHS was unable to provide immediate support at that time given the simultaneous changes in the organization and infrastructure of its billing systems. A renewed collaborative between the Departments could facilitate DPH's ability to contract with the health plans and providers and then claim for TB and other clinical services, such as STD care. For example, DPH is developing a platform off the SAPC-based Medi-Cal claiming translator to bill for DOT services. Other counties have leveraged their ability to bill Medi-Cal for DOT to contract with and bill private providers (e.g., a commercial health plan such as Kaiser) for public health services that otherwise would not receive any reimbursement. Ventura County DPH also has a contract with Kaiser to bill for its services. As another example, the County could build off of DMH's contract to provide eConsult psychiatrist services by offering both additional eConsult services available within DHS and also offering DMH's eConsult services through DHS' contracts with other health plans and/or their contracted providers.

Over the longer-term, bigger opportunities exist. The County has a large potential to increase the depth and breadth of managed care contracts with health plans and IPAs, particularly if it is able to market an integrated model of care. The County's efforts to attract and retain revenue-generating individuals will be critical to the future competitiveness and financial viability of the County's health Departments and its ability to fulfill its Section 17000 responsibilities without infusion of additional revenue. While the Departments are exploring ways to expand managed care contracts for their respective services, pursuing these arrangements within a highly integrated model of care that includes a full spectrum of mental health (mild to severe), physical health, substance abuse, and select public health services, could be more attractive to individuals and plans alike. This type of service offering might be particularly attractive to plans if it targets known high-utilizers or particularly complex (clinically and socially) or vulnerable populations that the County has a unique ability to serve and that private providers may not want to see. An agency could build a model to serve these people by combining the health offerings of the three Departments into one package, supplemented by social services available in other County departments. Integrating safety net services offered by these Departments would give the County greater expertise in handling more acute patients with multiple diagnoses and social issues, a benefit that could be leveraged to negotiate higher reimbursement rates.

Some stakeholders felt that such opportunities for greater managed care contracting were speculative at best. They pointed to DHS' history of losing market share among obstetric patients to community Medi-Cal providers in the 1990s and continued challenges in attracting large numbers of non-high-risk obstetric patients to the County. They also commented that the competitive challenges in the current Los Angeles health care marketplace were not taken into account and might make these managed care goals difficult to achieve. Finally, there is the danger that a health plan may be interested in only purchasing part but not all of the services offered.

Over time, the County may decide to enter into novel financing arrangements which would give the County greater flexibility in funding services and programs that currently have no available revenue stream. As an example, the County may wish to enter into risk-sharing relationships with the State and health plans in which it assumes full responsibility for the comprehensive provision of health services, including physical and behavioral health, by directing funds for SMH, SUD, and physical health services into a single capitated payment, although state law changes and federal approval would likely be required if Medi-Cal beneficiaries are to be involved. This type of financial integration would be an added support for clinical and service integration initiatives. While these opportunities are being pursued, it will be important to not disrupt existing strong relationships between plans and the County. For example, one health plan indicated that its relationship with DMH for referral of SMH services is "a model for the entire state." The County should strive to preserve these

relationships as it considers implementing or shifting to consolidated contracting arrangements. Prior to considering a consolidated contract with health plans to cover physical, mental, and specialized public health services, the County would need to consult with the State Department of Managed Health Care to determine if a full Knox-Keene health plan license is needed, and, if it is, would need to assess the organizational and operational implications of maintaining licensure.

Supplemental Medi-Cal managed care payments: For the last several years, DHS has been able to receive supplemental payments from Medi-Cal managed care plans using intergovernmental transfers (IGTs) to fund the non-federal share of increased capitation payments to the managed care plans, which then pass the money on to DHS. DHS cannot presently access all of the supplemental revenue that can be created through IGTs. It may be possible for DMH or DPH also to receive payment from Medi-Cal managed care plans using IGTs, as long as they can provide non-administrative services of benefit to the plans. Ideas for such services include immunization and STD care through DPH, or enhanced case coordination/case management service for those mentally ill individuals that shift between moderate and SMH care during the course of their illness. Implementation of such initiatives will require the approval of both the State and CMS. Given that there is a capped amount of supplemental Medi-Cal managed care revenue that can be IGT-funded, the County should help assure that each Department gets access to an appropriate share of these funds.

Cost-Based Reimbursement Clinics (CBRC) revenue for Public Health clinics: The County should evaluate the feasibility of obtaining CBRC revenue (a special Medi-Cal payment program that provides full cost reimbursement for outpatient services in DHS) for certain public health services, such as immunizations, STD testing, and women's health. Under current rules, CBRC is not available for specialty mental health services or for services in clinics which provide predominantly public health services. However, public health services could be eligible for CBRC if they were incorporated more fully into DHS clinics. Certain public health functions, such as Targeted Case Management (TCM) and Medicaid Administrative Activities (MAA) are already receiving partial Medi-Cal reimbursement through MAA and TCM programs. Careful analysis would need to be done to ensure that CBRC revenue would be superior to other revenue streams currently available to DPH for TCM and MAA programs. Analysis should also ensure that an appropriate mix and type of services are moved to DHS sites, considering geographic access, space/renovation needs to accommodate specific clinical conditions (e.g., TB), and impact on DPH clinics' designation as Essential Service Providers (ESP) under Covered California.

Patient Financial Services (PFS) reimbursement: DHS employs PFS workers to take Medi-Cal applications from patients and bills for and receives offsetting Medi-Cal administrative revenue of about \$15 million per year. Under an MOU with the State, these DHS employees assist with application completion, data entry, and make a preliminary eligibility determination which is confirmed by DPSS. DMH PFS/Eligibility Workers (EWs) assist clients with Medi-Cal applications but rely on DPSS staff to complete the eligibility process and thus do not receive administrative reimbursement. DPH does not employ EWs because it does not currently bill Medi-Cal, but is actively engaged in developing processes to bill for certain services. If that is successful, it may be appropriate for DPH to employ EWs to help with identifying and accessing coverage by third-party payers. The County may also be able to extend DMH and DPH access to the current MOU with the State, expanding funding for enhanced Medi-Cal eligibility activities.

Hospital Presumptive Eligibility (HPE): DHS is currently processing applications at its hospital locations for Medi-Cal HPE, which is a program providing full-scope Medi-Cal benefits for a short period of time to allow an ordinary Medi-Cal application to be taken and processed. DHS is evaluating ways to extend HPE to its outpatient clinics using hospital staff and could potentially extend this to DMH and DPH sites, though doing so would be operationally complex and would require substantial coordination across Departments. There are certain advantages of obtaining short-term Medi-Cal coverage in higher cost hospital and clinic settings. While it may not be beneficial to the County to extend HPE to all County sites, use of HPE at some DMH and DPH sites would help additional individuals enroll in Medi-Cal and could provide a temporary revenue source for certain individuals. This issue should be evaluated more fully before implementation begins.

Drawbacks and Risks of the Agency Model

In soliciting input on this report, many stakeholders were openly critical of the Board motion and the lack of public discussion before the item was placed on the agenda. Individuals described feeling “violated”, “ignored”, “offended”, “blindsided.” Stakeholders often commented that the County had “betrayed their trust,” and made it difficult for them to engage in a full discussion of the agency. This sentiment can only be addressed over time, by establishing transparent processes and maintaining open communication with stakeholders, including subsequent to the point at which this report is submitted to the Board.

Beyond extreme displeasure with the technical process, stakeholders raised a number of specific risks they felt could result from implementation of an agency model. Every organizational structure has potential risks, both perceived and real. It is important to understand these risks and their likelihood of coming to fruition, and to consider how they might be mitigated through both the structural design of an organization and through its careful implementation. With this in mind, this section describes ten categories of risk as expressed by stakeholders, offers thoughts on each area’s particular relevance to an agency model (vs. likelihood of coming to reality with any organizational change that would promote integration), and makes suggestions on how the County may be able to mitigate each risk, if it chooses to implement an agency, so that the County can maximize the benefit for LA County residents. The recommendations included in the “Proposed Structure” and “Implementation Steps” sections also are intentionally developed to include safeguards, checks and balances, and processes that can help reduce the likelihood that these risks would come to bear.

1. Concern regarding potential legal risks
2. Concern regarding potential human resource risks
3. Risk of history repeating itself: Fear of service/budget cuts and deprioritization of County functions
4. Risk of increased degree of bureaucracy
5. Risk that an agency may require financial investment for administrative positions
6. Risk that Departments may lose focus on the full breadth of their current missions
7. Risk that cultural differences may compromise integration efforts
8. Risk of medicalization of community-based mental health
9. Risk of disrupting existing service models and the staffing structures and partnerships they rely on
10. Risk agency planning may detract from the work of integration

Concern regarding potential legal risks

County Counsel reviewed potential legal risks associated with the agency model and did not identify any legal impediments. They did, however, raise several issues that will need to be monitored should the Board move forward with creating an agency.

- The Director of Health Services (which is interchangeable under the Charter and County Code with the Director of Hospitals), the Director of Mental Health, the Director of Public Health and the Health Officer are all positions to be appointed by the Board, in accordance with qualifications and requirements set forth in California law and the County Charter. However, nothing precludes these positions from being included within the agency structure.
- At this time, no reduction, closure, or elimination of medical services is expected such that the Beilenson hearing process would be triggered. As agency priorities are set and integration activities accelerate, the agency will need to work closely with County Counsel to monitor the applicability of the Beilenson hearing process if medical services are realigned or relocated.

- The implementation of an agency structure does not threaten the reimbursement each Department receives. While some funding is necessarily restricted by operation of law or agreements with funding agencies, such as certain mental health funds and public health-related grants, or requires the contribution of a match or maintenance of effort, as long as those restrictions are honored, no legal impediments based on revenue and reimbursement should exist. As stated previously, the proposed agency will preserve the existing budgets and funding streams of each Department.
- As previously discussed, the County has the potential to negotiate a consolidated contract with health plans to cover the provision of physical health (both physician and hospital cost components), mental health, and specialized public health services, such as directly-observed therapy for TB patients. County Counsel and Departmental representatives will need to consult with the State Department of Managed Health Care (SDMHC) to determine if full Knox Keene health plan licensure is needed as a prerequisite to the County participating in this kind of contractual arrangement. As the Board may be aware, DHS is in the process of converting its Knox Keene license to a restricted license as the result of winding down the Community Health Plan. If a plan license is required, the agency will have the ability, through a request for a material modification to SDMHC, to request the restricted license be expanded to a full license. The agency would have to take into consideration the organization and composition of the agency and the concomitant implications on maintenance of financial records, the performance of audits and such other aspects to ensure compliance with SDMHC's legal and regulatory requirements.
- DPH currently must audit and/or provide program oversight functions for Public Health-funded services provided by DHS and DMH (e.g., services funded by Children's Medical Services and Division of HIV and STD Programs). Creation of an agency model can be achieved without compromising DPH's role. Where there may be a perceived conflict, an audit division can be maintained separately from the programs that will be subject to audit. Thus, staff that are responsible for program implementation would not be vested with auditing that function.

Concern regarding potential human resource risks

The Department of Human Resources, CEO Classification/Compensation, and CEO Employee Relations (ER) did not identify any direct risks of creating a health agency. However, some County staff were apprehensive that the very act of creating an agency and appointing an agency director would have direct consequences on classification, compensation, and ER issues. Staff also felt unsure about how an agency would affect their work assignments and roles. Specific questions raised are included below.

- Will the creation of an agency result in layoffs or staffing reductions?
 - Creation of an agency would not impact Departmental budget appropriations so would not lead to staff layoffs. The agency's goal is to improve and enhance services and programs across all three Departments; budgetary or staffing reductions are not consistent with this goal.
- How will the agency affect roles and responsibilities of specific positions, geographic assignment, scope of practice, and team structure?
 - The creation of the agency itself will not immediately affect any of these issues. However, as integration progresses, the agency and Departments will need to communicate openly with staff and organized labor about ways in which job responsibilities and workflows/processes may be affected. If initiatives or program changes would affect wages, hours, or working conditions, they would be the subject of formal consultation with organized labor.

- Will the County be required to reconcile differences in HR and ER-related issues affecting employees of the same or similar classifications (e.g., pay differentials, differences in MOUs with labor unions, etc.)?
 - Where differences exist, they are based on differences in employee roles, responsibilities, or working conditions. The creation of an agency will not force these differences to be reconciled. Based on current case law, the County will be required to review differences if the agency has an impact on wages, hours or working conditions for any impacted classification. If there is no direct impact on wages, hours or working conditions, the County would only address these differences during MOU negotiations as needed. However, the agency could create a forum for better understanding the reasons for these differences and, when appropriate, advocate for a proper resolution.
- Will the creation of a new “agency director” item lead to the automatic downgrade of positions or affect the depth or number of unclassified positions in each Department?
 - The positions within each Department would continue as they are today. If the Board chooses to create an agency director position, it would not automatically downgrade roles in the County. The three levels of unclassified positions within each Department can also be maintained per language in the County Charter.
- Will the agency affect seniority pool as used, for example, to determine vacations?
 - The concept of “seniority” applies mainly to labor-represented classifications. MOUs that contain vacation scheduling provisions would still apply under an agency as would other standard practices for scheduling vacations. Other uses of seniority would also not be expected to change.
- If a reduction in positions within one Department were to become necessary, would this trigger a cascade in staff re-assignments across the agency to remain consistent with County seniority rules?
 - Cascades are typically handled within the department having the budgetary issues necessitating the workforce reduction. If not able to be managed within the department, the cascade is managed at the County level, including all departments with like items. This would remain the case under an agency model. Position reductions, while rare, have virtually always been able to be accommodated by filling vacant like items. These activities would be coordinated by the involved Department(s) and the Department of Human Resources in accordance with existing civil service rules, MOU provisions, and/or Board Policies.

Risk of history repeating itself: Fear of service/budget cuts and deprioritization of County functions

When the Department of Mental Health was merged into a single Department of Health Services, along with the Department of Public Health, in 1972, it ushered in six challenging years before DMH was split out again in 1978. Some of the funds that were supposed to be dedicated to mental health were directed to urgent or emergent needs in the hospitals. Leadership gaps and a geographic operating model further complicated the single department’s operations and contributed to the eventual separation. In the 1990s and 2000s, DHS, which was then made up of separate divisions of public health and hospital/clinic care faced financial deficits and went through a series of budget cuts. While the cuts were distributed across the Department they also included cuts to important population health programs. Population health advocates and some DPH staff who lived through these years perceived this as a cannibalization of public health’s budget. These budgetary concerns and the distinct missions of the public health and hospital/clinic arms of the Department were major reasons behind the split of DHS into two separate departments, DHS and DPH, in 2006.

Many people raised concern that creating an agency would be asking for history to repeat itself. As one stakeholder asked “If it didn’t work in 1972 and it didn’t work in the 2000s, why would it work now?” While not the exclusive focus, concern was often centered on preservation of Proposition 63 Mental Health Services Act (MHSA) dollars made possible by victory

in a hard-fought 2004 ballot initiative. MHSAs form the foundation of numerous mental health programs and services for clients across the County, including funds for prevention and early intervention, services, and infrastructure, including technology and training, and are rightfully protected by mental health advocates. Some stakeholders commented that despite the safeguards that protect the use of MHSAs for mental health programs, they worry that an agency would lead to the gradual diversion of funds for non-intended uses. Many people pointed to the DHS' budget as the likely target of such funds, dominated by hospitals with large fixed costs and with an industry known for acute/emergent problems. While many stakeholders were not aware of DHS' current fiscal surplus, even those that were aware expressed concern of money being taken from DMH (or DPH) to fund DHS if its fiscal outlook worsens in the future. One population health advocate voiced, "Clinical imperatives always trump public health. The urgency of 'now' trumps long-term benefits."

Cuts to a Department's budget are not possible in an agency structure without Board approval. Cuts to mental health in the 1970s and to public health in the early 2000s were perceived as possible without Board approval because of the organizational structure in place at the time of a single merged department. Department heads have the authority to recommend the movement of funds within their Department, but ultimately, all changes between Department budget units must be approved by the Board of Supervisors. Because the agency model preserves the structure of the three separate Departments, it would further highlight any budgetary shifts between Departments. If a situation arose in the future in which one Department faced a financial shortfall, the agency director would not have authority to cut funds or programs in another Department to fill the deficit.

While the dollars matter, stakeholders were also concerned that public health and mental health would be deprioritized and under-recognized in an agency model, similar to their perceived experience in a merged department. Several individuals pointed toward the merger of the California Department of Mental Health into the California Department of Health Care Services (DHCS) in 2011 as an appropriate parallel, calling mental health issues "functionally forgotten" at the State level and citing a dearth of communication with DHCS and senior Health and Human Services leaders.⁵⁵ Stakeholders expressed fear that an agency would similarly detract from attention paid to population health or mental health activities and goals. "The mental health client took a back seat for many years and now they are actually sometimes in the driver's seat. It would be a shame to lose that progress." Another commented, "Mental health gets steam-rolled by the other Departments already; won't that get worse?" "We'll be the ugly step-child," said one population health stakeholder. A DMH consumer expressed concern over "loss of focus and funding for mental health, even to the point that our coalition groups will be disbanded." "Mental health and population health will be swallowed up by health services." Others took a more personal view of the risk. "Change is scary when you are the most vulnerable, disadvantaged person in the room; you are scared you will be left behind." This concern of deprioritization and a perceived loss of standing also manifested in people being concerned the Departments would be unable to recruit talented leaders who are well-established experts in their field. This is particularly the case for DPH which has lacked a permanent director since September 2014. The suspected dominant agency was most frequently thought to be DHS, a fact attributed to its size, the acute and costly nature of hospital-based crises, and concerns the DHS director may concurrently hold the role of agency director. However, several stakeholders also expressed concern about how substance abuse would be impacted in an agency, particularly if it is moved from DPH to DMH. Many people stated they feared that SAPC would be subsumed by mental health or "overrun by mental health professionals not appropriately trained to treat addiction."

⁵⁵ This view of the State's merger of mental health and physical health was not unanimously shared. Several stakeholders commented that major progress on mental health and substance abuse issues would not have been made without the merger, such as the expansion of treatment for mild to moderate mental health disorders. A similar sentiment was shared regarding the movement of the Department of Alcohol and Drug Programs into DHCS in 2013; this shift was thought to be a primary factor in support for the expansion of the Drug Medi-Cal benefit and Drug Medi-Cal waiver design. Those who supported the State's reorganization viewed antagonism to the mergers as based on people's perception and experience of engagement in, for example, various State advisory groups, and not as reflective of actual attention to mental health and substance abuse issues at the policy level.

The concern that an agency may result in deprioritization or undervaluation of each Department's mission and activities was often also expressed in the context of concern about who would be selected to lead the agency. "Our director is an incredible ally; we don't trust that the person that comes next will be the same." "We fear we will be led by someone who doesn't understand us and won't listen to us." Stakeholders often focused on a specific concern that one of the three Department heads may be appointed to serve concurrently as the agency director. This idea was met with intense criticism by a number of stakeholders based on an assumption that it would lead the agency director to favor and focus disproportionately on his/her own Department, prioritize initiatives related to that Department, and siphon resources in a way that would benefit that Department, risking the neglect of critical County functions. Even if the individual was able to focus on the breadth of activity across the system, some feared this would come at the price of neglecting focus on his/her home Department. "[Having a department head also serve as the agency director] would be an absolute show-stopper." "It's not three Departments on equal footing. If there are disagreements, it's no question who would win. The agency director wouldn't be able to be a fair arbiter if they are also a Department head." As one way of addressing this concern, the Board could consider conducting an open, competitive recruitment for the agency director position, considering various candidates rather than immediately appointing a permanent agency director from among the current Department heads.

In contrast, others felt an agency structure would be best able to draw attention to a complex and comprehensive set of health-related activities. They felt that while not perfect, society and health leaders today had a far greater and more nuanced understanding of the critical role of population health and mental health activities than was the case in the 1970s, or even in the late 1990s and early 2000s. There is broad recognition of evidence that early investment can yield long-term savings: substance abuse and mental health treatment has been shown to save up to seven dollars for every dollar spent due to averted medical and societal costs (e.g., avoided incarceration).⁵⁶ There is also ample evidence of the effectiveness of health promotion activities, including those that target clinical, social, and behavioral interventions.⁵⁷ This acceptance may reduce the likelihood that an agency would lead to a deprioritization of a broad and diverse set of health-related activities.

Practical steps that can help build confidence that the needs of each Department will not be deprioritized or defunded in an agency include the following:

- **Select an agency director with experience in all three areas.** Selecting an agency director who has leadership experience in all three fields: mental health, public health, and physical health, can help to establish credibility, build trust, and decrease the likelihood that the agency will narrowly advocate on a limited set of issues.
- **Increase transparency into Department budgets.** Each County Department's budget is shared publicly, but its style and length make it challenging for people to understand. The development of clear, concise, Department-specific budget summaries, demonstrating the size of different funding streams and their uses, with historical comparisons, would be a valuable source of information to the public where not already available and could help to increase the practical level of transparency into County budget processes, reducing the likelihood that individuals or groups feel Department funding is being inappropriately diverted.
- **Clearly communicate any administrative savings from implementation of an agency structure.** Over time, The County may choose to move certain administrative functions to an agency level when doing so would

⁵⁶ Substance abuse: Ettner, SL, et al, (2006). "Benefit-cost in the California treatment outcome project: does substance abuse treatment 'pay for itself'?" *Health Services Research*, 41(1): 192-213. Mental health: Cutler, D, et al, (2003). "Your Money or Your Life: Strong Medicine for America's Health Care System." *Oxford University Press*. "Best Return on Investment (ROI): Mental Health and Substance Abuse Treatment." *National Alliance on Mental Illness*. (2009).

⁵⁷ Smedley, BD and Syme, SL, eds. (2000). "Promoting health: Intervention strategies from social and behavioral research." *Institute of Medicine*.

demonstrably improve service levels and help to reduce costs. The amount of total savings and uses of these funds should be clearly summarized and shared with the public.

Risk of increased degree of bureaucracy

One of the most commonly cited potential drawbacks of an agency is increased County bureaucracy, additional layers, “big government”. Many stakeholders criticized the agency for being a “hierarchical” structure, with “hierarchy” associated with increased bureaucracy (i.e., “red tape” generated by those in the hierarchy), a loss of control and power, and a lack of voice. Department personnel described a fear of “losing control” and having “diminished influence” within an agency, particularly if critical functions moved to an agency level, and of having “to work through yet one more layer of County bureaucracy for everything from ordering a pen to executing a contract for critical services.” As anyone who works in or with the County knows, the effect of too many layers and bureaucratic processes is delayed services and increased costs. While delays may harm any individual who use County services, they are especially detrimental to disadvantaged populations who are already challenged with accessing the system.

Stakeholder concern about the creation of an agency leading to additional bureaucracy stems from three assumptions: 1) That an agency would indiscriminately place key administrative and operational units (e.g., finance, contracting, human resources, IT) at the agency level, rather than leaving them within the Departments where they would be close to their programmatic and executive leadership. 2) That placing any units at the agency level would automatically increase the unwieldiness of operations, rather than improve efficiency and timeliness. 3) That the agency director would take a dictatorial, non-collaborative style and would micro-manage department operations, putting in place multiple process steps to be completed before departmental actions would be allowed to proceed. While hypothetically possible under an agency (or other structure), it is possible to implement an agency that does not produce this result. As one stakeholder phrased it “view the health agency role as a communication/coordination hub and not as a hierarchical overseer.”

An organization’s structure does not by itself generate bureaucracy; any organization and any organizational structure can be bureaucratic or not. Bureaucracy is rather a reflection of how an organization operates and makes decisions. Similarly, an organization is not “hierarchical” simply because of its structure and reporting relationships; it may not necessarily depend on its hierarchical structure in day-to-day communication and decision-making. For instance, each Department has a Department head (and often but not always a Chief Deputy Director) who directly supervise the senior leadership within the Department; despite this reporting relationship, stakeholders often described these same departments as “non-hierarchical” and “non-bureaucratic.” This sentiment more accurately reflects hierarchy and bureaucracy as a function of an organization’s policies and procedures and the governance style of its leadership as being either dictatorial or collaborative, including the willingness of leadership to empower managers and staff further down in the hierarchy and/or use team-based or cross-functional team approaches. One stakeholder, critical of this section in the draft report, commented “an agency isn’t bureaucratic if it can get things done. You want to see bureaucracy? Look at each of those three Departments, each with their own separate procedures, protocols, rules, and committees for dealing with problems and people. That’s bureaucracy.”

Taking a view that bureaucracy is dependent on both how an organization approaches decision-making and governance as well as its structure, the following characteristics may help to mitigate the risk that the agency would introduce more bureaucracy into the system.

- ***Place administrative functions at the agency level only when there are clear net benefits of doing so.*** There was broad agreement that functions should only move to an agency level if there was a clear and demonstrable benefit of doing so, taking into account both impact on services/programs and also administrative efficiencies and cost-

savings. Stakeholders agreed that dual placement of functions at both the Department and agency (e.g., retain HR exams unit within the Department structure but also add an exams unit at the agency level) would increase bureaucracy, cost, and would hamper operational efforts. Similarly, movement of an entire organizational unit (e.g., finance, contracting, HR) could risk destabilization of critical program support functions and should be done only after careful study. This report recommends that core administrative functions such as notably human resources, information technology, contracting/procurement, and finance, in addition to others initially, remain at the Department level and not be moved to or duplicated at the agency.

- **Maintain a flat/horizontal organizational chart at the agency level.** Multiple reporting layers can contribute to administrative costs, redundancy, and bureaucracy, and reduce the degree to which management is actively involved in decisions and operations. To avoid these risks, the agency should minimize multiple reporting layers within the agency.
- **Carefully select an agency director with the style and temperament needed to implement programs and achieve strategic goals in collaboration with internal and external stakeholders.** Additional detail is provided on desired characteristics of an agency director in the “Implementation Steps” section.

Many stakeholders were also concerned that the agency structure would diminish a Departments’ voice with the Board of Supervisors. This does not need to and should not be the case under an agency model. It was commonly assumed that the Department heads currently report directly to the Board, rather than to the County Chief Executive Officer and, until very recently, to the Deputy Chief Executive Officer for the Health Cluster who then reported to the County CEO.⁵⁸ Despite this lack of a direct reporting relationship to the Board, all three Departments have frequent and direct communications with individual Board offices and the Supervisors themselves. This open communication reflects both the importance of health-related issues in the County and also the ability of Department personnel to develop strong relationships with Board offices. Despite strong Department-Board communication, some felt that the Deputy CEOs and CEO hampered those open lines of communication with the Board and that the communications would have been more robust had there been a direct reporting relationship to the Board, while maintaining and respecting Brown Act requirements.

Often individual units, facilities, or programs within each Department also enjoy similar relationships with Board offices without communications being funneled through the Department head. It would be neither feasible nor productive for a Department head to interfere with those relationships; a similar fact holds true for an agency director. Access to the Board is not solely a reflection of one’s position and reporting structure. Open and direct lines of communication are a reflection of relationships built over time, the Board’s level of trust and confidence with the involved staff, and the importance of the issues at hand. As one concrete way to support and encourage continuation of direct lines of communication between Department heads and the Board, the Board could request regular public hearings on progress in implementing the agency in which Department directors, and not just the agency director, are requested to speak before the Board. Additionally, if an agency is created, the Board should openly encourage Department heads to discuss in private and publicly testify before the Board on issues within their Department that are of importance to the County, particularly those areas not currently being prioritized as a focus for the agency. Finally, it should be noted that constituents would still have the same access to the Board under an agency as they do under the current County structure. Members of the public, including clients/consumers/patients, family members, contracted agencies/providers, organized labor, and others should be encouraged to approach Board offices with their concerns and expectations under any organizational structure.

⁵⁸ The Deputy CEO/cluster lead position was functionally removed from the County CEO structure in December 2014.

Risk that an agency may require financial investment for administrative positions

A number of stakeholders felt that if an agency is created, the actual cost and budget of the agency and the way in which these funding needs would be met should be identified in advance, based on an expectation that the agency's administrative structure would need resources to be effective. The degree to which an agency would require funding for administrative positions would depend to a large extent on the structure of the agency. A large central agency with multiple new administrative positions and layers would both increase bureaucracy (see section above) and increase costs to the County with concerns that these costs would be covered by cutting services for already underserved communities.

If approved, a health agency can be designed in a way to minimize new costs. First, integration of administrative units should proceed only if such moves are cost-neutral or cost-saving. Second, care should be taken in adding leadership positions to the agency level. One economical approach to agency management would involve creation of a lean structure in which a handful of individuals would support coordination and strategic direction. This could be accomplished by either adding a small number of new personnel items to the agency⁵⁹ to reside at the agency level or by identifying individuals who would perform dual roles that are complementary of current assignments to help lead integration activities in a specific field (e.g., IT, finance). The benefit of the dual-role model would be to minimize administrative costs and build off of the strength and experience of each Department and its personnel. However, several stakeholders criticized it as unrealistic or likely to compromise the agency's ability to make progress in achieving service integration goals given people's inability to take on both roles. Further, this structure was thought likely to erode Departments' ability to meet their existing commitments or result in an agency disproportionately staffed with people from one Department. They viewed an agency-level role as being a full-time job even if there were sizeable synergies with the person's Department-level role. They also thought that this model would prove ineffective and that, over time, the agency would need to ask for additional funding from the County or would need to take funding from the Departments' individual budgets to fund agency functions. One suggestion for making this model more feasible included having the assignments to dual-roles be time-limited and/or rotating but, even with this suggestion, a number of stakeholders opposed the concept.

Regardless of whether they are selected from within Departments to serve in a dual-role or are brought onto new positions, individuals filling positions within an agency should be selected because they have the appropriate mix of experience, expertise, broad knowledge of work in the three Departments, professional strengths, and leadership style to be effective in a strategic/coordinating role. If new positions are added to create the agency, new County funding should be allocated in a transparent manner and should be subject to Board approval.

Risk that Departments may lose focus on the full breadth of their current missions

DHS, DMH, and DPH have distinct missions. They each employ a different mix of activities in pursuit of their mission, including those related to policy development/advocacy, regulatory functions, population health programs, and direct clinical services. A health agency would naturally focus on those areas where there is synergy in working more closely together and would not focus on those areas where there is no benefit from greater collaboration. Stakeholders raised concerns that in doing so, the time, energy, and resources of each Department may be shifted away from critical activities that are not the focus of the agency. An agency that focused only on the area of overlap between the three Departments, to the neglect of initiatives and priorities with other County departments, would be "an epic failure," as one stakeholder put it. These concerns exist on a number of levels and would need to be handled carefully under an agency structure.

⁵⁹ This could be accomplished in budget neutral manner by using available items, adding and deleting items, or filling unlike items; alternatively, it could be accomplished through new financial investment by the County.

- **Impact on constituent base of each Department:** Beyond specific programs, population health stakeholders called attention to the different scope of the three Departments with DPH's mission encompassing all ten million LA County residents rather than any single subset. DPH's responsibility in population health extends beyond the subset of individuals that are receiving care in DHS' or DMH's delivery system. If too closely aligned with either Department, DPH may be distracted from its broader mission or may create an impression that it will support DHS or DMH in achieving population health goals more than it supports other healthcare delivery systems in the County. Stakeholders questioned whether DPH would be able to practically continue programs serving all LA County residents rather than those who use DHS and/or DMH for clinical care. They saw this as a major reason to question whether there were sufficient benefits to public health in joining the agency. "I understand the clinical problem we are trying to solve for DMH and DHS, and perhaps for the personal care side of DPH. Services at the point of care operate in isolation, are inefficient, impossible to navigate, and leave crater-sized cracks for people to fall into. I don't, however, see the problem we are solving in bringing population health along for the ride."
- **Impact on roles and programs not involved in integration efforts:** An agency risks de-prioritizing areas that are not natural areas for interdepartmental integration such as DPH's work on restaurant inspections, childhood lead poisoning programs, etc.
- **Impact on collaboration with other County Departments:** DHS, DMH, and DPH work collaboratively with other non-health County departments on a variety of issues. Stakeholders questioned whether this high degree of interaction and collaboration would take a backseat to integration efforts that focus solely on DHS, DMH, and DPH. As an example, mental health staff mentioned that the vast majority of DMH's work that crossed over with other County departments did not involve either DHS or DPH, specifically citing programs involving the Probation Department, Sheriff's Department, DCF, DPSS, and CSS. DHS and DPH both are similarly involved in a number of collaborative activities with other County departments.
- **Impact on contracted providers and agencies:** Stakeholders questioned whether a health agency would focus disproportionately on directly-operated clinics at the expense of community agency partners. The Departments provide a different mix of services through contracted provider arrangements. While the agency would be comprehensively responsible for all services provided, regardless of whether they are directly operated or contracted out, many individuals and private provider groups felt there may be tendency to favor the needs of directly-operated sites.

The risk of narrowed focus depends in large part on who is selected to be the agency director. An agency has a greater risk of narrowing the focus of each Department if the individual selected to lead the agency does not have robust experience, knowledge, and appreciation of the issues central to each Department. An individual with experience in only one area may be most likely to focus efforts within an agency on those areas where he/she is most comfortable. The success of other local governments that utilize an agency structure but still have strong component departments was often attributed to the credentials of the agency director. For example, the New York City Department of Health and Mental Hygiene which operates as a merged Department combining mental health and public health, was noted by some stakeholders to be as strong as it is in part because of the national prominence of its prior Commissioner in the field of public health. Several stakeholders commented that an open, competitive process for selecting the agency director would help to ensure the County appoints the person best suited for the position. An agency should not be developed for one person's talents and charisma.

Implementation of an agency structure, in which the three Departments maintain Department status, helps to mitigate the above concerns, as opposed to a structure in which two Departments move under a third and lose their department status.

As Departments, DHS, DMH, and DPH would be expected to fulfill the entirety of their mission, establish strategic priorities and goals to accomplish that mission, and set budgets accordingly. The agency would help to ensure that goals affecting the entire County are prioritized alongside these activities, but not in place of them.

While most stakeholders expressed concern that the agency may limit the scope of each Department, some held the opposite opinion. They felt that, rather than hampering efforts to achieve Department-specific goals, an agency could help Departments focus additional time and energy on the areas that are uniquely theirs. Adding new energy and perspectives to tough, long-standing County problems related to health integration could free up time within Departments to focus on their unique scope of services.

Risk that cultural differences may compromise integration efforts

Naturally, the three separate Departments have three distinct cultures, though often there is a diversity of cultures within each Department as well. The culture of each Department is apparent in everything from its organizational structure, how administrative tasks such as HR and contracting are performed, approaches to collaboration and decision-making, the degree of centralization vs. regionalization, and methods for ensuring the cultural fit of their services and programmatic mix. Cultural differences are not limited to only County or contract staff; they also apply to differences in the ways in which services are designed and provided to clients/consumers/patients and the way in which individuals receiving services interact with the system. These characteristics are an important part of what has led to the successes of each Department.

Often, stakeholder sessions revealed that those working both inside and outside the County have much to learn about the culture and strengths of each Department, often relaying perspectives of other Departments that were based on a single experience or on historical reputation. Fear of the unknown and of how the agency would engage with clients/consumers/patients and external community partners also emerged as a strong driver of concerns over cultural friction. “I’m afraid the agency won’t give us a voice in the way that this Department does. The leadership here listens to and values our concerns.” “I worry the other Departments don’t work collaboratively with communities of color.” “The voice of the family and consumer is not strong even here; I fear it will get worse in an agency.”

The proposed agency model is explicitly not a merger. Unlike a merger, creation of an agency would maintain the Department structure and many core administrative functions as they currently exist. Given this fundamentally different structure, lessons drawn from mergers and acquisitions may not apply to an agency. Still, if created, an agency would seek to accelerate the rate of integration and, in doing so, differences in Departmental practices and norms may result in staff tension and friction. This is a natural tendency and will occur under any structural model, agency or otherwise, that is able to promote and support integration. Still, it will be critical for such differences and tensions to be openly and proactively addressed, rather than leaving them to languish and risk compromising integration efforts over the long-term.

The cultural differences between DHS, DMH and DPH should not be underestimated, but should also not be considered an insurmountable barrier. It is in part because of the differences between the Departments that there is so much benefit from greater integration and collaboration. One of the greatest challenges but also richest opportunities of any integration effort will be to promote integration while maintaining the positive attributes of each Department’s culture, building understanding of others’ strengths, and supporting the development of new sub-cultures so that staff can be fully engaged in integration activities. Cultural friction may arise and must be addressed. Cultural differences must be respected but can also be identified and leveraged to increase the capacity for integrated action. “By really looking at the differences between the Departments, the County may fuel the creation of a wider range of services and programs.”

Some stakeholders pointed to challenges in the creation of the Department of Homeland Security in 2002 as a potentially relevant case study regarding how to address cultural tension. Its creation represented the largest restructuring of the federal government, bringing together under one Department twenty-two different agencies that were formerly subordinate to eight different federal departments. Since that time, the Department of Homeland Security has faced a large number of departures from high-level staff blamed on clashing departmental cultures, an increase in lucrative private sector security jobs, and a high degree of pressure from elected officials and the media. To address the culture-related portion of these challenges, the Homeland Security Advisory Council's Homeland Security Culture Task Force generated a set of specific recommendations.⁶⁰ They noted the importance of clearly defining the new Department's role in establishing the vision, policies, strategies, and performance objectives needed to protect the United States, facilitating coordination between units, and empowering divisions to execute their respective goals rather than having primarily an operational role that duplicated the focus of the component organizations. The report suggested several steps to reduce cultural friction, including the need to build trust between component parts over time, to strive for a "blended" rather than single organizational culture that retains the strength of each and identifies with the shared mission, ethic, and vision of the agency, the importance of empowering front-line staff, and the need to be a good partner to external organizations through communication and collaboration. These recommendations are equally applicable to an LA County health agency or other structural model put in place.

Risk of medicalization of community-based mental health

The community mental health system as led by DMH is rooted in a recovery-based model of care among adults that emphasizes personal empowerment and resilience, social support, community connectedness, wellness, and the pursuit of hope and meaning in one's life as a means of reaching one's potential in life, and a resiliency-based model of care for children emphasizing integrated services, family and community involvement, etc. This is in comparison to a medical approach to mental illness that defined the field in previous decades, relying on diagnosis of disease, identification and treatment of symptoms and signs, and heavy use of medication and diagnostic testing. The recovery model is rightfully favored by mental health providers, clients, and advocates, many of whom fear that closer integration with DHS in particular will result in a shift away from recovery toward medicalization of mental health treatment. For the many individuals who have experienced first-hand the benefits of a recovery approach, and for the providers and advocates who serve them, this is a frightening possibility.

While the term "recovery" is not widely used in the physical health realm, the concepts underlying the model are not foreign to many physical health providers. Many clinicians acknowledge the failure of the medical model to address the root issues affecting their patient's health and life, particularly among low-income and other vulnerable populations, and believe in an approach that emphasizes individual empowerment, provision of culturally and linguistically competent care, and social determinants of disease. Issues of poverty, homelessness, unemployment, community violence, lack of access to healthy food and parks, social and spiritual isolation, and lack of purpose are large drivers of symptoms that land individuals in emergency departments and outpatient clinics and must be addressed. Despite this recognition in the physical health community, particularly among safety net providers, many physical health providers still manage patients first in the medical framework, and then address social, psychosocial, and environmental factors when medical interventions do not yield the expected result. They often order diagnostic tests to rule out unlikely but potentially dangerous diagnoses when more obvious social or environmental causes are left unaddressed. They often prescribe medications to treat the first sign of disease, without attention to the patient's other needs or willingness to engage in their own recovery. They often

⁶⁰ Homeland Security Advisory Council, (2007). "Report on the Homeland Security Culture Task Force." Accessed March 23, 2015 at: http://www.dhs.gov/xlibrary/assets/hsac_ctfreport_200701.pdf

manage individuals with chronic diseases with narrow attention to medications and laboratory values rather than emphasizing coping mechanisms and social supports.

There is much that the physical health community can learn from the mental health community about empowerment, hope, wellness, and recovery. In the best of worlds, this exchange of information would be facilitated through education about recovery, integration of recovery models into primary care and even emergency or specialty care settings. But while this learning is happening, it will be important to ensure that the physical health world's reliance on medicalization doesn't seep inappropriately into the community mental health model of care. To help prevent this from happening, clinical leadership should remain separate between DHS, DMH, and DPH and the agency should maintain strong roles for external coalitions and groups that emphasize recovery models. Staff and others well-versed in the recovery and/or resiliency models should play a key role in the design of integrated care models, so that the principles and concrete elements of these philosophies can be built into the fabric of service enhancement and expansion.

Risk of disrupting existing service models and the staffing structures and partnerships they rely on

Many stakeholders were concerned that agency leadership would establish different expectations for engagement with external partners and contractors with adverse effects on the individuals who benefit from these services and the providers/partners who appreciate the structure and tenor of current County relationships. Stakeholders voiced anxiety about how and where individuals would access care, fearing that individuals would be forced to change where they receive services, disrupting delicate and long-standing therapeutic relationships. They feared that any changes made would not be clearly communicated to the public. In particular, contracted providers doubted that a new agency director would be as supportive of existing external relationships and contract terms as the current Department leadership. Questions posed by external stakeholders focused both on whether or not services would be cut but also whether or not contracts would be changed even if service levels were held constant. In one exchange with a contracted provider: Provider: "Are there going to be reductions to service contracts?" CEO staff: "No, service levels will be maintained." Provider: "I don't mean if services in general will be maintained. I mean are you going to cut *my* contract for providing those services." On a few occasions, stakeholders compared the agency to the roll-out of the State's Coordinated Care Initiative, anxious over whether or not the agency would continue to keep them "in network" with implications for both provider reimbursement and continuity of care.

This issue is not reserved for contracted direct service providers. Similar sentiments were shared by private organizations that provide non-patient/client care services (e.g., family support, administrative support, and ancillary services). "Some bureaucrat I've never met is going to say 'we don't need [organization] anymore'." In some cases, the feedback is connected to specific individuals. "My organization has a great relationship with [Department leader]; I don't want things to change once the buck doesn't stop there."

Similar to the note regarding cultural friction above, these sentiments are not specific to an agency model; they would be equally relevant to any new/evolving leadership, organizational structure, or process through which the County might foster integration and change. If established, the agency can reduce this level of anxiety by establishing relationships with external partners, clearly communicating the agency's priorities and commitment to not disrupt existing services that are serving individuals well. When changes are considered, they should be done in an open and transparent manner, fully engaging external partners throughout the process.

While many stakeholders expressed concerns about how their role might be reduced, others saw the agency as an opportunity to expand their reach, helping to forge new connections with populations that could use their services or with

Departments who should be aware of their capabilities and programs. While some external organizations have well-established relationships with two or three Departments, many have very strong ties to only one, despite offering services that could benefit a broader set of individuals. Examples include community clinics able, or potentially able, to offer primary care, mental health, and substance abuse services; family support organizations; and consumer advocacy groups. Time spent building relationships, developing partnerships, and forging strategic alliances could help to bridge these gaps, benefiting the individuals served and the external entity through increased reach.

Risk agency planning may detract from the work of integration

Many individuals describe an atmosphere of distrust and suspicion of the process for evaluating the agency model and its goals, particularly given the absence of a stakeholder process before the item was brought for discussion by the Board. Some questioned whether or not an agency could recover, begin to build trust with these stakeholders, and focus time and attention on the work to be done. If efforts are not taken to ameliorate this distrust and fear, they could complicate the real work of the agency in integrating care. Given this, if implemented, it will be important for the agency director and other Department leadership to have the necessary skills, experience, and temperament to build trust-based relationships with stakeholders over time.

Additionally, some stakeholders raised the practical concern that focus on planning an agency would distract from the real work of integration that should be the primary focus for the Departments. One stakeholder commented: "Let the Board's answer be a simple yes or no; a lukewarm 'let's study it for a while' would be a terrible waste of everyone's time." Others felt a long planning period was necessary before the County "jumped into something it didn't want." "We've been married before and it didn't work; we should spend more than 60 days deciding if we want to get married again." If an agency is created, there is also concern about how the process of designing and establishing the agency will affect services. They described being fearful that energy would be spent investigating the feasibility and return on investment from various administrative restructures (e.g., HR, finance), rather than focusing on service-oriented initiatives. "The process of building an agency is a distraction from the real work; it could be a transitional quagmire lasting years."

Certainly the real work of an agency is in integrating services by establishing and achieving shared goals. The goal is not the creation of a complex organizational structure. This is an additional reason, beyond the concerns of bureaucracy noted above, why the agency should be structured in a lean and simple manner and why functions should only be moved to the agency level if there is a clear value-add of doing so. If executed in this way, design and implementation of the agency structure itself would be minimal so that staff may focus on the real work of integration.

Proposed Structure

As requested in the January 13th Board motion, this section describes an initial potential structure for a health agency that could be implemented if the Board chooses to proceed with the agency's creation.

Before discussing specific responsibilities that could be placed within an agency, it is helpful to note the approach taken with stakeholder recommendations to revise the location of programmatic divisions within and between Departments. Stakeholders volunteered several suggestions about shifts or "trades" in the placement of specific programmatic divisions that they thought should be made simultaneously with the creation of an agency. Some of the more commonly raised examples include: a) moving Emergency Medical Services from DHS to DPH, b) moving personal health services such as TB control, immunization clinics, and STD services from DPH to DHS, c) moving prevention and early intervention activities from DMH to DPH, and most commonly, d) moving substance abuse control (with or without the prevention component of SAPC) to DMH, DHS, or allowing it to have its own new Department "on equal footing" with DMH and DHS. Shifts of this nature are more operationally and organizationally complicated than the creation of an agency itself, given the impact on administrative support functions (e.g., HR, finance, IT) and the resulting separation from other clinical initiatives within the home department. As a result, this report recommends that if an agency is created, all Department programmatic divisions should be kept at least initially where they currently reside. Over time, agency and Department leadership should carefully assess the benefits and risks of these or other possible shifts and make adjustments where appropriate.

Placement of specific responsibilities and functions within a health agency

One defining role of an agency is that it can host certain administrative functions as a means of helping to streamline operations and reduce duplication. Programmatic and service delivery functions should not be moved to the agency level; they should be retained within the Departments with the agency working to coordinate and align strategy and operational implementations. Re-location and integration of administrative functions isn't the primary goal of an agency but such shifts can be an important catalyst for service integration, if done correctly, and can help to enhance operational efficiency and reduce costs over time. If done indiscriminately, however, such moves can be disruptive and harmful to ongoing Departmental activities. In considering whether and when an agency might place specific administrative functions at an agency level, several points emerged: the need to progress slowly, avoid duplication, stay lean, and respect Departmental expertise and culture.

Progress slowly: One benefit of an agency is its ability to streamline administrative functions, reduce duplication, and dedicate more funds to services of direct benefit to individuals and populations. While the possibility for efficiencies and cost-savings exist, these are long-term opportunities that must be carefully considered and planned for in order to avoid disrupting ongoing operations and services that rely on these support functions. Rather than rushing into a series of potentially disruptive changes, functions should only be moved when there is a clear strategic or operational advantage, economy of scale/efficiency to be gained, or when circumstances arise that present opportunities for change (e.g., personnel changes). Even when the possibility of savings exists, functions should only be moved to an agency level when there is demonstrable evidence that doing so will create a value-add in terms of improving service levels, enhancing departmental operations, and achieving economies of scale. Organizations are fluid; they need to be allowed to evolve over time based on the opportunities and challenges of the moment. As one stakeholder commented, "the natural inclination would be to move things right away in order to save money but this would be very disruptive. These shifts, if done right, would take years."

Avoid duplication: To avoid redundancy and bureaucracy, and to ensure that an agency either decreases administrative costs or is cost-neutral, an agency should be careful not to duplicate units or functions. Using HR as an example, it would not be wise to have each Department retain a full HR unit and also create an HR unit at the agency level. This would raise costs and increase the number of steps required to accomplish tasks within the County, ultimately leading to delays in downstream services and programs.

Stay lean: In order to keep costs and bureaucracy low, it is best to structure the agency as a lean body. A lean agency would imply very few management-level positions and could involve the use of strategic leads in different functional areas (e.g., IT, finance) in which a single individual is appointed to take on a strategic role at the agency level. These strategic leads would have a matrix reporting line with the corresponding Departmental lead for specific areas. These strategic leads must understand the functions and operational frameworks of each Department to ensure that the agency-level strategy takes into account the unique needs and requirements of each Department while advancing a cohesive vision to support agency objectives. It is possible to achieve these positions in a cost-neutral manner as described in the “Risks” section above. If, over time, certain functions move to the agency level, this would obviously increase the number of staff reporting to the agency (vs. the Departments). However units would only be moved to the agency when there is a clear value-add in terms of Departmental operations and if doing so would yield net financial savings.

In some cases, rather than appointing a specific individual to coordinate work on a topic at the agency level, a particular unit or team could be designated as the lead for the agency for those areas while remaining within their Department. In this center of excellence model, divisions with particular expertise on a given topic could support other Departments without having to relocate to the agency. As examples, DPH may be well-suited to provide a leadership role for the agency in grants solicitation, accounting, and fiscal management or employee wellness; DMH in providing instruction on use of the recovery model in clinical practice; and DHS in revenue maximization.

Respect Departmental expertise and culture: Small differences can have big impact on operations and on an organization’s culture and strength. Moving functions to an agency level without attention to these nuances could compromise critical technical functions by reducing content knowledge of the division. The risks of moving the finance unit from the Division of HIV and STD Programs to an agency finance unit is one example raised given the specialized knowledge and expertise required to perform Ryan White-related finance services. These moves could also weaken the overall fabric of an organization if such a unit were a core part of the Department’s identity. Some stakeholders raised concern that if DMH’s family/advocacy unit were moved to an agency level, in an effort to spread best practices to both DHS and DPH, that DMH would lose connection with a unit critical to its core identity.

With these guidelines in mind, below are the CEO’s recommendations on the placement of specific functions and roles at the agency level. Prior to decisions regarding these moves being finalized and executed, the agency and Departments should spend a reasonable period of time in a focused planning phase, working out operational and implementation details.

Recommendations for creation and/or reassignment of units (in full or in part) to an agency level

1. **Data/planning group:** The agency model may facilitate the sharing of certain data and information for care and treatment purposes as well as for statistical analysis and planning. As to care and treatment purposes, it should be noted that each Department currently maintains separate privacy practices as well as authorizations for the release of information and consent forms. Even within Departments, these may be replicated or refined at a division or facility level. Thus, the County system of care currently is a complex and sometimes overlapping process and often does not engender an environment conducive to coordinated care.

To address these needs, the agency should create a small data/planning unit made up of individuals reassigned from each Department (and/or acting in a Department liaison role) that would have responsibility for performing

analyses needed for planning and program design activities. Examples of specific roles would include: performing data matches in a manner that preserves information privacy and security, leading agency-wide data governance activities, developing business intelligence functions including development of performance metrics and indicators, performing geographic analyses, leveraging available data and analytic resources, and assisting in the data-based design of programmatic initiatives, such as high-utilizer programs and coordinated case management functions.

In developing this report, County Counsel was asked to explore the feasibility and legal issues related to this concept. Regarding improvement of information management for care and treatment purposes, Counsel concluded that the agency model would facilitate the Departments in adopting joint privacy practices and a universal authorization for the release of information. Counsel surveyed the agency models used in other jurisdictions and learned that they have a wide array of authorizations and consents to enable the sharing of client- or patient-specific information. Likewise, they have privacy practices that are implemented at the agency level so that they encompass all departments that comprise the agency. Counsel does not foresee significant legal obstacles to establishing similar policies and procedures in LA County. The agency must be cognizant that federal and State laws still provide heightened protections for certain information, such as that pertaining to substance abuse, mental health and STDs and, as a result, the agency will require authorization from the individual to share this sensitive information. However, several other counties that have moved to an agency model have followed this protocol, facilitating improved care coordination for individuals served by multiple departments.

As to information sharing at the agency level for statistical or planning purposes, an agency unit would be akin to the function currently implemented by the Service Integration Branch (SIB) of the CEO to support multiple County departments. Essentially, the agency would be interchangeable legally with the CEO's SIB in this arrangement. While DHS, DMH and DPH would still participate in SIB activities as needed for relationships with non-health departments, they would separately engage in data sharing projects at the agency level.

2. **Capital projects and space planning group:** As described in greater detail above, one advantage of an agency is the ability to better coordinate and plan use of County-owned and leased properties. Each Department has a unique inventory of facilities but also has several unmet needs including deferred maintenance issues, aging infrastructure, greater geographic access for clinical services, suboptimal floorplans and locations for current operations/services, etc. By having the agency take on a role in overall space planning, including management of capital projects, the County would be better positioned to create economies of scale, reduce cost, and improve the degree to which County-owned and leased buildings meet the needs of each Department as long as these activities replace rather than duplicate similar activities undertaken currently by CEO. In this structure, staff shifted from the Departments to the agency would still need to be dedicated to Department-specific projects. This function would not include actual facility management. These activities should remain in the Departments, closely aligned with clinical programs.
3. **Government affairs:** To ensure alignment in the County's policies on certain issues and create a stronger advocacy arm for health-related issues, the agency should have a unit dedicated to government and legislative affairs. This unit would not replace the policy units within each Department nor would it replace the role of Intergovernmental Relations in the CEO. Rather, it would be responsible for developing and/or consolidating, supporting, and advocating for positions that would be of benefit to any or all of the involved Departments. Positions recommended to the government entities would continue to be developed based on analyses and input from subject matter experts within each Department.

4. **Consumer affairs/advocacy/ombudsman:** Navigating the services provided in each of the three Departments can be challenging. A central unit could help individuals and external entities access services, find clear answers to questions that are not Department-specific, and facilitate open dialog with individuals and community stakeholders. This unit would be in addition to the existing consumer affairs/advocacy/ombudsman units that each Department currently operates; these Department units should continue operating. As suggested by Neighborhood Legal Services of Los Angeles County (NLSLA), such a program could also hold the following responsibilities with respect to consumer advocacy:⁶¹
- Enumerate the powers of the agency to investigate and resolve consumer complaints at both the intra- and inter-departmental level and ensure consistent handling of issues.
 - Hold the agency accountable for tracking and reporting the incidence and outcomes of consumer complaints.
 - Specify a timeline for investigation and resolution of complaints.
 - Ensure that client/consumer/patient protection organizations are able to work collaboratively with the agency to advocate on behalf of their clients and can escalate concerns when needed.

Several stakeholders also suggested that there would be substantial value to the County if the agency also had a specialized unit focused on workforce training. The goal of this unit would be to foster staff engagement and development and to promote a culture of continuous improvement well-versed in models of care that support service integration. The unit would help design and implement education and training on, for example, new care models and practices, techniques to identify and solve problems, consumer engagement, and cultural competency. Further discussions should be had among Departmental leadership to assess whether there is support for creation of this or similarly-focused units at the agency level and how such units would be staffed and structured given the different ways in which these functions are currently fulfilled in each Department.

A number of stakeholders specifically recommended that IT be immediately moved to the agency level as a shared function. While such a move might result in better aligned strategy, coordinated activities, and economies of scale with respect to IT support, etc., there are also sizeable risks of such a move. First is the concern that the agency would divert time and energy away from critical Public Health IT needs including those of Environmental Health, Disease Surveillance and Control and Emergency Preparedness and Response. Second is the concern that IT staff would be devoted to the implementation of the agency structure rather than the achievement of the desired clinical or operational objectives. Clinical service integration objectives may best be met by having IT entirely at the agency level over the longer-term, but progress can still be made by appointing an individual to be responsible for ensuring the strategic alignment of IT initiatives in each Department. For this reason, IT is included below as a strategy role and is not recommended to be completely shifted to the agency.

Over time, the Departments and agency should continue to examine whether a particular function would be best positioned at an agency rather than a Department level.

Recommendations for strategic roles within the agency, each filled by a single individual

It would not be prudent to immediately move most core administrative functions from the Departments to the agency level. Still it would be advantageous for the agency to be able to coordinate and align policy, strategy, and operations in key areas. The purpose of agency strategy roles is to help facilitate synergistic and coordinated strategic and operational decisions. Individuals in these roles could serve as a dotted-line supervisor for each Department's lead on a specific content area in a matrix reporting structure. The positions listed below would each be filled by a single individual. These positions

⁶¹ Adapted from NLSLA's letter providing comments on the draft document; full letter available in Appendix VII.

are not primarily operational in nature, but will have a strong role in helping to align operational activities in each Department and remove obstacles that may impede success on particular initiatives. Single individuals are recommended by the CEO to fill strategic roles at the agency level in the following areas:

1. **IT strategy:** While each Department should maintain responsibility for their own IT operations, it will be critical for the agency to align IT strategy and prioritize certain IT initiatives if it is to make progress integrating services. A single individual at the agency level focused on IT strategy would ensure decisions made are complementary or at least not antagonistic, would identify opportunities to leverage economies of scale, and would help to support priority service integration goals, while making sure Department-specific projects are not compromised.
2. **Revenue maximization:** All three Departments could benefit from having a single individual whose role is to understand the revenue streams within each Department and recognize opportunities to draw down additional State or federal funds. Part of this individual's responsibility would also be to clearly communicate the sources and uses of different revenue streams as a means of increasing confidence that the agency is preserving the intended use of different funds.
3. **Service contracting and procurement strategy:** Movement of contracting and purchasing functions to the agency level would risk severing a critical link between contract development and program business owners and is not recommended in this report. However, there are opportunities to better align contracting/purchasing strategy, such as through improved coordination on use of master agreements, RFP development, contract monitoring tools and protocols, etc. An individual serving as the strategic lead for contracting and procurement could help to capture these or other opportunities without risking significant disruption to these core functions.
4. **Human Resource (HR) /Employee Relations (ER) strategy:** Without detracting from the role of the CEO and DHR with respect to HR and ER functions, there would be advantages to having a single individual focused on HR/ER issues at the agency level, especially if they are focused on highly specialized content areas unique to health-related fields or the needs of certain health programs shared by the three Departments but not generally shared by those outside of DHS, DMH, and DPH.

One additional central strategy role that could be considered by the agency over time is a role coordinating managed care strategy. As each Department further develops its health plan and managed care relationships, it will be increasingly important for the agency to have a holistic view of the scope of activity and contracts being developed. A managed care lead could also identify and help implement joint contracting approaches as opportunities arise.

Beyond the recommendations above, the HR workgroup chaired by DHR further recommended that a Chief Strategic Officer position be created at the agency level to oversee agency-level individuals and help achieve the strategic/operational objectives of the agency. While this recommendation is in line with the structure of many County departments, it would be preferable to defer a decision about a Chief Strategic Officer position, or other deputy-level agency positions, to the permanent agency director once he/she is selected by the Board.

In summary, the proposed agency structure would include the following specific individuals/units reporting directly to an agency director:

- **Three Department heads:** Directors of DHS, DMH, and DPH.
- **Four agency-level units:** Data/planning, capital projects/space use, government affairs, and consumer affairs/advocacy/ombudsman. To be clear, this report recommends that core administrative functions including IT, finance, HR, contracting, purchasing, etc., all remain in their current Department location and should not be duplicated with an equivalent agency-level unit.

- ***Four individuals serving in a strategy/coordinating role in the following areas:*** IT, revenue maximization, service contracting and procurement, and HR/ER.

The role of the Health Officer

The Health Officer plays a critical role in a County health system and has specific statutory roles and responsibilities. It is critical that the County ensure the Health Officer is able to take immediate and necessary action, even if such action conflicts with the views of the DPH Director⁶² and/or agency director, can act autonomously from the agency director and his/her staff, and is strategically positioned to work collaboratively with each Department. The Health Officer will continue to be an unclassified position within DPH and will continue to hold all current responsibilities, including the responsibility to lead a County-wide disaster coordination and response effort, issuing orders to the general public and to health care facilities, etc. To preserve the autonomy and public accountability of the role, the Health Officer should also have a dotted reporting line directly to the Board of Supervisors.

⁶² In the case that the Health Officer is not held simultaneously by the DPH Director.

Possible Implementation Steps and Timeframe for Achievement of an Agency

The January 13th Board motion included a directive to report back on “possible implementation steps” with respect to creating a health agency. While the Board must first decide whether or not to move forward with creation of an agency, if it does wish to proceed, the following steps are recommended. These steps are those required from a legal/technical perspective, particularly as it relates to amendment of the County ordinance, and strategic/operational steps that, while not legally required, are recommended for consideration by the Board.

Several stakeholders, including the Mental Health Commission and Public Health Commission, have developed planning and/or integration principles to guide discussions and development of a new organizational structure. Many of these principles are relevant for a discussion of agency implementation and are included in Appendix VI.

Legal and technical steps required to create an agency

Currently, the three Departments are each created under separate ordinances contained in Title 2 of the Los Angeles County Code. Nothing in those ordinances is inconsistent with creation of an agency. The County's Charter requires the Board to provide by ordinance for the creation of offices not required by law. Therefore, at the Board's discretion, it could adopt an ordinance formally approving the creation of the agency. Such action is within the Board's authority under the police powers granted by the California Constitution. The agency ordinance would bring those separate Department ordinances under the umbrella of the agency structure by reference, with reporting lines from the Department heads to the agency director built into the agency ordinance. The position and authority of the agency director also would be created and defined in the agency ordinance itself. The authority of the Board to appoint the agency director, as it does for the directors of DHS, DMH and DPH, would also be part of the agency ordinance as provided in the County's Charter. The agency director position may be filled by any individual inside or outside the County as the Board chooses.

If necessary, the ordinance will also amend discrete provisions contained in each Department's ordinance if roles under the agency structure need to be clarified or modified. To the extent salaries or job titles must be modified to implement the agency, certain provisions of Title 6 may also require amendments. This could be accomplished using the ordinance that creates the agency and its director. These amendments can also be made over time as the agency structure evolves.

As with the majority of ordinances, the agency ordinance must have two readings at a Board meeting. The agency ordinance would be placed on the agenda for introduction, then return for adoption at a later meeting, which is typically the following week. The agency ordinance would then take effect thirty days after adoption. The agency ordinance must be effective before the agency structure can formally exist. Should the Board wish to direct County Counsel to prepare an ordinance to create the agency, that work could be completed within sixty days of the Board's direction to do so.

Strategic/operational steps related to implementation of an agency

Organizational change of any kind can be challenging and must be carefully implemented and managed. If an agency is created, steps should be taken to restore stakeholder trust in an ongoing and transparent public process and reduce the possible risks of an agency. As some stakeholders put it, “we love the concept; the devil is in the details of its execution.”

Appoint an agency director with the necessary skill and temperament to be successful

Stakeholders raised a number of concerns about who would be selected as an agency director. Several individuals and groups inquired about the process the Board of Supervisors would use in appointing an individual to lead an agency, particularly preferring that the Board choose to appoint an interim director while the County conducts a formal, open, competitive search for a permanent director. Several stakeholders stated a preference that a Department head not be permitted to concurrently serve as the agency director. Finally, others suggested that the agency director position should be filled by each Department head on a rotating basis (e.g., for two years each).

Stakeholders additionally weighed in on qualities they would want to see in an agency director. Some of the characteristics mentioned by stakeholders include the following:

- Possesses relevant background and professional experience in physical health, mental health, public health, and substance abuse, including development and implementation of integrated programs across all areas. Of note, several individuals commented that, of the three, a background in public health is the most important because of the breadth of its mandate and because of a desire to see public health exert greater influence over the clinical delivery system given the evolution of morbidity and mortality and the importance of focusing on social determinants. As one of stakeholder put it, “all of what an agency does is really public health at some level.”
- Highly values active and ongoing stakeholder participation and community engagement and commits to continued dialog regarding the design, implementation, and ongoing monitoring of integration activities. This includes supporting an active partnership with clients/consumers/patients, organized labor, contracted agencies/providers, the faith-based community, and others. Specifically,
 - The individual should embrace the concept of “nothing about us without us” referring to the empowerment and meaningful partnership with clients/consumers/patients in all aspects of the planning and implementation of programs and services.
 - The individual must highly value labor-management collaboration and the involvement of front-line workers in programmatic reform and continuous performance improvement.
 - The individual must embrace existing relationships with contracted agencies/providers, actively partnering with them to learn from successful programs already in place in community-based sites and to continuously improve services and programs County-wide.
- Explicitly supports robust, direct communication between Departments and the Board of Supervisors.
- Employs a collaborative, consensus-building leadership style that empowers staff, values transparency, and seeks to build trust-based relationships with staff, contractors, and external stakeholders.
- Views health and wellness in its most comprehensive sense, taking into account an individual’s physical, mental, social, and spiritual health, and the multiple environmental, occupational, and socio-economic factors that affect it, and embraces an inclusive perspective of the breadth of clinical, non-clinical, and recovery-based interventions that are needed to optimize health.
- Has a strong concern for the needs of vulnerable groups, un-served, underserved, and inappropriately served individuals, and a commitment to reducing health disparities among specific populations (e.g., ethnic/racial groups, LGBTQ, children, and others) by developing programs and services in partnership with local communities in a culturally proficient manner.

Establish and clearly communicate an integrated strategic plan and set of initial agency priorities

If an agency is created, careful attention should be dedicated to defining the agency vision and mission and creating an integrated strategic plan that will guide agency activities and priorities over the coming years. The agency director and the three Department heads will be held accountable for meeting these established agency goals as well as for achieving

Department-specific goals. While a strategic plan will be important to help define the specific activities of the agency, the appointed director should also ensure that the work of integration begins immediately. Early and transparent priority-setting will help to center people's attention on initiatives that will yield concrete benefits for LA County residents and will help to avoid the risk that "thinking about the agency" will create a shared enemy that distracts attention from the true goal.

Over the course of stakeholder discussions during past six months, individuals raised numerous potential issues that might be initial priority areas for an agency. Some of the most commonly raised ideas, or those where there was a high degree of consensus, are included below. Discussion of an agency's specific strategic priorities was not a centerpiece of every discussion, nor were all stakeholders willing to engage in discussion of possible strategic priorities while the Board was still considering the issue of organizational structure and governance. Given that fact, this should not be considered a fully-vetted list of strategic priorities. Additional input from the Board, County leadership and staff, and external stakeholders should be obtained before a formal set of priorities is established for the agency. Of note, some individuals felt that this should happen through a formal strategic planning or needs assessment process that takes place prior to a Board decision about the agency, whereas others felt that such a process would not practically be possible until after the Board provides further direction of its intent with respect to the agency. With this tension in mind, below is a suggested list of initial priorities. While there is work in progress to some degree on all of these initiatives, each would benefit from greater attention and a larger degree of collaborative, coordinated action by the Departments.

- Design and implement a streamlined process through which clients/consumers/patients access care across Departments, including mechanisms to reduce the need for duplicate registration processes, universal consent, single points of access, common patient identification processes, referral mechanisms, etc.
- Develop and implement a comprehensive diversion program for non-felony offenders with mental illness and/or substance use disorders who are deemed to be appropriate candidates for non-jail-based placement/treatment.
- Reduce chronic homelessness among individuals with health-related needs, including a targeted focus on the Skid Row area of downtown Los Angeles.
- Create additional capacity and diversity of placement options, including crisis residential placements, sobering centers, and acute diversion units, that can serve as alternative drop-offs or destinations for individuals facing psychiatric crisis, in an effort to ensure that individuals are cared for in the least restrictive, most therapeutic environment that is appropriate for their clinical condition.
- Reinvigorate a focus on preventing the incidence and adverse outcomes of youth violence and trauma.
- Move toward more timely, comprehensive assessments and ensure ongoing treatment is consistently delivered and having the desired impact on foster children and their social communities (e.g., school, home).

If an agency is created, the director (interim or permanent) should immediately initiate a process to obtain input on priority areas for focus, including but not limited to consideration of the above list. While this strategic planning process is important, strategic planning should not be considered as progress in and of itself; no individuals or populations are well-served by a strategic plan, however well-conceived. The goal of this effort should be to comprehensively, but also relatively rapidly, develop a shared set of priorities so that the agency can initiate the actual work of program design and implementation, in continued partnership with internal and external stakeholders.

Build transparent, ongoing, and meaningful partnership with internal and external stakeholders

"We want a voice." To be successful and responsive to the needs of individuals and populations, an agency should establish mechanisms to ensure ongoing, meaningful dialog and partnership with internal and external stakeholders, including those representing multiple perspectives and constituencies. A broad set of stakeholders, including clients/consumers/patients

and their families, community advocates, private providers, service agencies, and community-based organizations (including but not limited to the Departments' contracted partners), the 88 cities within LA County, organized labor, the faith-based community, and experts/leaders in the field should be actively included. Efforts should include bringing in the voices of mentally ill persons who are in jail or in institutional settings.

The goals of these stakeholder forum and processes include:

- Ensure community/public consultation, participation, and input into ongoing planning and decision-making processes, including but not limited to the development of the agency's strategic plan and the prioritization of integration initiatives.
- Provide feedback on the impact of those initiatives, intended or otherwise.
- Help to create metrics that offer early indications of success or problems and review them on a periodic basis. Additional discussion of the importance of these indicators is included below.
- Establish a forum to express concerns, help to resolve disputes, learn from one another and begin to build trust among groups not accustomed to working together.

The agency should actively seek the involvement of stakeholders with particular insight into the needs of disadvantaged, underserved, and vulnerable populations to provide critical input on areas of unmet need, how program design may affect specific groups, and the design of culturally competent services, and to serve as early warnings for adverse or unintended consequences of an initiative. This will be a critical element in ensuring an agency is successful in its role of helping to reduce health disparities and promoting access and parity across populations and services.

Many people expressed concern as to how the stakeholder process would be set up, fearing a "superficial, check-the-box, stakeholder process" or one that would not support bidirectional communication between stakeholders and the agency. As one step, some stakeholders expressed a preference for having an external facilitator help guide discussion at these fora. While stakeholder input is critical, careful attention would have to be paid to the membership of the group(s) formed to ensure broad representation across stakeholder types while ensuring the size of the group is still amenable to in-depth discussion of issues. Other mechanisms (e.g., focus groups, sub-committees, etc.) could be used as ways to obtain necessary input from a larger set of individuals. As an initial step, the Board could consider immediately establishing an agency advisory group, comprised of, for example individuals appointed by the County Commissions, organized labor and, as appointed by each Department, those representing the views of clients/consumers/patients and their families, community partners (including contracted and non-contracted organizations), community advocates/experts, and others.

Creation of an ongoing agency-level stakeholder process should not replace or supplant existing stakeholder engagement mechanisms and groups already established within each Department. To the contrary, existing groups and ways in which Departments and/or facilities/programs engage in dialog with stakeholders and involve them in program design, priority-setting, and decision-making should continue. These are often well-established groups/fora that serve an important role within their respective Department; their roles and responsibilities should remain unchanged.

Promote cultural competency in all health-related activities

LA County is one of the most ethnically and culturally diverse regions in the nation. Delivering services and programs, as operated, led, or funded by the County health Departments, in a culturally competent manner is critical. By improving access to high-quality health services and programs that are respectful of and responsive to the beliefs, practices, and cultural and linguistic needs of individuals with diverse backgrounds and experiences, the County is better positioned to address health disparities among specific populations and improve overall health outcomes. When developed and implemented as a framework, cultural competence enables systems, agencies, and groups of professionals to function

effectively to understand the needs of groups accessing health information, programs, and services in an inclusive partnership where the provider and the consumer meet on common ground.

A common thread in many discussions regarding the health agency was the need for greater cultural competency and humility across the breadth of the County's health-related activities. While each Department has operationalized efforts to deliver culturally competent programs and services in different ways, among the three Departments, many stakeholders commented that they viewed DMH as having the strongest foundation and infrastructure in support of cultural competency and recommended that the agency pattern efforts to enhance cultural competency after those taken by DMH. However, even in that Department, stakeholders commented that improvements could be made. These stakeholders expressed concerns that the hard-earned progress made in terms of prioritizing cultural competency may face setbacks under an agency model if the agency did not highly prioritize this area.

If created, an agency should explicitly recognize cultural competency as a foundational principle that should underlie its activities, along with other principles such as commitment to labor-management partnership, ongoing and transparent stakeholder engagement, and others. The agency, in recognition of the challenges presented by the health needs of diverse racial and ethnic communities with their own cultural traits and beliefs, will need to focus on promoting and fostering cultural competency among all workforce members through a variety of educational and human resource initiatives that help to instill the behaviors, attitudes and norms needed to support provision of culturally competent programs/services. This should include support for workforce training, including that of County staff and contracted workforce members, modification of performance management expectations, support for recruitment and retention of diverse workforce, availability of interpretation and translation services into threshold languages by service area, and, critically, design of programs to take into account all recognized domains of culturally competent services, including physical, intellectual, emotional, spiritual, social, environmental, and occupational realms.

With regard to designing services to meet the mental health needs of clients, particular attention should be paid to the recommendations made in the population reports published by the "California Reducing Disparities Project," a project of the California Department of Public Health that commissioned work on how to reduce disparities in mental health services among five priority populations: African Americans, Asians and Pacific Islanders, Latinos, Native Americans, and Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ). These reports put forward "population-focused, culturally competent...community-defined, strength-based solutions and strategies"⁶³ for addressing disparities in accessing mental health care and can be a major source of information to consider in designing culturally responsive initiatives.

Ensure accountability and oversight of the agency

Several individuals raised the need for outside, objective oversight of the agency on an ongoing basis. This would include evaluation of the fiscal, programmatic, workforce, and community-related impact of agency activities and processes. While this could be performed by any outside entity, the existing Commissions could fulfill this role. The relevant Commissions, including the Commission on Alcohol and Other Drugs, HIV Commission, Hospital and Health Care Delivery Commission, Mental Health Commission, and Public Health Commission could each be charged by the Board with assessing agency impact and reporting findings, qualitative and quantitative, to the Board on a regular (e.g., semi-annual) basis. Rather than or in addition to relying on the existing Commission structure, some stakeholders have also suggested that the Board appoint a new, independent Commission which would serve as an oversight and accountability body for the agency overall. Such an entity would, as with other Commissions, be accountable directly to the Board of Supervisors. Some suggested that such a Commission be patterned after the Ryan White Care Act in which a community planning council is delegated

⁶³ California Reducing Disparities Project, RFP, initially released by the California Department of Mental Health in 2009.

“power of priority setting for services and allocation of resources for those services directly to the community.” If appointed, some made a suggestion that the new agency-level commission be comprised of at least 51% active clients/consumers/patients of County services (directly operated or funded). Finally, some stakeholders specifically suggested that a separate entity be developed to focus specifically on review of population health issues as one means of ensuring the agency pays proper attention to this critical public health realm. One suggestion was for a “Community Prevention and Population Health Task Force” that would report on fiscal, operational, and policy issues, delivering reports directly to the Board.

Regularly and publicly report on agency progress, including indicators related to the agency’s impact

Many stakeholders were open about their concerns regarding the potential impact of an agency and asked “What will you do to guarantee that these things I fear won’t happen?” It is necessary but not sufficient for County and agency leaders to make clear reassurances that the risks of an agency will not become a reality. Leaders should also be expected to report publicly, on a regular basis, on the opportunities being pursued and whether or not risks are being appropriately prevented. Carefully developed and transparently tracked indicators can also be critical in alleviating anxiety, building trust, and establishing a foundation for interactions that can focus on the work of integration. Such indicators would help to highlight whether or not services and operational functions are improving, but also could provide early warnings of adverse consequences of the agency’s impact. Metrics will not cover all topics but should be broadly reflective of a variety of domains and functions. With respect to the development of these indicators, the following should be kept in mind:

- Metrics should cover a diverse array of activities, reflecting the full breadth of the Departments’ scope. This should include measures that highlight population health, physical health, and mental health services; policy/regulatory functions; community-based interventions; direct clinical services; and administrative practices. Each Department should independently validate that metrics are appropriately reflective of their scope and priorities.
- Metrics should focus on outcomes that are of direct importance to clients/consumers/patients such as access, customer experience, care quality, health outcomes, community responsiveness, as well as administrative processes required to get the work done.
- Metrics should be able to measure progress toward specific established integration priorities.
- Metrics should assess how effectively individuals in specific populations (e.g., underserved or underpenetrated ethnic groups, vulnerable populations) and geographies are able to access and/or be connected to services and health outcomes among these groups. This is critical to reducing health disparities and provides an objective way to judge the appropriateness of resource allocation.
- Measures that are not directly related to public-facing services can also be helpful if they provide information on the administrative and operational health of the agency. Covered areas could include staff satisfaction, HR efficiency, (e.g., time to fill an item), finance functions (e.g., time to process payment), and contracting/procurement functions.
- Measures should take into account work done by both directly-operated as well contracted providers/agencies.
- Measures of the financial impact of agency changes are critical in reassuring the community and building trust. This includes showing trends in and uses of different revenue streams and budget appropriations. It should also include estimated cost savings from administrative efficiencies gained, including ways of tracking the beneficiaries of these additional funds and how these savings are used.

Indicator reports, when routinely measured and publically reported in a clear way, can serve as a powerful method of ensuring accountability and transparency. The development of these indicators will take time and could benefit from the involvement of a wide range of external experts who can be neutral arbiters of what measures would be appropriate

reflections of an agency's possible impact. The role of these external perspectives should not be limited to only metric development. Their continued involvement in the review and interpretation of data and review or audit of external publications would enhance accountability and build public trust.

It would obviously not be appropriate to attribute all change, either positive or negative, to the impact of the agency. The agency would not be implemented in a vacuum; the work of Departments and external factors would continue to influence measured processes or outcomes. This fact should be taken into account both when designing the measures and also when interpreting the results. Reports should allow for qualitative interpretations of data, sharing a broader context and explanation of what is seen in the numbers.

Data and more qualitative points about the impact of the agency should be regularly (e.g., quarterly) shared before the Board of Supervisors. At such hearings, the agency director and each of the Department heads should be expected to report on agency priorities, activities, client/consumer/patient impact, including whether opportunities and risks are being realized. The report should also include a summary of any structural changes made to the agency. Community stakeholders representing a variety of perspectives should be encouraged to attend and speak about the impact of the agency to date.

Develop and publish clear, concise data on Departmental budgets, appropriation, revenue sources, and uses

The issue of clarity into financial data is related to the above discussion of indicators, but deserves specific attention. The single most common concern raised across stakeholder groups was that Department budgets, particularly those of DMH and DPH, would be cut over time to divert resources to other purposes, particularly within DHS. As discussed in the "Risks" section, the very structure of the agency makes it impossible for funds to be moved between Departments without Board approval. Still, stakeholders should be provided with continuous confirmation that Department funds are maintained within the Department and, at a more nuanced level, that more subtle means of manipulating budgets is not taking place.

The County budget process and its communications are dense, filled with technical jargon, and are difficult to understand by those not constantly immersed in the subject. Effectively alleviating stakeholder concerns that the agency will lead to cannibalization of Department budgets will require clear and transparent budget communications. Finance staff working with public communications experts should develop simple charts showing where key funding streams are being spent, including notably MHSA funds and County general fund dollars, and what those funds are buying (e.g., number of visits, days of placement, public service campaigns). The data behind these charts should also be made available to the public.

Clearly communicate changes with the public

External partners, community agencies, and service providers need to know the changes that are being made to Departmental structure and programs so they know where to go to get the information they need. Stakeholders expressed concern that the agency would lead to changes in administrative functions or shifts in roles and responsibilities within the County over time and that they would be left "out of the loop and wondering where to go." The need for clear and frequent communications cannot be overstated and, as several individuals noted, is not a particular strength of the County. Some suggested that those within the Departments with expertise in managing public communications could share best practices across the agency.

Create opportunities to build relationships and trust among staff

Each Department has a strong and unique cultural identity. These differing cultures can be an asset or a liability as the Departments work toward integration, depending on the degree of trust and respect that exists. The creation of an agency could promote opportunities to intermingle the cultures of the Departments in a way that shares best practices and builds off of the strengths and capabilities of one another. One stakeholder described needing to work to increase “the cultural competency [of the Departments] not just for the sake of the individuals we serve, but also in regards to the staff within our Departments.” It is possible to create an agency that works effectively together across its distinct parts to improve services to clients/consumers/patients, but doing so will require significant work and focused attention. The importance of this process was strongly emphasized by internal and external stakeholder alike.

To achieve this, front-line staff should be actively engaged in a discussion of agency mission and priorities and must be given opportunities to build relationships over time through real work. Where prior integration activities have succeeded in a sustainable and deep manner, success was attributed to a sense of shared mission and goals and a commitment from those involved working as a team to overcome operational barriers. Some individuals however cautioned that these interactions should not be forced: “Cultures need to simmer and not be immersed instantly; cultural understanding and relationships take time.” Trust is built over time through clear and open communications, transparency, and establishment and tracking of performance goals. The agency should be sure to invest in the resources needed to enable staff to do their work and promote a culture built on labor-management collaboration and partnership.

Conclusion

This document has attempted to outline integration opportunities, risks of an agency model, and potential ways in which these risks can be addressed through an agency's structure and implementation. The hope is that through this report, and the extensive internal and external stakeholder process that helped inform it, LA County leadership is well positioned to determine the best path for the County's three health-related Departments so that it may maximize opportunities for innovation and integration and ultimately improve the health and lives of all LA County residents.

The past six months has offered opportunity for numerous stakeholder discussions about a health agency as proposed by the Board of Supervisors. While there is not agreement among all stakeholders about the best path forward with respect to achieving the goals of integration, the Departments and many stakeholders feel that the process to date has solicited the breadth of various perspectives regarding the agency and the need for service and programmatic integration more generally. Certainly some individuals feel that the process should be extended longer, but this is not widely shared.

Having solicited a wide range of opinions, the Board of Supervisors has three general options as to how it may choose to proceed. First, it may decide the current structure and organizational relationships of the Departments within the County should be left unchanged, ceasing consideration of the agency and other models that would alter the County structure and Departmental relationships. Second, the Board may choose to proceed with creating an agency involving DHS, DMH, and DPH. Finally, the Board may choose to proceed with study and/or implementation of a different model, including the alternative models described on pages 12-13 of this report.

If the Board of Supervisors chooses to proceed with creating an agency, the following is a summary of recommended actions that could be taken:

- Direct County Counsel to prepare an ordinance to create the agency, amend the County Code as necessary to ensure consistency with the new agency model, and report back to the Board with the ordinance language within sixty days.⁶⁴
- Appoint an interim or permanent agency director, whose position may be temporarily placed within the CEO's office pending the agency's creation by ordinance, who can begin critical steps related to the agency's creation. Such steps may include:
 - Develop an agency mission and vision statement regarding the agency's role in enhancing and promoting the overall health and wellness of all LA County's residents.
 - Develop and hold agency director and Department heads accountable for achieving an initial set of integration priorities.
 - Begin process of selecting a set of indicators to be routinely tracked and reported to the Board as a means of gauging the agency's effectiveness and impact, including potential adverse consequences. Specific attention should be paid to indicators that can reflect sources and uses of existing Department funding streams.
 - Establish a mechanism for ensuring meaningful ongoing dialog with external stakeholders possibly via the immediate creation of an advisory body comprised of Commission representatives, organized labor, and, as appointed by each Department, representatives of clients/consumers/patients and their families, community-based organizations (contracted and non-contracted), community advocates/experts, and others.
- Establish a regular (e.g., quarterly) formal presentation as a set item before the Board of Supervisors in which the agency director and each of the Department heads report on agency priorities, activities, creation and funding of

⁶⁴ As noted in "Implementation Steps" section above, the agency ordinance must have two readings at a Board meeting before being adopted and would take effect thirty days after adoption.

agency-level roles, and whether opportunities and risks are being realized. Community stakeholders should be encouraged to attend and provide public comment about the impact of the agency to date.

- Direct existing relevant County Commissions to assess and report directly to the Board on the agency's impact.

Over the longer-term, the agency director should further investigate, as needed, or pursue specific opportunities to enhance integration between the three Departments. This should include particular attention to service integration activities as well as opportunities for maximizing available revenue/financing streams, ensuring optimal levels of IT integration, and optimizing use of space for both clinical and administrative purposes.

If the Board wishes to take an action other than creating an agency, the CEO is prepared to assist in whatever way is required.

Regardless of the Board's decision as to how best to proceed, the past six months have raised attention to the importance of service and programmatic integration between DHS, DMH, and DPH to improve the health of individuals and populations. This represents an important step forward for the County and, if taken advantage of, will produce lasting benefit for LA County residents.



SACHI A. HAMAI
Interim Chief Executive Officer

County of Los Angeles
CHIEF EXECUTIVE OFFICE

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
<http://ceo.lacounty.gov>

Board of Supervisors
HILDA L. SOLIS
First District

MARK RIDLEY-THOMAS
Second District

SHEILA KUEHL
Third District

DON KHABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

"To Enrich Lives Through Effective And Caring Service"

September 29, 2015

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVE THE STRATEGIC PRIORITIES AND OPERATIONAL FRAMEWORK FOR THE LOS ANGELES COUNTY HEALTH AGENCY

(ALL DISTRICTS)

(3 VOTES)

SUBJECT

Approval of the Strategic Priorities and Operational Framework for the Los Angeles County Health Agency (Health Agency).

IT IS RECOMMENDED THAT THE BOARD:

Approve the Strategic Priorities and Operational Framework for the Health Agency as developed by the temporary Health Agency Steering Committee.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

On August 11, 2015, the Board directed the Interim Chief Executive Officer to create a temporary steering committee ("Steering Committee"), comprised of the Directors of Health Services (DHS), Mental Health (DMH), Public Health (DPH) and the Public Health Officer, to develop within 45 days, taking into account input from community stakeholders, a strategic plan and operational framework for integrating the three Departments with priorities, specific outcome measures and a preliminary associated workplan.

The Strategic Priorities and Operational Framework as developed by the Steering Committee are attached. Five public convenings were held to obtain input from community stakeholders on the draft version of these documents. Formal written comments were also accepted and were taken into account in this final report to the Board.

During the August 11, 2015 Board meeting, the Steering Committee was also asked to consider creation of a Community Prevention and Population Health Task Force (Task Force). DPH is taking the lead role in developing and supporting the Task Force. This Task Force will play a key role in promoting healthy, equitable communities by making recommendations to the Board of Supervisors, the Health Agency, and DPH on improving health equity and population health in Los Angeles County. The Task Force will oversee DPH's ongoing County-wide community health planning efforts to improve the population health for all Los Angeles County community members, with a particular focus on guiding the development and implementation of the Community Health Improvement Plan (CHIP). The CHIP is a 5-year strategic plan for DPH and community stakeholders to collectively improve the health of all residents. In addition, the Task Force will create connections between the CHIP and other key plans and initiatives in Los Angeles County with similar goals, such as the DMH's "Health Neighborhoods" initiative which aims to improve coordination of services for behavioral and personal health and address social determinants of health, such as poor housing and poverty.

A draft proposal for the Task Force was developed and shared with community stakeholders at a September 23, 2015 public meeting. The draft proposal will be revised to incorporate feedback from stakeholders and submitted to the Board of Supervisors under separate cover. The draft proposal contains recommendations for the Task Force's mission, responsibilities, size, member terms, selection process, as well as the desired qualifications of Task Force members.

Implementation of Strategic Plan Goals

The recommended action supports Goal 1 - Operational Effectiveness and Goal 3 - Integrated Services Delivery.

FISCAL IMPACT/FINANCING

None.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

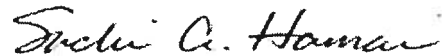
The recommended Strategic Priorities and Operational Framework take into consideration the input received from community stakeholders at the public convenings and throughout the public comment period, and reflect the Steering Committee's efforts to develop and fulfill the Health Agency's mission to improve the health and wellness of Los Angeles County residents through the provision of coordinated care and services.

The Steering Committee considers the strategic priorities to be three-year goals. Progress in each of the priorities over the next three years would yield substantial benefits to the residents of Los Angeles County and will require significant collaboration across each of the three Departments. Specific action steps and metrics, including indicators by sub-population and region/SPA where relevant, will be developed and modified over time. Overall progress in achieving these priorities will be shared in the quarterly updates to the Board on the Health Agency. Stakeholder input for specific priorities/goals will continue to be obtained over time in a manner and from groups/individuals relevant for each priority.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Your approval of this recommendation will improve access, health outcomes, and system efficiency.

Respectfully submitted,



SACHI A. HAMAI

Interim Chief Executive Officer

SAH:CRG:jp

Enclosures

c: Executive Office, Board of Supervisors
County Counsel
Auditor-Controller
Health Services
Mental Health
Public Health

Los Angeles County Health Agency Strategic Priorities
September 29, 2015

Consumer Access to and Experience with Clinical Services

Strategic Priority: Streamline access and enhance customer experience for those who need services from more than one Department, including by promoting information-sharing, registration, care management, and referral processes, training staff on cross-discipline practice, and increasing co-location of services.

Goal 1: Implement staff workflow processes and technical infrastructure necessary to ensure clients can access services in another Department without having to duplicate registration, financial screening, and eligibility/determination processes; where prudent, align Departments' financial policies governing eligibility and payment for services from self-pay individuals.

Goal 2: Develop joint care management plans for individuals served by more than one Department.

Goal 3: Implement Agency-wide referral processes and technical infrastructure and train staff on protocols through which clients can be identified and referred directly to services in or funded by another Department.

Goal 4: Expand number of directly-operated and contracted clinical sites at which individuals can receive co-located physical, mental, substance use, and public health services; train staff to effectively work within co-located sites.

Goal 5: Successfully implement DHS' Electronic Health Record (EHR) "ORCHID" at all DPH sites that deliver health care services suitable for ORCHID implementation.

Goal 6: Determine best short- and long-term course of action with respect to the secure sharing of personal health information, in a manner consistent with all applicable state/federal privacy and security regulations, on clients shared between DMH and DHS/DPH, including consideration of a Cerner Hub approach vs. potential shift to a single EHR with appropriate interfaces to contracted partners as needed to ensure efficient billing mechanisms.

Proposed outcome metrics:

- Number of DPH sites that have completed ORCHID implementation
- Board-approval of short- and long-term method for sharing clinical information between DMH and DHS/DPH
- Adoption of common registration, financial screening, and eligibility processes
- Increased number of staff cross-trained to properly identify and manage and/or refer individuals needing care within another domain
- Increased number of referrals between Departments that are appropriately dispositioned using a streamlined referral process; wait time to access services/programs post-referral
- Increased number of individuals with care plans incorporating more than one system
- Increased number of staff trained on effective care management practices within co-located clinical sites
- Increased number of individuals provided with multi-departmental services (directly operated and as contracted via the County) within co-located sites
- Enhanced customer experience as measured by surveys or other standard tools

Major organizational next steps:

- Map scheduling, registration, financial clearance/screening, and referral processes in each Department; convene a work group from the three Departments to determine how best to harmonize differences.
- Convene Health Agency IT Leadership Council comprised of technical and business leadership from each Department to ensure IT-related strategy and decisions made within each Department balance Agency-wide and Department-specific interests.
- Hire external consultant to perform a detailed, objective assessment of the best way to share information across the three Departments, understanding the needs of community partners and the complexity of financial/billing functions and responsibilities, including consideration of a health information exchange, interfacing existing applications, and implementation of an enterprise, single EHR for clinical functions.
- Convene a Health IT Task Force, including representation from DHS, DMH, DPH, Probation, Sheriff, CIO, and CEO, to assist consultants in the above evaluation, providing open access to their specific Department's resources and IT infrastructure, to ensure the outcome of the consultant's report outlines clear recommendations, to be delivered to the Board of Supervisors (BOS), regarding best short-and long-term strategy with respect to sharing/accessing clinical information; other County Departments (e.g., DCFS) should be consulted and involved as needed.
- Assess availability of space at all directly-operated clinical sites, including potential for space swaps.
- Evaluate and, where appropriate, develop mechanisms to align existing processes for obtaining input from clients/consumers/patients on service/program quality and customer experience, (e.g., surveys, complaints and grievances).

Housing and Supportive Services for Homeless Consumers

Strategic Priority: Develop a consistent method for identifying and engaging homeless clients, and those at risk for homelessness, across the three Departments, linking them with integrated health services, housing them, and providing ongoing community and other supports required for recovery.

Goal 1: Evaluate and reconfigure, as needed, housing and homeless services within the Agency and Departments to facilitate improved outcomes for homeless clients, including but not limited to the reduction/elimination of eligibility barriers and greater sharing of Departmental resources, to ensure that resources are available to homeless clients regardless of where they present.

Goal 2: Develop an accurate way to identify homeless clients, and those at risk of homelessness, currently served across the three Departments (e.g., development of a real-time unduplicated database, flag within shared client record) for the purpose of identifying priority clients who are determined to be likely to benefit from services from multiple Departments to regain health and residential stability.

Goal 3: Develop and implement shared standards and practices for ensuring a full range of housing, health, and prevention services are able to be delivered to clients based on client-specific needs.

Goal 4: Improve and expand upon multidisciplinary street engagement teams capable of effectively engaging homeless people living outdoors throughout the County with the express goal of securing interim and permanent housing.

Goal 5: Develop and open a range of “bridge” residential services that provide low-barrier, welcoming programs (e.g., sobering centers; day centers with showers, meals, and health services; recuperative care; detox centers; stabilization housing; congregate supervised living; and other effective bridges to permanent housing) for homeless individuals with complex health conditions in high density neighborhoods (e.g., Skid Row, Hollywood, Venice) and in unincorporated areas of LA County.

Goal 6: Maintain a real-time inventory of available residential slots, funded and usable by all three Departments, that facilitate immediate placement of homeless clients into available interim and permanent residential options appropriately matched to various need indicators (e.g., accessibility, level of on-site services, neighborhood, age).

Goal 7: Obtain Medi-Cal coverage, when possible, and successfully link individuals, where clinically appropriate, to comprehensive, integrated health services that are delivered in a way that is tailored for the unique needs of homeless individuals.

Goal 8: Develop screening questions for those conditions that lead to homelessness that could be incorporated into the practices of all three Departments along with methods and plans to link individuals to needed supports and services as part of the delivery of health care, mental health and public health services.

Goal 9: Engage in policy development and technical assistance activities to enhance the availability of high-quality, affordable, stable housing stock within LA County.

Proposed outcome metrics:

- Increased number of families at risk for homelessness that are provided support services to prevent homelessness

- Decreased number of emergency department visits and ambulance transports of homeless individuals for non-emergency services
- Decreased rate of incarceration for non-violent offenses related to being homeless
- Increased number of homeless individuals newly placed in Permanent Supportive Housing (PSH), including breakdown by geography (e.g., Skid Row, unincorporated areas)
- Increased percent of individuals housed by the Departments who remain housed two years after initial placement
- Increased number of individuals incarcerated in LA County jails who are housed upon community re-entry (among those who otherwise would have been homeless upon release)
- Increased number of homeless clients able to be placed in interim or permanent housing on the same day they have been identified as willing to move into housing and/or receive services
- Among homeless individuals assigned to a DHS or community partner medical home, increased number with at least one primary care visit in the past 12 months
- Increased number of homeless individuals who are linked to physical, mental, and/or substance use services
- Increased number of homeless individuals assisted via street outreach efforts in areas of the County experiencing high concentrations of people living outdoors

Major organizational next steps:

- Analyze housing/homeless-specific services and current program eligibility criteria in each Department to determine what level of further integration/consolidation would be useful toward achieving improved outcomes for homeless people, how these efforts interact with non-health related efforts, how eligibility criteria can be aligned Agency-wide, and any areas of additional funding needed to expand services.
- Explore with IT and other appropriate parties the most effective way to develop and maintain a real-time database/log of shared clients who are homeless.
- In partnership with other County Departments and non-County community partners, develop a priority list of types of residential programs that are most in need and develop a specific timeline for bringing them online.
- Work closely with CEO Homeless initiative coordinator to ensure other County departments (e.g., Sheriff, Probation, CDC, Fire, DPSS, DCFS) are working together to build a County-wide service system for homeless individuals.
- Work with DPSS and Community and Senior Services to create necessary program linkages and supports.

Overcrowding of Emergency Departments by Individuals in Psychiatric Crisis

Strategic Priority: Reduce overcrowding of County Psychiatric Emergency Services (PES) and private hospital Emergency Departments (EDs) by children and adults in psychiatric crisis.

Goal 1: Increase alternatives to PESs and private EDs across all regions of LA County by establishing additional psychiatric urgent care centers and crisis residential services, augmenting the spectrum of lower levels of care to include psychiatric recuperative care and additional crisis stabilization capacity, expanding access to structured outpatient services accessible to those at/before a time of crisis, and fully implementing the Alcohol and Drug Medicaid benefit.

Goal 2: Improve the utilization of inpatient services by ensuring that individuals who can be managed in a less restrictive setting are dispositioned appropriately and that those who are admitted to inpatient units are discharged as soon as clinically appropriate.

Goal 3: Maximize federal funds available for the purchase of services or placements to support care to individuals in or recently in crisis.

Goal 4: Assess and redesign existing processes to improve audits of IMD utilization in order to reduce length of stay and thus reduce wait times for those in public and private inpatient psychiatric units.

Goal 5: Ensure law enforcement and community-based mental health assessment teams are adequately trained on the wide array of outpatient service, programmatic (e.g., case management) and placement options available to individuals in psychiatric crisis.

Goal 6: Evaluate options to increase the stock of private psychiatric inpatient beds (e.g., increasing rates, developing mechanisms to take advantage of changes in the IMD exclusion).

Proposed outcome metrics:

- Decreased average morning census of children and adults on involuntary holds in County PESs and private EDs
- Decreased administrative days as a percent of inpatient psychiatric days in public and private hospitals
- Increased number of visits to urgent care centers by individuals on involuntary holds and ultimate disposition type (e.g., home, PES/ED, inpatient admission, community-based placement)
- Decreased average length of stay in public and private EDs by those on involuntary psychiatric holds
- Increased number of new urgent care centers opened
- Increased number of individuals in psychiatric crisis in public and private EDs who are discharged to non-locked settings with medication and outpatient follow-up plans
- Increased number of alcohol and drug residential and detox service placements/slots available
- Increased number of crisis residential beds available
- Recidivism rate among those visiting County PESs (and private EDs to the extent data is available)

Major organizational next steps:

- Assess current and anticipated future financial allocations from each Department toward individuals in psychiatric crisis, especially those on involuntary holds, so that resources can be maximally aligned toward services and placements most capable of responding to the needs of the target population.
- Assess and align, where indicated, DHS, DMH, and DPH clinical, programmatic, and housing services to create novel placements for individuals who could be diverted from EDs or inpatient units.

- Open additional 24/7 LPS-designated psychiatric urgent care centers, including at sites near Olive View-UCLA Medical Center, in the Antelope Valley, in the Long Beach area, in the East San Gabriel Valley, and in association with Harbor-UCLA Medical Center.
- Assess utilization of inpatient psychiatric units and IMDs to identify opportunities to improve flow.

Access to Culturally and Linguistically Competent Programs and Services

Strategic Priority: Ensure access to culturally competent and linguistically appropriate services and programs as a means of improving service quality, enhancing customer experience, and helping to reduce health disparities.

Goal 1: Implement mechanism to systematically collect and analyze Race, Ethnicity and Language (REAL) data and data for other culturally relevant factors (e.g., LGBTQ, physical disability) among consumers; use data to identify and report relevant health-related disparities and inform ongoing program design.

Goal 2: Systematically survey and publicly report client satisfaction with Department activities and services from a cultural perspective.

Goal 3: Design, establish, and implement core competencies for new employees and regularly train existing County workforce on providing culturally relevant care and customer service, including attention to the needs of specific race/ethnic groups, the disabled, veterans, LGBTQ, immigrant/refugees, the elderly, and other vulnerable groups within local communities.

Goal 4: Ensure clinical sites are able to provide real-time professional interpreter/translation services when required or requested by the client through building both in-person and technology-based (e.g., telephone, video-conferencing) resources; ensure clients are proactively made aware of their right to receive and the availability of such services.

Goal 5: Ensure clinical sites have signage and written client materials available in the preferred primary languages of their local communities.

Goal 6: Share and coordinate existing culturally appropriate efforts and staffing models across Departments that have been proven effective in reducing disparities, enhancing care coordination, and increasing community awareness of health issues and that have demonstrated positive health outcomes.

Proposed outcome metrics:

- Disparities according to REAL and other relevant cohorts
- Results from clients/consumers/patients surveys
- Evaluation of impact and effectiveness of training programs related to cultural competency; number of individuals who have completed training
- Percent of total clinical sites that can provide real-time access to translation/interpreter services
- Percent of sites that have completed self-assessments and enhancements of signage and written materials that met the cultural and linguistic needs of communities served

Major organizational next steps:

- Convene and/or evaluate existing Department-, program-, and/or facility-level cultural competency committees, comprised of consumers, their families, and front-line staff, to provide input on how to continually enhance cultural competency of existing programs.
- Perform cultural competency assessment of directly-operated and contracted sites using an externally validated tool appropriate to the size and diversity of the County.
- Create mechanism to formally survey clients/consumers/patients on cultural competency of services and programmatic offerings.
- Engage organized labor on ways to formally enhance delivery of culturally competent care/services.

- Conduct inventory of currently available translation/interpreter resources/infrastructure, signage, and written client materials within clinical sites.
- Assess the ability of specific programs/facilities to care for special populations (e.g., use of peers/those with lived experience, family involvement) and take advantage of the strengths of each Department.

Diversion of Corrections-Involved Individuals to Community-Based Programs and Services

Strategic Priority: Successfully divert corrections-involved persons with mental illness and addiction who may otherwise have spent time in County jail or State prison by placing them into structured, comprehensive, health programming and permanent housing, as tailored to the individual's unique situation and needs.

Goal 1: Establish the Office of Diversion and Re-entry with the capability to coordinate diversion efforts across Departments, create placements appropriate for the wide array of individuals who might be diverted and develop programs that support the recovery and improved health of these diverted individuals. The Office will provide contracting, technical and evaluation support, and expansion of current evidence-based diversion programs run by DHS, DMH, and DPH necessary for a successful County-wide intervention.

Goal 2: Establish placement opportunities and comprehensive health programs (i.e., physical health, mental health, public health, and substance use case management and clinical services) to address the needs of individuals deemed eligible for diversion.

Goal 3: Work with Court 95 and the LA County District Attorney's Office to establish sufficient community placements to meet the relevant demand among Misdemeanants Incompetent to Stand Trial (MIST) deemed eligible by law enforcement for diversion.

Goal 4: Build the necessary administrative infrastructure necessary to rapidly place potential diversion candidates into housing (e.g., possible creation of a Diversion Connection Access line with extended hour capabilities).

Goal 5: Develop diversion education and awareness campaign to heighten awareness of diversion opportunities and programs among County courts, prosecuting and defense attorneys, law enforcement and custody staff as well as mental health, substance use, and other relevant clinical staff.

Proposed outcome metrics:

- Increased number of individuals diverted from jail, by intercept and offender category (e.g., MIST)
- Percent of diverted individuals who successfully complete diversion plan
- Percent of diverted individuals who have not re-offended within one year following completion of their diversion plan
- Average time spent in custody after diversion plan is approved
- Increased number of diversion programs and housing units available to diversion clients
- Increased number of cases where diversion programs are the recommendation of the Courts

Major organizational next steps:

- Establish the organizational structure and key leadership positions within the Office of Diversion and Re-entry.
- Hire an Office Director and team with a sufficient leadership structure to interface with the courts and custody as well as develop and identify providers for required housing, placements, and programming.
- Build multi-department diversion stakeholder group to guide Office priorities.
- Continue to build relationship with District Attorney's ongoing diversion effort.
- Determine how DMH and Substance Abuse Prevention and Control (SAPC) programs and resources interact with and support a broad County diversion program.
- Align program metrics across each Department's current diversion programs.

Implementation of the Expanded Substance Use Disorder Benefit

Strategic priority: Maximize opportunities available under the recently approved Drug Medi-Cal waiver to integrate Substance Use Disorder (SUD) treatment services for both adults and youth into LA County's mental and physical health care delivery system.

Goal 1: Transition homeless and criminal justice-involved individuals receiving SUD residential treatment into appropriate Department housing programs as part of the SUD continuum of care.

Goal 2: Develop knowledge and skills of clinical staff in Departments' directly-operated and contracted primary and specialty care facilities on the American Society of Addiction Medicine's (ASAM) levels of care based on medical necessity, including the interaction of SUDs with physical health and mental health conditions, and how to appropriately screen and link individuals with SUDs into appropriate levels of care.

Goal 3: Advocate with the State Legislature and the Department of Health Care Services (DHCS) to place all drug treatment medications approved by the federal Food and Drug Administration (FDA) on the Drug Medi-Cal (DMC) formulary; expand the use of these medications by both mental and physical health practitioners within LA County's health care delivery system.

Goal 4: Increase the number of Departments' directly-operated and contracted providers that are DMC-certified.

Goal 5: Implement SUD Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol in Departments' directly-operated and contracted clinics and programs.

Proposed outcome metrics:

- Increased number of eligible homeless and criminal justice-involved individuals referred to DHS and DMH housing programs upon completion of their SUD treatment
- Increased number of SUD homeless and criminal justice-involved patients with co-occurring SUD mental health and/or physical health conditions housed in DHS and DMH programs
- Increased number of clinical personnel in directly-operated and contracted County clinics trained to accurately identify SUDs, provide Medical Assisted Therapy (MAT), and make referrals for SUD treatment based on medical necessity as determined by ASAM criteria
- Addition, by California DHCS, of all FDA-approved addiction treatment medications to the DMC formulary without a TAR requirement
- Increased number of Departments' directly-operated and contracted facilities that are DMC certified
- Increased number of Departments' directly-operated and contracted clinical personnel trained in SBIRT
- Increased percentage of Departments' clients in directly-operated and contracted clinics receiving an annual screening for substance use in the past year

Major organizational next steps:

- Prepare and submit the DMC Organized Delivery System (ODS) implementation plan required under the 1115 Waiver's DMC ODS Special Terms and Conditions to obtain BOS approval to opt into the Waiver.
- Upon BOS approval, submit the DMC ODS implementation plan to DHCS and Centers Medicaid and Medicare (CMS) for approval as required under the STCs.
- Establish workgroups comprised of DHS, DMH, DPH, other County departments, and key external stakeholders to execute the DMC ODS Waiver implementation plan once approved by DHCS and CMS.

- Provide technical assistance, training and infrastructure investments for the three Departments and their provider networks to build administrative, clinical, and workforce capabilities and capacity to meet the increased demand for SUD services under the DMC ODS Waiver.

Vulnerable Children and Transitional Age Youth

Strategic Priority: Improve the County's ability to link vulnerable children, including those currently in foster care, and Transitional Age Youth (TAY) to comprehensive health services (i.e., physical health, mental health, public health, and SUD services).

Goal 1: Develop comprehensive individualized treatment plans, including temporary and permanent placements able to provide integrated mental health, substance use, and physical health services, for children in foster care that are "difficult-to-place" due to health-related issues.

Goal 2: Develop and implement new approaches to community outreach and engagement to high-risk children/youth and TAY (e.g., those with HIV/STDs, homeless youth, LGBTQ, unaccompanied minors).

Goal 3: Continue to develop and evolve a comprehensive health services package (i.e., physical health, mental health, substance use, public health) available to Commercially Sexually Exploited Children (CSEC) in LA County.

Goal 4: Develop a package of comprehensive aftercare services, including mechanisms for appropriate referral and linkage available immediately upon release, for youth in Probation Camps and Juvenile Halls and TAYs in the adult corrections system.

Goal 5: Create or adopt an externally available mobile tracking and communication tool usable by TAY to help them gain access to educational and service information.

Proposed outcome metrics:

- Increased percent of "difficult-to-place" youth in DCFS system that are successfully linked with comprehensive treatment services and receive timely, appropriate residential placement in a home-like setting where feasible
- Decreased number of children/youth with physical and/or mental health challenges who experience placement disruptions
- Increased number of high-risk TAY newly linked to and receiving mental health and/or SUD services
- Increased number of CSEC youth using services from an agency Department
- Increased number of youth and TAY leaving the correctional system with an aftercare plan addressing mental health, substance use, and/or physical health needs
- Increased number of youth/TAY with full implementation of their aftercare plan
- Increased number of TAY who use an electronic tool to "stay in touch" with service providers, DCFS social workers, Probation officers or other parts of their community

Major organizational next steps:

- Establish a working partnership between the Agency, the County's Office of Child Protection, relevant County Departments (e.g., DCFS, Probation), and community-based entities (e.g., school districts).
- Evaluate current models of integrated treatment teams (e.g., Child and Family Teams implemented by DCFS and DMH) and determine their applicability and potential scalability for improving management of target populations.
- In partnership with DCFS, clearly define "difficult to place" youth appropriate for Goal 1 interventions.
- Convene workgroup, involving entities outside the Agency as needed, to develop a mechanism (e.g., utilize a common data collection system) to ensure that all Department programs that may interact with CSEC have a way to identify individuals and employ consistent methods to capture relevant information.

- Convene an agency-level CSEC workgroup to enhance Department collaboration on health-related issues; participate in County-wide CSEC workgroups as appropriate.
- Identify funding to create and/or implement the mobile tracking and communication tool.

Chronic Disease and Injury Prevention

Strategic Priority: Align and integrate population health with personal health strategies by creating healthy community environments and strengthening linkages between community resources and clinical services.

Goal 1: Expand access to chronic disease prevention programs (e.g., National Diabetes Prevention Program (NDPP)) for priority populations.

Goal 2: Scale and spread the use of team-based care approaches in Los Angeles (e.g., Community Health Worker (CHW), pharmacist-led Medication Therapy Management (MTM) programs) for persons with chronic health conditions.

Goal 3: Expand access to evidence-based tobacco cessation treatment for priority populations.

Goal 4: Reduce youth violence through strategies targeted at the community-level and broader social determinants of health. Example tactics to be pursued include building on the Parks After Dark (PAD) model to expand gang intervention and safe passage programs, integrating DHS, DMH and DPH services and outreach into community-based youth violence efforts, and promoting a school climate that ensures adequate access to high-quality and coordinated social, medical, and behavioral health services for students and families (e.g., a coordinated school health model).

Goal 5: Encourage and assist high-risk populations (e.g., those prescribed atypical anti-psychotics) to engage in exercise and movement and to access healthy food/nutrition options.

Proposed outcome metrics:

- Increased number of at-risk persons enrolled in chronic disease prevention programs (e.g., NDPP)
- Increased number of at-risk persons with well-controlled chronic conditions (e.g., heart failure, diabetes, hypertension)
- Increased number and level of satisfaction of clients reached with CHW and MTM programs
- Increased number of healthcare providers trained in the provision of evidence-based tobacco treatment interventions
- Decreased prevalence of tobacco use among adult LA County residents
- Increased number of schools with wellness policies that adopt and integrate elements of a coordinated school health model
- Increased number of PAD parks in communities with high rates of violence that include co-located social, physical, behavioral, and public health services
- Decreased number of serious and violent crimes and gang-related crimes in PAD park communities relative to comparison sites
- Decreased number of trauma-related ED visits and hospitalizations

Major organizational next steps:

- Develop assessment tools/methods for collecting needed baseline and ongoing performance/progress data for above initiatives.
- Perform baseline inventory and assessment of existing CDC-recognized NDPP providers in Los Angeles; develop and implement outreach and provider engagement strategy to promote and support broader provider participation.

- Perform baseline inventory and assessment of select existing team-based care models (e.g., community pharmacies screening programs, MTM programs); develop and provide technical assistance to agencies and providers interested in expanding participation.
- Establish standards of care for the delivery of evidence-based tobacco interventions; revise or update standards to address the assessment and treatment of tobacco dependence.
- Develop necessary education objectives, curricula, evaluation tools, and training schedules to enhance tobacco cessation efforts; train providers to deliver evidence-based tobacco cessation treatment.
- Analyze trauma-related data to better tailor and target prevention interventions.
- Conduct baseline inventory and assessment of existing violence prevention, social service, health and behavioral health resources in PAD park communities with a goal to develop a cross-referral system; convene key partners to develop and implement targeted strategies to facilitate referrals and coordination between organizations, provide technical assistance, and evaluate impact of initiatives.
- Analyze available data and assess impact of current programs targeted at social determinants of youth violence (e.g., diversion programs, Teen Court programs) to understand gaps and priority opportunities for future intervention.

Los Angeles County Health Agency Operational FrameworkSeptember 29, 2015

The mission of the Los Angeles (LA) County Health Agency (“Agency”) is to improve the health and wellness of LA County residents through provision of integrated, comprehensive, culturally appropriate services, programs, and policies that promote healthy people living in healthy communities. This will be achieved through the aligned efforts of the Departments of Health Services, Mental Health, and Public Health (“Departments”) and in partnership with our clients and their families and communities, LA County residents, organized labor, faith-based organizations, community providers and agencies, health plans, academia, and other stakeholders.

In pursuing their missions, the Agency and Departments shall adhere to the following operational framework, abiding by key values of clarity of purpose, transparent decision-making, mutual respect, and open communication with those inside and outside the County.

1. **The Agency shall address Board-supported priorities relevant to health and well-being.** The Agency shall work to implement Board-supported priorities related to the health and well-being of LA County residents. The Agency shall guide the strategic, operational, and administrative alignment of activities, decisions, and external advocacy agendas within and among the three Departments in support of these aims and will include an explicit focus on change management practices that may support and reinforce necessary modifications of County practices/structures. The Agency shall publicly report on progress made toward achievement of specific goals related to these priorities.
2. **Departments shall maintain the full breadth of their mission and scope of activities.** Each Department has a critical mission in supporting the health and well-being of LA County residents; such missions should be maintained and supported in a way that respects each Department as equal partners in achieving the County’s health-related goals. Departments shall continue to establish Department-specific priorities distinct from Agency-level priorities and initiatives and shall lead and participate in a full spectrum and scope of activities consistent with these priorities. Departments shall continue to enter into external contracts, grant agreements, and operational agreements with external entities (e.g., community-based organizations, private providers, health plans) in a manner consistent with Agency priorities.
3. **Departments shall be supported in fulfilling all legal responsibilities and mandates.** Departments shall be empowered and supported in delivering essential and legally-mandated services and in fulfilling their mandate to administer cross-departmental oversight and auditing processes. The Agency and Departments shall develop protocols to eliminate any conflict of interest that may arise during the course of a Department carrying out its regulatory and auditing responsibilities.
4. **Departments shall maintain independent and direct relationships with the Board of Supervisors.** Each Department should be expected to directly and regularly communicate with Board members in private and in public regarding Department-specific issues and concerns related to the Agency.
5. **Department budgets shall remain separate.** The budgets of the three Departments shall remain as separate appropriations within the County and shall not be merged within a single Agency budget. Services, budgets, and staffing for Department activities shall not be cut and financing streams shall not be redirected because of a transition to the Agency model. Over time, Department activities, services, and programs may be altered, integrated, and/or realigned between or among the Departments if such moves would demonstrably benefit the populations served by the County, with internal and external stakeholder input, and with approval of the Board. Current grant-funded activities shall not be redirected. Departments’ risk management responsibilities shall be maintained separately; incidents of potential liability, claims, and lawsuits shall continue to be financially addressed by the relevant

Department. The Agency shall conduct strategic review of Department budgets to facilitate appropriate alignment with both Agency and Department-specific Board-supported priorities. Only the Board of Supervisors, pursuant to applicable laws and regulations, and not the Agency Director, has authority to change and/or reallocate Departments' appropriations and expenditures.

6. **The Agency shall support Departments in creating effective organizational structures.** The Agency Director shall interact with the Department Heads with the goal of creating organizational structures that meet the needs of Departmental and Agency mission, vision, and scope of work.
7. **The Agency shall avoid unnecessary bureaucratic processes.** The Agency shall operate in such a way as to ensure strategic alignment of operational and administrative activities within and between Departments in pursuit of Board-supported priorities. Bureaucratic processes that may unnecessarily extend Departmental tasks and operations (e.g., Agency-level signatures required for routine operations such as grant applications, supply chain purchases, and personnel action requests) shall not be implemented.
8. **Functions shall shift to being conducted and/or coordinated Agency-wide to the extent this enhances integration and/or when doing so is of strategic value to the County.** Agency-wide functions shall be implemented when doing so would produce a clear added value to clients, the Departments, and the County, taking into consideration the operational requirements of achieving specific priorities and administrative inefficiencies and/or redundancies. Regardless of placement, core administrative functions (e.g., information technology, service and managed care contracting, purchasing, finance, human resources) shall be planned, led, and executed in a manner that supports both Agency and Department priorities.
9. **The Agency shall lead labor-management partnership activities to reduce duplication and enhance the level of County partnership with organized labor.** Department leadership, or specific subject-matter experts, should be active participants in all relevant labor/management meetings and initiatives.
10. **The Agency shall respect current Department relationships and commitments.** Existing relationships and contracts with external entities shall be respected and maintained. Departments shall continue to maintain and nurture current internal and external partnerships in pursuit of Department-specific and shared Agency goals and efforts.
11. **Both the Agency and Departments shall maintain mechanisms to engage a broad set of internal and external stakeholders.** Department-specific mechanisms and forums for engaging County-employed workforce and external stakeholders shall be maintained and supported. The Agency shall establish complementary mechanisms to build transparent and meaningful partnerships with relevant stakeholders. The Agency shall proactively invite input from individuals and organizations with a variety of different perspectives and areas of expertise, including staff, clients/consumers/patients, and community-based organizations, in the design, implementation, and evaluation of programmatic and policy initiatives. The Agency shall transparently and clearly communicate with and report to the public on Agency activities and plans.
12. **The Agency shall embrace a full spectrum of services and programs aligned with the health and wellness needs of individuals across the life course and reflecting different social, cultural, and demographic groups.** Services and programs shall reflect an appropriate balance of clinical, recovery, community-based, and policy-related preventive and population health initiatives able to optimize health outcomes. Services and programs should be designed and implemented within the context of local communities, in a culturally competent manner, and utilizing evidence-based practices where feasible.
13. **The roles and responsibilities of Board-appointed Commissions shall remain unchanged.** The creation of the Agency does not alter the roles and responsibilities of existing County Commissions. Each

Commission should continue to advise Departments and the Board on issues related to their areas of interest and expertise. As is the current practice within Departments, Commission input shall be given significant weight and consideration in Agency decision-making.

14. **The Agency shall not alter or interfere with the duties and responsibilities of the County Health Officer.** Should a Health Officer Order impact any operations within the Agency, the Agency Director shall assure compliance to protect the health and safety of all residents.
15. **The Agency shall support public health emergency response activities and other time-limited, high-priority County preparedness initiatives.** The Agency shall respond to emergencies or crisis-level activities through development and implementation of effective plans, trainings and exercises to assure integrated service delivery and unified communication. Departments shall retain their respective roles, responsibilities, and legal authorities during emergencies.
16. **The Agency Director shall administer Department Head performance evaluations.** Department Head performance evaluations shall be drafted by the Agency Director for review and input by the County Chief Executive Officer. The Board of Supervisors shall maintain the ultimate authority over any individual Department Head's final performance evaluation and associated merit pay.

MOTION BY MAYOR MICHAEL D. ANTONOVICH

AUGUST 11, 2015

HEALTH AGENCY

On January 13, 2015, the Board of Supervisors unanimously approved in concept the integration of Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH), to create a single unified health agency (Health Agency). Furthermore, the Board directed staff to report back with a proposed structure of such an Agency and a timeline of how it would be implemented.

As part of the evaluation of this proposal, the Interim Chief Executive Officer (CEO) was directed to establish a stakeholder/public participation process to ensure that their input was considered in the staff report. This process resulted in extensive forums being held throughout the County to receive recommendations from both internal and external stakeholders. The resulting staff report validates the need to move forward.

While all parties agree that greater integration of these services is critical to the County’s ability to address the needs of its patients, some critics of the Health Agency have argued that these three departments were linked in the past, but failed to provide integrated care delivery. This statement may be true, but it ignores how significantly the national thinking on health care has changed in the past 43 years.

This motion does not seek to eliminate or diminish the work done by DHS, DMH, or DPH. Nor does it subsume these departments into a “medical” model that ignores the recovery-based models and social determinants of health. The opposite is true.

National changes in the delivery of health care have created both significant opportunities and challenges for the County. New legislative mandates, service provisions and financing have caused a tremendous shift toward integrated delivery of care that better aligns physical, behavioral, community, and population health.

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

Further, we know that managing the care of our patients requires that we look closely at the social determinants of health, such as access to housing, food, and other necessities of life, as well as socio-economic factors that may affect how care is sought. By bringing together these three departments under a single Health Agency, we can bring to bear the available resources to meet our patients' needs.

Each day, the lives of the 10 million Los Angeles County residents are affected by the services provided by County Departments. Each program may have a different purpose, but all are unified in sharing one vision to "improve the quality of life in the County of Los Angeles by providing responsive, efficient, and high quality public services that promote the self-sufficiency, well-being, and prosperity of individuals, families, businesses, and communities."

Creating a single Health Agency is now a business imperative for the County to improve access, health outcomes, and system efficiency. In the present and expected future health care environment, and to best meet the needs of our constituents, the County must move from fragmentation to integration of its health care delivery system.

Creating a unified Health Agency also makes fiscal sense. Bringing these departments together can serve to increase the County's total delivery capacity by eliminating duplication among departments and allowing for creative multi-disciplinary collaboration to address such intractable problems as homelessness and diversion of criminal offenders.

Critics of a single Health Agency have also expressed concern that the voice of the individual departments, as well as the associated stakeholder groups, would be muted by the Agency model. This is not the intent. The department heads will still have direct access and regular interaction with the Board about their respective programs. Additionally, all three departments are supported by Board-appointed commissions with direct reporting to the Board and whose members have individual relationships with the Board members and their staff. This would continue to be the case under the Agency model.

Finally, those who oppose the Agency model argue that the larger entity could ignore long-standing community priorities by reallocating funding to other areas not supported by stakeholder groups. This Board recognizes the importance of maintaining separate departmental budgets to protect the unique funding streams and responsibilities of each department. Any changes or reallocations from one budget to another would require Board approval, just as such changes require now.

As the health care industry continues to experience dramatic shifts in how care is funded, a single Health Agency will also ensure the efficiency of administrative functions and potential cost savings. The County must embrace a cohesive delivery system in order to fully leverage and maximize all resources. This means moving from a “Department-centered” framework to a “client/patient/community-centered” model of care where there is no wrong door for those seeking care, especially the vulnerable, at-risk and socio-economically disadvantaged populations such as the homeless, infirmed and transitional age youth. Fully leveraging and coordinating each Department’s expertise and resources will result in continuous quality improvement and innovation, bringing about higher accountability, effectiveness, efficiency and advocacy.

This Board demonstrates sustained leadership and fiscal stewardship in preserving and strengthening the County safety net. The time is now to position the County for continuing success by establishing a single unified Health Agency to break down the bureaucratic barriers faced by the County’s patients and clients, identify and maximize synergies among DHS, DMH, and DPH programs, streamline operations, optimize finances, and align incentives so that all County staff can continue moving toward the goal of providing high quality and person-centered services across the full continuum of health services.

In its motion, the Board requested and received input from stakeholder groups. One of the ideas that came out of this discussion was the notion of an Office of Health Care Enhancement to facilitate the coordination and integration of services among the multiple County agencies. While this is a valid suggestion, such an office would have no accountability to the Board for implementing a coordinated system and would be advisory in nature. The Agency model holds not only the agency head, but the individual department heads accountable to implement initiatives to integrate service delivery.

The Board has, over the past several years, overseen an unprecedented expansion in the delivery of personal, public, and mental health services. This growth is based upon the notion of continuity and integration in the delivery all of these services. We are at a critical juncture in the evolution of the delivery of health care and it is crucial that we take action to facilitate the integration of services provided by our \$7 billion health care delivery system.

I, THEREFORE, MOVE that the Board of Supervisors:

1. Approve the establishment of a Health Agency to integrate the operations of the Departments of Health Services, Mental Health, and Public Health and direct the Interim Chief Executive Officer (CEO) to ensure that separate budgets are maintained for each Department;
2. Direct County Counsel to draft a County ordinance within 30 days to create a Health Agency and work with the Chief Executive Office and Department of Human Resources to establish an ordinance position of Health Agency Director;
3. Direct the Director of Human Resources and CEO Classification-Compensation to develop and submit to the Board a job description and associated position for the Health Agency Director within 30 days; and initiate recruitment for the Agency Director;
4. Instruct the Interim CEO to create a temporary steering committee, made up of the Directors of Health Services, Mental Health, Public Health, and the Public Health Officer to develop within 45 days, taking into account input from community stakeholders, a strategic plan and operational framework for integrating the three departments with priorities, specific outcome measures, and a preliminary associated workplan to include, but not be limited to, the following:
 - a. Streamlining access for those who need services from more than one Department and its community partners, including by promoting information-sharing, registration, and referral processes, training staff cross-discipline, and increasing co-location of services;
 - b. Reducing homelessness among individuals with health-related needs; and
 - c. Reducing overcrowding of public Psychiatric Emergency Services (PES) and private Emergency Departments (EDs) by individuals on involuntary psychiatric holds.
5. Direct the Interim CEO to convene a temporary Integration Advisory Board (IAB) made up of two representatives from each of the following Commissions: the Mental Health Commission, the Public Health Commission, Hospital and Health Care Delivery Commission, Commission on Alcohol and Other Drugs, and the Commission on HIV; one or two consumers from each Commissions' discipline; and one or two representatives from each Department's organized labor unions. The Commission and consumer representatives should be selected by public vote of each Commission. Labor representation will be determined by labor leadership. Two co-chairs of the IAB shall be selected by vote at the first public

meeting of the Advisory Board. The IAB will serve as an advisory body to the Board of Supervisors reporting in writing to the Board on at least a semi-annual basis for two years, on the impact (positive or negative) of the Health Agency on ongoing Departmental activities and operations and on achieving the County's health-related priorities. Commission and consumer representatives from each discipline should include comments as it relates to their particular area of focus; and

6. Establish a quarterly set item on the Board agenda in which the Agency Director and Department heads publicly report to the Board on the following topics:
 - a. Progress in achieving agency goals and specific indicators and outcome measures;
 - b. Financial status of each Department, including any notable changes in funding streams, sources and uses of funds by program and provider type, and number of individuals served; and
 - c. Stakeholder engagement process.

#

AMENDMENT BY SUPERVISOR HILDA L. SOLIS

August 11, 2015

- 4.
 - d. Ensuring culturally competent and linguistic appropriate care in the health agency and across all three agencies.

###

HLS:jyp

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

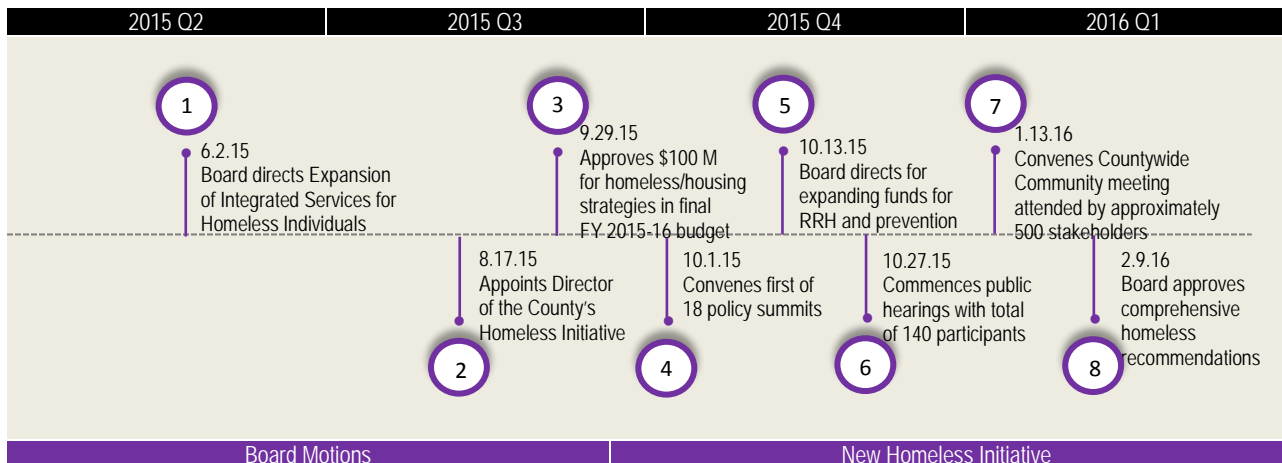


County of Los Angeles
AD HOC INITIATIVES

HOMELESS INITIATIVE		
Topic	Document	Date
Board Motions	1. Board Motion - Expanding Effective and Integrated Services for Homeless Single Adults in Regions with Highest Geographic Burden	6/2/15
	2. Board Motion - Replenishing and Expanding Funds for Rapid Rehousing, Prevention, and Supportive Services for Homeless Populations	10/13/15
	3. Board Motion - Affordable Housing Program	10/27/15
	4. Board Motion - Making Strategic Investments in the Los Angeles County's Homeless Initiative	2/9/16
Homeless Initiative	5. Board Letter - Homeless Initiative Recommendations and Report – Adopted	2/9/16

- Information Available on County Homeless Initiative Website at: <http://priorities.lacounty.gov/homeless/>
- Board Correspondence may be searched by title and date at: <http://portal.lacounty.gov/wps/portal/bc>

HOMELESS INITIATIVE TIMELINE



**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS
AND HILDA SOLIS**

JUNE 2, 2015

**Expanding Effective and Integrated Services for Homeless Single Adults in
Regions with Highest Geographic Burden**

On June 11, 2013, the Los Angeles County (County) Board of Supervisors (Board) directed the Chief Executive Officer (CEO) to develop recommendations to reprogram currently unspent Countywide Homeless Prevention Initiative (HPI) one-time funds and ongoing non-district funds starting in the 2013-14 Fiscal Year in a manner that promotes both permanent supportive housing and best practices, and allocates resources based on geographic burden and need as determined by the latest homeless count results for the Los Angeles, Glendale, Pasadena and Long Beach continua of care.

The CEO responded with a report dated October 30, 2013, which included recommendations that directed the Departments of Health Services (DHS), Mental Health (DMH), Public Social Services (DPSS), and Public Health (DPH) to establish a model of care for homeless single adults. The goal of the model of care is to permanently house and provide supportive services to homeless single adults who have physical and/or mental health conditions, and who may also have co-occurring substance use issues.

- MORE -

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS
AND HILDA SOLIS
JUNE 2, 2015
PAGE 2**

On November 12, 2013, the Board directed the CEO, in coordination with DHS, DMH, DPSS, and DPH, to implement the recommendations included in the CEO's October 30, 2013 report and establish a single adult model (SAM) plan to provide an infrastructure to reduce homelessness for the single adult population. The Board directed the CEO to disburse the currently unspent countywide one-time HPI funds and any ongoing non-district funds by Service Planning Areas (SPAs) based on the latest homeless counts of the four continua of care in the County.

The components of the SAM plan include rental subsidies, ongoing case management, and supportive services, interim housing, and multidisciplinary integrated teams (MITs) to provide street and shelter-based intensive engagement and support. The SAM plan also included distributing rental subsidy and staffing resources by SPA based on geographic burden. The plan recommended that seven MITs be created - one MIT each in SPAs 1, 2, 4, 5, 6, and 8 and one MIT for SPAs 3 and 7. According to the SAM plan, four full-time equivalent registered nurses (proposed in-kind County contribution) would be assigned to the MITs according to geographic need.

On May 11, 2015, the Los Angeles Homeless Services Authority (LAHSA) released its 2015 homeless count showing a high rate of homelessness in SPA 4 and SPA 6 and increasing homelessness Countywide (see Attachment I). The 2015 homeless counts for the County's four continua of care demonstrated that SPA 4 had the highest burden of homeless single adults (27.7%), followed by SPA 6 (16.2%), SPA 8 (12.1%) and SPA 2 (11.7%) (see Attachment II).

On May 19, 2015, DMH submitted a Board letter requesting approval of funding for seven MITs. According to the DMH transmittal, each of the seven MITs will be staffed equally, with 4 full-time staff and two part-time staff. It is imperative that resources for the SAM plan are targeted to the SPAs with the greatest geographic burden and need as demonstrated by the latest homeless count results, as has been directed by the Board.

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS
AND HILDA SOLIS
JUNE 2, 2015
PAGE 3**

The CEO and partners such as DMH, DHS, DPH, DPSS and LAHSA have been working to align and integrate funding in a way that maximizes the effectiveness of County resources and ensures that efforts are combined. There is a need to balance providing core services across the County while at the same time ensuring that the County address priorities based on the latest homeless counts and the needs of different regions.

WE THEREFORE MOVE THAT THE BOARD OF SUPERVISORS:

- 1) Approve the Department of Mental Health Board letter (Agenda No. 29) to enhance the provision of field-based integrated mental health, physical health and substance use services throughout the County to homeless single adults through establishment of Multidisciplinary Integrated Teams (MITs);
- 2) Direct the Interim Chief Executive Officer (CEO) and the Director of the Department of Mental Health to identify funds that can be used to add one MIT in the Skid Row region of SPA 4, and proportionally augment staffing for the MITs in SPA 6, SPA 8, and SPA 2, given that these regions demonstrate the highest geographic burden of homelessness among single adults, as determined by the 2015 homeless count results for the Los Angeles, Glendale, Long Beach and Pasadena continua of care (see Attachment II);
- 3) Direct the Director of Mental Health to work with County Counsel to determine the process for identifying a qualifying provider for the additional MIT to be implemented in the Skid Row region of SPA 4, to notify the Board prior to entering into any agreement for this area, and to amend contracts of providers delivering MIT services in SPAs 6, 8 and 2; and
- 4) Report back in writing in 60 days.

WE FURTHER MOVE THAT THE BOARD OF SUPERVISORS direct the Interim CEO, in coordination with the Directors of the Departments of Mental Health (DMH),

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS
AND HILDA SOLIS
JUNE 2, 2015
PAGE 4**

Health Services (DHS), Public Health (DPH), Public Social Services (DPSS) and the Los Angeles Homeless Services Authority (LAHSA) to:

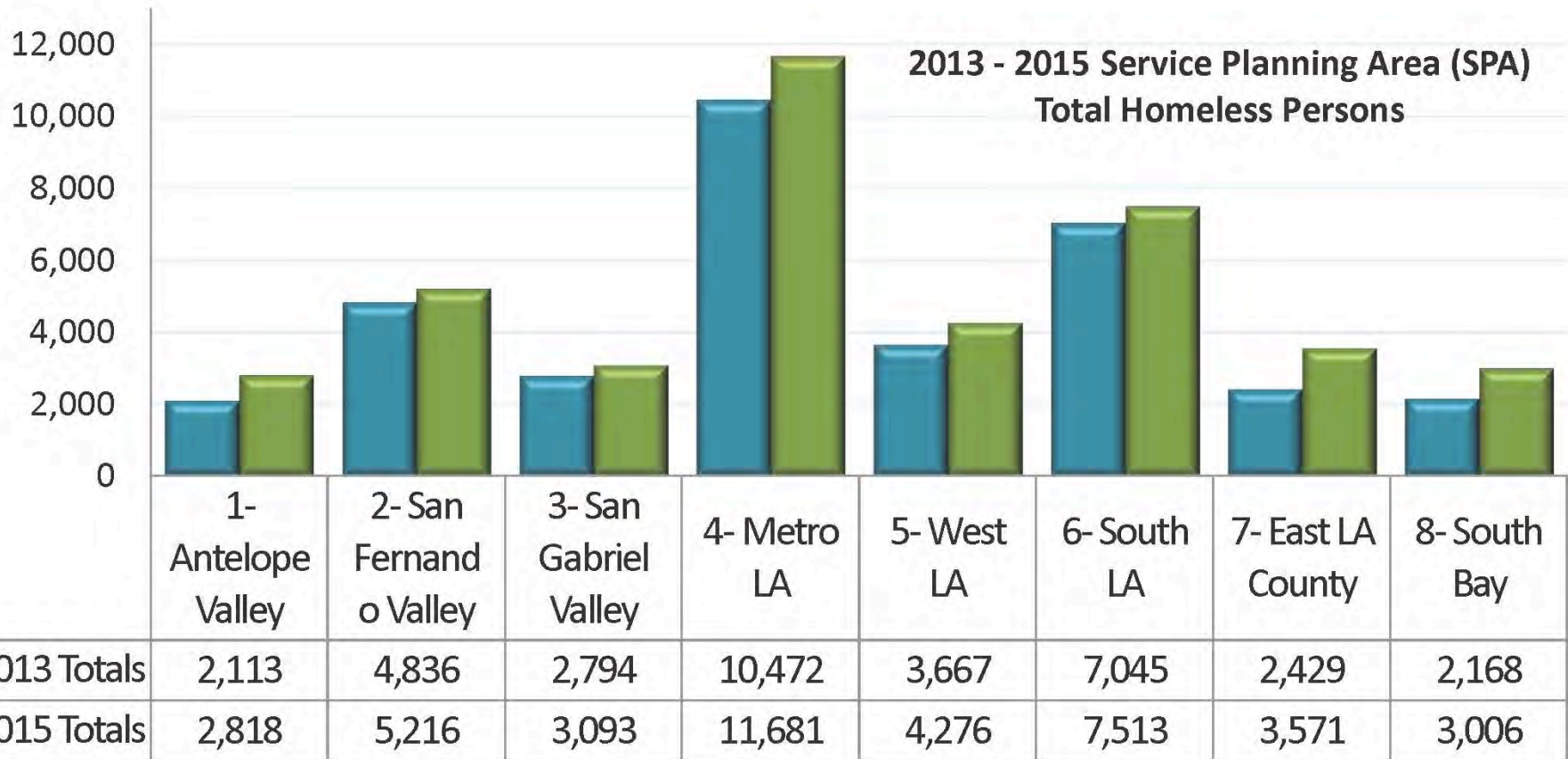
- 5) Report back in writing in 60 days on efforts to identify additional annual Homeless Prevention Initiative ongoing funds, as directed by the Board of Supervisors on June 11, 2013, given the results of the latest homeless counts; and
- 6) Provide an update on the coordination and implementation of all single adult homeless outreach and engagement efforts, including the Single Adult Model and MITs, the Coordinated Entry System for single adults, LAHSA outreach teams, DMH Homeless Outreach Mobile Engagement (HOME) Team, DMH Integrated Mobile Health Teams (IMHTs), and other current and proposed County-funded outreach teams, so that these efforts result in a systematic Countywide strategy.

YV/DW

2015 Service Planning Areas (SPAs)



Excluding Glendale, Long Beach and Pasadena, every SPA experienced an increase in homelessness since 2013.



ATTACHMENT II

Los Angeles County Single Adult Population, 2015				
Service Planning Areas	2015 Single Adults in LA Continuum of Care (CoC)	2015 Single Adults in Other CoCs (Glendale - SPA 2, Pasadena - SPA 3, and Long Beach - SPA 8)	2015 Total Single Adults in LA County	2015 % Per SPA Single Adults in LA County
1- Antelope Valley	2,168		2,168	6.0%
2- San Fernando Valley	4,081	127	4,208	11.7%
3- San Gabriel Valley	2,505	513	3,018	8.4%
4- Metro LA	9,958		9,958	27.7%
5- West LA	3,561		3,561	9.9%
6- South LA	5,826		5,826	16.2%
7- East LA County	2,833		2,833	7.9%
8- South Bay	2,456	1,936	4,392	12.2%
Total	33,388	2,576	35,964	100.0%

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS
AND MICHAEL D. ANTONOVICH**

October 13, 2015

Replenishing and Expanding Funds for Rapid Rehousing, Prevention and Supportive Services for Homeless Populations

The County of Los Angeles (County) is in the midst of a homeless crisis that affects more than 44,000 men, women and children who are sleeping in shelters, transitional housing programs, vehicles, and on the streets. Against this backdrop, the Interim Chief Executive Officer (CEO), at the direction of the Board of Supervisors (Board), has created a Homeless Initiative to develop, in coordination with a diverse group of public and private stakeholders, a comprehensive and regional strategy to meaningfully address homelessness. The Interim CEO also augmented the existing Homeless Prevention Initiative (HPI) Fund with an additional \$51 million one-time funding as part of the FY15/16 Supplemental Budget Adjustment, bringing the total amount of HPI funding available this fiscal year to \$101 million. These funds were intended to be set aside until the strategic planning efforts are completed in early 2016. However, given that homelessness has increased 12% since 2013, and with the harsh

- MORE -

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND MICHAEL D. ANTONOVICH
October 13, 2015
PAGE 2

winter months approaching, it is imperative that the County initiate investments in known gaps with best practices immediately in order to respond to the crisis at hand.

Studies have shown that rapid rehousing, which consists of temporary rental subsidies coupled with supportive services and partnerships with community landlords, can significantly shorten the time period in which a person is homeless. Rapid rehousing has also been shown to be more effective and cheaper than transitional housing when it comes to employment and permanent housing outcomes.

Over the last three years, the Board has made strategic investments in rapid rehousing programs for homeless families, particularly through the First 5 LA program, administered by Community Development Commission, and the Homeless Family Solutions System, administered by the Los Angeles Homeless Services Agency. Since 2013, both programs have housed over 2,500 families and only 6% have returned to homelessness. Separately, the region has leveraged federal funds through the Department of Veterans Affairs and put into place a Countywide system to rapidly rehouse homeless veterans. However, the County still does not have a rapid rehousing program for non-veteran homeless single adults.

There are several funding gaps that should be addressed immediately. One funding gap is related to the imminent termination in March 2016 of funding for the First 5 LA rapid rehousing program, which targets at-risk and homeless families with young children under the age of 6. In addition, many of the agencies that are administering the rapid rehousing funds for families have exhausted, or are close to exhausting, the remaining funds which will leave many families unassisted despite the infrastructure in place to provide assistance.

MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND MICHAEL D. ANTONOVICH
October 13, 2015
PAGE 3

The second funding gap relates to the lack of money to prevent families from entering into homelessness in the first place; these so-called “diversion” approaches are an important element of any rapid rehousing program to ensure that families which are on the brink of homelessness can also be targeted for assistance. Currently, there is no funding allocation to provide prevention services for this population, even though the infrastructure does exist to provide this assistance through the Family Solutions System.

The third funding gap relates to ensuring that there are rapid rehousing resources for single adults that are homeless but do not have long-term or significant service needs. Infrastructure exists to potentially allocate these funds, through the Department of Health Services’ Housing for Health Division which currently provides rapid rehousing (including employment) to the probation population. Non-chronic homeless single adults would benefit from rapid rehousing interventions and Housing for Health Division is well-poised to identify community landlords, administer tapering rental subsidies and provide home-based case management services.

Finally, flexible financial resources must be in place to ensure that homeless persons and families have access to ongoing supportive services once they are housed. While the rapid rehousing program model includes funding for supportive services, it is more challenging to secure funding for ongoing supportive services tied to permanent supportive housing. While efforts are underway to expand the availability of resources for permanent supportive housing, the County must also commit ongoing resources to ensure that funding for supportive services is available for all new developments. The County should optimize federal resources through the new Medicaid Waiver and other

MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND MICHAEL D. ANTONOVICH
October 13, 2015
PAGE 4

strategies for this, and should also assess what level of additional, ongoing resources should be allocated for this purpose.

The following recommendations build on existing initiatives and priorities that were previously approved by the Board. These strategies have been proven to prevent and end homelessness and would allow the County to make a more immediate and substantive impact while the Interim CEO completes the strategic planning process to address these issues. As was approved by the Board on June 11, 2013, County resources identified for these interventions, including ongoing non-district funds, will be allocated based on geographic need per Service Planning Area, as determined by the latest Homeless Count results for the Los Angeles, Glendale, Pasadena and Long Beach continua of care.

WE THEREFORE MOVE THAT THE BOARD OF SUPERVISORS:

Direct the Interim Chief Executive Officer to:

1. Allocate \$10,000,000 of the available Homeless Prevention Initiative Funds to the Department of Health Services' Housing for Health Division, to fund rapid rehousing for single adults who are not chronically homeless, including homeless single adults identified by the Coordinated Entry System, and report back to the Board in writing within 30 days with an operations and expenditure plan;
2. Allocate \$2,000,000 to the Los Angeles Homeless Services Authority to fund prevention activities for families on the brink of homelessness, in coordination with the Family Solutions System, and report back to the Board in writing within 30 days with an operations and expenditure plan;

MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND MICHAEL D. ANTONOVICH
October 13, 2015
PAGE 5

3. Transfer \$3,000,000 of available Homeless Prevention Initiative Funds to the Community Development Commission in order to augment and extend rapid-rehousing services for homeless families with children, through the end of FY15/16 so that no service disruption occurs, given existing grant resources are being exhausted and will expire in March 2016, and report back to the Board in writing within 30 days with an operations and expenditure plan;
4. Identify, as part of the Homeless Initiative Strategy, specific funding sources, including federal and state funds, that could be used to establish a sufficient ongoing pool of funds, in coordination with the Department of Health Services Master Agreement List for Intensive Case Management Services (ICMS), for supportive services tied to permanent supportive housing projects and provide an interim report in writing within 30 days; and
5. Provide a comprehensive report back, as part of the Homeless Initiative Strategy, on homelessness prevention activities within the County.

**WE FURTHER MOVE, ACTING AS THE BOARD OF COMMISSIONERS FOR
THE COMMUNITY DEVELOPMENT COMMISSION:**

6. Direct the Executive Director to accept and incorporate into their FY15/16 Budget, \$3,000,000 of Homeless Prevention Initiative Funds allocated by the County of Los Angeles, in order to augment and extend rapid rehousing services for homeless families with children, given existing grant resources are being exhausted and will expire in March 2016.

###

MOTION BY SUPERVISORS KUEHL
AND RIDLEY-THOMAS

October 27, 2015

Los Angeles County (County) is experiencing one of the worst housing crises in its history. A family living in the County is required to earn \$71,000 per year in order to afford the average rent for an apartment in Los Angeles. Unfortunately, the average renter household earns only \$39,000 per year, making it difficult for full-time childcare workers, security guards, nursing assistants, teachers, and many others to even afford a studio apartment in Los Angeles. The County is currently 527,000 units short in its supply of housing affordable to very low-income households. As a result, families “double up,” causing our region to be known as the over-crowding epicenter of the country with more families in unsustainable and unsafe living conditions than anywhere else. When a crisis strikes - a job lost or an injury that causes lost wages - these households fall into homelessness, and are often forced to look to the County for financial assistance.

In 2006, the Board of Supervisors (Board) implemented the Homeless Prevention Initiative, and in 2011, officially endorsed Home for Good’s plan to end chronic and veteran homelessness. Even so, over the past decade, the County’s commitment to addressing homelessness has fallen short, with no real comprehensive approach and

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

insufficient resources to meaningfully address a major component: the affordable housing crisis.

The lack of affordable housing has had a profound impact on the County and its residents. In January of this year, 15,857 families on CalWORKs were homeless. A shocking 53,575 individuals receiving General Relief were homeless during the same month. These individuals, many of them mothers and fathers, face extraordinary challenges in becoming gainfully employed. Even the exceptional person who can find a place to clean up for a job interview, get to the interview on time on the bus, and land a job, faces overwhelming odds against finding a job that pays enough money to rent an apartment in the County.

The housing crisis also impacts many of our County Departments, requiring inefficient expenditures on public safety, child protection, and healthcare. Taxpayers pay for children to stay in foster care because, even when their parents have done everything to show that they can safely care for their children, a judge cannot release a child to a family that does not have a place to live. Our hospitals hold patients longer than medically necessary because of the lack of a safe place to which a patient can be discharged. Men and women leaving jail who are homeless are much more likely to commit another crime and return to jail. Children who grow up in overcrowded homes or experience homelessness have profoundly worse health and educational outcomes than their peers.

Programs to preserve and create affordable housing were severely curtailed by the February 2012 statewide dissolution of Redevelopment Agencies, which had, up to that point, supplied much of the funding for affordable housing. Prior to their dissolution,

local Redevelopment Agencies were required to set aside a minimum of 20% of their revenues in special Low-and-Moderate Income Housing Fund accounts, which were used to create and preserve affordable housing throughout the County. These funds provided more than \$274 million per year for affordable housing in Los Angeles County. Recognizing the significant need to continue to ensure public financing for affordable housing projects, the Board has already committed \$101,051,000 in one-time redevelopment dissolution revenue to support this objective. The allocation of \$43.8 million of those funds has led to the creation of 1,137 new affordable apartments for low income families, seniors and households experiencing homelessness. The remaining \$52.7 million is projected to create 850 to 1,450 additional affordable apartments.

Los Angeles County has a unique opportunity to address the affordable housing crisis by providing substantial and sustained funding for the creation and operation of both short and long-term affordable housing for a variety of vulnerable populations. This would best be accomplished by creating a dedicated Affordable Housing Programs budget unit. Initially, the Chief Executive Officer (CEO) should identify \$20 million in FY 2016-17, with the goal of reaching full funding of \$100 million of new monies per year by FY 2020-21. The Affordable Housing Programs budget unit should be made up of new funding, potentially including redevelopment residual funds, which are not currently being invested in other housing programs, and its expenses should not supplant any existing spending on housing programs, including programs to be funded through the County's new Office of Diversion and Reentry.

Up to 8% of the Affordable Housing Program funds should be made available for County and Community Development Commission administrative expenses. Of the

remaining funds, no less than 75% should be allocated to support the production of new, or preservation of existing, affordable housing (including workforce housing and permanent supportive housing) for very low and extremely low-income or homeless households. The remaining funds will be reserved for rental assistance, rapid rehousing, shared housing, move-in assistance, and related services for individuals and families.

To ensure a coordinated, holistic and collaborative investment strategy, the Board should create an Affordable Housing Coordinating Committee, and an Executive Committee comprised of a subset of Coordinating Committee members. The Committees should include and be supported by the Chief Executive Officer. The Coordinating Committee should recommend models to address the affordable housing needs of a variety of priority populations including low income families, seniors, homeless individuals and families, transition age youth, people exiting our jails and juvenile justice system, child-welfare involved families, veterans, extremely low income individuals with physical disabilities, domestic violence survivors, and a broad range of individuals who are frequent users of County health and social service programs. The Committee should be tasked with evaluating all County housing programs, documenting our progress in meeting regional housing needs, and providing guidance on policy changes that should be considered in order to best serve the County's priority populations. The Committee should also analyze the County's ability to produce and secure affordable housing that contributes to the health of communities by locating housing near transportation, job centers, and other amenities.

Additionally, the Executive Committee shall develop a recommended funding allocation strategy to be presented to the Board of Supervisors as part of the Supplemental Budget phase.

As the County's partner in developing affordable housing projects Countywide, the Community Development Commission should also consider a variety of strategies in order to optimize its role in developing additional affordable housing units in the coming years.

WE, THEREFORE, MOVE that the Board of Supervisors:

1. Direct the Chief Executive Officer and the Auditor-Controller to create a new Affordable Housing Programs budget unit within the County General Fund.
2. Direct the Chief Executive Officer to report back during the Supplemental Budget phase of the Fiscal Year 2016-17 budget with a multi-year plan to provide new funding that is not already allocated for homelessness or housing programs for the Affordable Housing Programs budget unit. The plan should identify \$20 million in FY 2016-17, and recommend ways to increase annual allocations to the fund by \$20 million per year in each of the subsequent four fiscal years, to ultimately reach an annual allocation of \$100 million per year for this budget unit by FY 2020-21. Among potential funding sources, the plan should include strong consideration of the use of redevelopment residual and one-time dissolution funds. The plan should also explore potential leveraging of Mental Health Services Act funding to increase production of new permanent supportive housing.

3. Direct the Chief Executive Officer to allocate up to 8% of Affordable Housing Programs funds for County and Community Development Commission administrative expenses. A minimum of 75% of the remaining funds should be dedicated for production of new, or preservation and rehabilitation of existing, affordable housing for very and extremely low-income or homeless households, including workforce housing and permanent supportive housing for these households. The remaining funds will be available to support rental assistance, rapid re-housing, shared housing, and move-in assistance.

WE FURTHER MOVE that the Board of Supervisors:

4. Direct the Chief Executive Officer (CEO) to establish a Los Angeles County Affordable Housing Coordinating Committee including one representative from each of the following agencies: the Community Development Commission, the Housing Authority of the County of Los Angeles, the Department of Mental Health, the Department of Health Services, the Department of Public Health, the Department of Public Social Services, the Department of Community and Senior Services, the Sheriff's Department, the Probation Department, the Los Angeles Homeless Services Authority, the Department of Children and Family Services, and the Department of Regional Planning. An Executive Committee, comprised of representatives from the CEO, Community Development Commission, the Housing Authority of the County of Los Angeles, the Department of Mental Health, the Department of Health Services, the Department of Regional Planning, and the Los Angeles Homeless Services Authority, should lead the Committee's work.

5. Direct the CEO to hire appropriate technical advisers, as needed, to support the work of the Affordable Housing Coordinating Committee and the Executive Committee.
6. Instruct the Coordinating Committee to develop an Annual Affordable Housing Outcomes Report, which shall provide policy recommendations, gap analysis and information on the outcomes of all of the County's affordable housing investments including the Community Development Commission's housing programs, the Housing Authority of the County of Los Angeles's public housing and voucher programs, the Department of Mental Health's Mental Health Services Act Housing Program, the Department of Health's Housing for Health programs, the Office of Diversion and Re-Entry housing programs, the Los Angeles Homeless Services Authority's housing programs, the Department of Public Social Services' housing programs and any other county housing programs.
7. Instruct the Coordinating Committee to report back to the Board of Supervisors in 150 days with:
 - a. A template for the Annual Affordable Housing Outcomes Report; and
 - b. An assessment of the feasibility of implementing local hire requirements and requirements for hiring from social enterprises in the construction, operation, and maintenance of affordable housing developments, and the possibility of requiring certification for affordable housing operations and maintenance employees on all capital projects supported by the Affordable Housing Programs budget unit.

8. Direct the CEO, as part of the Homeless Initiative, to report back to the Board of Supervisors in 120 days with a recommendation on how the FY 2016-17 Affordable Housing Programs budget unit funds that are not reserved for production of new, or preservation and rehabilitation of existing, affordable housing for very and extremely low-income or homeless households should be invested.
9. Instruct the Executive Committee to recommend, through the Chief Executive Officer as part of the Supplemental Budget phase of the Fiscal Year 2016-17 budget, annual and multi-year funding allocation recommendations for the Affordable Housing Programs level budget unit, initially focused in FY 2016-17 on funding allocations for the 75% of the fund that is dedicated to the creation and preservation of housing, and continuing to report back to the Board of Supervisors in subsequent Supplemental Budget phases with future recommendations for the entire budget unit. In its annual recommendations, the Executive Committee shall consider regional housing needs and include an explanation in their recommendations for how geographic variables were assessed and utilized in the allocation recommendations.

WE FURTHER MOVE that the Board of Supervisors, acting as the Board of Commissioners for the Community Development Commission (CDC), direct the Executive Director to submit, within 150 days, a report that provides recommended policy or administrative actions necessary to facilitate the effective and efficient use of Affordable Housing Program resources committed to the CDC, and assesses the feasibility of:

- a) Developing a bi-annual NOFA process,
- b) Increasing the existing \$2.5 million project cap in unincorporated areas of the County,
- c) Requiring or incentivizing cities to invest in proposed affordable housing developments, potentially including a requirement of a sliding scale match to County funds. Cities that are receiving substantial redevelopment residual funds (more than \$4 million per year) should demonstrate a significant contribution to affordable housing production in their jurisdiction,
- d) Implementing strategies to support the creation of affordable housing for non-special needs extremely low-income households, as well as strategies for preserving affordability in existing housing such as rent controlled housing via rehabilitation,
- e) Establishing an iterative process for reviewing and amending service plans,
- f) Setting annual targets for available Project-Based Housing Choice Vouchers at levels adequate to fund all special needs units funded under NOFA 22 and annual targets for future years,
- g) Establishing project-specific social service reserves, and
- h) Strategies for incorporating recommendations from the County's Homeless Initiative in future affordable housing investments.

AMENDING MOTION BY SUPERVISOR MARK RIDLEY-THOMAS FEBRUARY 9, 2016

Making Strategic Investments in the Los Angeles County's Homeless Initiative

Los Angeles County (County) is in the midst of a homeless crisis that affects more than 44,000 men, women and children who are sleeping at night in emergency shelters, transitional housing programs, vehicles, and on the streets. This is a crisis that has been building for decades, driven by declining incomes and rising housing costs. The most vulnerable, those living with mental or physical disabilities and drug or alcohol addictions, and who lack family support, are the hardest hit. A humane and holistic approach that is fiscally sustained over the long term and aimed not only at rehousing persons that are homeless but preventing people from becoming homeless in the first place is needed.

The County has made several efforts and investments to address homelessness in a meaningful and sustained manner, including:

- Since November 2012, the County's Department of Health Services (DHS) Housing for Health Division has permanently housed 1,110 formerly homeless clients, and 1,500 more clients are in the pipeline to be housed by June 2016. Through the Housing for Health Division, the County is funding a portfolio of street engagement and clinical teams, interim housing, property management and landlord services, rental subsidies, and supportive services. Once individuals are placed in permanent housing, the County

- MORE -

MOTION

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

SOLIS _____

MOTION BY SUPERVISOR MARK RIDLEY-THOMAS
FEBRUARY 9, 2016
PAGE 2

funds non-profit providers that provide Intensive Case Management Services to ensure that clients remain stably housed.

- On June 11, 2013, June 2, 2015, and again on October 13, 2015, the Board of Supervisors (Board) directed the Chief Executive Officer (CEO) to identify additional ongoing funds to sustain the County's Homeless Prevention Initiative strategy.
- In June 2015, the Board approved additional dedicated outreach teams in Skid Row. The County is funding four integrated outreach teams in Skid Row, operated by DHS' Housing for Health Division. Also known as C3 (County-City-Community) teams, this Skid Row initiative leverages existing and ongoing County-funded programs and services, such as DHS recuperative care beds, affordable housing and home-based supportive services.
- In October 2015, the Board approved a \$15 million investment in Rapid Rehousing for single adults and families. The Board has also approved a multi-year plan to create, over five years, a \$100 million annual Affordable Housing Trust Fund to build and invest in affordable and permanent supportive housing throughout the County.
- The Board has also made special investments in various vulnerable homeless populations such as veterans, transition aged youth and women.
- On February 17, 2016, the County will celebrate the opening of the MLK Recuperative Care Center. The MLK Recuperative Care Center will accommodate 100 homeless patients and provide them with intensive case management services, health care oversight and linkage to permanent supportive housing. The opening of this facility will boost the number of recuperative care beds available Countywide from 63 to 163.

In August 2015, the CEO launched a Homeless Initiative, in collaboration with a diverse group of public and private stakeholders, to craft a strategic and comprehensive set of strategies to further address this homeless crisis. The Board applauds the thoughtful and inclusive approach undertaken by the CEO to develop comprehensive and actionable strategies. To ensure accountability and the best results for homeless individuals in the County and throughout the region, the Board must ensure that these strategies are carefully monitored, coordinated and integrated with each other as well as with related Board priority

**MOTION BY SUPERVISOR MARK RIDLEY-THOMAS
FEBRUARY 9, 2016
PAGE 3**

initiatives, such as the Office of Diversion and Re-entry and the Affordable Housing Trust Fund. The ultimate aim should be to demonstrate to the public that progress is being made to address homelessness across the region and that the County is accountable to its multiple stakeholders.

Furthermore, it is imperative that the Board continue to coordinate and leverage the County's activities with all 88 cities within the County. The success of the currently proposed homeless plan, particularly the portions focused on prevention, will rely on the active participation of the County's 88 cities. Cities will ultimately need to change policy, design programs and collaborate with other local jurisdictions to achieve scale.

Finally, it is critical that this initiative be a multi-faceted private/public partnership and includes businesses, residents and faith-based communities. For example, some faith-based organizations own surplus property that, with modest technical assistance, could be utilized to successfully house homeless people. The tremendous community participation at the public summits and hearings leading up to the development of the final recommendations of the Homeless Initiative, as well as record volunteer turnout for the 2016 Homeless Count, demonstrate the willingness of many residents to become involved in the effort to improve the quality of life for the County's most vulnerable residents. It will take the sustained will, engagement and commitment of every sector and every community in the County to meaningfully address the crisis.

I THEREFORE MOVE THAT THE BOARD OF SUPERVISORS: Approve the Chief Executive Officer's February 9, 2016 Homeless Initiative recommendations with the following amendments:

- 1) Direct the Chief Executive Officer (CEO) and all other departments and agencies responsible for allocation and oversight of the resources identified for this initiative (see Recommended Strategies to Combat Homelessness report and related addenda) to report back in 90 days with a plan to allocate and expend all funding based on geographic need per Service Planning Area if reasonable, as determined by the latest Homeless Count results for the Los Angeles, Glendale, Pasadena and Long Beach continua of care, to the extent feasible.

MOTION BY SUPERVISOR MARK RIDLEY-THOMAS
FEBRUARY 9, 2016
PAGE 4

- 2) Direct the CEO to report back to the Board of Supervisors (Board) in 30 days with a written plan that details how the nearly fifty adopted Homeless Initiative recommendations will be implemented in a manner that is cohesive and avoids duplication of effort. This report should include details on how the CEO will coordinate and integrate these strategies and activities across departments and with other related initiatives, such as the Office of Diversion and Reentry and the Affordable Housing Trust Fund. Periodic updates on the trajectory of the collective strategies, taken as a whole, should be communicated to the Board through the CEO's quarterly reports.
- 3) Direct the CEO to work with the Director of Department of Health Services (DHS) Housing for Health Division to report back to the Board in writing in 60 days on recommendations to help faith-based organizations repurpose existing residential and/or surplus properties for use as interim and/or permanent housing for homeless persons. The report back should include a process to develop and structure these partnerships, including recommendations on the most effective and expedient methods for assisting faith-based organizations in their desire to contribute any under-utilized properties to help end homelessness in the County.
- 4) Direct the CEO, in coordination with the Executive Director of the Community Development Commission (CDC), to report back to the Board in writing in 60 days on recommendations to create a database comprised of community residents interested in helping to facilitate the siting of affordable and permanent supportive housing across the County.
 - a. This database can be combined with social media to provide opportunities for advocacy so that interested community members can participate in the development and advancement of supportive housing in their neighborhoods.
 - b. The report should investigate and recommend the most appropriate entity to manage such a database, such as an existing advocacy stakeholder group working on affordable and permanent supportive housing development, as

MOTION BY SUPERVISOR MARK RIDLEY-THOMAS
FEBRUARY 9, 2016
PAGE 5

well as how philanthropy or other private enterprise might be involved in funding the startup costs and maintenance of the database.

- 5) Direct the CEO, in collaboration with the Executive Director of CDC, the Director of the Department of Regional Planning and the Director of the Department of Public Works (DPW), to report back in writing in 60 days on a pilot to incentivize developers to use prefabricated construction techniques to accelerate development of affordable and permanent supportive housing. This pilot would capitalize on Homeless Initiative Strategy F6 which will inventory and unlock underutilized public land for housing development.
 - a. The pilot would use lessons learned from the development of the nationally recognized Star Apartments in Skid Row, which used prefabricated construction.
 - b. Preferred development properties for the prefabricated construction pilot would be located near transportation and other supportive amenities.
 - c. Properties designated to fit the preferred criteria could be offered on an accelerated schedule to non-profit and for-profit housing developers.
 - d. In exchange for these discounted properties/land, developers would agree to use prefabricated construction techniques which should reduce construction costs and completion schedules.
 - e. Concurrently, the County should explore tax benefits for new and/or existing/established prefabrication manufacturers to locate in the County in order to reduce transportation costs, shorten delivery schedules, and lower risk concerns about product standards.
- 6) Direct the CEO to report back in 120 days in writing on a capacity building initiative to support cities that want to successfully partner with the County to achieve the outcomes sought in the Homeless Initiative.
- 7) Direct the CEO, working with County Counsel, and the Director of DPW to develop a Countywide local worker hire policy for Board approval in 30 days that, to the extent possible, applies to all capital projects undertaken as part of this homeless initiative

MOTION BY SUPERVISOR MARK RIDLEY-THOMAS
FEBRUARY 9, 2016
PAGE 6

as well as County construction projects with project budget greater than \$2.5 million and that, among other things, mandates that a minimum percentage of all hours be performed by disadvantaged workers including, e.g., homeless or formerly homeless individuals, veterans and former foster youth.

- 8) Direct the CEO, in collaboration with the Executive Director of the CDC and the Directors of DHS and Mental Health, to report back to the Board in writing in 60 days on a recommended strategy for the construction of not less than 1,000 units of permanent supportive housing over the next five years for homeless individuals diverted from the criminal justice system (production goal derived from the "Proposed Population Management Solutions" 2014 report issued by the Sheriff's Department). The report should explore predictable financing strategies such as tax-exempt bond financing and 4% Federal Tax Credits as well as State Low Income Housing Tax Credits with funding from the State's Special Needs Multi-Family Housing Program, but excluding funding from the County's Affordable Housing Programs budget unit.
 - a. The report should identify the County's real property assets including underutilized or vacant facilities that could be made available to realize the 1,000 units.
 - b. The report should identify opportunities to leverage private sector equity and capital that will be required for construction and permanent financing of 1,000 new units of permanent supportive housing utilizing the rental subsidies available from the Flexible Housing Subsidy Pool.
 - c. The report should also identify additional resources for the Flexible Housing Subsidy Pool based on cost savings achieved as a result of the County's efforts to divert individuals with health and behavioral health issues from the criminal justice system.

(YV/DW)



SACHI A. HAMAI
Chief Executive Officer

County of Los Angeles CHIEF EXECUTIVE OFFICE

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
<http://ceo.lacounty.gov>

"To Enrich Lives Through Effective And Caring Service"

Board of Supervisors
HILDA L. SOLIS
First District

MARK RIDLEY-THOMAS
Second District

SHEILA KUEHL
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

February 09, 2016


The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

ADOPTED

BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

P-1 February 9, 2016


PATRICK O'GAWA
ACTING EXECUTIVE OFFICER

HOMELESS INITIATIVE RECOMMENDATIONS (ALL AFFECTED) (3 VOTES)

SUBJECT

Approve a comprehensive set of recommended County strategies and administrative actions to combat homelessness in Los Angeles County.

IT IS RECOMMENDED THAT THE BOARD:

1. Approve the attached recommended strategies to combat homelessness (Attachment 1) and associated funding allocation (Attachment 1, Addendum A); and direct the Chief Executive Officer to report back to the Board on a quarterly basis regarding the implementation status and outcomes of each strategy.
2. Instruct the Chief Executive Officer to commence implementation of the Phase 1 strategies listed in Attachment 1, Addendum B by June 2016, with the implementation timeframes for the remaining strategies to be identified in the first quarterly report in May 2016.
3. Instruct the Chief Executive Officer to convene a Regional Summit to Combat Homelessness, including all 88 cities in the County, to discuss the County's strategies and specific city opportunities to combat homelessness, as identified in the recommended strategies and in Attachment 1, Addendum C.
4. Instruct the Chief Executive Officer to include establishment of an Office of Homelessness in the FY 2016-17 Recommended Budget.

5. Direct the Chief Executive Officer to develop an evaluation plan for the Homeless Initiative and include the plan in the second quarterly report in August 2016.
6. Direct the Chief Executive Officer to develop and submit for approval a proposed research plan on homelessness in Los Angeles County, in collaboration with United Way-Home for Good, and to address in the plan the potential utilization of both philanthropic funding and state/federal revenue received by departments as funding sources for research.
7. Delegate authority to the Chief Executive Officer and County departments, subject to review and approval of County Counsel, to: a) prepare and execute agreements and any subsequent amendments with the Community Development Commission (CDC) or the Los Angeles Homeless Services Authority (LAHSA) required to implement the recommended strategies; b) prepare and execute agreements with other entities, up to \$250,000, to implement the recommended strategies; and c) execute, as needed, any non-financial amendments or financial amendments which increase or decrease the total contract amount by not more than 10 percent.
8. Delegate authority to the Chief Executive Officer to adjust the maximum funding amount by no more than 10 percent for any recommended strategy.
9. Instruct the Chief Executive Officer, in collaboration with affected departments, to prioritize housing and related services for homeless single adults for whom the County incurs the highest costs, and identify potential resulting savings to be redeployed to combat homelessness.
10. Direct the Chief Executive Officer, in collaboration with the Board, to explore potential sources of ongoing revenue to continue and/or expand the implementation of the recommended Homeless Initiative strategies once the one-time funding for each strategy in Attachment 1, Addendum A has been exhausted.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Homeless Initiative Recommended Strategies to Combat Homelessness

On August 17, 2015, the Board of Supervisors launched the Homeless Initiative to combat the homeless crisis that pervades our communities. The primary initial objective of the Homeless Initiative was to develop a coordinated set of recommended strategies to combat homelessness. To achieve this objective, the Homeless Initiative convened 18 policy summits on nine topics from October 1 to December 3, 2015, which brought together County departments, cities and other public agencies, and a wide range of community partners and stakeholders.

This effort resulted in 47 recommended strategies (Attachment 1) divided into six areas, which are each key to combating homelessness:

- Prevent Homelessness
- Subsidize Housing
- Increase Income
- Provide Case Management and Services
- Create a Coordinated System
- Increase Affordable/Homeless Housing

To implement these strategies, an initial \$100 million in new one-time funding is recommended,

including \$55.7 million in net County cost previously approved by the Board and \$44 million in departmental funding (Attachment 1, Addendum A).

The Homeless Initiative has identified a sub-set of these strategies in Attachment I, Addendum B that will have the most impact in the shortest time, and recommends that implementation of these strategies commence by June 30, 2016. The Homeless Initiative estimates that \$42 million will be expended on these strategies by June 30, 2017, which will result in approximately 3,500 persons exiting homelessness and 2,000 persons prevented from becoming homeless. The County will establish additional targets in the future, based on the level of funding available and commitments by cities and community partners.

Integral to the development of the recommended strategies were policy and strategy briefs (available at <http://priorities.lacounty.gov/homeless/>) prepared for the 18 policy summits mentioned above. The various recommended strategies included in Attachment 1 identify the related strategy brief(s). A wide range of community, city and County experts contributed to the preparation of both the policy and strategy briefs.

Additionally, the recommended strategies reflect input from focus groups of current and recently homeless adults (Attachment 2) convened by LAHSA and public comments from over 200 individuals and organizations on the draft strategies that were released for public comment on January 7, 2016 (available at <http://priorities.lacounty.gov/homeless/>).

Summary of Recommended Strategies

The recommended strategies summarized below reflect the following key principles:

- Homelessness is an extraordinarily complex problem, which necessitates active, sustained collaboration amongst the County, cities and other public agencies, and a wide array of community partners.
- The web of established collaborative relationships in Los Angeles County provides a very strong foundation for the implementation of these strategies.
- These recommended strategies must strengthen and build upon current County efforts by:
 - Directing more resources to proven strategies;
 - Integrating existing programs and services more effectively;
 - Enabling cities to join the County in combating homelessness; and
 - Identifying opportunities to leverage mainstream criminal justice, health, and social services.

Prevent Homelessness - Combating homelessness requires effective strategies to reduce the number of families and individuals who become homeless, in addition to helping currently homeless families and individuals move into permanent housing. The recommended strategies in this area include:

- Development of a comprehensive homelessness prevention program for families (Strategy A1);
- Establishment of discharge planning guidelines for all County departments which have the potential to discharge individuals into homelessness (primarily the Sheriff's Department, Department of Health Services, Department of Public Health and Department of Children and Family Services) (Strategy A2); and
- Pursuit of multiple actions to better ensure that foster youth are not emancipated into homelessness (Strategy A4).

Subsidize Housing - Almost all homeless families and individuals lack sufficient income to pay rent on an ongoing basis, particularly given the extremely high cost of market-rate housing in Los Angeles County. In this context, subsidizing rent and related housing costs is key to enabling

homeless families and individuals to secure and retain permanent housing and to prevent families and individuals from becoming homeless. The recommended strategies in this area include:

- Expanding Bridge Housing for individuals exiting institutions who need short-term housing before they can secure permanent housing (Strategy B7);
- Providing subsidized housing to homeless disabled individuals pursuing Supplemental Security Income (SSI) and expanding the County's ability to recover the cost of those housing subsidies once the individual is approved for SSI (Strategies B1 and B2);
- Partnering with cities to expand the availability of rapid re-housing, which combines time-limited rental subsidies with the services that families and individuals need to gain the ability to pay their own rent (Strategy B3);
- Using a modest amount of local funds to help homeless families and individuals with a federal housing voucher secure subsidized housing (Strategy B4);
- Expanding bridge housing for individuals exiting institutions who need short-term housing before they can secure permanent housing (Strategy B7); and
- Dedicating a substantial portion of federal housing subsidies which become available through routine turnover to permanent supportive housing for chronically-homeless individuals (Strategy B8).

Increase Income - Most homeless families and individuals have the ability to increase their income to the point where they will be able to pay for their own housing in the future, if they secure the assistance they need. A high percentage of homeless adults can increase their income through employment; qualified disabled homeless individuals can increase their income through federal disability benefits. Rapid re-housing (Strategy B3) includes a heavy focus on employment.

Additionally, the recommended strategies in this area include:

- Helping homeless adults secure employment through subsidized employment for parents and County contracting with social enterprises (Strategies C1 and C2); and
- Helping qualified disabled homeless adults secure federal disability benefits through countywide advocacy programs for SSI and veterans benefits (Strategies C4, C5, and C6).

Provide Case Management and Services - Most homeless families and individuals need some level of case management and supportive services to secure and maintain permanent housing, though the specific need varies greatly, depending on the individual circumstances. The availability of appropriate case management and supportive services is critical to enabling homeless families and individuals to take advantage of an available rental subsidy, increase their income, and access/utilize available services and benefits. The recommended strategies in this area include:

- Establishing standards for supportive services and housing retention for recently-housed, formerly-homeless families and individuals (Strategies D1 and D3);
- Addressing the unique needs of homeless individuals involved with the criminal justice system, while in jail and upon release (Strategies D2, D4, and D6); and
- Ensuring that County departments collaborate closely with community-based homeless case managers (Strategy D5).

Create a Coordinated System - Given their complex needs, homeless individuals, families and youth often come into contact with multiple County departments, city agencies and community-based providers. For the most part, services are not well coordinated. This fragmentation is often exacerbated by disparate eligibility requirements, funding streams, and bureaucratic processes. Maximizing the efficacy of current programs and expenditures necessitates a coordinated system, which brings together homeless and mainstream services. The recommended strategies in this area include:

- Coordinating (a) law enforcement agencies and other first responders, (b) public housing authorities, and (c) public funders of supportive housing (Strategies E4, E5, E10, and E13) ;
- Leveraging opportunities associated with the Affordable Care Act to improve health, mental health, and substance use disorder treatment for homeless families/individuals (Strategies E2, E3, and

E16);

- Strengthening the emergency shelter system so that it can be an effective point of access to the broader homeless services system (Strategy E8);
- Strengthening outreach, engagement, and County support for homeless case management (Strategies E6, E7 and E11); and
- Enhancing data and data sharing (Strategy E12).

Increase Affordable/Homeless Housing - The lack of affordable housing overall, and homeless housing in particular, contribute substantially to the current crisis of homelessness. The County and cities throughout the region can increase the availability of both affordable and homeless housing through a combination of land use policy and subsidies for housing development. The recommended strategies in this area include:

- Collaborating with cities to maximize development opportunities for homeless housing (Strategies F1 and F3);
- Exploring opportunities to raise funds for the development of affordable/homeless housing (Strategies F2 and F5); and
- Pursuing innovative opportunities to increase the availability of affordable/homeless housing, such as second dwelling units and housing construction on public land (Strategies F4 and F6).

Role of Cities

All cities in the County were invited to participate in the Homeless Initiative planning process and had the opportunity to review and submit comments on draft versions of the recommended strategies. Adoption of the recommended strategies will create unprecedented opportunities for cities to partner with the County in combating homelessness, particularly by:

- Contributing city funding toward the cost of rapid re-housing for homeless city residents (Strategy B3);
- Dedicating federal housing subsidies to permanent supportive housing for chronically homeless individuals (Strategy B8);
- Ensuring that law enforcement and other first responders effectively engage homeless families and individuals (Strategies E4 and E5); and
- Using land use policy to maximize the availability of homeless and affordable housing (Strategies F1, F2, F4, and F5).

The City of Los Angeles was deeply involved in the County's policy summits and embarked on a parallel track in developing its own set of complementary strategies to combat homelessness. Nearly 30 cities from throughout the County participated in the Homeless Initiative policy summits.

Homelessness is not confined by jurisdictional boundaries. Establishing a strong, on-going partnership with cities in the region is critical to successfully combating homelessness. Therefore, a Regional Summit to Combat Homelessness, including all 88 cities in the County, is recommended to be convened to discuss the County's strategies, specifically those with city opportunities to combat homelessness, as set forth in Attachment 1, Addendum C.

Office of Homelessness, Evaluation Plan, Research Plan and Delegated Authority

To effectively coordinate both the implementation of the recommended strategies to combat homelessness and the County's other, ongoing efforts to combat homelessness, we are recommending that the establishment of an Office of Homelessness be included in the Fiscal Year 2016-17 Recommended Budget. The Recommended Budget will address the responsibilities of the Office of Homelessness and its placement within County government.

An effective, clear evaluation plan is vital to successful implementation of the recommended strategies, because the evaluation plan will identify the metrics and data needed to determine the effectiveness of each strategy.

It is important for the County to continue to work with community partners to research the complex issues that directly and indirectly contribute to homelessness and test the efficacy of new, innovative interventions. Accordingly, we are recommending that the Chief Executive Officer be directed to develop, and submit for approval, a proposed research plan on homelessness in Los Angeles County, in collaboration with United Way-Home for Good, including the potential utilization of both philanthropic funding and state/federal revenue received by departments.

In order to effectively and expeditiously implement and make necessary adjustments to the recommended strategies, it is important that delegated authority be provided to the Chief Executive Officer and County departments, subject to review and approval of County Counsel, to:

- Prepare and execute agreements and any subsequent amendments with the CDC or LAHSA required to implement the recommended strategies;
- Prepare and execute agreements with other entities, up to \$250,000, to implement the recommended strategies; and
- Execute, as needed, any non-financial amendments or financial amendments which increase or decrease the total contract amount by not more than 10 percent.

Services Homeless Single Adults Use and their Associated Costs

In a report prepared by the Chief Executive Office's Research and Evaluation Services (RES), it is estimated that close to \$1 billion per year is spent through six County departments to provide services to single homeless adults. The report titled, "The Services Homeless Single Adults Use and their Associated Costs" (Attachment 3), finds that in Fiscal Year 2014-15, Los Angeles County's Departments of Health Services, Mental Health, Public Health, and Public Social Services, the Sheriff, and the Probation Department spent an estimated total of \$965 million in providing services and benefits to homeless single adults. Furthermore, RES's analysis "suggests that 5% of the homeless single adult population in the County – roughly 1 out of every 20 – consumes 40 cents of every dollar spent on the full population." Focusing County efforts in identifying and assisting this small, high-user population to secure and retain permanent housing could free up resources that could be used to assist additional homeless individuals, families, and youth to exit homelessness.

Additional Revenue to Combat Homelessness

It is vital that the County place emphasis on exploring and securing additional revenue to continue to support the recommended strategies once the initial investment is expended. Therefore, it is recommended that the Chief Executive Officer, in consultation with the Board, explore all possible potential sources of on-going revenue to combat homelessness over the long-term.

Implementation of Strategic Plan Goals

The recommended actions are in compliance with the County Strategic Plan, Goal 1, Operational Effectiveness/Fiscal Sustainability, Goal 2, Community Support and Responsiveness, and Goal 3, Integrated Services Delivery.

FISCAL IMPACT/FINANCING

The recommended funding for the strategies set forth in Attachment 1, Addendum A includes \$99.7 million comprised of:

- One-time funding of \$51.1 million approved by the Board on September 29, 2015, and funding of \$4.6 million from the FY 2016-17 Affordable Housing dollars not identified for capital improvements, for a total of \$55.7 million; and
- County department funding comprised of \$5 million of one-time CalWORKs Fraud Incentives from the Department of Public Social Services, \$21.6 million of one-time AB 109 funding, \$15.4 million of one-time SB 678 funding from Probation, and \$2 million of one-time funding from the Department of Children and Family Services, for a total of \$44 million.

Additionally, ongoing departmental funding is expected to be available for nine strategies, as identified in Attachment 1, Addendum C.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Homelessness in Los Angeles County

LAHSA conducted a homeless count of Los Angeles County (excluding the cities of Glendale, Long Beach, and Pasadena, which conduct their own homeless count) in January, 2015. The total homeless population in Los Angeles County (including Glendale, Long Beach, and Pasadena) was 39,461 in 2013 and 44,359 in 2015, which represents a 12.4 percent increase. According to LAHSA, homeless persons enumerated in 2015 were twice as likely to be unsheltered (28,948 persons) as sheltered (12,226). Among the unsheltered population, the number in tents, makeshift shelters, and vehicles saw a significant increase of 85 percent from 2013 (5,335) to 2015 (9,335).

LAHSA has completed an analysis of the gap between the current amount of subsidized housing and the needed amount of subsidized housing in Los Angeles County, based on the results of the 2015 Homeless Count (Attachment 4).

Board Requests from the Homeless Initiative

On October 13 and December 15, 2015, the Board directed the Chief Executive Officer to prepare various reports relating to homelessness and submit them along with the Homeless Initiative's recommended strategies. The following reports are provided consistent with the Board's directives:

- Funding sources that could be used to establish an ongoing pool of funds, in coordination with the Health Services Master Agreement List for Intensive Case Management Services (ICMS), for supportive services tied to permanent supportive housing projects (Attachment 5);
- Comprehensive report on existing homelessness prevention activities in the County (Attachment 6); and
- Inventory of existing programs in the County that provide services to homeless youth (Attachment 7).

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommended set of coordinated strategies to combat homelessness will affirm the County's commitment to reduce the number of homeless families and individuals, maximize the alignment and effectiveness of current and future efforts, and lay the foundation for additional effective investments in the future.

CONCLUSION

In closing, I would like to acknowledge the following County departments/agencies for their invaluable participation and contribution to the development of the recommended strategies:

Alternate Public Defender
Animal Care and Control
Arts Commission
Beaches and Harbors
Child Support Services
Children and Family Services
Community and Senior Services
Community Development Commission/
Housing Authority of the County of Los Angeles
Consumer and Business Affairs
County Counsel
District Attorney
Fire Department
Health Services
Los Angeles Homeless Services Authority
Mental Health
Military and Veterans Affairs
Parks and Recreation
Probation
Public Defender
Public Health
Public Library
Public Social Services
Public Works
Regional Planning
Registrar-Recorder
Sheriff
Superior Court


This enormous breadth of participation across County government is a testament to the County's commitment to combating homelessness, and the successful implementation of the recommended strategies will depend on the continued participation and support of all of these departments.

The Honorable Board of Supervisors

2/9/2016

Page 9

Respectfully submitted,



SACHI A. HAMAI

Chief Executive Officer

SAH:JJ:PA:GR:ef

Enclosures

c: Executive Office, Board of Supervisors
County Counsel
District Attorney
Sheriff
Alternate Public Defender
Animal Care and Control
Arts Commission
Beaches and Harbors
Child Support Services
Children and Family Services
Community and Senior Services
Community Development Commission
Consumer and Business Affairs
Fire Department
Health Services
Los Angeles Homeless Services Authority
Mental Health
Military and Veterans Affairs
Parks and Recreation
Probation
Public Library
Public Health
Public Social Services
Public Works
Regional Planning
Superior Court

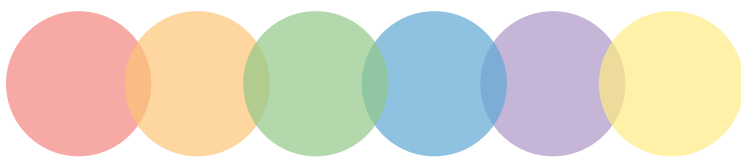
ATTACHMENTS

1. Recommended Strategies to Combat Homelessness
2. Los Angeles County Homeless Initiative Focus Group Summary Report
3. The Services Homeless Single Adults Use and their Associated Costs:
An Examination of Utilization Patterns and Expenditures in Los Angeles County
over One Fiscal Year
4. Report on Homeless Housing Gaps in the County of Los Angeles
5. Integrated Case Management Services for Permanent Supportive Housing:
Potential Funding Sources
6. Homeless Prevention Programs & Strategies for Individual & Families
7. Inventory of Existing Services for Transition Age Youth



Recommended Strategies to Combat Homelessness

Los Angeles County
Homeless Initiative



February 2016

Los Angeles County
Chief Executive Office

Recommended County Strategies to Combat Homelessness

E. CREATE A COORDINATED SYSTEM

- | | | |
|---|--|---|
| E1 Advocate with Relevant Federal and State Agencies to Streamline Applicable Administrative Processes for SSI and Veterans Benefits | E5 Decriminalization Policy | E12 Enhanced Data Sharing and Tracking |
| E2 Drug Medi-Cal Organized Delivery System for Substance Use Disorder Treatment Services | E6 Countywide Outreach System | E13 Coordination of Funding for Supportive Housing |
| E3 Creating Partnerships for Effective Access and Utilization of ACA Services by Persons Experiencing Homelessness | E7 Strengthen the Coordinated Entry System | E14 Enhanced Services for Transition Age Youth |
| E4 First Responders Training | E8 Enhance the Emergency Shelter System | E15 Homeless Voter Registration and Access to Vital Records |
| | E9 Discharge Data Tracking System | E16 Affordable Care Act Opportunities |
| | E10 Regional Coordination of Los Angeles County Housing Authorities | E17 Regional Homelessness Advisory Council and Implementation Coordination |
| | E11 County Specialist Support Team | |

B. SUBSIDIZE HOUSING

- B1** Provide Subsidized Housing to Homeless Disabled Individuals Pursuing SSI

- B2** Expand Interim Assistance Reimbursement to additional County Departments and LAHSA

- B3** Partner with Cities to Expand Rapid Re-Housing

- B4** Facilitate Utilization of Federal Housing Subsidies

- B5** Expand General Relief Housing Subsidies

- B6** Family Reunification Housing Subsidy

- B7** Interim/Bridge Housing for those Exiting Institutions

- B8** Housing Choice Vouchers for Permanent Supportive Housing

A. PREVENT HOMELESSNESS

- A1** Homeless Prevention Program for Families

- A2** Discharge Planning Guidelines

- A3** Housing Authority Family Reunification Program

- A4** Discharges From Foster Care and Juvenile Probation

D. PROVIDE CASE MANAGEMENT AND SERVICES

- D1** Model Employment Retention Support Program

- D2** Expand Jail In Reach

- D3** Supportive Services Standards for Subsidized Housing

- D4** Regional Integrated Re-entry Networks - Homeless Focus

- D5** Support for Homeless Case Managers

- D6** Criminal Record Clearing Project

C. INCREASE INCOME

- C1** Enhance the CalWORKs Subsidized Employment Program for Homeless Families

- C2** Increase Employment for Homeless Adults by Supporting Social Enterprise

- C3** Expand Targeted Recruitment and Hiring Process to Homeless/Recently Homeless People to Increase Access to County Jobs

- C4** Establish a Countywide SSI Advocacy Program for People Experiencing Homeless or At Risk of Homelessness

- C5** Establish a Countywide Veterans Benefits Advocacy Program for Veterans Experiencing Homelessness or At Risk of Homelessness

- C6** Targeted SSI Advocacy for Inmates

F. INCREASE AFFORDABLE/HOMELESS HOUSING

- | | | |
|---|---|---|
| F1 Promote Regional SB 2 Compliance and Implementation | F3 Support Inclusionary Zoning for Affordable Housing Rental Units | F5 Incentive Zoning/Value Capture Strategies |
| F2 Linkage Fee Nexus Study | F4 Development of Second Dwelling Units Pilot Program | F6 Using Public Land for Homeless Housing |

TABLE OF CONTENTS

- INTRODUCTION..... 1**
- A. PREVENT HOMELESSNESS 5**
 - A 1 Homeless Prevention Program for Families 6
 - A 2 Discharge Planning Guidelines..... 8
 - A 3 Housing Authority Family Reunification Program..... 10
 - A 4 Discharges From Foster Care & Juvenile Probation 12
- B. SUBSIDIZE HOUSING 15**
 - B 1 Provide Subsidized Housing to Homeless Disabled Individuals Pursuing SSI 16
 - B 2 Expand Interim Assistance Reimbursement (IAR) to additional County Departments
and the Los Angeles Homeless Services Authority 18
 - B 3 Partner with Cities to Expand Rapid Re-Housing 20
 - B 4 Facilitate Utilization of Federal Housing Subsidies..... 24
 - B 5 Expand General Relief Housing Subsidies 26
 - B 6 Family Reunification Housing Subsidy 28
 - B 7 Interim/Bridge Housing for those Exiting Institutions..... 30
 - B 8 Housing Choice Vouchers for Permanent Supportive Housing 32
- C. INCREASE INCOME..... 35**
 - C 1 Enhance the CalWORKs Subsidized Employment Program for Homeless Families..... 36
 - C 2 Increase Employment for Homeless Adults by Supporting Social Enterprise..... 38
 - C 3 Expand Targeted Recruitment and Hiring Process to Homeless/Recently Homeless People
to Increase Access to County Jobs 41
 - C 4 Establish a Countywide SSI Advocacy Program for People Experiencing Homelessness
or At Risk of Homelessness 43
 - C 5 Establish a Countywide Veterans Benefits Advocacy Program for Veterans Experiencing
Homelessness or At Risk of Homelessness 46
 - C 6 Targeted SSI Advocacy for Inmates 49
- D. PROVIDE CASE MANAGEMENT AND SERVICES..... 53**
 - D 1 Model Employment Retention Support Program 54
 - D 2 Expansion of Jail In Reach 56
 - D 3 Supportive Services Standards for Subsidized Housing 58
 - D 4 Regional Integrated Re-entry Networks- Homeless Focus..... 60
 - D 5 Support for Homeless Case Managers 62
 - D 6 Criminal Record Clearing Project 64

E. CREATE A COORDINATED SYSTEM 67

E 1 Advocate with Relevant Federal and State Agencies to Streamline Applicable Administrative Processes for SSI and Veterans Benefits 68

E 2 Drug Medi-Cal Organized Delivery System for Substance Use Disorder Treatment Services 70

E 3 Creating Partnerships for Effective Access and Utilization of ACA Services by Persons Experiencing Homelessness 72

E 4 First Responders Training 74

E 5 Decriminalization Policy 76

E 6 Countywide Outreach System 78

E 7 Strengthen the Coordinated Entry System 80

E 8 Enhance the Emergency Shelter System 82

E 9 Discharge Data Tracking System 84

E 10 Regional Coordination of Los Angeles County Housing Authorities 86

E 11 County Specialist Support Team 88

E 12 Enhanced Data Sharing and Tracking 90

E 13 Coordination of Funding for Supportive Housing 92

E 14 Enhanced Services for Transition Age Youth 94

E 15 Homeless Voter Registration and Access to Vital Records 96

E 16 Affordable Care Act Opportunities 98

E 17 Regional Homelessness Advisory Council and Implementation Coordination 102

F. INCREASE AVAILABLE AFFORDABLE/HOMELESS HOUSING 105

F 1 Promote Regional SB 2 Compliance and Implementation 106

F 2 Linkage Fee Nexus Study 108

F 3 Support Inclusionary Zoning for Affordable Housing Rental Units 110

F 4 Development of Second Dwelling Units Pilot Program 112

F 5 Incentive Zoning/Value Capture Strategies 114

F 6 Using Public Land for Homeless Housing 116

ADDENDA 119

Addendum A Summary of Recommended Funding 120

Addendum B Phase 1 Strategies 122

Addendum C Opportunities for Cities to Combat Homelessness 123

Addendum D Homeless Initiative Policy Summits - Participating Organizations 124

INTRODUCTION



On August 17, 2015, the Los Angeles County Board of Supervisors launched the Homeless Initiative to combat the homeless crisis that pervades our communities. The initial objective of the Homeless Initiative has been to develop and present to the Board of Supervisors these recommended County strategies to effectively combat homelessness.

SCOPE OF HOMELESS CRISIS

The homeless crisis in Los Angeles County has been increasing and demands an urgent, coordinated response from the County, cities, and community partners throughout the region. According to the Los Angeles Homeless Services Authority (LAHSA), the total point-in-time homeless population in Los Angeles County was 39,461 in 2013 and 44,359 in 2015, which equals a 12.4 percent increase. The homeless population in tents, makeshift shelters, and vehicles saw an enormous increase of 85 percent from 2013 (5,335) to 2015 (9,335).

DEVELOPMENT AND SUMMARY OF RECOMMENDED COUNTY STRATEGIES

To develop the recommended strategies, the Homeless Initiative conducted 18 policy summits on nine topics from October 1 to December 3, 2015, which brought together 25 County departments, 30 cities and other public agencies, and over 100 community partners and stakeholders. To support the discussions in the policy summits, detailed policy and strategy briefs were developed for each summit, all of which are available at priorities.lacounty.gov/homeless.

These policy summits resulted in 48 recommended strategies divided into six areas which are each key to combating homelessness:

- Prevent Homelessness
- Subsidize Housing
- Increase Income
- Provide Case Management and Services
- Create a Coordinated System
- Increase Affordable/Homeless Housing

The applicable strategy brief(s) are identified in each recommended strategy.

Overall, these recommended strategies reflect the following key principles:

- Homelessness is an extraordinarily complex problem which necessitates active, sustained collaboration amongst the County, cities and other public agencies, and a wide array of community partners.
- The web of established collaborative relationships in Los Angeles County provides a very strong foundation for the implementation of these strategies.
- These recommended strategies must strengthen and build upon current County efforts by:
 - > Directing more resources to proven strategies;
 - > Integrating existing programs and services more effectively;

- > Enabling cities to join the County in combating homelessness; and
- > Identifying opportunities to leverage mainstream criminal justice, health, and social services.

PHASE 1 STRATEGIES AND IMPLEMENTATION TIMEFRAMES

Within the set of recommended strategies, the following have been identified as having the greatest impact within the short- and medium-term, with implementation scheduled to commence by June 30, 2016:

Strategy A1 - Homeless Prevention Program for Families

Strategy B1 - Provide Subsidized Housing to Homeless Disabled Individuals Pursuing SSI

Strategy B3 - Partner with Cities to Expand Rapid Re-housing

Strategy B4 - Facilitate Utilization of Federal Housing Subsidies

Strategy B7 - Interim/Bridge Housing for Those Exiting Institutions

Strategy B8 - Housing Choice Vouchers for Permanent Supportive Housing

Strategy C2 - Increase Employment for Homeless Adults by Supporting Social Enterprise

Strategy D2 - Expand Jail In-Reach

Strategies E4/E5 - First Responders Training and Decriminalization Policy

Strategy E6 - Countywide Outreach System

Strategy E8 - Enhance the Emergency Shelter System

The remaining strategies will be divided between Phase 2 (implementation in the second half of 2016) and Phase 3 (implementation in 2017).



ROLE OF CITIES

Implementation of these strategies will create unprecedented opportunities for cities across the County to partner in combating homelessness, particularly by:

- Contributing city funding toward the cost of rapid re-housing for homeless city residents (Strategy B3);
- Dedicating federal housing subsidies to permanent supportive housing for chronically homeless individuals (Strategy B8);
- Ensuring that law enforcement and other first responders effectively engage homeless families and individuals (Strategies E4 and E5); and
- Using land use policy to maximize the availability of homeless and affordable housing (Strategies F1, F2, F4, and F5).

All cities in the County were invited to participate in the Homeless Initiative planning process, and the Homeless Initiative will reach out to cities across the County to join in the implementation of the strategies approved by the Board of Supervisors.

CONCLUSION

Taken as a whole, these recommended strategies are designed to maximize the effectiveness of current efforts to combat homelessness, expand certain key efforts, and implement new actions where appropriate. Though the current level of available funding is far less than the funding needed to eliminate homelessness in Los Angeles County, these strategies are designed to reduce the current number of homeless families and individuals, maximize the alignment and effectiveness of current and future efforts, and lay the foundation for additional effective investments in the future.

INTENTIONALLY LEFT BLANK

Strategy A

Prevent Homelessness



Combating homelessness requires effective strategies to reduce the number of families and individuals who become homeless, in addition to helping currently homeless families and individuals move into permanent housing. This includes reducing both the number of individuals who are discharged into homelessness from institutions such as jails, hospitals, and foster care, and the number of families and individuals who lose their housing and become homeless.

**Los Angeles County
Homeless Initiative**

Homeless Prevention Program for Families

POPULATION IMPACT

ALL FAMILIES TAY SINGLE ADULT VETERAN CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Los Angeles Homeless Services Authority and the Department of Public Social Services, in consultation with relevant County departments and key community stakeholders, to develop an integrated, comprehensive homeless prevention program for families which draws on the Homeless Family Solutions System (HFSS) model and builds upon current available County homeless prevention funding sources to address rental/housing subsidies, case management and employment services, and legal services.

DESCRIPTION

Los Angeles County has an opportunity to build on current programs and services to develop an integrated, comprehensive system to assist families on the verge of homelessness.

DPSS provides homeless prevention assistance to certain CalWORKs families in the form of eviction prevention, temporary rental subsidies and other financial services, but provides limited case management services and no legal services. First 5 LA funds home visitation programs which could play a role in identifying families who are at risk of homelessness. The County and City of Los Angeles fund the HRSS to expedite the delivery of housing and other supportive services to families experiencing homelessness, but has provided very limited homeless prevention services. The Board recently allocated \$2 million to HFSS for prevention purposes that could be useful to learn from and build upon.

LAHSA should develop, in collaboration with County agencies and family system partners, a comprehensive strategy to effectively identify, assess, and prevent families from becoming homeless, and to divert families in a housing crisis from homelessness. The strategy should consist of a multi-faceted approach to maximize and leverage existing funding and resources, evaluate and potentially modify policies that govern existing prevention resources to allow greater flexibility, prioritize resources for the most vulnerable populations, and create an outreach and engagement strategy to identify access points for families at risk of homelessness. The major areas critical to developing a homeless prevention system in Los Angeles County involve identifying additional and targeting current resources from multiple systems to focus on homeless prevention.

LEAD AGENCIES

Los Angeles Homeless Services Authority (LAHSA)
Public Social Services (DPSS)

COLLABORATING DEPARTMENTS/AGENCIES

- Children and Family Services
- Community and Senior Services
- Community Development Commission
- Consumer and Business Affairs
- County Office of Education
- First 5 LA
- Health Services
- Mental Health
- Probation
- Public Health

DESCRIPTION *continued*

Such a strategy would need to:

- A. Develop an approach to homelessness prevention across multiple systems, supportive services, and homeless services that address rental/housing assistance, case management and employment services, and legal services.
- B. Identify and review potential administrative barriers to better target and allocate homeless prevention interventions and programs.
- C. Review and evaluate the creation of a universal assessment to identify families who are at imminent risk of experiencing homelessness.
- D. Develop program thresholds for rental assistance that would prioritize families with the greatest potential to stay housed after one-time or short-term assistance.
- E. Provide an opt-in mechanism for cities who wish to contribute to the program.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Families on the verge of homelessness, subject to the eligibility requirements for the available funding streams.

POTENTIAL PERFORMANCE METRICS

- ◆ Increase in the number of families receiving homeless prevention services
- ◆ Increase in employment and income among potentially homeless families
- ◆ Number and percentage of families receiving services through this program who avoid eviction
- ◆ Percent of assisted families still in permanent housing at 6, 12, and 24 months following assistance

FUNDING

- ◆ \$5 Million in One-Time CalWORKs Fraud Incentive Funding
- ◆ Ongoing CalWORKs Single Allocation Funding currently used for Emergency Assistance to Prevent Eviction for CalWORKs Welfare-to-Work families
- ◆ Ongoing CalWORKs Single Allocation Funding currently used for temporary rental subsidies for CalWORKs Welfare-to-Work families who receive Emergency Assistance to Prevent Eviction

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could contribute to the program to enhance prevention services for families in their cities.



Strategy A2 | PREVENT HOMELESSNESS

Related to Strategy Briefs 7.1 and 8.1

Discharge Planning Guidelines

POPULATION IMPACT

ALL FAMILIES ✓ TAY ✓ SINGLE ADULT ✓ VETERAN ✓ CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Department of Health Services, in consultation with the Department of Children and Family Services, Department of Mental Health, Department of Public Health, the Sheriff, the Probation Department, the Veterans Administration, the Los Angeles Homeless Services Authority, the Hospital Association of Southern California, and key community agencies to utilize known best practices to develop/enhance Discharge Planning Guidelines, with the goal of preventing individuals from being homeless upon discharge.

DESCRIPTION

Relevant County institutions include foster care, DHS hospitals, jails and domestic violence (DV) shelters. Effective discharge planning prevents clients/patients from entering a “revolving door” in and out of homelessness and successfully reintegrates an individual back into his/her community with the goal of preventing the individual from falling into homelessness.

Potential programmatic elements of an effective discharge plan include, but are not limited to: Family Reunification; connection to the Coordinated Entry System; physical health care; substance use treatment; connection to a Federally Qualified Health Center; court-ordered services for perpetrators of domestic violence; and mental health treatment. The actual elements of an individual’s plan will depend on the individual’s circumstances.

Potential housing elements of an effective discharge plan include, but are not limited to: Recuperative Care; Board and Care; Motel Voucher; Halfway House; bridge housing; and permanent housing.

DHS will convene a workgroup comprised of the departments and agencies identified below to develop the recommended Discharge Planning Guidelines, including both common elements and elements that are specific to a particular department/institution. The workgroup will draw on best practices and established guidelines in use by other agencies.

LEAD AGENCY

Health Services

COLLABORATING DEPARTMENTS/AGENCIES

- Children and Family Services
- Community and Senior Services
- Domestic Violence Service Providers
- Los Angeles Homeless Services Authority
- Mental Health
- Probation
- Public Social Services
- Sheriff Department
- Veterans Administration
- Private Hospitals
- Public Health
- Cities that operate jails



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Single Adults, TAY, Veterans, Older Adults, and Chronically Homeless Adults

POTENTIAL PERFORMANCE METRICS

- ◆ Number of individuals who are homeless upon discharge from an institution
- ◆ Number of individuals who would have been homeless upon discharge and are successfully placed into some type of housing upon discharge
- ◆ Number of individuals who decline or opt-out of housing
- ◆ Reduction in cost and an increase in cost savings by implementing successful discharge plans
- ◆ Reduction in readmissions or recidivism rates

FUNDING

No cost to develop guidelines. The cost of implementing the guidelines will need to be addressed separately by each department.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities that operate jails which release inmates directly into the community could adopt discharge planning guidelines similar to those that will be adopted by LASD.

Strategy A3 | PREVENT HOMELESSNESS

Related to Strategy Brief 8.3b

Housing Authority Family Reunification Program

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Sheriff (LASD) and the Probation Department (Probation) to work with the Housing Authority of the City of Los Angeles (HACLA) and the Office of Diversion and Reentry to develop a plan to increase utilization of HACLA’s Family Reunification Program.

Direct the Housing Authority of the County of Los Angeles to evaluate the feasibility of implementing a similar program with its Section 8 vouchers, and report back with its findings.

DESCRIPTION

The goal of the Family Reunification Program is to house formerly incarcerated persons (FIP) released from the criminal justice system within the last 24 months with family members who are current participants of HACLA’s Section 8 Housing Choice Voucher Program.

This plan would serve to facilitate the connection of LASD and Probation clients to the program and allow them to make referrals directly from their systems to the three partner non-profit agencies currently working with HACLA. Non-profit organizations assist this population by providing supportive services to the FIP to ensure successful re-integration to the family and community.

LEAD AGENCIES

Housing Authority of the County of Los Angeles
 Sheriff Department
 Probation Department

COLLABORATING DEPARTMENTS/AGENCIES

Housing Authority of the City of Los Angeles
 and its non-profit partners
 Office of Diversion and Reentry





POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Section 8 families who would like to reunite with a formally incarcerated family member released from the criminal justice system within the last 24 months.

POTENTIAL PERFORMANCE METRICS

- ◆ Increase in number of families participating in this program
- ◆ A decrease in individuals discharged into homelessness

FUNDING

No funding required.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities which operate public housing authorities could also implement a Family Reunification Program.

Strategy A4 | PREVENT HOMELESSNESS

Related to Strategy Brief 8.5

Discharges From Foster Care & Juvenile Probation

POPULATION IMPACT

ALL FAMILIES ✓ TAY SINGLE ADULT VETERAN CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Departments of Children and Family Services and Probation, in conjunction with the the LA Homeless Services Authority (LAHSA), to develop a plan to strengthen the County’s Foster Care and Juvenile Probation System Discharge Policies. The strengthened policy should include at least the nine items set forth in the Description of this strategy.

DESCRIPTION

In addition to the plan strengthening the County’s current discharge policies for foster care and juvenile probation clients, it will serve to address gaps identified through the implementation of AB12, CA Fostering Connections to Success Act, particularly as AB 12 outcome data becomes available. One of the key changes made by AB 12 was extending the age that youth can remain in foster care to age 21. Youth are eligible for extended foster care if they are in out-of-home placement in the child welfare or juvenile probation system on their 18th birthday. The intent of extended foster care is to provide additional time that youth can utilize resources in order to increase positive outcomes that support long-term self-sufficiency and prevent homelessness.

LEAD AGENCIES

Children and Family Services
Probation

Depending on the age of the youth, Probation takes specific steps to connect youth with resources that support long term self-sufficiency and prevent homelessness by using the appropriate housing and services available.

COLLABORATING DEPARTMENTS/AGENCIES

Community and Senior Services
Community Development Commission
Housing Authority of the County of Los Angeles
Los Angeles County Office of Education
Los Angeles Homeless Services Authority
Mental Health
Public Library
Public Social Services

At a minimum, the “strengthened” policy should incorporate the following components:

- Convene transition planning meetings six months before discharge as opposed to the current 90 days before discharge, which does not allow sufficient time to identify and prepare the TAY for housing.
- Offer wrap-around support services to families when youth exit back to a family member’s home. Families need support when youth are coming from out-of-home placement.
- Ensure that community college or vocational training, at minimum, is part of the education component of the transition plan.

DESCRIPTION *continued*

- Link youth to supports that promote career pathways, e.g., the YouthSource system or programs funded through the Workforce Innovation and Opportunities Act (WIOA).
- Improve utilization of assessments for determining placement into the Supervised Independent Living Program (SILP) in order to determine if the SILP is an appropriate placement for the TAY and to provide broader access to the SILP. SILP placements can consist of shared housing with a friend or roommate in an apartment or other suitable setting, separate apartment rental, college dorm settings, or single room occupancy hotels.
- Systematically collect data regarding youth exit destinations.
- Increase housing capacity and housing/services options for non-minor dependents, including HUD's Family Unification Program (FUP) for youth at least 18 years old and under 22 years old who left foster care at age 16 or older and lack adequate housing. FUP vouchers can provide a youth up to 18 months of housing assistance, subject to program eligibility criteria established by HUD.
- As needed, ensure access to public benefits.
- Seek to extend data tracking of youth beyond discharge from the foster care or juvenile probation system (as part of the implementation of Strategy E9).

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities that operate WIOA programs could contribute to the implementation of this strategy.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

TAY and non-minor dependents

POTENTIAL PERFORMANCE METRICS

- ◆ Number of transition plans completed six months before discharge
- ◆ Increased enrollment into community college and vocational training
- ◆ Increased number of TAY being connected to YouthSource and WIOA
- ◆ Increased use of assessments for the purpose of proper placement
- ◆ Increase data entry on youth exit destinations
- ◆ Decrease in the number of TAY who leave a family placement without going to appropriate alternative housing
- ◆ Decrease in the number of homeless foster and Probation youth
- ◆ Increase in the number of former foster and probation youth in subsidized housing or transitional housing

FUNDING

Much of the plan could be accomplished at no additional cost; however, County General Funds and Title IV-E waiver funds could be considered to the extent that additional funding proves necessary.



INTENTIONALLY LEFT BLANK

Strategy B

Subsidize Housing



Almost all homeless families and individuals lack sufficient income to pay rent on an ongoing basis, particularly given the extremely high cost of market-rate housing in Los Angeles County. In this context, subsidizing rent and related housing costs is key to enabling homeless families and individuals to secure and retain permanent housing and to preventing families and individuals from becoming homeless. Given the scarcity of both federal and local funding for housing subsidies, it is critical that available subsidies be matched effectively to the needs of a particular family or individual.

Los Angeles County
Homeless Initiative

Provide Subsidized Housing to Homeless Disabled Individuals Pursuing SSI

POPULATION IMPACT

✓ ALL

FAMILIES

TAY

SINGLE ADULT

VETERAN

CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Departments of Public Social Services and Health Services to work together to maximize both the number of disabled homeless individuals applying for SSI who are placed in subsidized housing and the recovery of those rental subsidy costs through Interim Assistance Reimbursement for individuals approved for SSI.

DESCRIPTION

Research has demonstrated that providing housing for homeless disabled individuals greatly increases the likelihood that they will qualify for SSI. For individuals approved for SSI, housing subsidies are recouped through Interim Assistance Reimbursement (IAR), and the recouped funding can be used to provide a housing subsidy for an additional homeless disabled individual pursuing SSI.

Housing could be provided in three ways:

- A. Target current housing resources to individuals served through the proposed Countywide SSI Advocacy Program.
- B. Expand the number of GR Housing subsidies in the General Relief Housing Subsidy and Case Management Program (HSCMP) - Many of the individuals who will be helped by the proposed Countywide SSI Advocacy Program will be on GR.
- C. Expand the populations served through existing homeless housing programs such as the Single Adult Model (SAM) or Housing for Health programs to include as a targeted population disabled homeless individuals applying for SSI.

The goal would be to place individuals pursuing SSI in housing which they could sustain without a subsidy upon approval for SSI. For individuals not approved for SSI, case management staff would assist in developing a transition plan for housing support through other available resources.

LEAD AGENCIES

Health Services
Public Social Services

COLLABORATING DEPARTMENTS/AGENCIES

Los Angeles Homeless Services Authority
Mental Health
Military and Veterans Affairs
Probation



CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could implement this strategy in a complementary manner by providing funding to support subsidies for homeless disabled individuals pursuing SSI in their jurisdiction. For individuals approved for SSI, cities could recover the cost of the rental subsidies through Interim Assistance Reimbursement.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Housing subsidies could be provided to some or all of the individuals who are served by the proposed Countywide SSI Advocacy Program, including older adults. These individuals will likely have severe chronic health and mental health conditions, such that they may be among the most vulnerable and persistently homeless.

POTENTIAL PERFORMANCE METRICS

- ◆ Number of disabled individuals pursuing SSI who are placed in housing
- ◆ Number of individuals who maintain housing during the SSI application period
- ◆ Percent of individuals approved for SSI who retain permanent housing 6, 12, and 24 months after SSI approval
- ◆ Number of SSI applications filed
- ◆ Number of successful SSI applications at each stage (initial, reconsideration, appeal)
- ◆ Amount and percentage of rental subsidy costs recovered through IAR for individuals approved for SSI

FUNDING

- ◆ \$3.75 million in one-time HPI funding
- ◆ \$4 million in one-time AB 109 funding
- ◆ \$1 million in one-time SB 678 funding
- ◆ Interim Assistance Reimbursement (IAR) from the Social Security Administration (SSA) for housing subsidies provided to individuals who are subsequently approved for SSI. The amount reimbursed by SSA would be reinvested in housing subsidies for additional homeless disabled individuals pursuing SSI.

Strategy B2 | SUBSIDIZE HOUSING

Related to Strategy Brief 3.4

Expand Interim Assistance Reimbursement (IAR) to additional County Departments and the Los Angeles Homeless Services Authority

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Chief Executive Office to work with the California Department of Social Services to amend the existing Memorandum of Understanding with the California Department of Social Services to expand the ability to collect Interim Assistance Reimbursement (IAR) to additional County Departments and the Los Angeles Homeless Services Authority.

DESCRIPTION

IAR can be collected on behalf of homeless individuals and families who receive assistance in meeting their basic needs during the months their Supplemental Security Income (SSI) application is pending or during the months SSI is suspended. Agencies that provide basic needs for eligible participants using non-federal dollars are eligible to collect IAR if the individual is subsequently approved for SSI. Basic needs include shelter, interim housing, recuperative care, and rental subsidies.

Los Angeles County already has a Memorandum of Understanding in place with the California Department of Social Services (CDSS) which allows for the collection of IAR by County Departments. The agreement signed by the County of Los Angeles and CDSS may be modified in writing at any time by mutual consent and will not require any further action. The current Board letter and agreement allows for DPSS and DMH to collect IAR. The collection of IAR by additional County Departments and the Los Angeles Homeless Services Authority (LAHSA) will support the provision of assistance to additional homeless families/ individuals as IAR collected could be reinvested.

The current monthly SSI grant is \$889. For individuals who receive GR while their SSI application is pending, the County already recovers IAR for the \$221 monthly GR grant. Additionally, for GR participants receiving a GR rental subsidy, the County recovers \$400 per month for that subsidy. Therefore, for individuals receiving GR, with no GR rental subsidy, the monthly maximum additional IAR is \$661, while it is \$889 for individuals not receiving GR. For GR participants receiving a GR rental subsidy, the additional available IAR is \$261 per month.

LEAD AGENCY

Chief Executive Office

COLLABORATING DEPARTMENTS/AGENCIES

- Children and Family Services
- Community and Senior Services
- Health Services
- Los Angeles Homeless Services Authority
- Mental Health
- Probation
- Public Health
- Public Social Services



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

The collection of IAR should be expanded to the Departments of Health Services, Public Health, and Children and Family Services, the Probation Department and LAHSA.

POTENTIAL PERFORMANCE METRICS

- ◆ The amount of funding recouped through the IAR Program each year, by department

FUNDING

There is no cost to the County to implement this strategy.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities who fund rental subsidies for disabled homeless individuals pursuing SSI could also recover the cost of the rental subsidies through Interim Assistance Reimbursement.

Partner with Cities to Expand Rapid Re-Housing

POPULATION IMPACT

ALL ✓ FAMILIES ✓ TAY ✓ SINGLE ADULT ✓ VETERAN CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Department of Health Services and the Los Angeles Homeless Services Authority to partner with cities and expand the availability of rapid re-housing, as described per the description.

DESCRIPTION

The purpose of rapid re-housing is to help homeless families/individuals/youth with low-to-moderate housing barriers to be quickly re-housed and stabilized in permanent housing. Rapid re-housing connects homeless individuals and families, as well as vulnerable sub-populations such as older adults, to permanent housing through the provision of time-limited financial assistance, case management and targeted supportive services, and housing identification/navigation supports:

- Financial assistance includes short-term and medium-term rental assistance and move-in assistance, such as payment for rental application fees, security deposits, and utility deposits. Financial assistance can come in the form of a full subsidy, covering the full rent for a period of time, or a shallow subsidy, covering a portion of the rent with gradual decreases in the subsidy over time.
- Case management and targeted supportive services can include, but are not limited to: money management; life skills; job training; education; assistance securing/retaining employment; child care and early education; benefits advocacy; legal advice; health; mental health; substance use disorder treatment; community integration; and recreation.
- Housing Identification/navigation supports address barriers for individuals and families to return to housing, which includes identifying a range of safe and affordable rental units, as well as recruiting landlords willing to rent to homeless individuals and families. Landlord incentives can include items such as a repair fund and/or recognition at relevant landlord events. Housing navigation staff should assist

LEAD AGENCIES

Health Services
Los Angeles Homeless Services Authority

COLLABORATING DEPARTMENTS/AGENCIES

Children and Family Services
Community Development Commission
Community and Senior Services
Community-based organizations and housing providers
Housing Authority of the City of Los Angeles
Housing and Community Investment Department
Mental Health
Probation
Public Health
Public Social Services
Sheriff

DESCRIPTION *continued*

clients in housing search, assistance with completing and submitting rental applications, and understanding the terms of the lease.

Rapid re-housing is the most effective and efficient intervention for more than 50 percent of homeless individuals and families based on available data. The success rate for permanent placement is higher and recidivism rates are lower than other forms of housing interventions. However, it is not the best intervention for those who have been chronically homeless and/or face high barriers that impact housing placement, and is not the most effective intervention for all victims of domestic violence, human trafficking victims, and youth.

Rapid re-housing is generally categorized as a short-term housing resource lasting 6-12 months, but in some cases up to 24 months, if steady, but slow improvements are made by recipients in making the transition to self-sufficiency.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could contribute funding for homeless families, single adults, and youth within each city who are likely to succeed through rapid re-housing. Cities that receive Housing and Urban Development Emergency Solutions Grant funds could potentially utilize that funding source, among others.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Homeless families, single adults and youth who are not chronically homeless and would benefit from a short to intermediate housing intervention and supportive services to regain housing stability.

POTENTIAL PERFORMANCE METRICS

- ◆ Number/percent of families/individuals/TAY who can sustain unsubsidized housing upon program exit
- ◆ Number/percent of individuals, families, and TAY with permanent housing placement within 90 days
- ◆ Number/percent of returns to homelessness within 24 months of placement in permanent housing
- ◆ Number/percent with increased income from all potential sources at program exit

FUNDING

- ◆ \$8 million in one-time HPI funds, in addition to the \$10 million for rapid re-housing for single adults approved by the Board of Supervisors on October 13, 2015. Of this \$8 million, \$5 million is earmarked to serve families through the Homeless Families Solutions System and \$2 million is earmarked for TAY.
- ◆ \$11 million in one-time SB 678 funding.
- ◆ \$7 million in one-time AB 109 funding.
- ◆ Cities who want their homeless residents to access this program will be asked to contribute \$500/month per family/individual, which is approximately 50 percent of the actual rent subsidy cost. The County will fund the remainder of the rental subsidy and the full cost of the associated services, up to each city's share of the countywide homeless population based on the most recent homeless count. The average duration of rapid re-housing is 6-12 months per family/individual, so the total city cost would be \$3,000-

Partner with Cities to Expand Rapid Re-Housing *continued*

FUNDING *continued*

\$6,000 per family/individual who is permanently housed. Cities that choose to partner with the County would have the opportunity to collaborate with the County in identifying the families/individuals/youth who should have the highest priority for a slot in the program.

- ◆ Additional funding may be available from certain County departments on a per slot basis for specific populations, including the Department of Public Social Services, Department of Children and Family Services, Department of Health Services, and the Department of Mental Health.



Facilitate Utilization of Federal Housing Subsidies

POPULATION IMPACT



ALL

FAMILIES

TAY

SINGLE ADULT

VETERAN

CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Housing Authority of the County of Los Angeles (HACoLA) to develop the following temporary, two-year programs to encourage landlord acceptance of subsidized tenants with a Housing and Urban Development voucher issued by HACoLA:

1. Damage Mitigation/Property Compliance Fund;
2. Vacancy payments to hold units; and
3. Security Deposit Assistance.

DESCRIPTION

Federal housing subsidies play a critical role in combatting homelessness; however, the current very low vacancy rate in the rental housing market makes it very difficult for families and individuals with a federal subsidy to secure housing. To mitigate this problem, for two years, the County could provide the following incentives for landlords to accept subsidized tenants:

- Damage Mitigation/Property Compliance Fund. This program should be similar to Oregon’s Housing Choice Landlord Guarantee Program, which provides financial assistance to landlords to mitigate damage caused by tenants during their occupancy under the HUD Housing Choice Voucher Program, Family Unification Program, and Shelter Plus Care/Continuum. In addition, the program should provide landlords with modest financial assistance to repair and/or modify their property to comply with HUD Quality Housing Standards, if property non-compliance is the only barrier to accepting a subsidized tenant.
- Vacancy payments to hold units. Develop a program to provide landlords vacancy payments to hold a rental unit for 1-2 months once a tenant with a subsidy has been accepted by the landlord, while the landlord is going through the HUD approval process. This program is needed on a temporary basis, due to the current, exceptionally low rental housing vacancy rate in Los Angeles County. The County is already implementing such a program under the Department of Health Service’s Housing for Health Program and the Veterans Administration Supportive Housing Program.
- Security Deposit Assistance. Develop a

LEAD AGENCY

Housing Authority of the County of Los Angeles

COLLABORATING DEPARTMENTS/AGENCIES

Health Services
 Housing Authority of the City of Los Angeles
 Los Angeles Homeless Services Authority
 Other Public Housing Authorities

DESCRIPTION *continued*

program to provide security deposit assistance to homeless individuals and families by either covering the amount of the security deposit or having the County guarantee the deposit. The latter could be modeled after Monterey County’s Security Deposit Guarantee Program which allows low-income households to spread out the security deposit over a period of time. The County would sign an agreement with the landlord that guarantees them the full amount of the deposit while allowing the tenant to make monthly payments with no interest. If tenant defaults, the County would be responsible for paying the difference owed to the landlord.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations.

POTENTIAL PERFORMANCE METRICS

- ◆ Increased number of landlords willing to accept homeless households with housing subsidies

FUNDING

- ◆ \$2 million in one-time HPI funds for the three recommended programs, with no more than \$750,000 for the Security Deposit Assistance Program.

CONNECTION TO CITIES

✓ **SAME**

COMPLEMENTARY

NO CITY ROLE

Cities which have their own Public Housing Authorities could implement the same or similar programs to facilitate utilization of the housing subsidies which they issue. All cities could fund vacancy payments to facilitate rapid re-housing for their homeless residents.

Strategy B5 | SUBSIDIZE HOUSING

Related to Strategy Brief 9.6

Expand General Relief Housing Subsidies

POPULATION IMPACT

ALL FAMILIES ✓ TAY ✓ SINGLE ADULT ✓ VETERAN ✓ CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Department of Public Social Services to enhance and expand the General Relief Housing Subsidy and Case Management Program (GRHSCMP) by:

- Increasing the maximum rent subsidy from \$400 to \$475 per month;
- Incorporating a Rapid Re-housing model which includes housing location assistance and housing-related case management; and
- Increasing the number of available subsidies for disabled homeless GR participants pursuing Supplemental Security Insurance (SSI), through the utilization of the additional recommended funding described herein.

DESCRIPTION

The County could allocate additional funding to expand the General Relief Housing Subsidy and Case Management Project (GRHSCMP). Additionally, the GRHSCMP could be enhanced to align with a Rapid Re-housing model, which includes housing location assistance and housing-related case management, in addition to the housing subsidy. It is also recommended that the subsidy under the enhanced GRHSCMP be increased from the current \$400/month to \$475 per month.

The County will provide \$475, which supplements \$100 provided by the GR recipient for a total of \$575/month available for housing. Modestly increasing the subsidy amount by \$75/month will enhance both the homeless individual's ability to locate housing and the likelihood that the housing located will be permanent housing in which the individual can remain without a subsidy, upon SSI approval or employment.

LEAD AGENCY

Public Social Services

COLLABORATING DEPARTMENTS/AGENCIES

Community and Senior Services
Health Services
Los Angeles Homeless Services Authority
Mental Health
Public Health

Currently, approximately 75% of GRHSCMP subsidies are allocated to disabled GR participants pursuing SSI, while the remaining 25% are allocated to employable GR participants. It is recommended that 100% of any increased funding for this program be utilized for disabled GR participants pursuing SSI.

For GRHSCMP participants who secure SSI, the County recovers the full amount of the rental subsidy from the participant's retroactive SSI benefit, though the Interim Assistance Reimbursement process. Implementation of a Countywide SSI Advocacy Program, as recommended in Strategy C6, should increase the number of GRHSCMP participants who qualify for SSI and thereby increase the share of GRHSCMP expenditures which are recovered and available to provide a subsidy to an additional homeless, disabled GR participant pursuing SSI.



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

The target population for the program is homeless GR participants, including older adults, who are living on the streets or in shelters, and are either employable or potentially eligible to SSI. The expansion population will be limited to homeless disabled GR participants who are potentially eligible to SSI; however, a small percentage of homeless employable GR participants will continue to be served by the base funding for this program.

POTENTIAL PERFORMANCE METRICS

- ◆ Percent of program participants who secure SSI
- ◆ Amount and percentage of housing subsidy payments recovered through Interim Assistance Reimbursement following SSI approval
- ◆ Percent of employable recipients who exit GR with employment (This metric only applies to employable recipients served through the base funding for this program; however, those employable recipients will be impacted by the recommended changes to the program, including the increase in the rental subsidy from \$400 to \$475/month.)
- ◆ Percent of program participants who retain employment 6, 12, and 24 months after exiting this program

FUNDING

- ◆ Redirection of whatever portion of the \$5.8 million in ongoing annual NCC currently allocated for the General Relief Mandatory Substance Use Disorder Recovery Program (MSUDRP becomes available, as MSUDRP services become billable to Medi-Cal through implementation of the Drug Medi-Cal-Organized Delivery System waiver.
- ◆ Interim Assistance Reimbursement of GR rental subsidy payments for individuals who are approved for SSI.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could implement this strategy in a complementary manner by providing funding to support subsidies for homeless, disabled GR participants in their jurisdiction. For individuals approved for SSI, cities could recover the cost of the rental subsidies through Interim Assistance Reimbursement.

Strategy B6 | SUBSIDIZE HOUSING

Related to Strategy Brief 9.7

Family Reunification Housing Subsidy

POPULATION IMPACT

ALL FAMILIES TAY SINGLE ADULT VETERAN CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Department of Children and Family Services and Los Angeles Homeless Services Authority to provide rapid re-housing and case management services to families in the child welfare system where the parent(s)' homelessness is the sole barrier to the return of the child(ren), and the family meets the following criteria:

1. The child(ren) are currently placed in out-of-home care (including relative caregivers);
2. The parent(s) have complied with or are in substantial compliance with all court orders for the return of their children;
3. Homelessness is the sole barrier to the return of the child(ren) to their care; and
4. The family is a good candidate for rapid re-housing, rather than a longer-term housing subsidy.

DESCRIPTION

DCFS has oversight of thousands of children in out-of-home care throughout Los Angeles County. Families on CalWORKs whose child(ren) are removed lose eligibility to their CalWORKs cash grant, if there is no minor child remaining the home; therefore, the removal of the child(ren) can itself result in the family becoming homeless. Moreover, since homeless parent(s) without physical custody of a child are not eligible to receive a CalWORKs grant which could be used to pay for housing, children can remain in foster care for extended periods of time. A significant number of children in out-of-home placement could be reunited with their parents, if their parents were able to obtain and sustain suitable housing.

Rapid re-housing is the most effective and efficient intervention for more than 50 percent of homeless individuals and families based on available data. The success rate for permanent placement is higher and recidivism rates are lower than for other forms of housing intervention. However, notwithstanding the value of rapid re-housing, some families who initially appear to be well-suited to rapid re-housing may ultimately need a permanent housing subsidy. Such families should be granted priority access to a permanent, federally-funded housing subsidy. This is consistent with the current approach in the Homeless Families Solutions System administered by the LAHSA.

LEAD AGENCIES

Children and Family Services (DCFS)
Los Angeles Homeless Services Authority (LAHSA)

COLLABORATING DEPARTMENTS/AGENCIES

Community Development Commission
Housing Authority of the City of Los Angeles
Housing Authority of the County of Los Angeles
Probation
Public Social Services

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Homeless families with DCFS involvement, where the family's homelessness is the sole barrier to the return of the child(ren) from out-of-home placement.

POTENTIAL PERFORMANCE METRICS

- ◆ Number of families placed in housing
- ◆ Number and percentage of families who have retained housing after 12 months by service planning area
- ◆ Number and percent with increased income from all potential sources at program exit
- ◆ Number of families with no DCFS jurisdiction at program exit
- ◆ Number and percent of families who successfully transition to unsubsidized housing

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities which operate public housing authorities could commit Housing Choice Vouchers for families who participate in this program, but ultimately need an ongoing housing subsidy.

FUNDING

- ◆ DCFS funding that would otherwise be used for out-of-home placement, absent reunification, will be used to fund participation in this program by families which include an adult who is eligible to participate in the CalWORKs welfare-to-work program, including subsidized employment. An initial commitment of \$2 million from DCFS will enable the program to be implemented. Out-of-home placement cost savings will be tracked, based on an assumption that the child(ren) would have otherwise remained in placement for 12 additional months, and the savings will be reinvested to sustain the program on an ongoing basis. If savings exceed the cost of sustaining the program for families which include a CalWORKs parent who is welfare-to-work eligible, the "surplus savings" could be used for rapid re-housing for other families who meet the eligibility criteria for this program.
- ◆ \$1 million in one-time HPI funding for families who meet the eligibility criteria for this program, but do not include a parent who is eligible to participate in the CalWORKs welfare-to-work program.
- ◆ CalWORKs Single Allocation funding, including family reunification services for families who were receiving CalWORKs at the time that the child(ren) were removed.
- ◆ Housing Choice Vouchers, particularly from the Housing Authority of the City of Los Angeles (HACLA) and the Housing Authority of the County of Los Angeles (HACoLA), for families who ultimately need an ongoing housing subsidy at the end of the rapid re-housing program.
- ◆ Family Unification Program (FUP) vouchers from HACLA and HACoLA.

Interim/Bridge Housing for those Exiting Institutions

POPULATION IMPACT

✓ ALL

FAMILIES

TAY

SINGLE ADULT

VETERAN

CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Los Angeles Homeless Services Authority, in collaboration with the Department of Health Services (DHS), Department of Mental Health (DMH), Probation Department, Department of Children and Family Services (DCFS), and Sheriff (LASD) to develop and implement a plan to increase the interim/bridge housing stock across the County, including identification of funding that can be used to support the increase.

DESCRIPTION

The following housing types should be available for individuals exiting institutions:

- Shelter beds
- Stabilization beds
- Shared recovery housing (can be used for interim or permanent housing)
- Recuperative care beds
- Board and care (can be used for interim or permanent housing)

All of the above housing types are available in most jurisdictions throughout the United States. They are viewed as standards of care for most HUD Continuum of Care. Many shelter models are funded by HUD under the McKinney Vento Homeless Assistance Act. Recuperative care is less prevalent; however, in some jurisdictions, health plans and/or hospitals pay for these services privately. Shared Recovery Housing is a SAMHSA evidence-based best practice. None of these programs are billable to regular Medi-Cal, though health plans/providers may be able to use the capitated Medi-Cal funding they receive to pay for bridge housing for their Medi-Cal patients.

There will be a historic opportunity to increase the supply of bridge housing in 2016, when LAHSA will stop funding approximately 2000 transitional housing beds, per direction from the U.S. Department of Housing and Urban Development to shift funding away from transitional housing. LAHSA is currently in discussions with all impacted transitional housing providers regarding potential ways in which their facilities could be re-purposed, which includes the potential utilization of those facilities for bridge housing.

LEAD AGENCY

Los Angeles Homeless Services Authority

COLLABORATING DEPARTMENTS/AGENCIES

- Children and Family Services
- Community and Senior Services
- Health Services
- Mental Health
- Probation
- Public Health
- Sheriff
- Cities
- LA Care
- Health Net
- Hospital Association of Southern California



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations

POTENTIAL PERFORMANCE METRICS

- ◆ Number of individuals being discharged from institutions needing interim/bridge housing
- ◆ Number of individuals who are discharged from institutions to interim/bridge housing
- ◆ Number of individuals who are discharged from institutions to interim/bridge housing who are connected to physical health, mental health, substance use disorder treatment and sources of income
- ◆ Number of individuals who are discharged from institutions to interim/bridge housing who leave interim/bridge housing for permanent housing
- ◆ Number of individuals who are discharged from institutions to interim/bridge housing who leave prior to being able to transition to permanent housing

FUNDING

- ◆ \$3,250,000 in one-time HPI funding
- ◆ \$4,600,000 in one-time AB 109 funding
- ◆ \$3,400,000 in one-time SB 678 funding
- ◆ Additional funding could potentially come from DHS, DMH, LASD, DCFS, LAHSA, cities, managed care organizations (such as LA Care), and private hospitals.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could contribute funding for bridge housing and/or facilitate the siting of bridge housing within their jurisdictions.

Housing Choice Vouchers for Permanent Supportive Housing

POPULATION IMPACT

ALL

FAMILIES

TAY

SINGLE ADULT

VETERAN

✓ CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Housing Authority of the County of Los Angeles (HACoLA) to dedicate Housing Choice Vouchers (HCV) which become available through routine turnover to permanent supportive housing for chronically homeless individuals through the following tiered approach:

- Tier 1: HCV waiting list preference for chronically homeless individuals referred by a Community Based Organization – HACoLA will commit 35% of turnover vouchers for FY 2016-17 to chronically homeless individuals. HACoLA will increase this commitment to 50% for FY 2017-18 and each subsequent fiscal year, subject to acceptable success rates in securing permanent housing for chronically homeless individuals issued a voucher under this preference.
- Tier 2: HCV waiting list preference for homeless already registered on HACoLA's waiting lists – There are currently 1,100 applicants identified as homeless on a waiting list, and the remainder of available turnover units will be dedicated to this population.
- Tier 3: Project-Based Vouchers – Turnover vouchers are dedicated to the annual Project-Based Vouchers Notice of Funding Availability, administered by the Community Development Commission, which offers bonus points for projects that assist the chronically homeless. Mandated coordination using the Coordinated Entry System ensures that chronically homeless individuals will be assisted.

DESCRIPTION

Chronically homeless adults are the homeless population most in need of permanent supportive housing, which combines a permanent housing subsidy with case management, health, mental health, substance use disorder treatment and other services. The primary source of permanent housing subsidies is HCV (commonly known as Section 8), which are provided by the U.S. Department of Housing and Urban Development (HUD).

Though the number of Housing Choice Vouchers (HCV) has not grown in recent years, some vouchers become available each month through routine turnover, as current Housing Choice Voucher holders relinquish their vouchers. For the Housing Authority of the County of Los Angeles (HACoLA), approximately 700-800 Housing Choice Vouchers turnover each year. As part of their efforts to combat homelessness, various other jurisdictions across the country have dedicated 100% of their turnover HCV vouchers to homeless people or to one or more homeless sub-populations.

LEAD AGENCY

Housing Authority of the County of Los Angeles

COLLABORATING DEPARTMENTS/AGENCIES

Community Development Commission
Housing Authority of the City of Los Angeles
Los Angeles Homeless Services Authority
Other Public Housing Authorities



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Chronically Homeless Adults

POTENTIAL PERFORMANCE METRICS

- ◆ Significant reduction in the number of chronically homeless individuals

FUNDING

No local funding would be required for housing subsidies from HUD. The cost of services would be funded through a combination of Medi-Cal dollars, County General Fund, funding from other departments, and philanthropy.

CONNECTION TO CITIES

✓ **SAME**

COMPLEMENTARY

NO CITY ROLE

Cities which have their own Public Housing Authorities could dedicate a substantial percentage of available Housing Choice Vouchers for permanent supportive housing for chronically homeless individuals.

INTENTIONALLY LEFT BLANK

Strategy C

Increase Income



Most currently homeless families and individuals have the ability to increase their income to the point where they will be able to pay for their own housing in the future, if they secure the assistance they need to increase their income. A high percentage of homeless adults can increase their income through employment; severely disabled homeless individuals can increase their income through federal disability benefits. Enabling a high percentage of homeless adults to pay for their own housing is key to combating homelessness.

Los Angeles County
Homeless Initiative

Strategy C1 | INCREASE INCOME

Related to Strategy Brief 1.1

Enhance the CalWORKs Subsidized Employment Program for Homeless Families

POPULATION IMPACT

ALL FAMILIES TAY SINGLE ADULT VETERAN CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Department of Public Social Services (DPSS) to enhance the existing DPSS CalWORKs Subsidized Employment Program for homeless CalWORKs Families and those CalWORKs families housed through a Department of Children and Family Services Housing Subsidy.

DESCRIPTION

This would be an enhancement of the existing DPSS CalWORKs Subsidized Employment Program that would be targeted to CalWORKs families who are homeless/recently homeless/at risk of homelessness. It is recommended that the program be modeled after the Los Angeles Regional Initiative for Social Enterprise (LA: RISE) implemented by LA City in collaboration with the non-profit Roberts Enterprise Development Fund (REDF). The LA: RISE model takes an integrated wraparound approach to job creation and provides hard-to-serve individuals, specifically those with a history of homelessness and/or incarceration, and disconnected youth, with employment, counseling support and training.

This enhancement could be implemented by DPSS as an enhancement of the existing CalWORKs subsidized employment program with the South Bay Workforce Development Board or through an agreement with the Department of Community and Senior Services (CSS) in partnership with the LA City Workforce Development Board (WDB), which has an existing relationship with REDF. In either scenario, the LA: RISE program design and infrastructure could be leveraged and expanded to provide services countywide. The services will be specifically targeted to meet the needs of homeless families. Examples of services include:

- Subsidized employment/bridge jobs provided in a Social Enterprise supportive employment work environment that includes personal supports, case management and job readiness preparation.
- Recruiting and working with employers willing to hire hard-to-serve individuals with non-traditional backgrounds. This will include recruiting and working with small localized (mom and pop) employers.

LEAD AGENCY

Public Social Services

COLLABORATING DEPARTMENTS/AGENCIES

Children and Family Services
Community and Senior Services
Los Angeles Homeless Services Authority
Mental Health

DESCRIPTION *continued*

- Coordinated training provided through DPSS Greater Avenues to Independence (GAIN) Program and Workforce Investment Boards and Social Enterprise Employers on developing skills needed to obtain self-sufficiency.

Additional supports would be provided as needed to help homeless families maintain their subsidized employment, progress into unsubsidized employment, and retain their employment. This includes linkages to the existing Homeless Families Solution System (HFSS). Currently, CalWORKs homeless families are served through the mainstream CalWORKs Transitional Subsidized Employment Program; however, under this proposal, homeless families would instead be served through this specialized program design to meet their unique needs.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could implement this strategy in a complementary manner to the County. They could do this by participating as employers providing placement opportunities for program participants and by actively engaging their Chambers of Commerce to encourage local business participation as both placement sites and in hiring of program participants for unsubsidized employment.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Homeless CalWORKs families with an aided parent who is eligible to participate in the CalWORKs welfare-to-work program would be eligible to participate. The definition of “homeless” within the CalWORKs program includes families who lack a permanent fixed residence. This means that the definition includes families that range from literally homeless (e.g., sleeping in car) to those who are “couch surfing.” Additionally, victims of domestic violence and CalWORKs families recently housed through a housing subsidy from the Department of Children and Family Services would be served through this specialized Subsidized Employment program.

POTENTIAL PERFORMANCE METRICS

For Homeless CalWORKs Population

- ◆ Percentage of participants who are placed into subsidized employment and obtain unsubsidized employment.
- ◆ Percentage of participants placed into unsubsidized employment who retain employment for a period of time

For DCFS Population

- ◆ Percentage of families who remain stable and without DCFS involvement
- ◆ Percentage of participants with increased income over a period of time

FUNDING

The estimated cost per person is approximately \$10,500 - \$ 11,500 for a six-month assignment. Ongoing CalWORKs Expanded Subsidized Employment funding will be utilized for all homeless/at-risk CalWORKs families who qualify for this specialized program.

Strategy C2 | INCREASE INCOME

PHASE 1

Related to Strategy Briefs 1.3 and 1.4

Increase Employment for Homeless Adults by Supporting Social Enterprise

POPULATION IMPACT

✓ ALL

FAMILIES

TAY

SINGLE ADULT

VETERAN

CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Chief Executive Office to support Social Enterprises/Alternate Staffing Organizations to increase employment opportunities for Homeless Adults as described herein.

DESCRIPTION

Social Enterprises are mission-driven businesses focused on hiring and assisting people who face the greatest barriers to work. They earn and reinvest their revenue to provide more people with transitional jobs to become job ready with the basic skills necessary to compete and succeed in the mainstream workforce. They help people who are willing and able to work, but have the hardest time getting jobs, including individuals with a history of homelessness and/or incarceration, and youth who are out of school and out of work. Obtaining employment increases income and improves the individual's overall well-being.

Alternate Staffing Organizations (ASOs) operated by Social Enterprises provide temporary workers and act as intermediaries between employers and job seekers, helping employers attract and retain reliable, motivated workers and linking job seekers to competitive employment, opportunities for skills development and pathways to hire by employer customers. Unlike conventional temporary staffing companies, ASOs operated by Social Enterprises have a dual mission to satisfy their customers and promote workplace success for people with obstacles to employment, such as those with unstable housing history, criminal backgrounds, or those participating in recovery programs.

Many services procured by local government could be provided, in whole or in part, by Social Enterprises/ASOs.

LEAD AGENCY

Chief Executive Office

COLLABORATING DEPARTMENTS/AGENCIES

All County Departments which contract for goods and/or services

Community and Senior Services

County Counsel

Internal Services Department

Human Resources

DESCRIPTION *continued*

The County could utilize Social Enterprises/ASOs to help homeless/formerly homeless adults to increase their income through increasing employment opportunities by taking the following actions:

1. Enhance the procurement process to provide preferential treatment of Social Enterprises by awarding extra points during the scoring process and by expanding the County’s existing Transitional Job Opportunities Preference Program to provide preferential treatment to bidders that commit to subcontract with Social Enterprises;
2. Support the creation of Alternative Staffing Organizations (ASOs) operated by Social Enterprise entities and designate them as the preferred staffing agency for County Departments, contractors and sub-contractors to use for their temporary staffing needs;
3. Provide a Social Enterprise entity operating an ASO with a subsidy of \$2 per hour worked to reduce the markup passed on to the customer, thus making the ASO a more attractive option. ASOs are able to be self-sustaining by marking up wage rates. For example, a worker that is paid \$10 per hour may be billed to the customer at \$17. This “mark-up” covers employment taxes, workers compensation, mandated benefits, and any other margin needed to maintain the business. At the same time, the subsidies could help ASOs fund the critical support services needed to ensure the employees’ success;
4. Leverage the Department of Public Social Services (DPSS) transitional subsidized employment program for CalWORKs parents/relative caregivers, by placing some program participants in an ASO for temporary employment as a step toward long-term employment;
5. Develop and distribute a comprehensive inventory of the services currently being provided in Los Angeles County by Social Enterprises and ASOs to County contractors/ sub-contractors and County Departments. The enhanced Transitional Job Opportunity Preference Program/ASO Ordinance would encourage every contractor providing services to the County to work with Social Enterprises/ ASOs to perform functions consistent with its business needs, as part of its County contract; and
6. Encourage cities to adopt a Social Enterprise Agency Utilization Ordinance and provide a sample ordinance for cities to use, modeled on the County’s current Expanded Preference Program.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations, including homeless older adults.



Increase Employment for Homeless Adults by Supporting Social Enterprise *continued*

POTENTIAL PERFORMANCE METRICS

- ◆ Increase in the number of employment opportunities available for homeless people, recently homeless, or those at risk of homelessness resulting from increased utilization of social enterprises/ASOs
- ◆ Percentage of social enterprise employees who are able to move on to non-supported employment
- ◆ Number of workers engaged in ASO assignments
- ◆ Reduction in dependence on public benefits due to ASO assignment

FUNDING

- ◆ No associated funding is required for enhancing the procurement process.
- ◆ DPSS – CalWORKs Single Allocation and Enhanced Subsidized Employment funding already allocated for the CalWORKs Transitional Subsidized Employment Program could be used to support the use of ASOs for Paid Work Experience and On-the-Job training for CalWORKs parents/relative caregivers.
- ◆ \$2 million in one-time HPI funding to provide a subsidy of \$2 per hour worked to ASOs to reduce the markup passed on by ASOs to employers.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could adopt a Social Enterprise Agency Utilization Ordinance modeled on the County's current Expanded Preference Program.

Strategy C3 | INCREASE INCOME

Related to Strategy Brief 1.8

Expand Targeted Recruitment and Hiring Process to Homeless/ Recently Homeless People to Increase Access to County Jobs

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Department of Human Resources to expand outreach and targeted recruitment strategies to include those who are homeless or recently homeless.

DESCRIPTION

There are three fundamental design features of Civil Service Employment:

1. examination for civil service positions are public, competitive and open to all;
2. they rely upon a testing methodology to establish rank-ordered lists for hiring opportunities; and
3. there are often stringent background standards, including a job nexus assessment of an applicant’s criminal record.

Given the requirements of the civil service process, a targeted recruitment and flexible job requirements would acknowledge both the institutional barriers and the individual barriers often experienced by those who are homeless or recently homeless. The targeted outreach, recruitment and flexible job requirements would expand hiring opportunities for entry level positions of those who are homeless or recently homeless. This is an expansion of what the County currently does for GAIN/GROW participants and veterans.

LEAD AGENCY

Human Resources

COLLABORATING DEPARTMENTS/AGENCIES

All County Departments



Expand Targeted Recruitment and Hiring Process to Homeless/ Recently Homeless People to Increase Access to County Jobs *continued*



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Individuals, including older adults, who are homeless or formerly homeless would be eligible to participate in the targeted recruitment and hiring process upon being stabilized and assessed by a County department or designated homeless service provider as employment-ready.

POTENTIAL PERFORMANCE METRICS

- ◆ Percent of homeless or recently homeless applicants in targeted recruitments
- ◆ Percent of homeless or recently homeless applicants participating in targeted recruitment who secure civil service employment
- ◆ Percent of homeless or recently homeless applicants hired through targeted recruitment who successfully pass their initial probationary period

FUNDING

Existing Departmental funding to hire allocated staff

CONNECTION TO CITIES

✓ **SAME**

COMPLEMENTARY

NO CITY ROLE

Cities could implement a similar recruitment and hiring practice for positions within their jurisdiction.

Strategy C4 | INCREASE INCOME

Related to Strategy Brief 3.1

Establish a Countywide SSI Advocacy Program for People Experiencing Homelessness or At Risk of Homelessness

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Department of Health Services to collaborate with the Department of Public Social Services and other relevant County Departments to establish a Countywide Supplemental Security Income Advocacy Program as described herein.

DESCRIPTION

The recommended countywide Supplemental Security Income (SSI) Advocacy Program would provide assistance to eligible homeless individuals and those at risk of homelessness (including all disabled GR participants) in applying for and obtaining SSI or other related benefits Social Security Disability Insurance (SSDI) and Cash Assistance Program for Immigrants. The Program, modeled after DHS' former Benefits Entitlement Services Team (B.E.S.T), should be overseen by the Los Angeles County Department of Health Services because of its successful management of B.E.S.T. and its achievement of high outcomes and experience with large-scale contracting with homeless services agencies across the county. A Request for Proposals is targeted for release by the end of June, 2016, to secure two or more contractors, who could use subcontractors, as needed, to meet the geographic needs of the County.

LEAD AGENCY

Health Services

COLLABORATING DEPARTMENTS/AGENCIES

- Children and Family Services
- Los Angeles Homeless Services Authority
- Mental Health
- Military and Veterans Affairs
- Probation
- Public Health
- Public Library
- Public Social Services
- Sheriff

Referrals to the Countywide SSI Advocacy Program should be received via a warm hand-off from: (1) existing homeless entry points and systems of care, such as Housing for Health, the Coordinated Entry System (CES), Homeless Families Solutions System (HFSS), and the Single Adult Model (SAM); (2) the County Departments of Public Social Services, Mental Health, Public Health, Military and Veterans Affairs, and Children and Family Services, the Probation Department, and the Sheriff's Department; and (3) community-based organizations serving individuals who are homeless or at risk of homelessness.

Establish a Countywide SSI Advocacy Program for People Experiencing Homelessness or At Risk of Homelessness *continued*

DESCRIPTION *continued*

The necessary components of a successful SSI Advocacy Program include:

A. Benefits Specialist Resource Team(s) for each Service Planning Area (SPA) who will be responsible for:

- Receiving referrals from the various above-identified points of entry;
- Full-time co-location at DPSS' 14 General Relief offices;
- Conducting and/or leveraging outreach and engagement activities to identify eligible homeless individuals;
- Providing assessment and screening to ensure candidates meet both non-medical and medical requirements for SSI/SSDI or CAPI;
- Coordinating subsidized housing for those individuals enrolling in the program with existing homeless entry points, housing programs and housing subsidies;
- Coordinating record retrieval services with DMH/DHS/LASD based on client's medical/treatment history;
- Coordinating and leveraging Department of Mental Health, Department of Health Services and managed care systems to secure health care, mental health care and documentation of disability for clients completing a SSI/SSDI claim;
- Developing and filing high quality benefit applications;
- Coordinating and advocating with the Social Security Administration (SSA) and California Department of Social Services Disability Determination Services (DDS) regarding the status of pending benefit applications;
- Coordinating legal consultation for clients who have complex SSI/SSDI applications;

- Providing assistance for those at risk of losing, or requiring re-certification of their SSI benefits;
- Coordinating Interim Assistance Reimbursement (IAR) with relevant County Departments; and
- Coordinating benefits advocacy with the Veteran's Benefits Advocacy Team for eligible veterans.

B. Ongoing training & technical assistance for Homeless Services Agencies, Federally Qualified Health Centers, and County and other public agencies - Training and technical assistance could be from the Benefits Specialist Team or through a subcontract to maximize the reach to community organizations and clinicians. Training and technical assistance builds the capacity of the system to access SSI/SSDI and CAPI benefits at a faster and greater rate countywide and facilitates the movement of Los Angeles County's homeless disabled population onto federal/state benefits and off County general funds. Training and technical assistance should incorporate the following:

- Leverage training resources provided by the National SOAR Team;
- Provide training regarding specific requirements for SSI/SSDI and CAPI applications in the State of California;
- Incorporate the lessons learned from the B.E.S.T. project and other best practices;
- Develop and train homeless service providers and public agencies on the process for assessment and screening to ensure candidates meet both non-medical and medical requirements for SSI/SSDI or CAPI;
- Provide ongoing training and support to physicians and clinicians on identifying potential applicants and completing SSI/SSDI or CAPI documentation;

DESCRIPTION *continued*

- Develop a plan for internal quality assurance reviews to ensure the submission of high quality SSI/SSDI applications;
- Provide coordination with the SOAR program;
- Work with community stakeholders to develop a system of data collection for SSI//SSDI applications in Los Angeles County;
- Aggregate and analyze data regarding benefit applications for Los Angeles County;
- Track and report Los Angeles County SSI/SSDI outcomes to the national SOAR program; and
- Pursue continuous improvement of training and coordination to assure high quality benefits support for homeless residents.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Disabled homeless individuals, including older adults, and those at risk of homelessness in need of applying for and obtaining SSI, SSDI, or CAPI benefits.

POTENTIAL PERFORMANCE METRICS

- ◆ The number/percentage of individuals who initiate SSI/SSDI/CAPI applications
- ◆ The number/percentage of applications that are completed and submitted to SSA or DPSS
- ◆ The number/percentage of applications approved at each level of the application process
- ◆ The time to benefits establishment

FUNDING

\$6.8 million in ongoing annual DPSS funding from the General Relief SSI and Medi-Cal Advocacy Program which would be replaced by this recommended program

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could support the County's efforts by encouraging local community medical facilities to expedite requests for documentation from the Countywide Advocacy Program staff and/or provide funding for housing subsidies for their disabled, homeless city residents who are pursuing SSI. Cities could recover the subsidy amount through Interim Assistance Reimbursement and use the IAR to support a subsidy for another person.

Strategy C5 | INCREASE INCOME

Related to Strategy Brief 3.5

Establish a Countywide Veterans Benefits Advocacy Program for Veterans Experiencing Homelessness or At Risk of Homelessness

POPULATION IMPACT

ALL FAMILIES TAY SINGLE ADULT VETERAN CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Department of Military and Veterans Affairs to contract for one or more Homeless Veterans Benefits Specialist Resource Teams as described herein.

DESCRIPTION

The Department of Military and Veterans Affairs will contract for one or more Homeless Veterans Benefits Specialist Resource Teams to provide assistance to eligible homeless veterans in applying for and obtaining income and/or health benefits from the Department of Veterans Affairs. The program will be operated in partnership with community-based organizations to: (1) provide wraparound case management, health, and mental health supports to house enrolled veterans; and (2) acquire VA Service-Connected Compensation or VA Non-Service-Connected Pension benefits. The components of the proposed Veterans Advocacy Program include:

A. VA Benefits Specialist Resource Teams serving all Service Planning Area (SPA) of the County, including VA will be responsible for the providing services including, but not limited to the following:

- Conduct and/or leverage outreach and engagement activities to identify eligible homeless veterans;
- Receive referrals from DPSS, DHS, DMH and other County departments of veterans who need assistance with veteran’s benefits;
- Provide assessment and screening to determine whether veterans meet requirements for VA Service-Connected and Non-Service-Connected benefits;
- Coordinate with existing homeless entry points and housing programs to arrange subsidized housing or VASH Vouchers for those individuals enrolling in the program;
- Access relevant medical records from medical providers based on the veteran’s medical treatment, military service, and VA claims history;

LEAD AGENCY

Military and Veterans Affairs

COLLABORATING DEPARTMENTS/AGENCIES

Community-Based Organizations
Community and Senior Services
Health Services
Los Angeles Homeless Services Authority
Mental Health
Probation
Public Library
Veteran Service Organizations

DESCRIPTION *continued*

- Coordinate and leverage Veterans Health Administration, Los Angeles County Department of Military and Veterans Affairs “Navigator” program, Department of Mental Health, Department of Health Services, and managed care systems to assist the veteran to access health care, mental health care, and documentation of disability and, when applicable, its relationship to military service for veterans completing a VA Service-Connected and/or Non-Service-Connected claim(s);
- Develop and file high-quality benefits applications, including new and original, reopened, and increased rating claims;
- Coordinate and advocate with the Veterans Benefits Administration regarding status of pending benefits applications and appeals, as well as scheduling of compensation and pension examinations;
- Coordinate legal assistance to assist veterans who have complex Service-Connected/ Non-Service-Connected claims, including claims that require a character of discharge determination, claims that have been denied and are eligible to enter the appellate phase, and “clear and unmistakable error” claims; and
- Coordinate benefits advocacy with the proposed Countywide SSI Benefits Advocacy team, as needed.

B. Ongoing training and technical assistance for veterans and homeless service agencies, Federally Qualified Health Centers, and County and other public agencies – training and technical assistance will be conducted by a VA Accredited Agent and/or Attorney, and could be from the VA Benefits Specialist Team or through a subcontract to reach government and community organizations and clinicians that serve

veterans. Training and technical assistance should incorporate the following:

- Leverage training resources provided by the Supportive Services for Veterans Families program;
- Train homeless service providers and public agencies on the identification of eligible homeless veterans and the various veteran military discharge statuses;
- Train homeless service providers and public agencies on the process for assessment and screening to ensure veterans meet the requirements for VA Service-Connected compensation and Non-Service-Connected pension; and
- Provide ongoing training and support to physicians and clinicians on identifying potential applicants and completing Service-Connected and Non-Service-Connected documentation.

C. Provide quality assurance to ensure the submission of high quality Service-Connected/Non-Service-Connected applications:

- Access and monitor submitted veterans claims in VA database systems;
- Track and report programmatic outcomes; and
- Pursue continuous improvement of training and coordination to assure high quality benefits support for homeless veterans.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Homeless veterans, including veterans who are older adults, and those veterans at risk of homelessness in need of applying for and obtaining VA benefits or related services.

Establish a Countywide Veterans Benefits Advocacy Program for Veterans Experiencing Homelessness or At Risk of Homelessness

continued

POTENTIAL PERFORMANCE METRICS

- ◆ The number of veterans who initiate applications for VA Benefits
- ◆ The number of veterans transitioned to the SSI Benefits Specialist Resource Team when expected VA Benefits receipt would be less than the SSI/SSP rate
- ◆ The number of VA/SSI/SSP claims that are approved

FUNDING

\$1.2 million in Homeless Prevention Initiative funds out of the \$5 million approved for implementation of the Homes for Heroes report. Utilization of this funding for this strategy was already identified in the November 19, 2015 memorandum which provided the Board of Supervisors with the Homes for Heroes implementation plan.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could support the County’s efforts by encouraging local community medical facilities to expedite requests for medical records from the Countywide Veteran’s Benefits Advocacy Program staff and/or provide funding to support advocacy efforts for their city’s homeless veterans.



Strategy C6 | INCREASE INCOME

Related to Strategy Brief 8.3a

Targeted SSI Advocacy for Inmates

POPULATION IMPACT

ALL FAMILIES TAY ✓ SINGLE ADULT ✓ VETERAN ✓ CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Sheriff’s Department and the Department of Health Services, in collaboration with the Department of Mental Health, to develop an Supplemental Security Income (SSI) Advocacy Program for Inmates.

DESCRIPTION

The goal of the program would be to assist disabled, incarcerated individuals in completing and submitting their SSI application prior to discharge or in securing reinstatement of their SSI benefits, if the individual was receiving SSI prior to being incarcerated. This program should be a collaborative with the Countywide SSI Advocacy Program, as described in Recommended Strategy C4.

The following would be components of the program:

Pre-Release

- A. Facility gathers list of release-eligible inmates at least three months prior to discharge, six months is preferable.
- B. Benefits eligibility specialists are assigned to screen for SSI and SSDI eligibility. Screening encompasses:
 - Checking each inmate’s social security number, citizenship or eligible immigration status and current benefit status;
 - Meeting with inmate to complete a questionnaire to determine whether individual has a severe mental or physical impairment or is aged (age 65) for potential eligibility for SSI. Also review work history and get earnings record to determine potential eligibility for SSDI.
- C. Inmates who are potentially eligible for SSI or SSDI will be invited to participate in the advocacy program. Once the inmate decides to participate, he/she will be connected to the countywide SSI advocacy contractor (as described in Strategy C6) who will meet with the inmate in the jail to initiate a SSI/SSDI application and the inmate will sign

LEAD AGENCY

Health Services
 Sheriff (Care Transition Director)

COLLABORATING DEPARTMENTS/AGENCIES

Mental Health
 Social Security Administration

Targeted SSI Advocacy for Inmates *continued*

DESCRIPTION *continued*

release of information documents. Medical and mental health records are obtained from private providers, public providers, incarceration facility providers and other identified providers:

- An assessment is made by the contractor to determine if medical evidence is likely to be sufficient to prove disability according to SSA standards.
 - If assessment determines that available records may not be sufficient to show disability, refer individual to in-house or County medical and mental health providers for assessments and reports.
- D. Once sufficient medical evidence is gathered, forward eligible claims for disability to the Disability Determination Services (DDS) office. The contractor maintains contact with DDS and SSA to check on progress of the application.
- E. DDS/SSA makes the initial determination regarding disability while individual is still incarcerated.
- F. The contractor collaborates with Jail In Reach staff (as described in Recommended Strategy D2), who will work to locate interim or permanent housing to ensure an appropriate housing placement upon the inmate's discharge. The cost of housing from the release date to the SSI approval date can be recovered from the inmate's initial retroactive SSI benefit, through the Interim Assistance Reimbursement process.

Post-Release

- G. If medical eligibility is approved, upon discharge the same contractor will work with the individual to complete the application process. If medical eligibility is denied, the contractor will pursue an appeal.
- H. Once a formerly incarcerated individual begins receiving SSI or SSDI, an appropriate agency will assist the individual in transitioning to appropriate permanent housing, if the individual was placed in interim housing upon discharge.

Disabled inmates with a jail stay shorter than three months will be connected to the Countywide SSI Advocacy Program (Strategy C4) upon discharge.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Homeless individuals scheduled for release from an LA County jail within three to six months who have been assessed to have a severe mental or physical disability (Single adults, older adults, veterans, and chronically homeless).

POTENTIAL PERFORMANCE METRICS

- ◆ Number of incarcerated individuals assessed for potential SSI eligibility
- ◆ Number of individuals with sufficient medical evidence of disability to warrant an SSI application
- ◆ Number of SSI applications made prior to release
- ◆ Number of SSI applications medically approved prior to release
- ◆ Number of SSI applications medically approved post release
- ◆ Number of formerly incarcerated individuals who obtained SSI benefits
- ◆ Number of formerly incarcerated individuals who obtained housing paid for with SSI benefits.

FUNDING

\$1 million one-time funds from AB 109



CONNECTION TO CITIES

SAME

COMPLEMENTARY

✓ **NO CITY ROLE**



Strategy D

Provide Case Management and Services



Most homeless families and individuals need some level of case management and supportive services to secure and maintain permanent housing, though the specific need varies greatly, depending on the individual circumstances. The availability of appropriate case management and supportive services is key to enabling homeless families and individuals to take advantage of an available rental subsidy, increase their income, and access/utilize available public services and benefits.

**Los Angeles County
Homeless Initiative**

Strategy D1 | PROVIDE CASE MANAGEMENT AND SERVICES

Related to Strategy Brief 1.6

Model Employment Retention Support Program

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Department of Public Social Services and Community and Senior Services to identify the key components of a Model Employment Retention Support Program and work with relevant Departments to incorporate identified services into existing programs, as feasible.

DESCRIPTION

A model employment retention support program for newly-employed homeless/formerly homeless individuals could be incorporated into existing employment programs and homeless case management programs. Program elements of a model Employment Retention Support Program should include:

- Ongoing communication with newly-employed individuals to provide support and identify potential problems.
- Soft skills- Enhancing the newly-employed individual’s ability to successfully manage relationships with co-workers and supervisors. Retention services must include connection to soft-skill development such as trainings and community supports.
- Résumé building to encourage and support promotion, including the exploration of volunteer work to supplement employment.
- Effective communication and coordination with case managers and housing specialists, including constant assessment of new referrals and/or connections needed to support the newly-employed individual.
- Creating incentives to expand work-study opportunities to build skill sets.
- Communication and Life Skills – Modeling by case management staff of effective communication in a professional environment and appropriate dress code.
- A review of the Employer’s company policies and Employee Handbook.
- Coordinated referrals to Self-Help Support groups – provide free community support and develop soft skills necessary to maintain employment.
- Online training in self-help and empowerment.

LEAD AGENCIES

Community and Senior Services
Public Social Services

COLLABORATING DEPARTMENTS/AGENCIES

Military and Veterans Affairs
Mental Health
Probation
Workforce Development Boards

DESCRIPTION *continued*

- Possible adoption of the Offender Workforce Development Specialist model, including specialized training for case managers to assist individuals involved with the justice system.
- Mentorship opportunities within employment and housing programs that link and empower people seeking employment with those successfully maintaining employment.
- Financial literacy/budgeting – training and support to transition people to be self-sustaining through employment.

In addition to providing support to the newly-employed individual, to foster support at the employer level, coordination and communication with employers post-placement should include employer liaisons, available to the employer to identify issues/barriers as they arise in the course of employment, and identify service providers available to provide the needed support to the employee to address the issues identified by the employer.

As part of implementation of this strategy, County Departments will identify existing programs serving homeless families and individuals into which employment retention services could be incorporated.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities which operate Workforce Development Boards could focus on employment retention services for recently-employed, formerly-homeless individuals. In addition, cities could proactively recruit volunteers/mentors to be employer liaisons or coaches for recently-employed persons.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Individuals, including older adults, and families who have been recently housed and connected to employment will be eligible for ongoing employment retention support and referrals, as needed and available.

POTENTIAL PERFORMANCE METRICS

- ◆ Individuals who receive employment retention services
- ◆ Employment retention
- ◆ Percent of newly-employed individuals who experience income increase
- ◆ Percent of newly-employed individuals who secure promotions

FUNDING

To the extent that employment retention services can be incorporated into existing case management services, funding is not necessary to support this strategy. However, to the extent that recently-employed, formerly homeless individuals do not have access to case management services, there would be a cost associated with expanding one or more existing programs. As part of the implementation planning for this strategy, the capacity of current programs to incorporate employment retention services for the target population will be assessed.

Expansion of Jail In Reach

POPULATION IMPACT

✓ ALL

FAMILIES

TAY

SINGLE ADULT

VETERAN

CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Sheriff’s Department and Health Services to work with their non-profit partner agencies and collaborating County departments to expand Jail in Reach to make it available to all homeless people incarcerated in a Los Angeles County jail, subject to available funding.

DESCRIPTION

This program expansion for homeless inmates should include the following elements:

- Offer all homeless inmates jail in reach services from the beginning of incarceration.
- Provide case management to homeless inmates tailored to their individual need(s) and connect inmates to services such as mental health and substance use disorder treatment on an as-needed basis.
- Coordination of all services provided to homeless inmates so that physical health, behavioral health, housing, education, employment, mentorship, and other needs are integrated into one case plan monitored by one assigned case manager, with the goal of ensuring strong service integration.
- Recruit and fund community-based service providers from across the County so that services continue seamlessly post-release with the same case management team, including connection to housing specialists and access to bridge housing until a permanent housing plan can be implemented, employment support, benefits support, transportation, and other ongoing supportive services such as mental health treatment to help homeless inmates reintegrate successfully back into the community with adequate supportive services.

In addition, consideration should be given to the inclusion in the program of self-help support groups in jail, e.g., Alcoholics and Narcotics Anonymous that are run by jail inmates. Such support groups are an integral element of the Community Model in Corrections, an evidence-based practice.

LEAD AGENCY

Health Services
Sheriff

COLLABORATING DEPARTMENTS/AGENCIES

Alternate Public Defender
Community and Senior Services
Housing Authority of the City of Los Angeles
Housing Authority of the County of Los Angeles
Mental Health
Probation
Public Defender
Public Health
Public Social Services
County SSI Advocacy Contractors
Community-based Providers

DESCRIPTION *continued*

The Department of Health Services' Housing for Health intensive case management program provides a model for the style of case management that will be required for many individuals.



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless inmates in County jail including those being held prior to trial.

POTENTIAL PERFORMANCE METRICS

- ◆ Reduction in recidivism
- ◆ Reduction in homelessness
- ◆ Increased employment
- ◆ Improved healthcare outcomes
- ◆ Number of homeless inmates who receive Jail In Reach services

FUNDING

- ◆ \$2,000,000 in one-time HPI funding
- ◆ \$3,000,000 in one-time AB 109 funding

CONNECTION TO CITIES

SAME

COMPLEMENTARY

✓ **NO CITY ROLE**

Strategy D3 | PROVIDE CASE MANAGEMENT AND SERVICES

Related to Strategy Brief 9.3a

Supportive Services Standards for Subsidized Housing

POPULATION IMPACT

ALL FAMILIES ✓ TAY ✓ SINGLE ADULT ✓ VETERAN ✓ CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Instruct the Los Angeles Homeless Services Authority, in collaboration with the Departments of Mental Health, Public Health, Health Services, and Public Social Services, the Probation Department, and the Community Development Commission to draft and adopt a definition of supportive services and establish a set of standards for high-quality supportive services for persons in subsidized housing who have recently experienced homelessness.

DESCRIPTION

Supportive services are critical to effectively transitioning formerly homeless persons from being on the streets to becoming a thriving tenant and member of the community. Supportive services in subsidized housing involve the development of a trusting, genuine partnership and relationship between the service provider and the formerly homeless tenant. This connection brings value and enhances participation in the supportive services, furthering the tenant’s journey of recovery and housing stability. To most effectively achieve this goal, the County needs a consistent definition of supportive services that adhere to high quality standards, and are consistent with government funding requirements.

The definition of supportive services should consider existing established standards, such as those from Shelter Partnership’s 2009 study commissioned by the Community Development Commission, Home for Good’s Standards of Excellence, Veteran Affairs’ Supportive Services for Veteran Families/Veteran Affairs Supportive Housing guidelines for homeless veterans, and Housing Opportunities for Persons with AIDS guidelines. The definition should include, but not be limited to the following activities:

- Connection to financial benefits (such as General Relief, Supplemental Security Income [SSI], CalFresh, etc.).
- Connection to health coverage, which is generally Medi-Cal.
- Linkages to and direct connection/ collaboration with treatment-related services (such as mental health, physical health, and substance use disorder treatment).
- Linkages to job development and training programs, school, peer advocacy opportunities, advocacy groups, self-help support groups, and volunteer opportunities, as needed and wanted by the tenant.

LEAD AGENCY

Los Angeles Homeless Services Authority

COLLABORATING DEPARTMENTS/AGENCIES

Community Development Commission
 Health Services
 Housing + Community Investment Department, City of Los Angeles
 Housing Authority of the City of Los Angeles
 Housing Authority of the County of Los Angeles
 Mental Health
 Probation
 Public Health
 Public Social Services

DESCRIPTION *continued*

- Money management and linkage to payee services.
- Transportation and linkage to transportation services.
- Peer support services. (Utilizing people with lived experience in outreach, engagement, and supportive services is an evidence-based best practice.)
- Community-building activities, i.e., proactive efforts to assist tenants in engaging/participating in the community and neighborhood.
- Connection to specialized services provided to individuals who are: victims of Domestic Violence; Lesbian, Gay, Bi, or Transgender; transition age youth; or elderly.

Additionally, the standards for high-quality supportive services should specify that supportive services should be:

1. tenant-centered;
2. accessible;
3. coordinated; and
4. integrated.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities which operate a public housing authority could adopt the County’s definition of supportive services for formerly homeless adults and the County’s standards for high-quality supportive services.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Recently homeless adults in subsidized housing

POTENTIAL PERFORMANCE METRICS

- ◆ Number of agencies providing supportive services which adopt the County’s definition and high-quality standards

FUNDING

No funding required



Strategy D4 | PROVIDE CASE MANAGEMENT AND SERVICES

Regional Integrated Re-entry Networks- Homeless Focus

POPULATION IMPACT

ALL FAMILIES ✓ TAY ✓ SINGLE ADULT ✓ VETERAN ✓ CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Office of Diversion and Reentry (OD&R), in collaboration with the Care Transitions Unit of the new Integrated Jail Health Services division, and the Sheriff to incorporate a focus on homeless individuals into the multi-disciplinary, clinically-focused Regional Integrated Re-entry Networks which are already being developed.

DESCRIPTION

The attributes of a Re-entry Network include:

- Consist of high quality mental health, physical health and substance use disorder providers with an interest and expertise in serving the re-entry population;
- Be geographically convenient, patient-friendly, and culturally competent;
- Include seamless sharing of patient records between jail medical and behavioral health services and network providers; and
- Provide either integrated services or robust links to mental health, substance use disorder, housing, case management and other social services in the community.

LEAD AGENCY

Department of Health Services
Sheriff

COLLABORATING DEPARTMENTS/AGENCIES

Mental Health
Community and Senior Services
Public Social Services
Public Health
LA Care (and other local health plans)
Los Angeles Homeless Services Authority
Probation

The early planning for a Re-entry Network system has involved treatment providers, County departments and health plans. Future efforts will include a broad array of other service providers and community groups with a keen interest in the stability of justice-involved populations.

It is recommended that this planning include a focus on homeless populations, so that the Re-entry Networks incorporate at least the following three elements:

- a. High quality homeless service providers with expertise in engagement, housing placement and maintaining housing stability;
- b. Integration of the role of probation officers and others who may be in charge of community supervision of individuals using reentry network services; and

DESCRIPTION *continued*

- c. Development of the technical and cultural expertise to work with homeless justice-involved populations and support other providers in their regions who might benefit from assistance in managing homeless justice-involved individuals. This support may involve navigating services that support homeless justice-involved individuals, connections to job training or employment, connections to housing resources or move-in assistance, and/or the provision of homeless/housing case management.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Homeless, justice-involved adults.

POTENTIAL PERFORMANCE METRICS

- ◆ Number of homeless justice-involved individuals who secure permanent housing
- ◆ Number of homeless justice-involved individuals who are linked to clinical services/care
- ◆ Number of homeless justice-involved individuals who retain permanent housing

FUNDING

- ◆ \$800,000 in one-time HPI funding
- ◆ \$2,000,000 in one-time AB 109 funding
- ◆ Medi-Cal for those services which are covered

CONNECTION TO CITIES

SAME

COMPLEMENTARY

✓ **NO CITY ROLE**



Strategy D5 | PROVIDE CASE MANAGEMENT AND SERVICES

No Related Strategy Brief

Support for Homeless Case Managers

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Chief Executive Officer and the Los Angeles Homeless Services Authority to work with each department identified below as a collaborating department to develop and implement a plan for each department to support community-based homeless case managers, which reflects the extent and nature of each department’s interaction with homeless families/ individuals.

DESCRIPTION

Homeless case managers, who generally work for community-based organizations and often participate in the single adult Coordinated Entry System (CES) or Homeless Families Solutions System, play a key role in combating homelessness, by engaging homeless families and individuals, connecting them to housing, assisting them to navigate and access various public services, and providing ongoing support.

County departments can play a key role in supporting homeless case managers by:

1. helping homeless families/individuals connect to a homeless case manager;
2. responding effectively to homeless case managers assisting homeless families/ individuals to access and navigate County services; and
3. participating, where appropriate, in CES regional case conferencing and coordinated outreach meetings.

LEAD AGENCY

Chief Executive Office
Los Angeles Homeless Services Authority

COLLABORATING DEPARTMENTS/AGENCIES

- | | |
|-----------------------------------|-------------------------------|
| Alternate Public Defender | Fire Department |
| Animal Care and Control | Health Services |
| Beaches and Harbors | Mental Health |
| Child Support Services Department | Military and Veterans Affairs |
| Community and Senior Services | Parks |
| Community Development Commission | Public Health |
| Children and Family Services | Public Social Services |
| Consumer and Business Affairs | Probation Department |
| District Attorney | Public Defender |
| | Public Library |
| | Public Works |
| | Sheriff’s Department |

The specific role of each County department will vary depending on the extent and nature of the Department’s contact with homeless families/individuals.

To assist families/individuals connect to a homeless case manager, individual County departments could:

- Provide space for homeless case managers to collocate at their facilities and conduct in-reach with homeless families/individuals who go to the Department for services. (This would only be applicable to departments which serve a very high volume of homeless families/individuals.)
- Implement a standardized protocol to contact a homeless case manager (who could be a domestic violence service provider) to come to

DESCRIPTION *continued*

the department’s facility to engage a homeless family/individual who wishes to see a homeless case manager.

- Transport a homeless family/individual to a location where they could meet with a homeless case manager. (Few departments will have this capacity.)
- Provide a referral to a local homeless case manager to the homeless family/individual.

To respond effectively to homeless case managers assisting homeless families/individuals to access and navigate County services, individual County departments could:

- Establish a protocol for interacting with homeless case managers.
- Designate one or more homeless case manager liaisons at each location that provides services to a significant number of homeless families/individuals, plus a departmental liaison. (For some departments, a departmental liaison may suffice, if the frequency of contact with homeless families/individuals is low.)
- Facilitate relationships between local homeless case managers and the staff at various facilities.
- Participate, where appropriate, in CES regional case conferencing and coordinated outreach meetings.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could direct their departments which interact with homeless families/individuals to develop a plan to support homeless case managers.

The implementation plans which departments will develop under this strategy will complement the contribution of certain departments to the Countywide Outreach System (Strategy E6), Coordinated Entry System (Strategy E7), and County Specialist Support Team (Strategy E11).

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations, including victims of domestic violence and the older adult population.

POTENTIAL PERFORMANCE METRICS

More effective services for homeless families and individuals

FUNDING

None



Strategy D6 | PROVIDE CASE MANAGEMENT AND SERVICES

Related to Strategy Brief 8.6

Criminal Record Clearing Project

POPULATION IMPACT

ALL FAMILIES TAY ✓ SINGLE ADULT ✓ VETERAN ✓ CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Public Defender (PD), in collaboration with the Office of the Alternate Public Defender (APD), Probation Department (Probation), Department of Public Social Services (DPSS), and Sheriff’s Department to develop a Criminal Record Clearing Project (CRCP), as described herein.

DESCRIPTION

There are various barriers that homeless individuals face on a daily basis and one of hardest barriers to overcome is having a criminal record, which makes it especially difficult to obtain employment and housing, both of which are key to achieving self-sufficiency. In order to reduce this barrier, it is recommended that the PD, in collaboration with the APD, Probation, DPSS; and Sheriff:

- Develop and implement a CRCP, which could include utilization of a contract provider to coordinate the project;
- Ensure that CRCP is leveraged and coordinated with discharge planning protocols (Strategy A2), Jail in Reach (Strategy D2), regional integrated re-entry networks (Strategy D4), and bridge housing for those exiting institutions (Strategy B7) , as well as with DPSS employment programs;
- Develop a comprehensive training curriculum for participating agencies;
- Ensure clients are connected to County Alternative Courts, if eligible; and
- Create a CRCP team consisting of the aforementioned agencies and community-based partners that would be responsible for oversight and administration of the CRCP.

LEAD AGENCY

Public Defender

COLLABORATING DEPARTMENTS/AGENCIES

Alternate Public Defender
Community-Based Organizations which work with the criminal justice re-entry population
Community and Senior Services
District Attorney
Public Social Services
Probation
Non-profit legal service providers

Through strategic partnerships and collaborative efforts, the project will aim to identify homeless and formerly homeless job-seekers who have criminal records and connect them to a legal advocate who will assist them with record clearing and other legal barriers to achieve stable housing and employment. This project

DESCRIPTION *continued*

could be implemented as a two-year pilot, after which it could be evaluated and a determination could be made as to whether to extend the project based on the results and availability of funding.



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Homeless individuals who have recently completed their parole or probation supervision; homeless Individuals with criminal records who are currently enrolled in DPSS’ GAIN or GROW program; homeless individuals with criminal records who are seeking employment or housing; and homeless individuals being discharged from jail, hospitals or the foster care system with criminal records.

POTENTIAL PERFORMANCE METRICS

- ◆ Number of staff from CRCP agencies who complete the criminal record clearing training
- ◆ Number of individuals served through this program who complete and file a Prop 47 application or petition for criminal record dismissal (expungement)
- ◆ Number of individuals served through this program who demonstrate an increase in income within 6-12 months after a dismissal
- ◆ Number of individuals served through this program who maintain or secure housing within 6-12 months after a dismissal

FUNDING

- ◆ \$200,000 in one-time HPI funding

CONNECTION TO CITIES

SAME

COMPLEMENTARY

✓ **NO CITY ROLE**



Strategy E

Create a Coordinated System



Given their complex needs, homeless individuals, families and youth often touch multiple County departments, city agencies and community-based providers. For the most part, services are not well coordinated; this fragmentation is often compounded by disparate eligibility requirements, funding streams, and bureaucratic processes. Maximizing the efficacy of current programs and expenditures necessitates a coordinated system which brings together homeless and mainstream services. The extension of Medi-Cal to single adults through the Affordable Care Act, the County's commitment to criminal justice diversion, and the focus on collaboration between the County, cities, and community partners combine to create an historic opportunity to forge a coordinated system.

Los Angeles County
Homeless Initiative

Strategy E1 | CREATE A COORDINATED SYSTEM

Related to Strategy Brief 3.3

Advocate with Relevant Federal and State Agencies to Streamline Applicable Administrative Processes for SSI and Veterans Benefits

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Chief Executive Office to advocate with relevant Federal and State agencies to streamline applicable administrative processes, in order to enhance access to SSI and Veterans benefits for applicants who are homeless or at risk of homelessness.

DESCRIPTION

There is a significant opportunity to enhance access to SSI and Veterans benefits for applicants who are homeless or at risk of homelessness, through advocacy with the Social Security Administration, California Department of Social Services, Veterans Administration, Veterans Healthcare Administration, California Department of Corrections and Rehabilitation and any other relevant agencies to streamline applicable administrative processes. Such streamlined processes have been implemented in the past and could now be reinstated and enhanced. Specific opportunities include, but are not limited to:

1. Designating specialized local offices to handle SSI applications from County SSI Advocates;
2. Exempting cases of homeless clients applying for SSI from being transferred throughout the country; and
3. Collaboration with community- based organizations providing services to Veterans/ SSI applicants.

Advocacy is needed with the following Agencies:

- Social Security Administration- Administers Supplemental Security Income;
- California Department of Social Services Disability Determination Services – Reviews medical records as part of the SSI application process;
- Veterans Administration- Oversees the provision of veterans benefits;

LEAD AGENCY

Chief Executive Office

COLLABORATING DEPARTMENTS/AGENCIES

- Los Angeles Homeless Services Authority
- Health Services
- Mental Health
- Military and Veterans Affairs
- Public Social Services
- United Way/Home for Good
- Community-Based Organizations

DESCRIPTION *continued*

- Veterans Healthcare Administration – Oversees the provision of Veterans Healthcare services; and
- California Department of Corrections and Rehabilitation - Oversees State prison operations.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations

POTENTIAL PERFORMANCE METRICS

- ◆ Processing time for SSI and Veterans Benefits
- ◆ Approval rate for SSI and Veterans Benefits

FUNDING

There is no cost to the County to implement this strategy.



CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could support the County's effort through the League of Cities and/or Independent Cities Association. Individual cities could also support this effort.

Strategy E2 | CREATE A COORDINATED SYSTEM

Related to Strategy Brief 5.3

Drug Medi-Cal Organized Delivery System for Substance Use Disorder Treatment Services

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

- Direct the Department of Public Health’s (DPH’s) Substance Abuse Prevention and Control (SAPC) network to provide the full continuum of Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver services in a culturally competent manner to people experiencing homelessness.
- Direct DPH/SAPC to leverage new flexibility through the DMC-ODS waiver to increase access to substance use disorder (SUD) services by providing field-based services in the community for people experiencing homelessness.

DESCRIPTION

The approval of the California Department of Health Care Services (DHCS) DMC-ODS Waiver by the Federal Centers for Medicaid and Medicare Services (CMS) allows counties to voluntarily opt in to expand reimbursable services under the DMC program. This opportunity includes a fuller continuum of care and appropriate support services, standardizes level of care placements based on the American Society of Addiction Medicine (ASAM) criteria and medical necessity, ensures effective and appropriate care through quality assurance and utilization management efforts, more fully integrates physical and mental health services with the SUD service system, and transforms the overall treatment of SUD from an acute care model to a chronic care model.

The DMC levels of care (LOC) will include withdrawal management (formerly detoxification services), short-term sobering centers, residential treatment, and medication-assisted treatment, in addition to already available outpatient, intensive outpatient, and narcotic treatment programs. Additional services will also include a 24-hour toll-free access line to place individuals in the appropriate LOC, case management, recovery support, and coordination with physical and mental health. Placement at a particular LOC and service duration will be based on medical necessity, except for residential services for which the maximum service duration for adults is 90 days with a one-time 30-day extension if medically necessary, and a limit of two non-continuous 90-day episodes annually (standards vary for perinatal beneficiaries and adolescents). Criminal justice populations may be eligible for an extension of up to three months past the 90-day episode, for a total treatment length of six months if medically necessary.

LEAD AGENCY

Public Health

COLLABORATING DEPARTMENTS/AGENCIES

- Community-based providers
- Children and Family Services
- Health Services
- Housing Authority of the City of Los Angeles
- Housing Authority of the County of Los Angeles
- Mental Health
- Public Social Services
- Los Angeles Homeless Services Authority
- Medi-Cal Managed Care Organizations
- Probation
- Sheriff

DESCRIPTION *continued*

SAPC is targeting a launch date toward the end of 2016 for the new waiver services, but this timeline is dependent on County, State and Federal approvals. With the aim of expanding network adequacy, SAPC is currently reaching out to providers to encourage them to become DMC-certified. SAPC intends to provide training and technical assistance to providers seeking State DMC certification, including current DMH providers who wish to also be certified for DMC. Network adequacy is also dependent on the ability of DHCS to certify new providers and LOC, particularly residential treatment facilities.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All Medi-Cal beneficiaries who qualify for SUD services.

POTENTIAL PERFORMANCE METRICS

- ◆ Number of homeless individuals who are screened and identified as needing SUD treatment services
- ◆ Number of homeless individuals admitted to SUD treatment
- ◆ Number/ percent of homeless individuals who remained in treatment for at least 30 days
- ◆ Number/percent of homeless individuals in treatment who transitioned down to the next appropriate level of care (e.g., withdrawal to residential, residential to outpatient, and outpatient to recovery services)

FUNDING

DMC-ODS will fund SUD services.

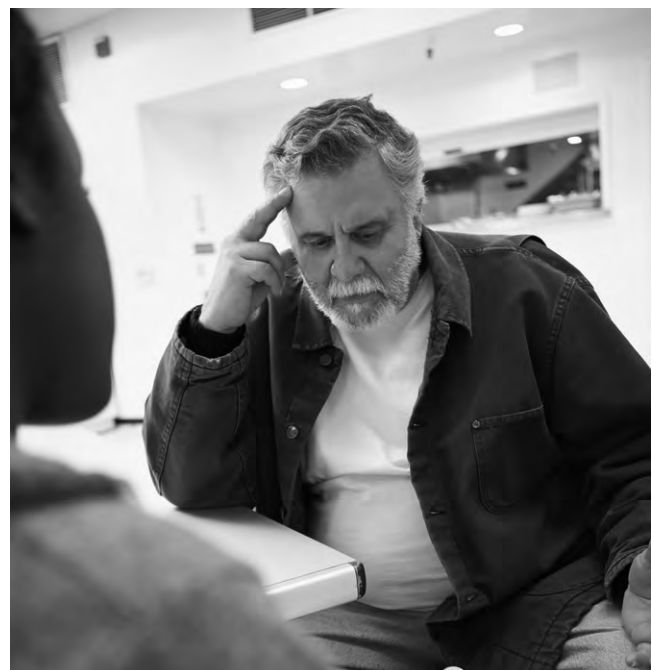
CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could facilitate the siting of residential SUD treatment facilities within their boundaries.



Strategy E3 | CREATE A COORDINATED SYSTEM

Related to Strategy Brief 5.4

Creating Partnerships for Effective Access and Utilization of ACA Services by Persons Experiencing Homelessness

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Health Agency to report back to the Board with recommendations to develop partnerships between health plans, health care providers, and homeless service providers to:

1. Identify and share information;
2. Emphasize case management for health care services;
3. Promote health literacy education; and
4. Connect the homeless to health care and services.

DESCRIPTION

1. Identify and Share Information

Establish practices to enable homeless service providers to share information on homeless clients to determine enrollment status, assigned health plan and health care provider, to the extent permitted by law. Frequently, individuals experiencing homelessness who receive services from homeless service providers are asked questions about their insurance type and health plan provider. Many are uncertain of their enrollment status. Technology and consents allowing health plans to cross-reference enrollees with clients in the Homeless Management Information System (HMIS) and automatically update the client’s health plan information in HMIS would be beneficial. On the health plan provider side, a report could then be generated for the health plans informing them of the homeless service program in which the client is enrolled and/or the most updated client contact information.

2. Case Management for Health Care Services

The needs of many persons experiencing homelessness are complex and, for those with the greatest vulnerabilities, pro-active health care treatment can either be difficult to access or be a lower priority for the person, thereby leading to high costs in public and private systems. In essence, ensuring that persons with complex health needs, who are experiencing homelessness, are linked to supportive field-based case management will increase the likelihood that they will proactively access needed health care services (i.e, health, mental health, and substance use disorder services). For example, housing and homeless service providers are well-positioned to deliver the types of services recommended for inclusion in the Health Homes model, including housing navigation; care coordination; transportation; health education; etc., though these services could be provided beyond health homes if Medi-Cal funding were available.

LEAD AGENCY

Health Services

COLLABORATING DEPARTMENTS/AGENCIES

- Community-based providers
- Children and Family Services
- FEMA Emergency Food and Shelter Program
- Public Health
- Public Library
- Mental Health
- Public Social Services
- Housing Authority of the City of Los Angeles
- Housing Authority of the County of Los Angeles
- Los Angeles Homeless Services Authority
- Medi-Cal Managed Care Organizations
- Probation
- Sheriff
- Skilled Nursing Facilities

DESCRIPTION *continued*

3. Health Literacy Education

Create a health literacy education program for homeless clients by funding community-based organizations with experience in health consumer education to create and execute the education program. This program would focus on educating homeless clients and those working with homeless clients on both enrollment and renewing health coverage (Medi-Cal), and how to navigate the health care system and access care, in particular within managed care organizations.

4. Connect Homeless People to Health Care and Services

Utilize the adult Coordinated Entry System (CES) and the Homeless Families Solutions System (HFSS) to connect homeless people to the Medi-Cal application process, health care providers, health plans, and housing resources. CES and HFSS assessment tools gather self-reported information about persons experiencing homelessness, including: insurance and health plan enrollment; physical health; mental health; substance use; and resulting impacts on housing stability. There is potential to gather more targeted information via these assessments (or brief supplemental assessments) that could assist housing providers, in conjunction with the health plans, to confirm eligibility for health care services.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Homeless Medi-Cal beneficiaries

POTENTIAL PERFORMANCE METRICS

- ◆ Percentage of homeless clients attending education programs who are still enrolled in Medi-Cal the following year
- ◆ Percentage of people attending education programs connected to primary care physicians (PCPs)
- ◆ Health outcomes of homeless clients participating in education programs
- ◆ Percentage of eligible persons enrolled in HMIS with a health care provider identified

FUNDING

Current Medi-Cal revenue, for some of the activities listed above in the description section.

CONNECTION TO CITIES

SAME

COMPLEMENTARY

✓ **NO CITY ROLE**



First Responders Training

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Sheriff’s Department to develop:

1. a training program and implementation plan for law enforcement, fire departments and paramedics throughout Los Angeles County, including but not limited to the LA County Sheriff’s Department (LASD) and the Los Angeles Police Department (LAPD); and
2. a Countywide protocol to address encampments and unsheltered homelessness.

DESCRIPTION

The proposed training program would educate law enforcement, fire departments, and paramedics, i.e., first responders, about the complex and diverse needs of the unsheltered homeless population and how to connect homeless individuals to appropriate services, so as to better prepare first responders when interacting with people experiencing unsheltered homelessness. The proposed training would emphasize awareness of, and strategies for dealing with, situations that arise among unsheltered homeless individuals due to an array of issues, such as, mental illness; alcohol and/or substance abuse/addiction (training in overdose Narcan protection/prevention is one component for addressing substance abuse); co-occurring substance abuse and mental illness; and/or physical health ailments. LASD and other police agencies interested in participating in the training will develop the training and protocol based on local and national best practices.

LEAD AGENCY

Sheriff

COLLABORATING DEPARTMENTS/AGENCIES

- Fire
- Community and Senior Services
- Health Services
- Los Angeles Homeless Services Authority
- LAPD
- Mental Health
- Probation
- Public Health
- Any first responder agencies Countywide that choose to be a part of this strategy

The proposed Countywide encampment/unsheltered homeless protocol would ensure that LA County, and police forces across the County, are responding to the crises of encampments and unsheltered homelessness in a manner that both improves efficiencies across jurisdictional boundaries and achieves more effective outcomes and collaboration among police agencies and homeless service providers.



DESCRIPTION *continued*

At a minimum, the protocol must:

- provide first responders with real time information on service providers in the immediate area where they are engaging people on the streets and encampments with the desirable end result being a warm transfer to a homeless service provider who can continue the engagement process, build rapport, and assist the homeless individual to move into housing.
- address the needs of victims of domestic violence (DV) so that first responders are prepared when they engage couples/DV victims on the street and in encampments.
- address the role of Adult Protective Services (APS) in addressing the needs of endangered seniors and dependent adults.
- address best practices for serving the LGBT population.
- incorporate the concepts of Trauma-Informed Care, as applicable to first responders.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Law enforcement, fire departments, and paramedics, i.e., first responders. Street homeless and homeless persons in encampments will benefit from the training because they will be engaged with greater sensitivity and understanding of their needs; however, the focus for this strategy is first responders. (The implementation of this strategy will complement the County’s Homeless Encampment Protocol.)

POTENTIAL PERFORMANCE METRICS

- ◆ Number of first responders trained
- ◆ Number of jurisdictions which adopt the countywide protocol

FUNDING

There would be three tiers of costs:

1. development of the training/protocol;
2. the cost for trainers to deliver the training; and
3. payment of wages for those who attend the training. The training could be added to current training curricula of first responder agencies, which might reduce the associated cost. For the Sheriff’s Department, this might include incorporating this training into the Crisis Intervention Training (CIT) recommended by the Mental Health Diversion Task Force, particularly given the high incidence of mental illness among homeless individuals living on the street and in encampments.

Each agency will absorb the cost of sending its first responders to the training or seek any needed funding through the applicable annual budget process. The cost for each trainee will include the cost of curriculum development and the cost of the trainers.

CONNECTION TO CITIES

✓ **SAME**

COMPLEMENTARY

NO CITY ROLE

The strategy will be applicable to all first responder agencies countywide.

Decriminalization Policy

POPULATION IMPACT

✓ ALL

FAMILIES

TAY

SINGLE ADULT

VETERAN

CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the LA County Sheriff’s Department (LASD), in collaboration with the District Attorney (DA), Public Defender (PD), Assistant Public Defender (APD), and Los Angeles Homeless Services Authority (LAHSA) to develop a decriminalization policy for use by the County and cities throughout the County.

DESCRIPTION

The criminalization of homelessness has long been seen in some communities as a strategy to address some of the more visible aspects of homelessness; however, over the past few years, there has been an increased understanding that criminalization harms individuals and communities and in fact can make it more difficult to address homelessness. With new efforts by the Federal Government to encourage communities to roll back these measures, there is an increased need for the County to build on current Sheriff’s Department policy and practice and take a leading role in promoting the decriminalization of homelessness throughout Los Angeles County. The decriminalization policy should:

1. Include a protocol that complements the County’s Homeless Encampment Protocol (the Encampment Protocol also includes best practices that can be applied to street homelessness), to ensure that the County does not disproportionately enforce existing County ordinances against homeless families and individuals;
2. Include a process to ensure greater collaboration between judicial agencies and local alternative courts, e.g., County Homeless Court, DMH’s Co-Occurring disorders Court, etc., to enable homeless individuals to address citation fines before they become a warrant and already-incurred warrants and fines, which are often a barrier to services and housing; and,
3. Support statewide efforts to stop criminalizing homelessness.

LEAD AGENCY

Sheriff

COLLABORATING DEPARTMENTS/AGENCIES

Alternate Public Defender
 District Attorney
 Probation
 Public Defender
 Los Angeles Homeless Services Authority
 Law enforcement agencies from cities that choose to adopt a similar policy
 Mental Health



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations, particularly homeless individuals living on the street and in encampments

POTENTIAL PERFORMANCE METRICS

This recommendation does not apply to a specific programs or services; therefore, the success will be measured by a reduction across the County in policies and practices which criminalize homelessness.

FUNDING

N/A. There is no direct cost associated with this strategy.

CONNECTION TO CITIES

✓ **SAME**

COMPLEMENTARY

NO CITY ROLE

The strategy could be implemented by each city in the County.

Countywide Outreach System

POPULATION IMPACT

ALL
 FAMILIES
 TAY
 SINGLE ADULT
 VETERAN
 CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Los Angeles Homeless Services Authority, in conjunction with relevant County agencies and community based organizations, to develop and implement a plan to leverage current outreach efforts and create a countywide network of multidisciplinary, integrated street-based teams to identify, engage and connect, or re-connect, homeless individuals to interim and/or permanent housing and supportive services.

DESCRIPTION

There would be at least one team in each Service Planning Area (SPA) of the County and each team should include the following staff: case manager(s), health outreach worker, mental health outreach worker, substance abuse provider, and LA Homeless Services Authority Emergency Response Team personnel. As needed, the teams would include outreach personnel from agencies that specialize in engaging TAY, Veterans, victims of domestic violence (DV) and Families.

The strategy requires a telephone hotline to connect to the street-based team(s) in each SPA with staff trained and well-versed in the services and housing opportunities in their respective SPA/region of the County.

For this strategy to be successful, it is imperative that all street teams operate with the same understanding of what it means to conduct outreach and what it means to engage homeless on the streets or in encampments. Department of Health Services' County+City+Community (C3) project, including a connection to Intensive Case Management Services (ICMS), is an appropriate model to emulate. Additionally, the outreach teams need to be aware of DV protocols and have a relationship with DV service providers. The definitions are as follows:

Outreach

Outreach is the critical first step toward locating and identifying a homeless person who is not otherwise contacting a government agency or service provider who can connect him/her to available services and housing resources. Outreach is a means of educating the community about available services, in this case for homeless individuals and families. Outreach is

LEAD AGENCY

Los Angeles Homeless Services Authority (LAHSA)

COLLABORATING DEPARTMENTS/AGENCIES

- Fire
- Health Services
- Mental Health
- Probation
- Public Health
- Public Social Services
- Sheriff
- City of LA and any of the other 87 cities that would like to collaborate in this effort
- United Way

DESCRIPTION *continued*

also a process for building a personal connection that may play a role in helping a person improve his or her housing, health status, or social support network.

Engagement

Engagement, when conducted properly, is a process that establishes a trusting relationship that can lead to a homeless person’s participation in services and housing. The process begins after the initial street outreach contact or, for example, when a homeless person presents at an agency such as DPSS, a CES provider agency, or an HFSS Family Support Center. The engagement process can take weeks to months. There is no standard timeline for successful engagement and an outreach worker/team should never be discouraged by initial rejections of their offers to assist a homeless individual. If an agency’s policies and resources do not allow for this time and consistent/persistent effort, the worker will more often than not fail at building the necessary relationship and the homeless person will likely not trust the next outreach worker/team who tries to engage them and offer housing and services.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could take an active role in the outreach/ engagement effort and/or provide additional funding/resources to bolster the efforts in their community. Certain cities have provided funding, in the past, for homeless outreach and engagement. Sometimes this has been done through enhanced Business Improvement District (BID) teams that have been trained to engage and connect clients to homeless housing and services.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Any individual, older adult, victim of domestic violence, youth, or family experiencing homelessness that is encountered during outreach and engagement activities. Families identified will be directed to the HFSS.

POTENTIAL PERFORMANCE METRICS

- ◆ Number of contacts-duplicated and unduplicated
- ◆ Number of people connected to health, mental health, substance abuse treatment, sources of income
- ◆ Number of people connected to interim housing
- ◆ Number of people permanently housed
- ◆ Number/percentage of people permanently housed who retain housing for 6, 12, and 24 months
- ◆ Number/percentage of people permanently housed who return to homelessness after 6, 12, and 24 months

FUNDING

\$3,000,000 in one-time HPI funding

Strategy E7 | CREATE A COORDINATED SYSTEM

Related to Strategy Briefs 6.1 and 7.1

Strengthen the Coordinated Entry System

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Los Angeles Homeless Services Authority (LAHSA), in collaboration with the departments/agencies listed below, to assess the adult Coordinated Entry System (CES), the Homeless Families Solutions System (HFSS), and the “under construction” coordinated system for transition age youth, develop a recommended plan to strengthen these three related systems, and submit the plan for consideration.

DESCRIPTION

The move toward CES culminated with the implementation of the Federal “Opening Doors” Strategic Plan to prevent and end homelessness, the HEARTH Act, and the requirement that Continuums of Care (CoC) create a coordinated or centralized assessment and housing placement system. This system must be used to prioritize access to housing and services based on service need in order for a CoC to be eligible for federal homeless assistance funding. Coordinated entry is the process through which people experiencing homelessness or at-risk of homelessness can easily access crisis services through multiple, coordinated entry points, have their needs assessed and prioritized consistently, and, based upon those needs, be connected with appropriate housing interventions and supportive services. For special sub-populations, such as victims fleeing domestic violence or human trafficking, or those who are HIV-positive, CES must ensure that data-tracking and matching protocols do not conflict with confidentiality provisions to maintain individual safety and overall well-being.

LEAD AGENCY

Los Angeles Homeless Services Authority (LAHSA)

COLLABORATING DEPARTMENTS/AGENCIES

- Community-based homeless service and housing providers
- Community Development Commission
- Children and Family Services
- Fire
- Health Services
- Mental Health
- Probation
- Public Health
- Public Social Services
- Sheriff
- Housing Authority of the City of Los Angeles
- Housing Authority of the County of Los Angeles
- United Way – Home for Good

The County and City of Los Angeles have come a long way in coordinating the delivery of homeless services and housing. Over the last several years, there has been greater service integration and cooperation among County departments, city agencies and community organizations. For example, in early 2013 CES for single adults rolled out in Skid Row and is now operational in all SPAs and coordinates housing and supportive services not only with the County and City of Los Angeles, but with networks of over 100 local housing providers as well. CES could be strengthened through more standardization and an enhanced administrative/technology infrastructure for the coordinated entry systems for single adults and families, as well as the youth system which is currently in pilot. In fiscal year 2014-15, 9,720 individuals were assessed for homeless services and roughly 1,738 were housed.

DESCRIPTION *continued*

The plan to strengthen CES and HFSS should include, but should not be limited to, the following three elements:

1. Strengthen the network of housing locators in each service planning area (SPA) to enhance communication, capitalize on best practices and housing/real-estate expertise in securing units, increase efficiency, and minimize duplication of landlord contacts.
2. Develop and implement a common core curriculum training for outreach workers, case managers and other staff participating in CES, inclusive of the various applicable protocols and processes, as well as how others, such as local law enforcement, should be directed to access CES.
3. Implement the following database improvements to the CES module within the Homeless Management Information System (HMIS): A) Assess the CES/HMIS platform to enhance functionality for local users, including the development of a system design workflow; B) Review and evaluate new user training for CES/HMIS, including the time to receive HMIS log-ins and identify process improvements to remedy deficiencies; and C) Identify data software that can support a CES/HMIS report feature by service planning area (SPA) and site specific reports, as well as a proposed budget for implementing this reporting feature.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could contribute funding to CES to support the connection of homeless populations within city boundaries to stable housing and supportive services.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations and sub-populations

POTENTIAL PERFORMANCE METRICS

- ◆ Number of permanent housing placements
- ◆ Length of time from VI-SPDAT screening to housing
- ◆ Number of persons engaged and assessed (in relation to the Point-in-Time Homeless Count)
- ◆ Number of matches completed resulting in housing
- ◆ Number/percentage of people permanently housed who retain housing for 6, 12, and 24 months
- ◆ Number/percentage of people permanently housed who return to homelessness after 6, 12, and 24 months
- ◆ Percent of permanent housing resources matched to homeless clients through CES
- ◆ Number of persons successfully diverted from the homeless services system

FUNDING

- ◆ \$2 million of one-time Homeless Prevention Initiative funding.
- ◆ Emergency Solutions Grant (ESG) funding is a potential funding source from the County and those cities which receive ESG funding.

Enhance the Emergency Shelter System

POPULATION IMPACT

✓ ALL

FAMILIES

TAY

SINGLE ADULT

VETERAN

CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Los Angeles Homeless Services Authority (LAHSA) to enhance the emergency shelter system, as described herein.

DESCRIPTION

The emergency shelter system should be enhanced to be an effective point-of-access to and component of an integrated homeless services system. An adequate crisis housing system ensures that individuals, families, and youth have a safe place to stay in the short-term, with access to resources and services that will help them exit homelessness quickly – optimally within 30 days

The emergency shelter system should be enhanced as follows:

1. Keep shelters open 24-hours a day/7 days a week. This would enable the shelter system to serve as a staging ground to triage/assess clients for housing, health, mental health, substance use disorder, and social service needs, particularly for outreach and engagement teams.
2. Transform emergency shelters and transitional housing into interim/bridge housing from which homeless families/individuals/youth could transition to the best suited form of permanent housing, such as rapid re-housing or permanent supportive housing. Housing location search assistance should be provided at each shelter by community-based housing locators, since such assistance is key to ensuring that the shelter system operates as effectively as possible with enough “throughputs” to move people out of the shelter system, thereby creating shelter capacity for additional homeless families/individuals/youth, including individuals and families fleeing domestic violence.
3. Establish “low threshold” common criteria for shelter eligibility across the county so that homeless families/individuals/youth can easily enter and remain in shelter without restrictive

LEAD AGENCY

Los Angeles Homeless Services Authority (LAHSA)

COLLABORATING DEPARTMENTS/AGENCIES

- Animal Care and Control
- Children and Family Services
- Community Development Commission
- Community and Senior Services
- Health Services
- Housing Authority of the City of Los Angeles
- Housing Authority of the County of Los Angeles
- Mental Health
- Probation
- Public Health
- Public Social Services
- Sheriff

DESCRIPTION *continued*

requirements that either preempt entry into the shelter system or force people to leave before they can transition to permanent housing.

4. Fully utilize the shelter bed assignment system in LAHSA's Homeless Management Information System so that any provider seeking a shelter bed could readily identify any available beds.
5. When possible, ensure that there is storage for belongings.
6. There needs to be confidentiality for those fleeing domestic violence and others who require it.
7. If shelters cannot accommodate pets for homeless individuals and families seeking shelter, have Animal Care and Control make alternative arrangements for pets.

There should also be a "diversion" component that helps at-risk households avoid entering shelter if alternatives can be identified and implemented, e.g. remaining in their current housing and/or placement into stable housing elsewhere, which might include living with family/and or friends.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could contribute funding for bridge/interim housing to address homelessness within city boundaries. The other potential role for cities is to modify emergency shelter conditional use permits that do not currently permit 24-hour a day/7-day a week operations.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations

POTENTIAL PERFORMANCE METRICS

- ◆ Number and percentage of individuals, families, and youth who exit to permanent housing from emergency shelter (broken out by type of housing obtained, population, and Service Planning Area (SPA))
- ◆ Number of days from housing referral for a family/individual in a shelter to housing placement (broken out by type of housing obtained, population, and SPA)
- ◆ Number and percentage of individuals, families, and youth place into permanent housing from a shelter who have retained housing after 12 months (by SPA)
- ◆ Number and percentage of disengagements from the shelter system without permanent housing or an acceptable alternative
- ◆ Returns to shelter within 6 and 12 months

FUNDING

- ◆ \$1.5million in one-time HPI funds.
- ◆ Los Angeles City will need to make a corresponding commitment to keep shelters open 24/7.

Strategy E9 | CREATE A COORDINATED SYSTEM

Related to Strategy Brief 8.4

Discharge Data Tracking System

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Los Angeles Homeless Services Authority (LAHSA), in collaboration with DHS, LASD, DPH, DMH, and DCFS, to develop a consistent, systemic approach to tracking and identifying people in an institution or residential setting who were homeless upon entry or who are at risk of being homeless upon discharge.

DESCRIPTION

As part of an overall effort to improve and enhance effective discharge planning processes to reduce and prevent homelessness within LA County, a consistent approach to tracking and identifying homeless persons and those at risk of being homeless upon discharge is critical. There is currently no consistent method of identifying and tracking current and potentially homeless persons in jails, hospitals, the foster care system, or other public systems which may discharge individuals into homelessness. To the extent permitted by law, such identification is key to the implementation of effective and appropriate discharge planning.

The main components of the system would include:

- Adopt common data elements with definitions to be incorporated into data and reporting structures within County departments involved in discharge planning.
- An update of LAHSA’s Homeless Management Information System data collection fields to track and report on homeless clients who were discharged from institutions.
- Utilize the County Enterprise Linkages Project to capture data and produce reports that can be used to measure progress in reducing homelessness and regularly inform discharge planning processes.

LEAD AGENCY

Los Angeles Homeless Services Authority (LAHSA)

COLLABORATING DEPARTMENTS/AGENCIES

- Children and Family Services
- Health Services
- Mental Health
- Probation
- Public Health
- Sheriff
- Private Hospitals
- Cities that operate jails



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Currently or potentially homeless persons, including the older adult population, who are in an institution or receive residential services from LASD, DMH, DHS, DPH, DCFS, private hospitals, and city jails.

POTENTIAL PERFORMANCE METRICS

- ◆ The rate of participation of agencies in utilizing the system and capturing data
- ◆ The quality of data produced
- ◆ Increase in homeless prevention activities before people are discharged

FUNDING

Each agency will absorb its own costs.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities that operate jails could utilize the same approach to data tracking

Strategy E10 | CREATE A COORDINATED SYSTEM

Related to Strategy Brief 9.4

Regional Coordination of Los Angeles County Housing Authorities

POPULATION IMPACT

✓ ALL FAMILIES TAY SINGLE ADULT VETERAN CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Housing Authority of the County of Los Angeles, in collaboration with the Housing Authority of the City of Los Angeles, to convene an ongoing, quarterly Homeless Issues Roundtable of all public housing authorities in Los Angeles County, for the purpose of identifying common issues related to combating homelessness and developing more integrated housing policies to assist homeless families and individuals. As appropriate, invite the the Departments of Community and Senior Services, Health Services and Mental Health, and community providers with subject matter expertise in housing to participate in the Roundtable.

DESCRIPTION

The Housing Authorities of Los Angeles County (HACoLA) and City (HACLA) have responded to local, state, and federal efforts to end homelessness by engaging in various collaborative activities that have proven to be beneficial to families and individuals in need across the County, such as:

- Partnership with the Los Angeles Homeless Services Authority (LAHSA) and the United Way of Greater Los Angeles to develop and utilize coordinated access systems that match homeless clients with housing resources and supportive services that meet their specific needs.
- Interagency agreements for several housing programs that allow families to locate units in either jurisdiction by eliminating the cumbersome “portability” process.
- Creation of a universal housing assistance application that eliminates the duplicative effort of completing several different applications when applying for multiple housing programs across both Housing Authorities.
- Alignment of policy, where possible, to facilitate a uniform eligibility determination standard across both Housing Authorities.

This history of collaboration between HACoLA and HACLA provides a foundation to institutionalize ongoing collaboration across all public housing authorities in the County with the goal of maximizing the positive impact on homeless families and individuals.

LEAD AGENCY

Housing Authority of the County of Los Angeles

COLLABORATING DEPARTMENTS/AGENCIES

Chief Executive Office
City Housing Authorities
Housing Authority of the City of Los Angeles
Los Angeles Homeless Services Authority



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Homeless populations with subsidized housing needs.

POTENTIAL PERFORMANCE METRICS

- ◆ Number of policies harmonized/integrated between agencies
- ◆ Number of forms standardized/harmonized between agencies

FUNDING

NA – This strategy does not require any funding to be implemented.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities which operate their own public housing authorities can ensure that their housing authorities participate in the Homeless Issues Roundtable.

Strategy E11 | CREATE A COORDINATED SYSTEM

County Specialist Support Team

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Chief Executive Officer, in collaboration with the departments listed below, to establish a countywide team of specialists to consult with community-based homeless case managers throughout the County.

DESCRIPTION

Homeless families and individuals often have difficulty navigating County service systems and accessing the services which they need, even when assisted by a community-based homeless case manager. To address this problem and support a countywide system of community-based homeless case managers, a countywide team of specialists is needed throughout the County. The team would consist of an appropriate representative from the Department of Children and Family Services, Department of Health Services, Department of Mental Health, Department of Public Health, Department of Public Social Services, and Probation). One of the participating departments would designate a manager to lead the team.

The team would consult with community-based homeless case managers throughout the County via phone, e-mail, and live chat, and perform the following functions, as needed:

1. intervene within their own departments on behalf of specific homeless families and individuals;
2. consult among themselves; and
3. identify systemic barriers that would then be addressed at a department-wide or countywide level.

LEAD AGENCY

Chief Executive Office

COLLABORATING DEPARTMENTS/AGENCIES

- Children and Family Services
- Health Services
- Los Angeles Homeless Services Authority
- Mental Health
- Public Health
- Public Social Services
- Probation Department



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Homeless families and individuals, including victims of domestic violence and the older adult population.

POTENTIAL PERFORMANCE METRICS

- ◆ Number of contacts with the team and team member
- ◆ Number and type of positive outcomes overall and by team member
- ◆ Number of systemic barriers identified
- ◆ Number of systemic barriers resolved

FUNDING

Each department would absorb the cost of its team member, with the possible exception of the department providing the manager to lead the team.

CONNECTION TO CITIES

SAME

COMPLEMENTARY

✓ **NO CITY ROLE**

Strategy E12 | CREATE A COORDINATED SYSTEM

Enhanced Data Sharing and Tracking

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Chief Executive Office and the Los Angeles Homeless Services Authority (LAHSA) to develop and implement a plan to enhance data sharing and tracking, as described herein.

DESCRIPTION

Data sharing and the development of homeless performance targets are central to the development and effective functioning of a coordinated system to combat homelessness.

The following actions are recommended:

1. Implement common categories for tracking homelessness across key County departments that touch or serve a large proportion of homeless residents, that differentiates between:
 - Those who are literally homeless using the U.S. Department of Housing and Urban Development’s (HUD’s) definition;
 - Those who are at imminent risk of homelessness using HUD’s definition; and
 - Those who are homeless under the individual department’s definition, but do not fall within the HUD definition.
2. Identify the costs for implementing homeless data collection on a monthly basis in the Departments of Public Social Services, Children and Family Services, Health Services, Mental Health, Public Health, Probation, Sheriff and the Community Development Commission. If there are no data elements to “flag” homelessness in departmental data systems, develop and implement a plan to add and utilize such departmental data markers.

LEAD AGENCY

Chief Executive Office
Housing Authority of the County of Los Angeles

COLLABORATING DEPARTMENTS/AGENCIES

- Children and Family Services
- Community Development Commission
- Community and Senior Services
- Health Services
- Hospital Association of Southern California
- Housing Authority of the City of Los Angeles
- Housing Authority of the County of Los Angeles
- Los Angeles County Office of Education
- Mental Health
- Probation
- Public Health
- Public Housing Authorities
- Public Social Services
- Sheriff
- United Way

DESCRIPTION *continued*

3. Develop a plan to make LAHSA a full partner in the Enterprise Linkages Project (ELP) data warehouse, which will include the uploading of Homeless Management Information System records to the ELP data warehouse on the same basis as the County departments participating in ELP, and access for LAHSA to County department data in ELP, to the extent permitted by law.
4. Work with County Counsel to explore the use of passive consent, to the extent permitted by law (including Health Insurance Portability and Accountability Act (HIPAA)), for ELP participating departments working with vulnerable homeless populations. This consent only relates to use of ELP data at an individual level, not at an aggregate level, as no consent is required for the use of deidentified ELP data for program planning and evaluation.
5. Develop Countywide targets to reduce chronic, veteran, family, single adult and TAY homelessness.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations

POTENTIAL PERFORMANCE METRICS

To be determined

FUNDING

\$1 million in one-time HPI funding



CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities with Public Housing Authorities could adopt the common method of data tracking described in number 1 above.

Strategy E13 | CREATE A COORDINATED SYSTEM

Related to Strategy Brief 9.2

Coordination of Funding for Supportive Housing

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Instruct the Director of the Community Development Commission/Housing Authority of the County of Los Angeles and the Los Angeles Homeless Services Authority, in consultation with the Department of Mental Health, the Housing Authority of the City of Los Angeles and the Los Angeles City Housing and Community Investment Department, to:

- Align priorities and processes in order to maximize capital, operating, and service funding for supportive housing.
- Develop a coordinated funding application and award process to dramatically reduce the time required to assemble project financing, with the goal of:
 - > Attracting cities to participate in a one-stop shop for all local capital and funding commitments.
 - > Allowing funders to be more strategic in the allocation of funds, while maximizing the leveraging of State and Federal funds available to the region.
 - > Creating a more streamlined and predictable system for developers, allowing them to maximize their production by creating more certainty about the availability of funds.
 - > Expanding to include other private and public funders through the Home for Good Funders Collaborative to maximize and leverage additional resources, including funds for services and other activities designed to operate and strengthen supportive housing.

DESCRIPTION

Supportive housing is an innovative and proven solution that combines affordable housing with services that help people who face the most complex challenges to live with stability, autonomy and dignity. Supportive housing has been shown to have positive effects on housing stability, employment, mental and physical health, and school attendance. In addition, supportive housing is cost-effective as cost studies across the country demonstrate that supportive housing results in tenants’ decreased use of homeless shelters, hospitals, emergency rooms, jails and prisons and therefore is often less costly than continued homelessness. Furthermore, supportive housing benefits communities by improving the safety of neighborhoods, beautifying city blocks with new or rehabilitated properties, and increasing or stabilizing property values over time.

Given the importance of supportive housing, there are multiple public agencies in Los Angeles County that regularly provide funding for the capital costs associated with the development of supportive housing. Enhanced coordination among these public agencies would increase the efficiency of the current funding system and thereby streamline the development of supportive housing.

LEAD AGENCIES

Community Development Commission
Los Angeles Homeless Services Authority

COLLABORATING DEPARTMENTS/AGENCIES

Health Services
Housing Authority of the County of Los Angeles
Housing Authority of the City of Los Angeles
Los Angeles City Housing and Community Investment
Department
Mental Health

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations, but primarily chronically homeless individuals

POTENTIAL PERFORMANCE METRICS

Increase in the number of supportive housing units

FUNDING

Not applicable



CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities which provide funding for the development of supportive housing could participate in the recommended ongoing working group.

Strategy E14 | CREATE A COORDINATED SYSTEM

Enhanced Services for Transition Age Youth

POPULATION IMPACT

ALL FAMILIES ✓ TAY SINGLE ADULT VETERAN CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Chief Executive Office (CEO) to work with the Los Angeles Homeless Services Authority to provide additional funding to support the expansion of the Youth Coordinated Entry System (CES) and programs providing housing navigation, access/drop-in centers, shelter, after care/case management and transitional housing for youth. Funding will be allocated based on geographic burden and need, as determined by the 2015 Homeless Count results for the Los Angeles, Glendale, Pasadena and Long Beach Continuums of Care.

Direct the Los Angeles Homeless Services Authority to work with the CEO, key county departments, the Los Angeles County Office of Education and a Community-Based Organization (CBO) serving mainstream youth to design a Youth Housing Stability Assessment pilot where one or more county departments, one or more school districts, and a CBO serving mainstream youth will administer a quick prescreening tool to determine if a youth should be referred to the Youth CES.

Direct the CEO and the Los Angeles Homeless Services Authority to work with the Los Angeles Coalition to End Youth Homelessness (LACEYH) to increase and maximize collaboration between County agencies and community-based organizations serving homeless youth.

DESCRIPTION

As directed by the Board on December 15, 2015, County Departments and Community-Based Organizations specializing in providing services to homeless youth (up to age 24) collaborated to: (1) discuss TAY homeless service needs; (2) identify gaps in available homeless services; and (3) discuss opportunities for enhanced coordination that would strengthen the homeless service delivery system for youth. Together, the group identified LAHSA’s Housing Inventory for TAY (Homeless Initiative Board Letter Attachment 7) and the Directory of Services for Homeless Youth (<https://www.ourchildrenla.org/community-center/directory/>) developed by Our Children Los Angeles (including its online app), as the most extensive, current inventories of available TAY homeless services. With respect to the \$5 million earmarked by the Board on December 15, 2015, strengthening the TAY homeless services system and enhancing the shelter system for youth, after care and transitional housing were identified as key service enhancements.

As homeless TAY are identified, a coordinated homeless service system is vital. Strengthening and providing additional access/drop-in centers where housing navigation options could be provided and expanding the current Youth CES by including TAY specific scoring and eligibility criteria is key to support the increased number of homeless youth in the County and ensuring access to homeless services.

One or more county departments, one or more school districts, and a CBO serving mainstream youth could pilot the practice of proactively assessing the housing status of TAY to identify those who are potentially homeless/at-risk of homelessness. The pilot will assess the impact of this routine assessment on the mainstream system’s ability to link homeless TAY, or those at risk of homelessness to homeless/homeless prevention

DESCRIPTION *continued*

services and enhance opportunities for coordination. By assessing the housing status of TAY served within the mainstream system, homeless/at-risk TAY may be identified sooner and diverted from homelessness or the duration of the TAY’s homelessness may be reduced.

Lastly, strengthening the ongoing collaboration between County departments and community-based organizations serving homeless youth is intended to result in:

1. the development of strategies to better coordinate services, resources and funding for TAY experiencing homelessness and housing instability;
2. identification of additional system gaps and solutions to fill those gaps; and
3. bringing to scale solutions and best practices that meet the housing and service needs of TAY experiencing homelessness and housing instability.

LEAD AGENCIES

Chief Executive Office
Los Angeles Homeless Services Authority

COLLABORATING DEPARTMENTS/AGENCIES

Children and Family Services
Community -Based Organizations
Community Development Commission
Health Services
Mental Health
Office of Education
Probation
Public Health
Public Social Services

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Transition Age Youth

POTENTIAL PERFORMANCE METRICS

- ◆ The number of TAY who are housed
- ◆ The number of TAY who maintain housing
- ◆ The number of TAY who become self-sufficient
- ◆ The number of TAY who are prevented from becoming homeless

FUNDING

- ◆ \$2 million one-time Homeless Prevention Initiative Funding to support expanded shelter, transitional housing and after care/case management services
- ◆ \$1 million one-time Homeless Prevention Initiative Funding to support housing navigation, access/drop-in centers and enhancement of the Youth CES
- ◆ \$2 million one-time Homeless Prevention Initiative Funding earmarked under Strategy B3, Rapid Re-housing
- ◆ All of this funding will be administered by LAHSA.

CONNECTION TO CITIES

SAME

✓ **COMPLEMENTARY**

NO CITY ROLE

Cities could contribute additional funding to support the key homeless services identified and proactively assess the housing status of TAY who receive services from city departments.

Strategy E15 | CREATE A COORDINATED SYSTEM

Homeless Voter Registration and Access to Vital Records

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Registrar-Recorder to collaborate with the Los Angeles Homeless Services Authority (LAHSA) and other County departments and homeless/housing service providers to enhance training and outreach efforts to homeless service providers and County agencies that serve homeless individuals, families and TAY by providing assistance in helping homeless citizens register to vote and access vital records, as described herein.

DESCRIPTION

The Registrar Recorder has been enhancing voter registration opportunities for homeless populations and organizations that serve the homeless throughout Los Angeles County as a result of:

1. A desire to lay the foundation for reaching out to communities who may have a greater chance of not being registered through the new Motor Voter law, which automatically registers to vote all eligible voters when they obtain or renew their driver’s license at the Department of Motor Vehicles (DMV).
2. Being contacted by homeless services agencies requesting voter registration information, and realizing this was an area where additional outreach was needed.

LEAD AGENCY

Registrar Recorder

COLLABORATING DEPARTMENTS/AGENCIES

- Beaches and Harbors
- Children and Family Services
- Community and Senior Services
- Health Services
- Homeless Service Providers
- Mental Health
- Military and Veterans Affairs
- Parks and Recreation
- Public Health
- Public Library
- Public Social Services
- Housing Authority of the City of Los Angeles
- Housing Authority of the County of Los Angeles
- Los Angeles Homeless Services Authority
- Probation
- Sheriff
- United Way

The Registrar Recorder offers a variety of outreach support which includes training, voter registration cards, tracking of voter registration, and educational materials in various languages (with an emphasis on best practices and rules specific for registering homeless populations), in addition to information on how to access vital records (birth, death and marriage certificates).

Next steps for enhancing educational information and conducting more targeted outreach and engagement on voter registration and access to vital records include:

1. Finalize a single-page document that educates individuals and organizations on voting rights.
2. Connect with LAHSA and other collaborating agencies to discuss enhancements to training on voter registration and how to access needed vital records.
3. Place voter polling facilities, when possible, within a reasonable proximity of homeless shelters and services.



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations

POTENTIAL PERFORMANCE METRICS

- ◆ Number of trainings conducted per quarter
- ◆ Number of homeless individuals/families/TAY registered to vote per quarter
- ◆ Number of homeless individuals/families/TAY provided with vital records per quarter

FUNDING

Costs will be absorbed by the Registrar-Recorder

CONNECTION TO CITIES

SAME

COMPLEMENTARY

✓ **NO CITY ROLE**

Strategy E16 | CREATE A COORDINATED SYSTEM

Related to Strategy Briefs 5.1, 5.2, and 5.5

Affordable Care Act Opportunities

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Health Agency to maximize the contribution of the Affordable Care Act to combating homelessness, by aggressively pursuing the nine goals related to homelessness in the Health Agency’s Strategic Priorities, with emphasis on: (1) maximizing revenue through the Whole Person Care (WPC) pilots and Health Homes; and (2) providing integrated physical health, mental health and substance use disorder services to address the unique needs of the homeless population within the larger health care system.

DESCRIPTION

The extension of full-scope Medi-Cal eligibility to almost all homeless individuals under the Affordable Care Act (ACA) creates a range of critical new opportunities to combat homelessness, including:

- Federal and state revenue to pay for physical health, mental health, and substance use disorder services;
- Potential additional funding under WPC, which is included in the State’s new 1115 Medicaid waiver, effective January 1, 2016;
- Potential additional funding under the Health Homes Benefit (Section 2703 of the ACA) which the State proposes to implement in Los Angeles County on January 1, 2018 for eligible beneficiaries with serious mental illness and for all others six months later.

LEAD AGENCY

Health Agency

COLLABORATING DEPARTMENTS/AGENCIES

- Children and Family Services
- Community-Based Providers
- Health Services
- Hospital Association of Southern California
- Housing Authority of the City of Los Angeles
- Housing Authority of the County of Los Angeles
- Los Angeles Homeless Services Authority
- Medi-Cal Managed Care Organizations
- Mental Health
- Private Hospitals
- Probation
- Public Health
- Public Social Services
- Sheriff

On September 29, 2015, the newly-formed County Health Agency identified homelessness as one of its top priority areas and released nine goals related to homelessness. These goals focus on strengthening the partnerships between the Agency, health plans, County departments, and homeless service providers, in addition to addressing the unique needs of homeless clients within the broader health care delivery system. As such, pursuit of these goals, in conjunction with the other recommended Homeless Initiative strategies, is the best way to maximize the contribution of the Affordable Care Act to combating homelessness.

The Health Agency’s goals regarding homelessness are:

Goal 1

Evaluate and reconfigure, as needed, housing and homeless services within the Agency and Departments to facilitate improved outcomes for homeless clients, including but not limited to the reduction/elimination of eligibility barriers and greater sharing

DESCRIPTION *continued*

of Departmental resources, to ensure that resources are available to homeless clients regardless of where they present.

Goal 2

Develop an accurate way to identify homeless clients, and those at risk of homelessness, currently served across the three Departments (e.g., development of a real-time unduplicated database, flag within shared client record) for the purpose of identifying priority clients who are determined to be likely to benefit from services from multiple Departments to regain health and residential stability.

Goal 3

Develop and implement shared standards and practices for ensuring a full range of housing, health, and prevention services are able to be delivered to clients based on client-specific needs.

Goal 4

Improve and expand upon multidisciplinary street engagement teams capable of effectively engaging homeless people living outdoors throughout the County with the express goal of securing interim and permanent housing.

Goal 5

Develop and open a range of “bridge” residential services that provide low-barrier, welcoming programs (e.g., sobering centers; day centers with showers, meals, and health services; recuperative care; detox centers; stabilization housing; congregate supervised living; and other effective bridges to permanent housing) for homeless individuals with complex health conditions in high density neighborhoods (e.g., Skid Row, Hollywood, Venice) and in unincorporated areas of LA County.

Goal 6

Maintain a real-time inventory of available residential slots, funded and usable by all three Departments, that facilitate immediate placement of homeless clients into

available interim and permanent residential options appropriately matched to various need indicators (e.g., Medi-cal necessity, accessibility, level of on-site services, neighborhood, age).

Goal 7

Obtain Medi-Cal coverage, when possible, and successfully link individuals, where clinically appropriate, to comprehensive, integrated health services that are delivered in a way that is tailored for the unique needs of homeless individuals.

Goal 8

Develop screening questions for those conditions that lead to homelessness that could be incorporated into the practices of all three Departments along with methods and plans to link individuals to needed supports and services as part of the delivery of health care, mental health and public health services.

Goal 9

Engage in policy development and technical assistance activities to enhance the availability of high-quality, affordable, stable housing stock within LA County.

The Health Agency goals strive to capitalize on the opportunities presented by the ACA by:

1. having no wrong entry points or ‘doors’ to care;
2. integrating an array of physical health, mental health, and substance use disorder (SUD) services;
3. remaining sensitive to the unique realities and lived experiences of homeless patients by maintaining a level of ‘homeless cultural competence’; and
4. effectively challenging public entities and community-based organizations to work together in unprecedented ways to maximize services to those who lack stable housing/shelter including new strategies, systems, and platforms to aggressively enroll and retain chronically homeless individuals on Medi-Cal.

Affordable Care Act Opportunities *continued*

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

Homeless families and individuals enrolled in
Medi-Cal

POTENTIAL PERFORMANCE METRICS

To be determined

FUNDING

Medi-Cal

CONNECTION TO CITIES

SAME

COMPLEMENTARY

✓ **NO CITY ROLE**



Strategy E17 | CREATE A COORDINATED SYSTEM

Regional Homelessness Advisory Council and Implementation Coordination

POPULATION IMPACT

ALL
 FAMILIES
 TAY
 SINGLE ADULT
 VETERAN
 CHRONICALLY HOMELESS ADULT

RECOMMENDATION

- Direct LAHSA to convene a public-private *Regional Homelessness Advisory Council* to ensure broad-based collective strategic leadership.
- Direct LAHSA to establish an intergovernmental *Homeless Strategy Implementation Group* jointly with County public administrative leaders, Los Angeles City public administrative leaders and LAHSA to coordinate the ongoing implementation of the approved homeless strategies.

DESCRIPTION

Regional Strategic Alignment

The purpose of a *Regional Homelessness Advisory Council* is to provide an enduring forum for broad-based, collaborative and strategic leadership on homelessness in Los Angeles County in alignment with Home For Good. The Advisory Council would facilitate wide understanding and acceptance of national and local best practices, and communicate goals, barriers and progress to community stakeholders.

Objectives for a Los Angeles Regional Homelessness Advisory Council include:

1. Provide strategic leadership to all homeless system stakeholders, including consumers, providers of housing and services, public funders, private philanthropy, and public officials.
2. Support implementation of best practices and evidence-based approaches to homeless programming and services.
3. Promote alignment of funding across all sectors (e.g. public mainstream, private non-governmental, and homeless-specific) and the leveraging of resources in the most effective way possible.
4. Coordinate programmatic approaches across all homeless system providers and mainstream systems.
5. Support a regional strategic response to identify and resolve the primary factors contributing to housing instability and homelessness.
6. Identify and articulate artificial barriers across geographic and political spheres, in order to eliminate them.

LEAD AGENCY

Los Angeles Homeless Services Authority

COLLABORATING DEPARTMENTS/AGENCIES

Chief Executive Office	LA City Housing & Community Investment Dept.
Children and Family Services	Various LA City public administrative agencies
Community Development Commission	Office of Education
Health Services	United Way of Greater Los Angeles
Mental Health	LA County Continuum of Care leadership
Probation	Philanthropy representatives
Public Health	Business Leadership
Public Social Services	Community-based organizations
Sheriff	
Housing Authority of the City of Los Angeles	
Housing Authority of the County of Los Angeles	

DESCRIPTION *continued*

- 7. Influence mainstream systems to ensure access and accountability to homeless consumers.
- 8. Track progress and evaluate results.

Intergovernmental Implementation Support

The purpose of a joint LA County-City *Homeless Strategy Implementation Group* is to provide ongoing leadership support and oversight of the implementation of aligned homeless system strategies. A formally convened body will ensure an ongoing forum for high-level coordination across jurisdictions between public administrative agencies charged with implementation of aligned homelessness strategies, including but not limited to, tracking metrics, removing barriers, resolving conflicts, promoting shared responsibility, and maximizing the effective utilization of resources by the respective agencies.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations, including the older adult population.

POTENTIAL PERFORMANCE METRICS

- ◆ Homeless population decrease/increase
- ◆ Length of time individuals/families remain homeless
- ◆ Housing placement and retention for all homeless sub-populations
- ◆ Recidivism (return to homelessness)
- ◆ New entrants to all system points – outreach, shelter, transitional housing, rapid re-housing, permanent subsidized housing and permanent supportive housing by referral source

FUNDING

No funding required. Existing administrative funding for departments and LAHSA will cover the cost of the needed staff time.

CONNECTION TO CITIES

SAME

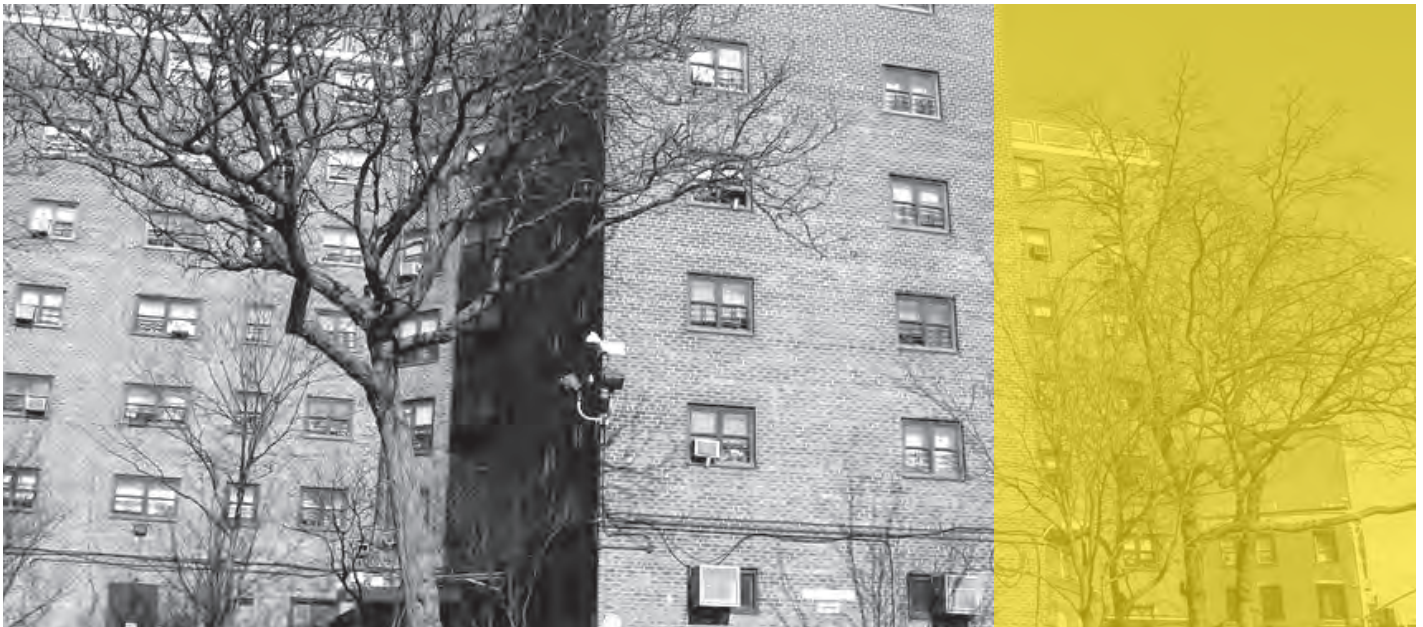
✓ **COMPLEMENTARY**

NO CITY ROLE



Strategy F

Increase Affordable/ Homeless Housing



The lack of affordable housing overall and homeless housing in particular contributes substantially to the current crisis of homelessness. The County and cities throughout the region can increase the availability of both affordable and homeless housing through a combination of land use policy and subsidies for housing development.

**Los Angeles County
Homeless Initiative**

Strategy F1 | INCREASE AFFORDABLE/HOMELESS HOUSING

Related to Strategy Brief 2.1

Promote Regional SB 2 Compliance and Implementation

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Department of Regional Planning to secure consultant assistance to develop a Countywide SB 2 strategy, which encompasses the following:

1. drafting an SB 2 model ordinance and set of best practices for distribution to jurisdictions throughout Los Angeles County; and
2. consulting with jurisdictions to promote compliance and/or implementation of SB 2.

These actions should occur in partnership with the State Department of Housing and Community Development and cities.

DESCRIPTION

SB 2 (Cedillo) is enacted state legislation that requires each city and County (for the unincorporated areas) to:

1. identify at least one zone where emergency shelters are permitted as a matter of right; and
2. treat transitional and supportive housing as a residential use of property, subject only to restrictions that apply to other residential dwellings of the same type in the same zone.

SB 2 was crafted with the objective not only of ensuring that emergency shelters, transitional housing, and supportive housing are permitted in each jurisdiction, but also to ensure a realistic potential for development, when there is a willing, private developer with adequate funding.

LEAD AGENCY

Regional Planning

COLLABORATING DEPARTMENTS/AGENCIES

None

While the County is in full compliance with SB 2 in the unincorporated areas, a number of cities in the County are not in compliance with SB 2.



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations are impacted.

POTENTIAL PERFORMANCE METRICS

- ◆ Number of cities that adopt ordinances that comply with SB 2
- ◆ Number of emergency shelter, transitional housing, and supportive housing projects permitted by right as a result of zoning code changes made by participating jurisdictions

FUNDING

\$75,000 in one-time Homeless Prevention Initiative funds to secure consultant to assist with development and implementation plan to encourage countywide compliance with SB 2.

CONNECTION TO CITIES

✓ **SAME**

COMPLEMENTARY

NO CITY ROLE

County is in compliance with SB 2. All local jurisdictions are required to be in compliance with SB 2.

Strategy F2 | INCREASE AFFORDABLE/HOMELESS HOUSING

Related to Strategy Brief 2.2

Linkage Fee Nexus Study

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Department of Regional Planning to conduct a nexus study for the development of an Affordable Housing Benefit program ordinance, as referenced in the December 8, 2015 Board motion on equitable development tools.

DESCRIPTION

An Affordable Housing Benefit Fee program (alternatively referred to as a housing impact fee or linkage fee program) in the unincorporated areas of the County would charge a fee on all new development to support the production of affordable/homeless housing and preservation of existing affordable/homeless housing. The fee would contribute to County affordable housing programs, including bridge housing, rapid re-housing, and permanent supportive housing.

A nexus study is necessary for the County to adopt a linkage fee for affordable housing. The purpose of the nexus study would be to accomplish the following:

- a. Document the nexus between new development and the need for more affordable housing;
- b. Quantify the maximum fees that can legally be charged for commercial and residential development; and
- c. Make recommendations about the appropriate fee levels with a goal to not adversely impacting potential new development.

The study should be conducted consistent with the goal of flexibility and adaptability to local economic conditions through some of the following key considerations:

- Assess appropriate fee rates for specific industry types;
- Explore potential exemptions for industries that would otherwise bear an unfair burden from the fee program;
- Set thresholds so that fee amounts vary by project size; and
- Explore applying fees in high-growth zones, expanding residential areas or near transit.

LEAD AGENCY

Regional Planning

COLLABORATING DEPARTMENTS/AGENCIES

None



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations

POTENTIAL PERFORMANCE METRICS

- ◆ Amount of fees received
- ◆ Number of affordable housing units constructed

FUNDING

\$450,000 in one-time Homeless Prevention Initiative funds to secure consultant to conduct a nexus study for a linkage fee for all new development.

CONNECTION TO CITIES

✓ **SAME**

COMPLEMENTARY

NO CITY ROLE

Each city which does not already have a Linkage Fee could conduct a nexus study and then implement a Linkage Fee, subject to the results of the nexus study.

Strategy F3 | INCREASE AFFORDABLE/HOMELESS HOUSING

Related to Strategy Brief 2.3

Support Inclusionary Zoning for Affordable Housing Rental Units

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Instruct the Chief Executive Officer and the Sacramento advocates to support amendment or clarification of the Costa-Hawkins Rental Housing Act to allow for an inclusionary housing requirement for new rental housing.

DESCRIPTION

Inclusionary housing, also known as inclusionary zoning or mixed-income housing, is a policy tool that requires or encourages private housing developers to include a certain percentage of income-restricted units within new market rate residential developments. The Costa-Hawkins Act, enacted in 1995, provides owners in rent control communities the right to establish initial rental rates when there is a change in occupancy of a dwelling unit and exempts housing constructed after 1995 from local rent controls. California courts have interpreted the Costa-Hawkins Act to mean that inclusionary zoning is prohibited for all newly-constructed rental units. Specifically, in Palmer/Sixth Street Properties v. City of Los Angeles (175 Cal. App. 4th. 1396 (2009), the Court of Appeals (Second District)) held that the Costa-Hawkins Act preempted local inclusionary housing ordinances for new rental units.

Los Angeles County (LAC) could support amending or clarifying the interpretation of the Costa-Hawkins Rental Housing Act (Costa-Hawkins Act) to allow an inclusionary housing requirement for new rental housing. Such authority would apply to the County for the unincorporated areas and to each of the 88 cities in the County within its own boundaries. Support for such a proposal would be consistent with the County’s State Legislative Agenda, section 5.1 Housing and Community Development, which reads: “Support proposals that provide incentives to local governments and/or developers to increase and protect affordable housing and flexibility for counties to promote a diversity of affordable housing types through local policies.”

LEAD AGENCY

Chief Executive Office

COLLABORATING DEPARTMENTS/AGENCIES

None



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations

POTENTIAL PERFORMANCE METRICS

- ◆ Number of cities adopting inclusionary zoning ordinances
- ◆ Number and type of affordable housing units created as a result of inclusionary zoning ordinances adopted by the County and cities

FUNDING

No funding required

CONNECTION TO CITIES

✓ **SAME**

COMPLEMENTARY

NO CITY ROLE

Cities could also advocate for an amendment or clarification of the Costa-Hawkins Rental Housing Act to allow for an inclusionary housing requirement for new rental housing.

Strategy F4 | INCREASE AFFORDABLE/HOMELESS HOUSING

Related to Strategy Brief 2.4

Development of Second Dwelling Units Pilot Program

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Direct the Department of Regional Planning to work with the the Community Development Commission, Chief Executive Office, and Department of Public Works to develop and recommend for Board approval a Second Dwelling Unit Pilot Program that:

1. expedites the review and approval processes to facilitate the development of second units on single-family lots in the unincorporated areas of the County;
2. provides technical assistance to homeowners, such as pre-approved architectural plans that would not require extensive engineering approvals; and
3. provides County incentives to assist homeowners in constructing new or preserving existing, unpermitted second units in exchange for providing long-term affordability covenants or requiring recipients to accept Section 8 vouchers, such as:
 - a. waiving or reducing permit fees and/ or utility/sewer hookup charges;
 - b. working with Community Development Financial Institutions or banks to provide easy-to-access low-interest loans;) and/or
 - c. providing grants that could use a mix of conventional home improvement loans, loan guarantees and CDBG or other funds.

DESCRIPTION

In 2003, the California Legislature passed AB 1866, which explicitly encouraged the development of second units on single-family lots. It precluded cities from requiring discretionary actions in approving such projects, and established relatively simple guidelines for approval. Some cities have adopted local ordinances and some have taken additional actions to help homeowners build second units. For example, the City of Santa Cruz made second units a centerpiece of its affordable housing strategy by providing pre-reviewed architectural plans, waiving fees for permitting and processing, and providing a free manual with instructions about the development and permitting process. The City also helped arrange financing with a local credit union to qualify homeowners for a period of time. This example shows how the locality removed barriers, and actively encouraged residents to pursue this type of development.

The County of Los Angeles has adopted an ordinance specifically regulating second units. The opportunity exists to develop processes to further facilitate the development of new second units and the preservation of existing, unpermitted second units. Similar opportunities exist in cities throughout the County. Construction cost of second dwelling units on single-family lots can be substantially less than creating a new unit of supportive housing because there would be no land costs involved. Per the Community Development Commission, the cost of building a new unit exceeds \$300,000 compared to the cost of developing a second dwelling unit that can range from \$25,000 to \$150,000, depending on the size of the unit.

LEAD AGENCY

Regional Planning
Community Development Commission

COLLABORATING DEPARTMENTS/AGENCIES

Chief Executive Office
Public Works

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations

POTENTIAL PERFORMANCE METRICS

- ◆ Number of second dwelling units approved under new program
- ◆ Number of households with a housing subsidy housed in a second dwelling unit under new program

FUNDING

\$550,000 in one-time HPI funds for pilot project (\$500,000 pilot project to fund grants and/or loans and/or loan guarantees and \$50,000 for administration)

CONNECTION TO CITIES

✓ **SAME**

COMPLEMENTARY

NO CITY ROLE

Each city could develop a program to promote the development of second dwelling units, which could be specifically tied to subsidized and/or homeless housing.

Strategy F5 | INCREASE AFFORDABLE/HOMELESS HOUSING

Related to Strategy Brief 2.5

Incentive Zoning/Value Capture Strategies

POPULATION IMPACT

- ✓ ALL
- FAMILIES
- TAY
- SINGLE ADULT
- VETERAN
- CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Instruct the Department of Regional Planning (DRP) to secure a consultant to assess the feasibility of implementing various Incentive Zoning/Value Capture strategies, including those outlined in DRP’s Equity Development Tools report provided to the Board on June 24, 2015, and in conjunction with the Board’s December 15, 2015 motion on equitable development tools. The consultant, with the direction of DRP, would be tasked with:

- coordinating with jurisdictions and stakeholders in the County to develop an inventory of best practices on incentive zoning/value capture strategies;
- Assessing the market conditions of the various unincorporated areas to determine where and which Incentive Zoning/Value Capture strategies would be most practical and effective; and
- Identifying potential uses of the generated funds.

DESCRIPTION

Incentive Zoning (IZ)/Value Capture (VC) is the concept that investments such as new transportation infrastructure and planning actions such as a zone change or density bonus can increase land values, generating increased profit opportunities for private landowners. Value capture strategies seek to redirect some of the increases in land values for public good. Value capture strategies include:

1. Public Benefits Zoning;
2. Incentive Zoning/Density Bonus;
3. Housing Overlay Zoning;
4. Tax Increment Financing;
5. Community Benefits Agreements;
6. Special Assessment Districts;
7. Development Agreements;
8. Infrastructure Financing Districts; and
9. Business Improvement Districts.

Incentive Zoning/Value Capture strategies could generate funding to support the preservation of existing affordable/homeless housing and/or construction of new affordable/homeless housing units. Such funding could be used for a range of specific uses, from preserving existing Single Room Occupancy (residential) hotels to construction of permanent supportive housing and workforce housing.

LEAD AGENCY

Regional Planning

COLLABORATING DEPARTMENTS/AGENCIES

Community Development Commission



POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations

POTENTIAL PERFORMANCE METRICS

Number of housing units preserved/developed with funding generated through implementation of Incentive Zoning/Value Capture Strategies

FUNDING

\$50,000 from one-time HPI funds to secure a consultant to assess the feasibility of implementing Incentive Zoning/Value Capture strategies in the unincorporated areas.

CONNECTION TO CITIES

✓ **SAME**

COMPLEMENTARY

NO CITY ROLE

Each city could systematically review opportunities to utilize Incentive Zoning/Value Capture strategies to preserve and/or develop affordable/homeless housing.

Strategy F6 | INCREASE AFFORDABLE/HOMELESS HOUSING

Related to Strategy Brief 2.6

Using Public Land for Homeless Housing

POPULATION IMPACT

- ALL
 FAMILIES
 TAY
 SINGLE ADULT
 VETERAN
 CHRONICALLY HOMELESS ADULT

RECOMMENDATION

Instruct the Chief Executive Office’s Real Estate Division and the Community Development Commission to work in collaboration with the departments of Internal Services, Fire, Health Services, Libraries, Parks and Recreation, Public Works, Regional Planning, and Sheriff, to assess the feasibility of making County-owned property available for the development of housing for homeless families/individuals, and develop a public land development strategy/program that shall include:

1. a comprehensive list of available County land suitable for housing, including identification of the top five most suitable properties ;
2. governing structure options, such as an agency authorized to own, hold, prepare, and dispose of public land for affordable housing;
3. identification of funds that can be used for pre-development of properties;
4. partnership opportunities with non-profit developers, if appropriate; and
5. policies to:
 - a. identify and protect publicly owned sites that are good for affordable housing;
 - b. define affordability levels on public land, e.g., homeless, very-low income, low-income, etc.;
 - c. engage communities in the development process;
 - d. link publicly owned land to other housing subsidies; and
 - e. reduce the cost of development through public investment in public land set aside for housing.

DESCRIPTION

In Los Angeles County, there are opportunities for using public land for affordable housing on many different types of sites, including vacant publicly owned land, under-utilized sites, parcels where existing public facilities are no longer needed, and as part of the development of new public facilities such as community centers, libraries, fire stations, and police stations. Discounted public land can provide a valuable subsidy to the development of affordable housing, as well as facilitate the development of affordable housing in transit-accessible, amenity-rich locations. The joint development of public facilities and housing properties can lead to infrastructure cost savings, better design, and more accessible public services.

Opportunities that support using public land for homeless housing include:

- AB 2135, which provides affordable housing projects the right of first refusal to obtain surplus land held by local governments, gives project developers more time to negotiate the purchase of the surplus land, and allows the land to be sold for less than fair market value as a developer incentive; and
- Establishing a Joint Powers Authority to acquire, hold, and dispose of public land for housing.

Various examples of discounted public land are available throughout the country. Examples of Public Land being used for Affordable Housing in Los Angeles County include:

- Affordable Housing on Metro Joint Development Sites;
- Affordable Housing on Los Angeles Unified School District property;

DESCRIPTION *continued*

- Homeless Housing on surplus Department of Motor Vehicle site in Hollywood;
- Affordable Housing on land purchased by former redevelopment agencies; and
- Housing for Homeless Veterans on U.S. Department of Veteran Affairs Property in Westwood.

LEAD AGENCY

Chief Executive Office
Community Development Commission

COLLABORATING DEPARTMENTS/AGENCIES

Fire
Health Services
Library
Internal Services Department
Parks and Recreation
Regional Planning
Sheriff

CONNECTION TO CITIES

✓ **SAME**

COMPLEMENTARY

NO CITY ROLE

Each city could pursue development of homeless housing on city-owned property.

POPULATION(S) TARGETED & OTHER CATEGORIZATIONS

All homeless populations

POTENTIAL PERFORMANCE METRICS

Number of housing units developed for homeless people on County and other publicly-owned properties

FUNDING

No cost to conduct the feasibility assessment and develop the strategy/program.



INTENTIONALLY LEFT BLANK

Addenda



Los Angeles County
Homeless Initiative

Summary of Recommended Funding

Focus Area/Recommended Strategy		RECOMMENDED FUNDING	
		HPI-NCC*	Department Funding
A. PREVENT HOMELESSNESS			
A1	Homeless Prevention Program for Families	0	\$5 million one-time CalWORKs Fraud Incentives (DPSS)
A2	Discharge Planning Guidelines	0	0
A3	Housing Authority Family Reunification Program	0	0
A4	Discharges From Foster Care and Juvenile Probation	0	0
B. SUBSIDIZE HOUSING			
B1	Provide Subsidized Housing to Homeless Disabled Individuals Pursuing SSI	\$3,725,000	\$1 million one-time SB 678 funding (Probation) \$4 million one-time AB 109 funding
B2	Expand Interim Assistance Reimbursement (IAR) to additional County Departments and Los Angeles Homeless Services Authority	0	0
B3	Partner with Cities to Expand Rapid Re-Housing	\$8,000,000**	\$11 million one-time SB 678 funding (Probation) \$7 million one-time AB 109 funding
B4	Facilitate Utilization of Federal Housing Subsidies	\$2,000,000	0
B5	Expand General Relief Housing Subsidies	0	Interim Assistance Reimbursement of Rental Subsidies and redirected NCC savings resulting from ACA impact on MSUDRP (DPSS)
B6	Family Reunification Housing Subsidy	\$1,000,000	\$2 million in one-time funding plus Reinvestment of Out-of-Home Placement savings (DCFS)
B7	Interim/Bridge Housing for those Exiting Institutions	\$3,250,000	\$3.4 million one-time SB 678 funding (Probation) \$4.6 million one-time AB 109 funding
B8	Housing Choice Vouchers for Permanent Supportive Housing	0	0
C. INCREASE INCOME			
C1	Enhance the CalWORKs Subsidized Employment Program for Homeless Families	0	CalWORKs Subsidized Employment (DPSS)
C2	Increase Employment for Homeless Adults by Supporting Social Enterprises	\$2,000,000	0
C3	Expand Targeted Recruitment and Hiring Process to Homeless/Recently Homeless People to Increase Access to County Jobs	0	0
C4	Establish a Countywide SSI Advocacy Program for People Experiencing Homelessness or At Risk of Homelessness	0	Current SSIMAP Funding (DPSS)***
C5	Establish a Countywide Veterans Benefits Advocacy Program for Veterans Experiencing Homelessness or At Risk of Homelessness.	\$1,200,000 (from Homes for Heroes funding)	0
C6	Targeted SSI Advocacy for Inmates	0	\$1 million one-time AB 109 funding
D. PROVIDE CASE MANAGEMENT AND SERVICES			
D1	Model Employment Retention Support Program.	0	0
D2	Expand Jail in Reach	\$2,000,000	\$3 million one-time AB 109 funding
D3	Supportive Services Standards for Subsidized Housing	0	0
D4	Regional Integrated Re-entry Networks – Homeless Focus	\$800,000	\$2 million one-time AB 109 funding
D5	Support for Homeless Case Managers	0	0
D6	Criminal Record Clearing Project	\$200,000	0

Summary of Recommended Funding

Focus Area/Recommended Strategy		RECOMMENDED FUNDING	
		HPI-NCC*	Department Funding
E. CREATE A COORDINATED SYSTEM			
E1	Advocate with Relevant Federal and State Agencies to Streamline Applicable Administrative Processes for SSI and Veterans Benefits	0	0
E2	Drug Medi-Cal Organized Delivery System (DMC-ODS) for Substance Use Disorder Treatment Services	0	Drug Medi-Cal-Outpatient Drug Services (DPH)
E3	Create Partnerships for Effective Access and Utilization of ACA Services by Persons Experiencing Homelessness	0	0
E4	First Responders Training	0	0
E5	Decriminalization Policy	0	0
E6	Countywide Outreach System	\$3,000,000	TBD
E7	Strengthen the Coordinated Entry System (CES)	\$2,000,000	0
E8	Enhance the Emergency Shelter System	\$1,500,000	0
E9	Discharge Data Tracking System	0	TBD
E10	Regional Coordination of Los Angeles County Housing Authorities	0	0
E11	County Specialist Support Team	0	0
E12	Enhanced Data Sharing and Tracking	\$1,000,000	0
E13	Coordination of Funding for Supportive Housing	0	0
E14	Enhanced Services for Transition Age Youth (TAY)	\$3,000,000	TBD
E15	Homeless Voter Registration and Access to Vital Records	0	0
E16	Affordable Care Act Opportunities	0	Medi-Cal (DHS/DMH/DPH)
E17	Regional Homelessness Advisory Council and Implementation Coordination	0	0
F. INCREASE AFFORDABLE / HOMELESS HOUSING			
F1	Promote Regional SB 2 Compliance	\$75,000	0
F2	Linkage Fee Nexus Study	\$450,000	0
F3	Support Inclusionary Zoning for Affordable Rental Units	0	0
F4	Development of Second Dwelling Units Pilot Program	\$550,000	0
F5	Incentive Zoning/Value Capture Strategies	\$50,000	0
F6	Use of Public Land for Homeless Housing	0	0
NEW FY 2015-16 FUNDING ALREADY ALLOCATED BY BOARD OF SUPERVISORS			
Rapid Re-housing for Single Adults		\$10,000,000	0
Rapid Re-housing for Families		\$3,000,000	0
Homeless Prevention for Families		\$2,000,000	0
Homes for Heroes- Combating Veteran Homelessness		\$3,800,000	0
Veterans' Housing Subsidies – Move-In Assistance		\$1,100,000	0
TOTAL NEW FUNDING		*\$55,700,000 one-time funding	****\$44,000,000 one-time funding plus additional Departmental funding
FY 2015-16 Homeless Prevention Initiative Base Funding		\$50,000,000	0
GRAND TOTAL		\$149,700,000	

Strategies with red shading are identified as Phase 1 strategies, targeted for implementation by June 30, 2016.

* \$55.7 million is comprised of: (1) \$51.1 million approved by the Board on September 29, 2015; and (2) \$4.6 million of FY 2016-17 Affordable Housing dollars that are not dedicated for capital expenditures.

** For Strategy B3 – Rapid Re-housing, \$2 million is earmarked to serve Transition Age Youth and \$5 million is earmarked for families.

*** \$6.8 million in ongoing annual DPSS SSIMAP funding has been identified for this strategy.

**** \$44 million is comprised of: (1) \$5 million of one-time CalWORKs Fraud Incentives from DPSS; (2) \$21.6 million of one-time AB 109 funding; (3) \$15.4 million of one-time SB 678 funding from Probation; and (4) \$2 million of one-time funding from DCFS.

Phase 1 Strategies

A. PREVENT HOMELESSNESS

A1 Homeless Prevention Program for Families

B. SUBSIDIZE HOUSING

B1 Provide Subsidized Housing to Homeless Disabled Individuals Pursuing SSI

B3 Partner with Cities to Expand Rapid Re-Housing

B4 Facilitate Utilization of Federal Housing Subsidies

B7 Interim/Bridge Housing for those Exiting Institutions

B8 Housing Choice Vouchers for Permanent Supportive Housing

C. INCREASE INCOME

C2 Increase Employment for Homeless Adults by Supporting Social Enterprise

D. PROVIDE CASE MANAGEMENT AND SERVICES

D2 Expand Jail In Reach

E. CREATE A COORDINATED SYSTEM

E4 First Responders Training

E5 Decriminalization Policy

E6 Countywide Outreach System

E8 Enhance the Emergency Shelter System

Opportunities for Cities to Combat Homelessness

Focus Area/Recommended Strategy	Key City Opportunities
A. PREVENT HOMELESSNESS	
A1 Homeless Prevention Program for Families	X
A2 Discharge Planning Guidelines	
A3 Housing Authority Family Reunification Program	
A4 Discharges From Foster Care and Juvenile Probation	
B. SUBSIDIZE HOUSING	
B1 Provide Subsidized Housing to Homeless Disabled Individuals Pursuing SSI	X
B2 Expand Interim Assistance Reimbursement (IAR) to additional County Departments and Los Angeles Homeless Services Authority	
B3 Partner with Cities to Expand Rapid Re-Housing	X
B4 Facilitate Utilization of Federal Housing Subsidies	
B5 Expand General Relief Housing Subsidies	
B6 Family Reunification Housing Subsidy	
B7 Interim/Bridge Housing for those Exiting Institutions	
B8 Housing Choice Vouchers for Permanent Supportive Housing	X
C. INCREASE INCOME	
C1 Enhance the CalWORKs Subsidized Employment Program for Homeless Families	
C2 Increase Employment for Homeless Adults by Supporting Social Enterprises	X
C3 Expand Targeted Recruitment and Hiring Process to Homeless/Recently Homeless People to Increase Access to County Jobs	
C4 Establish a Countywide SSI Advocacy Program for People Experiencing Homelessness or At Risk of Homelessness	
C5 Establish a Countywide Veterans Benefits Advocacy Program for Veterans Experiencing Homelessness or At Risk of Homelessness.	
D. PROVIDE CASE MANAGEMENT AND SERVICES	
D1 Model Employment Retention Support Program.	
D3 Supportive Services Standards for Subsidized Housing	
D5 Support for Homeless Case Managers	
E. CREATE A COORDINATED SYSTEM	
E1 Advocate with Relevant Federal and State Agencies to Streamline Applicable Administrative Processes for SSI and Veterans Benefits	
E2 Drug Medi-Cal Organized Delivery System (DMC-ODS) for Substance Use Disorder Treatment Services	
E4 First Responders Training	X
E5 Decriminalization Policy	X
E6 Countywide Outreach System	
E7 Strengthen the Coordinated Entry System (CES)	
E8 Enhance the Emergency Shelter System	X
E9 Discharge Data Tracking System	
E10 Regional Coordination of Los Angeles County Housing Authorities	X
E12 Enhanced Data Sharing and Tracking	
E13 Coordination of Funding for Supportive Housing	
E14 Enhanced Services for Transition Age Youth (TAY)	
E17 Regional Homelessness Advisory Council and Implementation Coordination	
F. INCREASE AFFORDABLE / HOMELESS HOUSING	
F1 Promote Regional SB 2 Compliance	X
F2 Linkage Fee Nexus Study	X
F3 Support Inclusionary Zoning for Affordable Rental Units	
F4 Development of Second Dwelling Units Pilot Program	X
F5 Incentive Zoning/Value Capture Strategies	X
F6 Use of Public Land for Homeless Housing	

Strategies with **red shading** are identified as Phase 1 strategies, targeted for implementation by June 30, 2016.

Homeless Initiative Policy Summits – Participating Organizations

COUNTY OF LOS ANGELES

Arts Commission
 Chief Executive Office
 Community Development Commission
 County Counsel
 Department of Child Support Services
 Department of Human Resources
 Department of Animal Care and Control
 Department of Beaches and Harbors
 Department of Children and Family Services
 Department of Community and Senior Services
 Department of Consumer and Business Affairs
 Department of Health Services
 Department of Mental Health
 Department of Military and Veterans Affairs
 Department of Parks and Recreation
 Department of Public Health
 Department of Public Social Services
 Department of Regional Planning
 District Attorney
 Fire Department
 Housing Authority of the County of Los Angeles
 Office of the Alternate Public Defender
 Office of the Public Defender
 Probation Department
 Public Library
 Sheriff’s Department

CITIES

City of Alhambra
 City of Arcadia
 City of Baldwin Park
 City of Bell Gardens
 City of Bellflower
 City of Beverly Hills
 City of Carson
 City of Cerritos
 City of Covina
 City of Diamond Bar
 City of El Segundo
 City of Glendale
 City of Glendora
 City of Hawaiian Gardens
 City of Hawthorne
 City of Hermosa Beach
 City of Inglewood
 City of Lawndale
 City of Long Beach
 City of Los Angeles

City of Lynwood
 City of Norwalk
 City of Palmdale
 City of Pasadena
 City of Pomona
 City of San Gabriel
 City of Santa Clarita
 City of Santa Fe Springs
 City of Santa Monica
 City of West Hollywood
 City of Whittier

OTHER GOVERNMENT AGENCIES

U.S Department of Veterans Affairs
 U.S. Department of Health and Human Services
 First 5 Los Angeles
 L.A. Care Health Plan
 Los Angeles Homeless Services Authority
 Los Angeles Unified School District
 San Gabriel Valley Council of Governments
 South Bay Council of Governments

NON-GOVERNMENTAL AGENCIES

211 Los Angeles County
 A Community of Friends
 A New Way of Life
 Alliance for Children’s Rights
 Alliance for Housing and Healing
 Amity Foundation
 APT Associates
 Ascencia
 Brilliant Corners
 California Apartment Association
 California Community Foundation
 Californians for Safety and Justice
 Catholic Charities of Los Angeles
 Center for Living and Learning
 Center for the Pacific Asian Family
 Central City Association
 Century
 Children Now
 Chrysalis
 City View
 City Watch LA
 Coalition for Responsible Community Development
 Conrad N. Hilton foundation
 Corporation for Supportive Housing
 Door of Hope
 Downtown Women’s Center

Homeless Initiative Policy Summits – Participating Organizations

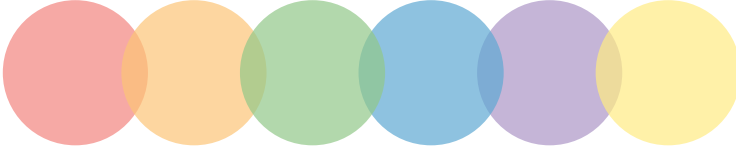
NON-GOVERNMENTAL AGENCIES cont.

East San Gabriel Valley Coalition for the Homeless
 Enterprise Community Partners
 First Place for Youth
 First Presbyterian Hollywood Church
 Goldfarb Lipman, LLP
 Good Seed
 Habitat for Humanity
 Health Net
 Help Me Help You
 Hilton Foundation
 Hollywood Media District, Business Improvement District
 Hollywood Presbyterian Church
 Hollywood Property Owners Alliance
 Homeless Health Care Los Angeles
 Homeless Outreach Program Integrated Care System
 Hospital Association of Southern California
 Housing Works
 Imagine LA
 Inner City Industry
 Inner City Law Center
 Integrated Recovery Network
 John Wesley Community Health Institute
 LA Family Housing
 LA Youth Network
 Lamp Community
 Legal Aid Foundation of Los Angeles
 Little Tokyo Service Center
 Los Angeles Centers for Alcohol and Drug Abuse
 Los Angeles Family Housing
 Los Angeles Regional Reentry Partnership
 Los Angeles Youth Network
 Mental Health Advocacy Services
 Mental Health America of Los Angeles
 My Friend's Place
 National Health Foundation
 Neighborhood Legal Services of Los Angeles County
 New Economics for Women
 Northeast Valley Health Corporation
 Ocean Park Community Center
 People Assisting the Homeless
 Poverty Matters
 Prototypes
 Proyecto Pastoral
 Public Counsel
 Rainbow Services
 Rapid Results Institute
 REDF
 Safe Place for Youth
 Saint Joseph Center
 Salvation Army
 San Fernando Valley Community Mental Health Center, Inc.
 San Fernando Valley Rescue Mission
 Sanctuary of Hope
 SCANP
 SCHARP
 SEIU
 SHARE!
 Shelter Partnership
 Skid Row Housing Trust
 South Park Business Improvement District
 Southeast Asian Community Alliance
 Southern California Grantmakers
 Southwestern Law School
 SRO Housing Corporation
 St. Anne's
 St. Joseph Center
 State Parole Division
 Step Up
 The Midnight Mission
 The Salvation Army
 Tong Consulting
 Union Rescue Mission
 Union Station Homeless Services
 Unite Way of Greater Los Angeles
 United Friends of the Children
 United Homeless Healthcare Partners
 United Way of Greater Los Angeles/Home for Good
 University of Calgary
 University of California, Irvine
 University of California, Los Angeles
 University of Southern California
 Upward Bound House
 Urban Partners
 Valley Oasis
 Volunteers of America Los Angeles
 Watts Healthcare Corporation
 Watts Labor Community Action Committee
 WCAY, Inc.
 Weingart Foundation
 Westside Coalition
 Women Organizing Resources, Knowledge and Services
 YWCA Santa Monica-Westside

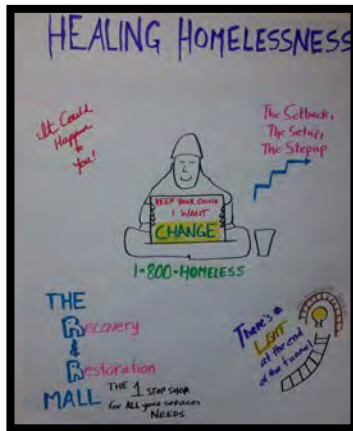
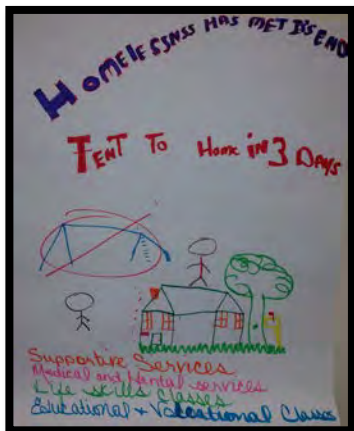
Los Angeles County
Chief Executive Office

Los Angeles County Homeless Initiative

priorities.lacounty.gov/homeless



Los Angeles County Homeless Initiative Focus Group Summary Report December 2015





Los Angeles County Homeless Initiative

Focus Group Summary Report

December 2015

I. Executive Summary

On behalf of the Chief Executive Office (CEO) of Los Angeles County and to advance the efforts of the Los Angeles County Homeless Initiative, the Los Angeles Homeless Services Authority (LAHSA) convened a series of focus groups with current and/or formerly homeless individuals. Convening people with lived homeless experience on a regular basis is essential to learn how public policies impact the homeless services delivery system. It is also important to understand how services are designed and delivered in order to improve the responsiveness, effectiveness, and accessibility of the system. These focus groups were designed using a facilitative and neutral process to obtain feedback from selected participants with lived homeless experience. While the majority of the analysis that generated the results presented in this report was conducted after the focus groups had convened, mechanisms were put in place (e.g. participant evaluation surveys) to gauge participants' assessment of the facilitative process throughout the series, as well as to improve their overall focus group experience.

The facilitative process focused on two primary areas: 1) Experiences with the homeless services delivery system, and 2) Improvements to the system. The first round of meetings targeted *prevention, access to resources, and discharges from institutions* as discussion topics. The second round of discussions focused on generating *solutions* to many of the issues raised during the first round. Based on both rounds of discussions, participants identified the following topics as key areas of concern:

- Support
- Information/Education/Awareness
- Mental Health Counseling
- Education and Training of Professionals
- Financial Assistance
- Comprehensive and Integrated Services
- Life Skills Coaching/Training
- Housing Based on Need
- Medical/Health/Mental Health Care
- Social Security Disability Insurance/General Relief/Other Public Benefits
- Legal Services
- Lack of Coordination and/or Exit Strategy
- Housing First
- Consumer Input and Oversight
- Integration of Services
- Improved Hiring and Training of Professionals and Staff

After careful analysis of the key findings that emerged during the discussion sessions, the following key themes were identified:

- Stigma and Isolation
- Awareness and Outreach

- Fragmentation of the System
- Access to Comprehensive Services and Resources

Finally, focus group participants made the following recommendations for the CEO to consider as it seeks to improve the homeless delivery system across Los Angeles County:

1. Increase stock of affordable housing.
2. Consider converting empty luxury condos and vacant lots to affordable housing.
3. Examine other systems of care that frequently engage with people experiencing homelessness (e.g. the healthcare system) and consider using existing facilities (e.g. hospitals) as intervention/access points for connecting people to the homeless services delivery system.
4. Include peer support (i.e. formerly homeless individuals) in all outreach activities.
5. Increase awareness about homeless risk factors and where to seek referral by launching an advertising campaign on public transportation and at public facilities.
6. Improve access to services and simplify service delivery by decreasing wait times and collocating referrals and services in one location.
7. Consider subsidizing transportation for people experiencing homelessness.
8. Implement programs that emphasize life skills.
9. Improve training of staff and professionals who engage with individuals experiencing homelessness to improve customer service.
10. Hire peers (i.e. formerly homeless individuals) to provide services.
11. Consider offering innovative opportunities to earn income in order to increase the economic stability of people experiencing homelessness.
12. Improve the discharge process from hospitals, jails, prisons, and other institutions by increasing coordination and integration among agencies and providers.
13. Implement comprehensive exit planning before a person is discharged from an institution.
14. Change policies around discharging individuals in the middle of the night.
15. Implement compassionate policies for people exhibiting at-risk behavior.
16. Implement Housing First policies.
17. Continue to seek input from people who are currently homeless or have experienced homelessness.
18. Include current and formerly homeless individuals in fiscal oversight of the homeless services delivery system.

Acknowledgements

The Los Angeles Homeless Services Authority (LAHSA) would like to thank the focus group participants for their time and dedication to this project, as well as the following community partners for their participation in nominating clients to be part of the focus groups: Skid Row Housing Trust, L.A. Family Housing, New Directions, Housing Works, SRO Housing, Home For Good, Veterans Administration, L.A. Coalition to End Youth Homelessness, L.A. County Department of Mental Health, Volunteers of America, Corporation for Supportive Housing, St. Joseph's Center, Los Angeles Mission, A Community of Friends, Peace Please, Jovenes Inc., Downtown Women's Center, L.A. County Department of Children and Family Services, East San Gabriel Valley Coalition for the Homeless. LAHSA also thanks the Los Angeles County Chief Executive Office, Phil Ansell, and Leticia Colchado for their leadership and guidance in the County Homeless Initiative process.

II. Background and Purpose

As part of the Los Angeles County's Homeless Initiative, the Los Angeles County Chief Executive Office (CEO) recognized the need to engage current and formerly homeless individuals in the planning process to address homelessness. The CEO collaborated with the Los Angeles Homeless Services Authority (LAHSA) to coordinate two focus group sessions with consumers of the homeless delivery system for the purpose of:

- Identifying current and potential policy and program barriers to stable housing;
- Identifying supportive services and resources that may not be available; and
- Generating ideas and recommendations based on the experiences of formerly or currently homeless people.

III. Methodology

Recruitment

LAHSA community partners and stakeholders were sent a letter requesting the nomination of current and/or formerly homeless individuals as potential focus group participants (See Appendix I). Community partners and stakeholders included: LAHSA Commissioners, homeless housing and supportive services providers, Home For Good, the Veterans Administration, Corporation for Supportive Housing, Coordinated Entry System providers, Family Solutions Centers, the Los Angeles Coalition to End Youth Homelessness, and the Los Angeles County Department of Mental Health. Based on the nominations received, LAHSA selected a total of 26 participants to invite. Efforts were made to ensure equal representation in each focus group (approximately 13 individuals) by Service Planning Areas (SPAs), with SPAs 1 through 3 as Group A, and SPAs 4 through 8 as Group B.

Participants were provided with subsidized transportation, refreshments, and lunch, and a \$50 gift card at the end of the second round of focus group meetings.

Focus Group Process

LAHSA's Policy and Planning Department facilitated four 3.5-hour focus groups with participants from each of

the 8 SPAs. SPAs 4-8 were convened on November 2, 2015 and November 16, 2015, and SPAs 1-3 were convened on November 13, 2015 and November 30, 2015 (See Appendix II for schedule).

The first round (Round 1) of the focus groups focused on providing participants with background information on the LA County Homeless Initiative planning process. Participants were provided with binders containing copies of all policy and strategy briefs available on the Initiative’s website to date at the time of the meeting. The discussion topics addressed during Round 1 were: 1) prevention, 2) accessing resources, and 3) discharge from institutions.

The second round (Round 2) of the focus groups focused on engaging participants in small group exercises that encouraged participants to brainstorm and identify solutions to some of the issues in the homeless delivery system that were raised during the first round. Participants were put into small groups with each group reporting results to the full focus group.

Analysis

At each focus group, facilitators and recorders captured participants’ feedback through use of poster boards, index cards, and questionnaire and/or survey data that were then recorded electronically. Key findings and themes were then identified.

IV. Results: Focus Group Demographic Questionnaire

A voluntary confidential demographic questionnaire was administered during the first round of focus groups (See Appendix III). The questionnaire was designed to include mostly open format questions so as to encourage true and insightful responses. There was an 85% participation rate (22 out of 26 questionnaires were returned).

The results were as follows:

Age

Table 1. Focus Group Age Demographics

<u>Age Range</u>	<u>Percentage of Respondents (n = 22)</u>	<u>Number of Respondents</u>
18-24	9%	2
25-49	23%	5
50 and older	68%	15

Gender

- 59% of respondents (13 individuals) identified as Male
- 41% of respondents (9 individuals) identified as Female

Race/Ethnicity

- 41% of respondents (9 individuals) identified as African American/Black
- 45% of respondents (10 individuals) identified as Caucasian/White
- 5% of respondents (1 individual) identified as Mixed Race
- 9% of respondents (2 individuals) identified as Other
- No participants indicated they were of Hispanic or Latino descent

Subpopulation (participants were allowed to select more than one subpopulation)

Table 2. Focus Group Subpopulation Demographics

<u>Subpopulation</u>	<u>Percentage of Respondents</u> (n = 22)	<u>Number of Respondents</u>
Single	91%	20
Long Term (Chronic)	23%	5
Domestic Violence Victim	14%	3
Youth	9%	2
Veteran	9%	2
Family	9%	2

Question #1: Thinking back on your experiences, how many times in your life have you experienced homelessness?

- 68% of respondents (15 individuals) experienced homelessness 1-4 times
- 32% of respondents (7 individuals) experienced homelessness more than five times

Question #2: How many times in your life have you had unstable housing or been on the verge of homelessness?

- 50% of respondents (11 individuals) experienced unstable housing 1-3 times
- 45% of respondents (10 individuals) experienced unstable housing more than three (3) times

Question #3: What is the longest amount of time you've experienced homelessness? What is the shortest amount of time?

- 91% of respondents (20 individuals) experienced a homeless episode that lasted at least one (1) year
- 55% of respondents (7 individuals) experienced a homeless episode that lasted at least three (3) years
- The shortest episodes experienced ranged from six (6) days to seven (7) months

Question #4: How has the experience of homelessness affected the way you think about yourself?

- 55% of respondents (12 individuals) reported that the experience of homelessness affected them negatively in how they thought about themselves
- 23% of respondents (5 individuals) reported that the experience of homelessness affected them positively in how they thought about themselves

- 9% of respondents (2 individuals) reported that the experience of homelessness had a neutral effect on how they thought about themselves

Question #5: How knowledgeable do you feel about housing and service resources?

- 5% of respondents (1 individual) reported having very little knowledge about housing and service resources
- 55% of respondents (12 individuals) reported having fair knowledge
- 27% of respondents (6 individuals) reported being very knowledgeable
- 14% of respondents (3 individuals) reported being extremely knowledgeable

Question #6: What have you heard, if anything at all, about the County’s planning process to address homelessness?

- 23% of respondents (5 individuals) reported hearing about \$100 million dollars and/or increased funding for homelessness
- 5% of respondents (1 individual) reported hearing about the County planning process
- 18% of respondents (4 individuals) reported hearing nothing at all

V. Results: Focus Group Evaluation Survey

In order to measure the overall effectiveness of the focus groups, participants were provided with a Focus Group Evaluation Survey at the end of each meeting (See Appendix IV). There were 11 questions utilizing the following scale:

- 1 = Strongly Agree
- 2 = Disagree
- 3 = Neutral
- 4 = Agree
- 5 = Strongly Agree

Responses were aggregated based on which round of the focus group the survey was administered, and results were averaged between the two groups. See the following table:

Table 3: Focus Group Participant Evaluation Survey Results

<u>Question</u>	<u>Round 1</u> (% out of 100) (n=23)	<u>Round 2</u> (% out of 100) (n=22)
1) Focus group information provided before your arrival was sufficient	76.5	91
2) The focus group was conducted in a professional manner	91	93.5
3) The facilitator(s) was effective	88	94.5
4) The focus group was interesting	89.5	92.5

5) The focus group was informative	91	95.5
6) There was sufficient time for the discussion	77.5	86
7) The focus group location was convenient	87	83.5
8) My participation in the focus group was worthwhile	88	94.5
9) I feel like my opinion mattered to the facilitator(s)	90	90.5
10) My understanding of L.A. County's planning process to address homelessness has increased	87	86
11) L.A. County should ask for feedback from individuals who have experienced or are currently experiencing homeless on a regular basis	94	94.5

Questions 1 and 3 saw the largest change in response, gaining 14.5 and 8.5 percentage points respectively. For Question 1, after Round 1 of focus groups, LAHSA made iterative and significant efforts to improve the amount of information participants received before Round 2, which may have contributed to the point increase.

For Question 3, the increase in points may be attributed to the way the focus groups were structured. Round 1 focused on three lengthy topics (prevention, accessing resources, and discharge from institutions), while Round 2 focused on a single topic (solutions). This may explain why participants reported they thought there was more time for discussion in the second round than in the first.

The highest marks were seen in Question 5, with approximately 96 percentage points given in Round 2, illustrating that participants felt the focus group was informative. Overall, participants felt strongly that the facilitators were effective, their participation in the focus group was worthwhile, and that the County should continue to seek feedback from individuals who have experienced, or are currently experiencing homelessness.

Question 7 saw the largest decrease in points between Round 1 and Round 2. Several participants from Group B voiced that the meeting location was not convenient for them, even though transportation was subsidized. This may be attributed to the very large geographic area that SPAs 1-3 cover, which includes the San Fernando Valley, the San Gabriel Valley, Santa Clarita, Palmdale, and Lancaster areas.

Participants were also given the opportunity to provide additional comments on the survey. Some of their responses include the following quotes:

- *"I am so glad to be able to sit in this summit which turned out to be very informative and enlightening. The focus/summit gave me more insight into the issue of homelessness, and also the wonderful collaboration and teams and resources that are available."*

- *“Thank you for the time to allow our voices to be heard in your focus group concerning homelessness. Wonderful fact finding experience.”*
- *“I feel that my voice on homelessness has been heard and valued at this group and look forward to participate in giving more input to help end homelessness.”*
- *“I would like to keep this group going.”*

VI. Results: Focus Group Discussion Key Findings

Round 1 of the focus groups covered the topics of prevention, access to resources, and discharge from institutions. Round 2 engaged participants in discussing solutions to many of the issues that were raised during Round 1. Participant responses were recorded and analyzed for frequency and intensity, and the following key findings were identified.

Prevention

Participants were asked two questions on the topic of prevention resulting in the following key findings:

- 1) What would have prevented you from becoming homeless?
 - a) Support
 - Support system from family members
 - Support from peers
 - Someone to trust
 - Mentors for youth
 - Willingness of the individual to reach out for support
 - Reintegration with family
 - b) Information/Education/Awareness
 - Awareness about the risk signs/factors of homelessness
 - Drug classes/rehab counseling
 - Domestic Violence classes
 - Employment services and training
 - Educational assistance
 - Public Service Announcements/advertisements about who to call when at risk or first homeless (e.g. a specific phone number like 1-800-HOMELESS)
 - Awareness that there are many faces of homelessness (e.g. people from disasters, jail, job loss, etc.)
 - c) Mental Health Counseling
 - Counselor/mentor for people taking care of sick loved ones
 - Counseling for grief of losing loved ones

- Mental health counseling for abuse victims/survivors
 - Mental health interventions for Veterans
 - Counseling/support for dealing with the stigma of becoming homeless, and the pride of not wanting to ask for help when you need it
- d) Education and Training of Professionals
- Better trained case managers who will “dig deeper” and ask clients about risk of being homeless instead of putting the responsibility on clients
 - Case managers who are better qualified and/or more knowledgeable about existing resources
 - Case managers who are compassionate
 - Holding abusive shelter staff accountable
- 2) What do people need to keep their housing?
- a) Financial Assistance
- Stable income
 - Rent control or subsidized housing
 - Financial support based on need
- b) Comprehensive and Integrated Services
- One location to access services (e.g. hygiene, medical, furniture, drug relapse prevention, support group, peer support)
 - Culturally-competent case management
- c) Life Skills Coaching/Training
- Financial literacy/budgeting
 - Employment/vocational training
 - How to clean housing unit so as to pass inspection
 - Someone to whom to be accountable
- d) Housing Based on Need
- “Meeting people where they are at”
 - Structured housing/rules (e.g. sober living enforced)
 - Choice of housing

Accessing Resources

Participants were asked to discuss their experiences in accessing the following resources: medical/health/mental health services, Social Security Disability Insurance (SSDI), General Relief, other public benefits, and legal services. Their key findings follow:

- 1) Medical/Health/Mental Health Care
- Wait times to access health services are too long
 - Once benefit obtained, services were mostly satisfactory
 - Compassionate workers at nonprofit health providers; not always the case at hospitals

- Linkages to other services were helpful, including linkages to housing

2) Social Security Disability Insurance/General Relief/Other Public Benefits

- Wait times to access income supports are too long
- Overwhelming lack of knowledge (of consumer) pertaining to how one should navigate applying for benefits (i.e. “too many hoops to jump through”)
- Application/eligibility process is expedited when healthcare professional such as a doctor or therapist can help with paperwork
- Lack of a home mailing address increases the chances of missing critical appointments, which jeopardizes eligibility

3) Legal Services

- Long waitlist to access legal services
- “Homeless Court” experience reported as very positive and effective in eliminating legal troubles

Discharge from Institutions

Participants were asked to discuss their experience of being discharged from institutions such as hospitals, jails, prisons, probation, foster care, or the armed services. Following are the key findings:

1) Lack of Coordination and/or Exit Strategy

- Oftentimes experience “dumping” when discharged from hospitals or jails; released in the middle of the night with nowhere to go
- Limited options when discharged from a hospital or jail; no access to telephones or personal belongings
- Lack of an aftercare plan or pre-release assessment from hospitals and jails
- Impersonal treatment from staff
- Shaming experienced by law enforcement
- Lack of coordination/integration from one institution to another
- For youth aging out of the child welfare system, extended or expanded foster care services exist but youth and staff working with youth need to be aware of them

Solutions

Participants were asked to discuss their ideas for solutions to the issues raised during Round 1 of the focus groups. Participants were put into small groups and presented with a prompt and then given time to brainstorm and present their ideas to the full focus group. Their responses and key findings follow:

In response to the prompt: Imagine you are playing a role in solving homelessness and you have all the resources at your disposal. If you had an opportunity to write the featured cover story of a magazine on homelessness, what would your magazine cover look like?

1) Housing First

- Meet people where they are by first supplying a permanent place to call home (i.e. “Give a key to a home and do the assessment after”)
- Fast track process into housing so people don’t miss appointments
- “Tent to home in three days”
- Convert empty luxury condos into affordable housing
- “Once you get your housing everything else is a piece of cake”

2) Consumer Input and Oversight

- Feedback mechanism for homeless and formerly homeless people to advocate for consumers and improve system(s)
- More consumer oversight of funding

3) Integration of Services

- Coordinate organizations and integrate funding mechanisms
- Centralized or collocation for access to services and resources (e.g. shelter, case management, transportation, medical, mental health, food, legal, life skills)

4) Improved Hiring and Training of Professionals and Staff

- Hire peers as staff (formerly homeless individuals)
- Train staff to be culturally sensitive, polite, respectful, and compassionate
- Hire staff who are experienced with and knowledgeable about homelessness
- Empower staff to be able to make swift decisions

VII. Discussion: Key Themes

Stigma and Isolation

A common theme expressed by participants was that of isolation and stigma. Participants shared about the overwhelming sense of loneliness they felt immediately prior to and during their episodes of homelessness. Due to various circumstances, participants were disconnected from support systems like family, friends, peers, and mental health counselors. The lack of having someone to trust and be accountable to was seen as a significant contribution to their homeless episodes.

Participants also shared about the stigma and discrimination they experienced during their episodes of homelessness. Their experiences often left them feeling overlooked or invisible in society on the one hand, while unsafe and targets for discrimination on the other, especially when it came to law enforcement and accessing basic necessities.

This theme was highlighted by one participant when he said:

“The one superpower you get when you become homeless is invisibility; people look right past you.”

Awareness and Outreach

Another common theme identified was that of the need for awareness and outreach, especially prior to and immediately during an episode of homelessness. When discussing the topic of prevention, some participants shared that there were many “red flags” or signs that they were at risk, but that they didn’t know who to talk to or where to go to find help for issues related to abuse, drug addiction, and job loss. For other participants, the reality of becoming homeless never occurred to them until it was too late, and that if they had been made aware of the risk factors, they or their families would have known to look for help. Participants also suggested more outreach and awareness around how to access resources when someone is at risk of or newly experiencing homelessness. Many participants shared that the most beneficial outreach they received was often conducted by peers – those individuals who were formerly homeless and employed in the homeless delivery system. Several participants also suggested that advertisements on buses and trains for a phone number to call for help be available.

Fragmentation of the System

Participants voiced concerns about the general lack of integration among service systems, especially when individuals are discharged from hospitals, jails, prisons, or the child welfare system. This lack of integration was seen as contributing to recidivism rates, relapse episodes, and frequent hospital stays. The fragmentation also left participants with information that was often segmented according to the system supplying the information, leaving individuals to figure out on their own how to integrate what they know across systems.

Participants also raised the issue of case management, and how many felt that the case management staff they encountered during their homeless episodes lacked sufficient knowledge about resources, empathy, or cultural competency to work with homeless individuals. Again, participants stressed the importance of having peers (formerly homeless individuals) as part of the service delivery system.

Access to Comprehensive Services and Resources

Participants were quick to note the need to quickly obtain housing first and foremost. The overwhelming opinion of the focus groups was to provide housing to individuals immediately so they can use that housing as a platform to address other issues in their lives. Without housing, participants said it was difficult to make and keep appointments for accessing services.

The lack of convenience when accessing services and resources was another area of concern. Participants shared that the fragmented service availability was a major barrier to accessing services. In particular, the lack of transportation between service providers and long wait times were identified as primary frustrations.

Participants were also very vocal about needing expanded resources beyond basic housing and financial support. Almost all participants voiced the need for the development of life skills, both for prevention and when exiting homelessness. Some of the categories identified for developing these life skills include financial management (i.e. budgeting), coaching for how to obtain employment and/or pursue educational goals, and coaching for how to maintain one’s housing.

Overall, participants reported having a positive experience when accessing mainstream and homeless resources, but by and large the length of time it took to receive benefits was too long. For example, one participant shared about a person needing psychiatric medication who had to wait two months before being seen by a doctor, which they identified as a major risk to the person's well-being.

VIII. Recommendations

Based on the focus group discussions, questionnaire and survey responses, and key findings and themes, the following is a list of participant recommendations for Los Angeles County to consider:

Housing

1. Increase stock of affordable housing.
2. Consider converting empty luxury condos and vacant lots to affordable housing.

Outreach and Information

3. Examine other systems of care that frequently engage with people experiencing homelessness (e.g. the healthcare system) and consider using existing facilities (e.g. hospitals) as intervention/access points for connecting people to the homeless services delivery system.
4. Include peer support (i.e. formerly homeless individuals) in all outreach activities.
5. Increase awareness about homeless risk factors and where to seek referral by launching an advertising campaign on public transportation and at public facilities.

Service Design and Delivery

6. Improve access to services and simplify service delivery by decreasing wait times and collocating referrals and services in one location.
7. Consider subsidizing transportation for people experiencing homelessness.
8. Implement programs that emphasize life skills.
9. Improve training of staff and professionals who engage with individuals experiencing homelessness to improve customer service and satisfaction.
10. Hire peers (i.e. formerly homeless individuals) to provide services.
11. Consider offering innovative opportunities to earn income in order to increase the economic stability of people experiencing homelessness.

Policies and Protocols

12. Improve the discharge process from hospitals, jails, prisons, and other institutions by increasing coordination and integration among agencies and providers.
13. Implement comprehensive exit planning before a person is discharged from an institution.
14. Change policies around discharging individuals in the middle of the night.
15. Implement compassionate policies for people exhibiting at-risk behavior.
16. Implement Housing First policies.

Consumer Input and Oversight

17. Continue to seek input from people who are currently homeless or have experienced homelessness.
18. Include current and formerly homeless individuals in fiscal oversight of the homeless services delivery system.

VI. Next Steps

LAHSA will gather all participants from these focus groups between January 7 and 13, 2016 to review the draft recommendations the County of Los Angeles CEO's office will be releasing for public comment. The recommendations will be reviewed and discussed, with a plan to share the response of participants to the County during the public comment period.

Appendix I: Focus Group Recruitment Letter

Dear Community Partner and Stakeholder,

As many of you are aware, the County of Los Angeles Chief Executive Office (CEO) under the leadership of Phil Ansell has been tasked with developing a coordinated set of strategies to combat homelessness throughout Los Angeles County. LAHSA has been participating in this process and is assisting with convening current and former homeless individuals to participate in a series of focus group sessions. You have been identified as a key stakeholder in addressing homelessness and are invited to participate in the recruitment of formerly homeless and homeless individuals in Los Angeles County. We need your assistance in nominating potential participants in focus groups we are holding with current and formerly homeless people.

This approach creates a mechanism for those who have experienced homelessness, receiving shelter or housing services, as well as accessing County and City resources to engage and have a participatory role in developing homeless strategies from their perspective. These sessions will be organized and allow participants to provide feedback, discuss issues and share recommendations generated at the stakeholder policy summits in October and November.

LAHSA will select a total of 24 participants to participate who will be divided into two focus groups (12 participants each) with the first sessions scheduled for the week of October 26, 2015. We are seeking a diverse group of participants who represent Veterans, Chronically Homeless, Families, and Youth to participate. We also would like participants who have experience accessing various systems and services. The second set of sessions will be held during the second week of December. In these focus groups, participants will provide feedback, discuss issues and share recommendations to inform the County's homeless strategy.

These sessions would result in the following:

- Identify current and potential policy and program barriers to stable housing;
- Identify what other supportive services and resources are or not available; and
- Generate ideas and recommendations based on experience of current and formerly homeless individuals.

We are seeking nominations from you and your organization for potential participants. For these focus groups, we will be subsidizing their transportation costs, providing lunch and working on another incentive for their participation. Please provide me with potential participants by Friday, November 6, 2015. For questions, please call Ronald Williams at [\(213\) 689-4091](tel:2136894091). You can also email nominations to Ronald Williams at rwilliams@lahsa.org. The following information will be needed for each nominee:

- Name:
- Population Category:
- Phone Number:
- Email:
- Address

Appendix II:

Los Angeles County Homeless Initiative Summit Focus Group Schedule

Focus Group A (SPAs 4-8): 811 Wilshire Blvd., 6th Floor, Los Angeles, CA 90017

- Monday, November 2, 2015 from 10:00 AM to 1:30 PM
- Monday, November 16, 2015 from 11:00 AM to 1:30 PM

Focus Group B (SPAs 1-3): 615 N. Fair Oaks Avenue, Suite 203, Pasadena, CA 91103

- Friday, November 13, 2015 from 9:00 AM to 12:30 PM
- Monday, November 30, 2015 from 9:00 AM to 12:30 PM

**Appendix III:
Participant Questionnaire**

Note: This is an anonymous questionnaire; answers will only be reported as aggregate data

1. Thinking back on your experiences, how many times in your life have you experienced homelessness?

2. How many times in your life have you had unstable housing or been on the verge of homelessness?

3. What is the longest amount of time you've experienced homelessness? What is the shortest amount of time?

4. How has the experience of homelessness affected the way you think about yourself?

5. How knowledgeable do you feel about housing and service resources? (Mark 'X' where appropriate)

No Knowledge	Very Little Knowledge	Fair Knowledge	Very Knowledgeable	Extremely Knowledgeable

6. What have you heard, if anything at all, about the County's planning process to address homelessness? If you have not heard anything, please write "Nothing."

Please provide the following information:

Your Age: _____

Your Gender: _____

Your Race and/or Ethnicity: _____

Your Experience of Homelessness As... (Circle All The Apply):

- Single In A Family Domestic Violence Victim Youth Veteran Long-Term

**Appendix IV:
Participant Evaluation Survey**

Using the following scale, please circle your best response:

Focus Group Evaluation Survey	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Focus group information provided before your arrival was sufficient.	1	2	3	4	5
2. The focus group was conducted in a professional manner.	1	2	3	4	5
3. The facilitator(s) was effective.	1	2	3	4	5
4. The focus group was interesting.	1	2	3	4	5
5. The focus group was informative.	1	2	3	4	5
6. There was sufficient time for the discussion.	1	2	3	4	5
7. The focus group location was convenient.	1	2	3	4	5
8. My participation in the focus group was worthwhile.	1	2	3	4	5
9. I feel like my opinion mattered to the facilitator(s).	1	2	3	4	5
10. My understanding of L.A. County's planning process to address homelessness has increased.	1	2	3	4	5
11. L.A. County should ask for feedback from individuals who have experienced or are currently experiencing homeless on a regular basis.	1	2	3	4	5

Additional comments:

The Services Homeless Single Adults Use and their Associated Costs

**An Examination of Utilization Patterns and Expenditures
in Los Angeles County over One Fiscal Year**

Chief Executive Office
Service Integration Branch
Research and Evaluation Services Unit

Written at the Request of the Chief Executive Office's *Ad Hoc* Homeless Initiative

Fei Wu, Ph.D.
Max Stevens, Ph.D.

January 2016

Table of Contents

Table of Contents i

Executive Summary v

1. Introduction 1

- 1.1. Estimated Gross Total Expenditure in FY 2014-15 1
- 1.2. Spending within General Service Areas 2
- 1.3. Net County Costs 2
- 1.4. The Study Population 3
 - 1.4.1. Demographic Composition 3
 - 1.4.2. The Exhaustiveness of the Study Population 3
 - 1.4.2.1. A Comparison with LAHSA’s Homeless Population Estimate 4
- 1.5. Data and the Components of the Cost Estimates 4
 - 1.5.1. Direct Service Costs 4
 - 1.5.2. Non-Individualized Program Costs 5
 - 1.5.3. Administrative Costs 5
- 1.6. Study Period 6
- 1.7. The Limitations of Our Approach 6
- 1.8. The Chapters and Organization of this Report 7

2. Estimates of Expenditures on Health-Related Services 8

- 2.1. Health Expenditures Overall 8
- 2.2. DHS Expenditures 9
 - 2.2.1. Overview for DHS Data 9
 - 2.2.2. DHS’s Estimated Overall Costs 9
 - 2.2.3. Inpatient, Outpatient and Emergency Costs 10
 - 2.2.4. Additional DHS Costs 11
- 2.3. DMH Expenditures 11
 - 2.3.1. Inpatient and Outpatient Services 12
 - 2.3.2. Additional DMH Services and Administrative Costs 14
 - 2.3.3. Net County Costs 15
- 2.4. DPH Expenditures 15
 - 2.4.1. Total SAPC Expenditures 15
 - 2.4.2. SAPC Expenditures by Service Type 17
 - 2.4.3. Additional DPH Programs and Costs 18
 - 2.4.4. DPH Expenditures Relative to Overall Adult Appropriations 18

3. Law Enforcement Expenditures 19

- 3.1. Combined Total Law Enforcement Expenditures 19
- 3.2. The Sheriff’s Department 20
 - 3.2.1. Overall Sheriff’s Department Expenditures in FY 2014-15 20
 - 3.2.2. Booking Costs 21
 - 3.2.3. Jail Stay Durations and Jail Day Maintenance Costs 22
 - 3.2.4. The Jail Ward 23
 - 3.2.5. Arrest Costs by the Duration of Jail Stays 23

3.2.6.	The Community Transition Unit and Administrative Costs	24
3.2.7.	Net County Costs.....	24
3.3.	Probation	25
3.3.1.	Homeless Probationers.....	25
3.3.2.	A Prorated Estimate of Study Population Probation Costs.....	25
3.3.3.	Net County Costs.....	26
4.	Social Services	27
4.1.	Monthly Benefits: General Relief and CalFresh	28
4.2.	Additional Costs	29
5.	Summary and Implications	30
5.1.	The Significance of Mental Health and Substance Abuse Services	30
5.1.1.	Inpatient and Emergency Services	31
5.2.	Inmates and Probationers	31
5.3.	DPSS, the Primary Source of Basic Survival for the County’s Homeless Adults	32
5.4.	High-Volume Service Users.....	32
5.4.1.	The Chronically-Homeless Subgroup.....	33
5.5.	Homeless Costs in the Context of Overall Departmental Resources	33
5.6.	Maximizing the Effectiveness of County Service Dollars	34

Tables

Table 1a. Homeless Single Adult Master File Data Source	3
Table 1b. Study Group Demographic Characteristics	3
Table 1c. Study Population versus LAHSA 2015 Estimate	4
Table 1d. Study Population Share of Direct Services Costs	4
Table 1e. Additional Homeless Program Costs, FY 2014-15	5
Table 1f. Study Group Administrative Cost Estimates	5
Table 2a. The Study Group’s Overall Use of Health-Related Services, FY 2014-15	8
Table 2b. The Study Group’s Overall DHS Utilization and the Associated Costs, FY 2014-15	9
Table 2c. Study Group’s Utilization of DHS Inpatient Services, FY 2014-15	10
Table 2d. The Study Group’s Overall DMH Utilization and Associated Costs, FY 2014-15	11
Table 2e. Study Group Utilization of DMH Outpatient and Crisis Stabilization Services, FY 2014-15	13
Table 2f. Study Group Utilization of DMH Inpatient and Residential Services, FY 2014-15	14
Table 2g. DPH Cost Estimate for the Study Population, Overall and by Program, FY 2014-15	16
Table 2h. The Study Population’s Utilization of DPH/SAPC Services Overall, FY 2014-15	17
Table 2i. Study Group Utilization of SAPC Narcotic Treatment and Residential Services, FY 2014-15	17
Table 3a. Study Group Overall Law Enforcement Costs, FY 2014-15	19
Table 3b. Study Group Total Arrests and Jail Costs, FY 2014-15	20
Table 3c. Study Group Arrests and Booking Costs, FY 2014-15	22
Table 3d. Study Group Jail Days and Jail Maintenance Costs, FY 2014-15	22
Table 3e. Study Group Utilization of Jail Ward Services, FY 2014-15	23
Table 3f. Arrest Costs by Length of Jail Stay, n=14,754 Persons in the Study Population Arrested in FY 2014-15	23
Table 3g. Time on Probation among Probationers in the Study Group	25
Table 3i. Estimated Probation Costs, FY 2014-15, n=2,795 Clients	26
Table 4a. DPSS Expenditures on the Study Population, FY 2014-15	27
Table 4b. Study Group Receipt of General Relief and CalFresh, FY 2014-15	29
Table 5a. Costs for Services Provided to Homeless Single Adults in Los Angeles County, FY 2014-15	30

Figures

Figure 1a. Expenditures on Homeless Single Adults, by County Agency, FY 2014-15	1
Figure 1b. Expenditures on Homeless Single Adults by General Service Area, FY 2014-15	2
Figure 1c. Net County Cost Expenditures on Homeless Single Adults, by Agency	2
Figure 1d. Distribution of Study Population FY 2014-15 Costs by Cost Type.....	6
Figure 2a. Health Expenditure on the Homeless Study Population, FY 2014-15.....	8
Figure 2b. DHS Expenditures on Adult Patients in Relation to the Departments' Estimated Budget Allocation, FY 2014-15	10
Figure 2c. DMH Expenditures on Adult Patients, Overall and for the Study Group, FY 2014-15	12
Figure 2d. Study Population Use of SAPC Services in Relation to the Program's Overall FY 2014-15 Budget.....	18
Figure 3a. Sheriff's Expenditures on Inmate Maintenance at Los Angeles County Jail Facilities, for the Study Group and Overall, FY 2014-15	21
Figure 3b. Probation Costs for Adult Felony Probationers and Healthright 360 Clients	26
Figure 4a. Estimated DPSS Expenditures on Single Adults, FY 2014-15.....	28
Figure 5a. Estimated County Mental Health and Substance Abuse Expenditures in Relation to Health Expenditures Overall, FY 2014-15	30
Figure 5b. Estimated County Mental Health and Substance Abuse Expenditure in Relation to Overall Costs, FY 2014-15	31
Figure 5c. County Expenditures on the Most Expensive Adults in the Study Population, FY 2014-15	32
Figure 5d. Combined County Spending on the Study Group across Six County Agencies in Relation to Approximated Total Expenditures on Adults Overall, FY 2014-15.....	33
Figure 5e. Estimated Distribution of Every County Dollar Spent in Providing Services to Homeless Single Adults.....	34

**The Services Homeless Single Adults Use and their Associated Costs:
Executive Summary**

Background

This executive summary provides a synopsis of a report the Chief Executive Office’s Research and Evaluation Services unit (CEO/RES) has prepared on the costs associated with services homeless single adults used through six County agencies in Fiscal Year (FY) 2014-15. The analysis informing RES’s cost estimates was conducted at the direction of the CEO’s *ad hoc* Homeless Initiative, which is tasked with developing a coordinated set of recommended County strategies to combat homelessness. RES’s report is based on a study population of almost 150,000 single adults who experienced homelessness for varying periods of time during the 12-month observation period. The findings offer an overview of the fiscal significance of homelessness for the County in general, as well as from the point of view of the individual County agencies most intensively involved with the provision of services to homeless men and women. In doing so, the analyses establish a basis in empirical data for the recommended strategies the Homeless Initiative will deliver to the Board of Supervisors.

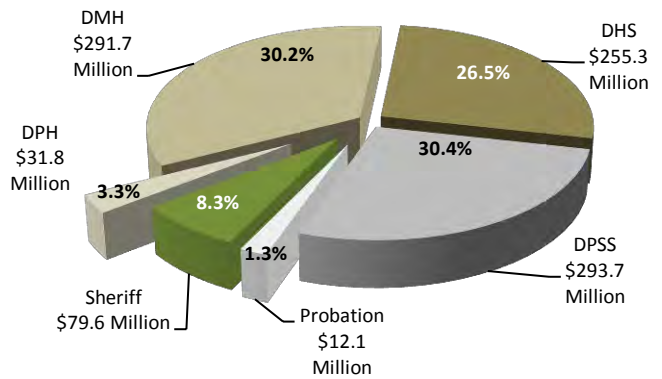
Overall Utilization and its Costs

The development of a strategic approach to homelessness for Los Angeles County reflects the Board’s recognition of the problem’s urgency both as a growing humanitarian crisis and as an ongoing strain on limited public resources. With respect to the latter, RES’s report is consistent with a mounting body of research showing the stark fiscal implications homelessness presents for public administrators and the agencies and programs they manage. The report examines Los Angeles County’s departments of Health Services (DHS), Mental Health (DMH), Public Health (DPH), Public Social Services (DPSS), the Sheriff, and Probation, six agencies that in FY 2014-15 spent an estimated combined total of \$965 million in providing services, benefits and care to the population of homeless single adults that forms the basis for RES’s analyses (Figure 1).

**Utilization and Spending by
General Service Area**

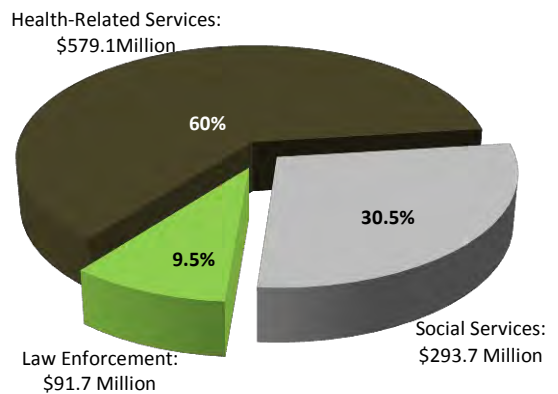
As shown in Figure 2, three-fifths of the County’s estimated spending on the study population in FY 2014-15 paid for health-related services provided through the County’s three health agencies (\$579.1 Million). DMH accounted for more than half of this health expenditure (\$291.7 Million), and DMH and DHS combined accounted

Figure1. Expenditures on Homeless Single Adults, by County Agency, FY 2014-15*



*Estimated Gross Total Expenditure: \$965 Million

Figure 2. Expenditures on Homeless Single Adults by General Service Area, FY 2014-15*



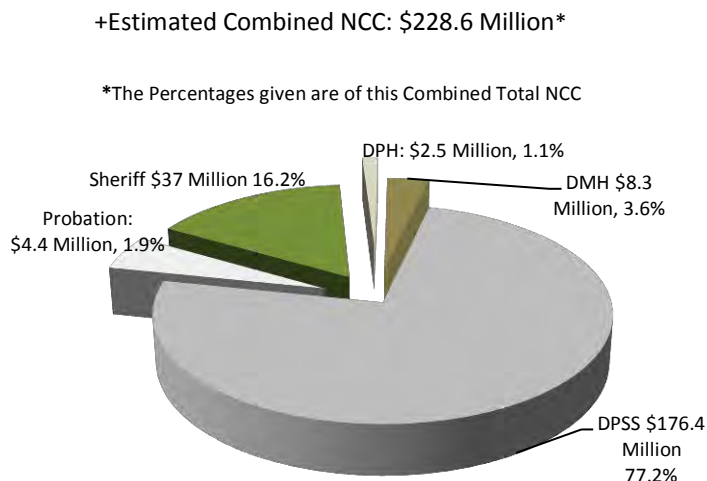
*Estimated Gross Total Expenditure: \$965 Million

for all but roughly 5%. DPSS incurred the largest costs of any of the six agencies (\$293.7 million) in providing cash benefits and homeless services through the General Relief (GR) Program, as well as Food Stamps benefits through the CalFresh program. Law enforcement spending on Sheriff’s Department arrests and jail days, along with rehabilitative services provided through Probation, accounted for 9.5% of the total combined expenditure.

Net County Costs

Given the expansion of Medi-Cal at the State level on January 1 of 2014, there may be some temptation to take comfort in the relative prominence of health-related expenditures observed in these costs and the presumed revenue this might suggest. However, while it is true that health expenditures comprise 60% of the costs shown in Figure 2, RES’s report estimates that roughly one-third of the spending across five of the six agencies examined – \$228.6 million out of \$710 million – was Net County Cost (NCC), which refers to spending that is not based on revenue and therefore represents charges to the County’s General Fund.¹ Largely due to payment of GR benefits, which are entirely NCC, DPSS incurred the most NCC among the agencies considered (\$176.4 million). The \$37 million in NCC attached to Sheriff’s Department arrests and jail stays comprises 16.2% of the total, and when these dollars are combined with Probation’s NCC for the fiscal year (\$4.4 million), law enforcement accounts for close to 18% of the total NCC. The two health agencies included in the calculations – DMH and DPH – account for the remaining \$10.8 million, 5% of the total NCC for the fiscal year.

Figure 3. Net County Cost+ Expenditures on Homeless Single Adults, by Agency, FY 2014-15*



Study Population

These cost estimates are based on a study population comprised of 148,815 single adults who each experienced at least one spell of homelessness between July 2014 and June 2015 (Table 1). The study group was assembled in a collaborative effort involving three County agencies – DHS, DPSS and Probation – each of which, upon request, provided files of single-adult clients who were flagged for being homeless in a service record during FY 2014-15.

Table 1. Homeless Single Adult Master File Data Sources		
Agency	Data Source	Clients to Study Group+
DPSS	LEADER / GR	114,037
LAHSA	HMIS	34,640
DHS	EDR/ORCHID	47,431
Probation	Probation Systems	2,795

+ These are counts of *unique clients by agency*

*The homeless DHS, Probation and DCFS clients added to the master file were encrypted and transferred using ELP protocols but were obtained through special requests because the homeless data flags in the administrative records kept by these agencies are not captured in ELP.

¹DHS’s FY 2014-15 costs and NCC are not included in this calculation for reasons described in section 2.2.1 of the full-length report.

The Los Angeles Homeless Services Authority also contributed a file of single adults with at least one record in the Homeless Management Information System (HMIS) of homeless services utilization during the 12-month observation period (Table 1). Clients in the files from the four agencies were assimilated into a composite file and then unduplicated, a process yielding the master study population of 148,815 single adults.

Data on Service Utilization and Service Costs

The estimates presented in RES’s report consider three different types of services and costs:

Direct Services and Benefits are those that can be directly attributed to individual utilizers of services such as costs associated with inpatient and outpatient health services, booking and jail day costs, and benefit payments to GR recipients. Records of the direct services costs included in the analyses are available to RES through the Enterprise Linkages Project (ELP) data warehouse and other data sources across the six County agencies considered in the analyses. Table 2 shows RES’s direct service cost estimates for services provided to the study population in FY 2014-15, by agency.

Table 2. Study Population Share of Direct Services Costs

Agency	Clients	Services	Costs	
			NCC	Total
DMH	39,073	1,044,874	\$6,161,044	\$252,245,388
*DHS	47,431	113,189	+	\$246,647,125
DPH	6,939	10,276	\$0	\$22,120,417
DPSS	114,037	688,766	\$176,443,752	\$241,060,006
Sheriff	14,754	19,433	\$32,824,849	\$74,133,443
*Probation	2,795	21,726	\$4,409,780	\$12,098,348
Total	148,815	1,898,264	\$219,839,425	\$848,304,728

+Section 2.2.1 provides an explanation for why DHS’s NCC is excluded from this report.
+These expenditures include administrative costs.

Non-Individualized Program Costs are expenditures attached to programs for which utilization of services at an individual level is either not recorded, not reliable, or was not available at the time this report was being prepared. Examples include the costs attributed to providing patients with supportive housing through DHS’s Housing for Health Program and the cost of services provided through the Sheriff’s Community Transition Unit (CTU). For these types of

Table 3. Additional Homeless Program Costs

Agency	Total	NCC	
		\$	%
DHS	\$8,616,167	+	+
DMH	\$18,495,731	\$1,135,000	6.1
DPH	\$8,363,528	\$2,514,024	30.0
DPSS	\$21,771,000	\$8,186,000	37.6
Sheriff	\$ 2,562,841	\$720,967	28.1
Total	\$59,809,267	\$12,555,991	21.0

+Section 2.2.1 of the full report provides an explanation for why DHS’s NCC is excluded from this report.

A total expenditure amount for FY 2014-15 was obtained and, to the extent possible, counts of the numbers of clients and numbers of *homeless* clients using services through these programs during the fiscal year were used to produce an estimate of the portion of the program costs attributable to homeless single adults. Table 3 shows the non-individualized expenditures added to RES’s cost estimates, by agency.

Administration: The third type of cost included in RES's estimates is administrative costs. All County agencies have stand-alone administrative appropriations in their annual budgets. These types of expenditures are an often overlooked but nevertheless critical component of the overall costs County agencies incur in providing services to their clients. The methods used to include these costs in RES's estimates varied depending on the type of information that was readily available.² Table 4 shows the administrative costs added to RES cost estimates, by agency.

Agency	Total	NCC	
		\$	%
DHS	\$50,797,395	+	+
DMH	\$20,961,592	\$962,137	4.6
DPH	\$1,659,031	\$0	0
DPSS	\$30,884,710	\$16,040,466	51.9
Sheriff	\$2,914,459	\$2,701,703	92.7
*Probation	\$1,863,146	\$1,620,937	
Total	\$109,080,333	\$21,325,243	19.6

+Section 2.2.1 of the full report provides an explanation for why DHS's NCC is excluded from this report.

*The estimated administrative costs for Probation, as well as the NCC attached to these costs replicate the proportions shown in the County's Recommended FY 2014-15 Budget, where administrative costs are 15.4% of the department's gross appropriation for the year and are 87% NCC.

Figure 4. Distribution of Study Population Costs by Cost Type, FY 2014-15⁵

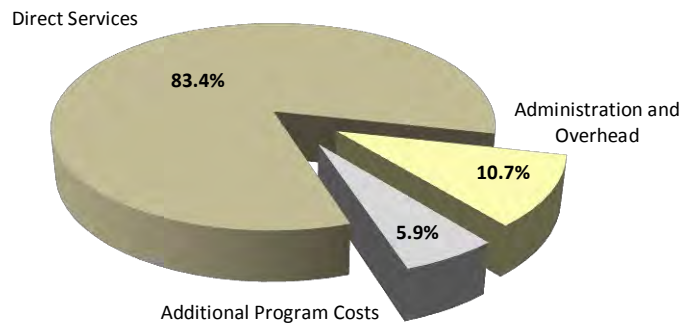


Table 5 summarizes the full cost estimates presented in the report. The six agencies examined spent an estimated combined total of \$964.5 million in providing services to the study population in FY 2014-15. The average cost per person over 12 months was \$6,481. DPSS spent the most in terms of Net County Cost (\$176.4 million), almost five times more than the Sheriff (roughly \$37 million). This is largely driven by GR, which is almost entirely NCC, as well as the high proportion of study population subjects who are GR recipients.

²For DHS and Probation, administrative costs are included in other service costs that are part of our estimates and, as a result of this, no additional calculation or extrapolation is needed. In the case of DPSS, FY 2014-15 administrative costs for GR and Calfresh were made available and RES performed some extrapolations to estimate the portion of these costs attributable to adults in the study population who utilized these benefits. For DMH, DPH and the Sheriff, administrative costs were not available to RES directly, which necessitated extrapolations based on information provided in the County's FY 2014-15 Recommended Budget.

Table 5. Costs for Services Provided to Homeless Single Adults in Los Angeles County, FY 2014-15

	*Client N=	% Study Population+	Estimated Expenditures			
			Direct Services**	TOTAL	NCC	Average Per Person
DHS	47,431	31.8	\$246,647,125	\$255,263,292	+++	\$5,381
DMH	39,073	26.3	\$252,245,388	\$291,702,711	\$8,258,181	\$7,466
DPH	6,939	4.7	\$22,120,417	\$32,142,976	\$2,514,024	\$4,632
DPSS	114,037	76.6	\$241,060,006	\$293,715,716	\$176,443,752	\$2,576
Sheriff	14,754	9.9	\$74,133,443	\$79,610,743	\$36,968,486	\$5,397
Probation	2,795	1.8	\$12,098,348	\$12,098,348	\$4,409,780	\$4,328
OVERALL TOTAL	148,815	100	\$848,304,728	\$964,533,787	\$228,612,438	\$6,481
Most Costly 5%	7,441	5.0	\$370,288,623	\$381,181,654	\$12,671,254	\$51,227
Most Costly 10%	14,882	10.0	\$476,865,568	\$499,132,698	\$27,474,588	\$33,539
Most Costly 20%	29,763	20.0	\$591,976,118	\$635,675,239	\$55,499,664	\$21,358
HMIS Chronic Homeless	7,675	5.2	\$54,747,979	\$60,467,810	\$5,134,767	\$7,879

*These are Unique Totals

+These percentages are based on the full study population, n=148,815

++In this context, the *Direct Services* category is intended to exclude both administrative expenditures and costs associated with programs that are recorded at an aggregate level in terms of utilization of the services they provide.

+++Section 2.2.1 of the full-length report provides an explanation for why DHS’s NCC is excluded from this report.

Key Findings

The Significance of Mental Health and Substance Abuse Services

The spread separating DMH from DHS and the Sheriff with respect to cost *per capita* is close to 40%. This is particularly remarkable given that close to one quarter of DHS’s inpatient and outpatient costs with respect to the study population were expenditures on psychiatric emergencies and hospitalizations (roughly \$58 million of \$246.6 million). The sum of DHS’s estimated psychiatric-related costs and DMH’s total costs - roughly \$350 million over 12 months - suggests that 60% of the County’s health spending on homeless single adults and more than one-third of the County’s overall spending on this population – are funds that pay for mental health treatment (Figure 5). When the study population’s DPH/SAPC costs (\$23.8 million) are added to the mental health/psychiatric total, the resulting implication is that close to 65% of the County’s health spending on homeless single adults and two fifths of the County’s overall spending on this population funds services for mental health and/or substance abuse treatment (Figures 5 and 6).

Figure 5. Combined Mental Health and Substance Abuse Costs+ in Relation to Health Costs Overall* for Services Provided to the Study Population, FY 2014-15

*Estimated Total Health Expenditure: \$579.1 Million

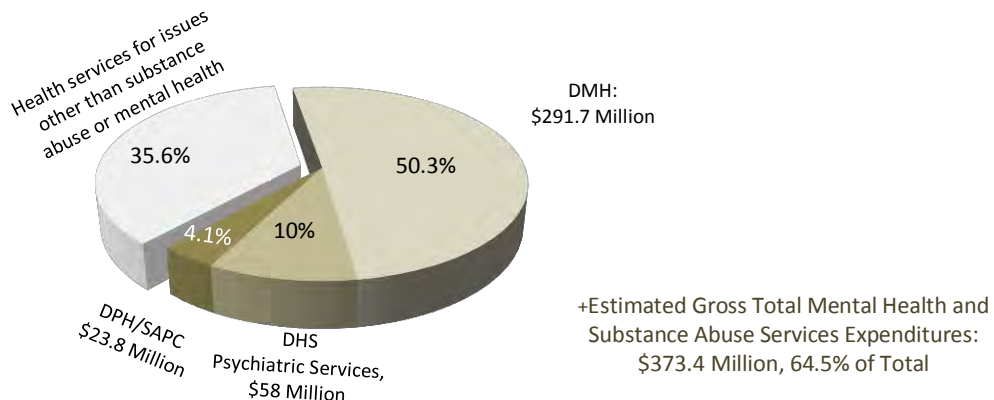
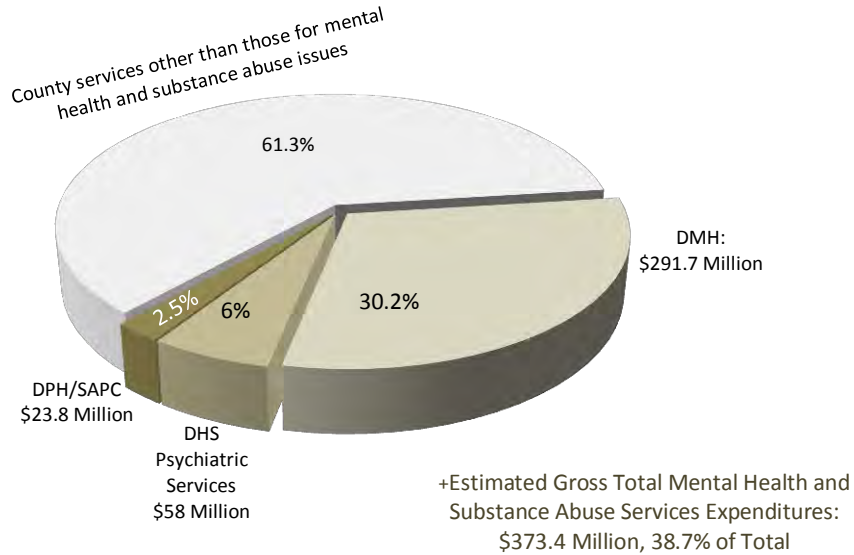


Figure 6. Estimated County Mental Health and Substance Abuse Expenditures+ in Relation to Overall Costs, FY 2014-15*

*Estimated Gross Total Expenditure Overall: \$964.5



Inpatient and Emergency Services

From the point of view of general service areas, mental health treatment is the biggest single component of the County’s costs with respect to homeless adults. Within the domain of mental health services, inpatient and emergency treatments are the primary factors driving spending. While only 13% of the DMH patients in RES’s study population required acute inpatient and/or residential services ($n=5,291$ adults), these patients accounted for roughly one-fifth of the DMH inpatient and outpatient costs for the study population over the observation period, at an average cost per patient (\$9,316) roughly 25% higher than the average for all the DMH patients in the study population. Psychiatric hospitalizations accounted for roughly 30% of DHS’s inpatient costs and psychiatric emergencies accounted for close to 38% of the department’s emergency costs.

Inmates and Probationers

RES’s analysis of County law enforcement data suggests one in ten adults in the study population were arrested by the Sheriff’s Department in FY 2014-15 ($n=14,754$ arrestees). The Department spent an average of \$5,396 on these arrestees in over 12 months and close to \$80 million overall (\$37 million NCC, 46.5% NCC). These expenditures paid for booking, jail days, medical services provided through the jail ward, and transitional services provided through the department’s Community Transitions Unit. Approximately seven in ten of the study population arrests involved time in custody that lasted no more than one month, but more than one in ten led to jail stays that lasted more than three months, and these lengthier stays accounted for more than half the jail costs for the study population (\$38.4 Million out of \$74.1 million). The costs of arrests and jail stays accounted for almost all of the law enforcement costs associated with the study population, as less than 2% of the study group received services through Probation during FY 2014-15.

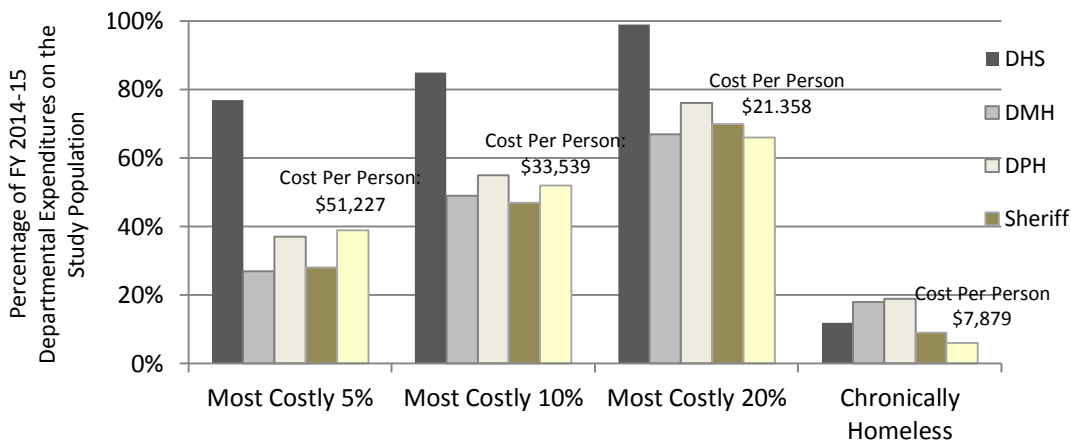
DPSS, the Primary Source of Basic Survival for the County’s Homeless Adults

DPSS incurred the largest overall costs among the agencies RES examined (\$293.7 Million). Almost four of every five adults in the study population was a DPSS client in FY 2014-15. As the provider of both a monthly cash stipend through the GR program and the distributor of Federal Food Stamp benefits through the Calfresh program, DPSS is the main source of basic subsistence for the homeless single adults in the County and a critical system of last resort. More than 7 out of 10 adults who received GR benefits during FY 2014-15 experienced a spell of homelessness at some point over the 12-months period. Two-thirds of these recipients experienced a disability that prevented them from participating in the GR program’s job- readiness activities for at least part of the time they received benefits, and more than 40% were coded by the department as unemployable during all the months in which they received benefits.

High-Volume Service Users, the Most Significant Driver of the Costs Associated with Homelessness

The concentration of spending on a small minority of high-volume service users is both the most striking aspect of RES’s results and one that is consistent with the current state of knowledge on the costs associated with homelessness. This pattern, as shown in Figure 7, is one observed from the standpoint of the County as a whole, as well as that of individual County agencies. While the average cost per person for the full study group across the six County agencies was \$6,481 for the 12-month observation period, the average among the most expensive 5% (n=7,441 adults) was eight times higher (\$51,227). The adults in this 5% subgroup accounted for \$381.1 Million in service costs, which is almost 40% of the total County expenditure on the study population. The intensity of concentrated spending slows somewhat thereafter, but the most expensive fifth of the study population (n=29,763 adults) nevertheless accounts for two-thirds of the County’s overall cost for the fiscal year.

Figure 7. County Expenditures* on the Most Expensive Adults in the Study Population, FY 2014-15+



*The average cost per person shown in the figure is based on expenditures across all six County agencies combined.

+DPSS and Probation are not shown because their benefits and services are fixed and provided on a recurrent and routine basis such that their costs per person do not vary dramatically (in contrast to the four departments included in Figure 7).

Fairly similar spending and utilization patterns are observed in looking at DMH, DPH and the Sheriff. In the case of DHS, the concentration is considerably more intensified. DHS's average cost per person for the most costly 5% of its patients in the study population ($n=4,743$ adults) is \$80,015. This subgroup, which comprises only 3.2% of RES's full study population, consumed \$189.8 million in DHS services, which is almost three-quarters of the department's expenditures on all the patients in the study group and roughly one-fifth of the County's costs on the entire study group. The most expensive 20% account for all but a small fraction of DHS's costs for services provided to the study population.

The Chronically-Homeless Subgroup

The chronically-homeless subgroup within the study population consists of 7,675 adults.³ Although there is some overlap between this subgroup and the most costly segments of the study population, the concentration of spending on the chronically homeless group is considerably less intensive. At the same time, however, this subgroup's average cost per person in looking at County services overall (\$7,879) is 21.6% higher than average and expenditures on these persons (\$60.5 million) constitute 6.3% of the County's overall spending on the study population.

Homeless Costs in the Context of Overall Departmental Resources

For each agency included in the report, RES measured the estimated expenditures in relation to a larger pool – or denominator - of departmental funding for services provided to adults. This was done to convey a sense of the relative impact of homelessness on departmental resources. This relational aspect of the overall analysis is imperfect and its intent is limited to a general approximation of the fiscal and financial significance of homelessness in Los Angeles County.⁴

³The HMIS file LAHSA made available to RES for the report included 7,675 persons flagged in the system because they met the federal Housing and Urban Development (HUD) criteria for categorization as *chronically homeless*. These adults comprise 5.2% of the study population. As adopted by HUD, the most up-to-date Federal definition of a *chronically homeless* person is one who: (a) is "homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; (b) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and (c) Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability." This definition includes any "individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria [a, b and c] before entering that facility"

⁴In making decisions about the inclusion and exclusion of funds from these larger gross financial denominators, a number of complexities prevent the uniform application of a standard set of business rules to all departments. Moreover, it is important to emphasize that budgets are related but analytically distinct from actual expenditures. In the case of DMH, as well as for part of the analysis of Probation, RES was able to build a larger departmental denominators based on information provided the unit received actual expenditures. For the other four other agencies, however, the funding denominators relied on information provided in the County's Recommended Budget for FY 2014-15. In these latter cases, RES proceeded with the assumption that budgets could be approached as a reasonable proxy for expenditures for the purposes of producing general estimates.

Figure 8. Combined Spending on the Study Group across Six County Agencies in Relation to their Approximate Total Expenditures on Adults Overall, FY 2014-15

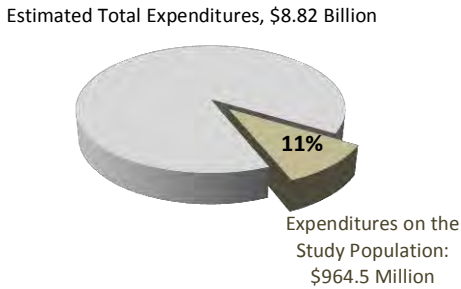
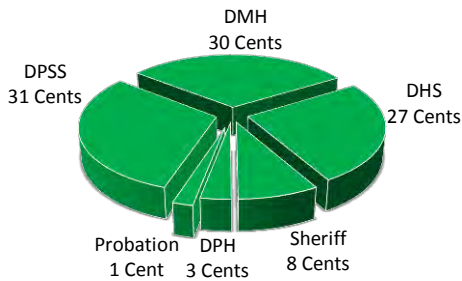


Figure 9. Estimated Distribution of Every County Dollar Spent on Providing Services to Homeless Single Adults, FY 2014-15



Given this caveat, the sum of these six departmental denominators, represented in Figure 8, is RES’s best effort to produce a reasonable approximation of the combined funding these agencies deployed in providing services to adults during FY 2014-15. Within this universe of overall spending, slightly more than \$1 out of every \$9 was spent on services provided to the study population. DPSS and DMH each account for about 30 cents on this dollar and DHS’s share is 27 cents. There is a significant spread separating these three agencies from the others. The Sheriff’s share is about 8 cents on the dollar, DPH accounts for three cents, and Probation accounts for a penny (Figure 9).

Maximizing the Effectiveness of County Service Dollars

The most general fiscal implication of RES’s report is that Los Angeles County spends close to \$1 Billion per year through the 6 departments included in the analyses in providing services and benefits to single adults who experience varying spells of homelessness in the course of a 12-month period. Additional, smaller costs are incurred by departments that are not included in this report. The establishment of a coordinated policy and

program environment that makes the most effective use of these resources is one of the fundamental objectives for the CEO’s *ad hoc* Homeless Initiative in delivering a set of coordinated County strategies to combat homelessness. RES’s analyses suggest that 5% of the homeless single adult population in the County - roughly 1 out of every 20 - consumes 40 cents of every dollar spent on the full population. Making inroads into the utilization patterns of this small segment of the population could ultimately free up funds to be reinvested strategically in ongoing efforts to combat homelessness. Accomplishing this will necessitate the implementation of more efficient and lasting alternatives that break repetitive cycles of Emergency Room visits, hospitalizations, expensive psychiatric inpatient treatments, arrests and re-arrests, etc.

Homelessness is not merely a problem of dollars and cents but, more importantly, one of the defining humanitarian issues Los Angeles County faces. Reducing and eventually ending the problem will not be easy or painless but is consistent with basic values of citizenship, fairness and decency. In forming the *ad hoc* Homeless Initiative, the Board of Supervisors and the County’s Chief Executive Officer have taken a decisive step in the process. The goal in preparing the report has been to arm the Initiative with information needed to present the Board with an effectively coordinated set of recommendations, one that provides the County with guidance in facing the difficult but worthwhile challenges that lay ahead and leads to enduring solutions.

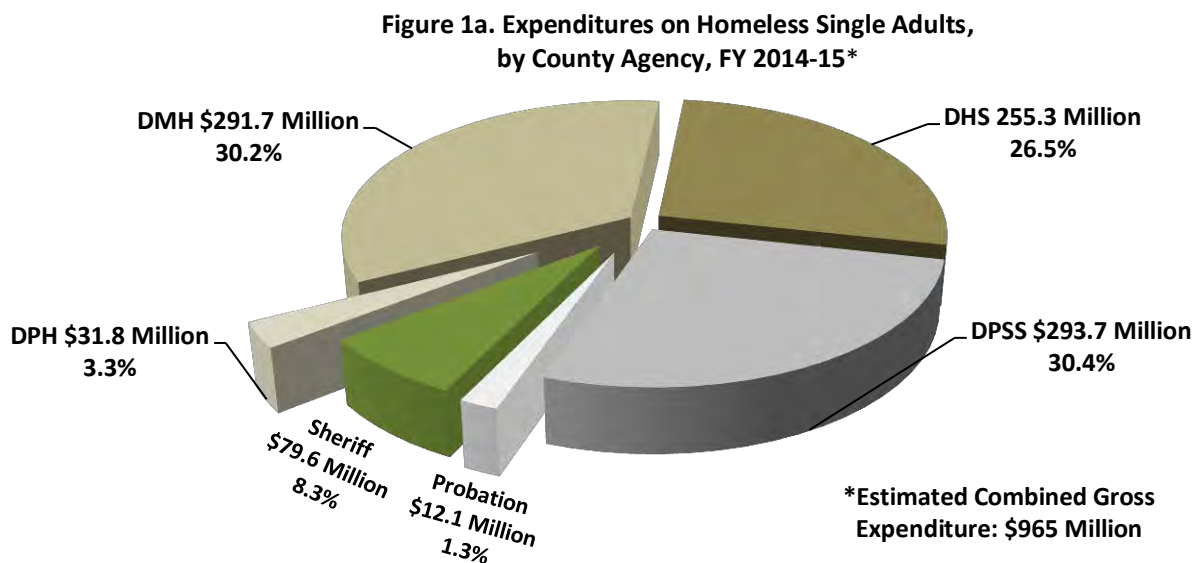
1. Introduction

This report presents estimates of the costs six Los Angeles County agencies incurred in providing services to roughly 150,000 single adults who experienced homelessness for varying periods of time during Fiscal Year (FY) 2014-15. The analysis informing the estimates was conducted at the direction of the Chief Executive Office's (CEO's) *Ad Hoc* Homeless Initiative, which is tasked with developing a coordinated set of recommended County strategies to combat homelessness. The information provided in what follows offers an overview of the fiscal significance of homelessness for the County as a whole, as well as from the point of view of the individual County agencies most intensively involved with the provision of services to homeless men and women. The analyses establish a basis in empirical data for the recommended strategies the Homeless Initiative will deliver to the Board of Supervisors.

1.1. Estimated Gross Total Expenditure in FY 2014-15

The development of a strategic approach to homelessness for Los Angeles County reflects the Board's recognition of the problem's urgency both as a growing humanitarian crisis and as an ongoing strain on limited public resources. With respect to the latter, this report is consistent with a growing body of research showing the stark fiscal implications homelessness presents for public administrators and the agencies and programs they manage. In the chapters that follow, we examine Los Angeles County's departments of Health Services (DHS), Mental Health (DMH), Public Health (DPH), Public Social Services (DPSS), the Sheriff, and Probation. In FY 2014-15, these six agencies spent an estimated combined gross total of \$965 million in providing services, benefits and care to the population of homeless single adults that forms the basis for our analyses (Figure 1a).

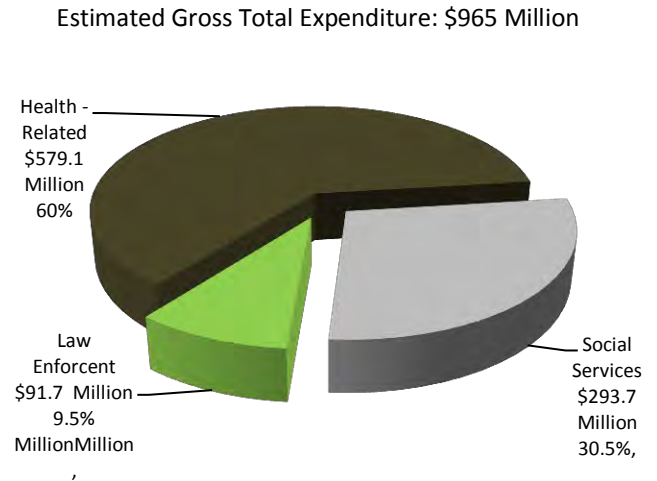
From the standpoint of all six agencies combined, the average cost per person over the 12 months of observation was \$6,481. Most significantly, however, the average cost among the most costly 5% of these service users ($n=7,441$ homeless single adults) was \$51,227 and these subjects accounted for almost 40% of the total combined annual gross costs. As will be discussed in detail in the final chapter of this report, a small minority of high-volume service users are the most impactful driver of the overall expenditures reflected in our estimates.



1.2. Spending within General Service Areas

As shown in Figure 1b, three-fifths of the estimated gross spending on single adults in the County who experienced homelessness in FY 2014-15 paid for health-related services provided through the County’s three health agencies (\$579.1 Million). DMH accounted for more than half of this health expenditure (\$291.7 Million), and DMH and DHS combined accounted for all but about 5%. DPSS incurred the largest costs of any of the six agencies (\$293.7 million) in providing cash benefits and homeless services through the General Relief Program, as well as Food Stamps benefits through the Calfresh program. Law enforcement spending on Sheriff’s Department arrests and jail days, along with rehabilitative services provided through Probation, accounted for 9.5% of the total combined expenditure.

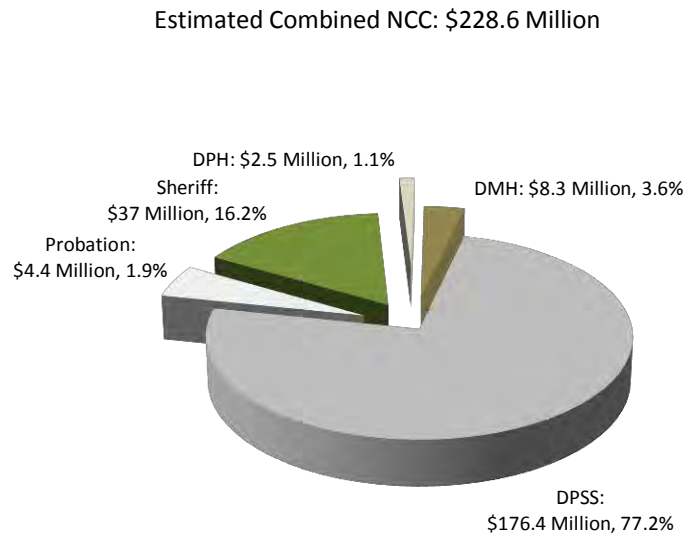
Figure 1b. Expenditures on Homeless Single Adults by General Service Area, FY 2014-15



1.3. Net County Costs

Given the expansion of Medi-Cal at the State level on January 1 of 2014, there may be some temptation to take comfort in the relative prominence of health-related expenditures observed in these costs and the presumed revenue this might suggest. However, while it is true that health expenditures comprise approximately 60% of the costs shown in Figure 1b, we estimate that roughly one-third of the spending across five of the six agencies examined – \$228.6 million out of \$710 million – was Net County Cost (NCC), referring to spending that is not driven by net revenue and therefore represents charges to the County’s General Fund.⁵ Largely due to payment of General Relief Benefits, which are almost entirely NCC, DPSS incurred the most NCC among the agencies considered (\$176.4 million). The \$37 million in NCC attached to Sheriff’s Department arrests and jail stays comprise 16.2% of the total, and when these dollars are combined with Probation’s NCC

Figure 1C. Net County Cost Expenditures on Homeless Single Adults, by Agency+



*The Percentages given are of the combined total NCC

+Section 2.2.1 provides an explanation for why DHS’s NCC is excluded from

⁵ DHS’s NCC is not included in this calculation for reasons that will be described in Chapter 2 of this report (Section 2.2.1).

for the fiscal year (\$4.4 million), law enforcement accounts for close to 18% of the total NCC. The two health agencies included in the calculations – DMH and DPH – account for the remaining \$10.8 million, which comprises close to 5% of the total NCC for the fiscal year.

1.4. The Study Population

Table 1a. Homeless Single Adult Master File Data Sources		
Agency	Data Source	Clients to Study Group+
DPSS	LEADER / GR	114,037
LAHSA	HMIS	34,640
DHS	EDR/ORCHID	47,431
Probation	Probation Systems	2,795

+ These are counts of *unique clients by agency*
 *The homeless DHS and Probation clients added to the master file were encrypted and transferred using ELP protocols but were obtained through special requests because the homeless data flags in the administrative records kept by these agencies are not captured in ELP

These cost estimates are based on a study population comprised of 148,815 unaccompanied adults who each experienced at least one spell of homelessness between July 2015 and June 2015 (Table 1a). The study group was assembled in a collaborative effort with three County agencies – DHS, DPSS and Probation – each of which, upon request, provided files of single-adult clients who were flagged as

being homeless in a service record during FY 2014-15. The Los Angeles Homeless Services Authority similarly provided a file of adults with at least one record in the Homeless Management Information System (HMIS) of using homeless services during the 12-month observation period (Table 1a). Clients in the files from the four agencies were assimilated into a composite file and then unduplicated. This process yielded a master study population file of 148,815 single adults who experienced homelessness in FY 2014-15.

1.4.1. Demographic Composition

Table 1b shows the study population’s demographic composition. Close to 70% of the subjects are male and their average age during the study period was 41, with almost four-fifths of the group was 27 years of age or older.⁶ Slightly more than 40% is African-American, 35% is White, close to 20 percent is Hispanic, and roughly 5% are “other,” a category which includes Asian and Pacific Islanders and American Indians.

Table 1b. Study Group Demographic Characteristics.		
Total Study Group N=148,815		
Age (Average = 41)	#	% of Study Group
18 to 26 (TAY)	32,555	21.87
27 to 45	57,028	38.34
46 to 64	55,347	37.20
65+	3,858	2.57
Gender	#	% of Study Group
Male	102,646	68.98
Female	45,115	30.32
Other	1,054	0.71
Race/Ethnicity	#	% of Study Group
White	51,993	34.81
African American	59,714	40.39
Hispanic	29,558	19.57
Others	7,550	5.23

1.4.2. The Exhaustiveness of the Study Population

To date, there is no uniformly applied homeless indicator in County service records, nor has a countywide mandate been imposed on service providers to ask their clients if they are homeless and to flag those who

⁶ This is the average age of the study population subjects based on the earliest record in FY 2014-15 that led to their inclusion in the study population (i.e. either DHS, DPSS or Probation service record in which they were flagged for homelessness or a record of using services recorded in HMIS).

say they are in agency-level service records. A sufficiently-sized study population therefore had to be built on data from the limited group of County agencies that track homelessness within their client populations. However, subjects were only included in the study group insofar as they used services these agencies provided during FY 2014-15 *and* were recorded as being homeless at the point in time of at least one of the service episodes.

1.4.2.1. A Comparison with LAHSA’s Homeless Population Estimate

Table 1c. Study Population versus LAHSA 2015 Estimate		
<i>n</i> =		
Study Population	148,815 single adults who experienced Homelessness in Los Angeles County during FY 2014-15.	
LAHSA Estimate	139,769 unaccompanied adults who experienced homelessness in the Greater Los Angeles COC in 2015	
Study Pop. Difference	#	%
	+9,046	+6.5%

A number challenges with respect to knowing how exhaustive and/or representative our study population is of the full universe of single adults who experienced homeless episodes within our 12-month observation window. However, efforts made by LAHSA to produce annual estimates offer some helpful clues. While

there are some key distinctions that should be noted, the roughly 150,000 single adults in our master study population is within 10,000 and 7% of LAHSA’s estimate of unaccompanied adults within the Greater Los Angeles Continuum of Care (COC) who were homeless during 2015 (Table 1c).⁴ The difference is likely due in large part to the more restrictive HUD definition of a homeless person and the smaller geographic area the LAHSA estimate covers, which does not include the cities of Long Beach, Pasadena, Glendale or Santa Monica.

1.5. Data and the Components of the Cost Estimates

1.5.1. Direct Service Costs

The estimates presented in this report consider three different types of costs. The first type, shown in Table 1d, is expenditure on services and benefits. That can be directly attributed to individual utilizers of services such as costs associated with inpatient and outpatient health services, booking and jail day costs, and benefit payments to

Table 1d Study Population Share of Direct Services Costs				
Agency	Clients	Services	Costs	
			NCC	Total
DMH	39,073	1,044,874	\$6,161,044	\$252,245,388
*DHS	47,431	113,189	+	\$246,647,125
DPH	6,939	10,276	\$0	\$22,120,417
DPSS	114,037	688,766	\$176,443,752	\$241,060,006
Sheriff	14,754	19,433	\$32,824,849	\$74,133,443
*Probation	2,795	21,726	\$4,409,780	\$12,098,348
Total	148,815	1,898,264	\$219,839,425	\$848,304,728
+Section 2.2.1 provides an explanation for why DHS’s NCC is excluded from this report.				
+These expenditures include administrative costs.				

⁷ To produce its estimate, LAHSA uses the point-in-time (PIT) results produced through its annual homeless count in combination with demographic information to produce an annualized estimate. The point-in-time count is parsed into persons who are homeless throughout the year and persons who recently became homeless. An extrapolation is then made to estimate the number of additional people who will likely become homeless over the year after the PIT count is completed. The initial estimate of (*n*=162,769) includes family members. In response to follow up inquiries about an estimate of the single adults in this larger count, LAHSA indicated that the PIT count includes 15,000 children, from which they project 7,000 families, meaning that between roughly 22,000 and 23,000 persons in the estimate are family members. The 139,769 estimate attributed to LAHSA in Table 2d is therefore the initial estimate minus the extrapolated family members (162,769-23,000 =139,769).

GR recipients. In all these examples, records documenting the delivery of the services and costs are structured so as to capture individual consumption in discrete episodes. Records of the direct services costs included in our analysis are available to us through the Enterprise Linkages Project (ELP) data warehouse and other data sources across the six County agencies considered in our analyses. All client-level service records examined for this report were encrypted and matched to our similarly encrypted master file of approximately 148,815 homeless single adults known to have experienced homelessness in FY 2014-15.

1.5.2. Non-Individualized Program Costs

Table 1e. Additional Homeless Program Costs			
Agency	Total	NCC	
		\$	%
DHS	\$8,616,167	+	n/a
DMH	\$18,495,731	\$1,135,000	6.1
DPH	\$8,363,528	\$2,514,024	30.0
DPSS	\$21,771,000	\$8,186,000	37.6
Sheriff	\$ 2,562,841	\$720,967	28.1
Total	\$59,809,267	\$12,555,991	21.0

+Section 2.2.1 provides an explanation for why DHS's NCC is excluded from this report.

The second type of cost is expenditure on programs for which utilization of services at an individual level is either not recorded, not reliable, or not available as of this writing. Examples include the costs attributed to providing patients with supportive housing through DHS's Housing for Health Program and the cost of providing jailed inmates with transitional services through the Sheriff's Community Transition Unit. For these types of programs, a total

expenditure amount for FY 2014-15 was obtained and, to the extent possible, counts of the numbers of clients and numbers of *homeless* clients using services through these programs during the fiscal year were used to produce an estimate of the portion of the program costs attributable to homeless single adults. Table 1e shows the non-individualized expenditures added to RES's cost estimates, by agency.

1.5.3. Administrative Costs

Table 1f. Study Group Administrative Cost Estimates			
Agency	Total	NCC	
		\$	%
DHS	\$50,797,395	+	+
DMH	\$20,961,592	\$962,137	4.6
DPH	\$1,659,031	\$0	0
DPSS	\$30,884,710	\$16,040,466	51.9
Sheriff	\$2,914,459	\$2,701,703	92.7
*Probation	\$1,863,146	\$1,620,937	
Total	\$109,080,333	\$21,325,243	19.6

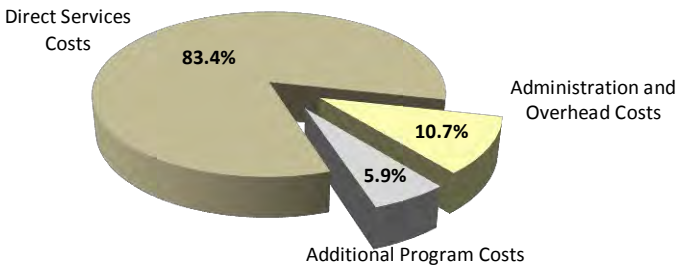
Section 2.2.1 provides an explanation for why DHS's NCC is excluded from this report.

*The estimated administrative costs for Probation, as well as the NCC attached to these costs replicate the proportions shown in the County's Recommended FY 2014-15 Budget, where administrative costs are 15.4% of the department's gross appropriation for the year and are 87% NCC.

The third type cost included in our estimates is administrative expenditures (Table 1f). All County agencies have stand-alone administrative appropriations in their annual budgets. These types of expenditures are an often overlooked but nevertheless a critical component of the overall costs County agencies incur in providing services to their clients. The methods used to include these costs in our estimates vary depending on a number of factors. For DHS and Probation, administrative and overhead costs are included in other service costs included in our estimates and, as a result of this, no

additional calculation or extrapolation is needed.⁸ In the case of DPSS, FY 2014-15 administrative costs for GR and CalFresh were made available and we performed some extrapolations to estimate the portion of these costs attributable to adults in the study population who utilized these benefits. For DMH, DPH and the Sheriff, administrative costs were not available to us directly, which necessitated extrapolations based on information provided in the County’s FY 2014-15 Recommended Budget.

Figure 1d. Distribution of Study Population FY 2014-15 Costs, by Cost Type⁹



1.6. Study Period

FY 2014-15 was selected as the study period for several reasons. Since this report will be used to inform recommendations on how to maximize the effectiveness and cost efficiency of resources allocated to Los Angeles County’s strategy to reduce homelessness, the Homeless Initiative directed RES to produce an annualized set of cost estimates based on the most recent Fiscal Year for which there is complete data.

1.7. The Limitations of Our Approach

A number of factors endemic to homelessness create challenges in attempting to produce a fully comprehensive account of services homeless people use and the costs associated with this utilization. Given the basic difficulties they encounter and the unpredictability of their lives from one day to the next, including the physical and mental disabilities often linked to extended periods of homelessness, the first step in conducting research on homeless men and women is to recognize that the population in question is more difficult to track with consistency and systematic rigor than is the case for persons who are observable within the mainstream currents of daily life. That only three of the six County agencies covered in this report even attempt to keep track of homelessness in their administrative records is a testament to this. Within this context, our approach in preparing this report was to examine the available information pragmatically and with as much flexibility as permissible without compromising the general validity of our analysis and calculations. It must be emphasized upfront that our analyses produce reasonably accurate *estimates*. Although these analyses are based on empirical data and are replicable, the resulting estimates are distinct from precision accounting or recordkeeping.

⁸For this reason, estimated administrative/overhead costs for Probation and DHS are shown in Table 1f but are not applied as an additional cost in the sections of this report that discuss services provided by DHS and Probation.

⁹The denominator for this figure is 5.4% larger than the total costs shown in this report because administrative/overhead costs for DHS and Probation are double-counted so as to avoid the overly speculative calculations that would be required to fully disaggregate them from the direct services costs.

These considerations are especially important with respect to the manner in which we assembled the master file for this report. The study group consists of persons who were homeless *at the time of a particular service episode* but not necessarily *at the time of all the services they used over the course of the full 12-month observation period*. On the one hand this means that there is an indeterminate amount of cost added to our estimates that corresponds to utilization that took place while the subjects in question were not homeless. On the other hand, however, our analysis does not capture services used by homeless persons who were not flagged for homelessness in the records of the four agencies that collaborated with us in building our master study population. This has significance, in particular, for the cost estimates we present for DMH, DPH's Substance Abuse Prevention and Control (SAPC) program, and the Sheriff's Department. Since these three agencies were not able to provide us with homeless client files for our study population, their homeless single adult clients are only included in our analysis if they also used services provided by one of the four agencies whose clients comprise our study population (DHS, DPSS, Probation and LAHSA). Given the size of the study group, we proceeded with the assumption that these countervailing tendencies towards over- and under-estimation would balance one another to an extent that makes our estimates valid aggregate approximations.

1.8. The Chapters and Organization of this Report

The chapters of this report are organized by general service area. Chapter 2 examines health-related services utilized through DHS, DMH and DPH. Chapter 3 focusses on law enforcement expenditures attached to arrests made by the Sheriff, jail days at Sheriff's facilities, and services provided through Probation. Chapter 4 examines DPSS's gross costs in providing the study population cash assistance and homeless services through GR and food stamps benefits through CalFresh. The concluding chapter considers the broad implications of the estimates described in Chapters 2, 3 and 4, and we examine the impact of the heaviest and most expensive service users in the study population.

2. Estimates of Expenditures on Health-Related Services

This chapter examines expenditures on services utilized through DHS, DMH and DPH. In FY 2014-15, these three agencies spent an estimated gross total of \$579.1 million in providing roughly 1.2 million health-related services to almost 77,000 unique homeless adults, more than half our study population. Patients in our study group used an average of 15.2 services through the three health agencies at an average of \$7,522 per patient over the year (Table 2a). The cost estimates provided in this chapter include additional administrative and program expenditures.

Table 2a. The Study Group's Overall Use of Health-Related Services, FY 2014-15

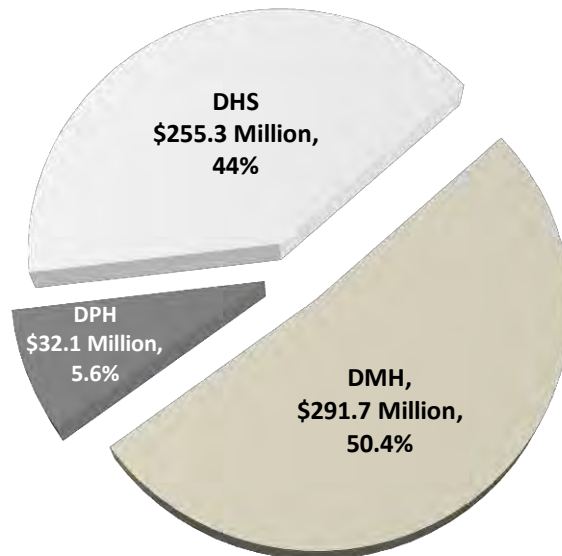
	# Patients	# Services	Average Cost Per+ Service	Costs+		Cost Per Patient+	
				NCC	Total	NCC	Total
DHS	47,431	113,189	\$2,255	*	\$255,263,292	*	\$5,382
DMH	39,073	1,044,874	\$279	\$8,258,181	\$291,702,711	\$211	\$7,466
DPH	6,939	10,276	\$3,128	\$2,514,024	\$32,142,976	\$362	\$4,632
Health Total	76,987	1,168,339	\$496	\$10,772,205	\$579,108,979	\$140	\$7,522
Top 5% in Cost	3,849	345,650	\$808	\$772,723	\$279,269,844	\$201	\$72,556
Top 10% in Cost	7,700	571,083	\$626	\$1,685,977	\$357,598,015	\$219	\$46,441
Top 20% in Cost	15,398	840,067	\$539	\$3,445,225	\$444,126,801	\$224	\$28,843
Chronic Homeless	7,467	121,131	\$444	\$920,244	\$53,730,618	\$123	\$7,196
%NCC: 3.3 (calculated based on DMH and DPH only)							
+Section 2.2.1 provides an explanation for why DHS's NCC is excluded from this report.							

2.1. Health Expenditures Overall

As shown in Figure 2a, DMH accounts for more than half the study population's total health costs for FY 2014-15, with expenditures summing to \$291.7 million. Less than 3% of these DMH costs are estimated to be NCC (\$8.3 million). DHS spent an estimated \$255.3 million, comprising 44% of the combined health expenditure on the study group. Finally, we estimate DPH spent \$32.1 million in providing treatment to the study population, amounting to 5.6% of the combined total health costs. While more than 7.8% of these DPH costs were NCC (\$2.5 million), expenditures associated with services provided through the department's Substance Abuse Prevention and Control (SAPC) program comprise three-quarters of our DPH estimate, (\$23.8 million), are 0% NCC.

Figure 2a. Health Expenditure on the Homeless Study Population, FY 2014-15

Estimated Combined Expenditure: \$579 million



2.2. DHS Expenditures

The estimated sum total of the costs DHS incurred in providing services to our study population in FY 2014-15 is \$255.3 million, an amount that includes \$50.8 million in administrative and overhead expenditures (19.9%). The DHS estimate is based on a data match against DHS records that yielded 47,431 patients who received services over the 12-month period of observation, a match rate of 31.9% of the study population (Table 2b).

2b. The Study Group's Overall DHS Utilization and the Associated Costs, FY 2014-15					
	# Patients	# Services	Average Cost Per Service+	Costs+ Total	Cost Per Patient+ Total
DHS In/Outpatient Subtotal 1	47,431	113,189	2,179	\$246,647,125	\$5,200
Psychiatric	10,544	14,689	3,946	\$57,968,235	\$5,498
Top 5% in Cost	2,372	20,221	9,386	\$189,795,876	\$80,015
Top 10% in Cost	4,743	40,494	5,384	\$218,036,545	\$45,970
Top 20% in Cost	9,486	68,551	3,563	\$244,274,202	\$25,751
HMIS Chronic Homeless	3,908	11,882	2,507	\$29,793,467	\$7,624
*Additional Programs	47,431	n/a	n/a	\$8,616,167	\$182
DHS Grand Total				\$255,263,292	\$5,381

2.2.1. Overview for DHS data

The projected costs and assumptions reflected in this report for the Department of Health Services (DHS) are based patient utilization records and the Department's FY 2014-15 average cost per workload. Therefore the cost amounts in this report for DHS reflect estimates and may not reflect actual costs. This is important to note in regard to possible planning exercises that focus on the DHS costs for the homeless population included in this study.

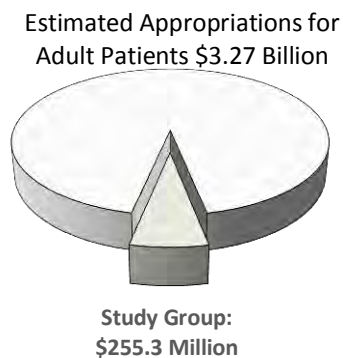
Further, there are additional considerations regarding the DHS costs that must be carefully reviewed prior to using the DHS data in future studies, such as the impact of Assembly Bill 85 (amended by SB 98), which implemented the Affordable Care Act in California and governs the County's minimum contribution to DHS for its total operations (aka "maintenance of effort" requirements).

2.2.2. DHS's Estimated Overall Costs

The DHS patients in our study population used roughly 113,000 outpatient and inpatient services, including emergency room visits and psychiatric emergencies and hospitalizations, for an average of 2.4 services and \$5,381 per person over 12 months. The \$246.6 million DHS inpatient and outpatient service subtotal comprises 96.6% of the grand total. The additional program expenditures, discussed further in section 2.3.2 total to \$8.6 million. The \$255.3 million grand total comprises 7.8% of the \$3.27 billion in DHS's adjusted budget allocation for services provided to adults.¹⁰

¹⁰To obtain an approximation of funds that pay for services provided to adults, we an overall FY 2014-15 budget allocation provided for us by DHS (\$3.88 Billion), which was then reduced 12%, to reflect the percentage of records in the ELP data warehouse of DJS services provided between 2010 and 2014 to unique DHS patients who were under the age of 18 at the time the services were delivered. While estimates of DHS expenditures presented in this chapter are based on the department's average workload cost calculations or FY 2014-15, by service type, the overall adult estimate represented in Figure 2b (\$3.27 Billion) is based on the department's adjusted budget allocation for FY 2014-

Figure 2b. DHS Expenditures on Adult Patients in Relation to the Department’s Estimated Budget Allocation, FY 2014-15



More than one-fifth of the patients in our DHS data match results received Psychiatric Emergency Services (PES) and/or was hospitalized at a DHS facility for psychiatric conditions. The total cost of the psychiatric inpatient and emergency services provided through DHS amounts to an estimated \$58 million, which is close to one quarter of the total DHS inpatient and outpatient cost for our study group, and is about 22.7% of the total DHS expenditure on the study population for the fiscal year.

The most costly 5% of the study group’s DHS patients in terms of inpatient and outpatient services ($n=2,372$ patients) are particularly striking. This segment of the study population consumed more three quarters of DHS’s inpatient and outpatient expenditures on the study group at an average cost of approximately \$80,000 per patient. The most costly fifth ($n=9,486$) consumed all but a small fraction of the inpatient and outpatient expenditures, at an average cost of roughly \$26,000 per patient.

2.2.3. Inpatient, Outpatient and Emergency Costs

A total of 3,970 adults, 8.4% of the DHS patients in our study group, were hospitalized and received roughly 41,000 days of inpatient treatment, an average inpatient stay of 10.5 days at an average cost of \$38,500 per inpatient episode. The total cost of these episodes is \$153.2 million. This means that less than 10% of the DHS patients in our study group, by virtue of their receipt of inpatient services alone, consumed approximately 60% of the study population’s total DHS expenditures for the fiscal year (Table 2c).

Table 2c Study Group Utilization of DHS Inpatient Services, FY 2014-15

	# Patients*	# Inpatient Days	Average Cost Per Service+	Costs	
				Total	Cost Per Patient Total
DHS Inpatient Subtotal 2	3,970	41,723	32,025	\$153,211,605	\$38,592
Psychiatric Inpatient	777	12,323	51,716	\$45,354,772	\$58,372
Top 5% in Cost	199	19,979	155,963	\$73,770,589	\$370,706
Top 10% in Cost	397	27,511	120,485	\$101,328,261	\$255,235
Top 20% in Cost	794	36,193	85,839	\$132,965,109	\$167,462
HMIS Chronic Homeless	415	5,199	27,288	\$19,237,799	\$45,356

Almost 30% of the study group’s inpatient days in FY 2014-15 were hospitalizations for psychiatric issues. The patients involved in these service episodes ($n=777$ patients) comprise less than 20% of the patients receiving inpatient services during the fiscal year, and less than 2% of the DHS patients in our study group,

15 and not actual expenditures. The denominator and numerator in the figure and accompanying discussion are therefore not fully standardized. For this reason, we emphasize that the inferences drawn are only intended to provide an approximation of how DHS’s expenditures on homeless single adults stand in relation to the department’s larger budget.

but they consumed 18% of the total DHS estimated expenditure on the study group. The average psychiatric inpatient cost per person (\$58,372) is 50% higher than the study group’s average inpatient cost per person.

More than one-third of the DHS patients in our study population were involved in 25,395 Emergency Room (ER) episodes during FY 2014-15 ($n=16,526$ patients), an average of 1.5 visits per ER patient at a total cost of \$33.2 million, 13% of the overall DHS expenditure on the study population for the fiscal year. More than 60% of the patients visiting DHS ERs received Psychiatric Emergency Services (PES) at a total cost of \$12.6 million, which accounts for more than 37% of the study group’s emergency expenditures overall.

2.2.4. Additional DHS Costs

As shown in Table 2b, we add \$8.6 million to our DHS estimate based on expenditures attached to additional programs. These are estimated costs associated with Housing for Health with and Recuperative Care of \$5.8 Million and \$2.8 million, respectively, for the Fiscal Year.

2.3. DMH Expenditures

The bulk of our analysis of the study group’s use of DMH services is based on comprehensive datasets of outpatient, crisis stabilization, acute inpatient and residential services records, which were prepared by DMH’s Clinical Informatics division. A data match linking our study population to these records produced 39,073 patients who received mental health treatment through the department in FY 2014-15, a match rate of 26.3%. These patients used more than 1 million inpatient and outpatient services for a total cost of \$252.2 million. When additional programming and estimated administrative expenditures are included, the grand total estimate for the fiscal year is \$291.7 million, an average of \$7,466 per patient. We additionally estimate that \$8.3 million (2.8%) of the total expenditure was NCC

Table 2d. The Study Group’s Overall DMH Utilization and the Associated Costs, FY 2014-15

	#* Patients	# Services	Average Cost Per Service	Costs+		Cost Per Patient+	
				NCC	Total	NCC	Total
DMH OP&IP Subtotal	39,073	1,044,874	\$241	\$6,161,044	\$252,245,388	\$158	\$6,524
Top 10% in Cost	3,907	441,652	\$278	\$2,623,238	\$122,765,101	\$671	\$31,422
Top 20% in Cost	7,814	649,821	\$260	\$3,800,588	\$169,009,319	\$486	\$21,629
HMIS Chronic Homeless	5,987	190,525	\$243	\$1,261,388	\$46,317,928	\$211	\$7,736
Additional DMH Services				\$1,135,000	\$18,495,731	\$29	\$473
**Non-Administrative Subtotal				\$7,296,044	\$270,741,119	\$187	\$6,878
Estimated Administrative Subtotal				\$962,137	\$20,961,592	\$25	\$536
DMH Grand Total				\$8,258,181	\$291,702,711	\$211	\$7,466

%NCC: 2.8%

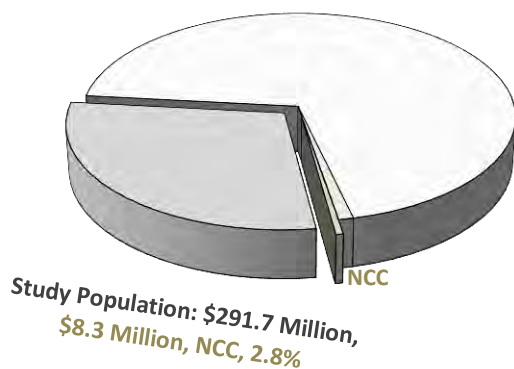
*A count of unique patients can be produced by un-duplicating based on either the DMH patient ID ($n=40,868$) or the master file ID (*Cohort_PID*) we created for our analysis of the full study group across all the agencies included in this report ($n=39,073$ DMH patient). This reduces the count by 4%. We use cohort PID for the sake of maintain consistency throughout the report and, relatedly, because parts of the report will merge and un-duplicate client across multiple agencies. Additionally, some of patients may have multiple DMH IDs.

+Cost Estimates are rounded to the nearest dollar.

**This row includes the programs tabulated separately in Table 3k. The administrative costs for those programs are not disaggregated from their total costs. For this reason, the costs of those programs are not included in the expenditure totals we use to estimate DMH’s administrative expenditures associated with providing services to our study population.

Figure 2c. DMH Expenditures on Adult Patients, Overall and for the Study Group, FY 2014-15

Estimated Adult Portion of DMH Budget
\$937.1 Million (\$28.6 Million NCC, 3.1%)



Based on calculations that draw on information DMH shared with us and the DMH section of Los Angeles County’s Recommended Budget for FY 2014-15, the department’s costs with respect to the study population comprise 31.1% of the \$937.1 million we estimate to be the adult share of DMH’s total budgeted appropriations for the fiscal year. This suggests that \$1.50 out of every \$5.00 DMH spends on adults pays for treatment provided to homeless patients.

Expenditures on the top 10% of the group in terms of total outpatient and inpatient costs (3,907 patients at a cost of \$122.8 million) were 4.6 times higher than for the study group as a whole. Patients in this top decile accounted for 42.3% of the total services used over the year and close to half the costs. The top fifth (7,814 patients at a total cost of \$169 million) consumed roughly 62% of the total outpatient and inpatient services provided to the study population and accounted for two-thirds of their overall costs.¹¹

2.3.1. Inpatient and Outpatient Services

DMH spent \$203 million in providing more than one million outpatient services to the patients in the study population, including crisis stabilization services, during FY 2014-15. (Table 2e). These expenditures account for 80.5% of the total FY 2014-15 DMH inpatient and outpatient service costs for the study population and 69.2% of the total expenditure on the study population.¹²

The most expensive 5% of the DMH patients in the study population (1,894 patients requiring expenditures of \$62.9 million) consumed 31% of both total outpatient services and outpatient costs. The 12-month cost per patient within this subgroup (\$33,185) is more than six times the average for all patients in the study population using outpatient services (\$5,356). Among the top 20% (7,578 patients at a total cost of \$130.5 million), the outpatient cost per patient (\$17,222) is more than three times the average.

¹¹In reviewing this report prior to its release, DMH asked us to include the following caveat: “The DMH expenditures on adult patients and the related costs presented in this summary do not fully capture all costs associated with serving this population. Therefore, should this report lead to further action, DMH recommends a more comprehensive and comparable analysis be conducted before action is taken.”

¹²Although Psychiatric Emergency Services (PES) provided at County Hospitals are Department of Health Services (DHS) treatments in terms of their provision and associated costs, they are captured in DMH data. To avoid double counting their costs in our report, we filtered PES episodes from the DMH service records for this analysis. Per DMH’s instructions, these service episodes were eliminated from the data by excluding all Mode 10 (SFC 24) services from the three DHS billing providers in the DMH services data we used for our analysis. The billing providers are (1) 1953 LAC-OLIVE VIEW/UCLA MEDICAL C; (2) 1962 LAC HARBOR UCLA MEDICAL CTR; (3) 1956 LAC/USC MEDICAL CENTER. Please note that Mode 15 services from these providers were retained in the data and counted. A total of 11,683 PES services were filtered out based on these guidelines.

Table 2e. Study Group Utilization of DMH Outpatient and Crisis Stabilization Services, FY 2014-15

	# Patients*	# Services	Average Cost Per Service	Costs+		Cost Per Patient+	
				NCC++	Total	NCC++	Total
Outpatient	36,644	1,017,071	\$193	\$0	\$195,843,119	\$0	\$5,344
Crisis Stabilization	5,715	15,181	\$469	\$0	\$7,113,919	\$0	\$1,245
DMH Subtotal 1	37,890	1,032,252	\$197	\$0	\$202,957,038	\$0	\$5,356
Top 5% in Cost	1,894	318,245	\$197	\$0	\$62,851,516	\$0	\$33,185
Top 10% in Cost	3,789	475,622	\$196	\$0	\$93,056,998	\$0	\$24,560
Top 20% in Cost	7,578	670,337	\$195	\$0	\$130,508,444	\$0	\$17,222
HMIS Chronic Homeless	5,890	187,755	\$193	\$0	\$36,226,828	\$0	\$6,151
				%NCC:: 0%			
*The sum of the numbers of patients who used outpatient services and crisis stabilization is larger than the subtotal, because the subtotal captures total unique clients and a patient can use both services multiple times.							
**The gross costs of the outpatient and crisis stabilization services shown in Table 2 are provided by service in the DMH data.							
+Cost Estimates are rounded to the nearest dollar.							
++According to information provided by DMH none or almost none of the costs shown in Table 2 would be NCC. For the purpose of making estimates, we assumed these costs to be 0% NCC.							

Inpatient services comprise less than 2% of the study group’s observed service episodes in the DMH data, but this is not especially meaningful since these services last multiple days (Table 2f). If service days are compared as opposed to service episodes – with one-day outpatient services counted as 1 day each - then inpatient services account for close to 12% of the total inpatient and outpatient service days observed for FY 2014-15.¹³ More than 12% of the observed DMH patients ($n=5,291$) received 121,487 days of inpatient care over 12 months, an average of 23 inpatient days per person, though the distinction between this average of cumulative *total inpatient days* per patient and the average duration of *discrete service episodes* should be underscored. The study population’s average length per acute inpatient episode is 6 days, and the average length per residential service episode is 46 days. Looking at the two types of inpatient services combined, the average length is 10 days.¹⁴

An estimated \$49.3 million was spent in providing inpatient services to the observed DMH patients, which includes residential services (Table 2f). Inpatient costs therefore constitute about one-fifth (19.5%) of DMH’s total inpatient and outpatient expenditures on the study group in FY 2014-15, and they comprise close to 17% of DMH’s overall study group expenditures. The \$41.4 million spent on *acute inpatient* services amounts to 84% of the inpatient expenditures and 14% of the overall expenditures over 12 months.

¹³ Psychiatric inpatient services provided at DHS facilities were deleted using the same criteria for the deletion of Psychiatric Emergency Services at DHS facilities to ensure costs are not double counted, i.e. Mode 10 services from the same three billing providers: (1) 1953 LAC-OLIVE VIEW/UCLA MEDICAL C; (2) 1962 LAC HARBOR UCLA MEDICAL CTR; (3) 1956 LAC/USC MEDICAL CENTER. Per DMH’s guidance, we verified that these services are captured in the DHS data we receive through the Enterprise Linkages Project (ELP data warehouse). A total of 849 DHS psychiatric inpatient services were deleted from the data.

¹⁴ For cases where the discharge date for an inpatient service episode is missing, we adhered to DMH’s instructions to calculate a proxy length of service equal to the average service duration for the facility in question. In cases where the actual discharge date was after the end of FY 2014-15, inpatient days were only counted through June 30, 2015.

Table 2f. Study Group Utilization of DMH Inpatient and Residential Services, FY 2014-15

	# Patients*	# Inpatient Days	Average Cost Per Service+	Costs+		Cost Per Patient+	
				NCC	Total	NCC	Total
Acute Inpatient	4,829	69,034	\$3,605	\$5,177,550	\$41,420,400	\$1,072	\$8,577
Residential	956	52,453	\$6,957	\$983,494	\$7,867,950	\$1,029	\$8,230
DMH Subtotal 2	5,291	121,487	\$3,905	\$6,161,044	\$49,288,350	\$1,164	\$9,316
Top 5% in Cost	265	40,452	\$5,389	\$1,672,650	\$13,381,200	\$6,312	\$50,495
Top 10% in Cost	529	60,118	\$5,233	\$2,623,238	\$20,985,900	\$4,959	\$39,671
Top 20% in Cost	1,058	81,717	\$4,864	\$3,800,588	\$30,404,700	\$3,600	\$28,738
HMIS Chronic Homeless	853	24,704	\$3,643	\$1,261,388	\$10,091,100	\$1,479	\$11,830
%NCC: 12.5%							
*The sum of the numbers of patients who used outpatient services and crisis stabilization is larger than the subtotal, because the subtotal capture total unique clients and a patient can use both services multiple times.							
+Deriving exact inpatient costs for DMH is complex due to the variety of contract types, reimbursement mechanisms, and authorization processes involved. For this study, inpatient and residential services costs were standardized and estimated by multiplying the inpatient length of stay by a \$600/day for acute inpatient services and \$150/day for residential services. The \$600 day rate for acute inpatient treatment was the LACDMH Medi-Cal inpatient Fee for Service for individuals aged 22 to 64 who used these services n FY14-15. The \$150 day rate for residential services is a FY 2014-15 proxy estimate provided by DMH. The tabulated cost estimates are rounded to the nearest dollar.							

2.3.2. Additional DMH Services and Administrative Costs

The technical appendix to this report shows DMH programs not captured in the data available through the ELP data warehouse or other sources but that have homeless-related costs added to the DMH total for the study population.¹⁵ The total cost of these programs is roughly \$18.5 million, which is equal to 6.3% of DMH’s total expenditures on the study population. Since the overlap between patients participating in these programs and patients in our study group is not known, the addition of their costs to the overall DMH estimate may inflate cost per person estimate by a maximum of \$474 (6.3%).¹⁶

In DMH’s FY 2014-15 budget, funds allocated to administration (\$156.7 million) are equal to 8.3% of the gross total appropriation for the fiscal year (\$1.88 billion).¹⁷ This is the basis for our estimated administrative costs for the study population of almost \$21 million, which is equal to 8.3% of the combined inpatient and outpatient subtotal shown in Table 2d.

¹⁵The technical appendix is available upon request. For an electronic copy, please contact Max Stevens at maxbstevens@ceo.lacounty.gov.

¹⁶Since the costs of these programs are not included in our calculation of administrative costs, the maximum overstatement they produce per person can be derived by subtracting their combined total (\$18.5 million) from the grand total shown in Table 2d (\$291.7 Million) and (a) dividing the difference (\$273,206,980) by the number of DMH patients in the study population and (b) subtracting this new cost per patient (\$6,992) from the cost per patient with the eight programs included in the denominator: \$7,466 – \$6,992=\$474 = maximum overstatement assuming none of the patients in the added programs are included in the outpatient and inpatient data match. However, this maximum overstatement is what would be the case if none of the DMH patients in our study group participated in the additional programs, which is highly unlikely.

¹⁷ This proportionality is retained in our estimate of the adult portion of the budget, where \$71.9 million are assumed to be the administrative costs attached to an \$865.2 million gross appropriation because all budget categories were reduced by the same degree in making the adult adjustment.

2.3.3. Net County Costs

The DMH section of Los Angeles County's Recommended Budget for FY 2014-15 indicates that 1.4% of the \$1.6 billion gross appropriation for DMH outpatient services is NCC. However, based on more specific information we received from DMH, a 0% NCC assumption was deemed to be appropriate for expenditures on the study group's DMH outpatient services utilization.¹⁸

The Recommended Budget categorizes 12.5% of psychiatric (DMH's) hospitalization costs as NCC. This is applied to the inpatient and residential costs for our study group (\$49.3 million), producing an estimate of \$6.2 million NCC. We additionally add the \$1.1 million NCC shown in Table 3k and slightly less than 1 million in administrative NCC for a total study group NCC of \$8.3 million, comprising 2.9% of the total DMH expenditure on the study population.

2.4. DPH Expenditures

DPH spent an estimated \$32.1 million, (\$2.5 million NCC, 7.8%) on patients in our study population. This result is based on a data match linking the study population to records of roughly \$23.8 million in services provided through the agency's Substance Abuse Prevention and Control (SAPC) program, as well as on information provided by DPH on its Community Health Services (CHS), HIV and STD, and Tuberculosis Control programs, which add a combined total of approximately \$8.4 million to the grand total (Table 2g). However, since necessary information on these three programs was only available for FY 2013-14, the funds they add to the estimate are imputed expenditures and assume that the volume of utilization and the associated costs would not differ significantly over two consecutive years.

2.4.1 Total SAPC Expenditures

Table 2g summarizes DPH's FY 2014-15 expenditures on SAPC patients in the study population, which sum to \$23.8 million, all of which is net revenue. The costs comprising this estimate funded the provision of substance use disorder treatment to almost 7,000 patients who initiated and used 10,276 services over the course of 12 months, an average of roughly 1.5 services per person and \$2,314 per service. DPH informs us that the SAPC service episodes captured in ELP are 0% NCC and that this extends to the program's administrative costs, which means that 100% of the program's expenditures – direct services and overhead

¹⁸DMH informs us that almost all outpatient services received by the types of adults in our study population are non-NCC, even if no revenue is generated. To illustrate the complexities involved, DMH notes the following: "if an adult client has Medi-Cal based on disability, then DMH would receive 50% of the cost as Medi-Cal revenue (Federal Financial Participation – FFP), but more than likely were would use MHSA dollars that [DMH] draws down to cover a 50% 'local match'. If the client did not have Medicare, Medi-Cal or other health coverage, the services may well be covered 100% by MHSA. However, DMH also receives several million dollars each year through a SAMSHA Block Grant, which under certain conditions would be used to cover the cost of care to indigent clients in lieu of using MHSA. The cost of acute inpatient stays in Fee For Service facilities is covered by the State, acute PDP's however are NCC. IMD's, a subset of the non-acute residential, on the other hand would be exclusively true NCC. I also believe that the State Hospital stays are NCC. For non-IMD non-acute residential facilities, it is even more complex but would involve a mix of MHSA, Medi-Cal, AB109, etc." *Authors note:* The County's Recommended Budget for FY 2014-15 categorizes 1.4% of DMH's appropriations for outpatient services as NCC (\$22.7 million out of \$1.64 billion). Alternatively categorizing 1.4% of the study group's outpatient costs as NCC would increase the total NCC for the year by (\$195.8 million*0.014=) \$2.7 million for FY 2014-15, increasing the total NCC for DMH to \$11 million, which would mean that 3.8% of the expenditures on the DMH patients in our study group were NCC.

– are net revenue. SAPC services available to adults receiving General Relief, which are provided through DPSS’s Mandatory Substance Abuse Recovery Program (MSARP), are not included here but are included in the administrative costs for the GR program, which are a component of the estimates we produce for DPSS’s FY 2014-15 expenditures.

2g DPH Cost Estimate for the Study Population, Overall and by Program FY 2014-15						
Overall	Patients	Costs		Cost Per Patient*		
		NCC	Total	NCC	Total	
Grand Total	6,939	\$2,514,024	\$32,142,976	\$362	\$4,632	
						NCC: 7.8%
SAPC	Patients	Costs		Cost Per Patient		
		NCC	Total	NCC	Total	
Non-Administrative Total	6,939	\$0	\$22,120,417	\$0	\$3,188	
Administrative Costs	6,939	\$0	\$1,659,031	\$0	\$239	
DPH Subtotal A (SAPC Total)	6,939	\$0	\$23,779,448	\$0	\$3,427	
						NCC: 0%
**Additional Programs	Patients	Costs		Cost Per Patient		
		NCC	Total	NCC	Total	
DPH Subtotal B	Unknown	\$2,514,024	\$8,363,528	n/a	n/a	
Community Health Services	unknown	\$2,305,028	\$2,305,028	n/a	n/a	
HIV and STD Programs Homeless	3,339	\$0	\$5,575,120	\$0	\$1,670	
Tuberculosis Control Homeless-Lodging	75	\$44,296	\$280,034	\$591	\$3,734	
Tuberculosis Control Incentives	328	\$164,700	\$203,346	\$502	\$620	
Tuberculosis Control Total	403	\$208,996	\$483,380	\$519	\$1,119	
						NCC:30.1%
*Since the SAPC patient count is used in the calculation of overall costs per patient, these costs will be inflated to the extent that there are non-SAPC patients among those in the study population using services through CHS Tuberculosis Control HIV and STD Programs. The number of non-overlapping patients is not known.						
**The study group cost totals for these programs include their administrative costs						

The provision and measurement of substance use disorder services is distinct from the manner in which other health services are typically delivered and recorded in that service episodes frequently remain open over several months and incur repeated costs over this period. Measures of utilization consequently appear to be more dispersed among the patient population than what is observed in looking at the DHS and DMH patients in our study population, though the total cost remains fairly concentrated among the most expensive patients. As shown in Table 2h, the most costly 5% of the study population’s SAPC patients (n=347) account for only 6.2% of the services used but roughly 37% of the total costs (\$8 million out of \$23.8 million). The cost per service among these patients is 4.5 times higher than the average for all the observed SAPC patients in the study group and their cost per person is 7.4 times higher than the average. The most expensive fifth of the confirmed DPH patients consumed less than one quarter of the services, but more than three quarters of the total cost.

Table 2h. The Study Population's Utilization of DPH/SAPC Services Overall , FY 2014-15

	# Patients	# Services	Cost Per Service	Costs+		Cost Per Patient+	
				NCC	Total	NCC	Total
Non-Admin Total	6,939	10,276	\$2,153	\$0	\$22,120,417	\$0	\$3,188
Administrative Costs	6,939	n/a	n/a	\$0	\$1,659,031	\$158	\$239
SAPC Total	6,939	10,276	\$2,314	\$0	\$23,779,448	\$0	\$3,427
*Top 5% in Cost	347	636	\$13,844	\$0	\$8,804,528	\$0	25,373
*Top 10% in Cost	694	1,268	\$10,418	\$0	\$13,209,810	\$0	19,034
*Top 20% in Cost	1,388	2,494	\$7,251	\$0	\$18,083,088	\$0	13,028
*HMIS Chronic Homeless	761	2,087	\$2,236	\$0	\$4,666,684	\$0	6,132
NCC: 0%							

2.4.2. SAPC Expenditures by Service Type.

The \$22 million in expenditures on residential services account for 85% of the study population's SAPC costs. As shown in Table 2i, the most expensive 20% of patients using these services consumed about two-thirds (\$14.5 million) of the total cost of residential services in FY 2014-15. Table 2i additionally shows the costs associated with Narcotic Treatment Program Services, which generate daily methadone dosage costs.

Table 2i Study Group Utilization of SAPC Narcotic Treatment and Residential Services, FY 2014-15*

	# Patients*	# Service Days	# of services	Average Cost Per Episode	Costs+		Cost Per Patient+	
					NCC	Total	NCC	Total
**Narcotic & Detox	1,331	9,987	1,728	690	\$0	\$1,192,039	\$0	896
+Narcotic Only	1,391	208,136	1,961	1,061	\$0	\$2,081,360	\$0	1,496
++Residential	2,032	162,650	2,386	7,855	\$0	\$18,742,532	\$0	9,224
DPH Subtotal 2:	4,089	380,773	6,075	3,624	\$0	\$22,015,930	\$0	5,384
Top 5% in Cost	204	53,274	339	18,060	\$0	\$6,122,400	\$0	30,012
Top 10% in Cost	409	85,687	643	15,189	\$0	\$9,766,428	\$0	23,879
Top 20% in Cost	818	127,077	1,201	12,045	\$0	\$14,465,700	\$0	17,684
HMIS Chronic Homeless	463	83,714	1,270	3,659	\$0	\$4,646,554	\$0	10,036
NCC: 0%								

*The costs calculated in this table are based on average service costs, by service type, which were calculated for us by SAPC program personnel. For service episodes that commenced prior to FY 2013-14 and/or continued beyond the end of the fiscal year, costs incurred during our 12-month observation window are applied.

**The costs applied to the SAPC Narcotic Treatment Program Services with no Detox component added are methadone dosage charges of \$10 per day.

+SAPC Narcotic Program Treatment Services are assigned the average cost of a SAPC outpatient service in FY 2014-15 (\$), as well as a \$10 per day methadone dosage cost for the duration of the service episode or 220 days, whichever is shorter.

++The average cost applied to the observed SAPC residential services are \$140.91 on the day of admission and \$114.85 on each additional bed day.

SAPC Outpatient and Day treatments and costs are added to our overall SAPC/DPH total but are not shown in a tabulation. While half the observed SAPC patients in the study population used these services, their total costs (\$104,487) account for less than one-half of one percent of the estimated total FY 2014-15 expenditures on the SAPC patients in our study population.

2.4.3. Additional DPH Programs and Costs

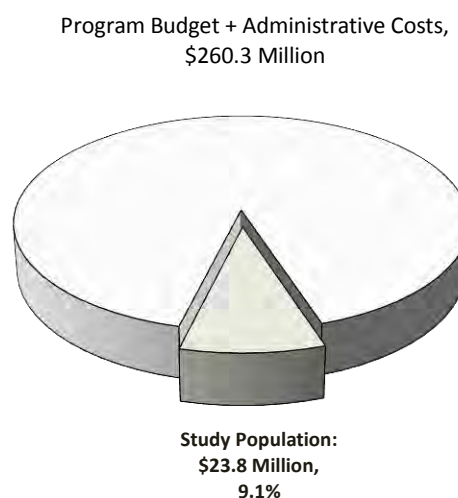
The costs attached to the three other DPH programs shown in Table 2g - CHS, (\$2.3million), HIV and STD Programs (\$5.6 million), and the Tuberculosis Control program (roughly \$483,380) - add \$8.4 million to the overall estimate of the costs associated with the study population's use of DPH services in FY 2014-15. These costs are assumed to include their associated administrative expenditures.¹⁹ As noted previously, the amounts these programs add to the overall estimate reflect data from 2013-14 and are therefore imputed and assumed to be approximately unchanged in FY 2014-15.

2.4.4. DPH Expenditures Relative to Overall Appropriations

DPH notes that the identification of the adult portion of the agency's budget is ill-advised because annual appropriations are not structured around quantifiable patient encounters, which means DPH is not able to parse expenditures by age group. The agency points out that its approach to the provision of health services is generally community-based as opposed to being centered on services provided to individual patients. To be consistent with this characterization, RES made no adult-based adjustments in producing an estimate of the portion of DPH's budget accounted for by the study population.

Based on the full FY 2014-15 gross appropriation for DPH as a whole in the County's Recommended Budget (\$909 million), the estimated \$32.1 million in expenditures on the study population suggests that 3.5% the agency's costs over the year provided treatment to homeless single adults. However, since SAPC costs comprise three-quarters of the DPH cost estimate for the study population, and since SAPC services are accounted for in DPH administrative records as services provided to individual patients, a more meaningful perspective is gained by noting that the \$23.8 million in SAPC expenditures on the study group comprise 9.1% of the SPAC's FY 2014-15 budget (roughly \$260.3 million with estimated administrative costs added, Figure 2d).

Figure 2d. Study Population Use of SAPC Services in Relation to the Program's Overall FY 2014-15 Budget



¹⁹ The costs added to the DPH estimate from these programs are based on expenditures associated with services and treatment provided to homeless patients. Information on these homeless-related expenditures was provided to us by DPH.

3. Law Enforcement Expenditures

This chapter provides estimates of the costs associated with the study population’s consumption of law enforcement resources through the Los Angeles County Sheriff’s and Probation departments. In particular, the costs related to Sheriff’s Department arrests are examined, including jail day maintenance costs and stays in the jail ward, which is the mechanism through which medical services are provided to inmates. It is important to re-emphasize that because the Sheriff’s Department was not one of the agencies contributing a client file to the construction of the study population, homeless arrestees are only included in the match results if they also utilized services through LAHSA, DPSS, DHS and/or Probation at some point during the 12-month period of observation since these are the four agencies whose clients comprise the master study population file. In the case of Probation, the service records available through the ELP data warehouse are restricted to start and end dates. This limitation, coupled with the difficulties involved in assigning costs to the department’s services at the client level, necessitated using information provided by Probation indicating that approximately 5.5% of the agency’s client population at any given time is homeless. This percentage was used to produce *pro rata* estimates for Probation’s FY 2014-15 expenditures with respect to the study population.

3.1. Combined Total Law Enforcement Expenditures.

As shown in Table 3a, the combined FY 2014-15 law enforcement cost estimate for the study population is \$91.7 million, 44.4% of which is NCC (\$40.7 million). A unique total of 15,855 adults accounted for these expenditures, an average of \$5,781 per person. Roughly 87% of the total law enforcement expenditures were costs associated with arrests and jail days (\$79.6 million). The remaining 13% of the combined cost is our prorated estimate of funds spent over 12 months in providing the probationers in the study population with rehabilitative services (\$12.1 million).

Table 3a. Study Group Overall Law Enforcement Costs, FY 2014-15						
	Clients+	*Cost Per Service	Costs		Cost Per Person	
			NCC	Total	NCC	Total
Sheriff	14,754	\$4,097	\$36,247,519	\$79,610,743	\$2,457	\$5,396
Probation	2,795	\$4,311	\$4,409,780	\$12,048,578	\$1,578	\$4,311
Law Enforcement Total	15,855	\$4,124	\$40,675,514	\$91,659,321	\$2,565	\$5,781
NCC: 44.4 %						
+These are unique row totals, which is why the law enforcement (overall) total is not equal to the sum of the individual agency row totals.						
*For the Sheriff, the service used as the basis for the cost per service is the total number of FY 2014-15 arrests involving subjects in the study population. In the case of Probation, the service used is the total number of cases. Since there is almost always one case per person, the cost per service and the cost per person for Probation are equal. Costs per service are rounded to the nearest dollar.						
+Costs per service are rounded to the nearest dollar as shown, but differ slightly from the cost basis of the calculations.						

3.2. The Sheriff's Department

3.2.1. Overall Sheriff's Department Expenditures in FY 2014-15

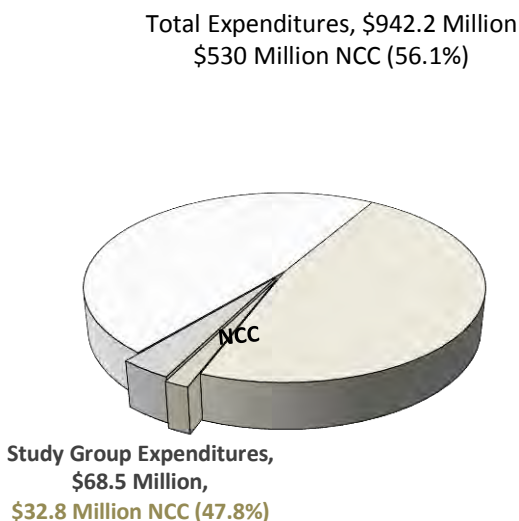
A total of 14,754 adults in the study population (10%) were arrested and booked 19,433 times in FY 2014-15. The estimated cost of these arrests, inclusive of booking costs, jail day maintenance expenditures, jail ward costs, and services provided through the Sheriff's Community Transition Unit, is \$76.7 million. Administrative costs add another \$2.9 million for a grand total of \$79.6 million, of which \$37 million (46.4%) is NCC (Table 3b).

	# Arrestees	# Arrests	+Total Cost Per Arrest	Costs		Cost Per Arrestee	
				NCC	Total	NCC	Total
**CTU	14,754	19,433	\$139	\$720,967	\$2,562,841	\$52	\$186
Non-Admin Subtotal	14,754	19,433	\$3,946	\$34,266,783	\$76,696,284	\$2,322	\$5,198
Top 5% Cost	738	1,003	\$21,411	\$9,384,649	\$21,475,169	\$2,716	\$29,099
Top 10% Cost	1,475	2,159	\$15,719	\$14,830,501	\$33,937,073	\$10,054	\$23,008
Top 20% Cost	2,951	4,571	\$10,817	\$21,607,219	\$49,444,436	\$7,321	\$16,755
Chronic Homeless	964	1,881	\$4,530	\$3,723,820	\$8,521,328	\$3,863	\$8,840
CTU	14,754	n/a	n/a	\$720,967	\$2,562,841	\$49	\$174
Administrative Costs	14,754	19,433	\$150	\$2,701,703	\$2,914,459	\$183	\$198
Sheriff's Grand Total	14,754	19,433	\$4,097	\$36,968,486	\$79,610,743	\$2,457	\$5,396
*NCC: 46.4%							
*The study population's non-administrative expenditures are 44.6% NCC, The addition of administrative costs raises the NCC proportion to 46.5%.							
+Costs per arrest are rounded to the nearest dollar as shown, but differ slightly from the cost basis of the calculations.							
**The CTU costs per arrestee are calculated based on the number of arrestees who were jailed (n=13,805). Although the CTU's services are not utilized by all inmates, the program places considerable emphasis on connecting homeless inmates to housing and supportive services. For these reasons, we add the full program amount provided to us by the Sheriff's Department.							

These total costs comprise 3.1% of the \$2.6 Billion in Sheriff Department's gross total budgetary appropriations for FY 2014-15 (adjusted), an amount that includes all items in the Sheriff's budget with the exception of the General Support item (484.7 Million, \$358.1 Million NCC), the subtraction of which in turn reduces the funds allocated for administrative expenditures by \$19 Million.

However, since the bulk of the costs shown in this section are those generated by jail days, a more accurate perspective on the fiscal significance of homelessness for the Sheriff is gained by looking more narrowly at the study population's share of Sheriff's Department FY 2014-15 appropriations for custody expenditures and Medical Department costs, which sum to \$942.2 million, not including administrative expenditures. We estimate the study populations jail day maintenance and jail ward (medical) costs for the same period to be \$68.5 million, 7.3% of the total funds the County allocated for these services over the year, suggesting that \$1 of every \$13.75 the Sheriff's Department spends in maintaining inmates at jail facilities is spent on homeless single adults (Figure 3a).²⁰

Figure 3a. Sheriff's Expenditures on Inmate Maintenance at Los Angeles County Jail Facilities, for the Study Group and Overall, FY 2014-15



The top 5% most costly arrestees ($n=738$) in the study group in terms of booking, jail day maintenance, and jail ward costs, account for roughly 30% of total arrest costs (\$21.5 million) and have costs per arrest (\$21,411) and per arrestee (\$29,099) that are each close to six times the average for the study population. The top fifth consumed two-thirds of the expenditures associated with arrests and jail days for the year (\$49.4 Million) at a cost per arrestee more than three times the study group average.

3.2.2. Booking Costs

Table 3c shows the booking costs for the arrestees in our study group, which are the flat \$287 (in FY 2014-15) charges incurred each time an arrestee is taken into custody and booked at a Sheriff's Department jail facility. The 19,433 arrests of persons in our study population during the fiscal year generated \$5.6 million in booking costs, which is 7% of the \$79.6 million in Sheriff's expenditures on the study population over the 12 months of observation.

²⁰ The data match results linking the study population to records of Sheriff's Department arrests and jail stays show that the study population's jail maintenance costs in FY 2014-15 amounted to \$65.5 million (Table 3D), and its jail ward costs were \$3.1 million (Table 3e). The sum of these costs is \$68.5 million. Information in the County's FY 2014-15 Recommended Budget indicates that the *combined gross* total appropriation for Sheriff's Custody services (\$720.5 million) and Medical Services Bureau (\$221.8 million) is \$942.2 million. The study group therefore consumed 7.3% of the Sheriff's non-administrative jail maintenance costs for the fiscal year ($68.5/942.2 = .073$). However, the Sheriff's Department notes that there may be some volatility and fluctuation in arrests of homeless persons from one year to the next.

Table 3c. Study Group Arrests and Booking Costs, FY 2014-15

	# Arrestees	# Arrests	Booking Cost	Costs		Cost Per Arrestee	
				NCC	Total	NCC	Total
Sheriff Subtotal 1	14,754	19,433	\$287	\$1,524,717	\$5,585,044	\$103	\$379
Top 5% Most Arrests	738	2,694	\$287	\$211,372	\$774,256	\$286	\$1,049
Top 10% Most Arrests	1,475	4,384	\$287	\$343,970	1,259,962	\$233	\$854
Top 20% Most Arrests	2,951	7,336	\$287	\$575,584	\$2,108,366	\$195	\$714
HMIS Chronic Homeless	964	1,881	\$287	\$147,584	\$540,599	\$151	\$561
				%NCC:: 27.3%			

3.2.3. Jail Stay Durations and Jail Day Maintenance Costs

The bulk of Sheriff’s costs are generated by the daily maintenance costs attached to jail days. Roughly 94% of the arrestees in the study group were jailed ($n=13,805$). These inmates comprise 9.3% of the full study population and consumed 647,784 jail days in FY 2014-15, an average of 47 cumulative days per person jailed. Among the larger group of arrestees, which include those arrested but not jailed ($n=14,754$), the average time in jail drops only slightly to 44 days per arrestee. The average jail stay attached to arrests, where the divisor is the 19,433 arrests logged for the study population in FY 2014-15 was roughly 33 days, inclusive of episodes in which arrestees are taken into custody and released on the same day, and is 36.3 days if the calculation is restricted to only those arrests that lead to days in jail. (Table 3d). However, the *median* length of stay, which is more resistant to atypical observations, is shorter by close to one month, 7 days with zero-day stays included and 9 days with zero days excluded, which indicates that a comparatively small proportion of study group inmates had lengthy stays.

Table 3d Study Group Jail Days and Jail Maintenance Costs, FY 2014-15

	Jailed	Days	+Cost per Jail Day	+Costs		+Cost Per Inmate	
				NCC	Total	NCC	Total
Men	11,000	532,408	\$96	\$22,063,924	\$51,073,899	\$2,006	\$4,643
Women	2,805	115,376	\$125	\$6,221,332	\$14,401,232	\$2,218	\$5,134
Sheriff Subtotal 2	13,805	647,784	\$101	\$28,285,257	\$65,475,132	\$2,049	\$4,743
Top 5% Cost	690	180,834	\$104	\$8,117,017	\$18,789,392	\$11,818	\$27,231
Top 10% Cost	1,381	297,619	\$102	\$13,178,372	\$30,505,490	\$9,543	\$22,089
Top 20% Cost	2,761	445,936	\$102	\$19,583,622	\$45,332,459	\$7,093	\$16,419
Chronic Homeless	912	46,680	\$100	\$2,026,569	\$4,691,134	\$2,210	\$5,144
				%NCC::43.4%			

+Costs are rounded to the nearest dollar differ slightly from the cost basis of the calculations.

The study population’s total jail day maintenance costs for the 12-month observation period, not including costs associated with time spent in the jail ward, is \$65.5 million. Men and women are subject to different day rates. Women are detained at only one facility (Pitchess South), which charges a daily maintenance rate \$30 higher per day than the average at facilities for men. Male inmates in the study population consumed roughly 78% of the total maintenance costs (\$51.1 million).

3.2.4. The Jail Ward

Inmates in need of medical services while incarcerated receive treatment through the Jail ward, which charges a flat daily cost for all services that is close to 30 times higher than the standard daily jail maintenance rate (\$2,802 per day in FY 2014-15). As shown in Table 3e, 251 of the inmates in study population consumed almost 11,000 jail ward days in FY 2014-15, an average of 4.4 days per jail ward stay and \$12,196 per inmate. The total cost of these services was roughly \$3.1 million over 12 months.

Table 3e. Study Group Utilization of Jail Ward Services, FY 2014-15

	# Inmates	# Jail Ward Days	Daily Jail Ward Costs	Costs+		Cost Per inmate	
				NCC	Total	NCC	Total
				Sheriff Subtotal 3	251	1,097	2,802
Top 5% Cost	13	384	2,802	\$1,055,344	1,075,784	\$81,180	82,753
Top 10% Cost	25	536	2,802	\$1,473,084	1,501,615	\$58,923	60,065
Top 20% Cost	50	712	2,802	\$1,956,783	1,994,682	\$39,136	39,894
Chronic Homeless	22	254	2,802	\$698,066	\$711,586	\$32,344	32,345
%NCC:: 98.1%							

3.2.5. Arrest Costs by the Duration of Jail Stays

Table 3f, shows the costs associated with the study population's *discrete* arrests, by the duration of jail stays in FY 2014. The costs shown are the \$74.1 Million in expenditures associated with arrests and jail days, including jail ward day but not administrative costs or CTU programmatic expenditures shown in Table 3b.

Table 3f. Arrest Costs by Length of Jail Stay, n=14,754 Persons in the Study Population Arrested in Fy 2014-15

Duration of Jail Stay	Arrested*	Arrests		Total Jail Days		Costs				
		***	% of Total	Count	% of Total	NCC	Total	% of Total	Per Person	Per Arrest
0-30 Days	10,932	13,803	71.0	88,716	13.6	6.1M	\$13.6M	18.4	\$1,240	\$982
31-45 Days	1,183	1,216	6.3	45,193	7.0	\$2.3M	\$5.1M	6.9	\$4,359	\$4,240
46-60 Days	860	871	4.5	45,778	7.0	\$2.2M	5.0M	6.8	\$5,833	\$5,759
61-75 Days	702	715	3.7	48,405	7.5	\$2.4M	\$5.2M	7.0	\$7,448	\$7,313
75-90 Days	730	762	3.9	62,006	9.5	\$3.0M	\$6.8M	9.2	\$9,303	\$8,912
91-120 Days	571	576	2.9	60,639	9.4	\$3.0M	\$6.7M	9.0	\$11,699	11,598
121-150 Days	398	401	2.1	54,065	8.3	\$2.6M	\$5.8M	7.8	\$14,601	14,492
151-180 days	349	350	1.8	58,511	9.0	\$2.7M	\$6.1M	8.2	\$17,565	\$17,515
181+ Days	739	739	3.8	186,043	28.7	\$8.8M	\$19.8M	26.7	\$26,740	\$26,740
Total	14,754	19,433	100	647,784	100	\$33.1	\$74.1M	100	\$5,025	

NCC: 44.7%

*Counts of persons arrested are unduplicated by row but *not within the column*. An arrestee with multiple jail stays of varying lengths is counted a maximum of one time in each horizontal row. Arrestees will be counted a minimum of two times in the vertical column (in cases where a person is arrested once and therefore counted once in the appropriate duration row and once in the total row), and a maximum of ten times (since there are nine duration intervals and one total row). For these reasons, the number in the total row is not equal to the sum of the arrestees counted in duration rows but is rather the count of the arrestees in our study population (n=14,754)

**Arrests are counted once for each time they occur including multiple times in the same row, where appropriate. The total row is therefore the sum of the duration rows and is equal to the number of FY 2014-15 arrests for the arrestees in our study population (n=19,443)

More than 18% of the expenditure on the study population is accounted for by persons who are arrested and released within 30 days and almost half is accounted for by those whose jail stays were less than four months. Jail stays lasting five or more months account for just above one third of the total expenditures, and stays lasting more than six months account for 28.7% of the total expenditures.

3.2.6. The Community Transition Unit and Administrative Costs

Additional costs in the amount of approximately \$2.6 million (\$720,967, NCC) are added to the overall Sheriff's estimate from the Department's Community Transition Unit. Additionally the study population's estimated share of Sheriff's administrative costs is \$2.9 Million (\$2.7 Million NCC).

3.2.7. Net County Costs

Our estimates of the NCC portion of the study population's arrest and jail expenditures are based on information provided in the County's Recommended FY 2014-15 budget and by the Sheriff's Department. The total amount appropriated for the items relevant to arrests and bookings in the Sheriff's FY 2014-15 budget is \$1.5 billion, of which 27.3% is NCC, and this is the proportion of the booking costs we identified as NCC in Table 3c.²¹ Estimates of the NCC portion of the study population's jail day maintenance expenditures (Table 3d) replicate the NCC portion of appropriations for the *custody* budget item identified in the FY2014-15 Recommended Budget (\$312.5 million of \$720.5 million, 43.4%). Similarly, the basis for RES's estimate that 98.1% of jail ward costs (Table 3e) and 92.7% of administrative costs are NCC (described in section 3.2.6) is based on the proportions shown in the Recommended Budget for the Medical Services Bureau and administrative expenditures.²² NCC for the Community Transition unit was identified for us by the Sheriff's Department. The sum of the NCC subtotals shown in Tables 3c, 3d, 3e, plus the additional NCC discussed in Section 3.1.7 and 4f is \$37 million, which is 46.5% of the total Sheriff's expenditures for the study population in FY 2014-15.

²¹Since Sheriff's Department bookings are processes that involve any number of budgeted activities in the Sheriff's annual appropriations, we calculate the NCC proportion of the booking costs shown in Table 3c based on the NCC for all non-administrative budget items combined other than custody and medical services, which are captured in the jail day and jail ward costs.

²²Information obtained from the Sheriff's Department indicates that the jail ward is the mechanism through which inmates receive medical attention. Since the Jail ward is not itemized with an appropriation in the County's Recommended Budget, we assumed that the NCC portion of jail ward day costs would replicate the NCC portion of the Medical Services Bureau NCC: In the FY 2014-15 Recommended budget, the gross appropriation for LASD's Medical Services Bureau is \$221.8 Million, of which \$217.5 Million is NCC ($\$217.5 \text{ million} / \$221.8 \text{ Million} = 0.981$). This is our basis for categorizing 98.1% of the jail ward costs shown in Table 3e as NCC. Similarly the FY 2014-15 Recommended Budget indicates that \$103.9 of the \$112million gross appropriation for administrative costs is NCC ($\$103.9 \text{ Million} / \$112 \text{ Million} = 0.927$); As such, we categorize 92.7% of the administrative costs discussed in section 3.2.6 as NCC.

3.3. Probation

Probation’s ability to identify persons within the agency’s client population who are homeless is aided by two factors. Firstly, the Probation Systems database includes a homeless flag. All probationers coded as *transient* in FY 2014-15 service records are included in our study population ($n=1,952$ adults). Secondly the agency provides housing and targeted services to clients who meet the eligibility criteria for programs such as Healthright 360, which is offered to non-violent felons who are homeless and who would have been under the supervision of State-level corrections agencies prior to passage and implementation of AB 109. A total of 843 probationers in our study population received homeless-related services through the Healthright 360 contract, bringing the total number of probationers in our study population to 2,795 adults, 1.9% of the study population.

From an administrative and financing point of view, Probation separates adult felony probationers and clients receiving services through Healthright 360, which the department categorizes as the AB 109 segment of its overall client population, as two separate groups. However, since CEO budget was able to produce an overall total of the department’s actual expenditures that combines the two populations, they are grouped together in RES’s estimates.

3.3.1. Homeless Probationers

	Probationers	Months on Probation		Average Time on Probation Per Person	
		FY 14-15	Total	FY 14-15	Total
		Healthright 360	843	6,696	14,285
Other Programs	1,952	15,030	55,205	7.7	22.5
Total	2,795	21,726	69,490	7.8	21.1

Table 3g shows the homeless probationers in our study population, i.e. those included either as a result of their use of services through Healthright 360 during FY 2014-15 and/or those who were identified as homeless in Probation’s database. In all, these clients were on probation during the

fiscal year for a total of 21,726 months, an average of 7.8 months per person. Almost 40% of those tabulated had no case closure date in their records, in which case we assumed that the cases were ongoing beyond the observation period.²³

3.3.2. A Prorated Estimate of Study Population Probation Costs

Given the difficulties involved in attempting to attach client-specific costs to the Probation data available to us through the ELP data warehouse, a prorated expenditure estimate was produced based on a combination of data match results, expenditure information produced by the CEO’s budget office, and information supplied to us by Probation.

Probation provided rehabilitative services to 36,375 adult felon probationers in FY 2014-15. The 1,952 homeless probationers in the study group therefore comprise 5.4% of the department’s adult felon

²³ Imposing a June 30, 2015 closure date on these cases enables us to compute the average amount of time a client is on Probation *during the observation period*. However, since the observation period is fixed, more elaborate time-to-event methods of analysis would be required to control for the distorting effect a client’s entry date otherwise has on the observed average *length of a case*.

population. Additionally, 14,437 adults received services through Healthright 360, which means that the 843 adults who in the study population because they used homeless services made available through the contract constitute 5.8% of the department’s FY 2014-15 Healthright 360 population. Although adult felon probationers and Healthright 360 clients are, from Probation’s point of view, separate populations, the CEO’s budget office provided RES with Probation’s actual FY 2014-15 expenditures, inclusive of costs associated with both populations, which total to \$219.3 million.

The 2,795 probationers in our study population comprise 5.5% of the total number of probationers in the adult felony and Healthright 360 groups combined. Proportional expenditures are therefore assumed for the study population, which amount to \$12.1 million, 5.5% of the \$219.1 million in total expenditures according to the CEO budget office. In relation to the data match results, the prorated calculation for the study group suggests that the department spends about \$1 million per month on its homeless adult clients, \$4,311 per client over the course of their time on Probation, which is an average of \$557 per client, per month (Table 3i)²⁴

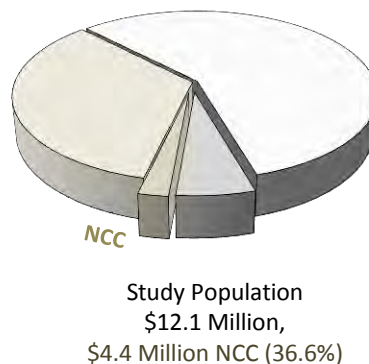
3.3.3. Net County Costs

Our estimate of the Net County Cost for the Probation clients in the study population is based on the FY 2014-15 Recommended Budget, where the gross appropriation for adult services is \$184.5 million, of which \$67.4 million is NCC (36.6%). Based on this proportion it is assumed that \$4.4 million (i.e. \$12.1 million*0.366) of the total expenditure on the probation clients in the study population is NCC.

NCC	Overall Cost	Total Per Month	Total Per Client	Monthly Per Client
\$4,409,780	\$12,048,578	\$1,004,048	\$4,311	\$555

Figure 3b. Probation Costs for Adult Felony Probationers and Healthright 360 Clients

Estimated Expenditures on Adults Overall: 219.3 Million



²⁴The average cost per client, per month is derived by dividing the overall study population cost for the fiscal year by the total number of Probation months for FY 2014-15, as shown in Table 3g: (12.1 Million/21,726 months = \$557).

4. Social Services

The social services expenditures summarized in this chapter are based on 114,037 DPSS clients who received GR and food stamps benefits through CalFresh during FY 2014-15. These clients comprise 77% of our study population and accounted for an estimated \$293.7 million in DPSS costs over the fiscal year, roughly three-fifths of which (\$176.4 million) is NCC (Table 4a). This estimate does not include expenditures associated with DPSS's provision of Medi-Cal eligibility services.

Table 4a. DPSS Expenditures on the Study Population, FY 2014-15							
	# Unique Recipients	Total Months Receipt*	Cost per Person, per Month*	Costs+		Cost Per Person	
				NCC+	Total	NCC	Total
*CalFresh,&GR	114,037	688,766	\$382	\$160,403,286	\$262,831,006	\$1,407	\$2,305
Administrative Costs	114,037	688,766	\$43	\$16,040,466	\$30,884,710	140	\$261
DPSS Grand Total	114,037	688,766	\$426	\$176,443,752	\$293,715,716	\$1,547	\$2,566
NCC: 60.1%							
*The GR costs component of the total cost shown in this row includes \$21.8 million allocated in DPSS's FY 2014-15 budget to GR Anti-Homelessness Programming (\$8.2 Million NCC)							

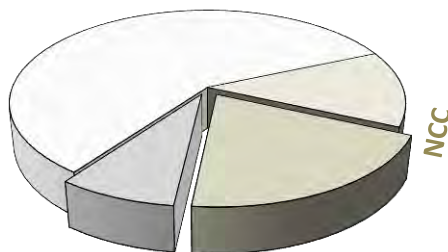
CalFresh and GR provide most of the benefits and services utilized by DPSS's single-adult clients. Producing an estimate of DPSS's total expenditures on single adults in FY 2014-15, including the associated administrative costs, necessitates calculating a prorated approximation of DPSS's costs in providing single adults with CalFresh benefits. The sum of these *approximated* CalFresh costs (\$630.3 million) and GR-related expenditures (\$253 million) is \$883.3 million, which is treated as an estimate of DPSS's total single-adult funding for FY 2014-15, excluding costs associated with Medi-Cal eligibility services and In-Home Supportive Services. It is further estimated \$248.6 million of these funds (28%) to be NCC.²⁵²⁶

Examined in relationship to each other, the single adult expenditure estimate and the study population's share of these costs, as summarized in Table 4a, suggest that one-third of DPSS's gross expenditures on single adults in FY 2014-15 were costs accounted for by homeless clients (Figure 4a). While the GR-related funds in the overall single adult estimate (\$253 million) account for 6.6% of the \$3.83 billion in DPSS's Recommended FY 2014-15 budget, they also account for two-thirds of the \$383.4 million NCC in the budget. By extension, 60.1% of the single adult NCC is accounted for by homeless clients (\$176.4 million out of \$293.7 million). In sum, although costs related to single adults are a small fraction of DPSS's gross annual expenditure, the majority of this spending is not net revenue. Moreover, the majority of the department's single-adult costs and Net County Costs are associated with providing services to homeless adults.

²⁵Direct benefit costs are assumed 100% NCC for GR and 0% NCC for CalFresh. The NCC portion of the \$21.8 million in the funds allocated to GR Anti-homelessness programming (\$8.2 million) is the amount identified as such in the County's FY 2014-15 budget. Additionally, DPSS's The Cash Assistance Program for Immigrants (CAPI) also provides benefits to single adults. Although CAPI is administratively subsumed under GR, the program is given its own budget item and funding allocation in the DPSS budget. CAPI is excluded from the our total FY 2014-15 single-adult expenditure estimate because a budgeted amount is available for the program, but we do not have the information necessary to determine the degree to which the program provided benefits to adults in our study population. The inclusion of CAI appropriations would therefore dilute our calculations insofar as the budgeted amount would be included in our denominator but the study group's share of these funds would not be represented in the numerator.

Figure 4a Estimated DPSS Expenditures on Single Adults, FY 2014-15

Estimated Expenditures on Adults Overall: \$883.3Million,
248.6 Million NCC (28.1%)



Study Population Expenditures:
\$293.7 Million,
\$176.4 Million NCC (60.1%)

To produce a DPSS cost estimate for FY 2014-15, the study population was matched against records of monthly benefits received through CalFresh in FY 2014-15. A data match for the purpose of determining the extent of GR receipt within the study population was not necessary since an exhaustive dataset of FY 2014-15 GR receipt was built into the master file created for this report. The calculations additionally drew from program and cost information provided by DPSS, as well as from the County’s FY 2014-15 budget.

4.1. Monthly Benefits: General Relief and CalFresh

DPSS paid 114,037 of its clients in our study group a total of \$241.1 million in monthly GR and CalFresh benefits over a net total of 688,766 months in FY 2014-15, an average annual cost of \$1,335 per person (Table 4b). These clients received GR benefits for a cumulative average of about six months per person at \$221 per month for a total in FY 2014-15 of \$152.2 million, 100% of which is NCC (Table 4b).

The GR recipients in the study population were also linked to employability status records in additional LEADER tables available to RES, which revealed that an average of roughly two-thirds of the recipients in the active monthly caseloads were categorized by DPSS as *unemployable* at some point during the observation period. Moreover, about 41% of the GR recipients in the study population ($n=46,528$) were coded as unemployable in all months during which they received GR benefits, including more than two-thirds of those in the chronically homeless subgroup ($n=1,343$). Employability status is significant with respect to DPSS’s monthly payment obligations insofar as these obligations are 100% NCC and those who are categorized as *unemployable* are exempt from otherwise mandatory participation in welfare-to-work program components, as well as from time limits on receipt of monthly benefits, for as long as they can demonstrate that their disabilities prevent them from working.

Table 4b. Study Group Receipt of General Relief and CalFresh, FY 2014-15

	# Unique Recipients	Total Months Receipt*	Average Cost per Person, per Month*	Costs+		Cost Per Person	
				NCC+	Total	NCC	Total
GR	114,037	688,766	\$221	\$152,217,286	\$152,217,286	\$1,335	\$1,335
Chronic Homeless	1,976	15,999	\$221	\$3,535,779	\$3,535,779	\$1,789	\$1,789
CalFRESH	71,910	555,267	\$160	\$0	\$88,842,720	\$0	\$1,235
DPSS Subtotal 1	114,037	688,766	\$350	\$152,217,286	\$241,060,006	\$1,335	\$2,114
%NCC:: 63.1%							

*The total number of months receipt shown in the table is an unduplicated net total, as opposed to a gross total. The net cumulative total months is more meaningful than a gross total (n=1,244,033 months) because the net total can be applied as a divisor to the total benefit payments to produce an average cost per person, per month. It should be noted, however, that the average cost per person, per month is not equal to 1/12 of the total cost per person because recipients do not GR and CalFresh for the same amount of time, but since all clients who received food stamps at some point in the 12-month observation period also received GR during the year, we use the total months of GR receipt (n=688,766) and the total number of GR recipients in the dataset (n=114,038) as the basis for our aggregate cost per-person and cost per month estimates.

Table 4b also shows our study population’s total receipt of food stamp benefits, which are available through the CalFresh program and funded almost entirely by the Federal government with the remainder of the benefits funded by the State through the California Food Assistance Program for legal immigrants. A data match linking the study group to DPSS records of CalFresh receipt yielded 71,910 clients who received food benefits for at least one month in FY 2014-15, a match rate of 48.3%. These persons consumed benefits in the amount of \$88.8 million over 555,267 months of receipt, an average of close to eight months per recipient at roughly \$1,235 per person for the year and \$160 per month.

4.2. Additional Costs

The DPSS budget for FY 2014-15 includes \$21.8 million allocated to GR Anti-Homelessness programming, (\$8.2 Million NCC), all of which is added to our estimate. The basis for the estimate of GR and CalFresh administrative costs, which total to \$30.9 Million, is shown in the appendix to this report.

5. Summary and implications

Table 5a summarizes the cost estimates discussed in this report. The six agencies we examined spent an estimated combined gross total of \$964.5 million in providing services to the study population in FY 2014-15. DPSS spent the most in terms of Net County Cost (\$176.4 Million), almost five times more than the Sheriff (roughly \$37 million). This is largely driven by GR, which is almost entirely NCC, as well as the high proportion of subjects in the study population who are GR recipients.

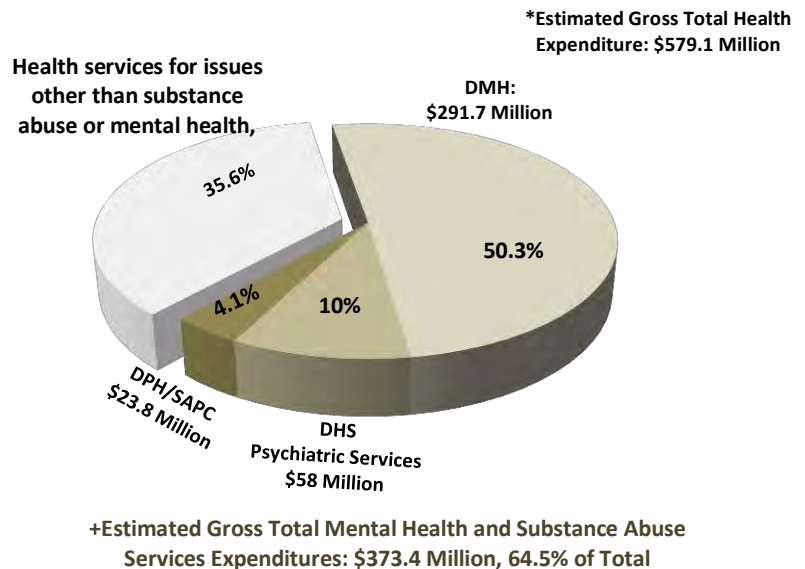
Table 5a. Costs for Services Provided to Homeless Single Adults in Los Angeles County, FY 2014-15							
	*Client N=	% Study Population+	Estimated Expenditures				
			Direct Services**	TOTAL	NCC	Average Per Person	
DHS	47,431	31.8	\$246,647,125	\$255,263,292	+++	\$5,381	
DMH	39,073	26.3	\$252,245,388	\$291,702,711	\$8,258,181	\$7,466	
DPH	6,939	4.7	\$22,120,417	\$32,142,976	\$2,514,024	\$4,632	
DPSS	114,037	76.6	\$241,060,006	\$293,715,716	\$176,443,752	\$2,576	
Sheriff	14,754	9.9	\$74,133,443	\$79,610,743	\$36,968,486	\$5,397	
Probation	2,795	1.8	\$12,098,348	\$12,098,348	\$4,409,780	\$4,328	
OVERALL TOTAL	148,815	100	\$848,304,728	\$964,533,787	\$228,612,438	\$6,481	
Most Costly 5%	7,441	5.0	\$370,288,623	\$381,181,654	\$12,671,254	\$51,227	
Most Costly 10%	14,882	10.0	\$476,865,568	\$499,132,698	\$27,474,588	\$33,539	
Most Costly 20%	29,763	20.0	\$591,976,118	\$635,675,239	\$55,499,664	\$21,358	
HMIS Chronic Homeless	7,675	5.2	\$54,747,979	\$60,467,810	\$5,134,767	\$7,879	

*These are Unique Totals
 +These percentages are based on the full study population, n=148,815
 ++In this context, the *Direct Services* category is intended to exclude both administrative expenditures and costs associated with programs that are either only recorded at an aggregate level in terms of utilization or are only available in an aggregated format.
 +++ Section 2.2.1 provides an explanation for why DHS's NCC is excluded from this report.

5.1. The Significance of Mental Health and Substance Abuse Services

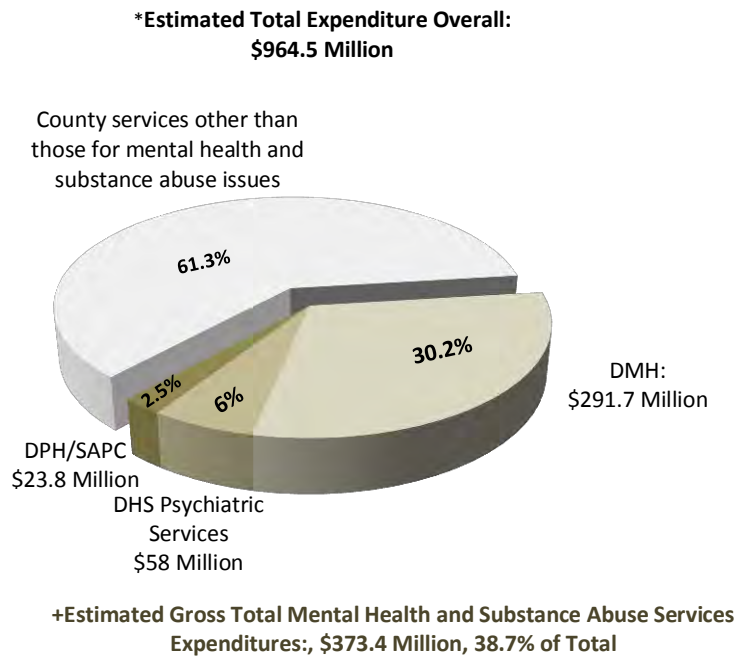
Looking more specifically at expenditures *per capita*, the spread separating DMH from DHS and the Sheriff is close to 40%. This is particularly remarkable given that close to one quarter of DHS's inpatient and outpatient costs with respect to the study population were expenditures on psychiatric emergencies and hospitalizations (roughly \$58 million of \$246.6 million). The sum of DHS's estimated psychiatric-related costs and DMH's total costs - roughly \$350 million over 12 months - suggests that 60% of the County's health spending and more than

Table 5a Estimated County Mental Health and Substance Abuse Expenditures+ in Relation to Health Expenditures Overall, FY 2014-15*



one-third of the County spending on homeless single adults overall – are funds that pay for mental health treatment. When the study population’s DPH/SAPC costs (\$23.8 million) are added to the mental health/psychiatric expenditures, the resulting implication is that more than three-fifths of the County’s health spending on homeless single adults and two fifths of the County’s overall spending on this population funds services for mental health and/or substance abuse treatment (Figures 5a and 5b). Moreover, to the extent that the composition of our study population underrepresents homeless SAPC and DMH patients, the proportions may be even higher.

Table 5b. Estimated County Mental Health and Substance Abuse Expenditures+ in Relation to Overall Costs, FY 2014-15*



5.1.1. Inpatient and Emergency Services

From the point of view of general service areas, mental health utilization is the biggest driver of the County’s costs with respect to homeless adults. Within the domain of mental health services, inpatient and emergency utilization - including residential services, inpatient hospitalizations and psychiatric ER visits – are the primary factor driving spending on homeless patients. While only 13% of the DMH patients in our study population required acute inpatient and/or residential services ($n=5,291$ adults), these patients accounted for roughly one-fifth of the DMH inpatient and outpatient costs for the study population and their average cost per patient (\$9,316) was roughly 25% higher than the average for all the DMH patients in the study population. Psychiatric hospitalizations accounted for roughly 30% of DHS’s inpatient costs and psychiatric emergencies accounted for close to 38% of the department’s emergency costs.

5.2. Inmates and Probationers

Although the data match results suggest that one in 10 of the adults in the study population were arrested by the Sheriff’s Department, the composition of the study population is such that this proportion is likely an underrepresentation of the extent to which law enforcement resources are utilized in arresting and jailing homeless persons. Nevertheless, the Sheriff spent an average of \$5,396 on those arrestees and inmates captured in our FY 2014-15 data match for an estimated total of \$80 million overall (\$37 million NCC, 46.5% NCC). Approximately seven in ten of the arrests involved time in custody that lasted no more than one month, but more than one in ten lead to jail stays that lasted more than three months, and these longer stays account for more than half the jail maintenance costs for the study population (\$38.4 Million out of \$74.1 million).

While the costs of arrests and jail stays are a key factor in the County costs associated with homeless single adults, less than 2% of the study population received services through Probation during the fiscal year.

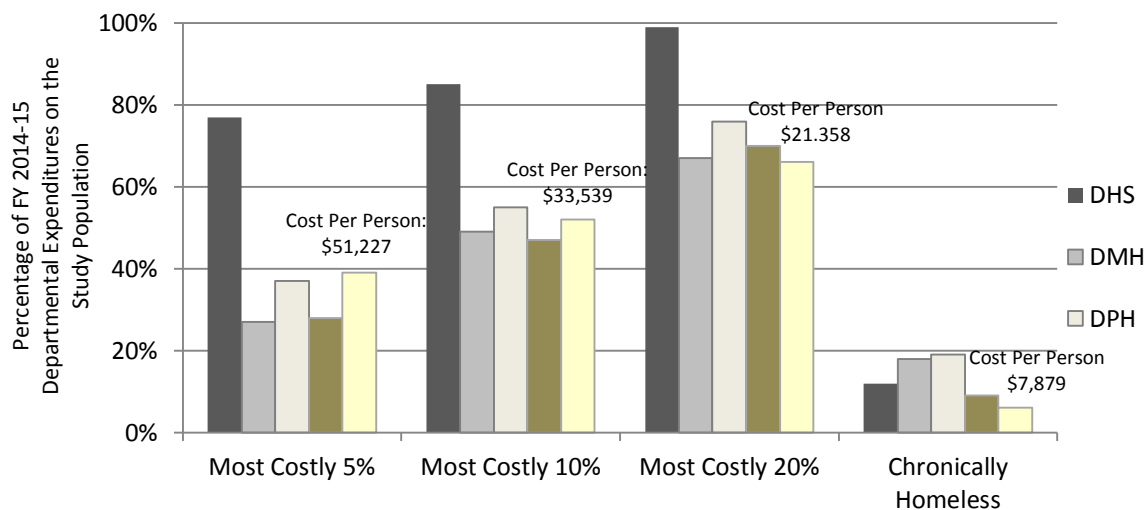
5.3. DPSS, the Primary Source of Basic Survival for the County’s Unaccompanied Homeless Adults

DPSS incurred the largest gross costs among the six agencies examined (\$293.7 Million). Almost four of every five adults in the study population was a DPSS client in FY 2014-15. As the provider of both a monthly cash stipend through the GR program and the distributor of Federal Food Stamps benefits through the CalFresh program, DPSS is the main source of basic subsistence for homeless single adults in the County and is, as such, a critical system of last resort. More than 7 out of 10 adults in the study group who received GR benefits during FY 2014-15 experienced a spell of homelessness at some point over 12 months. Two-thirds of these recipients experienced a disability that prevented them from participating in the GR program’s job readiness activities for at least part of the time they received benefits, and more than 40% were coded by the department as unemployable during all the months in which they received benefits.

5.4. High-Volume Service Users, the Most Significant Driver of the Costs Associated with Homelessness

The concentration of spending on a small minority of high-volume service users is both the most striking aspect of the results and one that is consistent with the current state of knowledge on the costs associated with homelessness. This pattern, as shown in Figure 5c, is one observed for the County as a whole, as well for individual County agencies. While the average cost per person for the full study group across the six County agencies was \$6,481 for the 12-month observation period, the average among the most expensive 5% ($n=7,441$ adults) was \$51,227, eight times the average. The adults in this subgroup accounted for \$381.1 million in combined service costs, which is almost 40% of the total County expenditure on the study population. The intensity of concentrated spending slows somewhat thereafter, but the most expensive fifth of the study population ($n=29,763$ adults) nevertheless accounts for two-thirds of the County’s overall cost for the Fiscal Year.

Figure 5c. County Expenditures* on the Most Expensive Adults In the Study Population, FY 2014-15+



*The average cost per person shown in the figure is based on expenditures across all six County agencies combined.

+DPSS and Probation are not shown because their benefits and services are fixed and provided on a recurrent and routine basis such that their costs per person do not vary dramatically by person (in contrast to the four departments included in Figure 5c).

Fairly similar spending and utilization patterns are observed in looking at DMH, DPH and the Sheriff. In the case of DHS, the concentration is considerably more intensified. DHS’s average expenditure per person for the most costly 5% of the patients in the study population ($n=4,743$ adults) is \$80,015. This subgroup, which comprises only 3.2% of our full study population, consumed \$189.8 million in DHS service costs, which is almost three quarters of DHS expenditures on all the patients in our study group and roughly one-fifth of the County’s costs on the entire study population. The most expensive 20% account for all but a small fraction of DHS’s costs in providing services to the study population.

5.4.1. The Chronically-Homeless Subgroup

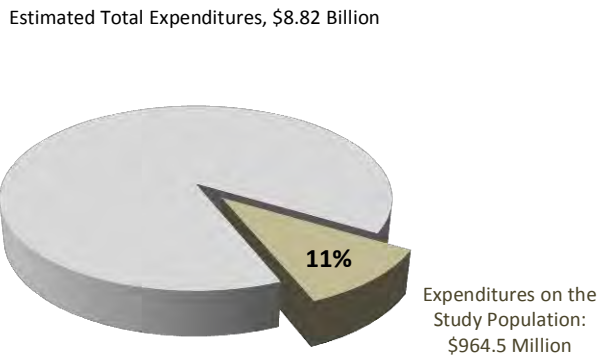
Although there is some overlap between the most costly segments of the study population and the chronically homeless subgroup ($n=7,675$ adults), the concentration of spending on the latter is considerably less intensive. At the same time, however, the chronically homeless subgroup’s average cost per person in looking at County services overall (\$7,879) is 21.6% higher than average and expenditures on these persons (\$60.5 million) constitute 6.3% of the County’s overall spending on the study population.

5.5. Homeless Costs in the Context of Overall Departmental Resources

For each agency included in this report, estimated costs were measured in relation to a larger pool – or denominator - of departmental funding for services provided to adults. This was done to convey a sense of the relative impact of homelessness on departmental resources. However, this relational aspect of the analyses is imperfect and its intent is limited to a general approximation of the fiscal and financial significance of homelessness in Los Angeles County. In making decisions about the inclusion and exclusion of funds from these larger gross financial denominators, a number of complexities prevent the uniform application of a standard set of business rules to all departments. Moreover, it is important to underscore that budgets are related but analytically distinct from actual expenditures. In the case of DMH, as well as for part of the analysis of Probation, larger departmental denominators were built from information provided to RES on actual expenditures. DHS provided an adjusted budget allocation for FY 2014-15. For the other three agencies, however, the funding denominators relied on information provided in the County’s Recommended Budget for FY 2014-15. In these latter cases, RES proceeded with the assumption that budgets could be approached as a reasonable proxy for expenditures for the purposes of producing general estimates.

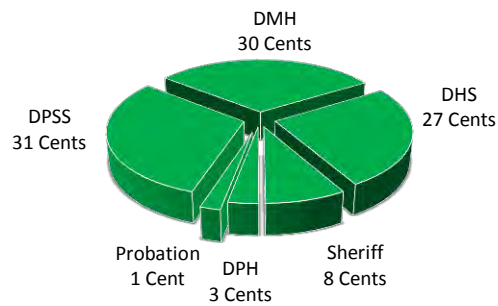
Given these limitations, the sum of these six departmental denominators, represented in Figure 5d, is our best effort to produce a reasonable approximation of the combined gross funding these agencies deployed in providing services to adults during FY 2014-15 (\$8.82 Billion) Within this universe of overall spending, slightly more than \$1 out of every \$9 was spent on services provided to our homeless study population.

Figure 5d Combined Spending on the Study Group across Six County Agencies in Relation to their Approximate Total Expenditures on Adults Overall, FY 2014-15



DPSS and DMH each account for about 30 cents on this dollar and DHS's share is 27 cents. There is a significant spread separating these three agencies from the others. The Sheriff's share is about 8 cents on the dollar, DPH accounts for three cents and Probation accounts for a penny (Figure 5e).

Figure 5e. Estimated Distribution of Every County Dollar Spent in Providing Services to Homeless Single Adults



5.6. Maximizing the Effectiveness of County Service Dollars

Los Angeles County spends close to \$1 Billion per year in providing services and benefits to single adults who experience varying spells of homelessness in the course of 12 months. The establishment of a coordinated policy and program environment that makes the most effective use of these resources is one of the fundamental objectives for the CEO's *ad hoc* Homeless Initiative. Our analysis suggests that 5% of the single homeless adults in the County – roughly 1 out of every 20 of these adults - consume 40 cents out of every dollar spent in providing services to this homeless population as a whole. Making inroads into the utilization patterns of this small segment will ultimately free up funds that could in turn be reinvested strategically in the ongoing efforts to reduce homelessness. Doing so will necessitate the implementation of more efficient and lasting alternatives that break repetitive cycles of Emergency room visits, hospitalizations, expensive psychiatric inpatient treatments, arrests and re-arrests, etc. Our analyses further suggest that coordinated interventions addressing tri-morbidity among the County's homeless men and women – i.e. adults with (often interrelated) combinations of mental health, substance use disorder and physical health issues – should be closely linked to efforts to provide safe, subsidized housing.

Homelessness is not merely a problem of dollars and cents but, more importantly, one of the defining humanitarian issues Los Angeles County faces. Reducing and eventually ending the problem will not be easy or painless but is consistent with basic values of citizenship, fairness and decency. In forming the *ad hoc* Homeless Initiative, the Board of Supervisors and the County's Chief Executive Officer have taken a decisive step in the process. Our hope is that this report will arm the Initiative with information needed to present the Board with an effectively coordinated set of recommendations, one that provides the County with guidance in facing the difficult but worthwhile challenges that lay ahead and leads to enduring solutions.

Report on Homeless Housing Gaps in the County of Los Angeles

Prepared by

The Los Angeles Homeless Services Authority

January 2016



Housing Gaps Analysis Objective

This model is intended to inform resource allocation decisions by providing a proposed best case system model for the Los Angeles region. The model is intended to provide a resource map necessary to achieve the functional end to homelessness in Los Angeles; that is, it is designed to answer the question “what additional subsidized housing and shelter do we need to end homelessness in LA, and what is the resulting cost?” The model assumes a number of best practices, including for example that the Emergency Shelter infrastructure is primarily used as bridge housing to navigate people into permanent housing outcomes.

Housing Gaps Analysis Methodology

The methodology for this analysis uses key population statistics and demographics to project the need for different kinds of housing interventions for the entire homeless population, and contrasts those needs with the current inventory of housing and shelter, to identify system gaps. The chart does not imply a recommendation to shift funding from current programs. To this end, the column titled “LA County Housing Gap (Exc. City) shows a 0 in areas where the City need is higher than the overall County need. Each data source is explained in Appendix A. The homeless population is provided by the annual Point-In-Time (PIT) count of homeless individuals and families. Since the count is a one-day number, not the total number of people who will experience homelessness over the course of a year, we use data from the local Annual Homelessness Assessment Report (AHAR), to extrapolate the annual population served. The AHAR data covers both those programs that are publically funded and for which there is data about service utilization in the Homeless Management Information System (HMIS), and those that are privately funded and that do not participate in HMIS. The HMIS service utilization data, such as average shelter bed stays, and retention rates for permanent supportive housing, provides key expected values for the types of programs operated locally, and is much richer than the AHAR data alone. So, for example, HMIS data show the percentage of shelter occupants who appear for less than 30 days and do not reappear in the data, and are therefore considered ‘self-resolvers’, and the model does not include a housing type for them. Finally, the model includes our Housing Inventory Count (HIC), which details the resources currently deployed in the County. The model also includes national best practices that are drawn from the national AHAR set of data, which is used to fill in data gaps from the local HMIS data; for example, there is limited data in the LA CoC HMIS on local Prevention programs, but other CoCs have such programs, so national data is used to refine the estimates.

Using data from PIT Homeless Count, HMIS and AHAR, the model estimates the housing resource needs for the homeless population, and what percentage of the population will likely require each specific resource. Turnover in each program is factored into the model, and reduces the overall gap in that resource. The shelter inventory of Transitional Housing is expected to serve youth and domestic violence survivors primarily, with some beds for those with substance abuse issues. The Emergency Shelter bed inventory is modeled to be connected to the housing outcomes above, so the length of time it takes for a permanent housing outcome in each program type drives the need for crisis housing. System improvements that reduce the time for permanent housing placements would increase shelter bed turnover and therefore reduce system need. Additional details of the methodology for each housing type are detailed in Appendix B.

Table 1: LA County Homeless Housing Gap Results

LA County Homeless Housing Gap Results					
Programs for Single Adults (Point-in-Time Unit/Bed Count)	Current System for Individuals (Units ¹)	Proposed System for Individuals (Units ¹)	LA Countywide Housing Gap	City of LA Housing Gap	LA County Housing Gap (Excl. City)
Permanent Supportive Housing	9,023	23,731	-14,708	-9,049	-5,658
Rapid Re-Housing ²	157	8,536	-8,379	-3,324	-5,055
Transitional Housing	2,946	1,463	1,483	1,626	-143
Emergency Shelter	3,629	6,310	-2,681	-552	-2,129
Prevention	0	1,505	-1,505	-600	-905
TOTAL	15,755	41,545	-25,790	-11,899	-13,890
Programs for Families (Point-in-Time Unit Count)	Current System for Families (Units)	Proposed System for Families (Units)	LA Countywide Housing Gap	City of LA Housing Gap	LA County Housing Gap (Excl. City)
Permanent Supportive Housing	1,482	2,115	-633	-845	0 ³
Rapid Re-Housing	640	490	0 ³	-110	0 ³
Transitional Housing	794	377	417	218	199
Emergency Shelter	1,093	691	402	180	221 ⁴
Prevention	0	1,050	-1,050	-630	-420
TOTAL	4,009	4,723	-714	-1,187	0

General Note: negative values indicate a resource gap relative to the proposed system allocation; positive values indicate a resource surplus.

Cost Implications

In analyzing the cost to fully fund the housing gaps detailed in Table 1, the following assumes incremental ramp-up toward fully implementation over five fiscal years at 20% per year. Table 2 details the aggregate number of additional units which would become available each year in LA County under a 5-year model. Transitional Housing has been excluded from the cost analysis, as the model shows a surplus for both individuals and families. Under this model, the unit totals in FY 2020-21 and associated cost represent the *increase* in housing and on-going annual funding that will be required following the ramp-up period. This cost would be in addition to the resources that are currently funded, represented in the *Current System* columns of Table 1.

¹ For Emergency Shelter and Transitional Housing programs serving single adults, the terms units and beds are used interchangeably.

² Rapid Re-Housing (RRH) units are able to support two unique households over a 12-month period, so the number of households permanently housed in a year is estimated to be twice the number of the RRH units.

³ The housing gap for the City exceeds the housing gap for the County.

⁴ The proposed system would require fewer emergency shelter units due to better overall resource utilization, faster crisis housing throughput and increased use of prevention.

Table 2: Additional Units of Housing Needed (Cumulative)

	Total Gap (Units)	FY2016-17	FY2017-18	FY2018-19	FY2019-20	FY2020-21
Permanent Supportive Housing	15,341	3,068	6,136	9,204	12,272	15,341
Rapid Re-Housing	8,376	1,675	3,350	5,025	6,700	8,376
Emergency Shelter	2,279	456	912	1,368	1,824	2,279
Prevention	2,555	511	1,022	1,533	2,044	2,555

The associated costs to meet the homeless housing need are based upon an average cost/unit in LA County, using a combination of housing provider surveys, historic financial assistance data, historic LA County shelter and transitional housing bed costs, and projected lengths of assistance (length of assistance estimates are detailed in Appendix B). Table 3 below provides the annual and aggregate cost for additional units needed in LA County. The specific per unit cost inputs are detailed in Appendix C. Note that the new construction and any associated costs have been excluded from this model, as the amount of needed new construction is unknown and the funding sources for such construction would likely be distinct from the funding sources for the costs included in this report.

As previously stated, the housing gaps represent the proposed size and configuration for a homeless housing system that will allow LA County to quickly house anyone who falls into homelessness or will imminently become homeless with the most appropriate and cost-effective intervention. A system ramp-up of this magnitude demands additional one-time resources to facilitate implementation. In particular, there are three, one-time funding categories that will be critical to the success of the effort:

1. Supplemental Outreach – With the majority of the LA County homeless currently living without shelter, more outreach funding is needed to identify, assess, and build connections with the future residents of this additional housing
2. Supplemental Housing Navigation – Housing navigators play a critical role in providing a single point of contact for someone as they work through the process of moving from the streets into housing. Gathering required personal documents, completing a housing application, and finding a housing unit are critical steps in successfully assisting someone to end her homelessness, and without the proper guide they are often insurmountable.
3. Supplemental Emergency Shelter – Shelter, and in particular 24-hour shelter, is also critical to achieving success. It provides a safe, secure location, off of the streets, where people can be connected to additional services and are accessible to case managers and housing navigators. It provides a temporary “home base” for a collaborative housing process and holistic supplemental supports.

Table 4 provides estimates of one-time funding required for these supplemental supports as well as the total funding required over five years, including the totals from Table 3.

Table 3: Annual, Cumulative Funding Required to Meet Gaps (in addition to current annual funding)

	FY2016-17	FY2017-18	FY2018-19	FY2019-20	FY2020-21	Cost Over Five-Year Ramp-Up	Annual Ongoing Cost (Post-FY2020-21)
Permanent Supportive Housing (Leasing)	\$37,110,528	\$74,221,056	\$111,331,584	\$148,442,112	\$185,564,736	\$556,670,016	\$185,564,736
Permanent Supportive Housing (Services)	\$16,326,538	\$32,653,076	\$48,979,614	\$65,306,152	\$81,638,011	\$244,903,390	\$81,638,011
Rapid Re-Housing	\$24,052,234	\$48,104,469	\$72,156,703	\$96,208,937	\$120,275,531	\$360,797,874	\$120,275,531
Emergency Shelter	\$5,825,400	\$11,650,800	\$17,476,200	\$23,301,600	\$29,114,225	\$87,368,225	\$29,114,225
Prevention	\$1,336,776	\$2,673,552	\$4,010,328	\$5,347,104	\$6,683,880	\$20,051,640	\$6,683,880
CES Outreach and Navigation	\$5,500,000	\$5,500,000	\$5,500,000	\$5,500,000	\$5,500,000	\$27,500,000	\$5,500,000
	\$84,651,476	\$169,302,952	\$253,954,429	\$338,605,905	\$423,276,383	\$1,269,791,145	\$428,776,383

Table 4: Supplemental Shelter and Services to Facilitate Ramp-Up (One-Time Costs)

		FY2016-17	FY2017-18	FY2018-19	FY2019-20	FY2020-21	Cost Over Five-Year Ramp-Up
CES Outreach, Navigators and Regional Coordinators	Staff Needed	165	165	165	165	165	
	Cost	\$8,250,000	\$8,250,000	\$8,250,000	\$8,250,000	\$8,250,000	\$41,250,000
Shelter	Beds Needed	1186	1186	1186	1186	1186	
	Cost	\$15,147,956	\$15,147,956	\$15,147,956	\$15,147,956	\$15,147,956	\$75,739,781
Total Cost		\$23,399,307	\$23,399,307	\$23,399,307	\$23,399,307	\$23,399,307	\$116,989,781
Grand Total		\$108,050,783	\$192,702,259	\$277,353,736	\$362,005,212	\$446,675,690	\$1,386,780,926

Using Federal Funding Sources to Offset Local Permanent Supportive Housing Cost

Approximately 4,000 Section 8 Housing Choice Vouchers turn over through attrition across the 20 public housing authorities within the County, each year. As a best practice, the US Interagency Council on Homelessness urges local jurisdictions to pair these vouchers with supportive services to create additional permanent supportive housing opportunities for homeless residents.⁵ This has the potential to offset a large portion of the local cost detailed in Tables 3 and 4, dependent upon the degree to which local housing authorities are willing to implement this strategy, by utilizing long-term federal housing subsidies to help address chronic homelessness. Table 5 below projects the potential local cost offset through this strategy both in terms of dollars and as a percent of the total potential 5-year leasing cost as detailed in Table 3. These projections and the cost assumptions in the prior tables exclude any new construction cost and examine only the rental assistance and supportive services to support additional permanent supportive housing.

Table 5: Potential Permanent Supportive Housing Leasing Cost Offset through Dedication of Section 8 Turn-over

Vouchers Dedicated	1st Year Cost Offset	2nd Year Cost Offset (Aggr.)	3rd Year Cost Offset (Aggr.)	4th Year Cost Offset (Aggr.)	5th Year Cost Offset (Aggr.)	% of Total Leasing Cost Offset
0	\$-	\$-	\$-	\$-	\$-	0%
1000	\$12,096,000	\$36,288,000	\$72,576,000	\$120,960,000	\$181,440,000	33%
2000	\$24,192,000	\$72,576,000	\$145,152,000	\$241,920,000	\$362,880,000	65%
3000	\$36,288,000	\$108,864,000	\$217,728,000	\$362,880,000	\$544,320,000	98%

As Table 5 demonstrates, over \$544M (98%) of the five-year projected local leasing cost for permanent supportive housing could be addressed through the strategic utilization of 75% of the existing federal housing subsidies which become available through routine turnover. In year 5 and each year thereafter, the annual local savings would be \$181M, which is 98% of the total leasing cost for an additional 15,341 units of permanent supportive housing.

There is also potential to offset a portion of the service costs associated with those additional permanent supportive housing units through the Affordable Care Act and potential Medi-Cal reimbursement leveraged with other existing programs administered by DMH, DHS, DPH and other County departments.⁶

⁵ https://www.usich.gov/resources/uploads/asset_library/PHA_Guidebook_Final.pdf

⁶ <https://aspe.hhs.gov/sites/default/files/pdf/77116/EmergPrac.pdf>

Table 6: Potential Permanent Supportive Housing Services Cost Offset through Medi-Cal

% of Supportive Services Cost Billed to Medi-Cal	1st Year Cost Offset	2nd Year Cost Offset (Aggr.)	3rd Year Cost Offset (Aggr.)	4th Year Cost Offset (Aggr.)	5th Year Cost Offset (Aggr.)
0%	\$-	\$-	\$-	\$-	\$-
10%	\$1,632,654	\$4,897,961	\$9,795,923	\$16,326,538	\$24,489,807
20%	\$3,265,308	\$9,795,923	\$19,591,845	\$32,653,076	\$48,979,614
30%	\$4,897,961	\$14,693,884	\$29,387,768	\$48,979,614	\$73,469,421

Table 6 provides estimates of the cost offset of Medi-Cal billing for services provided in permanent supportive housing programs. Over a 5-year period, approximately \$24.5M in services cost projected in this model could be avoided for each 10% increment of those services that are able to be reimbursed under Medi-Cal.

Projected Impact and Reductions in the Point-In-Time Homeless Count

The annual Greater Los Angeles Homeless Count provides the best tool we have to measure success in the goal of reducing and ending homelessness in Los Angeles. Concrete, substantial decreases in the point-in-time count are the end goal of the strategies proposed. Based upon historic success and utilization rates of the housing interventions, Table 7 details the potential impact to future point in time counts under this 5-year model. At the time of this report, the 2016 results are unknown. These projections assume no change in the total PIT enumeration from 2015 to 2106. With that in mind, these projections will need to be revised subsequent to the release of 2016 PIT count results.

Table 7: Projected Impact on Future PIT Counts⁷

	PIT 2017	PIT 2018	PIT 2019	PIT 2020	PIT 2021	PIT 2022
Decrease in PIT Count (Aggr.)	-3,036	-9,109	-15,181	-21,253	-27,326	-30,362
% Decrease from 2015 PIT	-7%	-21%	-34%	-48%	-62%	-68%
New PIT Total	41,323	35,250	29,178	23,106	17,033	13,997

The additional housing detailed in Table 2 has the potential to decrease the PIT count by about 14% each year. Those decreases have been staggered across six PIT counts because the PIT count occurs about half-way through the fiscal year.

From a systems perspective, the biggest challenges to decreasing the PIT count, aside from available housing subsidies, is the availability of affordable rental units and landlords willing to rent to individuals and families who are often perceived as financially riskier tenants. Currently, it’s taking at least three months for people with long and short term subsidies alike to find a vacant unit and move in.

⁷ Based upon 2015 PIT data, assumes no change in the rate of new homelessness

Consequently, a point-in-time snapshot would capture a quarter of the annual population who become homeless each year and utilize housing subsidies, based on the assumption that they will remain homeless for an average of 3 months. This means that with all other conditions remaining equal, fully meeting the housing gaps detailed in this report would only be able to lower the PIT count below 15,000. Until the external constraint of limited affordable housing stock is addressed, this will be the optimal equilibrium.

This does not imply that LA County's PIT count is bound to this constraint. A future where 15,000 residents are homeless every day is unacceptable and should not be the end goal. A few concrete strategies to shift that equilibrium are detailed below:

1. Aggressive development of new affordable housing to shorten the time to move-in, and consequently shorten the length of time people are homeless
2. Investments in shared housing program models to mitigate tightening rental vacancy rates across the County
3. Greater integration of other County Programs, as detailed in the LA County strategies report, to provide benefits and services to prevent low-income households from becoming homeless, decreasing the number of households becoming homeless
4. Increased funding in retention services for existing permanent housing programs to minimize returns to homelessness

With the primary solutions being time-limited and long-term rental subsidies, we are going to need more places for people to live that are actually affordable. The trend has been in the opposite direction, and that has kept people homeless for longer periods of time than necessary. Under this model, every additional day that the average homeless household spends looking for an affordable apartment increases the PIT count by more than 60. Not only does this increase the PIT count, but it also increases the shelter need, because more bridge housing is needed when more homeless households are looking for housing. Although the cost models employed in this report do not consider additional development, it must be acknowledged that heavy investment in additional affordable and homeless housing development is needed in order for even this less than perfect equilibrium to be achieved.

Appendix A: Data Sources

Annual Point-in-Time Count (PIT Count)

A PIT count is an unduplicated count on a single night of the people in a community who are experiencing homelessness that includes both sheltered and unsheltered populations. The PIT Count is the starting point in determining the overall need and determining the proposed system inventory.

Housing Inventory Chart (HIC)

The HIC is an annual inventory of beds and units for homeless persons. The HIC is used to populate the *current inventory* portion of the gaps analysis.

Homeless Management Information System (HMIS)

The HMIS is a database structure used by local jurisdictions to collect information about homeless individuals and homeless assistance programs. For this analysis, Los Angeles, Glendale and Pasadena HMIS was used to assess length of time individuals and families access different types of housing, service utilization patterns, levels of acuity, and permanent housing turnover rates (the Long Beach Continuum of Care maintains a separate HMIS database).

Annual Homeless Assessment Report (AHAR)

The AHAR documents the annual number of people who access homeless assistance programs as documented in the HMIS, as well as the proportion of beds and units that are documented in the HIC that are also represented in the HMIS data set. This information is used to extrapolate client numbers and patterns of service utilization for those beds and units that do not report in the HMIS and to estimate an annual unduplicated count of unique individuals and families who present for services over a twelve- month period.

Appendix B: Detailed Housing Gap Methodology

Permanent Supportive Housing

The Permanent Supportive Housing gap reflects the need for supportive housing options for homeless persons with disabling conditions who have often been homeless for long periods of time. The proposed system inventory takes into account:

- 1) The projected number of chronically homeless individuals and families who present at homeless assistance programs during the year and who require long-term supportive services and housing assistance (we assume that 75% of chronically homeless individuals and 100% of chronically homeless families fall into this category based upon acuity)
- 2) The portion of the current permanent supportive housing units that will remain occupied throughout the year (we assume that 85% of units for individuals and 92% of units for families do not turnover in the course of a year based upon historic data)
- 3) The number of chronically homeless individuals and families that do not present at homeless assistance programs during the year, based upon the PIT count

Rapid Re Housing

The Rapid Re-Housing gap reflects the need for time-limited rental assistance and supportive services, with the understanding that individuals and families will be able to stabilize in fair market housing and take over responsibility for the unit in the short to medium term. This gap assumes that the average length of assistance is 6 months, which implies that the average point-in-time “slot” will serve two households over a 12-month period. The proposed system inventory takes into account:

- 1) The projected number of chronically homeless individuals and families who present at homeless assistance programs during the year and who likely requires short to medium term supportive services and housing assistance (we assume that 25% of individuals and 0% of families fall into this category based upon acuity)
- 2) The projected number of non-chronically homeless individuals and families who present at homeless assistance programs during the year and who likely requires short-to-medium term supportive services and housing assistance (based upon historic data and acuity, we assume that 55% of individuals and 28% of families fall into this category)

Transitional Housing

The Transitional Housing gap reflects the need for intensive supportive services in a sheltered environment for 6-24 months. Best practices suggest that this type of housing can be effective for households fleeing domestic violence, transition age youth (18-24 year olds), and individuals with intense substance abuse challenges. The proposed system inventory takes into account the projected number of non-chronically homeless individuals and families who present at homeless assistance programs during the year and require this type of housing support (we assume that 10% of the

individual population and 16% of the family population fall into this category based upon historic data and acuity).

Emergency Shelter

The Emergency Shelter gap reflects the need for crisis shelter for individuals experiencing temporary housing instability, and for some, a longer stay while they search for a market rate unit or wait for a specific project-based supportive housing unit to become available. The proposed system inventory is designed to cover:

- 1) The projected number of non-chronically homeless individuals and families *who present at homeless assistance programs during the year* and who only need shelter while they resolve their own housing crisis; on average, these households stay in shelter for about one month (we assume that 30% of individuals and 26% of families fall into this category based upon historic data and acuity)
- 2) The projected number of homeless individuals and families who, over the course of the year, will need shelter temporarily while they are in the process of identifying a unit in rapid re-housing or permanent supportive housing programs; on average, these households stay in shelter for about three months
- 3) The projected number of homeless individuals and families who, over the course of the year, will need shelter temporarily while they are in the process of identifying a unit in a transitional housing program as detailed above; on average, these households stay in shelter for about two months

Note: The shelter gap assumes that the permanent supportive housing and rapid re-housing gaps have already been met. This is the amount of shelter required for on-going support of the remainder of the system and addresses annual in-flow into the homeless system. In the absence of those permanent housing options, additional shelter would be needed to prevent increases in the unsheltered population. Further, large scale implementation of additional permanent housing will require a temporary increase in shelter to provide the additional bridge housing required to facilitate move-in, as described in Table 4. The proposed system inventory reflects a “steady-state” need for shelter need in a County-Wide system.

Prevention

The Prevention gap reflects the need for one-time financial assistance to individuals and families who, but for this assistance, will most likely become homeless. The proposed system inventory takes into account the projected number of non-chronically homeless individuals and families who present at homeless assistance programs during the year and require this type of housing support; in most cases, this support will only last for one month (we assume that 5% of individuals and 30% of families fall into this category based upon historic data and acuity).

Appendix C: Housing Cost Inputs

The charts below detail the cost assumptions that were used for Table 3 and Table 4 in this report. The first set of estimates were provided by the Corporation for Supportive Housing, and utilize a combination of historic local data, surveys of permanent housing providers, and local fair market rental rates for LA County. The second set of estimates were created by LAHSA by analyzing historic budget amounts and projecting additional need for outreach and housing navigation to meet the need of the additional resources proposed in this report.

	Studio/1BR	2 BR+
Annual PSH Services Cost per HH	\$ 5,322	\$ 5,677
Annual PSH – Leasing per HH	\$ 12,096	\$ 20,100
Prevention Cost per HH	\$ 2,616	\$ 4,022
RRH Cost per HH	\$ 7,180	N/A

Emergency Shelter	\$ 35	per unit/per day
Regional Coordinators	\$ 125,000	per Service Planning Area
Outreach/Housing Navigators	\$ 50,000	per FTE

None of the estimates in this report assume capital costs associated with new housing development.

Integrated Case Management Services for Permanent Supportive Housing

Potential Funding Sources

On October 13, 2015, the Board of Supervisors adopted a homelessness motion introduced by Supervisors Mark Ridley-Thomas and Michael D. Antonovich directing the Chief Executive Office to identify, as part of the Homeless Initiative, specific funding sources, including federal and state funds, that could be used to establish a sufficient ongoing pool of funds for Intensive Case Management Services (ICMS) tied to permanent supportive housing (PSH) projects.

The list below provides a starting place to braid together disparate state, federal and local funding streams to help support ICMS, as no one funding stream can fully support such an endeavor. We will continue to research funding streams and pursue utilization of the funding streams identified below, when applicable, to ensure that we are maximizing all possible state/federal resources for ICMS. We will report on our progress as part of the quarterly Homeless Initiative reports to the Board.

Category	Funding Stream	Description
Affordable Care Act	Entitlement Funding: Medi-Cal Health Home Benefit	Health Home services will provide a comprehensive system of care coordination for Medi-Cal beneficiaries with chronic conditions, and will be implemented by all Medi-Cal health plans in the County. Health home providers will integrate and coordinate the full range of physical health, behavioral health, and community-based long term services and supports needed by beneficiaries with multiple chronic conditions. These services are expected to begin in January 2018 in Los Angeles County for people with two or more specified chronic conditions or one specified mental illness. Services include: Outreach and engagement; comprehensive care management; care coordination and health promotion; comprehensive transitional care; referral/linkage to community and social services; individual and family supports; and health information technology data. Payment methodologies and rates are still under development, but should be available for comment in two to three months. These services will provide comprehensive case management and overall care coordination, offsetting the costs of ICMS for PSH.
Medi-Cal Waiver	Competitive Application: Whole-Person Care (WPC) Pilot under 1115 Medi-Cal Waiver	WPC pilots will coordinate health, behavioral health, and social services in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective utilization of resources, subject to many details that remain to be determined. WPC pilots must define their target populations to identify clients who frequently access urgent and emergency services, often across multiple systems. WPC pilots may focus on individuals at risk of or experiencing homelessness who have a demonstrated medical need for housing or supportive services. WPC pilots need to have specific strategies to: <ul style="list-style-type: none"> Increase integration among County agencies, health plans and providers that serve high-risk, high-utilizing beneficiaries and develop an infrastructure that will support long-term service

		<p>integration;</p> <ul style="list-style-type: none"> • Increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries; • Reduce inappropriate emergency inpatient utilization; • Improve data collection and sharing to support ongoing case management, monitoring, and strategic program improvements; • Achieve targeted quality and administrative improvement benchmarks; • Increase access to housing and supportive services (optional); and • Improve health outcome for WPC participants. <p>Payments from the WPC pool are intended to support WPC pilots for infrastructure and non-Medicaid covered interventions, which could include elements of ICMS. Counties must match federal funds. The WPC pilots are part of the California's new 1115 Medicaid waiver which is in effect for five years from 2016 – 2020.</p>
State Mental Health Funds	County allocation: (Mental Health Services Act (MHSA)	<p>Proposition 63, the Mental Health Services Act, was designed to transform and expand California's county mental health service delivery system to provide innovative and more comprehensive, coordinated care to those with serious mental illness, particularly in under-served populations. MHSA funded programs fall under the categories of: Community Services and Supports; Prevention and Early Intervention; Innovation; Workforce Education and Training; and capital facilities and technology needs. MHSA can potentially support case management for individuals receiving MHSA-funded program services, prior to opening a DMH client case for outreach and engagement purposes. Using MHSA as the local match, Federal Financial Participation (FFP) may be drawn down for specialty mental health services provided by Medi-Cal certified providers to clients who meet the medical necessity criteria.</p>
Mental Health Medi-Cal	Entitlement: Medi-Cal Mental Health Rehabilitation	<p>Specialty mental health services are provided to Medi-Cal beneficiaries through Medi-Cal mental health plans (MHPs), which are part of a County mental health department. Specialty mental health services must be both medically necessary and a covered service under the Medi-Cal program. Rehabilitative mental health services include: Mental health services such as assessment, plan development, therapy (either group or individual), rehabilitation (either group or individual), collateral services (such as training or counseling for family members or significant others), and case management, along with other covered services such as medication support; day treatment intensive services; day rehabilitation; crisis intervention; crisis stabilization; adult residential treatment; crisis residential treatment; psychiatrist services; psychologist services; EPSDT; and targeted case management. Case management/brokerage is a covered service if appropriately</p>

		documented and claimed, and as long as specialty mental health criteria are met and administered by appropriately credentialed staff in a Medi-Cal-certified provider site.
Federal Substance Abuse Prevention and Treatment Block Grant	Non-competitive formula block grant with annual application for eligible entities: Substance Abuse Prevention and Treatment Block Grant (SABG)	<p>The SABG program's objective is to provide prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. The SABG program targets the following populations and service areas:</p> <ul style="list-style-type: none"> • Pregnant women and women with dependent children • Intravenous drug users • Tuberculosis services • Early intervention services for HIV/AIDS • Primary prevention services <p>Case management is an allowable activity under this block grant and will be part of the new Drug Medi-Cal covered benefit.</p>
Federal Substance Abuse Mental Health Services Administration Funding	Formula grant awarded to county mental health departments: Projects for Assistance in Transition from Homelessness (PATH) Grants	<p>PATH was authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. PATH funds community-based outreach, mental health and substance abuse services, case management, and limited housing services for people experiencing serious mental illnesses, including those with co-occurring substance use disorders who are homeless or are at risk of becoming homeless. PATH funds can be utilized for a variety of services including:</p> <ul style="list-style-type: none"> • Outreach services; • Screening and diagnostic treatment services; • Habilitation and rehabilitation services; • Community mental health services; • Alcohol or drug treatment services; • Staff training, including the training of individuals who work in shelters, mental health clinics, substance abuse programs, and other sites where individuals who are homeless require services; • Case management services; • Supportive and supervisory services in residential settings; • Referrals for primary health services, job training, educational services, and relevant housing services; and • Assistance with identifying and securing appropriate housing. <p>Case management and support services are allowable. Grantee requirements include development of a service plan and an annual budget for utilization of the funds.</p>
Federal Substance Abuse Mental Health Services Administration Funding	Competitive Grant – 3 year duration: Cooperative Agreements to Benefit Homeless Individuals (CABHI)	<p>The purpose of this program, which is jointly funded by the Center for Substance Abuse Treatment and Center for Mental Health Services, is to enhance or develop the infrastructure of states and their treatment service systems to increase capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services; permanent housing; peer supports; and other critical services for the following:</p>

		<ul style="list-style-type: none"> • Individuals who experience chronic homelessness and have substance use disorders (SUDs), serious mental illness (SMI), serious emotional disturbance (SED), or co-occurring mental and substance use disorders (CODs); and/or • Veterans who experience homelessness or chronic homelessness and have SUD, SMI, or COD; and/or • Families who experience homelessness with one or more family members who have SUD, SMI, or COD; and/or • Youth who experience homelessness and have SUD, SMI, SED, or COD. <p>Case management is a required service under the grant to address behavioral health conditions and link/retain individuals in housing and other necessary services.</p>
Federal Substance Abuse Mental Health Services Administration Funding	Competitive Grant: Grants for the Benefit of Homeless Individuals (GBHI)	GBHI is a competitively awarded grant program that enables communities to expand and strengthen their treatment services for people experiencing homelessness. Grants are awarded for up to five years to community-based or nonprofit entities and funded programs/services include: Substance abuse treatment; mental health services; wrap-around services; immediate entry into treatment; outreach services; screening and diagnostic services; staff training; case management; primary health services; job training; educational services; and relevant housing services. Case management services are used to retain clients in housing, provide other necessary services, including, but not limited to, primary care services and coordinating supportive services for the client.
U.S. Department of Health and Human Services	Competitive Grant: Health Care for the Homeless (HCH)	The HCH Program was first established through the McKinney Homeless Assistance Act of 1987. In 1996, Congress combined the HCH Program with Community Health Centers, Migrant Health Centers, and Primary Care in Public Housing under the Consolidated Health Center Program. HCH makes grants to community-based organizations in order to assist them in planning and delivering high-quality, accessible health care to people experiencing homelessness. The HCH Program is a competitive grant program, funding primary health, mental health, addiction, and social services with intensive outreach and case management to link clients with appropriate services.
Veterans Affairs Funding	Allocation to Continuum of Care: U.S. Veterans Affairs Supportive Housing (VASH) Program	VASH program combines Housing Choice Voucher (HCV) rental assistance for homeless Veterans with case management and clinical services provided by the Department of Veterans Affairs (VA). VA provides these services for participating Veterans at VA medical centers (VAMCs) and community-based outreach clinics. Case management is a component of the HUD-VASH program administered by the VA.
Veterans Affairs Funding	Competitive application: Supportive Services for Veteran Families (SSVF) Program	The SSVF program provides supportive services to very low-income veteran families transitioning to permanent housing to improve overall housing stability. SSVF program grantees (community based organizations and consumer cooperatives) provide eligible veteran

		<p>families with outreach, case management and assistance in obtaining VA and other benefits, which can include:</p> <ul style="list-style-type: none"> • Health care services; • Daily living services; • Personal financial planning services; • Transportation services; • Fiduciary and payee services; • Legal services • Child care; and • Housing counseling services. <p>Case management is a component of the SSVF program administered by the VA. SSVF can be used to provide an intensive short-term services intervention, such as Critical Time Intervention.</p>
<p>Administration for Children and Families (ACF)</p>	<p>Competitive grants administered by the Family and Youth Services Bureau within ACF: Runaway and Homeless Youth Programs</p>	<p>The Basic Center Program (BCP) helps create and strengthen community-based interventions that meet the immediate needs of runaway and homeless youth under 18 years old. In addition, BCP tries to reunite young people with their families or locate appropriate alternative placements. BCP provides the following services:</p> <ul style="list-style-type: none"> • Up to 21 days of shelter • Food, clothing and medical care • Individual, group and family counseling • Crisis Intervention • Recreation programs • Aftercare services for youth after they leave the shelter <p>The Street Outreach Program (SOP) supports work with homeless, runaway and street youth to help them find stable housing and services. SOPs focus on developing relationships between outreach workers and young people that allow them to rebuild connections with caring adults. The ultimate goal is to prevent the sexual exploitation and abuse of youth on the streets. Street outreach services include:</p> <ul style="list-style-type: none"> • Street based education and outreach • Access to emergency shelter • Survival aid • Treatment and counseling • Crisis intervention • Follow-up support <p>Case management and wraparound services are provided through these grants.</p>

<p>County General Fund in the Department of Health Services Budget</p>	<p>Housing for Health</p>	<p>The County Department of Health Services (DHS) launched HFH in November 2012 to provide services and housing assistance for homeless individuals who have complex health, mental health, and/or substance use needs and are high-users of DHS hospital services. In addition to the cost of permanent housing, HFH funds a flexible array of services, including intensive case management, crisis intervention, linkages to health, mental health, and substance use disorder services, assistance with benefits, housing search assistance for those who use tenant-based rent subsidies, and life skills and job skills training. HFH also funds interim housing options, including recuperative (respite) care to provide short-term stability for some homeless people experiencing chronic illness or recovering from hospitalization until they can move into permanent housing. Since the inception of the program in 2012, HFH has housed over 1,300 clients and will provide housing to an additional estimated 2,800 clients in 2016.</p>
--	---------------------------	---

HOMELESSNESS PREVENTION PROGRAMS & STRATEGIES FOR INDIVIDUALS & FAMILIES

On October 13, 2015, the Board instructed the Chief Executive Officer (CEO) to develop this report on homelessness prevention activities within the County. This document identifies current and proposed prevention-related interventions in response to that instruction.

The following factors are relevant to the programs identified below: 1) some of the programs listed are not only related to “homelessness prevention”, but have a homeless prevention strategy component(s); 2) for those programs that are not focused exclusively on homeless prevention, the funding amounts listed are not 100% set aside for prevention, i.e., a portion of the dollar amounts listed are used for the prevention component of the respective program; and 3) funding amounts are for Fiscal Year 2014-15 and are not available for all programs listed.

CURRENT LOCAL GOVERNMENT PREVENTION PROGRAMS

Program Name: Emergency Solutions Grant (ESG) (partially for homelessness prevention)	Lead Agency: Community Development Commission (CDC)	Population Served: Chronically Homeless, Families, Veterans, Youth	Funding: \$1,879,396
Program Description: ESG provides funding to: (1) engage homeless individuals and families living on the street; (2) improve the number and quality of emergency shelters for homeless individuals and families; (3) help operate these shelters; (4) provide essential services to shelter residents, (5) rapidly re-house homeless individuals and families, and (6) prevent families/individuals from becoming homeless. The Los Angeles Homeless Services Authority (LAHSA) administers the ESG program for the CDC.			
Program Name: Community-Based Mental Health: Housing Specialists (partially for housing retention for formerly-homeless individuals)	Lead Agency: Department of Mental Health (DMH)	Population Served: Transition Age Youth (TAY) and Adults with mental illness	Funding: \$1,867,000
Program Description: Countywide Housing Specialists (TAY and Adult) – Provides housing assistance to those who are homeless and retention services for those that have transitioned into housing.			
Program Name: Housing Assistance Programs, Countywide (partially for homelessness prevention)	Lead Agency: DMH	Population Served: Persons with mental illness	Funding: \$682,445
Program Description: Provides funding to assist mental health consumers without the financial resources to afford the costs associated with moving into permanent housing (i.e. security deposit, household goods needed to start a home) and/or avoid eviction due to unexpected financial hardship.			

HOMELESSNESS PREVENTION PROGRAMS & STRATEGIES FOR INDIVIDUALS & FAMILIES

Program Name: Housing Assistance Programs: MHPA (directly operated) (partially for homelessness prevention)	Lead Agency: DMH	Population Served: Persons with mental illness	Funding: \$644,115
---	----------------------------	--	------------------------------

Program Description:
Provides funding to assist directly operated FSP consumer's permanent housing move-in costs, on-going rental assistance, and purchase of household goods to start a home; and/or avoid an eviction due to an unexpected financial hardship.

Program Name: Housing Assistance Programs: TAY (entirely for homelessness prevention)	Lead Agency: DMH	Population Served: TAY with mental illness	Funding: \$782,405
---	----------------------------	--	------------------------------

Program Description:
In collaboration with the Department of Children and Family Services, the TAY Transitional Housing Program provides housing to emancipated TAY with mental illness exiting the foster care system and at risk of becoming homeless.

Program Name: Emergency Assistance to Prevent Eviction (EAPE) Program (entirely for homelessness prevention)	Lead Agency: Department of Public Social Services (DPSS)	Population Served: CalWORKs Welfare-to-Work (WtW) families	Funding: \$2.5M
--	--	--	---------------------------

Program Description:
Helps CalWORKs WtW families who are behind in rent and/or utility bills due to a financial crisis which could lead to an eviction and homelessness. It provides eligible families with a once-in-a-lifetime maximum of up to \$2,000 to pay their past due rent and/or utilities for up to two months to help them keep their housing.

Program Name: CalWORKs Homeless Assistance (HA) Program (partially for homelessness prevention)	Lead Agency: DPSS	Population Served: CalWORKs Welfare-to-Work (WtW) families	Funding: \$12,238,179
---	-----------------------------	--	---------------------------------

Program Description:
Provides temporary Housing Assistance (HA) and permanent HA. Temporary HA provides temporary shelter payments to homeless families while they are looking for permanent housing. Permanent HA helps homeless families secure a permanent residence or provides up to two months back rent when the family has received a pay rent or quit notice.

HOMELESSNESS PREVENTION PROGRAMS & STRATEGIES FOR INDIVIDUALS & FAMILIES

Program Name: CalWORKs 4 Month Rental Assistance (partially for homelessness prevention)	Lead Agency: DPSS	Population Served: CalWORKs Welfare-to-Work (WtW) families	Funding: \$570,663
Program Description: Helps homeless CalWORKs Welfare to Work families to remain in non-subsidized permanent housing by providing a short-term rental subsidy. Families receiving Permanent Housing Assistance, Move in Assistance, and/or Emergency Assistance to Prevent Eviction may qualify for a rental subsidy of up to \$500 per family (based on the family size) for up to four consecutive months or longer for families receiving CalWORKs family stabilization services.			

Program Name: CalWORKs Housing Relocation Program (HRP) (partially for homelessness prevention)	Lead Agency: DPSS	Population Served: Families	Funding: \$1,050
Program Description: Provides a one-time-only relocation subsidy of up to \$1,500 to eligible CalWORKs WtW participants working 20 hours or more per week or with a documented offer of employment for 20 hours or more per week. Travel time from current housing to employment/day care must exceed one hour one-way. In addition, the rental cost for the prospective residence must not exceed 60% of the family's total monthly household income. The HRP pays up to \$1,500 for move-in costs and an additional \$405 for appliances (stove and/or refrigerator) if not available in the rental housing.			

Program Name: Housing Opportunities for Persons with AIDS (HOPWA) (partially for homelessness prevention)	Lead Agency: LA Housing and Community Investment Department	Population Served: Persons with HIV/AIDS	Funding: \$16M (FY 13-14)
Program Description: HOPWA is a Federally funded program that provides assistance with housing and supportive services for low income persons living with HIV/AIDS and their families. The LA Housing and Community Investment Department is responsible for administering the HOPWA Program countywide. The Program goals are to maintain stable housing, reduce the risk of homelessness, and increase access to services.			

Program Name: Families Housing Assistance Program (FHAP) (partially for homelessness prevention)	Lead Agency: LA Homeless Services Authority (LAHSA)	Population Served: Families	Funding: \$125,000 annually
Program Description: Provides tapering monthly rental assistance to homeless families for up to one year. Eligible populations are homeless families with legal custody of one or more dependent children under the age of 18. Families must come from shelters located in the City of Los Angeles or be referred by street outreach services within the City of Los Angeles.			

HOMELESSNESS PREVENTION PROGRAMS & STRATEGIES FOR INDIVIDUALS & FAMILIES

CURRENT LOCAL COMMUNITY PREVENTION PROGRAMS

Program Name: FEMA Emergency Food and Shelter Program (partially for homelessness prevention)	Lead Agency: United Way of Greater Los Angeles (United Way)	Population Served: Families and Single adults	Funding: Not available
Program Description: The Program was created to meet the needs of hungry and homeless people throughout the US by allocating Federal funds for the provision of food and shelter. Program funds are used to provide the following: food in the form of served meals or groceries; lodging in shelters or hotels; one month's rent or mortgage payment; one month's utility bill; and equipment needed to feed or shelter people (up to \$300 limit per item).			
Program Name: Utility Assistance (partially for homelessness prevention)	Lead Agency: United Way	Population Served: Families and Individuals	Funding: Not available
Program Description: On behalf of Southern California Gas Company and Southern California Edison, respectively, the United Way administers two programs: the Gas Assistance Program (GAP) and the Energy Assistance Fund (EAF) Program, respectively. The Programs are funded by customer contributions through an annual campaign, which are matched by the utilities. There are approximately 90 disbursement agencies located in 12 counties, approximately 33 are in Los Angeles County. Maximum assistance is \$100.00 and can only be received one time in a 12-month period.			
Program Name: Eviction Defense for Low Income Families	Lead Agency: Public Counsel	Population Served: Families	Funding: Not available
Program Description: Public Counsel's eviction defense team provides assistance through direct representation of families at risk of homelessness (eviction) at the Stanley Mosk and Pasadena Courthouses. In addition, through their clinics, Public Counsel assists self-represented tenants to defend their right to stay in their home and avoid becoming homeless.			
Program Name: Homelessness Prevention Project	Lead Agency: Inner City Law Center (ICLC)	Population Served: Low-Income tenants	Funding: Not available
Program Description: ICLC's Homelessness Prevention Project seeks to preserve safe and decent housing for low-income tenants in Los Angeles. ICLC's pro bono attorneys defend low-income tenants from eviction and help prevent homelessness.			

HOMELESSNESS PREVENTION PROGRAMS & STRATEGIES FOR INDIVIDUALS & FAMILIES

PROPOSED LOS ANGELES COUNTY HOMELESS INITIATIVE STRATEGIES

Strategy Number / Name: A1 – Homeless Prevention Program for Families (exclusively for homelessness prevention)	Lead Agency: LAHSA	Population Served: Families	Funding: \$5M in one-time funding
---	------------------------------	---------------------------------------	---

Strategy Description:
LAHSA and DPSS, in collaboration with County agencies and family system partners (not clear what prior 3 words mean), will develop a comprehensive strategy, which draws on the Homeless Family Solutions System (HFSS) model and builds upon current available County homelessness prevention funding sources, to address rental/housing subsidies, case management, employment services, and legal services, to effectively identify, assess, and prevent families from becoming homeless, and to divert families in a housing crisis from homelessness. The strategy will consist of a multi-faceted approach to maximize and leverage existing funding and resources, evaluate and potentially modify policies that govern existing prevention resources to allow greater flexibility, prioritize resources for the most vulnerable populations, and create an outreach and engagement strategy to identify access points for families at risk of homelessness.

Strategy Number / Name: A2 – Discharge Planning Guidelines (exclusively for homelessness prevention)	Lead Agency: Department of Health Services (DHS)	Population Served: Single adults, TAY, Veterans and Chronically homeless	Funding: There is no cost for developing the guidelines.
--	--	--	--

Strategy Description:
DHS, with County agencies and key community-based partners, will develop/enhance Discharge Planning Guidelines utilizing known best practices, with the goal of preventing individuals from being homeless upon discharge from institutions, including foster care, DHS hospitals, and jails. Potential programmatic elements of an effective discharge plan include, but are not limited to: Family Reunification; connection to the Coordinated Entry System; physical health care; substance use treatment; connection to a Federally Qualified Health Center; and mental health treatment. Various housing types will also be identified in the Guidelines.

Strategy Number / Name: A3 – Housing Authority Family Reunification Program (exclusively for homelessness prevention)	Lead Agencies: Los Angeles Sheriff Department, Probation Department, and Housing Authority of the County of LA (HACoLA)	Population Served: Individuals scheduled for release from incarceration whose families are in housing supported by a Section 8 housing subsidy	Funding: No funding required
---	---	--	--

Strategy Description:
The goal of the Family Reunification Program is to house formerly incarcerated persons (FIP) released from the criminal justice system within the last 24 months with family members who are current participants of the Housing Authority of the City of LA’s Section 8 Housing Choice Voucher Program. HACoLA will also explore the feasibility of implementing a similar program with its Section 8 Vouchers.

HOMELESSNESS PREVENTION PROGRAMS & STRATEGIES FOR INDIVIDUALS & FAMILIES

<p>Strategy Number / Name: A4 – Discharges From Foster Care & Juvenile Probation (exclusively for homelessness prevention)</p>	<p>Lead Agency: Departments of Children and Family Services & Probation</p>	<p>Population Served: TAY & Non-Minor Dependents</p>	<p>Funding: No funding required</p>
---	--	---	--

Strategy Description:

The goal is to develop a plan to strengthen discharge policy for the County’s foster care and juvenile probation populations. In addition to strengthening the County’s current discharge policy, the plan will serve to address gaps identified through the implementation of AB12, CA Fostering Connections to Success Act, particularly as AB 12 outcome data becomes available.

<p>Strategy Number / Name: B7 – Interim Bridge Housing (exclusively for homelessness prevention)</p>	<p>Lead Agency: LAHSA</p>	<p>Population Served: Single Adults, Chronically Homeless Adults, and TAY</p>	<p>Funding: \$11.25M</p>
---	--------------------------------------	--	-------------------------------------

Strategy Description:

The goal of the strategy is to develop and implement a plan to increase the interim/bridge housing stock across the County, including identification of funding that can be used to support the increase, in addition to the \$11.25 million already recommended for this strategy. There will be an opportunity to increase the supply of bridge housing during 2016, when LAHSA will stop funding approximately 2000 transitional housing beds, per direction from the U.S. Department of Housing and Urban Development to shift funding away from transitional housing. Bridge housing is a very useful housing type for persons exiting institutions who otherwise could exit into homelessness.

INVENTORY OF EXISTING SERVICES FOR TRANSITION AGE YOUTH

As directed by the Board on December 15, 2015, County Departments and Community-Based Organizations specializing in providing services to homeless youth (up to age 24) collaborated on an inventory of existing programs that utilize drop in centers, emergency, transitional, or permanent supportive housing, as well as a continuum of care that includes individualized case management, educational support or job preparation and placement, life skills training, and mental health/substance use disorder support.

Together, the group identified the following Los Angeles Homeless Services Authority Housing Inventory for Transition Age Youth, combined with the Directory of Services for Homeless Youth (<https://www.ourchildrenla.org/community-center/directory/>) developed by Our Children Los Angeles (including its online app), as the most extensive, current inventories of available TAY homeless services.



Los Angeles County Housing Inventory for Homeless TAY

Housing Resources:

Shelter Beds	195
Shelter & TH Beds for Mino	80
Transitional Beds	868
Supportive Housing Units	391
	<i>*50 units are in development. Current units in operation = 341</i>
TOTAL TAY BEDS/UNITS	1534

HOUSING RESOURCES DATA

TYPE	SERVICE PROVIDER	Program Name	ADDRESS	CITY, ZIP	SPA	NUMBER OF YOUTH BEDS		PIT Utilization Rate (If known)
						Total	Beds for Unaccompanied Minors	
Emergency Shelter	California Hispanic Commission (CHCADA)	DMH TAY Division - Enhanced Emergency Shelter Program (EESP)	11046 Valle Mall	El Monte, 91731	3	10		
Emergency Shelter	Gateways	DMH TAY Division - Enhanced Emergency Shelter Program (EESP)	423 N. Hoover	Los Angeles, 90004	4	12		
Emergency Shelter	Women Shelter of Long Beach	DMH TAY Division - Enhanced Emergency Shelter Program (EESP)		Long Beach	8	7		
Emergency Shelter	LA Gay & Lesbian Center	DMH TAY Division - Enhanced Emergency Shelter Program (EESP)	1220 N. Highland Ave.	Los Angeles, 90038	4	10		
Emergency Shelter	Good Seed	DMH TAY Division - Enhanced Emergency Shelter Program (EESP)		Los Angeles	6	8		
Emergency Shelter	1736 Family Crisis Center	DMH TAY Division - Enhanced Emergency Shelter Program (EESP)		Los Angeles	6,8	27		
Emergency Shelter	Covenant House	Emergency Shelter	1325 N. Western Ave.	Los Angeles, 90027	4	60		98%
Emergency Shelter	Los Angeles Gay & Lesbian Community Services Center	Emergency Overnight Bed Program	1220 Highland Ave	Los Angeles, CA 90028	4	14		100%
Emergency Shelter	Jovenes, Inc.	LaPosda Emergency Shelter	1320 Pleasant Ave.	Los Angeles, 90033	4	12		63%
Emergency Shelter	L.A.Youth Network	Taft Youth Shelter	1719 & 1754 Taft Ave	Los Angeles, 90028	4	23	23	76%
Emergency Shelter	1736 Family Crisis Center	Emergency Youth Shelter	1736 Monterey Blvd.	Hermosa Beach, 90254	8	6	6	17%
Emergency Shelter	Catholic Charities of Los Angeles, INC.	Angel's Flight Shelter	357 S. Westlake Ave.	Los Angeles, 90057	4	16	16	38%

TYPE	SERVICE PROVIDER	Program Name	ADDRESS	CITY, ZIP	SPA	NUMBER OF YOUTH BEDS		PIT Utilization Rate (If known)
						Total	Beds for Unaccompanied Minors	
Emergency Shelter	Children of the Night	Children of the Night	14530 Sylvan St.	Van Nuys, 91411	2	24	24	63%
Emergency Shelter	Pathways To Your Future	TAY Winter Shelter Program	6900 S. Wetsern Ave.	Los Angeles, 90047	6	35		
Transitional	ACOF - Step Out	DMH ILP		Compton	6	20		
Transitional	Anti-Recidivism Coalition	ARC Supportive Housing on Bromont (transition in place)			2	24		
Transitional	Athena	DMH ILP		Alhambra; San Gabriel	3	18		
Transitional	BRIDGES Inc	Casitas Tranquilas				15		27%
Transitional	Burbank Housing Corps	Linden House				4		100%
Transitional	California Council for Veterans Affairs	GPD - Women & Children First				2		
Transitional	Center for Human Rights and Constitutional Law	Freedom House-Casa Libre Homeless Youth Shelter				8	8	50%
Transitional	Covenant House	Rights of Passage	1325 N. Western Ave.	Los Angeles, 90027	4	34		100%
Transitional	David and Margaret	Transitional Housing Program Plus (THP-Plus), THP+FC		La Verne; Glendora	3, 4	32		100%
Transitional	Divinity Prophet	A Home for Us	1239 W. Rosecrans Ave #17	Gardena, 90247	8	6		
Transitional	Ettie Lee Homes	Transitional Housing Program Plus (THP-Plus)		Lancaster	1,2,5	11		
Transitional	Family Promise of Santa Clarita Valley	Interfaith Hospitality Network			1	6		
Transitional	First Place for Youth	Transitional Housing for Homeless Young People	5800 South St.	Lakewood, 90713	4,5,6,7	20		
Transitional	First Place for Youth	My First Place TAY Housing Stabilization Project-SD5	Scattered Sites		5	16		75%
Transitional	Florence Crittenton of So. California	Transitional Housing Program Plus (THP-Plus)		Lancaster	1,3,6,7,8	27		
Transitional	Gramercy Housing Group	Gramercy Court			4	15		93%
Transitional	Hathaway-Sycamores	TAY-Transitional Housing Program			2,3,4,6,7	154		

TYPE	SERVICE PROVIDER	Program Name	ADDRESS	CITY, ZIP	SPA	NUMBER OF YOUTH BEDS		PIT Utilization Rate (If known)
						Total	Beds for Unaccompanied Minors	
Transitional	Hillview Mental Health	DMH ILP		Pacoima	2	14		
Transitional	Homes for Life	Athena Homes	26 S. Almansor St.	Alhambra, 91801	3	18		89%
Transitional	House of Yaweh	House of Yaweh Transitional Housing				6		67%
Transitional	Jovenes, Inc.	Casa Olivares	1320 Pleasant Ave.	Los Angeles, 90033	4	7		86%
Transitional	Jovenes, Inc.	Transition to My Place			4	13		46%
Transitional	L.A.Youth Network	TLP Program	6118 Carlos Ave.	Los Angeles, 90028	4	17	3	
Transitional	L.A.Youth Network	Beachwood Group Home	2471 N. Beachwood Dr.	Los Angeles, 90068	4	12		
Transitional	Pacific Clinics	TAY Housing Stabilization Project			3	16		75%
Transitional	Penny Lane Centers	Transitional Housing for Homeless Young People	44040 Division St.	Lancaster, 93535	1,2	64		50%
Transitional	Rancho San Antonio	Rancho San Antonio Transitional Housing Program				15		93%
Transitional	Richstone Center	Transitional Housing Program Plus (THP-Plus)		Hawthorne	8	7		100%
Transitional	Salvation Army	The Way In	5939 Hollywood Blvd.	Los Angeles, 90028	4	4		100%
Transitional	Sanctuary of Hope	Hope Place		Los Angeles	6	8		100%
Transitional	St. Anne's	The Bogan Center, St. Anne's Maternity Homes	151 N. Occidental Ave.	Los Angeles, 90026	4	38		
Transitional	Step Up On Second	Step Up On Bromont				7		100%
Transitional	The Teen Project	Freehab Transitional Housing for TAY	8140 Sunland Blvd.	Sun Valley, 91352	2	40		31%
Transitional	United Friends of the Children	Pathways to Independence	7061 W. Manchester	Los Angeles, 90045	5,6,7,8	125		
Transitional	The Village Family Services	TAY Transitional Housing Program	7843 Lankershim Blvd.	No. Hollywood, CA 91605	2	12		
Transitional	Volunteers of America	Independent Living Program-Women's Care Cottage	6428 Whitsett Ave.	North Hollywood, 91606	2	16		94%
Transitional	Wings of Discovery	Other Transitional Housing Programs		La Verne	3	2		

TYPE	SERVICE PROVIDER	Program Name	ADDRESS	CITY, ZIP	SPA	NUMBER OF YOUTH BEDS		PIT Utilization Rate (If known)
						Total	Beds for Unaccompanied Minors	
Transitional	Youth Moving On	Other Transitional Housing Programs		Pasadena	3	20		
Transitional	YWCA	Housing and Education Program	2019 14th St.	Santa Monica, 90405	5	6		60%
Supportive Housing	Penny Lane Centers	Permanent Housing for Persons with Disabilities	8600 Columbus Ave	North Hills, 91343	2	14		
Supportive Housing	Los Angeles Gay and Lesbian Center	TAY Independent Living Program	1745 N. Wilcox	Los Angeles, 90028	4	12		
Supportive Housing	Abode Communities; United Friends of the Children	Casa Dominguez	15727 South Atlantic Ave.	East Rancho Dominguez, 90221	2	7		
Supportive Housing	Step Up On Second	Daniel's Village	1619 Santa Monica Blvd.	Santa Monica, 90404	5	7		100%
Supportive Housing	Coalition for Responsible Community Development (CRCD)	36th St Apartments	157 East 36th St.	Los Angeles, 90011	6	10		
Supportive Housing	Women Organizing Resources, Knowledge, and Services (WORKS); Housing Works	Young Burlington	820 South Burlington Ave.	Los Angeles, 90057	4	20		
Supportive Housing	Coalition for Responsible Community Development (CRCD)	Broadway Apartments	4775 South Broadway	Los Angeles, 90037	6	10		
Supportive Housing	Clifford Beers Housing; Coalition for Responsible Community Development (CRCD)	28th St Apartments	1006 East 28th St.	Los Angeles, 90011	6	8		
Supportive Housing	Jovenes, Inc.	Progress Place	1208 Pleasant Ave.	Los Angeles, 90033	4	14		
Supportive Housing	LINC Housing; United Friends of the Children	Palace Hotel	2640 East Anaheim St.	Long Beach, 90804	8	14		
Supportive Housing	Coalition for Responsible Community Development (CRCD)	Epworth Apartments	6525 S. Normandie Ave.	Los Angeles, 90044	6	19		

TYPE	SERVICE PROVIDER	Program Name	ADDRESS	CITY, ZIP	SPA	NUMBER OF YOUTH BEDS		PIT Utilization Rate (If known)
						Total	Beds for Unaccompanied Minors	
Supportive Housing	Jovenes, Inc.	Boyle Hotel	1781 East 1st St.	Los Angeles, 90033	4	5		
Supportive Housing	Little Tokyo Service Center; Pilipino Workers Center (PWC)	Larry Itliong Village	153 Glendale Blvd.	Los Angeles, 90026	4	9		100%
Supportive Housing	Step Up On Second	Step Up On Vine	1057 N. Vine St.	Hollywood, 90038	4	8		
Supportive Housing	Little Tokyo Service Center; Koreatown Youth & Community Center (KYCC)	Menlo Apartments	1230 Menlo Ave.	Los Angeles, 90006	4	5		
Supportive Housing	LA Housing Partnership (LAHP); Penny Lane Centers	Mid Celis Apartmetns	1422 San Fernando Rd	San Fernando, 91340	2	10		40%
Supportive Housing	Penny Lane Centers	Rayen Apartments	15305 Rayen St	North Hills, 91343	2	25		
Supportive Housing	LINC Housing; Dept. of Mental Health	Mosaic Gardens at Huntington Park	6337 Middleton St.	Huntington Park, 90255	7	15		40%
Supportive Housing	L.A. Gay & Lesbian Center-On Site	TAY Independent Living Program	1611 N. Schrader Blvd.	Los Angeles, CA 90028	4	8		93%
Supportive Housing	David & Margaret Home, Inc.	Cedar Springs	1332 Palomares Avenue	Laverne, 91750	3	35		
Supportive Housing	Clifford Beers Housing	28th St Apartments	1006 East 28th St.	Los Angeles, 90011	6	8		
Supportive Housing	A Community of Friends	Huntington Square	6101 State St	Huntington Park, 90255	7	15		
Supportive Housing	Coalition for Responsible Community Development (CRCD)	HACLA Section 8 Homeless Programs	Scattered Sites		6	58		46%
Supportive Housing	Penny Lane Centers	Penny Lane Permanent Housing Center Program				15		27%
Supportive Housing	Penny Lane Centers/ Abbey Road	Moonlight Villas				12		
Supportive Housing	AMCAL Multi-Housing Inc	Terracina				15		173%

TYPE	SERVICE PROVIDER	Program Name	ADDRESS	CITY, ZIP	SPA	NUMBER OF YOUTH BEDS		PIT Utilization Rate (If known)
						Total	Beds for Unaccompanied Minors	
Supportive Housing	KIWA/Little Tokyo Service Center CDC	Casa Yonde			4	10		100%
Supportive Housing	West Hollywood Community Housing Corporation	Courtyard at La Brea			4	3		100%
					TOTALS:	1534	80	



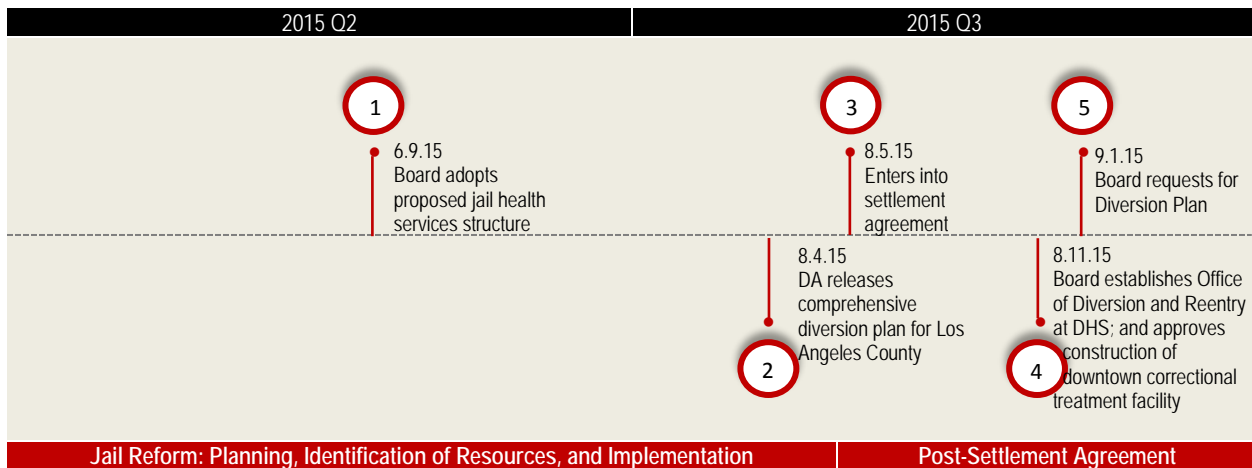
County of Los Angeles
AD HOC INITIATIVES

SHERIFF'S DEPARTMENT INITIATIVE (DIVERSION, RE-ENTRY, AND MENTAL HEALTH)

Topic	Document	Date
Jail Health Services	1. Board Letter - Approval of Proposed Jail Health Services Structure - Adopted	6/9/15
Correctional Treatment	2. Board Correspondence - Providing Treatment, Promoting Rehabilitation, and Reducing Recidivism: An Initiative to Develop a Comprehensive Diversion Plan for Los Angeles County. District Attorney, Mental Health Advisory Board Report: A Blueprint for Change	8/4/15
Settlement Agreement	3. Settlement Agreement - County enters into settlement agreement with federal government and identifies resources and strategies to better address needs of offenders with mental health conditions	8/5/15
Office of Diversion & Re-entry	4. Board Motion - Expanding Effective Diversion Efforts in Los Angeles County	8/11/15
	5. Board Motion - Report Back on Diversion Plan within 90 days of Hiring the Director of the Office of Diversion	9/1/15
	6. Board Correspondence - Office of Diversion and Re-Entry Status Report	3/14/16

- Information Available on County Sheriff's Initiative Website at: <http://priorities.lacounty.gov/sheriff/>
- Board Correspondence may be searched by title and date at: <http://portal.lacounty.gov/wps/portal/bc>

SHERIFF'S DEPARTMENT INITIATIVE (DIVERSION & RE-ENTRY) TIMELINE





SACHI A. HAMAI
Interim Chief Executive Officer

County of Los Angeles
CHIEF EXECUTIVE OFFICE

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
<http://ceo.lacounty.gov>

"To Enrich Lives Through Effective And Caring Service"

Board of Supervisors
HILDA L. SOLIS
First District

MARK RIDLEY-THOMAS
Second District

SHEILA KUEHL
Third District

DON KNABE
Fourth District


MICHAEL D. ANTONOVICH
Fifth District

June 09, 2015

ADOPTED

BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

15 June 9, 2015


PATRICK OGAWA
ACTING EXECUTIVE OFFICER

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

**APPROVAL OF PROPOSED JAIL HEALTH SERVICES STRUCTURE
(ALL DISTRICTS)
(3 VOTES)**

SUBJECT

Approval of the proposed integrated jail health services organizational structure and the transition of jail health staff from the Department of Mental Health and Sheriff's Department Medical Services Bureau to the Department of Health Services.

IT IS RECOMMENDED THAT THE BOARD:

1. Approve the proposed organizational structure to create a single, integrated jail health services unit that consolidates the currently separate jail health services functions under a single Correctional Health Director within the Department of Health Services and instruct the Interim Chief Executive Officer to work with County Counsel, Sheriff's Department, Departments of Health Services, Mental Health, Public Health, and Human Resources to complete Phase Zero planning activities related to the implementation of this structure.
2. Instruct the Interim Chief Executive Officer to work with the affected departments noted above to implement Phase One of the transition to the new jail health services organizational model, including the transfer of Sheriff's Department Medical Services Bureau and Department of Mental Health staff and services, as described herein, to the Department of Health Services, pending labor consultations and completion of necessary Phase Zero planning activities.
3. Instruct the Interim Chief Executive Officer to work with the affected departments noted above to implement Phase Two of the transition, including the transfer of the remaining Sheriff's Department

Medical Services Bureau staff and services, as described herein, to the Department of Health Services within approximately 12-18 months of the initiation of Phase One, assuming the transition process is successful and the Board does not determine that any problems or concerns warrant reconsideration of the timing or scope of Phase Two.

4. Approve interim ordinance authority, pursuant to County Code Section 6.06.020, for the Department of Health Services to recruit and hire three (3.0) new jail leadership positions, subject to allocation by the Interim Chief Executive Officer, and instruct the Department of Health Services and the Interim Chief Executive Officer to take necessary steps to commence a classification study of the current Medical Services Director position in the Medical Services Bureau.

5. Direct County Counsel to prepare the required ordinance changes to facilitate the transition of jail health and mental health services currently performed by the Medical Services Bureau and the Department of Mental Health.

6. Instruct the Interim Chief Executive Officer, the Departments of Mental Health and Health Services, and the Sheriff's Department to examine staffing for jail mental health services and propose any changes required to achieve an enhanced level of mental health services within the County jails beyond the requirements of the Department of Justice settlement agreement, if necessary.

7. Instruct the Interim Chief Executive Officer, the Departments of Public Health and Health Services, and the Sheriff's Department to begin an assessment of the programmatic components, associated costs, and possible funding streams of a comprehensive substance abuse treatment program in the jails that is linked to community-based treatment services with an initial report back to the Board within 90 days.

8. Instruct the Sheriff and the Director of the Department of Health Services to report on a quarterly basis the progress of the phased implementation of the integrated jail health services organizational model.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

On March 3, 2015 (Item No. 2, Agenda of March 3, 2015), the Board directed the Interim Chief Executive Officer (CEO), in conjunction with County Counsel and the Directors of the Department of Human Resources (DHR), Health Services (DHS), Mental Health (DMH), Public Health (DPH), and the Sheriff's Department (LASD), to report back to the Board in writing summarizing the status of jail health services in Los Angeles County, including issues pertaining to physical health, mental health, and public health. The report is also to outline a set of proposed approaches and strategies to address the highlighted issues and improve the overall quality and delivery of the care provided in the County jails.

A multi-departmental workgroup was immediately formed to discuss issues pertaining to provision of health, mental health and public health services within the jails. They developed a proposal for a new integrated jail health care services organizational structure intended to address the challenges of the current County jail health care system. This working group built upon preexisting and ongoing efforts by the LASD to assess and improve the quality of health and mental health services for those in its custody. The Attachment provides detailed information on the status and challenges of the current County jail health care system resulting from the ongoing focus on this issue by LASD and other County leaders; the report presents the proposed alternative integrated structure, and a multi-

phased implementation plan. The integrated structure was developed by consensus of the workgroup and will be formed by transferring existing staff from LASD's Medical Services Bureau (MSB) and DMH to DHS and by adding new functions (e.g., reentry services and a substance abuse director), as needed, to create a single integrated organizational model. Special consideration was given to the structure to ensure that the Sheriff could carry out his legal obligations to oversee the operation of the jails and attend to the needs of those in his custody and enhance the nature and continuity of health services for individuals who move in and out of the jails.

One of the primary goals of the proposed structure is to add a new Correctional Health Director (CHD) to be the overall single point of leadership for jail health services. The CHD will work with an expanded clinical leadership team to lead the provision of health services pursuant to a memorandum of understanding (MOU) with the Sheriff and in collaboration with custody personnel who will ensure proper access to care. In addition to the CHD, the leadership team will include the addition of two new positions: a Care Transitions Director who will ensure that a care model is in place to effectively link inmates to reentry services upon their release, and a Substance Use Treatments Director who will build and lead a substance abuse treatment program within the jails. These three new leadership positions are in addition to existing leadership positions (Jail Medical Director, Jail Mental Health Director, and Jail Nursing Director) that already exist within LASD and DMH. While DHS will be the appointing authority for the position, both DHS and LASD will actively participate in the selection of the Correctional Health Director. Further, the Departments will communicate and collaborate on the review of the performance, or process to terminate employment, of such individual.

The workgroup also developed a multi-phased implementation plan that will begin with a Phase Zero focused on operational planning. Approval of the first recommendation will allow for the creation of the proposed organizational structure and continued progress on Phase Zero planning activities, including, but not limited to, the development of MOUs to govern the roles and relationships under the proposed structure; County ordinance changes to reflect staffing changes; development of a jail health services budget funded by movement of necessary funding from DMH and LASD to DHS; classification and compensation studies to allocate the new leadership and other existing positions; communication with stakeholders (employees, labor partners, and the community) to ensure the success of the proposed jail health services redesign; and planning/development of a substance abuse services program with linkage to community-based treatments. The latter element is critical in that adequately resourced substance use services in the jails are needed to ensure successful community reentry and reduced recidivism. Phase Zero is estimated to take approximately six months.

Approval of the second recommendation will also allow for implementation of Phase One, which will involve the transfer of LASD MSB provider staff (i.e., physicians, nurse practitioners and physician assistants) and all DMH jail health staff (e.g., provider, social work, nursing, clerical, administrative positions) to DHS over the course of 12-18 months. During this transition period, the Departments will collaboratively assess opportunities and identify major gaps and funding needs in order to enhance efficiencies, reduce duplication of efforts, and develop new clinical programs and care models, etc. It is anticipated that these milestones will be accomplished after the County concludes labor consultations.

Approval of the third recommendation will allow for implementation of Phase Two, which will involve the transfer of all remaining MSB clinical and non-clinical staff (nursing, pharmacy, radiology, laboratory, other ancillary areas, health information management, clerical, etc.), absent any unforeseen issues or concerns. Phase Two is projected to start after the completion of Phase One, but the precise timing will be dependent on the involved Departments' assessment of progress and

achievements in Phase One, readiness for additional staff movements, the status of overall health services in the jails, and the identification of any issues or concerns that may warrant further consideration in regard to the propriety and/or timing of this phase. With Phase Two staff movements, responsibility of the associated functions will move to DHS. For example, when the MSB pharmacy staff moves to DHS, the responsibility for medication procurement, pharmacy equipment, and formulary management will also move to DHS.

Approval of the fourth recommendation will provide ordinance authority to allow DHS to start the recruitment process to hire 3.0 new positions responsible for leading the proposed organizational structure once CEO Classification and Compensation determines the appropriate level and classification of each position. Once funding for these positions is determined, the Interim CEO will make recommendations to the Board for approval of any necessary budget actions.

Approval of the fifth recommendation will direct County Counsel to prepare the required County ordinance amendments to reflect staffing changes, including the creation of the 3.0 new positions, for introduction and adoption by the Board.

Approval of the sixth recommendation will allow for a comprehensive review of existing jail mental health programs and resources to determine specific areas that may require changes in order to keep pace with existing and growing demand for mental health services in the jails.

Approval of the seventh recommendation will allow for programmatic and financial assessments to begin with respect to developing a comprehensive substance abuse treatment program in the County jails.

Approval of the last recommendation will require that the Board be provided with quarterly progress reports.

Implementation of Strategic Plan Goals

The recommended actions support Goal 3 Integrated Services Delivery intended to maximize opportunities to measurably improve client and community outcomes and leverage resources through the continuous integration of health, community, and public safety services.

FISCAL IMPACT/FINANCING

The CEO is reviewing the potential revenue sources to fund DHS' provision of integrated healthcare services in the jails. Once that review is complete, LASD, DHS and DMH will submit requests for budget adjustments to your Board as the phased implementation progresses. Such requests may be made either in the mid-year or in the next fiscal year budget process. There will also be continued focus on identifying revenue sources to support these costs to the extent possible, such as Mental Health Service Act or Assembly Bill 109 funding.

The CEO will also work with DHS to create a budgetary structure to ensure positions and funding transitioned to DHS for integrated jail health services remain dedicated for that purpose.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

As a part of Phase Zero, County Counsel will work with the Departments to determine amendments that are necessary to the County Code in order to implement the new proposed structure and to reflect the staffing changes. The amendments will be presented to the Board for adoption before

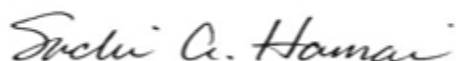
staffing changes occur.

Appropriate consultations will be conducted with the impacted employee organizations regarding the proposed structure and staff changes. Every effort will be made to implement changes in a manner that both acknowledges the positive relationship the LASD has enjoyed for years with its medical and nursing staff and that provides staff with enhanced opportunities for professional growth and development as part of the implementation of an integrated health services model.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

The integration of jail health, mental health and public health services under the supervision of a single Correctional Health Director working in collaboration with DHS and LASD custody personnel will implement a number of enhancements, such as coordinated primary care and preventative care; improved workflows and clinical processes, access to care and discharge/reentry planning; enhanced jail mental health services; emphasis on substance use services; and improved opportunities for recruitment, retention and training of jail health staff.

Respectfully submitted,



SACHI A. HAMAI

Interim Chief Executive Officer

SAH:CRG

MM:bjs

Enclosures

c: Executive Office, Board of Supervisors
County Counsel
Sheriff
Auditor-Controller
Health Services
Human Resources
Mental Health
Public Health

**REPORT ON ENSURING QUALITY HEALTH CARE SERVICES
IN LOS ANGELES COUNTY JAILS
(ITEM NO. 2, AGENDA OF MARCH 3, 2015)**

On March 3, 2015, the Board directed the Interim Chief Executive Officer, in conjunction with County Counsel and the Directors of the Department of Human Resources, Health Services, Mental Health, Public Health, and the Sheriff's Department, to report back to the Board in writing in 30 days summarizing the status of jail health services in Los Angeles County, including issues pertaining to physical health, mental health, and public health. The report is to also outline a proposed approach and strategy to address these issues and improve the overall quality and delivery of the care provided. On April 1, 2015, the Board granted an extension for the submission of this report.

BACKGROUND

The Medical Services Bureau (MSB) of the Los Angeles Sheriff's Department (LASD) is under the direction of the Assistant Sheriff of Custody Operations and coordinates access to medical services for approximately 17,500 sentenced and pre-trial inmates currently housed within the County jail. With over 1,700 budgeted employees and an annual budget of \$238 million, MSB is comprised of physicians, nurses, and other clinical/non-clinical staff who provide or support provision of medical care to inmates. This includes a vast array of on-site primary and specialty care services such as dental and oral surgery, eye care, pharmacy, radiology, laboratory, orthopedics, obstetrics and gynecology, general surgery, urology, HIV, and neurology. MSB also operates a 160-bed state-licensed Correctional Treatment Center where skilled nursing facility level care is provided.

In addition to the services provided by MSB, the Department of Mental Health (DMH), the Department of Public Health (DPH) and the Department of Health Services (DHS) also provide services to County inmates. DMH employs around 300 staff including psychiatrists, psychologists, social workers, and mental health nurses who provide direct mental health evaluation and treatment to any inmate determined to need these services. In addition to providing mental health treatment for those in the general inmate population, DMH operates 40 mental health inpatient beds, approximately 550 high observation housing beds and another 1,500 moderate observation or step-down beds. DPH provides limited in-custody substance use treatment services, tuberculosis (TB) screening and evaluation, and screening and treatment for HIV and sexually transmitted infections. DHS is the primary referral department for MSB providers when inmate-patients are in need of specialty medical care, acute care, surgery, or advanced diagnostic or therapeutic services not provided at the jails. Inmate-patients are transported to a DHS facility, mainly LAC+USC Medical Center, for care. In the past two years, in partnership with LASD, DHS has also begun to provide on-site services at Twin Towers Correctional Facility, including urgent care services provided by Board-Certified emergency room physicians and specific on-site specialty services (e.g., cardiology and orthopedics). Attachment A is the organizational chart that depicts the current structure and programmatic areas of responsibility of each department as it relates to jail health services. A full description of the jail health services provided by each department is provided in Attachment B.

The table below summarizes the approximate investment by each County department for services provided to County inmates. Because federal legislation stipulates that all entitlements, such as Medicaid, are lost or suspended when a person is sentenced, jail health

services are funded primarily by net County cost and Assembly Bill 109 (AB109) funds or, in the case of DMH programs, by Sales Tax Realignment funding.

Department / Program ¹	2013-14 Actuals	2014-15 Final Budget	2014-15 Budgeted Positions
LASD MSB	\$221,791,637	\$238,215,000	1,719.0
DHS ²	48,429,211	48,911,000	46.0
DMH	33,300,000	40,119,000	293.0
DPH - Division of HIV and STD Programs	1,934,404	2,667,000	12.0
DPH - Tuberculosis	131,131	131,000	1.0
DPH - Substance Abuse Treatment and Prevention	90,000	90,000	0.0
Total	\$305,676,383	\$330,133,000	2,071.0

CURRENT SYSTEM ISSUES

While staff within LASD, MSB, DMH and DPH work hard and are deeply committed to providing appropriate care, the current system that provides health care for LASD inmate-patients faces a variety of challenges related to 1) the organizational structure in which jail health services are provided, 2) the care models currently in use, and 3) care coordination and integration.

Organizational Structure and Leadership

The existing health care system in the County jails lacks unified organizational leadership. In other California Counties that do not contract out jail health services to a private entity, jail health clinical programs are created and supervised by county clinical professionals in an integrated approach model. In Los Angeles County, MSB is overseen by a custody-led structure, while DMH and DPH have separate reporting lines of authority without a single unifying leader overseeing all aspects of the provision of care and without a seamless provision and transition of services both during and after incarceration. The majority of medical care staff report to LASD. However, specialty medical care which largely occurs outside of the jail facilities reports to DHS and mental health reports to DMH. DPH’s various areas of involvement in the jail are themselves separate from one another as well as from the services provided by LASD, DHS, and DMH. Further, the connection of services from the time an inmate is in custody until they are released into the community is not always seamless. The result is a complicated web of relationships that makes it challenging to coordinate and integrate services and ensure accountability for providing care in a timely and high quality manner.

The proposed change in organizational structure and leadership will enhance the clinical rigor of existing clinical programs, provide direct oversight by knowledgeable, experienced health care

¹ DPH programs include the Division of HIV and STD Programs (DHSP), Tuberculosis (TB) Program, and Substance Abuse Prevention and Control (SAPC).

² DHS budgeted positions reflect only those 46.0 positions specifically used in to the LAC+USC jail clinic, emergency department and inpatient areas. It does not include the effort of staff from other areas of the hospital that also provide services to County inmates.

leaders with a broad perspective on health care, and better ensure the uninterrupted provision of care for individuals who cycle in and out of county custody. This proposed leadership change will allow the hard working, committed, and dedicated staff, such as the many physicians, psychiatrists, nurses, pharmacists and technicians, already working in the jails to provide care to inmates in an integrated system designed by and under the direct authority of health care professionals. This will afford greater accountability and collaboration for the various health care disciplines, mirror nationally recognized approaches for a unified correctional health care system, and provide enhanced opportunities for professional growth for nurses and nurse practitioners.

Care Model

Today, jail physical health care services are primarily focused on addressing an inmate's immediate and acute issues (i.e., broken arm, active seizure, head trauma) as jails historically were short term correctional systems. That has changed with Public Safety Realignment and the jail health care system must adapt to the changing inmate demographics. There is potential for growth toward a model that emphasizes both acute and chronic issues while providing primary care and preventative services. In jail mental health, available staff and resources must focus on the needs of the most acutely-ill inmates. Although this is the right priority, the growth in demand for such services over recent years has led to significant stress on existing staff and clinical space where the services are provided. In the area of substance abuse services, while LASD estimates that about 60% of inmates (nearly 11,000 individuals at any one time) have active substance abuse problems without a concurrent mental health issue, only a small amount of funding targets the treatment of these problems. The absence of a more robust substance abuse services program within the jail with linkage to community-based treatment upon an inmate's release is a weakness of today's jail health care model. Moreover, the lack of adequate treatment facilities to address the health and mental health needs of those in the County's custody in the best possible environment presents an added challenge.

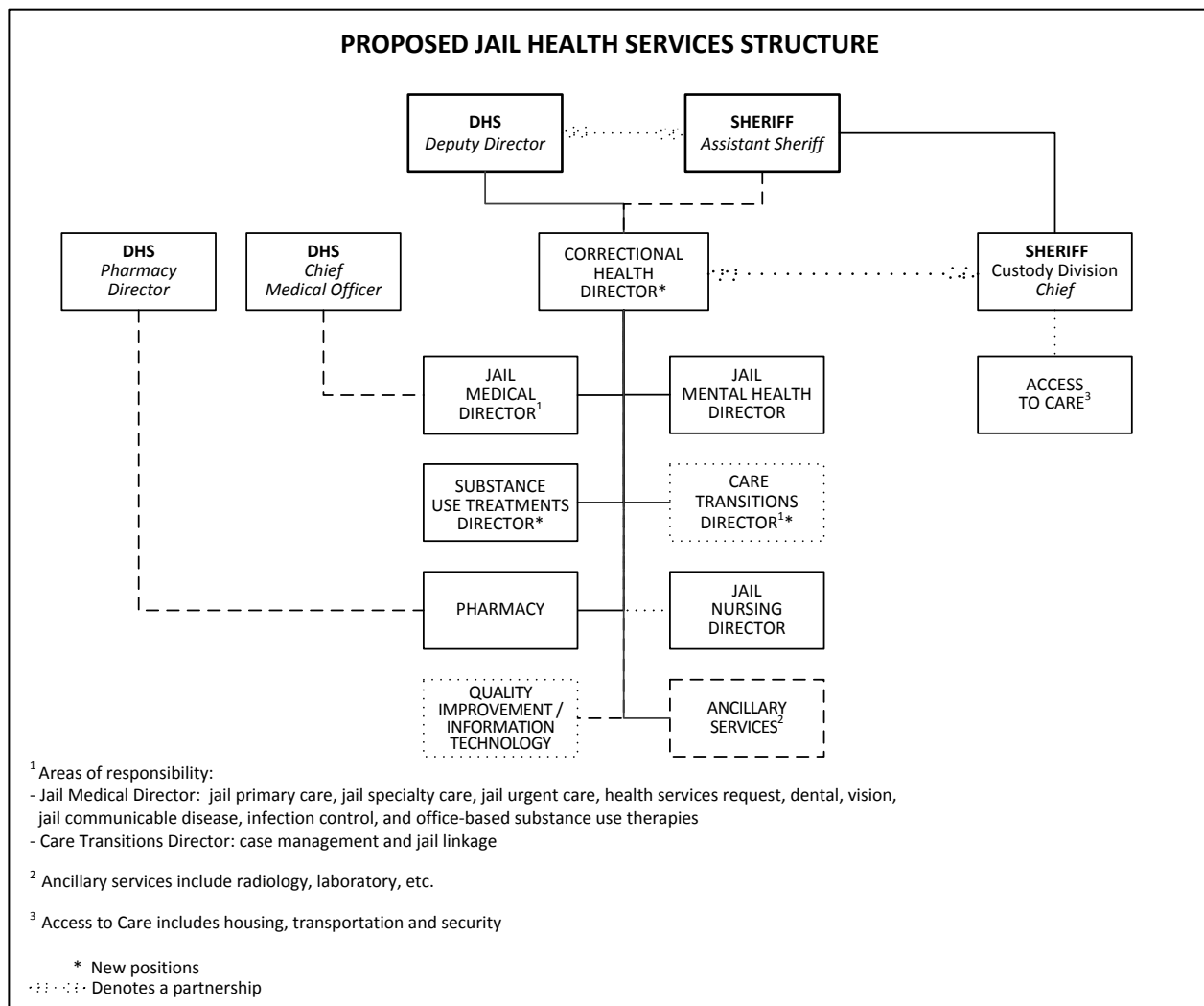
Care Coordination

Under the current structure, the County is not maximizing the opportunity to (a) coordinate health care services between the different departments providing care to those in custody, and (b) coordinate reentry services at the time of an inmate's release. Within custody, care coordination challenges are driven by the existing organizational structure where departments and service lines are functioning in both organizational and physical plant silos (i.e., mental health housing is not close to medical services). In regards to reentry care coordination, the opportunity to improve in this area is heightened with the opportunity inherent in the Affordable Care Act. Less than 5 years ago, most inmates were not eligible for coverage either through the Health Insurance Exchange or Medicaid expansion. Today, most are eligible for coverage. In order to capitalize on this coverage and the opportunity to draw inmates with ongoing health care needs into care upon community reentry, the existing efforts and strategies to link to such services in the community must become more robust. Building up the reentry linkage systems and resources within the jails must also be complemented by an increased focus on organizing and augmenting community-based services able to care for the needs of the reentry population.

THE PATH FORWARD: JAIL HEALTH SERVICES ORGANIZATIONAL MODEL

The Sheriff and other County leaders recognize these challenges and the need to develop new strategies and approaches. Special consideration was given to the structure to ensure that the Sheriff could carry out his legal obligations to oversee the operation of the jails and attend to the needs of those in his custody and enhance the nature and continuity of health services for individuals who move in and out of the jails. All parties agree that in order to optimize jail health

services and community reentry, a more cohesive organizational structure should be considered. This structure will allow the County to better meet the health care needs of the current jail population and better seize the opportunities under the Affordable Care Act to support inmates when they reenter our communities. The proposed organizational structure will create a stronger, more visible health leadership team with authority to set the ultimate vision for health care services within the jails and will operationalize full integration of health services currently delivered by multiple different County departments. The proposed jail health services organizational structure is laid out below.



The goals of the proposed structure are to:

1. Establish a single point of leadership for jail health services – as provided by health professionals working in partnership with those responsible for custody-related duties – by enhancing clinical programs and models of care to better meet the ongoing comprehensive health needs of the inmate population in an efficient, integrated, and coordinated manner, and

2. Effectively link inmates to reentry services upon their release from jail.

The key characteristics of the organizational structure include:

- Overall jail health services leadership will be provided by a new Correctional Health Director (CHD), who is a medical professional, selected by LASD and DHS, reporting to a Deputy Director of DHS with a dotted line reporting relationship to the Assistant Sheriff. Recognizing the importance of this role to both DHS and LASD, the appointment will be the result of a collaborative selection process and the CHD will be expected to work in conjunction with LASD on a day-to-day basis. While DHS will be the appointing authority for the position, the Departments will communicate and collaborate on the review of the performance of, or process to terminate employment, of such individual.
- Five major aspects of jail health services will report to the CHD:
 - A Jail Medical Director, responsible for physical health components of jail health services and directly responsible for all medical provider staffing, including physicians, physician's assistants, nurse practitioners and dentists. This individual will be selected by and directly report to the CHD.
 - A Jail Mental Health Director, directly responsible for leading and supervising all mental health staff working in the County jail. This individual will be selected by and directly report to the CHD
 - A Jail Nursing Director, responsible for supervising nursing and ancillary staff, selected by and directly reporting to the CHD.
 - A Care Transitions Director, designed to create and direct the systems to support care coordination and linkage to out of jail services to optimally support inmates when they reenter communities upon their release, will be selected by and directly report to the CHD. This represents a new position in the County.
 - A Substance Use Treatments Director, who elevates the importance of substance use treatment services in the jails and can focus on the creation of substance use treatment programs within the jail and linkage to programs upon reentry, will be selected by the CHD in partnership with DPH-SAPC, and directly reports to the CHD. This also represents a new position in the County.
- Two ancillary areas, including pharmacy and quality improvement/information technology, will serve as support functions to the jail health services structure and will report directly to the CHD.

Explicit within the proposed structure is a strong partnership relationship between DHS and LASD. The importance of this partnership cannot be overemphasized. Although DHS ultimately supervises the CHD and drives the clinical program, LASD and DHS, together, help to provide oversight of his/her day-to-day activities. Similarly, although LASD controls the access to care for inmate-patients, the plans and protocols to ensure access will be developed by both departments. It is because of this strong partnership that a phased implementation approach is possible, as is discussed in detail later in this report.

OPPORTUNITIES OF THE PROPOSED STRUCTURE

This proposed organizational structure ensures that leadership over health care activities in the jails will be directed by experienced health care professionals and all existing and new health activities provided by various County departments will come together under a single umbrella with a single vision toward integration and coordination. Reducing the level of separation

between clinical disciplines and establishing a clinically-experienced leadership team will set a new, consistent and whole-person focus that will manifest in the form and function of the resulting health care delivery system.

More specifically, the proposed organizational structure will allow for: (a) enhancement of the existing care model to emphasize primary care and preventative care; (b) creation of a robust substance abuse services program; (c) augmentation of the existing mental health services structure to better meet the high acuity needs of seriously mentally ill inmates while integrating more basic mental health services in the primary care program; (d) improvements in the overall operational effectiveness through maximizing staff capabilities, providing opportunities for professional development and establishing workflows and clinical processes; (e) better recruitment and retention of staff with a focus on physicians and other providers; (f) improvements in the adequacy of clinical space with ongoing consideration of longer term strategies to develop a needed correctional treatment facility; (g) the coordination with custody staff to ensure access to care; (h) improvements to the existing clinical quality program; (i) improvements in procurement; and (j) improvements in discharge/reentry planning for inmate-patients with chronic medical, mental health and substance treatment needs, and disease control efforts.

Emphasis on Primary Care and Preventative Service

Under the proposed structure, physical health services within the jail will be modeled around widely accepted primary care principles. This begins by hiring primary care providers who are board certified and organizing them into teams to provide care in specific areas of the jail. Next is to establish a focus on health screening, preventative services and the identification of chronic disease with subsequent evidence-based management and regular follow-up. Furthermore, the primary care model will integrate basic mental health and substance use screening and interventions to allow inmates who manifest or present with issues in these areas but who were not identified and served at the time of booking, to receive indicated care. As with any strong primary care model, the use of referral to specialty services will be actively managed so that inmate-patients who have specialty care needs are gaining access to these specialty services in an efficient and timely manner and, most importantly, that the specialist recommendations are implemented while the inmate is under LASD custody. The placement of correctional health care services under the leadership of DHS will more likely assure that the primary care-specialty care connection is tightly coordinated and appropriately used. By broadly implementing eConsult, the DHS specialty referral system, primary care providers in the jails will enjoy the full benefit of immediate specialist input and more reliable follow-up to their referrals.

Another area of opportunity under the proposed organizational structure is to deepen the partnership with DPH in the areas of TB, HIV and sexually transmitted disease (STD) services and infection control. Although the DPH resources focused in these areas will remain under DPH, the new organizational structure and specifically the broader role of the Jail Medical Director, will allow for a deeper partnership between the classic DPH responsibilities in the jail and the medical care. For example, when health care screening is completed in the Inmate Reception Center, there are opportunities to complete additional screenings without significant increases in workload if these are done collaboratively with the jail health leadership team. Having a strong partnership between DPH's HIV section and the Jail Medical Director will more likely ensure HIV positive inmates are identified early in their incarceration, started or re-started on medications and provided appropriate care services.

Build Substance Use Treatment Services

The need to enhance substance use treatment services in the jails is critical. Substance abuse services have not previously been a central aspect of care for jail health services. The addition of in-custody substance abuse treatment services will require a dedicated funding stream to yield downstream savings related to reducing recidivism associated with chronic substance use. Currently, very few inmates with known substance abuse issues receive services. Having an accountable leader, the Substance Use Treatments Director, reporting directly to the CHD, will allow a program to develop over time that seeks to provide services in a targeted way within a variety of clinical settings - including primary care and the mental health areas. Developing such a program will help ensure that inmates who suffer from addictions might withdraw safely, begin indicated treatment in-custody and be linked to ongoing services upon their release. With such a model, not only will patient safety improve but recidivism rates are expected to decline, as inmates are more likely to continue treatment within the community and avoid future drug-related arrests. This said, as a jail-based substance abuse treatment program grows, the need for improved access to services at reentry is imperative. DPH-SAPC leadership will support the Substance Use Treatments Director to build programs in the jail and work with contractors to build community-based reentry treatment programs for inmates. The goal is to provide a well-coordinated and thoughtful model to serve people both in and out of custody.

Enhance Jail Mental Health

Mental health services in the jails will continue to move toward more aggressive identification and triage of mental health issues at the time of booking as well as other elements called for and being put into place through the United States Department of Justice (DOJ) settlement agreement. The current high acuity mental health areas beginning to mirror the programming and staffing found in "institutionalized" settings such as acute hospitals and specialized mental health facilities. Specifically, more 24/7 services are in the process of being provided so that acute issues arising during late night hours and weekends outside of the inpatient unit can be immediately addressed. With the proposed transition of jail mental health from DMH to DHS, the current experience within DHS operating the acute psychiatric services in hospitals will inform the program design within the jails. An initial, comprehensive review of the mental health programs in the jails and existing resources to deliver these programs is required. Having this done under the leadership of the CHD supplemented by experienced correctional mental health experts will develop a set of priorities and opportunities to continue to enhance services to meet the greater acuity needs of what has been a rapidly growing mental health population within our jails and evaluate the need for additional mental health treatment resources.

Operational Effectiveness

Under the proposed organizational structure, the CHD sets the clinical direction and operational priorities for jail health services. This person functions similar to a hospital chief executive officer. They have ultimate responsibility for staffing, clinical practice, and budgets, and with his or her leadership team, will make decisions as to how care is delivered. In contrast to the current model where care is designed and implemented in silos, the proposed structure will allow programs to be designed and implemented in a collaborative environment wherein each area is informing the final form. For example, with a greater focus on primary care and integrating behavioral health into primary care, mental health services which may not be easily available today to the population of inmates with significant chronic disease issues will become more readily available. With a greater number of nurses receiving additional mental health training, the opportunity for nurses to recognize deterioration in functional status is more likely to trigger a referral when an inmate's mental health condition worsens. The entire correctional health care team will be built to work more as a team rather than independently and will be better able to treat the whole person as opposed to isolated conditions.

Currently, MSB provides a limited number of ancillary services in the confines of the jails. DHS will work to enhance the type and quantity of ancillary services available on-site at MSB, reducing the time, security risks and costs of transporting inmates out of the jail for treatment services. These will include, but are not limited to, the greater availability of point-of-care testing, a wider array of radiology examinations such as ultrasound and CT, and on-site physical and occupational therapy. A priority will also be placed on developing a dialysis unit at MSB so that this service can be provided in a more-timely, clinically appropriate, and cost-effective manner. Additionally, decisions about such things like which equipment to buy, where to provide certain ancillary services, which tests to provide during intake and how to build a cost-effective yet comprehensive pharmacy and supply formulary will be done more efficiently and effectively when these decisions are driven from a single vision.

Recruitment, Retention and Training of Staff

Under the proposed structure, the physical health and mental health physicians, physician's assistants, nurse practitioners as well as the dentists and eye care providers will ultimately become DHS employees through a deliberate and well managed process of transition. In the physical health areas, this creates an immediate opportunity to recruit higher quality, board-certified, primary care providers from a larger DHS applicant pool when vacancies within the jail exist. Some providers may be attracted to a split role, part-time practice in the community, part-time in the jail – flexibility not available when hired by LASD. In the area of mental health, DHS will continue to establish an environment and expectations among providers that more closely mirror an institutional setting where services are available around the clock. DHS will work with DMH during the transition period to retain existing clinical staff and further efforts to recruit and fill vacancies with high quality clinicians. Additionally, DHS can support all existing correctional health care providers, including nurses, by implementing more training and professional development activities as well as by consistently evaluating and improving clinical processes and procedures. These efforts will create a consistent and reliable clinical care environment in which to practice and in turn provide the structure and milieu many providers and other health care professionals rely on to do their job well. DHS will also bring to the jails some of the successes the Department has had in supporting the training of nurses from within the system to become mid-level providers who remain in the jail during their nurse practitioner training and assume jail clinician duties upon their completion. This strategy will be a valuable way to provide nurses with a promotional job-ladder while allowing those who are passionate about serving inmate-patients to continue fulfilling this mission.

Access to Care

A hallmark of the proposed organizational structure is the deliberate and direct link between jail health leadership and the LASD Chief of Custody Operations responsible for ensuring inmate access to care. This Chief and his or her team must work to ensure inmates can access the care they need, when they need it. This coordination must be constantly emphasized because without such coordination, inmates will not be able to access fully the benefits of improved clinical services. Custody and jail health leadership must design new systems and accountability metrics to better ensure patients are scheduled for care in a way that is appropriate given the custody responsibility for keeping a safe and controlled environment within the jails. These systems must ensure general clinical care is a priority but also that emergency or urgent care can be accessed immediately when clinically necessary.

Clinical Space

Many existing areas for the delivery of clinical care in the LASD facilities are not as conducive as they should be to obtaining a comprehensive clinical history and physical exam or for

maintaining patient/client confidentiality. The new jail health leadership team can work with LASD and DHS clinical space design experts to determine opportunities to utilize existing space for a variety of direct clinical and non-clinical (e.g., case management, referral/linkage) activities. Renovations may be required in order to create an environment that fosters the provision of high quality care and is attractive to staff considering roles in jail-based settings. Without improvements in these areas, certain clinical workflows are more challenging to implement and potential shortcomings in the care model may persist. Under the CHD, these space improvements can be prioritized so to create the optimal conditions given space size, locations and configuration. Moreover, the jail health leadership team can participate in ongoing efforts to assess and promote the development of a new and improved correctional treatment facility.

Quality Improvement

DHS will immediately begin to work with current LASD clinicians, who will become employees of DHS under the proposed structure, to establish a more robust quality improvement program. This begins by establishing more detailed and prescriptive quality policies and procedures. It will also require enhancing capacity to gather and analyze data from the jail electronic health record, a Cerner system called Jail Health Information System (JHIS). The robust quality improvement program will support ongoing improvement in clinical staffing and help prioritize the future planning of the jail health system. An important benefit of creating a robust quality improvement program is to mitigate risk and liability. As with every system, errors occur in the day-to-day delivery of care. The quality program will allow the jail health services team to identify these errors, perform investigations into root causes, and act swiftly to put in place the systems, policies, procedures, and trainings needed to prevent such errors in the future, as well as individual staff corrective measures when appropriate, needed to prevent such errors in the future.

Procurement

As the largest entity purchasing health care related equipment and supplies in Los Angeles County, DHS can support LASD in acquiring items needed for care delivery in a more efficient and clinically appropriate manner. DHS has the expertise on how medical equipment and supplies in different clinical areas are evolving and on value-based purchasing analyses and can apply this knowledge to purchases required in jail settings.

Discharge and Reentry Planning

Stakeholders and department leaders agree that one of the strengths of the proposed organizational structure for jail health services is its strong focus on discharge planning and linkage to care efforts and the prominent role of the newly-proposed Care Transitions Director responsible for managing and leading these activities. Given Medicaid expansion and the near universal coverage of inmates under the Affordable Care Act, few inmates should leave jail without having started a process to newly gain or regain health coverage. For those released with a chronic illness or a persistent substance use disorder requiring additional follow-up, this coverage is imperative to connecting the inmate-patient with a medical/behavioral health home as a means to receiving ongoing care and support. Furthermore, because LASD and DHS use the same electronic health record vendor, Cerner, the information collected and documented in the jail can be shared with a DHS provider who can serve the patient once they are released. The development of the Cerner Hub, set to launch in the next 12-18 months, creates an opportunity to allow the services provided in the jail to more seamlessly inform care in the community, and vice versa. For those patients seeking care outside of directly-operated County settings, additional steps will need to be taken to be sure that medical information is appropriately transmitted to the community-based responsible provider(s), while maintaining compliance with all relevant privacy and information security regulations. This connection to

community-based care can be enhanced through establishment of local reentry networks, involving both public and private providers, throughout the various communities of Los Angeles County who can be specifically trained and engaged to provide care to this unique population in a reliable and coordinated way. With the addition of a partnership with the local health plans, LA Care and Health Net, the coordination and continuity of care for the Los Angeles County reentry population can be optimized and potentially serve as a national model.

PROPOSED HEALTH AGENCY MODEL

In January 2015, the Board approved in concept the creation of a health agency, uniting DHS, DMH, and DPH under a single umbrella structure. A report to the Board on the opportunities, drawbacks, proposed structure, implementation steps, and timeline is due to the Board by June 30, 2015. The departments agree that the proposed structure for jail health services as proposed in this report would adapt very well under an agency model.

However, it should be stressed that the restructuring of jail health services to have a single point of leadership able to integrate services across the full spectrum of clinical needs is a positive step, independent of whether a health agency is formed. The opportunities previously discussed will allow the County to address the interconnected health issues and improve the overall quality and delivery of health care services provided within the jail system while maximizing health outcomes of the County's incarcerated and post-incarcerated population.

LABOR AND WORK FORCE POINTS FOR CONSIDERATION

To facilitate the transition of services and ease Labor concerns, it will necessary to maintain an open channel of communication with the various labor representatives throughout each phase of employee movement. Labor's early involvement in the transition process, such as allowing labor input on operational effectiveness, staff movement, recruitment, retention and training will aid in relieving employee apprehension related to these operational changes. It will also be important to develop a more formal approach to support staff transitions and change management. This could involve use of County (e.g., DHR) or non-County resources on an as-needed basis.

It will also be advantageous to promptly address with Labor the level of competency expected by DHS that may not have been as strongly emphasized in LASD.

These efforts may require a re-evaluation of applicable memoranda of understanding (MOU) provisions. Purposely, this would ensure that the parties have a clear understanding of how specific DHS related MOU provisions will translate to the LASD staff who are transferred to DHS and/or if specific MOU provisions that are pertinent only to LASD should continue to be applicable to the staff following their transfer to DHS.

IMPLEMENTATION PLAN

The transition of jail health services to DHS would be implemented in three phases. It must be stressed, that the work to implement the expected DOJ and known Rosas settlement terms are currently underway and therefore, it is critical that LASD be able to meet considerable milestones in response to those terms before it can successfully implement the transition of jail health services. As a result, this plan would not begin implementation until all involved departments can be focused on the work, which is estimated to be completed this coming fall. The work required for this transition will involve many resources already deployed for DOJ and

Rosas implementation. So that the success of that work and the transition contemplated in this report back are not compromised, a fall timeframe for the transition to begin is the most realistic.

Because of the enormity of the work involved in the proposed reorganization and restructuring and because of the need to stage and sequence the transition, a phased transition is recommended. Furthermore, as LASD prepares for a new clinical environment within the jails, moving areas in phases will allow for a more cautious and measured approach to unfold, protecting against potential disruptions in staffing or erosion of the quality of existing clinical programs.

The proposed organizational structure would be assessed and, where appropriate, implemented in three phases. At a high level, this will start with a Phase Zero planning phase, a Phase One in which LASD provider staff and all DMH staff would transition to DHS, and Phase Two in which remaining LASD MSB staff and functions (e.g., nursing staff, technicians, pharmacy, etc.) would move, absent any issues or concerns that provide a basis for revisiting the timing or nature of this phase. These phases are described in detail below.

Phase Zero

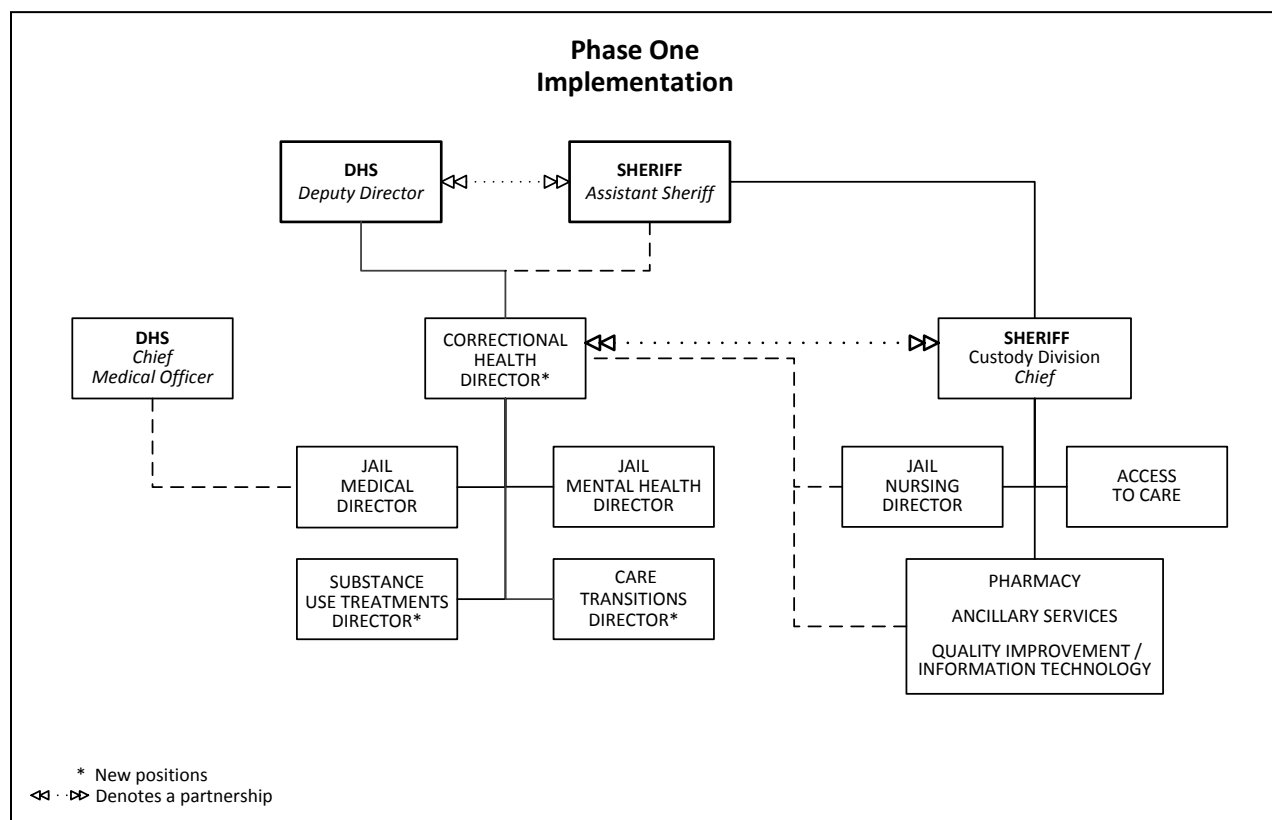
The following immediate steps, to occur over 6 months, are recommended in order to begin operational planning for Phases One and Two described below.

- Evaluate need for changes to County ordinances: County Counsel will review relevant County ordinances to determine what amendments are necessary in order to implement the new proposed structure. This is particularly true of staffing additions and changes that are being contemplated. County Counsel will work with all departments to ensure that the appropriate ordinances are amended and proposed to the Board for adoption before staffing changes occur.
- Develop jail health services budget: Existing budgets and item controls for each of the entities (DMH, DHS and LASD MSB) being considered for movement under the proposed organizational restructuring must be fully vetted to ensure they are accurate and that sufficient funding is available for jail health services. Without a meticulous examination of current item controls, budgets and expenditures and a clear understanding of the adequacy of current funding levels, the proposed transition will be difficult. This analysis will also include discussions with the CEO as to how future cost-of-living adjustments will be managed and funded.
- Plan for addition of new leadership roles: The creation of and securing funding for the three new leadership positions (i.e., CHD, Care Transitions Director, and Substance Use Treatments Director) are critical components of the proposed model. In this initial planning period, duty statements will be written so that classification/compensation can allocate the appropriate positions. New funding for these positions is required. Additionally, the medical director position currently allocated to MSB will require a re-classification study given the larger scope of responsibility assigned to this position in the proposed organizational structure.
- Establish initial stakeholder communication strategy: Communication with internal and external stakeholders with an emphasis on County personnel and labor partners will play a crucial role in the success of this proposed jail health services redesign. As such, a clear, continuous and inclusive communication strategy with all the stakeholders is paramount and will begin immediately.

- For county labor partners, this process would involve an initial written invitation to impacted union locals to meet for a review of the redesign. Those labor organizations that respond to this written invitation will be identified as ongoing participants in the development and implementation of the organizational changes, particularly in the area of employee impact.
- Establish MOU: Clear and comprehensive agreements must be developed to govern the roles and relationships between LASD and DHS under this proposed organizational model. In assessing the MOU, special consideration will need to be given to the fact that the Sheriff maintains statutory responsibility for all aspects of jail management and that all parties remain equally committed to providing constitutionally mandated health care and access to those services in the jails during and after the transition. Clarity in the MOU is particularly important given that Phase One involves having most MSB clinical personnel remaining under the supervision of LASD (i.e., nursing, pharmacy, laboratory, and radiology staff). Given this, a clear delineation is needed for how the DHS-supervised clinical leadership will provide these personnel their clinical and operational direction while maintaining a direct reporting relationship to LASD. The MOU will also help govern the budgetary and fiscal considerations that will become clearer during Phase Zero. Similar to the MOU established between DHS and the Probation Department for the provision of medical services within the Juvenile Probation system, the MOU between LASD and DHS will focus on roles and responsibilities for each department needed to build strong clinical programs and ensure timely access to care. The MOU will clearly outline roles and responsibilities of LASD and DHS. Example of topics to be addressed in the MOU include:
 - Establishing that the CHD sets the clinical priorities, including where staffing must be augmented or reduced, which screening questions will be administered, and which medications and supplies will be ordered and which will not.
 - Establishing who sets the jail health budget and how budgetary issues are handled between DHS and LASD or DHS and other involved departments.
 - Describing the relationship between DHS staff and LASD staff during Phase Zero and Phase One, before staff move to DHS.
 - Establishing regular meeting schedules between involved departments and including how progress will be assessed toward implementation of this jail health transition plan.As the content of the MOU is developed, it will be shared in the quarterly reports to the BOS, if the proposed concept is approved.
- Assess and address labor and work force related activities: Labor representatives will be afforded the opportunity to provide input on the transfer of employees to DHS. CEO Employee Relations will facilitate meetings with the various labor unions to address and resolve, when appropriate, employee concerns related to salaries, supervisory reporting structures, and possible layoffs/reductions; enhance the employee transfer process; and clarify/implement applicable MOU related provisions. This strategy of open communication and transparency would continue through Phase Zero and Phase Two of the transition process.
 - As the County is currently negotiating with the labor organizations on successor MOUs, CEO Employee Relations will identify and propose MOU language revisions to ensure that MOU provisions are applied appropriately to all affected employees (e.g., eliminate/reduce departmental specific MOU provisions).

Phase One

If the proposed organizational structure is approved in concept by the Board and the Sheriff, Phase One, to occur over the course of 12 to 18 months, would involve the transfer of MSB providers (physicians, nurse practitioners, physician assistants and dentists) and all DMH clinicians (physicians, nurse practitioners, physicians assistants, and psychiatric social workers) and staff to DHS as shown in the organizational chart below. DHS and LASD will work together to assess opportunities to enhance efficiencies in clinical and administrative functions in order to generate cost savings. This may include opportunities to reduce redundancy in roles currently split among departments, to reclassify certain positions, etc. The departments will also assess major gaps in services, including the need for additional specialty or diagnostic services³, the need for a comprehensive substance use treatment program, and physical space for clinical and non-clinical activities, seeking additional funding as needed if costs are not able to be covered within the existing jail health services budget. Attachment C outlines the work involved to accomplish Phase One.



Phase Two

In Phase Two, all remaining MSB staff, including nursing staff, pharmacy staff, and any other remaining clinical and clinical support staff will be transferred to DHS. The timing of Phase Two changes will be dependent on successfully completing the Phase One transition, estimated to take 12-18 months from the beginning of Phase One in the absence of any unforeseen issues or concerns.

³ The implementation of a more robust clinical care model will likely result in an increased level of referrals for specialty and other health services and ultimately, the need for additional staff and financial investment.

DHS, DMH and LASD will continually assess and evaluate progress, opportunities, and challenges to determine if additional structural changes, leadership/supervisory positions, and work process changes may be necessary. A progress update will be provided to the Board and the Sheriff on a quarterly basis with a focus on progress toward implementation of the distinct phases as well as ways the Board and the Sheriff can support the swiftest path toward an integrated clinical care program that ensures appropriate health care to inmates, focuses acutely on reentry efforts, and ensures a commitment to increasing substance abuse services to criminally involved individuals in Los Angeles County.

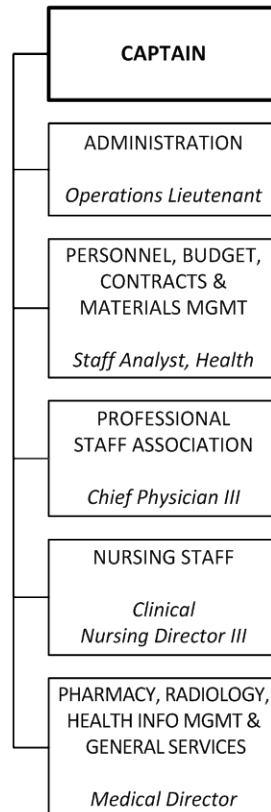
CURRENT DELIVERY OF JAIL HEALTH, MENTAL HEALTH, AND PUBLIC HEALTH SERVICES

DEPARTMENT OF HEALTH SERVICES
LAC+USC Medical Center

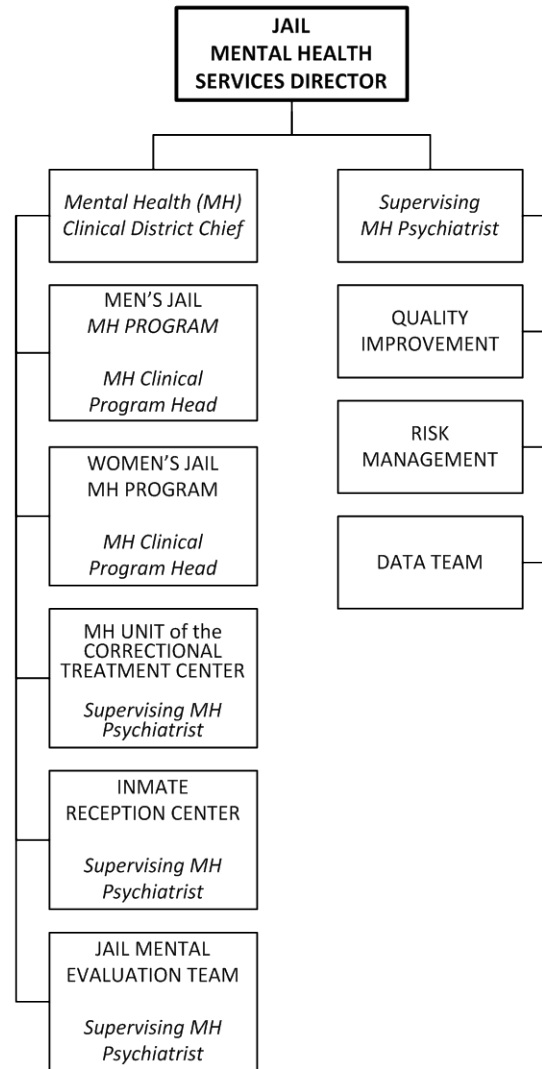
PRIMARY REFERRAL DEPARTMENT FOR MSB PROVIDERS

SPECIALTY MEDICAL CARE, ACUTE CARE, SURGERY, DIAGNOSTIC, OR THERAPEUTIC SERVICES

SHERIFF'S DEPARTMENT
Medical Services Bureau (MSB)



DEPARTMENT OF MENTAL HEALTH
Jail Mental Health Services



DEPARTMENT OF PUBLIC HEALTH
Jail Public Health Services

COMMUNICABLE DISEASE CONTROL & PREVENTION

TUBERCULOSIS SCREENING & EVALUATION

HIV & STD SCREENING & TREATMENT

SUBSTANCE USE TREATMENT SERVICES

COUNTY JAIL HEALTH SERVICES

DEPARTMENT OF HEALTH SERVICES

Historically, the DHS has had a Memorandum of Understanding (MOU) with LASD, last updated in October 1997, which effectively obligates DHS to provide specialty care, diagnostic care, therapeutic care, inpatient hospitalization, and surgical care to inmates when LASD MSB is unable to provide these services themselves. To this end, DHS has always maintained a specialized jail clinical area at LAC+USC Medical Center. This specialized area includes a 15 bay emergency room staffed by the LAC+USC Emergency Department, a 5 exam room specialty clinical area where LAC+USC providers deliver specialty care services to inmate-patients transported to LAC+USC 5 days per week. There is also a 24 bed inpatient medical-surgical unit where inmate-patients in need of acute medical care can be admitted and cared for by LAC+USC inpatient staff.

In addition to this work by DHS, approximately two years ago, at the request of the Board, DHS executed an inmate specialty care agreement and MOU with LASD to augment medical services available on-site at MSB. As a result, DHS engaged USC Medical School to help provide some of these services. Specifically, since the spring of 2013, DHS provides the following services at MSB sites:

- 16 hours per day, 365 days per year, urgent care services provided by board certified emergency room physicians and physician assistants working each shift, and
- 12 hours per week Obstetrics and Gynecology specialty services with a focus on the care of the highest risk pregnant women under LASD's custody.
- 2 full time nurses designated as care coordination nurses who support the care of inmates whose conditions rely heavily on care provided beyond the four walls of the jails. Examples include inmates with cancer care, major orthopedic injuries, cardiac issues and multiple, complex medical conditions.
- Access for MSB providers to eConsult to consult with DHS for specialty care and facilitate referrals patients from the jails to LAC+USC for specialty care services. This has allowed patients to come to LAC+USC with the right level of work-up done before their visit and ensures those who need more immediate specialty care are appropriately triaged.
- A growing group of specialty care trained nurse practitioners (NP) working at the jail under the supervision of DHS specialty providers at LAC+USC. This NP specialty model has allowed many patients to receive more timely specialty care in the jails as opposed to waiting for a visit slot at LAC+USC.
- Installation of a mobile computed tomography (CT) scanner in MSB to help with the evaluation of closed head injuries, a frequent issue at LASD.
- Point-of-care testing to support the clinical decision making of providers working at MSB so more immediate diagnostic information is available and more appropriate and timely care can be provided.

The objectives of the recent collaboration between DHS and LASD MSB have focused on (a) improving the accessibility of care for inmates; (b) improving quality and coordination of care; (c) reducing inmate transportation required for care.

DEPARTMENT OF MENTAL HEALTH

Jail Mental Health Services (JMHS) programs are administered by DMH and provide care to men and women identified as having mental health needs while incarcerated in the Los Angeles County jails. Services are provided at four locations: the Twin Towers Correctional Facility (TTCF), Men's Central Jail (MCJ), Century Regional Detention Facility (CRDF), and North County Correctional Facilities (NCCF).

Approximately 3,500 individuals, or 20% of the current average jail census of nearly 17,500, receive mental health services on any given day. The JMHS client census is comprised of approximately 2,950 men and 550 women. Over two-thirds of these clients are housed in mental health areas of TTCF and CRDF, with the remainder housed in the general population areas of TTCF, CRDF and MCJ. Included in the client census are on average 450 inmates that are incarcerated under the provisions of Assembly Bill (AB) 109, the Public Safety Realignment Act.

JMHS has a jail-based staff of 302 individuals, including psychiatrists, psychologists, social workers, psychiatric nurses and technicians, service coordinators, and case workers that function as group leaders and release planners, substance abuse counselors, recreation therapists, and support and administrative staff. The collaboration between DMH and LASD extends from an individual's entrance to jail to his/her exit. Services are organized by programs that work in concert with each other to provide a continuum of mental health care.

- Inmate Reception Center (IRC) - Located at TTCF, IRC is the entry point for male offenders into the jail system. All are screened by LASD custody staff for medical and mental health issues, with over 3,600 referred monthly for mental health assessment. Women are similarly processed through a Reception Center at CRDF, with over 800 referred monthly.
- Mental Health Unit of the Correctional Treatment Center - Also known as the Forensic Inpatient Program, it is a 46-bed licensed unit located in TTCF to provide acute psychiatric inpatient care and is Lanterman-Petris-Short (LPS) designated to provide involuntary treatment for individuals most in need due to their immediate danger to self or others and/or grave disability that severely interferes with their ability to function.
- High Observation and Moderate Observation Housing - The Men's Program, located in TTCF, and the Women's Program at CRDF provide two levels of care: High Observation Housing (HOH) for clients at risk of dangerous behavior or self-harm who require intensive observation and care including risk precautions, but do not require hospitalization. Moderate Observation Housing (MOH) is the dormitory level of care that is for more stable clients whose mental health needs can be cared for in a less intensive and more open setting, but preclude their tolerating general population housing. Approximately 85-90% of these inmates have co-occurring substance use disorders.
- Jail Mental Evaluation Teams - Comprised of mental health clinicians and specially trained deputies, as well as psychiatrists, other clinicians, and release planners, the teams identify inmates in the general and special population housing areas of TTCF and MCJ who were not previously recognized as having mental health care needs. Two additional JMETS teams serve the NCCF for screening of inmates that may require mental health care. In the general population areas of CRDF, the Women's Program provides medication management and follow-up care.

- Jail Linkage Program - This program is critical as increasing emphasis has been placed on re-entry planning and linkage to community services and supports for mental health clients at all levels of care. The team works throughout the system with clients who require comprehensive release planning such as conservatorship and placement in Institutions for Mental Disease (IMD) or IMD Step-down facilities, as well as with clients who require less intensive assistance related to housing, benefits establishment and linkage to outpatient mental health treatment in the community. Release planning is done collaboratively between JMHS and DMH Countywide Resource Management (CRM) for AB 109 clients.
- CRM Vivitrol Administration - This project is for AB 109 clients with co-occurring mental illness and opiate dependence. Through this project, clients who have been appropriately screened can receive one administration of Vivitrol approximately one week before their scheduled release date and can then be linked with an AB 109-funded community clinic that can continue the Vivitrol protocol upon the clients' release.
- Misdemeanor Incompetent to Stand Trial (MIST) - This program is for misdemeanor offenders who have been adjudicated Incompetent to Stand Trial (IST), including those who refuse psychiatric medication. JMHS provides competency restoration services for these clients through the MIST program, including administration of court-authorized medications. JMHS is currently exploring legal avenues to also administer medication pursuant to a court order for felony offenders ISTs who are pending transfer to a State hospital for competency restoration services.
- Tele-psychiatry - This program was recently initiated at NCCF and currently serves a limited number of inmates to assist with overcrowding of inmates on psychiatric medications at TTCF and MCJ. The program identifies relatively stable inmates on psychotropic medications to be moved to NCCF, which has more available beds than in TTCF and a less restrictive, more modern facility than MCJ. Clients are selected based on diagnosis, class of psychotropic medications, review of their IS records, and review of their electronic medical records (EMR). Qualifying clients have remained stable on their current medications for a period of at least a month, do not have a psychotic diagnosis, are not taking antipsychotics, and do not have evidence of problematic behaviors or suicide attempts documented in their IS records or their EMR. The clients go to NCCF with a 90 day supply of medications as ordered in their EMR. The JMHS psychiatrist trained in using Telepsychiatry sees the clients every 90 days via Telepsychiatry to assess their stability and renew their medications. Any urgent or emergent situations are dealt with by transferring the client back to the IRC clinic for assessment. The appropriateness of their returning to NCCF is also discussed. The program goal is to maintain an average census of about 40 clients with the plan to assess the feasibility of expanding the services.

The focus of care throughout the DMH JMHS programs is on stabilizing clients' mental illness; engaging them in treatment for mental health and co-occurring substance use disorders; and immediately beginning to develop and/or solidify release plans for housing; mental health care (including but not limited to institutional care, Full Service Partnerships, integrated services/supportive housing projects, and outpatient clinics); access to benefits, employment or education; and connecting or reconnecting with families and other community supports. Community partners are encouraged to provide in-reach while referred clients are still incarcerated.

DEPARTMENT OF PUBLIC HEALTH

Three programs within DPH have strong involvement and experience working with LASD: the Division of HIV and Sexually Transmitted Diseases (STD) Programs, the Tuberculosis (TB) Control Program, and the Substance Abuse Prevention and Control Program.

Division of HIV and STD Programs (DHSP)

LASD plays a critical component in DHSP's overall HIV and STD control strategy as many persons at risk for or diagnosed with HIV or STDs interact with the criminal justice system in the following areas: locating DHSP staff to work in the jail, 2) contracting with community based organizations (CBO) to provide services in the jail, and 3) funding positions in LASD through a cross-departmental MOU. In addition, DHSP works closely with LASD's Medical Services Bureau and Community Transition Unit.

Currently, five DHSP staff at the jails full time to perform HIV and STD screening in Men Central Jail's "K6G" dorm, which houses gay/bisexual men and transgender women, and the women's inmate reception center at Century Regional Detention Facility (CRDF). At least twice a week, staff members distribute condoms in the K6G dorm, where prevalence of HIV exceeds 20%. Two DHSP public health investigators (PHIs) perform partner elicitation and notification services for inmates with high priority STDs, and follow-up of syphilis and HIV cases released prior to receiving their results to ensure linkage to care and treatment of partners.

DHSP-funded CBOs fall into two categories: five organizations that provide HIV transitional case management (TCM) and pre-release planning services for HIV positive inmates and one organization that provides sexual health education with inmates at high risk of HIV and STDs. Historically, the yield from the TCM program has been less than optimal due to several factors, many of which relate to the lack of true LASD institutional support or appreciation for the role such programs play in improving individual and even public health outcomes after individuals transition back to their communities. Recently, based on a pilot program, DHSP decided to invest up to six additional DHSP staff to serve as health navigators to meet with HIV positive inmates once before release and work with them for 6-12 months after release from jail to ensure their continuity of medical care and link them to appropriate social services in the community.

DHSP currently funds one public health nurse (PHN) who serves as an HIV nurse case manager, ensuring that all incoming and exiting HIV positive inmates are started and released with their medications. The PHN also communicates with patients' HIV providers in the community to get recent medication lists and laboratories to reduce errors and unnecessary repeat testing. DHSP and LASD recently renewed and modified the MOU to include an additional PHN position to assist with the high HIV positive inmate caseload, which is usually around 300-350 inmates at a given time. DHSP has also historically loaned one of its Program Manager I items to LASD to hire a staff member to serve as a Jails HIV Services Coordinator and function as a liaison between LASD and DHSP to coordinate HIV and STD public health activities with LASD custody staff. This position is currently vacant due to staff retirement.

DHSP has worked closely with MSB's Infection Control Unit (ICU). The ICU staff includes a medical epidemiologist (currently vacant), and epidemiologist, and a team of committed public health nurses who ensure appropriate patient management for a variety of communicable diseases, including non-HIV STDs, TB, hepatitis, influenza, and help address any outbreak situations (examples include MRSA, norovirus). The ICU team has been a critical asset to many members of the DPH to help to implement new public health programs, such as offering accelerated schedule hepatitis A/B vaccination in the K6G dorm, as well as providing influenza vaccination in the dorms for inmates with chronic diseases. These examples highlight the potential for implementing evidence and guideline best practices to improve the health of this vulnerable population.

Lastly, over the past two years, DHSP has worked with the Community Transition Unit to coordinate release times for HIV positive inmates who are being released into residential programs or are working closely with one of our health navigation pilot programs. This program has been very successful in allowing DHSP to ensure that the clients receiving case management services are linked to services but it remains very limited in scope and would benefit from significant investment to scale it up and apply it to a much broader cross section of inmates.

TB Control Program

The DPH's TB Control Program currently funds 1.5 FTE staff to conduct case management and pre-release planning for inmates infected with tuberculosis to ensure appropriate treatment and follow-up inside and outside of custody. Also, staff monitors medication adherence and oversees discharge planning to ensure continued treatment. Over the past four years, 59 TB cases were diagnosed at the time of incarceration (approximately 10-15 infectious cases/year are identified of inmates entering the jail). Approximately 250 inmates per year are worked up as potential TB cases.

Substance Abuse Prevention and Control Program (SAPC)

Current SAPC programming that relates to the LASD includes the following:

- The Sentenced Offender Drug Court (SODC) program was established in 1998 at the request of the Los Angeles County Superior Court. SODC is an intensive substance use disorder (SUD) treatment approach for convicted, non-violent felony offenders facing lengthy state prison terms for drug-related offenses. SAPC currently contracts with Principles, Inc., (dba IMPACT) for the provision of in-custody SUD treatment services. With an in-custody 60-bed capacity for male clients at Pitchess Detention Center and 24 beds for female clients at the Century Regional Detention Facility, the in-custody treatment services are court-ordered for up to 90 days. Upon release from in-custody treatment, clients continue residential or outpatient SUD treatment services, depending on the severity needs of the client. The client remains under the supervision of the dedicated drug court bench officer and probation for the duration of their community-based treatment services.
- SAPC currently contracts with Homeless Health Care Los Angeles (HHCLA) to operate a Community in the LASD Community Resource and Re-entry Center (CRRRC). The HHCLA staff provide on-site SUD screening and assessment, and are able to make and coordinate SUD treatment referrals for recently released persons.
- SAPC is currently developing the Substance Treatment and Re-Entry Transition program (START), which will incorporate in-custody and community-based SUD treatment services. The in-custody program, pending Board approval, will implement In-Custody Education Treatment (ICET) services in accordance with the LASD's Education Based Incarceration Maximizing Education Reaching Program. The community-based treatment component entails LASD conducting a risk/needs assessment to identify female inmates for an initial 90-day episode of SUD residential care in a supervised non-custodial setting, as an alternative to incarceration.

IMPLEMENTATION PLAN STEPS PHASE ONE

These are the priority activities that need to be accomplished in the first 12 months following approval of the proposed organizational structure:

- Hire/appoint an interim Correctional Health Director, interim Jail Medical Director, interim Jail Mental Health Director, Substance Use Treatments Director, and interim Care Transitions Director.
- Appoint an interim Jail Nursing Director.
- Have the DHS Director of Quality Improvement work with jail health services leadership to establish an executive peer review process and improve physician credentialing.
- Establish the appropriate MOU(s) that governs the transition of existing MSB providers (physicians, nurse practitioners, and physician assistants) to DHS.
- Establish the transition plan to govern the transition of existing DMH providers to DHS.
- Work with DHR, CEO, and DHS/DMH/LASD Human Resources to transition personnel from LASD and DMH to DHS.
- Hire primary care providers to fill existing LASD MSB vacancies.
- Restructure the existing clinical nursing infrastructure to improve leadership, improve front line nurse workflows, and enhance nursing decision support to ensure safe, timely, and appropriate care.
- Improve chronic care management programs for inmates, including redesigning the intake and sick call systems (ensuring mental health issues are addressed in both of these areas) and enhancing access to urgent care.
- Redesign clinical space to enhance inmate-patient care and staff working conditions.
- Restructure pharmacy and medication administration systems, processes, purchasing, staffing, and space allocation.
- Streamline supply procurement and material management systems in all LASD facilities.
- Implement a robust quality and risk program founded on peer review and continuously reevaluate system-level data.
- Develop and implement a robust access to care tracking mechanism to improve access to services and accountability for missed services.
- Enhance jail system public health practice and expertise and consider refilling the vacant Infection Control Physician position to maximize infection and disease control efforts, including compliance with Title 15 requirements.
- Work with custody to optimize housing decisions for persons with medical, mental health and substance use conditions in order to improve population management strategies and resources for inmates in need of medical and mental health/ADA housing.
- Enhance in-custody residential substance abuse treatment programs.

1 LORETTA E. LYNCH

Attorney General

2 MARK J. KAPPELHOFF

Deputy Assistant Attorney General

3 Civil Rights Division

JUDITH C. PRESTON

4 Acting Chief, Special Litigation Section

LAURA L. COON, Special Counsel, Special Litigation Section

5 LUIS E. SAUCEDO, Counselor to the Chief, Special Litigation Section

CATHLEEN S. TRAINOR

6 Trial Attorneys

U.S. Department of Justice

7 Civil Rights Division, Special Litigation Section

8 950 Pennsylvania Avenue, N.W., PHB 5026

Washington, D.C. 20530

9 Telephone: (202) 514-6255

Email: laura.coon@usdoj.gov; cathleen.trainor@usdoj.gov

10 EILEEN M. DECKER

11 United States Attorney

LEON W. WEIDMAN

12 Assistant United States Attorney

Chief, Civil Division

13 ROBYN-MARIE LYON MONTELEONE (State Bar No. 130005)

Assistant United States Attorney

14 Assistant Division Chief, Civil Rights Unit Chief, Civil Division

JOANNA HULL (State Bar No. 227153)

15 Assistant United States Attorney

16 300 North Los Angeles Street, Suite 7516

Los Angeles, California 90012

17 Telephone: (213) 894-2458/6585; Facsimile: (213) 894-7819

E-mail: Robby.Monteleone@usdoj.gov; Joanna.Hull@usdoj.gov

18 Attorneys for Plaintiff

19 UNITED STATES OF AMERICA

20
21 MARY C. WICKHAM

Interim County Counsel

22 RODRIGO A. CASTRO-SILVA (SBN 185251)

Senior Assistant County Counsel

23 BRANDON NICHOLS (SBN 187188)

Assistant County Counsel

24 KAREN JOYNT (SBN 206332)

Deputy County Counsel

25 648 Kenneth Hahn Hall of Administration

500 West Temple Street

26 Los Angeles, California 90012

Tel: (213) 974-1811 Fax: (213) 626-7446

27 Email: rcastro-silva@counsel.lacounty.gov

bnichols@counsel.lacounty.gov

28 kjoynt@counsel.lacounty.gov

1 Attorneys for Defendants
2 COUNTY OF LOS ANGELES and LOS ANGELES
3 COUNTY SHERIFF JIM MCDONNELL, in his
4 Official Capacity

5 UNITED STATES DISTRICT COURT
6 FOR THE CENTRAL DISTRICT OF CALIFORNIA
7 WESTERN DIVISION

8
9 UNITED STATES OF AMERICA,

10 Plaintiff,

11 v.

12 COUNTY OF LOS ANGELES AND
13 LOS ANGELES COUNTY SHERIFF
14 JIM MCDONNELL, in his Official
15 Capacity,

16 Defendants.

CV No. 15- 5903

**JOINT SETTLEMENT
AGREEMENT REGARDING THE
LOS ANGELES COUNTY JAILS;
AND STIPULATED [PROPOSED]
ORDER OF RESOLUTION**

17 **I. INTRODUCTION**

18 1. The United States of America, acting through the United States
19 Department of Justice ("United States"), the County of Los Angeles ("County")
20 and Sheriff Jim McDonnell, in his official capacity ("Sheriff"), (collectively, the
21 "Parties") share a mutual interest in treating all members of the community with
22 respect, promoting safe and effective custodial care, protecting public safety, and
23 upholding the constitutional rights of prisoners.¹

24 2. The Los Angeles County Jails ("Jails") are an integral part of the
25 public safety system in Los Angeles County, California. Together, the Jails form

26
27 ¹ "Prisoners" is a defined term in Section III of this Agreement and includes
28 pre-trial detainees and individuals convicted of a criminal offense.

1 the largest jail system in the nation and house among the highest populations of
2 prisoners with mental illness. Maintaining these facilities is an immensely
3 complex enterprise -- approximately 15,500 to 19,500 prisoners are held in custody
4 daily, spread across multiple custody facilities, numerous patrol stations, and over
5 29 courthouses. These facilities' primary function is to incarcerate individuals
6 accused or convicted of committing a crime. In doing so, these facilities provide
7 food, shelter, and clothing, but must also address the serious medical and mental
8 health needs of the prisoners and ensure their reasonable safety.

9 3. The United States acknowledges that the County and the Sheriff have
10 demonstrated a renewed commitment to reforming the Jails and have begun to
11 implement improved policies and practices designed to enhance the treatment and
12 care of prisoners with mental illness. The County and the Sheriff are also
13 exploring strategies to safely divert individuals with mental illness from the
14 criminal justice system, whenever possible. The United States further
15 acknowledges that the number of suicides at the Jails decreased in 2014 from the
16 previous year. In addition, the County and the Sheriff have made significant
17 commitments to protect prisoners from abuse and excessive force by staff that
18 further the Parties' mutual interest. Finally, the United States acknowledges that
19 some of the needed changes the County and the Sheriff seek to implement through
20 this Agreement will require the allocation of additional resources to the Sheriff's
21 Department and the Los Angeles County Department of Mental Health ("DMH").

22 4. Accordingly, this Joint Settlement Agreement Regarding the Los
23 Angeles County Jails ("Agreement") is intended to build upon measures that are
24 underway and to sustain systemic improvements that are designed to protect
25 prisoners from conditions in custody that place them at unreasonable risk of harm
26 from suicide, self-injurious behavior, or unlawful injury by others, in accordance
27 with their constitutional rights. This Agreement also is expected to have collateral
28 benefits that promote public safety, improve confidence in the County's criminal

1 justice system, and support the County's and the Sheriff's collaborative efforts to
2 expand comprehensive and effective mental health diversion and re-entry programs
3 that are designed to lead to more positive outcomes in the care and custody of
4 individuals with serious mental illness who are also participants in the criminal
5 justice system.

6 **II. BACKGROUND**

7 5. The County owns and funds the operations of the Jails. The Sheriff's
8 Department is responsible for providing care, custody, and control of prisoners at
9 the Jails. The Sheriff's Department Medical Services Bureau provides medical
10 care within the Jails. DMH is responsible for providing mental health care in the
11 Jails through its Jail Mental Health Services program.

12 6. The Sheriff is an elected official who is responsible for operating and
13 exercising authority over the Jails.

14 7. In June 1996, the Department of Justice notified the County and
15 Sheriff that it was opening an investigation under the Civil Rights of
16 Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, to determine whether
17 the conditions in the Jails violate the constitutional rights of its prisoners.

18 8. In September 1997, the Department of Justice issued a findings letter
19 alleging that mental health care at the Jails violated prisoners' constitutional rights.
20 The letter further alleged that systemic deficiencies contributed to the violations,
21 including inadequate: (1) intake screening and evaluation; (2) diagnosis; (3)
22 referral to mental health professionals; (4) treatment plans; (5) administration of
23 medications; (6) suicide prevention; (7) tracking and medical record keeping;
24 (8) staffing; (9) communication; and (10) quality assurance.

25 9. In December 2002, following extensive negotiations and additional
26 site visits, the Parties entered into a Memorandum of Agreement (MOA) that
27 outlined a series of reforms to ensure that adequate and reasonable mental health
28

1 care services are provided at the Jails. The MOA also included measures to protect
2 prisoners with mental illness from abuse and mistreatment.

3 10. Under the MOA, the County and the Sheriff have made significant
4 improvements to the delivery of mental health care at the Jails, including
5 implementing electronic medical records, increasing mental health staffing, and
6 developing roving evaluation teams composed of mental health professionals and
7 specially-trained custody staff. Despite considerable progress, the United States
8 alleges that systemic deficiencies remain related to suicide prevention and mental
9 health care that violate prisoners' constitutional rights. The Department of Justice
10 notified the County and the Sheriff of these allegations in a letter dated June 4,
11 2014, following on-site evaluations with expert consultants.

12 11. In September 2013, the Department of Justice opened a separate
13 investigation of the Jails under CRIPA and 42 U.S.C. § 14141 ("Section 14141")
14 to address allegations of use of excessive force against all prisoners at the Jails, not
15 just prisoners with mental illness. During the course of the investigation, the
16 County and the Sheriff entered into a comprehensive settlement agreement to
17 resolve *Rosas v. McDonnell*, Case No. CV 12-0428-DDP (C.D. Ca. filed on Jan.
18 18, 2012) (hereinafter "*Rosas*"), a class action lawsuit alleging abuse and excessive
19 force by staff at certain Jails located in downtown Los Angeles. As part of the
20 *Rosas* settlement agreement, the County and the Sheriff have agreed to implement
21 significant measures to protect prisoners from excessive force by staff, including
22 improvements in policies, training, incident tracking and reporting, investigations,
23 resolution of prisoner grievances, prisoner and staff supervision, and
24 accountability.

25 12. This Agreement addresses remaining allegations concerning suicide
26 prevention and mental health care at the Jails resulting from the partial
27 implementation of the 2002 MOA and current conditions within the Jails. This
28 Agreement also extends the remedial measures in the Implementation Plan of the

1 Rosas settlement agreement to fully resolve the Department of Justice's CRIPA
2 findings regarding alleged mistreatment of prisoners with mental illness and claims
3 under Section 14141 regarding alleged excessive force against prisoners at all of
4 the Jails.

5 13. As indicated in Section VII of this Agreement, the Parties consent to a
6 finding that this Agreement complies in all respects with the provisions of the
7 Prison Litigation Reform Act, 18 U.S.C. § 3626(a).

8 14. Except to enforce, modify, or terminate this Agreement, this
9 Agreement, and any findings made to effectuate this Agreement, will not be
10 admissible against either the County or the Sheriff in any court for any purpose.
11 Moreover, this Agreement is not an admission of any liability on the part of the
12 County or the Sheriff, and/or either of its employees, agents, and former employees
13 and agents, or any other persons, and will not constitute evidence of any pattern or
14 practice of wrongdoing.

15 III. DEFINITIONS

16 15. The following definitions will apply to terms in this Agreement:

- 17 (a) "Sheriff's Department" refers to the Los Angeles County Sheriff's
18 Department, which is responsible for all custody, corrections, and
19 security functions within the Los Angeles County Jails system,
20 including the provision of medical care to prisoners through the
21 Sheriff's Department Medical Services Bureau.
- 22 (b) "Jails" refers to the Los Angeles County Jails system, and shall
23 include Men's Central Jail ("MCJ"), Twin Towers Correctional
24 Facility ("TTCF"), Inmate Reception Center ("IRC"), Century
25 Regional Detention Facility ("CRDF"), North County Correctional
26 Facility ("NCCF"), Pitchess Detention Center ("PDC"), and other
27 facilities in which prisoners are detained or held in custody by the
28 County and the Sheriff, including lockup facilities and courthouse

1 holding areas as well as any visiting area in the facility, and any
2 facility that is built, leased, or otherwise used, to replace or
3 supplement the current Jails or any part of the Jails.

4 (c) "United States" or "DOJ" refers to the United States Department of
5 Justice, specifically the Special Litigation Section of the Civil Rights
6 Division and the United States Attorney's Office for the Central
7 District of California, which represent the United States in this matter.

8 (d) "The County" refers to the County of Los Angeles, the Los Angeles
9 County Sheriff's Department, the Los Angeles County Department of
10 Mental Health, and the agents and employees of the Sheriff's
11 Department and the Department of Mental Health. The Department
12 of Mental Health ("DMH") includes any successor County department
13 that assumes the duties and responsibilities of DMH.

14 (e) "Sheriff" refers to the Los Angeles County Sheriff, currently Jim
15 McDonnell, an independently-elected constitutional officer, in his
16 official capacity, and any predecessors or successors in office,
17 including any designated acting or interim Sheriff.

18 (f) "Custody staff" means sworn deputy sheriffs and custody assistants.

19 (g) "Days" are measured in calendar days; weekend days and County
20 holidays are included.

21 (h) "Normal business work days" means all days except for weekend days
22 and County holidays.

23 (i) "Describe" means provide a clear and detailed description of
24 something done, experienced, seen, or heard.

25 (j) "Document" when used in this Agreement as a verb means
26 completing a record of information either in hard copy or in electronic
27 format.
28

- 1 (k) "Effective Date" means the date the Court enters the signed
2 Agreement as an order of the Court, or July 1, 2015, whichever is
3 earlier.
- 4 (l) "Emergency maintenance needs" means a need that if left unattended
5 could result in imminent danger to the life, safety, or health of
6 prisoners.
- 7 (m) An "emergent" or "urgent" mental health need, as used in this
8 Agreement, is one which the Arrestee Medical Screening Form (SH-
9 R-422) or its equivalent and/or the Medical/Mental Health Screening
10 Questionnaire indicate that immediate action is required to preserve
11 life, prevent serious bodily harm, or relieve significant suffering.
- 12 (n) "Good cause" means fair and honest reasons, regulated by good faith
13 on the part of either party, that are not arbitrary, capricious, trivial, or
14 pretextual.
- 15 (o) "Implement" or "implementation" means putting a remedial measure
16 into effect, including informing, instructing, or training impacted
17 personnel as required by this Agreement, and ensuring that policies or
18 procedures are in fact followed.
- 19 (p) "Include," "includes," or "including" means "include, but not be
20 limited to" or "including, but not limited to."
- 21 (q) "Jail Reception Centers" mean all Sheriff's Department processing
22 facilities that handle incoming bookings and arrests and that are
23 responsible for medical and mental health screenings and
24 classification, including the Inmate Reception Center and the Century
25 Regional Detention Facility. This does not include Sheriff's
26 Department station jails.
- 27
28

- 1 (r) "Mental Health Housing" refers to prisoner housing areas in the Jails
2 that include only the Forensic In-Patient (FIP), High Observation
3 Housing (HOH), and Moderate Observation Housing (MOH) areas.
- 4 (i) "Correctional Treatment Center" or "CTC" refers to the
5 licensed health facility with a specified number of beds within
6 the Jails designated to provide health care to that portion of the
7 prisoner population that does not require a general acute care
8 level of services, but which is in need of professionally
9 supervised health care beyond that normally provided in the
10 community on an outpatient basis.
- 11 (ii) "Forensic In-Patient" or "FIP" can be used interchangeably
12 with Mental Health Unit of the Correctional Treatment Center
13 (MHU CTC). The FIP is located in the CTC and houses
14 prisoners who present an acute danger to self or others or are
15 gravely disabled due to a mental illness and require inpatient
16 care.
- 17 (iii) "High Observation Housing" or "HOH" refers to designated
18 areas for prisoners with mental illness who require an intensive
19 level of observation and care and/or safety precautions.
- 20 (iv) "Moderate Observation Housing" or "MOH" refers to
21 designated areas for prisoners with a broad range of mental
22 health diagnoses and functioning whose mental health needs
23 can be cared for in a less intensive and more open setting than
24 the HOH areas, but preclude general population housing.
- 25 (s) "Monitor" or "Independent Monitor" means the individual selected by
26 the Parties whose duties, responsibilities, and authority are set forth in
27 Section VI of this Agreement.
28

- 1 (t) "Subject Matter Experts" or "SMEs" means the individuals selected
2 by the Parties whose duties, responsibilities, and authority are set forth
3 in Section VI of this Agreement.
- 4 (u) "Prisoners" or "Prisoner" is construed broadly to refer to one or more
5 individuals detained at, or otherwise housed, held, in the custody of,
6 or confined at the Jails based on arrests, detainers, criminal charges,
7 civil contempt charges, or convictions.
- 8 (v) "Psychotropic medication" means any substance used to treat mental
9 health problems or mental illness and is capable of modifying mental
10 activity or behavior.
- 11 (w) "Qualified Medical Staff" refers to physicians, physician assistants,
12 nurse practitioners, registered nurses, certified nursing assistants, and
13 licensed vocational nurses, each of whom is permitted by law to
14 evaluate and care for the medical needs of patients.
- 15 (x) "Qualified Mental Health Professional" or "QMHP" refers to
16 psychiatrists, psychologists, psychiatric social workers, psychiatric
17 nurses, and others who by virtue of their education, credentials, and
18 experience are permitted by law to evaluate and care for the mental
19 health needs of patients.
- 20 (y) "Clinical Restraints" is any device that limits a person's ability to
21 move freely and has been ordered or approved by a licensed
22 psychiatrist for the purpose of managing behavior that appears to be
23 symptomatic of a mental illness.
- 24 (z) "Security Restraints" is any device that limits a person's ability to
25 move freely and has not been ordered by a licensed psychiatrist or
26 Qualified Medical Staff.
- 27 (aa) "Serious mental illness" includes psychotic disorders, major mood
28 disorders (including major depression and bipolar disorders), and any

1 other condition (excluding personality disorders, substance abuse and
2 dependence disorders, dementia, and developmental disability) that is
3 associated with serious or recurrent significant self-harm, suicidal
4 ideation, imminent danger to others, current grave disability, or
5 substantially impaired ability to understand routine instructions, or
6 that prevents access to available programs. Although personality
7 disorders alone generally do not qualify as serious mental illness,
8 personality disorders associated with serious or recurrent significant
9 self-harm do qualify as serious mental illnesses.

10 (bb) "Suicide attempt" means any serious effort to commit an act of self-
11 harm that can result in death and involving definite risk.

12 (cc) "Serious suicide attempt" means a suicide attempt that resulted in or
13 could have resulted in significant and life-threatening injury.

14 (dd) "Suicide Precautions" means any level of watch, observation, or
15 measures specifically intended to prevent suicide or self-harm and
16 includes both Suicide Watch and Risk Precautions as defined in this
17 Agreement.

18 (ee) "Suicide Watch" means the level of watch, observation, or measures
19 intended to identify and safely maintain prisoners who are imminently
20 suicidal and require admission to the Mental Health Unit of the
21 Correctional Treatment Center (MHU CTC or FIP) on a 72-hour hold,
22 in accordance with California Welfare and Institutions Code Section
23 5150.

24 (ff) "Risk Precautions" means a level of watch, observation, or measures
25 used to identify and safely maintain those prisoners who require
26 heightened observation and daily re-evaluation, and require admission
27 to HOH but are not considered to pose an imminent risk of suicide.
28

- 1 (gg) "Suicide resistant location" means a housing assignment in which
2 known or apparent suicide hazards do not exist or have been removed.
- 3 (hh) "Self-injurious behavior" means any behavior that is self-directed and
4 deliberately results in injury or the potential for injury to oneself and
5 there is no evidence of suicidal intent.
- 6 (ii) "Serious self-injurious behavior" means self-injurious behavior where
7 the injury is significant enough that it could lead to loss of life or limb
8 or have serious medical complications.
- 9 (jj) "Direct constant observation" means continuous uninterrupted
10 observation of a prisoner within a proximity that ensures the observer
11 can both see and hear the prisoner to assure the prisoner's well-being,
12 absent extraordinary circumstances.
- 13 (kk) "Unobstructed visual observation" means continuous but not
14 necessarily uninterrupted observation within a reasonable physical
15 distance of the prisoner(s).
- 16 (ll) "Train" means to instruct in skills to a level that the trainee has the
17 demonstrated proficiency, through an assessment or evaluation, to
18 implement those skills as and when called for. "Trained" means
19 proficient in the skills.
- 20 (mm) Throughout this Agreement, the following terms are used when
21 discussing compliance: substantial compliance, partial compliance,
22 and non-compliance. "Substantial Compliance" means that the
23 County and the Sheriff have achieved compliance with the material
24 components of the relevant provision of this Agreement in accordance
25 with the Monitor and SMEs' monitoring plan and compliance
26 measures. "Partial Compliance" means that the County and the
27 Sheriff have achieved compliance on some, but not all, of the material
28 components of the relevant provision of this Agreement. "Non-

1 compliance” means that the County and the Sheriff have not met most
2 or all of the material components of the relevant provision of this
3 Agreement. Non-compliance with mere technicalities, or temporary
4 failure to comply coupled with prompt and appropriate corrective
5 action during a period of otherwise sustained compliance, will not
6 constitute failure to maintain Substantial Compliance. At the same
7 time, temporary compliance during a period of otherwise sustained
8 Non-compliance will not constitute Substantial Compliance.

9 (nn) “Policy” or “Policies” mean regulations, directives, or manuals,
10 regardless of name, that have been approved by a senior executive
11 within the Sheriff's Department (“LASD”) or DMH and that describe
12 the duties, functions, or obligations of LASD or DMH staff and
13 provide specific direction in how to fulfill those duties, functions, or
14 obligations. References to “existing” policies mean those policies in
15 effect on the Effective Date of this Agreement, and include any
16 subsequent revisions or changes made to those policies after the
17 Effective Date of this Agreement.

18 **IV. OVERALL OBJECTIVES AND GOALS**

19 16. Consistent with constitutional standards, the County and the Sheriff
20 will provide prisoners at the Jails with safe and secure conditions and ensure their
21 reasonable safety from harm, including serious risk from self-harm and excessive
22 force, and ensure adequate treatment for their serious mental health needs. In order
23 to achieve and maintain these objectives, the County and the Sheriff agree to
24 continue, and where appropriate enhance, their current policies and practices, and
25 to implement the additional measures set forth in this Agreement.

26 17. The Parties recognize that the County and the Sheriff have made
27 considerable progress to improve conditions and the delivery of mental health care
28 at the Jails, but that additional measures are necessary to provide prisoners at the

1 Jails with safe and secure conditions, ensure their reasonable safety from harm,
2 including serious risk from self-harm and excessive force, and meet the serious
3 mental health needs of prisoners, in accordance with prisoners' constitutional
4 rights. The measures set forth in this Agreement address the following areas: (1)
5 training; (2) suicide hazard inspections; (3) intake; (4) medical records; (5) mental
6 health referrals; (6) mental health follow-up; (7) suicide risk procedures; (8)
7 staffing; (9) environmental conditions; (10) allowable property privileges; (11)
8 communication related to mental health; (12) safety checks; (13) quality
9 improvement plan; (14) mental health housing; (15) medication; (16) restraints;
10 (17) suicide death reviews and critical incident reviews; (18) mental health
11 treatment; and (19) use of force. The County and the Sheriff agree to maintain an
12 adequate system of mental health screening, assessment, treatment planning, and
13 record-keeping as specifically set forth in this Agreement.

14 **V. SUBSTANTIVE PROVISIONS**

15 **A. Training**

16 18. Within three months of the Effective Date, the County and the Sheriff
17 will develop, and within six months of the Effective Date will commence
18 providing: (1) a four-hour custody-specific, scenario-based, skill development
19 training on suicide prevention, which can be part of the eight-hour training
20 described in paragraph 4.8 of the Implementation Plan in *Rosas* to all new
21 Deputies as part of the Jail Operations Continuum and to all new Custody
22 Assistants at the Custody Assistants academy; and (2) a two-hour custody-specific,
23 scenario-based, skill development training on suicide prevention to all existing
24 Deputies and Custody Assistants at their respective facilities, which can be part of
25 the eight-hour training described in paragraph 4.7 of the Implementation Plan in
26 *Rosas*, through in-service Intensified Formatted Training, which training will be
27 completed by December 31, 2016.

28 These trainings will include the following topics:

- 1 (a) suicide prevention policies and procedures, including observation and
- 2 supervision of prisoners at risk for suicide or self-injurious behavior;
- 3 (b) discussion of facility environments and staff interactions and why
- 4 they may contribute to suicidal behavior;
- 5 (c) potential predisposing factors to suicide;
- 6 (d) high-risk suicide periods and settings;
- 7 (e) warning signs and symptoms of suicidal behavior;
- 8 (f) case studies of recent suicides and serious suicide attempts;
- 9 (g) emergency notification procedures;
- 10 (h) mock demonstrations regarding the proper response to a suicide
- 11 attempt, including a hands-on simulation experience that incorporates
- 12 the challenges that often accompany a jail suicide, such as cell doors
- 13 being blocked by a hanging body and delays in securing back-up
- 14 assistance;
- 15 (i) differentiating between suicidal and self-injurious behavior; and
- 16 (j) the proper use of emergency equipment.

17 19. Commencing July 1, 2015, the County and the Sheriff will provide:

- 18 (a) Custody-specific, scenario-based, skill development training to new
- 19 Deputies during their Jail Operations training, and to existing
- 20 Deputies assigned to Twin Towers Correctional Facility, Inmate
- 21 Reception Center, Men's Central Jail, the Mental Health Housing
- 22 Units at Century Regional Detention Facility, and the Jail Mental
- 23 Evaluation Teams ("JMET") at North County Correctional Facility as
- 24 follows:
 - 25 (i) 32 hours of Crisis Intervention and Conflict Resolution as
 - 26 described in paragraphs 4.6 and 4.9 of the Implementation Plan
 - 27 in *Rosas* to be completed within the time frames established in
 - 28 that case (currently December 31, 2016). Deputies at these

1 facilities will receive an eight hour refresher course consistent
2 with paragraph 4.6 of the Implementation Plan in *Rosas* every
3 other year until termination of court jurisdiction in that case and
4 then a four hour refresher course every other year thereafter.

5 (ii) Eight hours identifying and working with mentally ill prisoners
6 as described in paragraph 4.7 of the Implementation Plan in
7 *Rosas* to be completed by December 31, 2016. This training
8 requirement may be a part of the 32-hour training described in
9 the previous subsection. Deputies at these facilities will receive
10 a four hour refresher course consistent with paragraph 4.7 of the
11 Implementation Plan in *Rosas* every other year thereafter.

12 (b) Commencing July 1, 2015, the County and the Sheriff will ensure that
13 new Custody Assistants receive eight hours of training in the Custody
14 Assistant academy, and that all existing Custody Assistants receive
15 eight hours of training, related to identifying and working with
16 mentally ill prisoners as described in paragraph 4.7 of the
17 Implementation Plan in *Rosas*. This training will be completed by
18 December 31, 2016. Custody Assistants will receive a four hour
19 refresher course consistent with paragraph 4.7 of the Implementation
20 Plan in *Rosas* every other year thereafter.

21 20. Commencing no later than July 1, 2017, the County and the Sheriff
22 will provide:

23 (a) Custody-specific, scenario-based, skill development training to
24 existing Deputies assigned to North County Correctional Facility,
25 Pitchess Detention Center, and the non-Mental Health Housing Units
26 in Century Regional Detention Facility as follows:

27 (i) 32 hours of Crisis Intervention and Conflict Resolution as
28 described in paragraphs 4.6 and 4.9 of the Implementation Plan

1 in *Rosas* to be completed by December 31, 2019. Deputies at
2 these facilities will receive an eight hour refresher course
3 consistent with paragraph 4.6 of the Implementation Plan in
4 *Rosas* every other year until termination of court jurisdiction in
5 that case and then a four hour refresher course every other year
6 thereafter.

7 (ii) Eight hours identifying and working with mentally ill prisoners
8 as described in paragraph 4.7 of the Implementation Plan in
9 *Rosas* to be completed by December 31, 2019. This training
10 requirement may be a part of the 32-hour training described in
11 the previous subsection. Deputies at these facilities will receive
12 a four hour refresher course consistent with paragraph 4.7 of the
13 Implementation Plan in *Rosas* every other year thereafter.

14 21. Consistent with existing Sheriff's Department policies regarding
15 training requirements for sworn personnel, the County and the Sheriff will ensure
16 that existing custody staff that have contact with prisoners maintain active
17 certification in cardiopulmonary resuscitation and first aid.

18 22. Within six months of the Effective Date and at least annually
19 thereafter, the County and the Sheriff will provide instructional material, to all
20 Sheriff station personnel, Sheriff court personnel, custody booking personnel, and
21 outside law enforcement agencies on the use of arresting and booking documents,
22 including the Arrestee Medical Screening Form, to ensure the sharing of known
23 relevant and available information on prisoners' mental health status and suicide
24 risk. Such instructional material will be in addition to the training provided to all
25 custody booking personnel regarding intake.

26 **B. Suicide Hazard Inspections**

27 23. Within three months of the Effective Date, the County and the Sheriff
28 will commence a systematic review of all prisoner housing, beginning with the

1 Mental Health Unit of the Correctional Treatment Center, all High Observation
2 Housing areas, all Moderate Observation Housing areas, single-person discipline,
3 and areas in which safety precautions are implemented, to reduce the risk of self-
4 harm and to identify and address suicide hazards. The County and the Sheriff will
5 utilize a nationally-recognized audit tool for the review. From this tool, the County
6 and the Sheriff will:

- 7 (a) develop short and long term plans to reasonably mitigate suicide
8 hazards identified by this review; and
9 (b) prioritize planning and mitigation in areas where suicide precautions
10 are implemented and seek reasonable mitigation efforts in those areas.

11 24. The County and the Sheriff will review and inspect housing areas on
12 at least an annual basis to identify suicide hazards.

13 **C. Intake**

14 25. The County and the Sheriff will ensure that any prisoner in a Sheriff's
15 Department station jail who verbalizes or who exhibits a clear and obvious
16 indication of current suicidal intent will be transported to IRC, CRDF, or a medical
17 facility as soon as practicable. Pending transport, such prisoners will be under
18 unobstructed visual observation, or in a suicide resistant location with safety
19 checks every 15 minutes.

20 26. Consistent with existing Sheriff's Department policies, the County
21 and the Sheriff will follow established screening procedures to identify prisoners
22 with emergent or urgent mental health needs based upon information contained in
23 the Arrestee Medical Screening Form (SH-R-422) or its equivalent and the
24 Medical/Mental Health Screening Questionnaire and to expedite such prisoners for
25 mental health evaluation upon arrival at the Jail Reception Centers and prior to
26 routine screening. Prisoners who are identified as having emergent or urgent
27 mental health needs, including the need for emergent psychotropic medication, will
28

1 be evaluated by a QMHP as soon as possible but no later than four hours from the
2 time of identification.

3 27. Consistent with existing Sheriff's Department policies, the County
4 and the Sheriff will ensure that all prisoners are individually and privately screened
5 by Qualified Medical Staff or trained custody personnel as soon as possible upon
6 arrival to the Jails, but no later than 12 hours, barring an extraordinary
7 circumstance, to identify a prisoner's need for mental health care and risk for
8 suicide or self-injurious behavior. The County and the Sheriff will ensure that the
9 Medical/Mental Health Screening Questionnaire, the Arrestee Medical Screening
10 Form (SH-R-422) or its equivalent, and/or the Confidential Medical Mental Health
11 Transfer Form are in the prisoner's electronic medical record or otherwise
12 available at the time the prisoner is initially assessed by a QMHP.

13 28. The County and the Sheriff will ensure that any prisoner who has been
14 identified during the intake process as having emergent or urgent mental health
15 needs as described in Paragraph 26 of this Agreement will be expedited through
16 the booking process. While the prisoner awaits evaluation, the County and the
17 Sheriff will maintain unobstructed visual observation of the prisoner when
18 necessary to protect his or her safety, and will conduct 15-minute safety checks if
19 the prisoner is in a cell.

20 29. The County and the Sheriff will ensure that a QMHP conducts a
21 mental health assessment of prisoners who have non-emergent mental health needs
22 within 24 hours (or within 72 hours on weekends and legal holidays) of a
23 registered nurse conducting an intake nursing assessment at IRC or CRDF.

24 30. Consistent with existing DMH policies, the initial mental health
25 assessment will include a brief initial treatment plan. The initial treatment plan
26 will address housing recommendations and preliminary discharge information.
27 During the initial assessment, a referral will be made for a more comprehensive
28 mental health assessment if clinically indicated. The initial assessment will

1 identify any immediate issues and determine whether a more comprehensive
2 mental health evaluation is indicated. The Monitor and SMEs will monitor
3 whether the housing recommendations in the initial treatment plan have been
4 followed.

5 **D. Medical Records**

6 31. Consistent with existing DMH and Sheriff's Department policies, the
7 County and the Sheriff will maintain electronic mental health alerts in prisoners'
8 electronic medical records that notify medical and mental health staff of a
9 prisoner's risk for suicide or self-injurious behavior. The alerts will be for the
10 following risk factors:

- 11 (a) current suicide risk;
- 12 (b) hoarding medications; and
- 13 (c) prior suicide attempts.

14 32. Information regarding a serious suicide attempt will be entered in the
15 prisoner's electronic medical record in a timely manner.

16 33. The County will require mental health supervisors in the Jails to
17 review electronic medical records on a quarterly basis to assess their accuracy as
18 follows:

- 19 (a) Supervisors will randomly select two prisoners from each clinician's
20 caseload in the prior quarter;
- 21 (b) Supervisors will compare records for those prisoners to corroborate
22 clinician attendance, units of service, and any unusual trends,
23 including appropriate time spent with prisoners, recording more units
24 of service than hours worked, and to determine whether contacts with
25 those prisoners are inconsistent with their clinical needs;
- 26 (c) Where supervisors identify discrepancies through these reviews, they
27 will conduct a more thorough review using a DMH-developed
28

1 standardized tool and will consider detailed information contained in
2 the electronic medical record and progress notes;

- 3 (d) Serious concerns remaining after the secondary review will be
4 elevated for administrative action in consultation with DMH's
5 centralized Human Resources.

6 34. The County and the Sheriff will conduct discharge planning and
7 linkage to community mental health providers and aftercare services for all
8 prisoners with serious mental illness as follows:

9 (a) For prisoners who are in Jail seven days or less, a preliminary
10 treatment plan, including discharge information, will be developed.

11 (b) For prisoners who are in Jail more than seven days, a QMHP will also
12 make available:

13 (i) for prisoners who are receiving psychotropic medications, a 30-
14 day prescription for those medications will be offered either
15 through the release planning process, through referral to a re-
16 entry resource center, or through referral to an appropriate
17 community provider, unless clinically contraindicated;

18 (ii) in-person consultation to address housing, mental
19 health/medical/substance abuse treatment, income/benefits
20 establishment, and family/community/social supports. This
21 consultation will also identify specific actions to be taken and
22 identify individuals responsible for each action;

23 (iii) if the prisoner has an intense need for assistance, as described in
24 DMH policies, the prisoner will further be provided direct
25 linkage to an Institution for Mental Disease ("IMD"), IMD-
26 Step-down facility, or appropriately licensed hospital;

27 (iv) if the prisoner has a moderate need for assistance, as described
28 in DMH policies, and as clinically appropriate to the needs of

1 the prisoner, the prisoner will be offered enrollment in Full
2 Service Partnership or similar program, placement in an Adult
3 Residential Facility (“Board and Care”) or other residential
4 treatment facility, and direct assistance accessing community
5 resources; and

6 (v) if the prisoner has minimal needs for assistance, as described in
7 DMH policies, the prisoner will be offered referrals to routine
8 services as appropriate, such as General Relief, Social Security,
9 community mental health clinics, substance abuse programs,
10 and/or outpatient care/support groups.

11 (c) The County will provide a re-entry resource center with QMHPs
12 available to all prisoners where they may obtain information about
13 available mental health services and other community resources.

14 **E. Mental Health Referrals**

15 35. Consistent with existing DMH and Sheriff’s Department policies, the
16 County and the Sheriff will ensure that custody staff, before the end of shift, refer
17 prisoners in general or special populations who are demonstrating a potential need
18 for routine mental health care to a QMHP or a Jail Mental Evaluation Team
19 (“JMET”) member for evaluation, and document such referrals. Custody staff will
20 utilize the Behavior Observation and Referral Form.

21 36. Consistent with existing DMH policies, the County and the Sheriff
22 will ensure that a QMHP performs a mental health assessment after any adverse
23 triggering event, such as a suicide attempt, suicide threat, self-injurious behavior,
24 or any clear decompensation of mental health status. For those prisoners who
25 repeatedly engage in self-injurious behavior, the County will perform such a
26 mental health assessment only when clinically indicated, and will, when clinically
27 indicated, develop an individualized treatment plan to reduce, and minimize
28 reinforcement of, such behavior. The County and the Sheriff will maintain an on-

1 call system to ensure that mental health assessments are conducted within four
2 hours following the notification of the adverse triggering event or upon notification
3 that the prisoner has returned from a medical assessment related to the adverse
4 triggering event. The prisoner will remain under unobstructed visual observation
5 by custody staff until a QMHP has completed his or her evaluation.

6 37. Sheriff's Court Services Division staff will complete a Behavioral
7 Observation and Mental Health Referral Form and forward it to the Jail's mental
8 health and/or medical staff when the Court Services Division staff obtains
9 information that indicates a prisoner has displayed obvious suicidal ideation or
10 when the prisoner exhibits unusual behavior that clearly manifests self-injurious
11 behavior, or other clear indication of mental health crisis. Pending transport, such
12 prisoner will be under unobstructed visual observation or subject to 15-minute
13 safety checks.

14 38. Consistent with existing DMH policies and National Commission on
15 Correctional Health Care standards for jails, the County and the Sheriff will ensure
16 that mental health staff or JMET teams make weekly cell-by-cell rounds in
17 restricted non-mental health housing modules (e.g., administrative segregation,
18 disciplinary segregation) at the Jails to identify prisoners with mental illness who
19 may have been missed during screening or who have decompensated while in the
20 Jails. In conducting the rounds, either the clinician, the JMET deputy, or the
21 prisoner may request an out-of-cell interview. This request will be granted unless
22 there is a clear and documented security concern that would prohibit such an
23 interview or the prisoner has a documented history of repeated, unjustified requests
24 for such out-of-cell interviews.

25 39. The County and the Sheriff will continue to use a confidential self-
26 referral system by which all prisoners can request mental health care without
27 revealing the substance of their request to custody staff or other prisoners.

28

1 40. The County and the Sheriff will ensure a QMHP will be available on-
2 site, by transportation of the prisoner, or through tele-psych 24 hours per day,
3 seven days per week (24/7) to provide clinically appropriate mental health crisis
4 intervention services.

5 **F. Mental Health Follow Up**

6 41. Consistent with existing DMH policies, the County and the Sheriff
7 will implement step-down protocols that provide clinically appropriate transition
8 when prisoners are discharged from FIP after being the subject of suicide watch.
9 The protocols will provide:

- 10 (a) intermediate steps between highly restrictive suicide measures (e.g.,
11 clinical restraints and direct constant observation) and the
12 discontinuation of suicide watch;
13 (b) an evaluation by a QMHP before a prisoner is removed from suicide
14 watch;
15 (c) every prisoner discharged from FIP following a period of suicide
16 watch will be housed upon release in the least restrictive setting
17 deemed clinically appropriate unless exceptional circumstances
18 affecting the facility exist; and
19 (d) all FIP discharges following a period of suicide watch will be seen by
20 a QMHP within 72 hours of FIP release, or sooner if indicated, unless
21 exceptional circumstances affecting the facility exist.

22 42. Consistent with existing DMH policies, the County and the Sheriff
23 will implement step-down protocols to ensure that prisoners admitted to HOH and
24 placed on risk precautions are assessed by a QMHP. As part of the assessment, the
25 QMHP will determine on an individualized basis whether to implement “step-
26 down” procedures for that prisoner as follows:
27
28

- 1 (a) the prisoner will be assessed by a QMHP within three Normal
2 business work days, but not to exceed four Days, following
3 discontinuance of risk precautions;
- 4 (b) the prisoner is counseled to ameliorate the negative psychological
5 impact that any restrictions may have had and in ways of dealing with
6 this impact;
- 7 (c) the prisoner will remain in HOH or be transferred to MOH, as
8 determined on a case by case basis, until such assessment and
9 counseling is completed, unless exceptional circumstances affecting
10 the facility exist; and
- 11 (d) the prisoner is subsequently placed in a level of care/housing as
12 determined by a QMHP.

13 43. Within six months of the Effective Date, the County and the Sheriff
14 will develop and implement written policies for formal discipline of prisoners with
15 serious mental illness incorporating the following:

- 16 (a) Prior to transfer, custody staff will consult with a QMHP to determine
17 whether assignment of a prisoner in mental health housing to
18 disciplinary housing is clinically contraindicated and whether
19 placement in a higher level of mental health housing is clinically
20 indicated, and will thereafter follow the QMHP's recommendation;
- 21 (b) If a prisoner is receiving psychotropic medication and is placed in
22 disciplinary housing from an area other than mental health housing, a
23 QMHP will meet with that prisoner within 24 hours of such placement
24 to determine whether maintenance of the prisoner in such placement is
25 clinically contraindicated and whether transfer of the prisoner to
26 mental health housing is clinically appropriate, and custody staff will
27 thereafter follow the QMHP's recommendation;
- 28

1 (c) A QMHP will participate in weekly walks, as specified in Paragraph
2 38, in disciplinary housing areas to observe prisoners in those areas
3 and to identify those prisoners with mental health needs;

4 (d) Prior to a prisoner in mental health housing losing behavioral credits
5 for disciplinary reasons, the disciplinary decision-maker will receive
6 and take into consideration information from a QMHP regarding the
7 prisoner's underlying mental illness, the potential effects of the
8 discipline being considered, and whether transfer of the prisoner to a
9 higher level of mental health housing is clinically indicated.

10 **G. Suicide Risk Procedures**

11 44. Within six months of the Effective Date, the County and the Sheriff
12 will install protective barriers that do not prevent line-of-sight supervision on the
13 second floor tier of all High Observation Housing areas to prevent prisoners from
14 jumping off of the second floor tier. Within six months of the Effective Date, the
15 County and the Sheriff will also develop a plan that identifies any other areas in
16 mental health housing where such protective barriers should be installed.

17 45. Consistent with existing Sheriff's Department policies, the County
18 and the Sheriff will provide both a Suicide Intervention Kit that contains an
19 emergency cut-down tool and a first-aid kit in the control booth or officer's station
20 of each housing unit. All custody staff who have contact with prisoners will know
21 the location of the Suicide Intervention Kit and first-aid kit and be trained to use
22 their contents.

23 46. The County and the Sheriff will immediately interrupt, and if
24 necessary, provide appropriate aid to, any prisoner who threatens or exhibits self-
25 injurious behavior.

26 **H. Staffing**

27 47. The County and the Sheriff will ensure there are sufficient custodial,
28 medical, and mental health staff at the Jails to fulfill the terms of this Agreement.

1 Within six months of the Effective Date, and on a semi-annual basis thereafter, the
2 County and the Sheriff will, in conjunction with the requirements of Paragraph 92
3 of this Agreement, provide to the Monitor and DOJ a report identifying the steps
4 taken by the County and the Sheriff during the review period to implement the
5 terms of this Agreement and any barriers to implementation, such as insufficient
6 staffing levels at the Jails, if any. The County and the Sheriff will retain staffing
7 records for two years to ensure that for any critical incident or non-compliance
8 with this Agreement, the Monitor and DOJ can obtain those records to determine
9 whether staffing levels were a factor in that critical incident and/or non-
10 compliance.

11 **I. Environmental Conditions**

12 48. Within three months of the Effective Date, the County and the Sheriff
13 will have written housekeeping, sanitation, and inspection plans to ensure the
14 proper cleaning of, and trash collection and removal in, housing, shower, and
15 medical areas, in accordance with California Code of Regulations (“CCR”) Title
16 15 § 1280: Facility Sanitation, Safety, and Maintenance.

17 49. Within three months of the Effective Date, the County and the Sheriff
18 will have a maintenance plan to respond to routine and emergency maintenance
19 needs, including ensuring that shower, toilet, sink, and lighting units, and heating,
20 ventilation, and cooling systems are adequately maintained and installed. The plan
21 will also include steps to treat large mold infestations.

22 50. Consistent with existing Sheriff’s Department policies regarding
23 control of vermin, the County and the Sheriff will provide pest control throughout
24 the housing units, medical units, kitchen, and food storage areas.

25 51. Consistent with existing Sheriff’s Department policies regarding
26 personal care items and supplies for inmates, the County and the Sheriff will
27 ensure that all prisoners have access to basic hygiene supplies, in accordance with
28 CCR Title 15 § 1265: Issue of Personal Care Items.

1 **J. Allowable Property Privileges**

2 52. The County and the Sheriff will implement policies governing
3 property restrictions in High Observation Housing that provide:

4 (a) Except when transferred directly from FIP, upon initial placement in
5 HOH:

6 (i) Suicide-resistant blankets, gowns, and mattresses will be
7 provided until the assessment set forth in section (a)(ii) below is
8 conducted, unless clinically contraindicated as determined and
9 documented by a QMHP.

10 (ii) Within 24 hours, a QMHP will make recommendations
11 regarding allowable property based upon an individual clinical
12 assessment.

13 (b) Property restrictions in HOH beyond 24 hours will be based on
14 clinical judgment and assessment by a QMHP as necessary to ensure
15 the safety and well-being of the prisoner and documented in the
16 Electronic Medical Record.

17 53. If otherwise eligible for an education, work, or similar program, a
18 prisoner's mental health diagnosis or prescription for medication alone will not
19 preclude that prisoner from participating in said programming.

20 54. Prisoners who are not in Mental Health Housing will not be denied
21 privileges and programming based solely on their mental health status or
22 prescription for psychotropic medication.

23 **K. Communication Related to Mental Health**

24 55. Relevant custody, medical, and mental health staff in all High
25 Observation Housing units will meet on Normal business work days and such staff
26 in all Moderate Observation Housing units will meet at least weekly to ensure
27 coordination and communication regarding the needs of prisoners in mental health
28 housing units as outlined in Custody Services Division Directive(s) regarding

1 coordination of mental health treatment and housing. When a custody staff
2 member is serving as a member of a treatment team, he or she is subject to the
3 same confidentiality rules and regulations as any other member of the treatment
4 team, and will be trained in those rules and regulations.

5 56. Consistent with existing DMH and Sheriff's Department policies, the
6 County and the Sheriff will ensure that custody, medical, and mental health staff
7 communicate regarding any change in a prisoner's housing assignment following a
8 suicide threat, gesture, or attempt, or other indication of an obvious and serious
9 change in mental health condition.

10 **L. Safety Checks**

11 57. Within three months of the Effective Date, the County and the Sheriff
12 will revise and implement their policies on safety checks to ensure a range of
13 supervision for prisoners housed in Mental Health Housing. The County and the
14 Sheriff will ensure that safety checks in Mental Health Housing are completed and
15 documented in accordance with policy and regulatory requirements as set forth
16 below:

- 17 (a) Custody staff will conduct safety checks in a manner that allows staff
18 to view the prisoner to assure his or her well-being and security.
19 Safety checks involve visual observation and, if necessary to
20 determine the prisoner's well-being, verbal interaction with the
21 prisoner;
- 22 (b) Custody staff will document their checks in a format that does not
23 have pre-printed times;
- 24 (c) Custody staff will stagger checks to minimize prisoners' ability to
25 plan around anticipated checks;
- 26 (d) Video surveillance may not be used to replace rounds and supervision
27 by custodial staff unless new construction is built specifically with
28 constant video surveillance enhancements and could only be used to

1 replace 15 minute checks in non-FIP housing, subject to approval by
2 the Monitor;

3 (e) A QMHP, in coordination with custody (and medical staff if
4 necessary), will determine mental health housing assignments.

5 (f) Supervision of prisoners in mental health housing will be conducted at
6 the following intervals:

7 (i) FIP: Custody staff will perform safety checks every 15
8 minutes. DMH staff will perform direct constant observation or
9 one-to-one observation when determined to be clinically
10 appropriate;

11 (ii) High Observation Housing: Every 15 minutes;

12 (iii) Moderate Observation Housing: Every 30 minutes.

13 58. Within three months of the Effective Date, the County and the Sheriff
14 will revise and implement their policies on safety checks. The County and the
15 Sheriff will ensure that safety checks in non-mental health housing units are
16 completed and documented in accordance with policy and regulatory requirements
17 as set forth below:

18 (a) At least every 30 minutes in housing areas with cells;

19 (b) At least every 30 minutes in dormitory-style housing units where the
20 unit does not provide for unobstructed direct supervision of prisoners
21 from a security control room.

22 (c) Where a dormitory-style housing unit does provide for unobstructed
23 direct supervision of prisoners, safety checks must be completed
24 inside the unit at least every 60 minutes;

25 (d) At least every 60 minutes in designated minimum security dormitory
26 housing at PDC South, or other similar campus-style unlocked
27 dormitory housing;

28

- 1 (e) Custody staff will conduct safety checks in a manner that allows staff
2 to view the prisoner to assure his or her well-being and security.
3 Safety checks involve visual observation and, if necessary to
4 determine the prisoner's well-being, verbal interaction with the
5 prisoner;
- 6 (f) Custody staff will document their checks in a format that does not
7 have pre-printed times;
- 8 (g) Custody staff will stagger checks to minimize prisoners' ability to
9 plan around anticipated checks; and
- 10 (h) Video surveillance may not be used to replace rounds and supervision
11 by custodial staff.

12 59. Consistent with existing Sheriff's Department policies regarding
13 uniform daily activity logs, the County and the Sheriff will ensure that a custodial
14 supervisor conducts unannounced daily rounds on each shift in the prisoner
15 housing units to ensure custodial staff conduct necessary safety checks and
16 document their rounds.

17 **M. Quality Improvement Plan**

18 60. Within six months of the Effective Date, the Department of Mental
19 Health, in cooperation with the Sheriff's Unit described in Paragraph 77 of this
20 Agreement, will implement a quality improvement program to identify and address
21 clinical issues that place prisoners at significant risk of suicide or self-injurious
22 behavior.

23 61. The quality improvement program will review, collect, and aggregate
24 data in the following areas and recommend corrective actions and systemic
25 improvements:

- 26 (a) Suicides and serious suicide attempts:
- 27 (i) Prior suicide attempts or other serious self-injurious behavior
- 28 (ii) Locations

- 1 (iii) Method
- 2 (iv) Lethality
- 3 (v) Demographic information
- 4 (vi) Proximity to court date;
- 5 (b) Use of clinical restraints;
- 6 (c) Psychotropic medications;
- 7 (d) Access to care, timeliness of service, and utilization of the Forensic
- 8 In-patient Unit; and
- 9 (e) Elements of documentation and use of medical records.

10 62. The County and the Sheriff's Unit described in Paragraph 77 of this
11 Agreement will develop, implement, and track corrective action plans addressing
12 recommendations of the quality improvement program.

13 **N. Mental Health Housing**

14 63. The County and the Sheriff will maintain adequate High Observation
15 Housing and Moderate Observation Housing sufficient to meet the needs of the jail
16 population with mental illness, as assessed by the County and the Sheriff on an
17 ongoing basis. The County will continue its practice of placing prisoners with
18 mental illness in the least restrictive setting consistent with their clinical needs.

19 64. Within six months of the Effective Date, the County and the Sheriff
20 will develop a short-term plan addressing the following 12-month period, and
21 within 12 months of the Effective Date, the County and the Sheriff will develop a
22 long-term plan addressing the following five-year period, to reasonably ensure the
23 availability of licensed inpatient mental health care for prisoners in the Jails. The
24 County and the Sheriff will begin implementation of each plan within 90 days of
25 plan completion. These plans will describe the projected capacity required,
26 strategies that will be used to obtain additional capacity if it is needed, and identify
27 the resources necessary for implementation. Thereafter, the County and the Sheriff
28 will review, and if necessary revise, these plans every 12 months.

1 **O. Medication**

2 65. Consistent with existing Sheriff's Department policies, the County
3 and the Sheriff will ensure that psychotropic medications are administered in a
4 clinically appropriate manner to prevent misuse, hoarding, and overdose.

5 66. Consistent with existing DMH policies, prisoners in High Observation
6 Housing and Moderate Observation Housing, and those with a serious mental
7 illness who reside in other housing areas of the Jails, will remain on an active
8 mental health caseload and receive clinically appropriate mental health treatment,
9 regardless of whether they refuse medications.

10 67. Within three months of the Effective Date, the County and the Sheriff
11 will implement policies for prisoners housed in High Observation Housing and
12 Moderate Observation Housing that require:

- 13 (a) documentation of a prisoner's refusal of psychotropic medication in
14 the prisoner's electronic medical record;
- 15 (b) discussion of a prisoner's refusal in treatment team meetings;
- 16 (c) the use of clinically appropriate interventions with such prisoners to
17 encourage medication compliance;
- 18 (d) consideration of the need to transfer non-compliant prisoners to higher
19 levels of mental health housing; and
- 20 (e) individualized consideration of the appropriateness of seeking court
21 orders for involuntary medication pursuant to the provisions of
22 California Welfare and Institutions Code sections 5332-5336 and/or
23 California Penal Code section 2603(a).

24 68. Within six months of the Effective Date, the County and the Sheriff
25 will develop and implement a procedure for contraband searches on a regular, but
26 staggered basis in all housing units. High Observation Housing cells will be
27 visually inspected prior to initial housing of inmates with mental health issues.

28

1 **P. Restraints**

2 69. Consistent with existing DMH policies regarding use of clinical
3 restraints, the County and the Sheriff will use clinical restraints only in the
4 Correctional Treatment Center and only with the approval of a licensed psychiatrist
5 who has performed an individualized assessment and an appropriate Forensic
6 Inpatient order. Use of clinical restraints in CTC will be documented in the
7 prisoner's electronic medical record. The documentation will include the basis for
8 and duration of the use of clinical restraints and the performance and results of the
9 medical welfare checks on restrained prisoners. When applying clinical restraints,
10 custody staff will ensure a QMHP is present to document and monitor the
11 condition of the prisoner being placed in clinical restraints.

12 70. Within three months of the Effective Date, the County and the Sheriff
13 will have policies and procedures regarding the use of Security Restraints in HOH
14 and MOH. Such policies will provide that:

- 15 (a) Security Restraints in these areas will not be used as an alternative to
16 mental health treatment and will be used only when necessary to
17 insure safety;
- 18 (b) Security Restraints will not be used to punish prisoners, but will be
19 used only when there is a threat or potential threat of physical harm,
20 destruction of property, or escape;
- 21 (c) Custody staff in HOH and MOH will consider a range of security
22 restraint devices and utilize the least restrictive option, for the least
23 amount of time, necessary to provide safety in these areas;
- 24 (d) Whenever a prisoner is recalcitrant, as defined by Sheriff's
25 Department policy, and appears to be in a mental health crisis,
26 Custody staff will request a sergeant and immediately refer the
27 prisoner to a QMHP.
28

1 71. The County and the Sheriff will ensure that any prisoner subjected to
2 clinical restraints in response to a mental health crisis receives therapeutic services
3 to remediate any effects from the episode(s) of restraint.

4 **Q. Suicide Death Reviews and Critical Incident Reviews**

5 72. The County and the Sheriff will develop and implement policies and
6 procedures that ensure that incidents involving suicide and serious self-injurious
7 behavior are reported and reviewed to determine: (a) whether staff engaged in any
8 violations of policies, rules, or laws; and (b) whether any improvements to policy,
9 training, operations, treatment programs, or facilities are warranted. These policies
10 and procedures will define terms clearly and consistently to ensure that incidents
11 are reported and tracked accurately by DMH and the Sheriff's Department.

12 73. Depending on the level of severity of an incident involving a prisoner
13 who threatens or exhibits self-injurious behavior, a custody staff member will
14 prepare a detailed report (Behavioral Observation and Mental Health Referral
15 Form, Inmate Injury Report, and/or Incident Report) that includes information
16 from individuals who were involved in or witnessed the incident as soon as
17 practicable, but no later than the end of shift. The report will include a description
18 of the events surrounding the incident and the steps taken in response to the
19 incident. The report will also include the date and time that the report was
20 completed and the names of any witnesses. The Sheriff's Department will
21 immediately notify the County Office of Inspector General of all apparent or
22 suspected suicides occurring at the Jails.

23 74. The Sheriff's Department will ensure that there is a timely, thorough,
24 and objective law enforcement investigation of any suicide that occurs in the Jails.
25 Investigations shall include recorded interviews of persons involved in, or who
26 witnessed, the incident, including other prisoners. Sheriff's Department personnel
27 who are investigating a prisoner suicide or suspected suicide at the Jails will ensure
28

1 the preservation of all evidence, including physical evidence, relevant witness
2 statements, reports, videos, and photographs.

3 75. Within three months of the Effective Date, the County and the Sheriff
4 will review every suicide attempt that occurs in the Jails as follows:

5 (a) Within two working days, DMH staff will review the incident, the
6 prisoner's mental health status known at the time of the incident, the
7 need for immediate corrective action if any, and determine the level of
8 suicide attempt pursuant to the Centers for Disease Control and
9 Prevention's Risk Rating Scale;

10 (b) Within 30 working days, and only for those incidents determined to be
11 a serious suicide attempt by DMH staff after the review described in
12 subsection (a) above, management and command-level personnel
13 from DMH and the Sheriff's Department (including Custody Division
14 and Medical Services Bureau) will meet to review relevant
15 information known at that time, including the events preceding and
16 following the incident, the prisoner's incarceration, mental health, and
17 health history, the status of any corrective actions taken, and the need
18 for additional corrective action if necessary;

19 (c) The County and the Sheriff will document the findings that result
20 from the review of serious suicide attempts described in subsection (b)
21 above; and

22 (d) The County and the Sheriff will ensure that information for all suicide
23 attempts is input into a database for tracking and statistical analysis.

24 76. The County and the Sheriff will review every apparent or suspected
25 suicide that occurs in the Jails as follows:

26 (a) Within no more than two working days, management and command-
27 level personnel from DMH and the Sheriff's Department (including
28 Custody Division and Medical Services Bureau) will meet to review

1 and discuss the suicide, the prisoner's mental health status known at
2 the time of the suicide, and the need for immediate corrective or
3 preventive action if any;

4 (b) Within seven working days, and again within 30 working days,
5 management and command-level personnel from DMH and the
6 Sheriff's Department (including Custody Division and Medical
7 Services Bureau) will meet to review relevant information known at
8 that time, including the events preceding and following the suicide,
9 the prisoner's incarceration, mental health, and health history, the
10 status of any corrective or preventive actions taken, and the need for
11 additional corrective or preventive action if necessary;

12 (c) Within six months of the suicide, the County and the Sheriff will
13 prepare a final written report regarding the suicide. The report will
14 include:

- 15 (i) time and dated incident reports and any supplemental reports
16 with the same Uniform Reference Number (URN) from custody
17 staff who were directly involved in and/or witnessed the
18 incident;
- 19 (ii) a timeline regarding the discovery of the prisoner and any
20 responsive actions or medical interventions;
- 21 (iii) copies of a representative sample of material video recordings
22 or photographs, to the extent that inclusion of such items does
23 not interfere with any criminal investigation;
- 24 (iv) a reference to, or reports if available, from the Sheriff's
25 Department Homicide Bureau;
- 26 (v) reference to the Internal Affairs Bureau or other personnel
27 investigations, if any, and findings, if any;
- 28

- 1 (vi) a Coroner's report, if it is available at the time of the final
- 2 report, and if it is not available, a summary of efforts made to
- 3 obtain the report;
- 4 (vii) a summary of relevant information discussed at the prior review
- 5 meetings, or otherwise known at the time of the final report,
- 6 including analysis of housing or classification issues if relevant;
- 7 (viii) a clinical mortality review;
- 8 (ix) a Psychological Autopsy utilizing the National Commission on
- 9 Correctional Health Care's standards; and
- 10 (x) a summary of corrective actions taken and recommendations
- 11 regarding additional corrective actions if any are needed.

12 77. The County and the Sheriff will create a specialized unit to oversee,
13 monitor, and audit the County's jail suicide prevention program in coordination
14 with the Department of Mental Health. The Unit will be headed by a Captain, or
15 another Sheriff's Department official of appropriate rank, who reports to the
16 Assistant Sheriff for Custody Operations through the chain of command. The Unit
17 will be responsible for:

- 18 (a) Ensuring the timely and thorough administrative review of suicides
- 19 and serious suicide attempts in the Jails as described in this
- 20 Agreement;
- 21 (b) Identifying patterns and trends of suicides and serious suicide
- 22 attempts in the Jails, keeping centralized records and inputting data
- 23 into a unit database for statistical analysis, trends, and corrective
- 24 action, if necessary;
- 25 (c) Ensuring that corrective actions are taken to mitigate suicide risks at
- 26 both the location of occurrence and throughout the concerned system
- 27 by providing, or obtaining where appropriate, technical assistance to
- 28

1 other administrative units within the Custody Division when such
2 assistance is needed to address suicide-risk issues;

3 (d) Analyzing staffing, personnel/disciplinary, prisoner classification, and
4 mental health service delivery issues as they relate to suicides and
5 serious suicide attempts to identify the need for corrective action
6 where appropriate; and recommend remedial measures, including
7 policy revisions, re-training, or staff discipline, to address the
8 deficiencies and ensure implementation; and

9 (e) Participating in meetings with DMH to develop, implement, and track
10 corrective action plans addressing recommendations of the quality
11 improvement program.

12 78. The County and the Sheriff will maintain a county-level Suicide
13 Prevention Advisory Committee that will be open to representatives from the
14 Sheriff's Department Custody Division, Court Services, Custody Support Services,
15 and Medical Services Bureau; the Department of Mental Health; the Public
16 Defender's Office; County Counsel's Office; the Office of the Inspector General;
17 and the Department of Mental Health Patients' Rights Office. The Suicide
18 Prevention Advisory Committee will meet twice per year and will serve as an
19 advisory body to address system issues and recommend coordinated approaches to
20 suicide prevention in the Jails.

21 **R. Mental Health Treatment**

22 79. (a) Unless clinically contraindicated, the County and the Sheriff will
23 offer prisoners in mental health housing:

- 24 (i) therapeutically appropriate individual visits with a QMHP;
25 (ii) therapeutically appropriate group programming conducted by a
26 QMHP or other appropriate provider that does not exceed 90
27 minutes per session;

1 (b) The County and the Sheriff will provide prisoners outside of mental
2 health housing with medication support services when those prisoners are
3 receiving psychotropic medications and therapeutically appropriate individual
4 monthly visits with a QMHP when those prisoners are designated as Seriously
5 Mentally Ill.

6 (c) The date, location, topic, attendees, and provider of programming or
7 therapy sessions will be documented. A clinical supervisor will review
8 documentation of group sessions on a monthly basis.

9 80. (a) The County and the Sheriff will continue to make best efforts to
10 provide appropriate out-of-cell time to all prisoners with serious mental illness,
11 absent exceptional circumstances, and unless individually clinically
12 contraindicated and documented in the prisoner's electronic medical record. To
13 implement this requirement, the County and the Sheriff will follow the schedule
14 below:

15 (i) By no later than six months after the Effective Date, will offer
16 25% of the prisoners in HOH ten hours of unstructured out-of-
17 cell recreational time and ten hours of structured therapeutic or
18 programmatic time per week;

19 (ii) By no later than 12 months after the Effective Date, will offer
20 50% of the prisoners in HOH ten hours of unstructured out-of-
21 cell recreational time and ten hours of structured therapeutic or
22 programmatic time per week;

23 (iii) By no later than 18 months after the Effective Date, will offer
24 100% of the prisoners in HOH ten hours of unstructured out-of-
25 cell recreational time and ten hours of structured therapeutic or
26 programmatic time per week.

27 (b) No later than six months after the Effective Date, the County and the
28 Sheriff will record at the end of each day which prisoners in HOH, if any, refused

1 to leave their cells that day. That data will be presented and discussed with DMH
2 staff at the daily meeting on the following Normal business work day. The data
3 will also be provided to the specialized unit described in Paragraph 77 and to
4 DMH's quality improvement program to analyze the data for any trends and to
5 implement any corrective action(s) deemed necessary to maximize out-of-cell time
6 opportunities and avoid unnecessary isolation.

7 **S. Use of Force**

8 81. Except as specifically set forth in Paragraphs 18-20 of this
9 Agreement, and except as specifically identified below, the County and the Sheriff
10 will implement the following paragraphs of the Implementation Plan in *Rosas* at all
11 Jails facilities, including the Pitchess Detention Center and the Century Regional
12 Detention Facility, by no later than the dates set forth in the Implementation Plan
13 or as revised by the *Rosas* Monitoring Panel: Paragraphs 2.2-2.13 (use of force
14 policies and practices); 3.1-3.6 (training and professional development); 4.1-4.10
15 (use of force on mentally ill prisoners); 5.1-5.3 (data tracking and reporting of
16 force); 6.1-6.20 (prisoner grievances and complaints); 7.1-7.3 (prisoner
17 supervision); 8.1-8.3 (anti-retaliation provisions); 9.1-9.3 (security practices); 10.1-
18 10.2 (management presence in housing units); 11.1 (management review of force);
19 12.1-12.5 (force investigations, with the training requirement of paragraph 12.1 to
20 be completed by December 31, 2016); 13.1-13.2 (use of force reviews and staff
21 discipline); 14.1-14.2 (criminal referrals and external review); 15.1-15.7
22 (documentation and recording of force); 16.1-16.3 (health care assessments); 17.1-
23 17.10 (use of restraints); 18.1-18.2 (adequate staffing); 19.1-19.3 (early warning
24 system); 20.1-20.3 (planned uses of force); and 21.1 (organizational culture).

25 82. With respect to paragraph 6.16 of the *Rosas* Implementation Plan, the
26 County and the Sheriff will ensure that Sheriff's Department personnel responsible
27 for collecting prisoners' grievances as set forth in that paragraph are also co-
28 located in the Century Regional Detention Facility.

1 83. The County and the Sheriff will install closed circuit security cameras
2 throughout all Jails facilities' common areas where prisoners engage in
3 programming, treatment, recreation, visitation, and intra-facility movement
4 ("Common Areas"), including in the Common Areas at the Pitchess Detention
5 Center and the Century Regional Detention Facility. The County and the Sheriff
6 will install a sufficient number of cameras in Jails facilities that do not currently
7 have cameras to ensure that all Common Areas of these facilities have security-
8 camera coverage. The installation of these cameras will be completed no later than
9 June 30, 2018; with TTCF, MCJ, and IRC completed by the Effective Date; CRDF
10 completed by March 1, 2016; and the remaining facilities completed by June 30,
11 2018. The County and the Sheriff will also ensure that all video recordings of
12 force incidents are adequately stored and retained for a period of at least one year
13 after the force incident occurs or until all investigations and proceedings related to
14 the use of force are concluded.

15 84. The Sheriff will continue to maintain and implement policies for the
16 timely and thorough investigation of alleged staff misconduct related to use of
17 force and for timely disciplinary action arising from such investigations.

18 Specifically:

- 19 (a) Sworn custody staff subject to the provisions of California
20 Government Code section 3304 will be notified of the completion of
21 the investigation and the proposed discipline arising from force
22 incidents in accordance with the requirements of that Code section;
23 and
24 (b) All non-sworn Sheriff's Department staff will be notified of the
25 proposed discipline arising from force incidents in time to allow for
26 the imposition of that discipline.

1 85. The County and the Sheriff will ensure that Internal Affairs Bureau
2 management and staff receive adequate specialized training in conducting
3 investigations of misconduct.

4 86. Within three months of the Effective Date, the County and the Sheriff
5 will develop and implement policies and procedures for the effective and accurate
6 maintenance, inventory, and assignment of chemical agents and other security
7 equipment. The County and the Sheriff will develop and maintain an adequate
8 inventory control system for all weapons, including OC spray.

9 **VI. IMPLEMENTATION, COMPLIANCE ASSESSMENT,**
10 **ENFORCEMENT, AND TERMINATION**

11 **A. Review and Implementation of Policies, Procedures, and Programs**

12 87. The County and the Sheriff are committed to continuous quality
13 improvement and have taken significant steps to review and update policies and
14 procedures to protect the constitutional and federal rights of prisoners at the Jails.
15 Where necessary, the County and the Sheriff will maintain existing policies,
16 procedures, and practices to support the substantive provisions in this Agreement.

17 88. The County and the Sheriff will review all relevant policies,
18 procedures, and other written executive-approved directives within four months of
19 the Effective Date to ensure that they are consistent with the terms of this
20 Agreement, unless they were reviewed and revised for such purposes within six
21 months preceding the Effective Date.

22 89. (a) If the County or the Sheriff create or materially revise a policy
23 related to this Agreement after the Effective Date, the following process will be
24 followed before implementation:

- 25 (1) the County and Sheriff will provide a copy of the proposed policy to
26 the Monitor and DOJ prior to its implementation;
- 27 (2) the Monitor and DOJ will have 30 days to review the policy and
28 submit comments, if any, to the County and the Sheriff;

- 1 (3) if the Monitor and DOJ do not submit any comments within the 30-
- 2 day period, the County and the Sheriff will begin implementation of
- 3 the policy no later than 180 days after the expiration of the 30 day-
- 4 review period or notice that no comments will be forthcoming;
- 5 (4) if the Monitor or DOJ objects to the proposed policy, the Monitor or
- 6 DOJ will note the objection in writing to all Parties within the
- 7 respective review period;
- 8 (5) if there is any objection to the proposed policy, the County and the
- 9 Sheriff will have 30 days to address the objection(s);
- 10 (6) if the Monitor and the Parties cannot resolve the objection(s), either
- 11 Party may ask the Court to resolve the matter;
- 12 (7) the Monitor may extend any time frame within this paragraph by up to
- 13 15 additional days. Further extensions may be granted by the Monitor
- 14 with the agreement of both Parties when necessary to permit amicable
- 15 resolution of objections.

16 (b) If after the Effective Date, the County or the Sheriff is confronted with a
17 critical circumstance requiring immediate action, the County or the Sheriff may
18 create or substantially revise, and then implement, a policy related to this
19 Agreement without the prior review of the Monitor and DOJ, so long as the
20 review, comment, and objection procedures set forth above in subparagraph (a) are
21 followed immediately upon implementation.

22 90. The County and the Sheriff will provide relevant staff with any policy
23 that is created or materially revised after the Effective Date if it relates to the
24 provisions of this Agreement. The County and the Sheriff will further document
25 that any such policy has been received by that staff and that such staff has been
26 trained, instructed, or briefed, as appropriate, on that policy.

1 **B. Compliance Coordination Unit**

2 91. The County and the Sheriff will establish and maintain a compliance
3 coordination unit for the duration of this Agreement. The unit will:

- 4 (a) serve as a liaison between the Parties and the Monitor and assume
5 primary responsibility for collecting information the Monitor requires
6 to carry out the duties assigned to the Monitor;
- 7 (b) maintain sufficient records to document that the requirements of this
8 Agreement are being properly implemented (e.g., census summaries,
9 policies, procedures, protocols, training materials, investigations,
10 incident reports, tier logs, use-of-force reports);
- 11 (c) provide written answers by electronic mail or other format when
12 necessary and any documents requested by the Monitor or DOJ
13 concerning implementation of this Agreement in a timely manner;
- 14 (d) coordinate and monitor compliance and implementation activities,
15 including coordination between Custody and DMH staff, and assist
16 managers in assigning compliance tasks to County or Sheriff
17 personnel; and
- 18 (e) ensure that the County and the Sheriff notify DOJ and the Monitor of
19 any suspected or apparent suicide within 24 hours and make related
20 reports available to the Monitor and DOJ for inspection.

21 **C. Self-Assessments and Reports**

22 92. (a) Fifteen days before the end of the reporting period described in
23 Paragraph 109 of this Agreement, the County and the Sheriff will provide the
24 Monitor and DOJ a Self-Assessment Status Report that includes:

- 25 (1) the actions taken by the County and the Sheriff during the review
26 period to implement this Agreement including the status of ongoing
27 and continuous improvement activities;

- 1 (2) responses to concerns or recommendations made in prior reports by
- 2 the Monitor;
- 3 (3) a summary of any audits related to the provisions of this Agreement
- 4 that were completed in the reporting period; and
- 5 (4) relevant trend data including the information described in Paragraphs
- 6 61 and 77(a).

7 (b) Self-Assessment Status Reports prepared pursuant to this Paragraph will
8 be treated as confidential and not further disclosed or attached to any court
9 document, unless filed under seal with Court approval, without the consent of the
10 County and the Sheriff or by order of the Court. The Monitor, SMEs, and other
11 monitoring staff, however, will be permitted to use the information contained in
12 the Self-Assessment Status Reports to prepare the Monitor's reports to the Court.

13 **D. Independent Monitor**

14 93. In order to assess and report on the implementation of this Agreement
15 and whether the implementation is having the intended beneficial impact on
16 conditions at the Jails, the Monitor, the SMEs, and their staff will:

- 17 (a) conduct the audits, reviews, and assessments specified in this
- 18 Agreement;
- 19 (b) review County and Sheriff policies, procedures, training curricula, and
- 20 other documents related to this Agreement developed and
- 21 implemented pursuant to this Agreement;
- 22 (c) conduct such additional audits, reviews, and assessments consistent
- 23 with this Agreement as the Monitor and the Parties jointly agree are
- 24 appropriate, or in the case of a dispute which the Parties cannot in
- 25 good faith resolve, as ordered by the Court; and
- 26 (d) evaluate the implementation of Section V.S. of this Agreement
- 27 concerning use of force consistent with the Settlement Agreement and
- 28 Implementation Plan-approved in *Rosas*.

1 94. The Parties have selected Richard Drooyan as the Independent
2 Monitor. The Monitor and his staff will not, and are not intended to, replace or
3 assume the role and duties of the County or the Sheriff and will have only the
4 duties, responsibilities, and authority conferred by this Agreement.

5 To assess and report whether the provisions of this Agreement have been
6 implemented, and whether the County and the Sheriff are in compliance with the
7 substantive provisions of this Agreement, the Monitor will:

8 (a) evaluate the implementation of Section V (“Substantive Provisions”)
9 of this Agreement and, where applicable, the Settlement Agreement
10 and Implementation Plan approved in *Rosas*;

11 (b) conduct specific audits, reviews, and assessments consistent with this
12 Agreement or otherwise if the Parties agree in writing; and

13 (c) prepare reports as provided in this Agreement.

14 95. The Parties have also selected Bruce C. Gage, M.D., and Manuel
15 David Romero as Subject Matter Experts (“SMEs”). The SMEs and their staff will
16 not, and are not intended to, replace or assume the role and duties of the County or
17 the Sheriff and will have only the duties, responsibilities, and authority conferred
18 by this Agreement. The SMEs will, in conjunction with the Monitor, assess
19 compliance with the substantive provisions of this Agreement by providing
20 expertise within the scope of their subject matters.

21 96. The Monitor and/or SMEs may hire or contract with additional
22 persons with knowledge or expertise not already provided by the SMEs, or where
23 delegation to a subordinate staff member would be appropriate, as reasonably
24 necessary to perform the tasks assigned by this Agreement. The Monitor will
25 notify the County, the Sheriff, and DOJ in writing when the Monitor or SMEs are
26 considering such additional persons. The Parties will have an opportunity, if
27 desired, to interview the candidate(s) and request reasonable information about the
28 candidate’s background and experience. If the Parties agree to the Monitor’s

1 proposal, the Monitor or SMEs will be authorized to hire or contract such
2 additional persons. If the Parties do not agree to the proposal, the Parties will have
3 ten business days to disagree with the proposal in writing. The Parties will not
4 unreasonably withhold approval. If the Parties are unable to reach agreement
5 within ten business days of receiving notice of this disagreement, the Court will
6 resolve the dispute.

7 97. If not already developed by the Monitor and SMEs and agreed-to by
8 the Parties before the execution of this Agreement, within three months of the
9 appointment of the Monitor and SMEs by the Court, the Monitor and SMEs will
10 develop a plan for conducting the above audits, reviews, and assessments, and will
11 submit that plan to the Parties for review and approval. The plan will:

- 12 (a) set out a methodology for reviewing each of the substantive
13 provisions of this Agreement, including which provisions will be
14 assessed together, if any, and the thresholds for achieving Substantial
15 Compliance; and
16 (b) set out a schedule for conducting the assessments required by this
17 Agreement.

18 98. The Monitor, SMEs, and any person hired or contracted to assist the
19 Monitor or SMEs will be subject to (a) the supervision and orders of the Court
20 consistent with the terms of this Agreement; (b) the terms of this Agreement; (c)
21 any applicable law; and (d) any security protocols while in the Jails.

22 99. The County and the Sheriff will bear all reasonable fees and costs of
23 the Monitor, the SMEs, and their staff. Travel, lodging, and per diem expenses
24 will be reimbursed at the same rate as provided for County employees. In the
25 event that any dispute arises regarding the reasonableness or payment of the
26 Monitor's, SMEs', or their staff's fees and costs, the Parties and the Monitor will
27 attempt to resolve the dispute cooperatively before seeking the assistance of the
28 Court.

1 100. At the request of the County and the Sheriff, and with the consent of
2 the DOJ, the Monitor, SMEs, and their staff may provide technical assistance.
3 Such assistance may not interfere with the Monitor's or SMEs' duties under this
4 Agreement, create additional duties or obligations that are enforceable under this
5 Agreement, or otherwise alter or modify the terms of this Agreement.
6 Additionally, whenever the County or the Sheriff identifies and implements its
7 own quality improvement measures that are not related to any of the terms of this
8 Agreement, those quality improvement measures will not be monitored or enforced
9 under this Agreement.

10 101. Should all the Parties agree that the Monitor, a SME, or a member of
11 their staff has exceeded his or her authority or is not fulfilling his or her duties in
12 accordance with this Agreement, the Parties may petition the Court for the
13 immediate removal and replacement of the Monitor, SME, or staff person. After
14 good faith attempts to resolve such issues informally, any Party may petition the
15 Court for the removal of the Monitor, a SME, or any member of their staff, for
16 good cause, which may include, but is not limited to: gross neglect of duties;
17 willful misconduct; inappropriate personal relationship with a Party, any Party
18 employee, or prisoner; conflicts of interest; any criminal conduct; or any
19 significant violations of security protocols during the pendency of this Agreement.

20 102. The Parties recognize the Monitor and SMEs may have existing
21 clients who may now be, or in the future may be, adverse to the County or the
22 Sheriff in transactions or litigation. For the duration of this Agreement, however,
23 unless such conflict is waived by all Parties, the Monitor, the SMEs, and their staff
24 will not accept any new employment or retention for consulting services regarding
25 alleged actions or inactions by the County or the Sheriff, or any County or Sheriff's
26 employee, including any actions or inactions involving any prisoner that present a
27 conflict of interest with the Monitor's, SME's, or staff member's responsibilities
28 under this Agreement, including being retained (on a paid or unpaid basis) by any

1 current or future litigant or claimant, or such litigant's or claimant's attorney, in
2 connection with a claim or suit against the County, the Sheriff, or their
3 departments, officers, agents, or employees. Similarly, the Monitor, the SMEs,
4 and their staff will not accept employment or provide consulting services (on a
5 paid or unpaid basis) by any Defendant to this matter to act as a defense witness in
6 connection with a private claim or suit against the County, the Sheriff, or their
7 departments, officers, agents, or employees. This provision does not apply to any
8 proceeding before a court related to performance of contracts or subcontracts for
9 monitoring this Agreement.

10 **E. Access and Confidentiality**

11 103. With the exception of documents within the attorney-client and
12 attorney-work-product privileges, and notwithstanding the confidentiality
13 restrictions of the Health Insurance Portability and Accountability Act ("HIPAA"),
14 the California Confidentiality of Medical Information Act (Civil Code § 56, *et*
15 *seq.*), and California Welfare and Institutions Code § 5328 (related to
16 confidentiality of mental health records), the Monitor, SMEs, their staff, and the
17 United States, its attorneys, consultants, and agents will have full and complete
18 access to the Jails and all relevant individuals, facilities, prisoner medical and
19 mental health records, documents, data, and meetings related to the provisions of
20 this Agreement.

21 104. Other than as expressly provided in this Agreement, the Monitor, the
22 SMEs, their staff, and DOJ will maintain confidential all, and will not distribute or
23 disclose any, non-public information provided by the County and the Sheriff
24 pursuant to this Agreement. This Agreement will not be deemed a waiver of any
25 privilege or right the County or the Sheriff may assert, including those recognized
26 at common law or created by statute, rule, or regulation, against any other person
27 or entity with respect to the disclosure of any document or information.

28

1 **F. Public Statements, Testimony, and Records**

2 105. Except as required by the terms of this Agreement, an order from the
3 Court, the express written agreement of all Parties, or at meetings of the County of
4 Los Angeles Board of Supervisors, the Monitor, SMEs, and their staff will not
5 make any public or press statements (at a conference or otherwise), issue findings,
6 offer expert opinion, or testify in any other litigation or proceeding regarding any
7 matter or subject that he or she may have learned as a result of his or her
8 performance under this Agreement. If the Monitor, SMEs, or any of their staff
9 receive a subpoena, he or she will promptly notify the Parties and thereafter advise
10 the subpoenaing court of the terms of this Agreement.

11 106. The Monitor, SMEs, and their staff will be permitted to initiate and
12 receive ex parte communications with all Parties.

13 107. The Monitor, SMEs, and their staff are not a State, County, or local
14 agency, or an agent thereof, and accordingly, the records maintained by them, or
15 any of them, will not be deemed public records subject to public inspection. If the
16 Monitor, SMEs, or any of their staff receive a request for inspection of their
17 records related to this Agreement, he or she will promptly notify the Parties.

18 108. This Agreement is enforceable only by the Parties. No person or
19 entity is intended to be a third-party beneficiary of the provisions of this
20 Agreement for purposes of any civil, criminal, or administrative action, and
21 accordingly, no person or entity may assert any claim or right as a beneficiary or
22 protected class under this Agreement.

23 **G. Monitoring Reports**

24 109. Every six months, the Monitor will file public written reports with the
25 Court describing the steps taken by the County and the Sheriff to implement this
26 Agreement and evaluating the extent to which the County and the Sheriff have
27 complied with this Agreement. Specifically, the Monitor and SMEs will evaluate
28 the status of compliance for each substantive provision of this Agreement using the

1 following standards: (1) Substantial Compliance; (2) Partial Compliance; and (3)
2 Non-compliance. In order to assess compliance, the Monitor and SMEs will
3 review a sufficient number of pertinent documents to accurately assess current
4 conditions, interview all relevant staff, interview a sufficient number of prisoners
5 to accurately assess current conditions, and take other reasonable actions consistent
6 with this Agreement, as needed, to fulfill their responsibilities under this
7 Agreement. The Monitor, the SMEs, and their staff will be responsible for
8 independently verifying representations from the County or the Sheriff regarding
9 progress toward compliance, and examining supporting documentation. Each
10 monitoring report will describe the steps taken by members of the monitoring team
11 to analyze conditions and assess compliance, including reference to the documents
12 reviewed and individuals interviewed, and the factual basis for the Monitor's and
13 SMEs' findings. Such reports and findings will not be admissible by or against the
14 County or the Sheriff in any proceeding other than a proceeding related to the
15 enforcement of this Agreement initiated and handled exclusively by the County,
16 the Sheriff, or the United States.

17 110. At least 30 days before the anticipated filing of such reports, the
18 Monitor will provide the Parties with a draft copy and an opportunity to respond.
19 The Monitor will consider the Parties' responses and make appropriate changes, if
20 any, before filing. The Parties may file separate responses with the Court within
21 15 days after the filing by the Monitor although nothing in this Agreement will be
22 construed to require the filing of such responses. All public court filings by the
23 Monitor and any Party will be written with due regard for the privacy interests of
24 individual prisoners and staff and the interest of the County and the Sheriff in
25 protecting against disclosure of information not permitted by this Agreement.

26 111. Except for the provisions of Section V.S. of this Agreement that have
27 different Compliance Periods under the Settlement Agreement, Implementation
28 Plan, and Monitoring Protocols approved in *Rosas*, upon the Monitor's and SMEs'

1 conclusion that the County and the Sheriff have achieved and maintained
2 Substantial Compliance with a substantive provision of this Agreement for a period
3 of twelve (12) consecutive months, the Monitor and SMEs will no longer be
4 required to assess or report on that provision. Where the Monitor and SMEs
5 conclude that the County and the Sheriff have achieved and maintained Substantial
6 Compliance with a substantive provision of this Agreement, as described
7 immediately above, at one Jail facility but not at other facilities, the Monitor and
8 SMEs will no longer be required to assess or report on that provision as it applies
9 to the facility found to be in sustained compliance. The Parties expect that there
10 will be multiple independent operative compliance periods under the supervision
11 of the Monitor.

12 112. If the Monitor identifies a critical and time sensitive issue that the
13 County or the Sheriff should address during a six-month reporting period and that
14 should not be delayed until the time the Monitor must provide the Parties with a
15 draft copy of the monitoring report, the Monitor will provide the Parties with a
16 verbal report on the critical issue as soon as possible, and the Monitor will provide
17 a written report to the Parties within 30 days of the Monitor's identification of the
18 critical issue.

19 **H. Court Jurisdiction, Modification, Enforcement, and Termination**

20 113. The Court shall retain jurisdiction over the implementation of this
21 Agreement at the existing Jails or any other facility used to replace or supplement
22 the Jails for all purposes.

23 114. The County and the Sheriff will ensure that all of the terms in this
24 Agreement are implemented. Unless otherwise provided in a specific provision of
25 this Agreement, the implementation of this Agreement will begin immediately
26 upon the Effective Date.

27
28

1 115. Unless otherwise agreed to under a specific provision of this
2 Agreement, the County and the Sheriff will implement all provisions of this
3 Agreement within six months of the Effective Date.

4 116. To ensure that the substantive provisions of this Agreement are
5 implemented in accordance with the terms of this Agreement, the Court will retain
6 jurisdiction to enforce this Agreement only until either:

7 (a) the County and the Sheriff have achieved and maintained Substantial
8 Compliance with each and every substantive provision of this
9 Agreement for a period of twelve (12) consecutive months (or other
10 time period provided in a specific provision of this Agreement or the
11 relevant Compliance Period under the Settlement Agreement,
12 Implementation Plan, and Monitoring Protocols approved in *Rosas*);
13 or

14 (b) the Monitor, with Court approval, determines that the overall
15 objectives and goals of this Agreement have been met even where the
16 specific requirements of substantive provisions of this Agreement may
17 be only in Partial Compliance.

18 Either of the conditions described in sub-paragraphs (a) or (b) above will be
19 deemed to fully satisfy this Agreement. At that time, the County and the Sheriff
20 may seek to terminate this Agreement with the Court consistent with the
21 requirements of the Prison Litigation Reform Act, 18 U.S.C. § 3626(b).

22 117. The United States acknowledges the good faith of the County and the
23 Sheriff in committing to the reforms set forth in this Agreement. The United
24 States, however, reserves the right to seek enforcement of the provisions of this
25 Agreement with the Court if it determines that the County or the Sheriff has failed
26 to substantially comply with any substantive provisions of this Agreement. Before
27 pursuing any remedy with the Court, the United States agrees to give written notice
28 to the County and the Sheriff in accordance with the Local Rules of the Central

1 District of California. The County and the Sheriff will have 30 days from receipt
2 of such notice to cure the alleged failure (or such additional time as is reasonable
3 due to the nature of the issue and agreed upon by the Parties). During the 30-day
4 period, the Parties will meet and confer in good faith to resolve any disputes
5 regarding the alleged failure or to otherwise explore a joint resolution. The
6 Monitor and SMEs may assist the Parties in reaching a mutually agreeable
7 resolution to the alleged compliance failure, including facilitating conference
8 meetings and providing relevant factual assessments.

9 118. In case of an emergency posing an imminent and serious threat to the
10 health or safety of any prisoner or staff member at the Jails, the United States may
11 omit the notice and cure requirements set forth above and seek enforcement of the
12 Agreement with the Court.

13 119. The Parties may jointly stipulate to make changes, modifications, and
14 amendments to this Agreement, which will be effective absent further action from
15 the Court, 30 days after a stipulation signed by all of the Parties has been filed with
16 the Court. Any Party may seek to modify this Agreement with the Court if that
17 Party establishes by a preponderance of the evidence that a significant change in
18 the law or factual conditions warrant the modification and that the proposed
19 modification is suitably tailored to the changed circumstances.

20 120. The Parties agree to defend the provisions of this Agreement. The
21 Parties will notify each other of any court or administrative challenge to this
22 Agreement. In the event any provision of this Agreement is challenged in any state
23 court, removal to a federal court shall be sought by the Parties.

24 121. The County and the Sheriff agree to promptly notify DOJ if any term
25 of this Agreement becomes the subject of collective bargaining consultation and to
26 consult with DOJ in a timely manner regarding the position the County or the
27 Sheriff takes in any collective bargaining consultation connected with this
28 Agreement.

1 122. This Agreement will constitute the entire integrated agreement of the
2 Parties and will supersede the 2002 Memorandum of Agreement Between the
3 United States and Los Angeles County, California, Regarding Mental Health
4 Services at the Los Angeles County Jail ("2002 MOA"). No prior or
5 contemporaneous communications, oral or written, will be relevant or admissible
6 for purposes of determining the meaning of any provisions herein, in this litigation
7 or in any other proceeding.

8 123. The Agreement will be applicable to, and binding upon, all Parties,
9 their officers, agents, employees, assigns, and their successors in office.

10 124. Failure by any Party to enforce this entire Agreement or any provision
11 thereof with respect to any deadline or any other provision herein will not be
12 construed as a waiver of the Party's right to enforce other deadlines or provisions
13 of this Agreement.

14 **VII. STIPULATION PURSUANT TO THE PRISON LITIGATION**
15 **REFORM ACT, 18 U.S.C. § 3626**


16 125. The Parties stipulate and the Court finds, pursuant to 18 U.S.C. §
17 3626(a), that although this matter was not actually litigated or resolved on the
18 merits, the prospective relief in this Agreement is narrowly drawn, extends no
19 further than necessary to correct the violations of federal rights as alleged by the
20 United States in its Complaint, is the least intrusive means necessary to correct
21 those alleged violations, and will not have an adverse impact on public safety or
22 the operation of a criminal justice system. If the Court does not make the requisite
23 findings and the United States' Complaint is dismissed with prejudice, the Parties
24 agree that this Agreement will become a binding Memorandum of Agreement that
25 will supersede the 2002 MOA. Any admission made for purposes of this
26 Agreement is not admissible if presented by third parties in another proceeding.


1 Respectfully submitted this ___ day of ____, 2015.

2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28


For the UNITED STATES OF AMERICA:

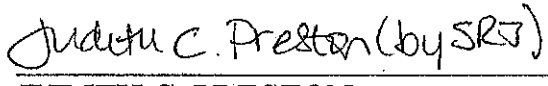
LORETTA E. LYNCH
Attorney General

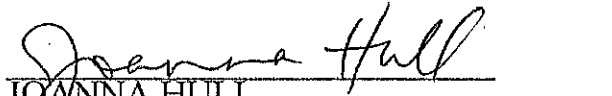

EILEEN M. DECKER
United States Attorney



MARK KAPPELHOFF
Acting Deputy Assistant Attorney
General

LEON W. WEIDMAN
Assistant United States Attorney
Chief, Civil Division

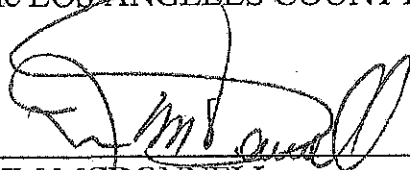

ROBYN-MARIE LYON MONTELEONE
Assistant United States Attorney
Assistant Division Chief
Civil Rights Unit Chief, Civil Division


JUDITH C. PRESTON
Acting Chief

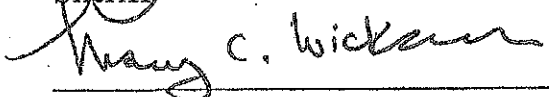

JOANNA HULL
Assistant United States Attorney
U.S. Attorney's Office for the
Central District of California
300 North Los Angeles Street, Suite 7516
Los Angeles, California 90012


LAURA L. COON
Special Counsel
LUIS E. SAUCEDO
CATHLEEN S. TRAINOR
Trial Attorneys
U.S. Department of Justice
Civil Rights Division
Special Litigation Section
950 Pennsylvania Avenue, NW
PHB 5026
Washington, D.C. 20530

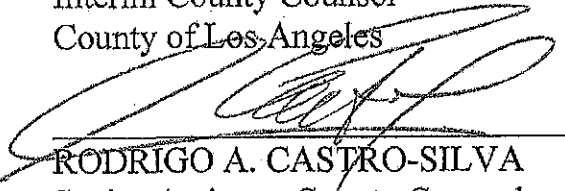
1 For the COUNTY OF LOS ANGELES and the LOS ANGELES COUNTY
2 SHERIFF, in his official capacity:



JEM MCDONNELL
Sheriff



MARY C. WICKHAM
Interim County Counsel
County of Los Angeles



RODRIGO A. CASTRO-SILVA
Senior Assistant County Counsel
County of Los Angeles

15 SO ORDERED this _____ day of _____, 2015.

UNITED STATES DISTRICT JUDGE

28

MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND SHEILA KUEHL

AUGUST 11, 2015

Expanding Effective Diversion Efforts in Los Angeles County

For more than a year, the Board of Supervisors (Board) has demonstrated its commitment to improving the treatment of persons with mental illness and substance abuse challenges, while preserving public safety. A successful jail diversion approach would re-direct individuals with serious mental illness and co-occurring substance use disorders from the criminal justice system to an integrated treatment system.

On May 6, 2014, the Board adopted a motion directing several departments, under the leadership of the District Attorney, to move expeditiously toward establishing a comprehensive diversion program for Los Angeles County (County). The Board supported the District Attorney’s leadership in convening a broad County workgroup to conduct a comprehensive assessment of the existing mental health diversion programs used by the County, and currently available permanent supportive housing.

On July 29, 2014 and on April 14, 2015, respectively, the Board continued to demonstrate its commitment to diversion efforts in the County by approving \$20 million in the FY14-15 Budget and an additional \$10 million in the FY 15-16 Budget.

On June 9, 2015, the Board suspended the Jail Master Plan and instructed the Interim Chief Executive Officer to consider community-based alternative options for treatment, including but not limited to mental health and substance abuse treatment.

Also on June 9, 2015, the Board moved to create a single, integrated jail health organizational structure and shift the entire Sheriff’s Department Medical Services Bureau supervision and budget, including positions and Department of Mental Health staff services, to

- MORE -

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND SHEILA KUEHL
AUGUST 11, 2015
PAGE 2**

the Department of Health Services (DHS). The action was intended to dramatically improve quality and coordination of care while better facilitating successful re-entry into the community.

Data supports that it is prudent to invest taxpayer resources in a comprehensive diversion program that promotes integrated community care. Diversion efforts can be more effective than jails at treating mental illness, enhancing public safety, reducing repeat offenses and producing better outcomes. For these reasons, diversion alternatives, including the development of permanent supportive housing and integrated services, have been advanced in the context of the Board's consideration of replacing the antiquated Men's Central Jail with modernized correctional treatment centers for men and women. With the Board's recent acceptance of the MacArthur Foundation Safety and Justice Challenge, the Sheriff and Board reaffirmed their joint commitment to find ways to safely reduce incarceration in jails.

The District Attorney's well-researched report entitled Providing Treatment, Promoting Rehabilitation and Reducing Recidivism: An Initiative to Develop a Comprehensive Plan for Los Angeles County includes findings derived from the efforts of the District Attorney's Criminal Justice Mental Health Advisory Board and various working groups.

Among other things, the District Attorney's comprehensive report describes how diversion needs to occur across "sequential intercept" points defined as:

Intercept One: Law Enforcement/Emergency Services, when the justice system first contacts an individual, before arrest.

Intercept Two: Post-Arrest/Arrest, as the prosecuting agency decides whether or not to file criminal charges.

Intercept Three: Courts/Post-Arrest/Alternatives to Incarceration, when the criminal charges are resolved either by a dismissal, a guilty plea or a trial.

Intercept Four: Community Reentry, when the individual is released back into the community.

Intercept Five: Community Support, when the person continues to have access to resources to facilitate successful reintegration into the community.

The report also identifies gaps, potential programs and successful existing programs that need further support.

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND SHEILA KUEHL
AUGUST 11, 2015
PAGE 3**

The time for action is now. The first step is to create a leadership structure to implement the various working group recommendations, supported by dedicated resources and the tremendous existing expertise of County departments. This leadership team should recommend policies and priorities, enhance integration across departments, and coordinate crisis intervention as well as discharge planning. This leadership team should also develop standardized tools that can be used across the County and judicial system for triage and prioritization.

DHS is well-poised to act as a home for these comprehensive diversion efforts. DHS has been tasked with delivery of all inmate health, mental health and substance abuse services. The DHS' Housing for Health Programs established the Flexible Housing Subsidy Pool in early 2014, as well as ongoing contracts for Intensive Case Management and Property Management. Housing for Health has already housed almost 1,000 medically fragile homeless persons. Through its Flexible Housing Subsidy Pool, DHS is expected to provide housing subsidies for at least 2,400 persons, who will be linked with wrap-around, intensive case management services. Housing for Health is housing former inmates who are on probation, with funding from the Probation Department to provide rapid re-housing interventions.

WE THEREFORE MOVE THAT THE BOARD OF SUPERVISORS:

1. Improve coordination and implementation of diversion efforts throughout Los Angeles County (County) by executing the following:
 - a. Establish a Director of the Office of Diversion position within the Department of Health Services (DHS) who would be responsible for oversight and coordination of all County-wide diversion of persons who have mental illness or substance abuse issues, and persons who are homeless or at risk of becoming homeless upon discharge. This position shall coordinate closely with the Jail Care Transitions Director.
 - b. Allocate 5 new positions to the Office of Diversion, which shall include expertise in housing, health, mental health/alcohol and drug prevention and legal/justice issues.

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND SHEILA KUEHL
AUGUST 11, 2015
PAGE 4**

- c. Direct County Counsel to work with the Interim Chief Executive Officer to draft a County ordinance within 60 days and take any other actions necessary to create the Office of Diversion.
 - d. Establish a Permanent Steering Committee that is convened by the Interim Chief Executive Officer, and is co-chaired on an interim basis by the District Attorney and Director of Health Services pending hire of the Director of the Office of Diversion. This Permanent Steering Committee shall consist of one leadership representative from each of the following departments: Chief Executive Office, Superior Court, Public Defender, Alternative Public Defender, District Attorney, Sheriff's Department, Probation, Fire Department, Department of Mental Health, Substance Abuse Prevention and the Control division of the Department of Public Health, and DHS. The purpose of this advisory committee to the Office of Diversion is to develop and drive forward recommendations so diversion seamlessly occurs across all intercepts.
 - i. The Permanent Steering Committee shall meet at least on a monthly basis;
 - ii. The Permanent Steering Committee shall work in collaboration with and be informed by the working groups established by the District Attorney.
2. Task the Office of Diversion and Permanent Steering Committee to identify or create a more standardized diversion assessment tool that all County departments (including the Superior Court) and key private provider partners will use to triage persons with mental illness and substance abuse issues, and persons who are homeless, to determine which services (including housing) are most appropriate.
 - a. Report back in writing on recommendations, including proposed roll-out, priority populations, projects and training, within 60 days of the Permanent Steering Committee's first meeting. Priority populations should include the elderly (ages 62 and older) and veterans.
 3. Direct County Counsel to draft a Memorandum of Understanding between all members of the Permanent Steering Committee, the Sheriff's Department (and any

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND SHEILA KUEHL
AUGUST 11, 2015
PAGE 5**

other interested local police departments), and the Los Angeles Homeless Services Authority on how they will work together to appropriately divert persons with mental health, substance abuse and/or physical health issues, and/or who are at risk of homelessness when encountered by law enforcement and emergency services.

4. Direct the Interim Chief Executive Officer (CEO) to create a diversion fund made up of the following funds and allocate it to the new Office of Diversion:
 - a. 50% of Senate Bill (SB) 678 funds that have accumulated in the Community Corrections Performance Incentives (CCPI) Special Revenue Fund and 50% of all future SB 678 funds that are received by the County beginning in FY 2015-16;
 - b. 50% of all new Public Safety Realignment/Assembly Bill 109 (AB 109) funds that are received in excess of the amounts budgeted in the FY 2015-16 Adopted Budget;
 - c. \$20M set aside in the FY 2014-15 Supplemental Budget pursuant to the Board of Supervisor's (Board) July 29, 2014 action;
 - d. \$10M set aside in the FY 2015-16 Recommended Budget pursuant to the Board's April 14, 2015 action;
 - e. All new funding allocated by the Board for the purposes of diversion as defined above;
 - f. All revenue earned, generated or drawn down as part of delivering diversion services so that those funds further diversion efforts and do not replace money allocated for other programs; and
 - g. The County Counsel and Interim CEO should report back to the Board in writing within 30 days with any concerns or issues identified regarding the proposed transfers.
5. Direct the Director of the Office of Diversion, within 90 days from adoption of this motion, in coordination with the Permanent Steering Committee, to report back to the Board with specific written recommendations related to the allocation of the

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND SHEILA KUEHL
AUGUST 11, 2015
PAGE 6**

diversion funds such that any funding restrictions applicable to any of the financing sources are adhered to so that at least 1,000 individuals are diverted across all intercepts and the diversion funds are dedicated as follows:

- a. 40% for housing;
 - i. Housing funds shall be allocated for rapid re-housing, permanent supportive housing, higher levels of care including board and care facilities and with provisions within each allocation for crisis housing pending placement.
 - ii. Housing shall include related integrated supportive services, such as case-management, mental health treatment, substance abuse treatment, job training and connections to community-based services.
 - iii. These housing activities shall be implemented in coordination with the Single Adult Model and Coordinated Entry System.
- b. 50% for the otherwise unmet costs of expansion of existing successful or implementation of promising diversion and anti-recidivism programs, especially those administered in community settings, such as:
 - i. Development of locked, secure, and unlocked mental health treatment beds, including, skilled nursing facilities, institutions for mental diseases and those able to handle dually diagnosed persons.
 - ii. Expansion of successful integrated health programs such as mental health urgent care centers, multidisciplinary integrated teams, forensic full service partnerships, wellness center slots, field capable clinical services in alternative settings;
 - iii. Development of jail mental health teams in Public Defender and Alternate Public Defender offices;
 - iv. Expansion of diversion and alternative sentencing projects, like those currently in the Van Nuys and San Fernando courts;
 - v. Expansion of the Just-in-Reach program, including the launch of a Pay-for-Success initiative; and

**MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND SHEILA KUEHL
AUGUST 11, 2015
PAGE 7**

- vi. New sobering center programs, with the first to be located in the Skid Row area, as well as residential detox and treatment programs.
 - c. 10% for overhead, staffing, consultants, evaluation, and training, including crisis intervention training for law enforcement.
 - d. \$20,188,910 of SB 90 reimbursement shall be set aside to expand community -based capacity for specialized substance use treatment services.
 - e. Include in the report back any recommended adjustments to any assigned percentage allocations identified above, especially given any concurrent or updated analysis on gaps and capacity needs.
6. Direct the Director of the Office of Diversion and the Interim CEO to report back in writing in 90 days on how to develop a pipeline of no less than 1,000 permanent supportive housing units over the next five years to support a jail diversion program, including evaluating whether the County has available property within or in close proximity to its medical campus sites that it can make available for development of permanent supportive housing.
7. Direct the Director of the Office of Diversion and the Interim CEO to work with the District Attorney and report back in writing in 90 days on a proposed plan to evaluate the efficacy of this diversion initiative.

###

(YV/DW)

MOTION BY MAYOR MICHAEL D. ANTONOVICH

AUGUST 11, 2015

Amendment to Item 49-C:

The recent independent study by Health Management Associates and Pulitzer/Bogard & Associates ("HMA report") recommended that the Board move forward with the replacement of the Men's Central Jail with a Consolidated Correctional Treatment Facility (CCTF) with a bed capacity between 4,600 and 5,060. The prior independent study by Vanir Construction Management recommended a bed capacity of approximately 4,885. The HMA report also projected an increase in the jail bed need for the medical/mental health population to 6,722 without implementation of best practices by 2025. Thus, the jail plan and diversion strategies must go hand-in-hand to protect public safety and properly treat and divert offenders who can be safely supervised and treated in the community.

The County's jail system now houses inmates with longer sentences and greater medical and mental health treatment needs since the implementation of AB 109. The wave of the future for corrections is not simply to house offenders but to provide robust services and programs, including increased educational and vocational opportunities. Most of the County's existing jail facilities were built more than 50 years ago and are not conducive for programming and treatment services. Thus, once the CCTF is operational, the total jail capacity can be adjusted based on the successes of diversion and aging and costly facilities can be downsized or closed, as appropriate.

- M O R E -

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

I, THEREFORE, MOVE that the Board of Supervisors direct the Interim Chief Executive Officer (CEO) to:

1. Immediately notify the contractors (AECOM and DLR) to resume work on the Consolidated Correctional Treatment Facility (CCTF) and Mira Loma which was halted by the Board on June 9;
2. Ensure that the CCTF and Mira Loma projects move forward simultaneously as a single project , including the timing of awarding the design-built construction contracts and a local worker hire requirement for the CCTF;
3. Reduce the previously approved capacity of the CCTF from 4,885 to 4,600 beds with the majority of the beds dedicated for mental health treatment and substance abuse detoxification needs;
4. Provide the state Public Works Board all documents required to establish Mira Loma as a project and maintain eligibility in the AB 900 grant program provided item 2 above is upheld; and
5. Provide status reports to the Board on a quarterly basis or as significant developments occur.

I, FURTHER, MOVE that the Board of Supervisors request the Interim CEO to work jointly with the Sheriff to provide a written report in 6 months that identifies facilities that are the oldest and most costly to operate and can be downsized or closed in the future to offset any increases in bed capacity at CCTF.

#

MDA:apo
consolidatedcorrectionaltreatmentfacility

AMENDMENT BY SUPERVISOR HILDA L. SOLIS

August 11, 2015

The name of the office should be the Office of Diversion *and Re-Entry* instead of the Office of Diversion.

The proposed Permanent Steering Committee should include:

- The Los Angeles City Attorney's Office
- Significantly more community representation, at least:
 - One representative from a mental health service provider
 - One representative from a mental health advocacy organization

The Office of Diversion and Re-Entry should be jointly responsible, with the Sheriff's Department, for developing the application for the second phase of the MacArthur grant.

###

HLS:bp

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

MOTION BY MAYOR MICHAEL D. ANTONOVICH

AUGUST 11, 2015

AMENDMENT TO ITEM #49-C:

I, **THEREFORE, MOVE** that the Board of Supervisors require that development and expansion of treatment services and housing capacity in the community include a robust community outreach and input from those residing in the surrounding neighborhoods and are directly affected.

#

MDA:tbo
diversionamendment49c081115

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

I, THEREFORE MOVE that the Board:

5. Instruct the Director of the Office of Diversion, ~~within 90 days from adoption of this motion~~ within 90 days from the hiring of the Director of the Office of Diversion, in coordination with the Permanent Steering Committee, to report back to the Board with specific written recommendations related to the allocation of the diversion funds such that any funding restrictions applicable to any of the financing sources are adhered to so that at least 1,000 individuals are diverted across all intercepts and the diversion funds are dedicated as follows:

6. Instruct the Director of the Office of Diversion and the Interim Chief Executive Officer to report back in writing ~~in 90 days~~ within 90 days from the hiring of the Director of the Office of Diversion on how to develop a pipeline of no less than 1,000 permanent supportive housing units over the next five years to support a jail diversion program, including evaluating whether the County has available property within or in close proximity to its medical campus sites that it can make available for development of permanent supportive housing; and

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

7. Instruct the Director of the Office of Diversion and the Interim Chief Executive Officer to work with the District Attorney and report back in writing in ~~90 days~~ report back in writing within 90 days of the hiring of the Director of the Office of Diversion on a proposed plan to evaluate the efficacy of this diversion initiative.

#

HLS/bp

AMENDMENT TO S1, ITEM C MOTION BY
SUPERVISORS KUEHL AND SOLIS

September 1, 2015

I, THEREFORE, MOVE that the Los Angeles County Sheriff's Department and the Los Angeles County Department of Public Health establish a gender-responsive advisory board, consisting of county staff, Board of Supervisor representatives, advocates, experts in managing female inmates, previously incarcerated persons and designated inmates, to review the program model at Mira Loma to ensure that the programming is evidence-based in reducing recidivism. This committee should further evaluate strategies to reduce the negative impact of locating the Mira Loma facility away from downtown Los Angeles, including the use of contract transportation for visitors, the use of videoconferencing for attorney consultation, encouraging family reunification and reduction in transportation time for court appearances. Additionally, this committee should examine national best practices for visiting and family reunification in that it is clear, as demonstrated by research, that inmates who remain connected to family and positive influences in their lives are more successful upon reentry. This advisory board is to report back to the Board of Supervisors in 180 days.

S: SG/Mira Loma

MOTION

SOLIS	_____
RIDLEY-THOMAS	_____
KUEHL	_____
KNABE	_____
ANTONOVICH	_____

AMENDMENT BY SUPERVISOR HILDA L. SOLIS
AND SUPERVISOR SHEILA KUEHL

September 1, 2015

WE, THEREFORE MOVE that the Board:

1. Request that the Sheriff draft and present to the Board for review a Scope of Work (and a cost estimate) for a long-term scenario-based strategic plan for the Los Angeles County Jail System within 180 days. This plan should consider the implications and strategic responses for a future in which the jail population significantly increases or decreases.

#

HLS/bp
SK/sg

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

MOTION BY MAYOR MICHAEL D. ANTONOVICH

SEPTEMBER 1, 2015

AMENDMENT TO SUPERVISOR KUEHL AND SOLIS' RECOMMENDATION FOR GENDER-RESPONSIVE ADVISORY BOARD FOR THE MIRA LOMA DETENTION FACILITY

I, THEREFORE, MOVE that the Board of Supervisors consider using existing county owned facilities that are in close proximity to downtown Los Angeles as options for expanding capacity for community-based treatment services for the mentally ill, substance abusers or for re-entry purposes in the future.

#

MDA:amg

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

AMENDMENT BY SUPERVISOR MARK RIDLEY-THOMAS

September 1, 2015

I, THEREFORE, MOVE THAT THE BOARD OF SUPERVISORS:

Include the Medical Services Bureau, consisting of the Department of Health Services, Department of Mental Health and the Department of Public Health, in collaboration with the Sheriff's Department, for the development of a long-term strategic plan related to the Los Angeles County Jail System and jail population management.

#

(DJJ)

MOTION

SOLIS	_____
RIDLEY-THOMAS	_____
KUEHL	_____
KNABE	_____
ANTONOVICH	_____



Health Services
LOS ANGELES COUNTY

**Los Angeles County
Board of Supervisors**

March 14, 2016

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

TO: Supervisor Hilda L. Solis, Chair
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **OFFICE OF DIVERSION AND RE-ENTRY
STATUS REPORT**

Mitchell H. Katz, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Medical Officer

Christina R. Ghaly, M.D.
Deputy Director, Strategy and Operations

On August 11, 2015, Supervisors Ridley-Thomas and Kuehl introduced a motion to improve the coordination and implementation of diversion efforts throughout Los Angeles County (LA County). The Board of Supervisors (Board) approved the motion on September 1, 2015, and directed the following:

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

www.dhs.lacounty.gov

- 1) Establish a Director of the Office of Diversion and Re-Entry (ODR) position within the Department of Health Services (DHS) who would be responsible for oversight and coordination of all Countywide diversion of persons who have serious mental illness or substance use disorder (SUD) issues, and who are homeless or at risk of becoming homeless upon discharge, with this position to coordinate closely with the Jail Care Transitions Director;
- 2) Allocate five new positions to the ODR, which shall include expertise in housing, health, mental health/alcohol and drug prevention and legal/justice issues;
- 3) Establish a Permanent Steering Committee (PSC) that is convened by the Chief Executive Officer and is co-chaired on an interim basis by the District Attorney and the Director of Health Services pending hire of the Director of the ODR. The PSC is to consist of one leadership representative from each of the following Departments: Chief Executive Office (CEO), Superior Court, Public Defender (PD), Alternate Public Defender (APD), District Attorney (DA), Sheriff (LASD), Probation, Fire, Mental Health (DMH), Substance Abuse Prevention and the Control (SAPC) and DHS, and also include a member of the Los Angeles City Attorney's Office and a member from the City Attorney's Association. The PSC should also have significant and meaningful

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

www.dhs.lacounty.gov



community representation with at least one representative from a mental health service provider and one representative from a mental health advocacy organization. The purpose of the PSC is to advise the ODR and to drive forward recommendations so diversion seamlessly occurs across all intercepts. The PSC shall meet at least on a monthly basis and work in collaboration with and be informed by the working groups established by the DA;

- 4) Create a diversion fund and allocate it to the new ODR, with the Interim County Counsel and the Chief Executive Officer to report back to the Board in writing within 30 days with any concerns or issues identified regarding the proposed transfers.

This memo is intended to provide an update regarding the work of the ODR, a new division within DHS. The memo also serves to share ODR's initial plan for utilizing a portion of the funding provided by the Board in order to build programs that effectively divert persons with serious mental illness and SUDs who encounter the criminal justice systems.

Organizational Structure

On October 6, 2015, your Board approved establishing a Director, ODR (UC) position within DHS. On November 9, 2015, the position was posted to the DHS Human Resources site. DHS has shared the job announcement broadly and we have received five applications and certified three applicants to an eligible list. The Board approved the amendment to the County Ordinance that officially created the ODR on November 17, 2015. In addition to the Director position, DHS in partnership with CEO Classification has established five positions subordinate to the Director position in order to facilitate the work for the ODR. We currently have an Interim Director and two other staff. DHS Human Resources staff is currently working on the job announcements and will begin recruitment. Attached is the current proposed organizational chart for ODR. It has been shared with each Board office and CEO staff.

Permanent Steering Committee (PSC)

Six PSC meetings have been held since September 2015. The interim ODR Director co-chairs each meeting with the DA's office. All meetings have been well attended and productive. In November 2015, DHS requested that each Board office nominate two community members to the PSC. In December 2015, community representatives began attending the PSC as members. We look forward to involving approximately 10 community representatives on the PSC and firmly believe that the success of Countywide diversion efforts requires broad based involvement from communities and community-based service providers/partners.

To date, the focus of the PSC meetings have included discussions about the membership of the PSC and how the PSC will act to advise the ODR on an ongoing basis, funding for ODR, including spending priorities, and discussions about the diversion and re-entry programs ODR is developing and those it will partner to support.

Funding

On September 29, 2015, as part of the FY 2015-16 Supplemental Budget, the County created a new budget unit in the General Fund for Diversion and Re-entry, consistent with input from County Counsel. The combined adjustments of multiple funding sources have provided the Diversion and Re-entry budget unit with appropriation authority of \$63.5 million of one-time funding and \$25 million of ongoing funding. Of the one-time funding, \$60.2 million is Net County Cost (NCC). Of ongoing funding, \$10 million is NCC.

The Board motion establishing ODR specifies that of the total ODR funding, 50% is dedicated to programming and support to entities who drive diversion (i.e., community service providers, courts, clinical departments, LASD, Probation); 40% to housing to support the creation of at least 1,000 units of permanent supportive housing as well as a focus on interim, bridge or other housing such as board and care or clinically enhanced housing; and 10% to training, staff and evaluation.

In addition to the ODR funding already captured above, ODR is currently anticipating funds from SB 678 and the County's Homelessness Initiative to be available for diversion services. See below for the specifics:

SB 678 and ODR

In November 2015, ODR and Probation staff began discussing how SB 678 funding and program planning will support Countywide diversion and re-entry efforts. In brief, SB 678 allocates funds to the Chief Probation Officer of each county to facilitate the provision of supervision, sanctions and services in an effort to improve outcomes for felony offenders on probation. Funds allocated for this purpose must be used to provide supervision and rehabilitative services consistent with evidence-based community corrections practices and programs. To this end, included in Probation's proposed SB 678 multi-year spending plan is a recommendation that approximately \$18.8 million in one-time funds be set aside on a fee-for-service basis to enable ODR to work with other County departments to support the services and housing needs of all felony probationers with an emphasis on moderate to high-risk felony probationers, the target population of SB 678 funding. The programs that could potentially be supported with SB 678 funds may include:

- Mental health services including Cognitive Behavioral Therapy (CTB);
- Substance use disorder (SUD) services;
- Housing services and access to housing subsidies;
- Job training and employment services;
- Transportation;
- Life skills training; and
- Program evaluation consistent with SB 678 requirements

Probation has identified CBT and SUD services as the components most appropriate for the ODR to facilitate. Housing services are intended to be supported through SB 678 funding provided to the County's high priority Homelessness Initiative(s). The SB 678 proposed spending plan is pending discussion with the Board and CEO in anticipation of formal approval in April, 2016.

ODR and County's Homelessness Initiative

On February 9, 2016, the Board heard and adopted the CEO's report entitled "Recommended Strategies to Combat Homelessness". Among the 47 adopted strategies, many have either a direct focus on the work of the ODR or will have an impact. More specifically, Recommendations D2 and D4, Expand Jail In-Reach and Regional Integrated Re-entry Networks – Homeless Focus put the ODR in a leading role for implementation. These initiatives will bring \$2.8 million from the County's Homelessness Initiative funding and \$5 million from Assembly Bill (AB) 109 funding to ODR to support the development of the integrated re-entry networks and expand jail in-reach, in partnership with LASD.

Diversion and Re-entry Efforts

Since the ODR was established in the fourth quarter of 2015, interim staff members have focused on identifying priority programs to implement. Over the first six months, ODR has provided support to many existing projects and programs and in other instances, began to implement new programs. The following is a highlight of many of the projects or programs ODR has focused on and lists the category of funding that each effort is attributed to: training, program or housing.

- 1) Investment in Crisis Intervention Training (CIT) for LASD patrol (Training): In California and throughout the country, recent high-profile encounters between law enforcement officers and mentally ill persons have highlighted the need for additional mental health training for patrol personnel to enhance competence when interacting with mentally ill or substance using persons. In May 2015, the President's Task Force on 21st Century Policing recommended law enforcement agencies make CIT a part of both basic recruit training and in-service training. The goals of CIT include reducing use of force in the field; improving the linkage of persons with mental illness and SUDs to services rather than booking and incarceration; and reducing recidivism. Already, LASD provides a training similar to CIT to all deputies in the custody division. ODR has made it a priority to work with LASD to support CIT training for patrol deputies.

The current CIT roll-out plan is to provide 32 hours of in-classroom mental health training to patrol deputies. The core elements of CIT include training on mental health signs and symptoms, appropriate medications and their side effects, use of verbal de-escalation techniques, active listening skills, and improved police tactics using safe restraint techniques that result in reduced use of force. Funding details for CIT are addressed below.

- 2) Expansion of Mental Health Evaluation Teams (MET) throughout the County (Program): Since 2010, calls to LASD that involve a mentally ill person have increased by 55%. Nearly 40% of all LASD use of force incidents involves a mentally ill person. The LASD currently partners with DMH in offering specially-trained field units, called a Mental Evaluation Team (MET), to deal with mentally ill community members in crisis (e.g., barricaded suspects, suicides in progress, other self-inflicted injuries). A MET consists of a Deputy Sheriff and a DMH Clinician who

respond in an unmarked Sheriff's vehicle. MET provides crisis intervention techniques to diffuse potentially volatile situations, prepares appropriate documentation to assist custodial agencies in the placement of the mentally ill, acts as a liaison to community and judicial agencies, and gives court testimony regarding the mental health or emotional stability of mentally ill persons. MET assist patrol personnel, ideally trained in CIT, by arranging placement or providing transport for an individual to an appropriate facility. MET reduce the potential for use of force incidents and provide mentally ill persons with an immediate clinical assessment and related mental health services (acute inpatient hospitalization to private and County hospitals or services through the Urgent Care Centers (UCC), linkage, intensive case management, training, etc.). Through MET, mentally ill persons are diverted from incarceration and/or hospitalization, when appropriate, and instead are provided alternative care in the least restrictive environment through a coordinated and comprehensive approach.

The expansion of MET within the LASD will augment an already growing number of similarly trained and staffed law enforcement teams around the County including the 32 System-wide Mental Assessment Response Teams (SMART) in Los Angeles Police Department and the 17 mental health response teams housed within many local city law enforcement agencies. Additionally, DMH has three clinicians assigned to the LASD Metropolitan Transit Authority (MTA)-Crisis Response Unit and two clinicians with the LASD Community College Bureau. Funding for MET expansion is detailed below.

- 3) Sobering Center (Program): ODR is working to develop plans for the County's first "Sobering" Center, to be located in the Skid Row area. The center's goals are to provide a safe environment, health monitoring and connection to services for individuals experiencing acute intoxication from alcohol or other substances who might otherwise be cited or arrested by law enforcement or admitted to an emergency room or psychiatric emergency room. A site has been identified and a workgroup consisting of the DHS, DMH, SAPC, LASD, LAPD and LAFD has been defining the scope of services, to include an integrated care model. The center is expected to have a capacity of 40-50 beds and an average length of stay of 8-24 hours, with some individuals staying up to 48 hours as staff work to connect them to SUD treatment, bridge housing and other services. The center is anticipated to open during the late summer or early fall of 2016. Funding for this first sobering center is detailed below.
- 4) Implementation of the Mentally Ill Offender Crime Reduction (MIOCR) grant program (Program): MIOCR is a collaboration between DHS, DMH, SAPC, LASD, DA, PD, and Probation to provide jail in-reach, enhanced discharge planning and linkage to community services for 30 jail inmates per year with mental illness and co-occurring physical health or SUDs. A total of \$1.8 million in funding is available over three years and will be managed and administered through ODR. A critical program element will be the 30 Full Service Partnership program slots DMH will provide as an in-kind match. Items are currently being allocated for the four-person interdisciplinary project team, and staff recruitment has begun.

- 5) Proposition 47 implementation (Program and Housing): ODR has been involved in the work focused on Proposition 47 implementation in LA County. Specifically ODR is leading the work to set Countywide priorities for funding that might be available from the State to implement Proposition 47 locally. ODR is also participating with the CEO and Community and Senior Services to develop a GIS map of Prop 47 clients and existing public and private service providers. Finally, ODR in partnership with SAPC has worked with the City Attorney's Office on creating a pilot program for approximately 15 enrollees wherein a shortened course of substance use treatment, on the order of 16 weeks, could be provided to potential eligible participants. The pilot will essentially test the efficacy of a 12 to 16-week as opposed to a much longer treatment program. The treatment program will be augmented by providing access to housing and job training, as needed by participants.

- 6) Assessment and referral support for four new Community Collaborative Courts (CCCs) (Program): ODR has begun to work with the Los Angeles Superior Courts to help support the new CCC model. The intention is to provide the Courts with staff support to help guide assessments and planning for specific clients. Also, the ODR will support these Courts with slots or beds in specific programs so that clients can be seamlessly and immediately referred into programs that have been deemed clinically appropriate and acceptable to all parties involved in determining the client's diversion plan. DMH as well as SAPC will also directly participate in supporting these Courts. There is a great opportunity to learn from this focused work with the four CCCs. This learning can be spread to other courts across the County focused on diversion options.

- 7) Misdemeanor Incompetent to Stand Trial (MIST) Community-Based Restoration (MIST CBR) project (Program): Since the inception of the ODR in August, ODR has launched a successful project called the Misdemeanor Incompetent to Stand Trial Community-Based Restoration Program (MIST CBR). Previous to our efforts, on any given day, approximately 200 inmates charged with misdemeanors, frequently crimes of poverty such as trespassing, are housed in our jail and have been declared incompetent to stand trial due to a serious mental disorder. This group of inmates primarily consists of chronically homeless, mentally ill persons often in high observation housing (HOH), a designated area of the jail, who are generally the most impaired inmates within our jail system. Led by ODR, which closely coordinates the effort by several County departments, including the Mental Health Court (Department 95), the DMH Countywide Resource Management team, the Jail Mental Health providers, the Public and Alternate Public Defenders, the DA, the LASD custody leadership team and community outpatient and inpatient providers, we have referred over 100 MISTs as of this writing, and 80 have been conditionally released to the appropriate level of care and followed intensively. This has reduced the overall MIST population in the jail from 200 on any given day to about 150. This effort has required partnerships that have never before existed in the County and procedures/actions that have never before taken place. Many new inter-departmental policies and relationships have been created to support this program. Our goal is to no longer house the majority of this population in the jail, but instead in the community. The MIST CBR effort has also set the foundation for the focused work on other populations currently incarcerated or stuck in the criminal justice

system whose mental health or substance use disorders are under-addressed and undertreated by virtue of the lack of assessment, treatment options and/or systematic focus on connecting them to care. We will build on the MIST CBR effort so to transition more low-level offenders who are currently incarcerated and move them into community-based treatment and services.

- 8) Normandie Village East (Program): A pilot project between DMH and LASD, Normandie Village East provides an Enriched Residential Services (IMD Step Down) program to AB109 inmates with intensive mental health needs, who have 60-90 days left to serve on their sentence. Participants are monitored via an electronic monitoring anklet and housed in a licensed Adult Residential Facility that serves up to 42 individuals at any given time. Gateways Hospital and Mental Health Center provides residential and mental health services to the participants who will receive specialized, intensive residential program services addressing their substance abuse and mental health care needs. DMH and LASD have partnered with ODR to ensure that we maximize the availability of this resource by referring a sufficient number of inmates who meet program criteria. In future years, when initial program funding is spent, ODR will consider further supporting this program.
- 9) Creation of policies and agreements with the Courts, Public Defenders, Alternate Public Defenders and District Attorney's offices (Program): ODR is exploring how pre-sentenced inmates in County jail with serious mental illness or SUDs can be moved quickly into treatment beds which will be enhanced by sufficient community-based navigation and stabilization supports so to avoid re-incarceration and clinical de-compensation. A first project is exploring the use of a 30-bed acute inpatient psychiatric unit at a local private community hospital to be used for current inmates who require treatment under an involuntary hold and who could, after a period of stabilization, safely return to their communities with wrap around support. If this first project is successful, there is potential to expand with similar programs in other parts of the County.
- 10) Expansion of residential drug treatment programs such as provided at Prototypes (Program): On October 6, 2015, your Board instructed County departments that provided AB 109 treatment and support services to expand the pool of eligible populations that can be served utilizing AB 109 funding. In response, ODR and SAPC initiated discussion with Prototypes, a community-based SUD treatment program specializing in serving women, to expand residential treatment accessibility in its Second Chance Women's Reentry Court (WRC) program. The WRC provides women facing a return to State prison or lengthy jail terms with the opportunity to enter residential SUD treatment followed by outpatient treatment, re-entry planning, and aftercare services. SAPC applied its delegated authority to augment Prototypes' AB 109 contract for FY 2015-16 to add 12 additional beds for diversion and re-entry populations. DPH then worked with the PD's Office to identify and place incarcerated women eligible for the WRC who also met the expanded population criteria. Since January 2016, 11 incarcerated women that were previously waitlisted were admitted to the Prototypes WRC. Using programs with capacity, like Prototypes, is an important strategy for ODR. Although additional program capacity

is surely needed, the first step in successful diversion activities is to fully utilize existing capacity.

- 11) Expansion of Institutions for Mental Disease (IMDs) and enhanced residential settings (Program): The ODR has been considering, in partnership with DMH, the role of expanding mental health beds to achieve the mission of diverting eligible clients into community-based programs. There is no doubt that an expansion of community mental health beds is needed to accommodate clients pre-booking and post-booking. Currently ODR is working with DMH to assess current capacity in both unlocked and locked settings to accommodate ODR target clients. Once this assessment is complete, we will propose how some proportion of ODR service funding can be used to maximally expand the number of beds available for diversion and re-entry purposes. One key strategy will be to work with DMH in creating and/or identifying beds that are able to draw down federal funding through Medicaid – this is generally unlocked but service-enriched housing.
- 12) Pay for Success (Program and Housing): The ODR and DHS' Housing for Health program, in collaboration with the CEO and LASD, currently lead LA County's Pay for Success (PFS) initiative. The initiative will focus on the end-to-end provision of holistic, supportive jail in-reach and post-release permanent supportive housing services to 300 homeless LA County inmates who have frequent contact with the criminal justice system as well as complex physical and/or behavioral health conditions that contribute to negative housing and criminal justice/recidivism outcomes.

Homelessness and incarceration are mutual risk factors, and evidence suggests that recently released inmates who are homeless are at greater risk for recidivism than those who are stably housed following release from custody. Combined with limited/low income and criminal history, offenders reentering society who suffer from complex physical and/or behavioral health conditions face significant barriers in securing stable housing and continuing needed treatment, resulting in higher rates of recidivism, homelessness, and poor health outcomes.

The intervention consists of two linked components: pre-release jail in-reach supportive services and immediate interim housing in anticipation of permanent supportive housing upon release from jail. The jail in-reach services will be carried out by DHS contracted intensive case management services providers. These providers will connect clients to interim housing immediately upon release from jail and then to permanent supportive housing. Once the client is housed, the original jail in-reach service provider will continue to provide intensive case management services to help the client maintain their housing and to support their health and well-being through connection to physical health, mental health, and substance use treatment services. Permanent supportive housing, a key component of the program, will be provided through the DHS's Flexible Housing Subsidy Pool (FHSP). The FHSP program is operated by Brilliant Corners, also a DHS contracted provider, and provides housing location services, ongoing rental subsidy payments, and housing retention services.

The LA County PFS initiative builds on the existing Just In Reach (JIR Pilot and JIR 2.0) program, a collaboration between the Corporation for Supportive Housing (CSH) and the LASD. JIR was first launched in 2008 and provides jail in-reach services and connection to leveraged supportive housing resources. CSH will serve as the PFS intermediary with technical assistance from Third Sector Capital Partners.

The County team and partners are developing a work plan for the project construction phase through expected program launch by July 2017, or earlier, if the deal structuring and fundraising efforts are completed ahead of schedule. The estimated cost of the intervention is \$21.2 million to serve 300 individuals over the five year PFS funding term. DHS and its partners submitted a grant application for \$2 million in funding to the Board of State and Community Corrections, a grant application for \$1.3 million in funding to the federal Housing and Urban Development and Justice Departments, and have also engaged various philanthropic partners in support of the PFS initiative. The PFS initiative is being arranged through the strong guidance of the Board offices as this type program arrangement is new not only in the County but across the Country.

- 13) Connecting Criminal Justice and Health Care Initiative (Training and Program): Los Angeles County was selected as one of two jurisdictions from across the nation to participate in a promising learning collaborative led by the Urban Institute and Manatt Health Solutions entitled *Connecting Criminal Justice and Health Care*. DHS submitted an application in December that included many partners such as the LASD, LA Care Health Plan, California's Department of Health Care Services and California Department of Corrections and Rehabilitation.

The learning collaborative has three areas of focus: (a) advancing efforts to enroll eligible inmates in Medicaid; (b) improving re-entry services for those with health issues that need services upon release; and (c) exploring opportunities to increase the impact of Medicaid in supporting health services to those in custody. The Urban Institute-led review committee chose the Los Angeles application over dozens of others in large part due to the transformative work the Board has already moved forward over the past 12 months. Specifically, the review panel cited the creation of the Integrated Jail Health Services initiative as well as the important work of the Office of Diversion and Re-entry as particularly promising opportunities to allow Los Angeles to become a leading example in the nation for how to serve justice involved populations.

We look forward to the many hours of free, high-quality, consulting services and the exposure to best practices from other jurisdictions which we will receive through the learning collaborative. These supports should help us advance our work in Los Angeles more swiftly.

- 14) Integrated Re-entry Network: A planning effort involving DHS, LA Care, HealthNet, DMH, SAPC, LASD, Probation,, and selected community partners is currently underway to explore the development of a "re-entry network" of health care providers to serve individuals returning to the community from jail. The group has been working to identify gaps in services for the re-entry population and has

recommended an initial focus on the following populations: those who are medically fragile or have chronic health conditions, pregnant women, those on psychotropic medications, and those with a SUD, including those who may benefit from Medication Assisted Therapy (MAT). The initial vision for a network includes identifying one or two sites for immediate follow up care upon release, implementing seamless sharing of patient records between jail and re-entry providers, incorporating community health workers to help newly released individuals link to care, and providing either integrated services or robust links to mental health, SUD, housing, case management and other social services in the community.

ODR Housing (40% of ODR budget)

The Board motion which established the ODR was specific in regards to the types of housing and the housing-related services ODR funding should support. Housing funds shall be allocated for rapid re-housing, permanent supportive housing, higher levels of care including board and care facilities and with provisions within each allocation for crisis housing pending placement. Housing shall include related integrated supportive services, such as case management, linkage to mental health and substance abuse treatment, job training and connections to community-based services. The motion also specifically called for ODR to establish no less than 1,000 units of permanent supportive housing over five years for diversion purposes.

In order to achieve these goals, ODR will partner with DHS' Housing for Health division. A key ODR position is the ODR Housing Director who reports directly to the ODR, Deputy Director. The ODR will also fund 2.0 FTE Staff Analysts to support the development of the ODR housing program and portfolio.

Based on initial ODR funding, funds available for housing include \$25.4 million in one-time funds and \$10 million in ongoing funding. Over the five year timeframe included in the motion, there is a total of \$75.36 million available to support housing activities during this five-year period. For purposes of budgeting, it is assumed that a residential slot (for both interim and permanent housing) has an average annual cost of \$18,000 per year inclusive of support service costs (Intensive Case Management Services) and operating or rental subsidies. ODR will seek to offset County funding with federal funding in the form of federal housing vouchers or Medicaid funding, when possible.

Interim and Permanent Housing Cost Projection

The chart below includes the cost of providing 200 slots of housing each year (including support services and move-in costs) for five years for a total of 1,000 slots. It assumes a steady ramp up of approximately 17 units per month over the five-year period.

Year	Total number of housing slots	Cost
1	200	\$2,383,000
2	400	\$5,983,000
3	600	\$9,583,000
4	800	\$13,183,000
5	1000	\$16,783,000
Total	1000 units over 5 year period	\$47,915,000

Staffing Needs for Housing for Health

The following additional staff are needed for the DHS Housing for Health division to develop and implement the additional interim and permanent supportive housing slots:

Position	Role	Description
Staff Analyst #1	Project Manager	New project development, implementation, and contract monitoring.
Staff Analyst #2	Access and Referral Specialist	Managing interim housing beds and permanent housing for diversion and re-entry individuals.

The cost of these new staff is calculated at \$238,256 per year including salaries and benefits or \$1,191,280 for 5 years.

First year costs for 200 interim and permanent supportive housing slots and staffing will total \$2,621,256. To achieve 1,000 units of PSH over 5 years, the total interim and permanent supportive housing and staffing cost is approximately \$49.25 million of the \$75.36 million available for these and other housing needs. ODR leadership will be developing a long range housing spending plan that continues to grow toward 1,000 units of PSH and also creates other housing for diversion purposes such as sober living environments and clinically-enriched housing.

Infrastructure Development

- 1) Program Database/Inventory: The CEO will lead the efforts to maintain an inventory of existing diversion programs organized by five distinct intercept points: Law Enforcement/Emergency Services, Post Arrest/Arrestment, Courts/Post-Arrestment/Alternatives to Incarceration, Community Re-entry, and Community Support. This inventory will serve as a tool to assess available resources, identify gaps in services, and determine points of interception at which an intervention can be made to prevent individuals with mental illness or SUDs from entering or penetrating deeper into the criminal justice system. ODR will support the CEO in this formative stage and soon take over the maintenance and oversight of the inventory. It will be used to help identify gaps and opportunities for development of ongoing diversion programming and strategies.

- 2) Diversion Assessment Tool: The ODR has led an effort involving LASD, Probation, SAPC, DMH and DHS to create a Countywide assessment tool to be used in-custody, in the field, in a program or in a courtroom, so to establish a consistent way to identify diversion opportunities for potentially eligible clients and connect these clients with appropriate services in an immediate and simple manner.
- 3) Diversion Dashboard: The ODR has created a very simple dashboard to update the number of persons diverted from jail or prison as a result of ODR's efforts and partnerships. This dashboard will be shared each month at the ODR PSC.
- 4) Diversion Database: ODR staff have created an encrypted, secure, web-based system for tracking diversion participants and referring them into programs quickly and efficiently. This database has been vetted by DHS, the LA Superior Court and County Counsel. Due to its success as an essential tool for patient releases in the MIST CBR program, ODR is expanding its use to other programs in which persons are released from the jail into treatment and housing programs. Using this same database in the courts and other venues where diversion is possible is also being considered.
- 5) Evaluation: The evaluation framework for ODR efforts is still in development. Initial metrics we will track will all be person-level and will include number of persons diverted from jail; number enrolled into a treatment or housing program, number who leave their treatment or housing programs (for those who have specific placements) and; number who are re-arrested or recidivate.

Funding Priorities for the Remainder of FY 2015-16 and for FY 2016-17

ODR has received a number of budget requests from various partners to fund diversion related programs. As these requests come to our attention, they are being considered as a part of the larger ODR strategic planning process. Three efforts are being put into the FY 2016-17 recommended budget. Additional efforts are being finalized and will be included in the FY 2016-17 Final Changes budget or the FY 2016-17 Supplemental Budget.

Recommended Budget

- 1) Crisis Intervention Training: LASD has proposed that ODR support a plan to provide a 32-hour training to approximately 2,161 patrol personnel over the next six years. These 2,161 patrol personnel will be joined each year by hundreds of Sheriff Deputies who transition from the custody areas into patrol and who, in their custody roles, have received a similar training to CIT to ensure they were equipped to manage mental illness of individuals in custody. Depending on the rate of custody to patrol transition, at the end of six years between 4,000 and 5,000 patrol deputies will have received mental health training and requisite maintenance training, consisting of an eight hour training every three years, so the skills stay fresh and up to date. The total investment for the six-year training plan will be offset by approximately \$6.4 million of ODR funding disbursed at \$1.4 million in the first year and \$1 million in each of the last five years. The ODR funding will augment the revenue that LASD

will receive because a portion of the training has been built into the contract city cost model as well as the departmental support through existing resources the Sheriff has committed to ensuring a sufficient number of patrol deputies receive the CIT training.

- 2) Housing: ODR will transfer \$2,621,256 to Housing for Health for two Staff Analysts and year one funding for supportive housing for 200 diversion eligible participants.
- 3) Sobering Center: The current planned sobering center, described above, sited adjacent to the Skid Row area downtown will have capacity of 40-50 clients at a time. Estimated length of stay is less than 24 hours. The current estimated project cost with one-time start up and first-year operating expenses is approximately \$4.8 million, with \$1.7 million in one-time costs and \$3.1 million in ongoing costs. We anticipate opening in the late summer or early fall of this year.

Final Changes Budget

- 1) MET expansion: In order to provide sufficient coverage and service to LASD's vast geographical area and population, a phased MET expansion is being proposed. Phase I of the MET expansion will be to go from five funded teams to ten. ODR will provide \$1.81 million to LASD and \$464,100 to DMH to fund the Phase I expansion. During the expansion in FY 2016-17, LASD, DMH and ODR will work together to evaluate the impact of the first phase of expansion and determine whether changes are needed for the planned expansion in future years.
- 2) Expansion of Mental Health beds: We anticipate earmarking roughly \$3-5 million in ODR funding to support the expansion of IMD and acute beds needed to prevent the incarceration or ongoing incarceration of persons with serious mental illness. Many of these individuals are currently in jail. The precise funding allocation will be based on the ability to identify vacant beds that can be used for this purpose. Included in this planning process is an assessment of expanding acute psychiatric bed capacity within our DHS operated County hospitals. Also, DMH is exploring the development of ODR Psychiatric Health Facilities (PHFs) which can provide care comparable to an acute psychiatric facility as well as purchasing additional forensic IMD beds.
- 3) Expansion of assessment staff and other staff: Staff are needed to help in many areas of diversion. For example, custody staff are needed to help support jail in-reach and court-related efforts. These staff will likely be embedded in court linkage, jail linkage or in the creation of a SUD linkage program. At this time, there is not a specific, fully vetted budget request for such positions. In all likelihood, we will make this budget submission for the FY 2016-17 Supplemental Budget.

Other Updates

McArthur Award Update

On January 25, 2016, the Los Angeles County MacArthur Safety and Justice Challenge (SJC) working group, led by LA County Assistant Sheriff Terri McDonald, completed its final

task in the grant selection process: the structured interview. During this interview the SJC team took the opportunity to reiterate the innovative steps taken by the County to reduce the jail population, provide community-based treatment and re-entry services, and enhance public safety; as well as to elaborate on the proposed initiatives which would be facilitated through a grant award:

- A significant expansion of the Bail Deviation process is to facilitate the release of potentially thousands of arrestees prior to arraignment each year through own recognizance (OR) release or reduced bail. This will be accomplished by automatically screening arrestees (scaling up from 17% currently screened to 100%) using a validated static risk assessment tool.
- The creation of a new Resource Release Program (RRP) to further increase the use of pretrial release for those defendants who do not qualify for release at the bail deviation stage or at arraignment. In close collaboration with the Defense Bar, RRP would facilitate these releases through the innovative and centralized coordination of community-based resources. This will enable Defense attorneys to more efficiently and effectively pursue a Detention Review Hearing to advocate for their clients' release
- Post-sentencing, the use of grant funds to increase the number of inmates in community-based Alternative to Custody (ATC) treatment programs, including an innovative program for mothers of young children.

The MacArthur Foundation has indicated they will announce the award recipients in mid-March 2016.

The Stepping Up Initiative and The Council of State Governments

ODR has assembled a team to join the National Association of Counties (NACo), the Council of State Governments (CSG) Justice Center, and the American Psychiatric Association Foundation (APA Foundation) in leading a national initiative to help advance counties' efforts to reduce the number of adults with serious mental illness and co-occurring SUDs in jails. With support from the U.S. Justice Department's Bureau of Justice Assistance, the initiative builds on the many innovative and proven practices being implemented across the country.

On February 9, 2016, the Board passed a Resolution to participate in the National Stepping Up Initiative. According to the resolution, the County, "is now well-poised to assume a leadership role nationally. The stated goals of the Stepping Up Initiative are to convene expert leaders and decision makers; commence a dialogue regarding data, treatment and service capacity; and create an action plan with measurable outcomes to safely reduce the number of people with mental illnesses in the jails. The Stepping Up Initiative complements this Board's existing practices and goals regarding mental health diversion."

The ODR team will be joining the National Summit to advance county-led plans to reduce the number of people with mental illnesses in jails in the spring of 2016 in Washington, DC, that includes counties that have signed on to the Call to Action, as well as state officials and community stakeholders such as criminal justice professionals, treatment providers, people with mental illnesses and their advocates, and other subject-matter experts.

From February 29 to March 2, 2016, staff from the CSG spent time with ODR in order to better understand our current processes and policies and provide some advice on key areas to address as we pursue an aggressive and innovative diversion and re-entry agenda. In addition, CSG visited a DMH urgent care center and the BJA CARE program during their time in Los Angeles. This is further testimony of the leading role Los Angeles plays in the national conversation. We anticipate a report from the CSG team soon.

Next Steps

County departments and stakeholders will continue to collaborate under the leadership of the ODR on the above-listed initiatives as well as a variety of different opportunities which emerge as the diversion work spreads across the County.

As an immediate next step, the ODR will work to create a budget submission to the CEO to provide funding for aspects of the programs and initiatives outlined above. We are also helping review and prioritize the budget requests of other departments where the activities funded through those requests impact the County's overall diversion and re-entry efforts.

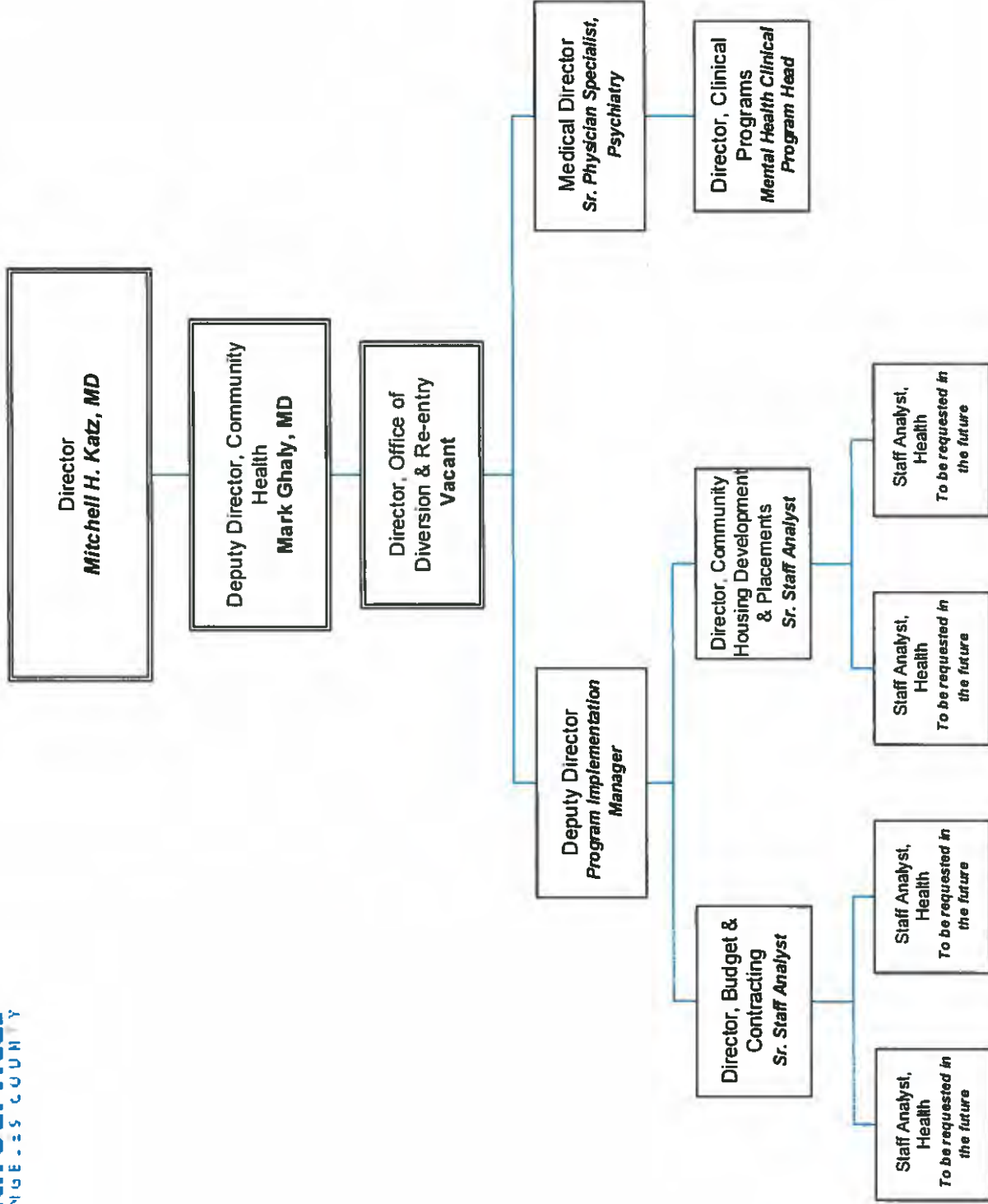
If you have any questions or require additional information, please contact Mark Ghaly, M.D., Deputy Director of Community Health and Integrated Programs and Interim Director, Office of Diversion and Re-entry, at (213) 240-8107 or mghaly@dhs.lacounty.gov.

MHK:MG:jp

Attachment

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
ODR Permanent Steering Committee

OFFICE OF DIVERSION AND RE-ENTRY



Mark Ghaly, MD
Deputy Director, Community Health

Date



JACKIE LACEY
LOS ANGELES COUNTY DISTRICT ATTORNEY

HALL OF JUSTICE
211 WEST TEMPLE STREET, SUITE 1200 LOS ANGELES, CA 90012-3205 (213) 974-3500

August 4, 2015

TO: Mayor Michael D. Antonovich
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe

FROM: Jackie Lacey 
District Attorney

SUBJECT: **PROVIDING TREATMENT, PROMOTING REHABILITATION AND
REDUCING RECIDIVISM: AN INITIATIVE TO DEVELOP A
COMPREHENSIVE PLAN FOR LOS ANGELES COUNTY
(Board Agenda of May 6, 2014)**

This report responds to your May 6, 2014 Board motion requesting the District Attorney work in conjunction with the Sheriff, Fire Chief, Directors of the Department of Mental Health, Health Services, Public Health, Veterans Affairs, and Public Social Services, Public Defender, Chief Probation Officer, Chief Executive Office, Alternate Public Defender, and Executive Director of the Countywide Criminal Justice Coordination Committee to conduct a comprehensive assessment of the existing mental health diversion programs used by the County of Los Angeles and currently available permanent supportive housing.

The attached report, developed by the above listed public officers, collectively known as the Criminal Justice Mental Health Advisory Board (Advisory Board) analyzes the need for mental health and substance abuse diversion services along the criminal justice continuum. The recommendation developed by the Advisory Board provides for a comprehensive mental health diversion program for each stage of the criminal justice continuum.

The initial step to preventing unnecessary incarceration and improving the outcome for the mentally ill who come into contact with the criminal justice system is to improve the contact with first responders. This can be accomplished by a county-wide commitment to Critical Incident Training and the pairing of law enforcement and mental health professionals that will increase the provision of appropriate services and decrease the likelihood of violent confrontation. It is not enough for first responders to know that alternatives to incarceration are needed, the appropriate facilities must be available. A comprehensive list of the existing housing and the need for additional bed space is discussed. While there are existing diversion programs throughout the court system, successful diversion plans require stable housing, comprehensive medical, mental health and addiction recovery services, as well as job training and placement.

Each Supervisor
August 4, 2015
Page 2

This report identifies gaps in these service areas and sets forth a plan of action to move Los Angeles County forward.

The goal of mental health diversion is to treat mentally ill criminal defendants safely and appropriately, providing the supportive social and medical services these individuals need in order to build healthy and productive lives, free of criminal activity and substance abuse, while ensuring public safety. Together, Los Angeles County can muster the will and the resources needed to accomplish this goal.

I look forward to providing the Board a report on our progress in the implementation of the mental health diversion programs.

If you have any questions or would like additional information, please let me know.

jm

Attachment

c: Executive Office, Board of Supervisors
Chief Executive Office, Sachi A. Hamai
Criminal Justice Mental Health Advisory Board
Alternate Public Defender, Janice Y. Fukai
Countywide Criminal Justice Coordination Committee, Mark Delgado
Department of Mental Health, Marvin J. Southard, D.S.W.
Los Angeles City Attorney's Office, Mike Feuer
Los Angeles County Mental Health Commission, Terry Lewis-Nwachie, M.S.
Los Angeles Fire Department, Daryl L. Osby
Los Angeles Police Department, Charlie Beck
Los Angeles Public Health Department, Cynthia A. Harding, M.P.H.
National Alliance on Mental Illness, Mark Gale
Probation Department, Jerry E. Powers
Public Defender's Office, Ronald L. Brown
Sheriff's Department, Jim McDonnell
Superior Court, Sherri R. Carter
United States Attorney's Office, Eileen M. Decker

MENTAL HEALTH ADVISORY BOARD REPORT A BLUEPRINT FOR CHANGE



JACKIE LACEY
District Attorney

August 4, 2015

TABLE OF CONTENTS

STATEMENT OF PURPOSE	1
EXECUTIVE SUMMARY	3
LOCAL STAKEHOLDER DISCUSSIONS AND THE SEQUENTIAL INTERCEPT MODEL	9
Intercept One: Law Enforcement/Emergency Services	9
Intercept Two: Post-Arrest/Arraignment	10
Intercept Three: Courts/Post-Arraignment/Alternatives to Incarceration.....	10
Intercept Four: Community Reentry.....	10
Intercept Five: Community Support	11
CRIMINAL JUSTICE MENTAL HEALTH ADVISORY BOARD AND WORKING GROUPS	12
Law Enforcement Working Group (Intercept One).....	13
Community Based Restoration Working Group (Intercept Three).....	13
Criminal Justice Working Group (Intercepts Two and Three)	13
Treatment Options and Supportive Services Working Group (Intercepts One through Five)	14
Pre-Booking Diversion Working Group (Intercept One)	14
Data and Systems Connectivity Working Group (Intercept One through Four)	15
Long Beach Mental Health Diversion Working Group (Intercepts One through Five)	16
CRISIS INTERVENTION TEAM (“CIT”) TRAINING.....	17
CO-DEPLOYED LAW ENFORCEMENT TEAMS.....	20
MENTAL HEALTH URGENT CARE CENTERS: THE FIRST 24 HOURS AFTER A MENTAL HEALTH CRISIS.....	22
OTHER TREATMENT OPTIONS: AFTER THE FIRST 24 HOURS	24
Law Enforcement Hospital Beds	24
Institutions for Mental Diseases (“IMD” beds)	24
Crisis Residential Treatment Programs	24
Full Service Partnerships (“FSP”)	25
Field Capable Clinical Services (“FCCS”).....	25
Wellness Centers.....	25
Assisted Outpatient Treatment Program (“AOT”)	25

PERMANENT SUPPORTIVE HOUSING AND OTHER HOUSING OPTIONS	26
Permanent Supportive Housing	26
Bridge Housing	28
Shelter Plus Care	28
Department of Mental Health Shelter Plus Care	28
HUD-VASH Vouchers	28
Rapid Re-Housing	28
Mental Health Services Act (“MHSA”) Housing Program	28
Coordinated Entry System	29
Department of Health Services – Flexible Housing Subsidy Pool	29
Breaking Barriers Program	29
Just In Reach Program	30
CO-OCCURRING SUBSTANCE ABUSE DISORDERS	33
Alcohol and Drug Free Living Center Services	32
Co-Occurring Integrated Care Network (“COIN”)	32
Probation Department Co-Occurring Caseloads	32
Co-Occurring Disorders Court (“CODC”)	33
Women’s Community Reintegration Services and Education Center (“Women’s Center”)	33
Men’s Integrated Reentry Services and Education Center (“Men’s Center”)	33
Sobering Centers	33
Residential Medical Detoxification Services	33
Residential Treatment Services	34
IMD Beds Designated for Co-Occurring Disorders	34
IMPACT OF PROPOSITION 47	35
CURRENT JAIL PROGRAMS AND RESOURCES	36
LASD Population Management Bureau	36
Affordable Care Act Program	36
Jail Mental Evaluation Teams (“JMETs”)	36
AB 109 Mental Health Alternative Custody Pilot Program	37
LASD Inmate Services Bureau, Education Based Incarceration Unit (“EBI”)	37
Restoration of Competency “ROC” Programs	37
Jail Linkage Program	37
Mental Health Forensic Outreach Teams (“FOT”)	37
Public Defender and Alternate Public Defender Jail Mental Health Team	37
CURRENT COURT PROGRAMS AND RESOURCES	39
Department of Mental Health Court Linkage/Court Liaison Program	39
Mental Health Court/Department 95	39
Veteran’s Court	40
Santa Monica Homeless Court Program	40
Homeless Court Clinic	40

EXPANSION OF MENTAL HEALTH DIVERSION RELATED STAFFING AND SERVICES.....	41
Criminal Justice Mental Health Diversion Permanent Planning Committee.....	41
Sheriff’s Department Mental Evaluation Bureau	41
Countywide Adult Justice Planning and Development Program.....	41
Forensic Additions to Existing Mental Health Programs	41
Reentry Referral and Linkage Network of Care	41
RECOMMENDATIONS.....	43
CIT Training	43
Mental Health Treatment Resource Expansion, Priority	43
Permanent Mental Health Diversion Planning Committee.....	43
Public Health/Health Services Treatment Resource Expansion	43
Housing Services Enhancements	43
Co-Deployed Teams	44
Data Improvements	44
Public Defender and Alternate Public Defender Jail Mental Health Teams	44
Mental Health Treatment Resource Expansion, Lower Priority.....	44
LASD Mental Health Bureau.....	44
CONCLUSION	45
ATTACHMENT 1	46

CRIMINAL JUSTICE MENTAL HEALTH ADVISORY BOARD REPORT

STATEMENT OF PURPOSE

In Los Angeles County, mentally ill offenders may be incarcerated in the county jail for significant periods of time. Many of these offenders also suffer from co-occurring substance abuse disorders and chronic homelessness. For lower-level crimes, when mental health treatment can appropriately take place somewhere other than the jail while preserving the safety of the public, continued incarceration may not serve the interests of justice. The jail environment is not conducive to the treatment of mental illness.

As stated in this Board's Motion, dated May 6, 2014, *“Diversion can address the untreated mental illness and substance abuse that is often the root cause of crime. By providing appropriate mental health services, substance abuse treatment, and job readiness training, as well as permanent supportive housing when it is needed, the mentally ill are stabilized and less likely to commit future crimes.”* Such positive interventions can not only change the lives of mentally ill offenders but also others, including family members, victims whose future harms can be prevented and the community as a whole.

In addition to the ethical implications of incarcerating mentally ill offenders, there are also fiscal ones. Our jail is a scarce resource which must be used wisely to house those who pose a danger to public safety, or for whom incarceration is otherwise necessary and appropriate.

Our jail should not be used to house people whose behavior arose out of an acute mental health crisis merely because it is believed—whether correctly or otherwise—that there is no place else to take that person to receive treatment instead. Indeed, even in instances in which it could arguably cost more to divert such mentally ill persons from the jail, it is still the right thing to do.

Mental health diversion is not a jail reduction plan. Although a successful mental health diversion program could result in some reduced need for jail beds in years to come, there will always be a need for mental health treatment to take place within the jail. That is because offenders at all levels of the criminal justice continuum can find themselves afflicted by mental illness, including those charged with serious and violent crimes including the ultimate crime of murder. Due to the nature of charges pending and their level of dangerousness, violent offenders may need to be housed at the county jail while they receive mental health treatment. Indeed, under current jail conditions, those mentally ill offenders must be carefully handled and monitored to prevent them from posing a danger to themselves and other inmates while they are incarcerated.

Mental health diversion also must not come at the price of victims' rights. It is not just a priority, but a given, that the rights of victims will be preserved while efforts are being made to enhance mental health diversion.

Should any future reduction in the jail population occur as a result of the mental health diversion project, it would enable serious and violent felony offenders who are not mentally ill to serve a

longer percentage of their sentences. Such a result would enhance public safety, but would not reduce the need for jail beds.

In the criminal justice system, the term “diversion” is often used as a legal term of art to describe alternative programs which prevent someone from suffering a criminal conviction. This report uses the term “diversion” more broadly. As used in this report, diversion includes all circumstances ranging from pre-arrest to post-conviction, in which mentally ill persons can be prevented from entering the jail at all, can be redirected from the jail into treatment, or can receive linkage to services (during and after incarceration) to help prevent them from returning to custody.

Viewed through this lens, mental health diversion is not new, but is alive and well in Los Angeles County. For some years, various key individuals, public entities, and community based organizations have planned, developed, and implemented programs that prevent mentally ill individuals from being incarcerated and instead divert them into community-based mental health treatment. However, these efforts have often gone unrecognized, due to a lack of general knowledge. What is new is the current active collaboration and commitment to this project which is shared by all of the stakeholders. A spirit of communication, innovation, and enthusiasm exists for this project which is unprecedented. With the allocation of additional resources, our County will be able to improve upon what is already being done.

Progress is being made on the issue of how to most effectively divert mentally ill offenders from the jail, but it is a large task that will not happen overnight. The experiences of other large jurisdictions which have faced this problem have taught us that steady, incremental progress can and will work over time.

The District Attorney’s Office provides the following report regarding the continuing work of the Criminal Justice Mental Health Advisory Board, as directed by this Board’s Motion dated May 6, 2014. This report will discuss existing efforts, identify gaps in services and suggest priorities for how to improve mental health diversion efforts on an ongoing basis.

EXECUTIVE SUMMARY

Statement of Purpose

The Criminal Justice Mental Health Advisory Board was convened to safely divert non-violent mentally ill offenders from the jail, into community treatment options. This is an ambitious, long-term goal which will take time and fiscal resources to fully effectuate.

Mental health diversion is not a jail reduction plan. There will always be the need for mental health treatment to take place in the jail, since offenders at all levels of the criminal justice continuum can find themselves afflicted by mental illness, including those charged with serious crimes, violent crimes and even the ultimate crime of murder.

Criminal Justice Mental Health Advisory Board and Working Groups

Over the past year, the Advisory Board has made significant progress in assessing mental health resources and identifying strengths, weaknesses and priorities for improvement. Local stakeholders participated in a “Summit” and a “Mini-Summit” which introduced them to the “sequential intercept model” of mental health diversion planning. The sequential intercept model identifies all “intercept points” along the criminal justice continuum where contact with those who suffer from mental illness occurs and appropriate intervention can take place. The five intercepts are: (1) Law Enforcement/Emergency Services First Contact; (2) Post-Arrest/Arrest; (3) Courts/Post-Arrest/Alternatives to Incarceration; (4) Community Reentry; (5) Community Support.

Using the sequential intercept model as an aid to discussion, the Advisory Board has met regularly over the past year. Most recently, the Advisory Board has begun to create and deploy Working Groups, which are designed as active problem solvers for subject areas deemed worthy of further study. The Working Groups are dynamic in nature and will evolve over time as current problems are solved and new ones are identified. The current Working Groups are: (1) Law Enforcement Working Group; (2) Community Based Restoration Working Group; (3) Criminal Justice Working Group; (4) Treatment Options and Supportive Services Working Group; (5) Pre-Booking Diversion Working Group; (6) Data and Systems Connectivity Working Group; (7) Long Beach Mental Health Diversion Working Group.

Data Collection and Sharing

Data collection and data sharing must be made a priority. It will also be necessary to establish metrics so that the efficacy of mental health diversion can be evaluated on an ongoing basis. These issues will be addressed in the Data and Systems Connectivity Working Group from an inter-departmental perspective.

Crisis Intervention Team (“CIT”) Training

Training is the most important priority for mental health diversion, because change cannot be effectuated without it. The first opportunity to divert a mentally ill person is when first responders encounter a person at the scene. At that point, law enforcement officers can take the person to a

community treatment option instead of the jail, but how the situation unfolds and whether the mentally ill person is arrested can be highly dependent upon how the first responders are trained.

The original Crisis Intervention Team (“CIT”) training was a 40 hour model, which is fully endorsed by the Advisory Board and by the District Attorney. CIT training will help to raise awareness of and sensitivity to mental health issues and provide law enforcement officers with the tools necessary to interact more effectively and compassionately with mentally ill persons in the field. Educating law enforcement officers about community based treatment options will encourage them to use those options in lieu of arrest and booking. Skills training to defuse potentially violent situations will make those encounters safer for both law enforcement and mentally ill persons alike and help to prevent encounters from turning violent or even fatal. In addition, CIT training will lead to decreased litigation and judgment costs.

Over the next six years, the LASD has created an ambitious plan to have 5,355 patrol deputies complete the full 40 hour CIT training. For smaller law enforcement agencies, an alternative 16 hour model will be available under the auspices of the District Attorney and Criminal Justice Institute, commencing in January, 2016.

Co-Deployed Law Enforcement Teams

The Department of Mental Health has paired with a total of seventeen different law enforcement agencies in the field, to provide crisis intervention services. The co-response model pairs a licensed mental health clinician with a law enforcement officer. Together, they jointly respond to patrol service requests where it is suspected that a person might have a mental illness, so that appropriate referrals to treatment facilities can be made. These teams have been universally praised by mentally ill persons who have interacted with them, and family members who have seen their loved ones treated with compassion and understanding.

These specially trained co-deployed teams are known as Mental Evaluation Teams (“MET”) by the LASD and as the System-wide Mental Assessment Response Team (“SMART”) by the LAPD. Regardless of the name, the demand for services is so great that there are not enough teams to provide sufficient coverage. Therefore, the Advisory Board recommends both expanding the MET and SMART teams, as well as providing CIT training for all officers whenever possible.

Mental Health Urgent Care Centers: The First 24 Hours After a Mental Health Crisis

When a law enforcement officer encounters a mentally ill person in the field, the choice is to either take the person to a crowded emergency room and possibly wait for an average of 6 to 8 hours, or arrest the person, book the person into the county jail, and return to their duties within the hour.

Mental health Urgent Care Centers (“UCCs”) provide another option. UCCs are acute care mental health facilities where mentally ill persons can be taken for specialized evaluation, but their stay must be less than 24 hours. Investing in UCCs takes the pressure off County hospitals by freeing up emergency rooms to deal with medical health crises as they arise, thus enhancing care for both medical and mental health patients. DMH currently has underway a plan to add three additional

UCCs to be located near Harbor UCLA, the San Gabriel Valley and the Antelope Valley. The Advisory Board endorses this plan.

Other Treatment Options: After the First 24 Hours

After a law enforcement officer has transported a mentally ill person to an Urgent Care Center, the person should then be linked to appropriate inpatient or outpatient mental health treatment options. Los Angeles needs the right combination of treatment services to serve the mentally ill population, and good linkage to those services. Current treatment options include law enforcement hospital beds, Institutions for Mental Diseases (“IMD” beds), Crisis Residential programs, Full Service Partnerships (“FSPs”), Field Capable Clinical Services, Wellness Centers and the Assisted Outpatient Treatment program.

In order for mentally ill persons to be diverted from the jail into community based treatment options, those treatment resources must be adequate to address a mental health crisis both during and after the first 24 hours. Therefore, the Advisory Board recommends increased mental health treatment resources in each of these categories.

Permanent Supportive Housing and Other Housing Options

Mentally ill individuals who are homeless are significantly more likely to become involved in the criminal justice system, and to remain incarcerated, than those who have a stable housing environment. It is also more difficult to engage homeless mentally ill individuals with treatment, resulting in high-cost utilization of medical, emergency and mental health care systems which could have been avoided by providing permanent supportive housing.

There are a variety of housing options and programs available, such as bridge housing, Shelter Plus Care, federal housing vouchers, Rapid Re-Housing and the Mental Health Services Act (“MHSA”) Housing Program. However, there are clearly insufficient resources in the area of permanent supportive housing.

The Department of Health Services has created an innovative rent subsidy program called the Flexible Housing Subsidy Pool, which provides permanent supportive housing. The Flexible Housing Subsidy Pool allows a provider to contract for housing, providing a range of options that include intensive case management, wrap-around services and move-in assistance. To fund the program, DHS has partnered with private foundations, which provides maximum flexibility because participants are not restricted based on criminal history, and the restrictive federal definition of homelessness does not apply.

The Advisory Board recommends a significant investment in a variety of permanent supportive housing beds to be dedicated to mentally ill offenders, both through the Flexible Housing Subsidy Pool and through the Department of Mental Health Specialized Housing Program. It is also recommended that a Mental Health Diversion County Housing Director position be created to administer these beds and generally oversee housing issues related to mentally ill offenders.

Co-Occurring Substance Abuse Disorders

Up to 80 percent of mentally ill offenders also suffer from co-occurring substance abuse disorders. As a practical matter, someone who is actively high on drugs or alcohol may be violent and combative, and will not immediately be amenable to mental health treatment or able to be received at an Urgent Care Center.

Therefore, an increased investment in services to help stabilize mentally ill offenders is recommended. In particular, Sobering Centers which would be able to be accessed by first responders should be pursued by the County. In addition to Sobering Centers, there is also a need for Residential Detoxification Services.

Additional investment in residential drug treatment services is also recommended, to provide substance abuse treatment for up to 90 days.

Finally, for the most acutely mentally ill offenders, there is currently an insufficient supply of IMD beds for individuals with serious mental illness and co-occurring disorders, so 40 additional beds are recommended.

Current Jail Programs and Resources

This report catalogues and describes the existing jail programs which are most relevant to mental health diversion. Of particular interest is the proposed expansion of the Public Defender and Alternate Public Defender Jail Mental Health Team. This innovative jail program is aimed at a broader, more holistic representation of mentally ill offenders who are housed at the county jail.

The Advisory Board supports this request for psychiatric social workers and clinical supervisors. Clients are much more likely to be forthcoming and cooperative with a psychiatric social worker assigned to their own legal team than with a clinician who is not. Enhancing this relationship could greatly assist in the evaluation of appropriate placement options outside of the jail.

Current Court Programs and Resources

Next, this report catalogues and describes the existing court programs which are most relevant to mental health diversion. One such program is the Department of Mental Health Court Linkage/Court Liaison Program, a collaboration between DMH and the Superior Court in which clinicians are co-located at 22 courts countywide. This recovery based program serves adults with mental illness or co-occurring substance abuse disorders who are involved with the criminal justice system. Last year's figures show that the Court Linkage Program helped to divert a total of 1,053 persons out of 1,997 referrals. This group of about a thousand mentally ill offenders annually is placed across the spectrum of available treatment options. The Advisory Board endorses the expansion of this program.

Expansion of Mental Health Diversion Related Staffing and Services

The Advisory Board also proposes the creation of a new, permanent planning committee. Based on the experiences of other jurisdictions, mental health diversion will be a long-term project for years to come. Therefore, a permanent leadership structure will be necessary.

The Advisory Board recommends a small, workable Permanent Planning Committee, to be comprised of one representative from each of the following County Departments: District Attorney, Public Defender, Sheriff's Department, Department of Mental Health, Department of Public Health, Department of Health Services, proposed new Mental Health Diversion County Housing Director, and others appointed by the District Attorney on an as-needed basis. These personnel would be management-level employees, with significant operational experience, who could bridge the gap between high-level policy recommendations and actual implementation decisions.

Recommendations

Based on this report, the Advisory Board recommends the following actions:

- 1. Fund CIT Training.**
- 2. Expand Primary Mental Health Treatment Resources. (Urgent Care Centers; Crisis Residential Treatment Programs; "Forensic" or "Justice Involved" versions of Full Service Partnerships; Field Capable Clinical Services and Wellness Centers; IMD beds for co-occurring disorders; DMH administrative staffing items; Court Linkage expansion).**
- 3. Establish the Permanent Mental Health Diversion Planning Committee.**
- 4. Expand Public Health/Health Services Treatment Resources. (Sobering Centers and Residential Substance Abuse Treatment facilities).**
- 5. Enhance Housing Services. (Create Mental Health Diversion County Housing Director; fund permanent supportive housing beds both within the Department of Health Services Flexible Housing Subsidy Pool and within the Department of Mental Health Specialized Housing Program).**
- 6. Expand Co-Deployed Teams.**
- 7. Prioritize Data Improvements to Enhance Data Collection, Data Sharing and Performance Metrics.**
- 8. Establish the Public Defender and Alternate Public Defender Jail Mental Health Team.**

- 9. Expand Secondary Mental Health Treatment Resources. (Men's Integrated Reentry Services and Education Center; Co-deployed DMH personnel at Probation Offices on a pilot project basis).**
- 10. Fund the LASD Mental Health Evaluation Bureau. (Fiscal Year 2016-2017).**

LOCAL STAKEHOLDER DISCUSSIONS AND THE SEQUENTIAL INTERCEPT MODEL

On May 28, 2014, a Countywide Mental Health Summit (*hereafter the “Summit”*) was convened. Policy Research Associates was employed as a consultant to assess existing mental health resources in Los Angeles County, identify strengths and weaknesses, and help identify priorities for improvement.

Initial funding for the Summit was provided by the California Endowment and by the Aileen Getty Foundation, and it was hosted by the USC Gould School of Law. The Summit was attended by a myriad of stakeholders, including the District Attorney’s Office, the Department of Mental Health (“DMH”), the Sheriff’s Department (“LASD”), the Superior Court, the Public Defender’s Office, the Alternate Public Defender’s Office, the Probation Department, the Executive Director of the CCJCC, the Chief Executive Office, the Los Angeles Fire Department, the Los Angeles Public Health Department, the Los Angeles City Attorney’s Office, the United States Attorney’s Office, the Los Angeles County Mental Health Commission, the National Alliance on Mental Illness (“NAMI”) and dozens of others.

On July 8 and 9, 2014, a smaller series of local stakeholder meetings took place (*hereafter, the “Mini-Summit”*). The Mini-Summit was convened so that further evaluation of existing mental health resources and recommendations for improvements to services could take place in a more focused setting.

During both the Summit and Mini-Summit, participants were introduced to the “*sequential intercept model*” of mental health diversion planning which has been successfully utilized in other jurisdictions, including Miami-Dade County, Florida. The sequential intercept model identifies all places or “*intercept points*” along the criminal justice continuum where contact with those who suffer from mental illness occurs and appropriate intervention can take place.

Because our system is so large and complex, there has necessarily been a high degree of specialization by individuals whose work takes place at completely different intercept points of this model. The sequential intercept model has clarified and focused local discussion and helped flush out interplay between the different decision points. *For example, a decision made regarding the length of custody imposed as part of a criminal sentence (such as 90 days versus 120 days in the county jail) can legally foreclose certain public healthcare and housing benefits from being available to a person later upon their release, solely as a result of the length of time spent in custody.* Learning more about this type of systemic interplay will help inform policy decisions made in the criminal justice system. The following is an introduction to the sequential intercept model.

❖ Intercept One: Law Enforcement/Emergency Services

Intercept One is the first justice system contact with an offender, before an arrest. First contact may include a call to a 911 operator by a family member, an on-site evaluation by a paramedic, or a law enforcement response to a crime in progress. Pre-booking diversion is essentially an evaluation of whether a situation is truly criminal or non-criminal in nature,

and it occurs at Intercept One. If a person is diverted to treatment instead of jail at this intercept, there will be no arrest and no case will be presented to a prosecutor for consideration.

❖ **Intercept Two: Post-Arrest/Arraignment**

After first contact, an offender is typically taken to the county jail. Next, the prosecuting agency decides whether to file criminal charges or decline charges. The period of time between an offender's arrest and their first appearance in court at arraignment is locally referred to as "second chance" diversion, because regardless of the original determination in the field, a prosecutor independently reevaluates whether an incident should be handled criminally or non-criminally.

If a prosecutor declines to file a criminal case, the person will be released, possibly without services. This lack of services is problematic, and possible solutions are being explored during ongoing discussions. If criminal charges are brought, the mentally ill offender appears in court at an arraignment, a criminal defense attorney is appointed or retained and a judge will either release a person on their own recognizance or set bail. Diversion at Intercept Two minimizes custody time, because it takes place early in the process, and may or may not include a criminal conviction. Not all offenders are suitable for diversion at Intercept Two, because less information is known at arraignment than later, and some decisions must be made more deliberatively.

❖ **Intercept Three: Courts/Post-Arraignment/Alternatives to Incarceration**

If a criminal case is not resolved at arraignment, other court proceedings take place. Ultimately, a criminal case may resolve either by a dismissal, a guilty plea or a trial. A sentence may include a combination of custody and supervision.

Depending on the mental health and criminogenic factors involved, some offenders will need the structure provided by formal supervision in order to be successfully diverted from custody. Thus, a dismissal will not be suitable in every case. Instead, diversion efforts at this intercept can also employ alternatives to incarceration as a sentencing choice upon conviction. Within Intercept Three, there is also a special class of offenders who are so acutely mentally ill that they are declared incompetent to stand trial. When that happens, criminal proceedings are suspended and jurisdiction transfers to the Mental Health Court, Department 95. Offenders who are incompetent to stand trial present unique issues which are distinct from other mentally ill offenders.

❖ **Intercept Four: Community Reentry**

Whether a person is criminally convicted or not, if they are taken into custody, at some point they will be released back into the community. Appropriate discharge planning, including jail "in-reach" efforts, can greatly assist in successful reentry.

Intercept Four issues include where a person will live, whether they will be able to support themselves, what access to mental health and other health services they will have, whether

or not they will be supervised by the criminal justice system and the like. For example, if a person is receiving medication, a plan should be put into place so that they are linked with mental health services and their course of medication can continue uninterrupted.

❖ *Intercept Five: Community Support*

This Intercept focuses on the person's continued and permanent access to resources, after the transition from jail to the community. Ongoing peer and family support are important.

The need for permanent supportive housing is another significant policy issue, which will be discussed separately in this report. Although transitional housing can help get a person back on his or her feet, some mentally ill offenders will need more assistance than transitional services can provide. Appropriate needs evaluations can assist in determining the need for more permanent resources.

Using the sequential intercept model, existing programs and priority needs were incorporated into the Policy Research Associates report, which is attached as Attachment 1. Those priorities have continued to inform further discussion during Criminal Justice Mental Health Advisory Board meetings, which have addressed issues relating to each of the intercept points.

CRIMINAL JUSTICE MENTAL HEALTH ADVISORY BOARD AND WORKING GROUPS

Since the District Attorney provided her interim report to this Board on November 12, 2014, she has led the Criminal Justice Mental Health Advisory Board (*“Advisory Board”*) as the chair of monthly stakeholder meetings. The Advisory Board collaboration has produced significant early successes.

First, a new court diversion pilot project was created at the San Fernando and Van Nuys courts, the Third District Diversion and Alternative Sentencing Pilot Project (*“Third District” project*). The Third District project can assist up to 50 criminal defendants at a time who are chronically homeless and suffer from a serious mental illness. This program is based on the “Housing First” model, which provides supportive housing first, thereby creating an environment conducive to treatment for individuals to combat their mental illnesses and co-occurring substance use disorders. The Housing First model motivates offenders to succeed, because they want to keep the housing provided through the program rather than return to the streets.

Eligible crimes for the Third District program include both misdemeanors and felonies. Defendants charged with misdemeanors earn a full dismissal of their charges following successful completion of a 90 day diversion program, without having to plead guilty. For felony crimes, a defendant must initially enter a plea of guilty or no contest and complete an 18-month program; upon successful completion, an offender earns early termination of probation and dismissal of charges. This ongoing pilot project was a collaboration between the Department of Mental Health, District Attorney, Public Defender, Alternate Public Defender, Indigent Criminal Defense Appointments Program, Los Angeles City Attorney’s Office, Superior Court, Probation Department, Department of Public Health, LASD, San Fernando Valley Community Mental Health Center and Department of Veteran’s Affairs. In June, 2015, the stakeholders met once again to refine the selection criteria for the program in order to serve more participants.

Also in June, 2015, Los Angeles County was awarded a competitive Mentally Ill Offender Crime Reduction (*“MIOCR”*) grant for \$1.8 million dollars. This grant will address the problem of “offender tri-morbidity” by diverting these at-risk offenders from custody. Tri-morbid offenders have three factors which can lead to their early demise: They are mentally ill, suffer from substance abuse and are medically fragile.

The MIOCR grant proposal submitted by Los Angeles was ranked first among all of the jurisdictions which competed for funding. Perhaps the greatest strength of the Los Angeles County grant proposal was the extensive collaboration which went into it. The District Attorney’s Office applied for the grant as the lead department on behalf of the collaborative team. The Board of State and Community Corrections (*“BSCC”*) has provided a contract which was received and executed by the District Attorney’s Office in accordance with the July 1, 2015 implementation date.

The Advisory Board is currently meeting every other month in order to more effectively deploy and support specialized Working Groups. These Working Groups are practical problem-solvers whose subject areas were deemed worthy of further study in detail. The Working Groups are dynamic in nature, and will evolve over time as current problems are solved and new ones are identified.

❖ **Law Enforcement Working Group. (Intercept One)**

This group is chaired by Chief Jim Smith of the Monterey Park Police Department. The Law Enforcement Working Group has developed training for first responders, who include law enforcement officers, dispatch employees, fire department personnel and others. The training is modeled after the Crisis Intervention Team Training (“CIT”) model which originated in Memphis, Tennessee. The Law Enforcement Working Group has made substantial progress on CIT training over the past year, which will be discussed separately in this report.

❖ **Community Based Restoration Working Group. (Intercept Three)**

The Community Based Restoration Working Group (“Restoration Working Group”) is chaired by Judge James Bianco, who is the bench officer assigned to Department 95, Mental Health Court. The Restoration Working Group convened to consider treatment options for offenders who are mentally incompetent to stand trial. These offenders are often actively psychotic, cannot care for themselves, and have been found incompetent to stand trial because their mental illness is so acute that they cannot understand the nature of the criminal charges against them or rationally assist their defense attorneys.

In particular, the Restoration Working Group has focused on the population of misdemeanor incompetent to stand trial (“MIST”) defendants. There are currently a total of about 130 MIST defendants in the county jail. The MIST population is a priority because these offenders are being held on misdemeanor charges and but for their mental illnesses, would likely have already completed their criminal cases and been released. On the other hand, criminal charges cannot simply be dismissed for a variety of legal and practical reasons.

The Restoration Working Group is piloting an ambitious project to divert up to 100 MIST defendants from the jail for treatment in the community. At this time, appropriate residential treatment beds are being identified and an individualized plan is being created for each MIST offender, depending on their needs. However, due to the nature of this population, there may not be an appropriate treatment setting for each of these offenders, who require extensive care and monitoring.

The Restoration Working Group will explore whether it would be feasible to place some of these MIST defendants into a skilled part nursing facility, which is a facility akin to a nursing home, but for persons who are anticipated to recover. Los Angeles County does not currently have any skilled part nursing facilities. At this time, it is not yet known if there is a sufficient population which would need such a facility to justify the creation of one in our County.

❖ **Criminal Justice Working Group. (Intercepts Two and Three)**

The Criminal Justice Working Group is chaired by Judge Scott Gordon, who is the Assistant Supervising Judge of the Criminal Division. The Criminal Justice Working Group was formed to address court and jail-related issues.

Initially, the group will design a pilot project to divert up to 100 defendants from the county jail into community based treatment options as alternative sentencing. In contrast to the MIST defendants, who are under the jurisdiction of the Mental Health Court, the Criminal Justice Working Group will focus on defendants who remain under the direct jurisdiction of the criminal courts.

The Criminal Justice Working Group will also address justice stakeholder training for prosecutors, defense attorneys and others in the justice system— even judges. These training recommendations will educate stakeholders regarding the benefits of mental health diversion, legal issues, available resources and the like. The Criminal Justice Working Group will also consider related issues such as victims' rights. It is anticipated that the Criminal Justice Working Group will provide a ready forum to address any local procedural or policy issues regarding case processing which will arise during all phases of the mental health diversion project on an ongoing basis.

❖ **Treatment Options and Supportive Services Working Group. (Intercepts One through Five)**

The Treatment Options Working Group is chaired by Flora Gil Krisiloff, Department of Mental Health. It will seek to maximize the use of existing treatment resources and to develop new options in the future.

Available treatment resources are a universal need which is critical for successful diversion efforts at every intercept point. Los Angeles County does not simply need “more beds” but rather, the right kind of beds in the right combination to serve a mentally ill offender population which is very diverse in its needs. Notwithstanding that diversity, the Treatment Options Working Group will identify common problems which are amenable to solution.

The Treatment Options Working Group will consider treatment options broadly, both in the jail as well as upon reentry. This discussion will include the intersection of mental health, substance abuse and the need for supportive housing. One idea to be explored is the development of multi-disciplinary teams to ensure the delivery of integrated services to homeless and mentally ill clients. The Treatment Options Working Group will be empowered to generate recommendations for best practices.

❖ **Pre-Booking Diversion Working Group. (Intercept One)**

The Chair of this group is to be determined. The Pre-Booking Diversion Working Group will address practical issues regarding how offenders can appropriately be selected for pre-booking diversion rather than brought to jail. The Pre-Booking Diversion Working Group will also examine the “second chance” time period for diversion after booking, but before criminal charges have been filed.

This discussion will be more nuanced than merely creating a list of criminal offenses that are either included or excluded for diversion, even if that could be definitively done. Some individualized evaluation of each offender must necessarily take place, such as what circumstances brought them to the attention of law enforcement, the severity of their mental

illness, whether they have housing and available support persons, and the like. The Pre-Booking Diversion Working Group will generate protocol recommendations and discuss strategies for success based on all of the relevant factors.

The Pre-Booking Diversion Group will also critically examine how and why welfare related calls which are initially non-criminal in nature can transform, resulting in a county jail booking and criminal case. Successfully preventing entry into the jail at this intercept point could reduce the incompetent to stand trial population in the jail, and in particular, the MIST population who are booked on misdemeanor charges and can remain in the jail for some time.

❖ **Data and Systems Connectivity Working Group. (Intercepts One through Four)**

This group is chaired by Todd Pelkey, who is the Chief of the District Attorney Systems Division. The Systems Working Group will discuss data collection and data sharing issues, including appropriately maintaining privacy and patients' rights.

Systems solutions can help create better linkage to available services. "Linkage" means more than simply making an appointment. For example, after incarceration, the treatment provider who receives the client needs information about the treatments which were provided to the client while incarcerated, in order to avoid unnecessary duplication and give the person what they need. Equally important, upon return to jail, knowledge about a client's recent clinical history can potentially reduce risk and speed the delivery of services.

In our County, the Sheriff's Department, Probation Department and Department of Health Services all use Cerner Health Information Systems. The Cerner Hub is software which can facilitate transparent exchange of clinical information between participating implementation sites. Netsmart, the health information vendor for the Department of Mental Health, is currently involved in discussions with Cerner to enable Netsmart systems to participate in health information exchange through the Cerner Hub. If successfully deployed, Los Angeles would be among the first sites to use this approach in production. Adding DMH to the Cerner Hub community would greatly simplify the task of coordinating care for clients shared among the participating departments.

By early 2016, the Department of Health Services will complete its implementation of the Online Read-time Centralized Health Information Database ("ORCHID"). ORCHID is an electronic health record system which provides a unique identifier for each patient to track his or her services throughout the clinical specialties and patient care venues. ORCHID is built on a platform that will also be used by the Sheriff's Department Medical Services Bureau and the Probation Department's Juvenile Health Services, to enable real-time access to patient records for their shared patients. In a separately pending motion, this Board is considering whether it would be better to pursue system linkage solutions or to integrate all electronic health record systems into a single platform.

The Systems Working Group will also consider possible use of the Justice Automated Information Management System ("JAIMS"), which was developed after the enactment of AB 109, to possibly store or share anonymized data related to mental health diversion.

Perhaps the most important topic to be discussed by the Systems Working Group will be how data collection and data sharing will inform evidence-based practices. Over the long term, data regarding mental health diversion will be crucial, in order to record what is being done here and preserve it for analysis by outside experts. Indeed, our ongoing mental health diversion efforts must be data driven so that we can quantify our successes, identify trends and learn from our experiences. It is anticipated that in the future, the Systems Working Group will be able to identify systems related gaps which could be remedied by additional fiscal resources.

❖ **Long Beach Mental Health Diversion Working Group. (Intercepts One through Five)**

This group is chaired by Kelly Colopy, who is the Director of the Long Beach Department of Health and Human Services. The Long Beach Working Group was convened to discuss issues specific to Long Beach, which is the second largest city in the County. The group will create and launch a Long Beach pilot project, which is especially appropriate because Long Beach has its own Police Department, City Prosecutor, and Health and Human Services Department. There are 88 municipalities within the County of Los Angeles, and each of these locations feeds mentally ill offenders into the county jail. Therefore, the experiences of cities such as Long Beach are important to the overall mental health diversion project.

CRISIS INTERVENTION TEAM (“CIT”) TRAINING

Training is currently the single most important priority, because change cannot be effectuated without it. Law enforcement training will raise awareness of and sensitivity to mental health issues, and provide law enforcement officers with concrete tools to interact more effectively and compassionately with mentally ill persons in the field.

There are several benefits to Crisis Intervention Team training (“CIT” training). First, educating law enforcement officers about community based treatment options will encourage them to use those options instead of booking mentally ill persons into the jail. Skills training in field interactions—in particular, how to defuse potentially violent situations—makes these encounters safer for both law enforcement and mentally ill persons alike, and helps to prevent encounters from turning violent or even fatal.

This is not only a more enlightened approach, but it is also a fiscally wise one. CIT training means that law enforcement officers will be less likely to suffer from workplace related injuries and disabilities. Based on the experiences of other jurisdictions, CIT training will also pay for itself over time, in reduced litigation and judgment costs. The LASD has estimated that up to 40 percent of use of force incidents may involve mentally ill persons.

The original, highly successful CIT training was based on a 40 hour model. However, this can impose a heavy burden on law enforcement agencies. Logistically, CIT training requires law enforcement agencies not only to send personnel to the training for a week, but also to provide backfill coverage while those officers are gone. Indeed, that can be the largest cost involved. This can be quite challenging for law enforcement agencies, whether they are large or small.

The District Attorney fully endorses the full 40 hour CIT training model whenever it can be employed, but recognizes the practical realities involved and the need for flexibility. Accordingly, the Law Enforcement Working Group has developed an alternative 16 hour CIT training program for local implementation in Los Angeles County. In developing the 16 hour CIT training model, the District Attorney’s Office contributed technical and resource assistance through the Criminal Justice Institute, which is a training entity administered through the District Attorney’s Office. The Law Enforcement Working Group has identified key training priorities, developed a proposed curriculum, and recruited trainers.

On June 3, 2015, the Law Enforcement Working Group staged a successful half day “Train the Trainers” event at the Burbank Fire Department Training Center. Once fully online, local CIT training will be scheduled as two 16 hour training sessions per month, serving a maximum of 25 participants per training session, for a minimum of one year, and is currently planned to continue indefinitely. Due to the sheer scope of this training effort, these sessions will require a multitude of trainers from a variety of agencies and backgrounds, some of whom will work as teams and others who will rotate in and out of service. These trainers will include representatives from DMH, the LAPD, and the National Alliance on Mental Illness (“NAMI”) whose family members, close friends, and themselves have been impacted by mental illness.

Also due to the magnitude of this training effort and ancillary issues associated with it, the District Attorney has identified an immediate need for a Training Liaison who would be hired

as a District Attorney employee. Because CIT training is at its heart a law enforcement concern, the Training Liaison would ideally be either a current or retired high-level managerial law enforcement officer. The District Attorney is currently considering candidates for this position. In addition, the District Attorney requests funding for a Management Assistant position. The Management Assistant position is necessary in addition to the Training Liaison to assist with administrative tasks related to scheduling and organizing the training. In addition to the law enforcement aspect of the anticipated training burden, there will also be significant training needs on an ongoing basis for stakeholders such as attorneys and even judges.

The District Attorney's Office is also working directly with the state Peace Officer Standards and Training Commission ("POST") to seek approval of the 16 hour CIT training curriculum. POST approval is anticipated and if granted, actual CIT training programs may be presented as soon as January, 2016.

The value of CIT training is universally recognized by the law enforcement community. In fact, the larger local law enforcement agencies are each already planning to satisfy their own training needs. For example, the District Attorney is informed that the LAPD, which has embraced CIT-type training for some time, plans to present additional training sessions at least once a month during the next year. The CHP already has underway its own plan to provide a 12 hour block of CIT training to each of its officers statewide.

The Sheriff's Department has proposed a comprehensive six-year plan to incrementally train each of its 5,355 patrol deputies in the full 40 hour CIT training. Although deputies receive six hours of mental health training as new recruits in the Academy, this is not adequate to prepare them for the numerous contacts with mentally ill persons that actually occur once they are deployed as deputies. The Sheriff's Department has created a three-part plan to better train its deputies.

First, the Sheriff's Department is currently providing Baseline Training (3 hours) and Intermediate Training (8 hours) to deputies. As of June 8, 2015, more than 1,200 patrol deputies have received the Baseline Training, which provides an overview of mental health issues that first responders encounter in the field and strategies which may apply to specific situations. The Intermediate Training is a mental health awareness class, which provides students with the tools to better recognize symptoms and behaviors associated with mental illness and fundamentally, to understand that behavior engaged in by a mentally ill person relates to a medical condition that the person has not chosen to have. Students are also taught how to better communicate with mentally ill persons. As of June 8, 2015, more than 700 personnel have attended the Intermediate Training. Finally, the Sheriff's Department plans to provide a 40 hour Advanced Training, to be conducted 40 weeks per year with a class size of 24 students. The Advanced Training is true CIT training. Topics covered will include: Mental health signs and symptoms, appropriate medications and their side effects, use of verbal de-escalation techniques, active listening skills, and improved police tactics using safe restraint techniques that result in reduced use of force. During Fiscal Year 2015-2016, the LASD will send 480 patrol personnel to CIT Training. Deputies who complete the training will return to their patrol areas and be available to respond to and assist with incidents involving mentally ill persons when co-deployed Mental Evaluation Teams (discussed in the next section) are not available. The value of this ambitious plan cannot be overstated.

Because each of the larger law enforcement agencies are already planning their own independent CIT training programs, the participants in the 16 hour CIT training sessions sponsored by the District Attorney and Criminal Justice Institute will largely be drawn from the 48 smaller police agencies in the County.

Simply stated, CIT training is a good idea whose time has finally come, one which is worthy of the full support of this Board.

CO-DEPLOYED LAW ENFORCEMENT TEAMS

The Department of Mental Health's Emergency Outreach Bureau has teamed with law enforcement agencies in the field, to provide crisis intervention services throughout Los Angeles, various municipalities, and the unincorporated areas of the County. This co-response model pairs a licensed mental healthcare clinician with a law enforcement officer. Together, they jointly respond to 911 calls and patrol service requests where it is suspected that a person might have a mental illness, make appropriate referrals to treatment facilities, and facilitate hospitalization when necessary.

These specially trained, co-deployed field teams are known as Mental Evaluation Teams ("MET") by the Sheriff's Department and as the System-wide Mental Assessment Response Team ("SMART") by the LAPD. Regardless of the name by which the co-deployed teams are known, the mission and partnership with the Department of Mental Health remain the same. DMH has estimated that these teams may contact over 6,500 mentally ill persons per year.

In addition to partnering with the LASD and LAPD to deploy the MET and SMART teams, DMH has also partnered with a total of fifteen other law enforcement agencies which also employ co-deployed teams: Alhambra Police Department; Bell Gardens Police Department; Burbank Police Department; City of Bell Police Department; City of Vernon Police Department; Downey Police Department; Gardena Police Department; Hawthorne Police Department; Huntington Park Police Department; Long Beach Police Department; Pasadena Police Department; Santa Monica Police Department; Signal Hill Police Department; South Gate Police Department; Torrance Police Department. Also, the Metropolitan Transit Authority ("MTA") contracts with the LASD for four Crisis Response Teams, funded by the MTA. These four teams primarily serve homeless individuals and respond to critical incidents involving mentally ill persons on public transportation such as buses and trains. DMH also has plans underway to partner with six additional law enforcement agencies on co-deployed teams, once appropriate memoranda of understanding are approved and executed.

Co-deployed teams roll out in the field and use their specialized training and experiences to help to defuse potentially violent situations. The teams respond to persons in crisis, barricaded suspects, suicides in progress such as jumpers, and a variety of other volatile situations. The MET teams are praised by both mentally ill persons who have interacted with them, and family members who are grateful to have seen their loved ones appropriately treated with compassion and understanding. Co-deployed teams are a bright spot in the ongoing relationship between law enforcement and the communities that they police.

Unfortunately, the demand for services is so great in Los Angeles that there are never enough co-deployed teams to respond. Because the team coverage areas currently occupy such a large geographic area of the County, there is often a lengthy response time. The co-deployed teams certainly cannot respond to every call which involves a possible mental health issue. That is why, in addition to adding new MET teams, the LASD has also focused on improving mental health training for all of its deputies, a wise investment in the future.

The Sheriff's Department currently has only eight MET teams to cover the entire County, and would need at least a total of twenty-three to provide sufficient coverage and services for the vast

geographic area and population involved. Both the Department of Mental Health and LASD propose the expansion of these teams.

In addition, plans are currently underway for the LAPD to add one additional SMART team per shift per Bureau, for a total of sixteen additional teams. The Department of Mental Health will provide clinicians for each of these teams.

MENTAL HEALTH URGENT CARE CENTERS: THE FIRST 24 HOURS AFTER A MENTAL HEALTH CRISIS

The following problem is presented every day in Los Angeles County. Upon encountering a mentally ill offender in the field, a law enforcement officer faces a choice. The officer could take the person to a crowded hospital emergency room, and possibly wait for an average of 6 to 8 hours there, during which time their assigned patrol area would lack coverage. Or, the officer could take the person to jail, book them there, and be back out on patrol within the hour.

In order to successfully divert mentally ill offenders from the jail, there must be places to take them where they can receive treatment instead. In addition, sufficient resources must be invested into those alternative treatment locations so that they are not overloaded by demand.

Mental Health Urgent Care Centers (“UCCs”) are the logical resource to fill this gap. Urgent Care Centers are acute care provider locations, where a mentally ill person can be taken so that their needs can be evaluated. Urgent Care Centers are not residential facilities. In fact, a person can only remain at an Urgent Care Center for a maximum time period which is less than 24 hours.

During that initial 24 hour window of time, a crisis can be averted. A person can be stabilized and allowed to go home, if they have housing and a support system. On the other hand, a person might be unable to care for themselves and need to be civilly committed on a 72 hour hold (commonly called a “5150 hold” since it is authorized by Section 5150 of the Welfare and Institutions Code). Or, the person’s mental health needs could fall somewhere in the middle, and they can be linked to other services such as recovery-oriented community-based resources.

Because these UCCs specialize in mental health care, they are capable of making mental health determinations promptly and professionally. Investing in adequate mental health UCCs takes pressure off County hospitals by freeing up emergency rooms to deal with medical health crises as they arise, thus enhancing care for both medical and mental health patients. The mental health UCCs provide integrated services, including treatment for co-occurring substance abuse disorders. The Department of Mental Health currently has four UCCs, and a fifth is already slated to be reopened in November, 2015. Of these, two are currently designated under the Lanterman-Petris-Short Act (“LPS designation”) and operate twenty-four hours a day, seven days a week. A facility must be designated under the LPS in order for 5150 holds to be made. DMH already has plans in place to have all of the mental health UCCs in the County, both current and future, designated under the LPS. Each of these UCCs are located in close proximity to hospitals.

The Department of Mental Health is planning to add three additional UCCs to be located near Harbor UCLA, the San Gabriel Valley, and the Antelope Valley, which will serve an additional 54 individuals at any given time. These UCCs will operate twenty-four hours a day, seven days a week. It is anticipated by DMH that these three new UCCs will serve approximately 49,275 persons per year. It is estimated that between 15 and 20 percent of those individuals would have otherwise been incarcerated. These three additional UCCs will primarily be used as assessment and staging facilities for the Assisted Outpatient Treatment program (discussed in the following section) and proposed pre-booking diversion.

The mental health UCCs are a prudent and necessary investment of resources, but cannot be used in every situation. For example, mentally ill persons who are actively under the influence may not

appropriately be taken directly to UCCs. Therefore, there is also a significant separate need for stabilization and detoxification services to be offered at Sobering Centers and Residential Detoxification Centers, as well as longer term Residential Drug Treatment, as discussed later in this report in the section entitled, “Impact of Co-Occurring Substance Abuse Disorders.”

OTHER TREATMENT OPTIONS: AFTER THE FIRST 24 HOURS

After a law enforcement officer has transported a mentally ill person to a mental health Urgent Care Center, what happens next—after the first 24 hours—is also important. Ideally, the person would be linked to appropriate mental health treatment, whether inpatient or outpatient. On the other hand, if a gap in services occurs, law enforcement could receive another call about the same person. Clearly, this would increase the likelihood that upon a second or subsequent call, the person might then be transported to the jail instead.

Los Angeles needs the right combination of treatment options to serve the mentally ill population, and good linkage to those services. There are several different types of mental health treatment services currently available, as follows.

Law Enforcement Hospital Beds The Department of Mental Health provides some dedicated acute psychiatric inpatient services, specifically for uninsured individuals who are brought in by law enforcement. These facilities are located at Aurora Charter Oak Hospital in Covina and College Hospital in Cerritos. The law enforcement bed program serves approximately 300 mentally ill individuals per year.

Institutions for Mental Diseases (“IMD” beds) Institutions for Mental Diseases are licensed long term care psychiatric facilities which may be locked, and are similar to hospital beds. The Department of Mental Health contracts with these IMD facilities to provide care for persons who no longer meet the criteria for acute care but are not clinically ready to live in a board and care facility or other less restrictive treatment settings. Most IMD residents have received services in the past, have had failed board and care placements, and have been in and out of County hospitals, jails, or other IMD beds. They include the most severely mentally ill persons who typically may be the subject of conservatorships.

Crisis Residential Treatment Programs Crisis Residential Treatment Programs have been nationally recognized for over 25 years as an effective model for diversion from psychiatric emergency rooms and as a “step-down” from inpatient hospital and jail care. Mentally ill persons can stay at adult crisis residential treatment programs for up to thirty days, but the usual expected stay is ten to fourteen days. These facilities are not locked, but offer augmented supervision and intensive mental health services.

The County currently has only three Crisis Residential Treatment Programs with a total of 34 beds that provide housing and very intensive mental health services and support for those mentally ill individuals who can benefit from additional stabilization and linkage to ongoing community-based services.

The Department of Mental Health is currently using SB 82 funds to develop and implement 35 additional Crisis Residential Treatment Programs for a total increase of 560 beds. DMH estimates that these additional beds will serve an estimated 17,030 additional people per year, based on an average 12 day length of stay.

Full Service Partnerships (“FSP”) The Full Service Partnership Program serves individuals with mental illness who need intensive, integrated wrap-around services. These are individuals whose criminal justice and psychiatric histories place them at risk of institutionalization, frequent psychiatric hospitalizations, homelessness and incarceration. FSP services support individuals as they transition to lower levels of care and participants engage in the development of their treatment plan which is focused on wellness and recovery. The treatment team is available to provide crisis services to a client twenty four hours a day, seven days a week. FSP providers may be community based organizations or others who contract with the Department of Mental Health. Though comprehensive, these services cannot be used for everyone due to cost issues.

Field Capable Clinical Services (“FCCS”) The Field Capable Clinical Services program is a field-based service program, which assists persons who are either graduating from Full Service Partnerships or were never in need of that level of intensive support and individualized case management. The treatment team is available twenty-four hours a day, seven days a week by telephone to provide crisis services to the client.

Wellness Centers The Wellness Center Program is an outpatient clinical service, for persons who are either graduating from Full Service Partnerships or Field Capable Clinical Services, or were never in need of that level of support. Wellness Center services support individuals in the community.

Assisted Outpatient Treatment Program (“AOT”) Assembly Bill 1421 established the Assisted Outpatient Treatment Demonstration Project Act of 2002 (“Laura’s Law”). Laura’s Law created a process for the courts, probation, and the mental health systems to order supervised outpatient treatment of mentally ill adults who would otherwise resist treatment. The Assisted Outpatient Treatment Program can also be used on a voluntary basis by participants who are engaged in their own treatment.

In May 2015, the Department of Mental Health fully implemented an Assisted Outpatient Treatment program and expanded its intensive Full Service Partnership network by 300 slots and its enriched residential services network by 60 slots. The Assisted Outpatient Treatment Team screens requests, conducts extensive outreach to engage patients, develops petitions and manages the court processes to connect Assisted Outpatient Team enrollees with Full Service Partnerships or enriched residential services that have dedicated funding for these persons.

PERMANENT SUPPORTIVE HOUSING AND OTHER HOUSING OPTIONS

Mentally ill individuals who are homeless are significantly more likely to become involved in the criminal justice system than those who have a stable housing environment. In addition, once they do come into the justice system, they are much more likely to remain in custody than be released on bail or their own recognizance. Because they lack a stable residence, officers are more likely to take them to jail than issue a citation, and judges are more likely to conclude that they will fail to appear for a future court date and order them to remain in custody.

It is also more challenging to consistently engage homeless individuals in treatment services, and too often, their connections with the County's system of care are precipitated by crisis situations and law enforcement contacts rather than being guided by an established treatment plan. The result is high-cost utilization of medical, emergency, and mental health care systems by homeless mentally ill individuals, as well as their increased likelihood of cycling in and out of the criminal justice system.

As such, a discussion of appropriate housing models for mentally ill, justice-involved populations is integral to any mental health diversion and re-entry effort. In particular, the availability of permanent supportive housing is critical to stem the tide of recidivism. The provision of safe, stable, and affordable housing—with necessary supportive services—has been found to be one of the most effective strategies for reducing recidivism.

In response to the direction of this Board's May 6, 2014 motion, the following sections provide an inventory of currently available permanent supportive housing in the County, an assessment of housing service gaps identified for people with severe mental illness, and recommendations for addressing permanent supportive housing needs.

Permanent Supportive Housing Permanent supportive housing is affordable housing with indefinite leasing or rental assistance, combined with supportive services designed to assist homeless persons who suffer from disabling conditions to achieve housing stability. Permanent supportive housing service providers proactively engage tenants and offer treatment plans. The supportive services made available are voluntary and participation is not a requirement of maintaining eligibility for the permanent housing.

The premise of permanent supportive housing is that the effectiveness of mental health, substance abuse disorder, and other treatment interventions is significantly limited when individuals are homeless and in unstable living environments. In contrast, providing homeless, mentally ill individuals with stable, supportive housing promotes better outcomes with regard to health, public safety, and personal dignity among the housed individuals.

There are three types of permanent supportive housing models: Single-site based, mixed-population, and scattered-site models.

- A. Single-Site Model Permanent Supportive Housing** This is traditionally a single multi-family apartment building with all units occupied by supportive housing residents and with the benefit of on-site supportive services.
- B. Mixed-Population Model Permanent Supportive Housing** This is traditionally a single multi-family apartment building where a portion of the units are set aside for supportive housing residents and may include on-site supportive services. Both single site and mixed population models of permanent supportive housing are traditionally produced using community development or affordable housing financing.
- C. Scattered-Site Model Permanent Supportive Housing** This is financial rental assistance funds provided directly to residents who then secure rental housing from private landlords in the community. The most common program which provides this form of supportive housing is the federal Housing Choice Voucher (“Section 8” program). Supportive services are then provided directly to tenants through mobile teams in the community.

To provide an inventory of available permanent supportive housing, this report relied upon data reported by the Los Angeles Homeless Services Authority (LAHSA). LAHSA is an independent Joint Powers Authority which was created in 1993 by the City and County of Los Angeles. LAHSA operates as the lead agency for the Los Angeles Continuum of Care and is responsible for collecting an annual Housing Inventory Count information of all beds and units in the Continuum of Care’s eight Service Planning Areas.

The 2015 Housing Inventory Count has been completed, but has not yet broken down the data into a detailed analysis. Therefore, this report relies upon both 2014 and 2015 data, as identified below:

- 17,172 total permanent supportive housing beds of varying type (2015 Housing Inventory Count);
- 3,606 permanent supportive housing beds which are expressly set aside for individuals who are chronically homeless, mentally ill, returning from jail, or multi-diagnosed (2014 Housing Inventory Count);
- 4,285 permanent supportive housing beds which are uncategorized, so it is unclear whether or not they would be available to the criminal justice mentally ill offender population (2014 Housing Inventory Count);
- 1,903 “other permanent housing” beds, which do not include supportive services, and are thus not actually considered to be permanent supportive housing in the total count (2014 Housing Inventory Count).

Notwithstanding these figures, there remains a significant gap between the available housing and the demand for housing options for the homeless and mentally ill population. In addition to permanent supportive housing, there are other kinds of housing as well, which are described as follows. However, substituting temporary or transitional housing for permanent housing, when permanent housing is truly necessary, does not solve the ultimate problem and can result in more transition points where people can fall between the cracks.

Bridge Housing Bridge housing is temporary housing for people in need while a housing navigation team works with clients to secure appropriate permanent supportive housing once it becomes available. Bridge housing has no set maximum stay and is generally provided through local, accessible service organizations within the Continuum of Care. By minimizing barriers to participate, clients are encouraged to move from the streets into a safe bed. Having a stable location greatly assists clients to keep meetings and appointments.

Shelter Plus Care Shelter Plus Care provides federally subsidized housing through a services-match grant for individuals and families who meet the Department of Housing and Urban Development's ("HUD") definition of homelessness. The supportive services match must be equal to or greater than the rental assistance award. These grants allow a variety of housing rental situations. To be eligible, a person must be homeless, with a mental illness, substance abuse problem, HIV/AIDS, or a dual diagnosis. Shelter Plus Care does not require a background check.

Department of Mental Health Shelter Plus Care This is similar to Shelter Plus Care housing, but participants must be Department of Mental Health clients. DMH contracts with the Housing Authority of the City of Los Angeles ("HACLA") and the Housing Authority of the County of Los Angeles ("HACoLA"), to provide Shelter Plus Care certificates to eligible clients. To be eligible, individuals must be at least 18 years of age, meet the HUD criteria for homelessness, have a diagnosis of severe and persistent mental illness, including a co-occurring substance use disorder, and agree to maintain active contact with DMH for case management and other mental health services for as long as the certification is valid (at least five years).

HUD-VASH Vouchers This is a veteran's housing program, which combines Section 8 rental assistance vouchers with case management and clinical services, which are provided by the Los Angeles Veterans Affairs Medical Center ("Medical Center"). Clients must be Veterans Affairs Supportive Housing ("VASH") eligible veterans. The Medical Center determines whether homeless veterans and families are eligible for VASH benefits. The local housing authority determines eligibility for the rental subsidy. As a condition of the program, participants must receive case management services from the Medical Center.

Rapid Re-Housing This program is designed to help persons who recently became homeless, not the chronically homeless. It quickly provides housing, so recipients may pursue employment, health and social service needs and get back on their feet.

Mental Health Services Act ("MHSA") Housing Program There are a total of 976 Mental Health Services Act funded units which are an option for some homeless mentally ill offenders returning to the community from custody, but some offenders will not qualify based on their criminal history. If an offender is enrolled in a Full Service Partnership program, they are eligible to receive assistance with their housing needs, and in these situations the Department of Mental Health can provide a subsidy by using MHSA funds to rent a unit from a private property owner. Under this program, DMH requires that the tenant be engaged in mental health treatment, and the housing developments must provide onsite supportive services.

In addition to permanent supportive housing, there are various short term stay beds in the County such as emergency shelters. However, they cannot effectively be used for mental health diversion from the jail since they are too uncertain and short term in nature—since they are usually first-come, first-served, a spot is not certain even on a day-to-day basis.

There are several significant efforts currently in progress within the County, regarding housing services.

Coordinated Entry System The Coordinated Entry System is an effort to capture and electronically input data from clients and landlords to create a real-time list of individuals experiencing homelessness in our communities, and to quickly triage and efficiently match these individuals to available housing resources and services that best fit their needs. Clients are surveyed using an assessment tool known as the “VI-SPDAT,” which provides a survey score. Clients identified with the greatest need of a particular housing type are referred to eligible housing opportunities as they become available. The Coordinated Entry System relies on the Homeless Management Information System, which is a federally mandated database used to collect information on homelessness. Housing providers that receive any federal HUD funding are required to input their available units by type, subsidy, eligibility criteria and number of units into the system, to ensure an accurate inventory of beds available for potentially qualifying tenants. All homeless service providers are encouraged to participate even if they do not receive federal funding. As of September 2014, LAHSA reported a participation rate of 65% for emergency shelter programs, 67% for transitional housing programs and 83% for permanent housing programs.

Department of Health Services - Flexible Housing Subsidy Pool The Flexible Housing Subsidy Pool is a rental subsidy program which currently provides permanent supportive housing to patients who are homeless and have experienced two or more hospital visits in one year. This program allows the provider to contract for housing, providing a range of options that include intensive case management, wrap-around services, and move-in assistance. To fund the program, DHS has partnered with private foundations, which provides maximum flexibility because participants are not restricted based on criminal history and the restrictive federal definition of homelessness does not apply. DHS has established a goal of securing 10,000 permanent supportive housing units for this program.

Breaking Barriers Program Breaking Barriers was jointly launched by the Probation Department and the Department of Health Services in June, 2015. It is a two-year pilot program to provide rapid re-housing and case management services for eligible offenders supervised by the Probation Department. These offenders are homeless, have been identified as moderate to high risk of re-offending, and have expressed a desire to seek full-time employment. Each client is provided intensive case management, employment services, a housing unit and a rental subsidy, with the client contributing a percentage of their monthly income towards the rent. Once stabilized, participants work to successfully “transition in place,” eventually taking over the full rental payment amount so that they can continue to reside in their unit once participation in the program expires. The maximum length of program participation is 24 months, with case management aftercare services continuing for 3 months after program completion.

Just In Reach Program This Sheriff's Department program was developed to improve custody discharge planning for homeless individuals who repeatedly cycle through the jail, primarily due to their homelessness. Just In Reach targets individuals who are either currently homeless or at risk of homelessness, repeat offenders, and those who are charged with lower level offenses; specifically, offenders who have been in jail three times in the last three years and who have been homeless three times in the last five years. The program offers participants comprehensive assessments, case plans, and linkage to community services to assist participants to secure permanent supportive housing and remain self-sufficient.

Notwithstanding each of these resources and programs which are currently underway, significant gaps in services remain: Los Angeles County currently has no permanent supportive housing dedicated to the justice-involved population with mental illness.

Permanent supportive housing beds are needed to serve this specific population, who currently face many barriers to successful re-entry, such as housing restrictions based on their history of incarceration and long housing wait lists. This population currently must independently apply for supportive housing through the standard homeless service delivery system.

Even with an investment into additional permanent supportive housing, it is clear that some homeless mentally ill offenders exiting custody would not have immediate access to a permanent supportive housing placement until a spot becomes available in the system that could be matched to meet their individualized service needs.

This is particularly true because there are a myriad of legal definitions and requirements which may apply, especially for federally funded housing programs, which often restrict participation based upon criminal background checks and make it difficult for the justice involved homeless population reentering the community to stabilize.

For example, for programs funded under federal HUD guidelines, the federal definition of homelessness applies. Under that definition, inmates who serve 90 days or more of custody in the county jail do not qualify as homeless, even if they were homeless before they entered the jail. Instead, they would have to reestablish homelessness, such as by going to an emergency shelter, before being processed onto a list for appropriate housing.

There is also a federal housing restriction which would prevent a person who is being released from jail from returning to live at their original home, if it would mean cohabiting with a family member who holds a Section 8 voucher. This means that even when there is a family member of a mentally ill person who is willing to have them, it would prevent them from being welcomed back into the home. Instead, the mentally ill offender would have to compete for their own permanent supportive housing or face homelessness.

To address these gaps, the County should also secure additional bridge housing capacity for this specific population. Bridge housing would provide a safe bed for the population of justice involved homeless individuals exiting custody until appropriate permanent supportive housing can be secured.

Additional investment should also be made into subsidized housing through the Flexible Housing Subsidy Pool, Shelter Plus Care and DMH Shelter Plus Care programs to provide the County with the flexibility to quickly and strategically invest in housing and services based on need and availability. Focusing on connecting these resources to the most difficult to house population would help to break the cycle of returns to custody.

The following housing-related recommendations are made to this Board:

1. Allocate sufficient funding to the Flexible Housing Subsidy Pool for 200 permanent supportive housing scattered site units for a five-year period. These will provide immediate access to housing for the mentally ill population leaving custody;
2. Allocate sufficient funding to the Flexible Housing Subsidy Pool for rapid re-housing rental assistance for 200 people for a five-year period;
3. Allocate sufficient funding to contract for 200 units to be subsidized by the federal Rental Assistance Program that are prioritized for qualifying mentally ill offenders exiting custody in need of permanent supportive housing;
4. Allocate sufficient funding for 400 supportive housing units to be provided through new construction or rehabilitation of single site or mixed population developments;
5. Allocate sufficient funding within the Department of Mental Health Specialized Housing Program to add housing subsidies for approximately 300 individuals to be housed in permanent supportive housing and 200 individuals to be placed in bridge housing while participating in Full Service Partnership, Field Capable Clinical Services and Wellness Center treatment services. It is anticipated that this funding would allow DMH staff to negotiate with private housing providers on behalf of inmates to pay for move-in costs and provide rental assistance.

It is recommended that a Mental Health Diversion County Housing Director position be created to generally oversee housing issues related to mentally ill offenders who are justice involved. Housing issues are often fragmented due to the different entities involved at the city, county, state and federal level; for example, the Housing Authority of the City of Los Angeles (“HACLA”); Housing Authority of the County of Los Angeles (“HACoLA”) and the Los Angeles Homeless Services Authority (“LAHSA”). If appointed, the proposed Mental Health County Housing Director would serve as a member of the Permanent Mental Health Diversion Planning Committee, discussed more fully in this report in the section entitled “Proposed Expansion of Mental Health Diversion Related Staffing and Services.”

CO-OCCURRING SUBSTANCE ABUSE DISORDERS

As instructed by this Board's motion dated May 6, 2014, the stakeholders have assumed as a goal the diversion of a total of 1,000 mentally ill offenders from the jail into community based treatment options, although that certainly will not happen overnight. According to the Department of Public Health and the Department of Mental Health, approximately 80 percent of those persons may have a co-occurring substance abuse disorder involving drugs, alcohol or both. This would require planning for the appropriate service referrals and placement of approximately 800 additional mentally ill offenders also suffering from substance abuse problems.

The Department of Public Health, the Department of Mental Health and the Sheriff's Department all agree that mental illness with co-occurring substance abuse disorder is a priority problem among this offender population which presents specialized treatment challenges. For example, mentally ill offenders who suffer from substance abuse disorders may need stabilization and/or medically managed care in a Sobering Center, Residential Detoxification or Residential Drug Treatment Program before accessing appropriate mental health treatment. Mentally ill persons suffering from untreated substance abuse disorders are less likely to accept available mental health resources and engage in their own mental health treatment.

The following current programs and resources relate specifically to co-occurring substance abuse disorders:

Alcohol and Drug Free Living Center Services Currently, the Department of Public Health offers alcohol and drug free living center ("ADFLC") services in limited capacity for clients who are enrolled in outpatient substance abuse disorder outpatient services. These are housing facilities where clients recovering from alcohol and drug problems reside, and the presence of and use of alcohol or drugs, other than prescribed drugs, is forbidden. This type of housing environment is suitable for individuals with a stable co-occurring disorder condition.

Co-Occurring Integrated Care Network ("COIN") This court-based program is a collaboration between the Department of Public Health, the Department of Mental Health and the Superior Court. The COIN program serves the needs of AB 109 offenders who have a co-occurring chronic substance abuse disorder coupled with a severe and persistent mental illness, by making intensive, inpatient services available. The Probation Department and the Parole Revocation Court identify offenders who are at a high risk for relapse and would benefit from integrated substance abuse and mental health treatment. The COIN program was established in 2013, but recently expanded in early 2015 to serve clients in an additional two service areas. Twenty beds are reserved specifically for AB 109 supervised persons with co-occurring disorder.

Probation Department Co-Occurring Caseloads The Probation Department has developed Co-Occurring Caseloads. Persons with mental health issues and co-occurring substance abuse disorders who are under court supervision are identified, and provided with a Deputy Probation Officer who specializes in these issues. The Deputy Probation Officers assigned to this caseload are provided additional training in order to build a knowledge base of what services are available in the community for these supervised persons, and how to

more effectively supervise them. The Probation Department developed a 20 hour course on this subject entitled “Case Management of AB 109 Clients with Co-Occurring Disorders” which was available to both Deputy Probation Officers and Supervising Deputy Probation Officers.

Co-Occurring Disorders Court (“CODC”) Co-Occurring Disorders court is an option for offenders who have failed at previous attempts at substance abuse treatment and who have a severe or persistent mental illness. Specified low-level felony charges are eligible for this program. The court requires a guilty plea, followed by 90 days at the Antelope Valley Rehabilitation Center and then placement into a full service partnership which includes medication, housing, benefits evaluation, and educational and vocational assistance.

Women’s Community Reintegration Services and Education Center (“Women’s Center”) The Women’s Center is a jail in-reach program for women with mental health needs who are being released from jail at the Century Regional Detention Facility. These women struggle with histories of repeated arrests and incarcerations, persistent mental illness and co-occurring substance abuse disorder, domestic and community violence, unemployment, financial instability and children in out-of-home placement. Through the Department of Mental Health, the Women’s Reintegration Center provides release planning groups, one-to-one interviews, and outpatient services upon release to equip these women with the life skills necessary to succeed outside of jail.

There currently does not exist an analogous men’s program. However, the Department of Mental Health already has a plan underway to add one as follows:

Men’s Integrated Reentry Services and Education Center (“Men’s Center”)_The Men’s Center will serve men with mental illnesses and co-occurring substance abuse disorders being released from Men’s Central Jail or Twin Towers Correctional Facility. The Men’s Center will be able to serve up to 40 clients at a time, assuming an average length of stay in the community for 59 1/2 days. The Men’s Center will not only provide an innovative model of care for men who struggle with their mental illnesses and other life issues, but will also serve as an education and training center for a variety of integrated care providers and interns.

Four key gaps in services have been identified relating to the co-occurring disorder population, for which additional resources are recommended:

- 1. Sobering Centers** Los Angeles County currently does not have any Sobering Centers, which would provide a place for first responders to take mentally ill persons who are not suitable to be brought to an Urgent Care Center, as an alternative option to jail. The typical model for a Sobering Center would be an 8 hour stay before being referred to other services.
- 2. Residential Medical Detoxification Services** These residential facilities are directed toward the care and treatment of persons in active withdrawal from alcohol and/or opiate dependence, for up to 14 days.

- 3. Residential Treatment Services** Residential treatment facilities provide a structured, 24 hour a day environment which are non-institutional and non-medical, but provide rehabilitation services to clients suffering from substance abuse disorders. Clients can stay for up to 90 days, and more days may be required with clinical justification.

- 4. IMD Beds Designated for Co-Occurring Disorders** For the most acutely mentally ill offenders, there is currently an insufficient supply of IMD beds for individuals with serious mental illness and co-occurring substance abuse disorder, who are in need of treatment in a secure setting. The Department of Mental Health is requesting funding for 40 additional IMD beds for individuals with co-occurring disorders rather than have them remain in the jail. These beds could serve individuals with criminal justice histories who are placed on conservatorships.

IMPACT OF PROPOSITION 47

On November 5, 2014, Prop. 47 was enacted by the voters of California. Prop. 47 reduced common felony theft and drug possession offenses to misdemeanors. Although the long-term impact of Prop. 47 on the jail population and mental health diversion efforts cannot completely be known at this time, two observations can be made.

First, Prop. 47 did not result in any immediate reduction in the mentally ill population in the jail even though the total jail population has dropped. To the contrary, the mentally ill population has gradually increased. According to the Sheriff's Department, the average jail population mental health count in 2013 was 3,081 total inmates; in 2014, it was 3,467 total inmates; and as of June 16, 2015, it was 3,614 total inmates. This could be the result of an overall increase in the mentally ill population in the County, but may also be a result of more diagnoses being made due to increased attention and sensitivity to this issue. Regardless of the reasons for this increase in the mental health population, the numbers are certainly not any lower after Prop. 47.

Second, Prop. 47 crimes by definition are non-violent and lower-level. Presumably, this could make it more difficult to identify offenders for mental health diversion, since there would be fewer non-violent felony offenders in the county jail to choose from for diversion. It is difficult to reconcile these competing observations. Further analysis of the mentally ill jail population may shed light upon these issue and guide further discussion regarding diversion.

On June 9, 2015, this Board instructed the interim CEO to provide an independent analysis of the actual number of treatment beds and other beds needed at the new Consolidated Correctional Treatment Facility ("CCTF") and to conduct a capacity assessment of all community-based alternative options for treatment including, but not limited to, mental health and substance abuse treatment.

CURRENT JAIL PROGRAMS AND RESOURCES

There are currently a variety of jail programs which provide mental health treatment for those who are currently incarcerated, seek to link them to services upon their release, or are alternative custody programs. In particular, the following current efforts are noteworthy.

LASD Population Management Bureau The Sheriff's Department has enhanced its transitional services systems through collaboration with the Department of Mental Health and Jail Mental Health Services. The LASD works with Jail Mental Health case managers to process vital records such as birth certificates and California ID cards. This is a preliminary step to completing Affordable Care Act (Medi-Cal) enrollment. With the assistance of the Department of Public Social Services, benefits are effective the day of release from custody.

If a mentally ill inmate is entitled to Homeless General Relief, a coordinated release is conducted and the client is driven to the Department of Public Social Services immediately following release to receive their General Relief benefits. Additionally, through a collaborative effort with Jail Mental Health Services, the inmate is linked with services such as emergency shelter before their discharge date, so that they will have someplace to live when they are released.

In fact, the Sheriff's Department has consistently provided transportation assistance to take offenders from the jail directly to a myriad of services, including mental health services, residential substance abuse programs, transitional housing, emergency shelters, employment services, social services, mother-infant residential programs, veteran-specific programs, parolee substance abuse service, HIV services, temporary financial assistance and food benefits to families and individuals. This transportation service has filled a gap to greatly assist offenders to connect with needed services upon their release.

Affordable Care Act Program On July 1, 2014, the Sheriff's Department began the Affordable Care Act ("ACA") Project. This is a two-year grant program in collaboration with the Departments of Mental Health, Public Health, Health Services and Public Social Services. All sentenced inmates who are within 60 days of their release date are contacted and assisted to complete and submit Medi-Cal applications, which are processed within 45 days of their release. Inmates who require hospitalization outside of the custody environment, or who are in community treatment with electronic monitoring, can use their benefits as a source of payment for care. As of May, 2015, a total of 8,175 applications were taken and 1,766 inmates received benefits upon their release from custody.

Jail Mental Evaluation Teams ("JMETs") The JMETs are co-deployed teams where DMH clinicians are paired with Sheriff's personnel within the jail, just as the MET teams are co-deployed teams in the field. The JMETs oversee care of inmates in the general population who are on psychiatric medications but are not severely mentally ill and do not require specialized mental health housing. The JMETs also regularly go through the jail to promptly identify inmates who were not identified as having mental health problems upon their initial intake at the jail, or who have decompensated while incarcerated, so that they can receive services.

AB 109 Mental Health Alternative Custody Pilot Program The Sheriff's Department is currently working with the Department of Mental Health on a new alternative to custody program, which will have a 42 bed capacity. The location, Normandie Village East, is a licensed adult care residential facility which is a "step-down" from higher levels of care.

AB 109 offenders who have been incarcerated for low-level and non-violent offenses that appear to be a result of their mental illnesses will be eligible. Referrals to the program will be accepted from various sources including Jail Mental Health Services, the Department of Mental Health Court Linkage Program and the LASD. Admissions will be authorized through the DMH Countywide Resource Management Center. Program participants will be electronically monitored. Criteria are currently being developed to select participants, and discussions are ongoing regarding appropriate mental health programming. There is a October, 2015 goal for implementation.

LASD Inmate Services Bureau, Education Based Incarceration Unit ("EBI") The Sheriff's Department has expanded its mental health programming services to both the male and female population. Currently, the LASD provides mental health programming to over 200 mentally ill inmates a week. This includes specific life skills classes taught by the Five Keys Charter School and by other outside volunteers. Exploratory discussions are underway regarding how to better organize and present material to optimize time and access to sub-groups within the mentally ill population. The LASD is also deploying "comfort dogs" to visit the mental health floors on a regular basis.

Restoration of Competency "ROC" Program Ordinarily, felony offenders who are mentally incompetent to stand trial receive mental health treatment at a state hospital, to restore them to competency. However, there are so few state hospital beds that there is a waiting list for treatment, resulting in lengthy delays while these persons remain in custody, awaiting treatment. At any given time, Los Angeles may have up to two hundred felony inmates who are incompetent to stand trial. In response to this problem, the LASD has entered into a contract with the San Bernardino County Sheriff's Department and Liberty Healthcare regarding services to restore these defendants to mental competency.

The Restoration of Competency "ROC" Program has a 76 bed capacity and is anticipated to be implemented this summer. The ROC program is an intensive, individualized treatment program comparable to restoration services at a state hospital. Treatment is provided by an array of mental health professionals. The sooner offenders can be restored to mental competency, the sooner they can move through the justice system and complete their criminal cases. This program is entirely funded by the state.

Jail Linkage Program Inmates with mental illness require specialized assistance with release planning. The Department of Mental Health Jail Linkage Program works throughout the jail system with clients who require all levels of release planning assistance, from minimal to comprehensive. Jail Linkage personnel coordinate with Jail Mental Health Services, with Department of Mental Health Countywide Resource Management for AB 109 clients, and with the LASD Community Reentry Resource Center, which was created by the Sheriff's Population Management Bureau in 2014 as an information source for all inmates being released.

Mental Health Forensic Outreach Teams (“FOT”) Many inmates with mental illness do not successfully transition to treatment and services in the community, which increases the possibility of recidivism. Forensic Outreach Teams under contract with the Department of Mental Health assist approximately 1,260 inmates annually who are released from county jails upon the completion of AB 109 sentences.

Forensic Outreach Teams can provide both jail in-reach and intensive short-term case management for up to 60 days after release, for persons referred to contracted AB 109 providers. Jail in-reach efforts help to build relationships with inmates before they re-enter the community. Building trust in providers and the health care system can help offenders comply with treatment recommendations regarding health, mental health, and/or substance abuse issues. After release, the Forensic Outreach Teams provide additional assistance for successful linkage to community services.

Public Defender and Alternate Public Defender Jail Mental Health Team The Public Defender has conceived and proposed an innovative new jail program aimed at a broader, more holistic legal representation of detained mentally ill offenders who are housed at the county jail. Public Defender clients would be referred through their existing attorney of record, by the existing Public Defender Mental Health Unit, or otherwise. Once referred, the clients would be evaluated by in-house psychiatric social workers, so that the Public Defender’s Office could begin to engage proactively with their clients at the earliest possible stage of the criminal justice process. This type of expert assistance would enable the Public Defender’s Office to actively collaborate with other justice stakeholders such as the Sheriff’s Department and Department of Mental Health.

The Public Defender has also requested the addition of psychiatric social workers to be housed at their branch offices throughout the County. Both the jail social workers and the branch social workers would be well-placed to efficiently communicate “real-time” information about their clients’ mental state to assigned attorneys in courts and therefore address longstanding gaps in communication from county jail to courtroom personnel, including judges and attorneys. This increased communication will reduce case continuances, expedite case processing, better facilitate the delivery of mental health services, reduce jail overcrowding, and improve the overall administration of justice.

The Advisory Board supports this proposed new program not only for Public Defender clients, but also for offenders who are represented by the Alternate Public Defender as well. Clients who suffer from mental illnesses and are interviewed in the jail are much more likely to be willing to be frank and forthcoming with a psychiatric social worker who is assigned to their own legal team, than with a clinician who is not. Indeed, mentally ill clients commonly fail to fully cooperate with Department of Mental Health personnel or admit their active symptoms, such as visual and auditory hallucinations, due to the nature of the jail environment and their own concerns that making such admissions could be used against them and possibly result in additional incarceration.

Therefore, the Advisory Board believes that this proposal has merit and should be supported by this Board.

CURRENT COURT PROGRAMS AND RESOURCES

Department of Mental Health Court Linkage/Court Liaison Program The Court Linkage program is a collaboration between the Department of Mental Health and the Los Angeles County Superior Court. Court Linkage is staffed by a team of 21 mental health clinicians who are co-located at 22 courts countywide. This recovery based program serves adults with mental illness or co-occurring substance abuse disorders who are involved with the criminal justice system.

Through the Court Linkage Program, there is a specialized program by which offenders can be placed in licensed, long term psychiatric care (“IMD”) beds. The specialized Court Linkage IMD bed program serves 50 individuals at any given time who are pre-adjudicated and agree to receive treatment in lieu of sentencing. The program served 112 individuals in Fiscal Year 2013-2014.

Although full figures for Fiscal Year 2013-2014 are not yet available, last year’s figures show that the Court Linkage Program helped to divert a total of 1,053 persons out of 1,997 possible referrals. This group of about a thousand mentally ill offenders annually is placed across the spectrum of available treatment options, which were discussed in detail in the preceding section entitled, “Other Treatment Options: After the First 24 Hours.”

There are several reasons why not every offender who is contacted by the Court Linkage Program can actually be diverted: Some refuse services; some are sentenced by the court to state prison or otherwise in a way that would foreclose treatment; some may not have an available treatment option which matches their mental health needs; some may have an available treatment option from a mental health perspective, but one which is not acceptable to the court and counsel from a public safety perspective. Again, it bears emphasis that not every mentally ill offender can safely be removed from a custodial setting.

However, the fact that more than half of the offenders contacted by the Court Linkage Program are able to be diverted is a significant success, which is worthy of attention. The Court Linkage Program is a resource which may benefit from additional expansion of assigned personnel in future years. The District Attorney’s Office is currently preparing a new office policy memorandum to ensure that each of the office’s deputies is aware of the efforts made by the Court Linkage Program and appropriately coordinates with the Department of Mental Health so that they can evaluate mentally ill offenders for potential diversion opportunities.

The Court Liaison Program provides ongoing support to families and educates the court and the community at large regarding the specific needs of mentally ill individuals. Mental Health Court Liaison services include on-site courthouse outreach to defendants, individual service needs assessments, providing information to individuals and the court about appropriate treatment options, development of post-release plans, linkage of individuals to treatment programs, expedited mental health referrals, and providing support and assistance to defendants and families in navigating the court system.

Mental Health Court/Department 95 The Los Angeles County Mental Health Court handles matters which are referred from criminal courts throughout the County. The court is staffed with lawyers from the District Attorney’s Office, Public Defender and Alternate Public Defender. Department 95 handles a wide range of proceedings, including issues relating to mental incompetence to stand trial, post-conviction defendants who were adjudicated as not guilty by

reason of insanity, or alleged to be a mentally disordered offender (“MDO”) and are the subject of a petition for restoration or an extension of a parole commitment.

The 2014 Superior Court Annual Statistics Report provides a snapshot example of the volume of matters handled in Department 95. In 2014, an average of 198 new cases per month were sent to Department 95 upon the issue of incompetence to stand trial; this does not include the cases carried over from 2013. The total number of cases under the supervision of the Mental Health Court during 2014 was 118,551.

Veteran’s Court Veteran’s Court is a diversion program for veterans charged with felonies who suffer from post-traumatic stress disorder or traumatic brain injury. Most of the veterans in this court have alcohol or drug addiction problems and if these problems were caused or exacerbated by military service, the veteran will be considered for the program. Veterans from all areas of the county are eligible to participate. A guilty plea is required and a dismissal is the usual result for successfully completing the program. All costs of housing, transportation and treatment are borne by the Veterans’ Administration.

Santa Monica Homeless Court Program This program, operated by the Santa Monica City Attorney’s Office in coordination with the Superior Court, is available to homeless individuals who have quality of life or other minor misdemeanor charges pending. Following the successful completion of a 90 day program, charges are dismissed. Services such as mental health treatment, substance abuse assistance, job placement, and assistance in finding permanent supportive housing are provided through the City of Santa Monica and are largely funded through annual grants.

Homeless Court Clinic This program, operated by the Los Angeles City Attorney in coordination with the Superior Court, serves adults who are either homeless or at risk of homelessness, who may also suffer from mental illness, substance/alcohol addiction, co-occurring disorders, or are veterans. The program helps to resolve legal barriers to care and connect them with appropriate service providers to address the challenges that they face on the road to recovery, including permanent supportive housing. In exchange for community obligation hours worked by participants, certain traffic and quality of life offenses, such as low-level misdemeanor charges, warrants and fines can be resolved. These clinics operate as mobile one-day events where participants are assisted by a myriad of stakeholder representatives and service providers.

EXPANSION OF MENTAL HEALTH DIVERSION RELATED STAFFING AND SERVICES

In addition to the need for additional resources earmarked for CIT training and co-deployed MET teams, as well as expansion of the mental health Urgent Care Centers, Crisis Residential beds and other available treatment services, the following improvements are also proposed.

Criminal Justice Mental Health Diversion Permanent Planning Committee Based upon the experiences of other large jurisdictions, it is anticipated that mental health diversion will be a long-term project for some years to come. The Advisory Board and Working Group participants are committed to the project, but cannot reasonably devote full-time attention to it, since each has other primary job duties which are also important. The District Attorney fully and personally supports this effort and is committed to leading it indefinitely.

It will be necessary to dedicate additional permanent employee positions to fully implement mental health diversion. This cannot be accomplished by any one person given the nature and magnitude of the anticipated workload, and the need for collaborative input. Therefore, the Advisory Board recommends a small, workable Permanent Planning Committee, to be comprised of one representative from each of the following County Departments: District Attorney, Public Defender, Sheriff's Department, Department of Mental Health, Department of Public Health, Department of Health Services, proposed new Mental Health Diversion County Housing Director, and others appointed by the District Attorney on an as needed basis. These personnel would be management-level employees, with significant operational experience, to be able to bridge the gap between high-level policy recommendations and actual implementation decisions.

In addition to the employee needs related to the Permanent Planning Committee, both the Sheriff's Department and the Department of Mental Health are requesting additional funding for employees and other costs, as follows:

Sheriff's Department Mental Evaluation Bureau In future years, the Sheriff's Department proposes to establish a new Mental Evaluation Bureau in order to enhance current services to mentally ill persons. For example, a serious problem exists involving mentally ill persons who are the subject of repeated calls for service, which cost the County millions of dollars in emergency resources without positive outcomes.

The new Mental Evaluation Bureau would operate 24 hours a day, seven days a week. Upon encountering a mentally ill person in crisis, patrol deputies could communicate with Desk Operations Triage to coordinate service calls and determine whether the co-deployed MET teams would roll out. If the Triage Desk determined that a call involves a person who was the subject of frequent calls for intervention, a referral to a Consolidated Case Management Team would be made.

The Sheriff's Consolidated Case Management Team would help manage cases that involve persons with a history of violent criminal activity caused by mental illness, and cases that involve persons whose mental illness has caused numerous responses by law enforcement or the deployment of substantial resources. The Consolidated Case Management Team would be the liaison point with the Homicide Bureau-Missing Persons Unit to determine whether a missing

person had been placed on a 5150 hold. The Consolidated Case Management Team would also manage a database to track and update contacts with mentally ill persons and other data which would help to evaluate and improve departmental crisis responses. Finally, the Consolidated Case Management Team would attempt to link mentally ill offenders with available resources.

The Mental Evaluation Bureau would also include a Crisis Negotiations Team, Training Unit and Community Relations Unit. The Crisis Negotiations Team would handle situations involving hostage takers, barricaded suspects, and other persons who pose an immediate, violent threat to themselves or the community.

The Training Division would create and maintain a Mental Health Training Manual, review use of force incidents involving mentally ill persons, review and revise office policies regarding contacts with mentally ill persons, and conduct both basic mental health training and CIT training. The Community Relations Unit would act as a liaison with the Department of Mental Health, other stakeholders and the community in implementing jail diversion programs.

The Mental Evaluation Bureau would be co-supported by the Department of Mental Health. The total staffing request for the Mental Evaluation Bureau is currently estimated at 68 Sheriff's Department personnel and 32 Department of Mental Health personnel. However, funding will be requested from the County no sooner than Fiscal Year 2016-2017.

Countywide Adult Justice Planning and Development Program The Department of Mental Health also requests four additional administrative staffing items to help conceptualize, develop and implement the jail diversion plan. This program infrastructure would help ensure that a wide range of mental health programs are made available at all intercepts in the criminal justice system, and to oversee the existing Mental Health Jail Linkage Program and Court Linkage Programs, which have been discussed separately in preceding sections of this report.

Forensic Additions to Existing Mental Health Programs As previously described, the Department of Mental Health already has services which were designed for the non-criminal population, but proposes to expand with separate "Forensic" or "Justice Involved" versions of the same programs, which would permit a specialized focus on the criminal justice population: Full Service Partnership, Field Capable Clinical Services and Wellness Centers.

Reentry Referral and Linkage Network of Care This proposal is a computer systems network solution designed for the Department of Mental Health, building on existing Jail Linkage and Countywide Resource Management Programs. Ideally, this would be an easily accessible online resource which could: (1) capture and store the assessments of post-release needs of mentally ill inmates; (2) identify service providers to meet the needs; (3) consolidate referral information for each inmate in a format that can be easily printed and shared with an inmate; (4) communicate electronically with service providers to make the referrals; (5) receive electronic responses back from service providers regarding referrals, such as acknowledgement of receipt and confirmation of placement; (6) allow electronic communication with the clients upon their release.

RECOMMENDATIONS

Based on this report, the Advisory Board recommends the following:

1. CIT Training

- Train 5,355 patrol deputies in the full 40 hour CIT Training over the next six years;
- Support the 16 hour CIT training program under the auspices of the District Attorney and Criminal Justice Institute;
- District Attorney Training Liaison and District Attorney Management Assistant.

2. Mental Health Treatment Resource Expansion, Priority

- Add three new Department of Mental Health Urgent Care Centers;
- Add 35 new Crisis Residential Treatment Programs;
- Add “Forensic” or “Justice Involved” versions of Full Service Partnerships, Field Capable Clinical Services and Wellness Centers; in the alternative, increase the staffing of current programs to support anticipated pre-booking diversion of mentally ill offenders;
- 40 additional IMD beds designated for co-occurring disorders;
- Four Additional DMH administrative staffing items;
- Additional Court Linkage personnel.

3. Permanent Mental Health Diversion Planning Committee

- Create and maintain the Permanent Planning Committee.

4. Public Health/Health Services Treatment Resource Expansion

- Sobering Centers;
- Residential Medical Detoxification Services;
- Residential Substance Abuse Treatment Facilities.

5. Housing Services Enhancements

- Create Mental Health Diversion County Housing Director position.
- 200 permanent supportive housing beds through Flexible Housing Subsidy Pool for five years;
- 200 rapid re-housing beds through Flexible Housing Subsidy Pool for five years;
- 200 units to be subsidized by federal monies;
- 400 supportive housing units through new construction or rehabilitation;
- Fund within the Department of Mental Health Specialized Housing Program, 300 housing subsidies for permanent supportive housing and 200 housing subsidies for bridge housing.

6. Co-deployed teams

- MET team expansion of 15 additional teams to a minimum total of 23 teams.
- SMART team expansion of 16 additional teams, to a minimum total of 34 teams.

7. Data improvements

- Development of Cerner Hub inter-departmental interface or other solution to data sharing problems;
- Department of Mental Health Reentry Referral and Linkage Network of Care.
- Based upon these data sharing solutions, set aside funds for a consultant to be employed which can assist the County with metrics which will allow management by outcomes to take place.

8. Public Defender and Alternate Public Defender Jail Mental Health Teams

- Jail based psychiatric social workers and supervisors;
- Branch based psychiatric social workers and supervisors.

9. Mental Health Treatment Resource Expansion, Lower Priority

- Men's Integrated Reentry Services and Education Center;
- Co-deployed Department of Mental Health personnel at Probation offices, to be commenced on a pilot project basis at five offices which span the geographic boundaries of the county.

10. LASD Mental Health Bureau

- Establish the new Mental Health Bureau. (Fiscal Year 2016 - 2017)

CONCLUSION

Various counties, municipalities, and metropolitan areas across the country have commenced the journey towards improving the interface between the low level mentally ill criminal offender and the criminal justice system. The keys to their success have been making modest, pragmatic first steps to improve systemic responses to the problem; the “all in” collaboration of the pertinent criminal justice system partners; and the willingness to make a long term commitment to the goal of improving the plight of mentally ill offenders in the criminal justice system.

Through the work of the Criminal Justice Mental Health Advisory Board, unprecedented collaboration has been demonstrated by the criminal justice system partners. Further, the many efforts to date by public and private entities to treat mentally ill persons in Los Angeles County has been laudable. What is needed at this critical juncture is the integration, coordination, and expansion to scale of these resources. This report represents a plan for going forward. Being ever mindful of public safety and victims’ rights, it is time to take the next steps in the long journey.

Los Angeles County District Attorney's Office

Sequential Intercept Mapping Report – LA County, CA

Executive Summary

Prepared by: Policy Research Associates, Inc.
Hank Steadman, Ph.D.
Dan Abreu, M.S., C.R.C., L.M.H.C.
Travis Parker, M.S., L.I.M.H.P., C.P.C.

The Los Angeles County District Attorney's Office contracted with Policy Research Associates, Inc. (PRA) to develop behavioral health and criminal justice system maps focusing on the existing connections between behavioral health and criminal justice programs to identify resources, gaps and priorities in Los Angeles County, CA. On May 28, 2014, approximately 100 participants attended a county-wide summit/kickoff held to begin this process and address the significant issue of persons with behavioral health disorders involved in the criminal justice system. Additionally, there were 46 cross-systems partners from mental health, substance abuse treatment, health care, human services, corrections, advocates, consumers, law enforcement, health care (emergency department and inpatient acute psychiatric care), and the courts that participated in the Los Angeles County Sequential Intercept Mapping and priority planning on July 8, 2014.

There is a longstanding recognition that persons with behavioral health disorders are over-represented in the criminal justice system. The Sequential Intercept Mapping workshop has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along five distinct intercept points: Law Enforcement and Emergency Services, Initial Detention and Initial Court Hearings, Jails and Courts, Re-entry, and Community Corrections/Community Support.
2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.
3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population.

The recommendations that follow are informed by the work of PRA over the last 18 months in Chicago, Illinois; New Orleans, Louisiana; New York City, New York; as well as Miami, Florida. In addition, PRA has provided training and technical assistance to over 100 jurisdictions, Tribes, and states across the United States. The recommendations stemming from the Los Angeles County Sequential Intercept Mapping are timely, as they also support many of the recommendations set forth in the 2011 Administrative Office of the Courts Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report. Additionally, the California Mental Health Wellness Act of 2013 supports the work and recommendations of the cross-systems Sequential Intercept Mapping group in that it ensures key behavioral health and criminal justice collaborators are involved in the planning and implementation of key strategic initiatives needed to improve the lives and outcomes of justice involved individuals with behavioral health disorders.

The products of the Sequential Intercept Model workgroup culminated with the recommendation of formalizing a county wide planning body to address the needs of justice involved persons with co-occurring mental health and substance use disorders being the number one priority. PRA concurs with this as the top priority, as formalized planning bodies promote the needed communication, collaboration and coordination which must be present in order for quality diversion programs and efforts to occur. Los Angeles County currently has a number of mental health and criminal justice initiatives that already involve criminal justice partners and can either directly support the work of the county wide planning body or that can be integrated with the work of the planning body. Existing efforts include, but are not limited to: Integrated Behavioral Health Information Systems (IBHIS); The Corporation for Supportive Housing (CSH) Mental Health, Jail Diversion and Supportive Housing Proposal; CSH/Department of Mental Health (DMH) funded Emergency Room diversion programs; and Advancing Safe and Healthy Homes Initiatives/DMH Healthy Homes Initiative. It will be critical for this county wide planning body to not only consider how it will relate to these on-going planning efforts, but also how it will influence the planning and implementation of future efforts.

The quality and growth of this formalized planning body is strongly supported by the second priority, which calls for the utilization of data analysis and data matching to better inform decisions regarding diversion opportunities for justice involved persons with behavioral health disorders. Additionally, the second priority recommends the creation of a criminal justice/mental health technical assistance/resource center. PRA concurs with the priority level of this recommendation and has extensive experience working with Centers of Excellence, including those in Ohio, Illinois, Florida and Pennsylvania. Los Angeles currently has a number of key experts county-wide who can be utilized to implement its specialized center for communication, coordination and collaboration.

At the conclusion of the Los Angeles County systemwide summit and Sequential Intercept Mapping workshop, PRA took note that there are several on-going initiatives, some of which have been identified above, that currently address identified gaps or can increase access to care for justice involved individuals with behavioral health disorders if awareness is raised and needs identified. Rather than taking a heavy focus on the development of new initiatives and resources, PRA is instead utilizing an “adapt and expand” approach to the priorities and recommendations stemming out of the gaps identified during the Sequential Intercept Mapping workshop. This “adapt and expand” approach is designed to not only improve county-wide system response to justice involved persons with behavioral health disorders, but also to create additional capacity to better reach and engage this underserved population of individuals in Los Angeles County.

At **Intercept 1**, PRA recommends that Los Angeles County enhance/expand law enforcement’s specialized response and mental health crisis response, such as Systemwide Mental Assessment Response Teams (SMART), Mental Evaluation Teams (MET), and Crisis Intervention Teams

(CIT). There are also insufficient resources available for Los Angeles County's Psychiatric Mobile Response Teams (PMRT). Participants in the Summit Workshop and Mapping Workshop were satisfied with the quality of these law enforcement specialized response and mental health crisis response teams; however, multiple participants cited examples noting the need for additional resources and expansion to better serve and have a broader impact for justice involved individuals with behavioral health disorders. PRA makes this recommendation based upon our extensive nationwide work with specialized law enforcement and mental health crisis response systems such as CIT, as well as our current work with Intercept 1 Early Diversion Substance Abuse and Mental Health Services Administration (SAMHSA) grantees in Colorado, Tennessee and Connecticut. It will be important for Los Angeles County to include criminal justice/behavioral health partners such as law enforcement, crisis stabilization centers, and psychiatric emergency departments in these enhancement/expansion planning meetings.

At **Intercept 2**, PRA recommends the expansion of diversion opportunities at arraignment and the improvement of screening efforts for diversion at later stages. The DMH Mental Health Court Linkage Program is an innovative resource that Los Angeles County has operated for 10 years. Mapping workshop participants reported that the program's capacity to serve persons has not increased during that same period. Utilization of this program was uneven across the county and there was a lack of alignment between the judiciary, prosecutors and the Court Linkage Program regarding diversion philosophy. It is also recommended at Intercept 2, that Los Angeles County implement a Probation Pre-Trial Release program. There is a notable absence of Intercept 2 diversion opportunities present for justice involved persons with behavioral health disorders in Los Angeles County. PRA has seen the value of diversion efforts at this Intercept based upon our work over the last dozen years with just under 20 SAMHSA grantees from across the United States engaged in Targeted Capacity Expansion (TCE) jail diversion efforts.

At **Intercept 3**, PRA recommends the expansion of post-arraignment diversion opportunities for defendants with behavioral health disorders who are charged not only with misdemeanors, but also low level felony offenses. Strategies listed above in Intercept 2 also apply for this Intercept. Expanding capacity for the DMH Court Linkage Program, improving stakeholder alignment regarding diversion and implementing a pre-trial supervision program can increase potential diversion opportunities at Intercept 3. In addition, adding a jail diversion screening component at the jail can increase identification of potential diversion candidates. Jail diversion staff can work with the Court Linkage Program and defense counsel to present a diversion plan to the courts. Diversion strategies at this Intercept should seek to minimize collateral sanctions, such as the housing and employment barriers which are often present for individuals post-incarceration. For justice involved persons with behavioral health disorders, these collateral sanctions also impede recovery. Specialty courts are not required for Intercept 3 diversion. Pre-trial supervision or periodic status updates by providers to the court for proscribed time frames can be very effective as well. For more serious felony level charges, persons can be sentenced to probation with conditions tailored to mental health treatment if appropriate.

At **Intercept 4**, PRA recommends expanding the capacity of the DMH Jail Navigator program as well as the capacity of existing reentry programs found through providers such as: Just In Reach, the Los Angeles City Attorney's Office HALO Program, Women's Reentry Court, and the Los Angeles Sheriff Department's Community Reentry Center. Both the Summit and Mapping workshop participants identified extensive resources devoted to reentry planning. Many of these programs reported being able to service additional individuals with additional funding. The DMH Jail Navigators in particular were identified as needing more resources to keep pace with the high volume of referrals and short time frames with which to link individuals to needed services at the point of reentry, including behavioral health and support services.

At **Intercept 5**, PRA recommends the provision of training on the Risk, Need, Responsivity (RNR) and Cognitive Behavioral Health Interventions. Other than housing, which was a gap across all Intercepts, there were not any specific gaps or priorities identified in this Intercept. There are many Best Practices and innovative programs operating within Los Angeles County at this Intercept, including specialized mental health Probation Department caseloads, co-location of mental health staff in Probation Department offices and peer-run programs for Probation clients. The Probation Department performs risk assessments to determine supervision and program needs utilizing RNR principles to manage caseloads. It is important to uniformly share risk assessment information with behavioral health providers and to expand RNR training and Cognitive Behavioral Training to include behavioral health providers in order to insure that criminogenic needs are addressed in behavioral health settings.

The prevalence of individuals with behavioral health disorders in jails and prisons is higher than in the general population. PRA has seen that, on a national level, alternatives to incarceration have gained momentum as a humane and cost effective strategy to reduce criminal justice costs and improve access to needed services and supports without compromising public safety. The early identification of individuals with behavioral health needs at each level or Intercept of contact with the criminal justice system can improve not only their access to care, but also long-term treatment outcomes. The effects of these types of interventions are increasingly showing promise with benefits to society and the potential for long term cost savings.

Los Angeles County District Attorney's Office

Sequential Intercept Mapping Report – LA County, CA

Prepared by: Policy Research Associates, Inc.
Hank Steadman, Ph.D.
Dan Abreu, M.S., C.R.C., L.M.H.C.
Travis Parker, M.S., L.I.M.H.P., C.P.C

Acknowledgement

PRA wishes to thank the Los Angeles County District Attorney's Office for the assistance with the coordination of this event.

Introduction:

The Los Angeles County District Attorney's Office contracted with Policy Research Associates (PRA) to develop behavioral health and criminal justice system maps focusing on the existing connections between behavioral health and criminal justice programs to identify resources, gaps and priorities in Los Angeles County, CA.

Background:

The *Sequential Intercept Mapping workshop* has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along five distinct intercept points: Law Enforcement and Emergency Services, Initial Detention and Initial Court Hearings, Jails and Courts, Re-entry, and Community Corrections/Community Support.
2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.
3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population.

The participants in the workshops represented multiple stakeholder systems including mental health, substance abuse treatment, health care, human services, corrections, advocates, individuals, law enforcement, health care (emergency department and inpatient acute psychiatric care), and the courts. Dan Abreu, M.S., C.R.C., L.M.H.C., and Travis Parker, M.S., L.I.M.H.P., C.P.C., Senior Project Associates for SAMHSA's GAINS Center for Behavioral Health and Justice Transformation and Policy Research Associates, Inc., facilitated the workshop session.

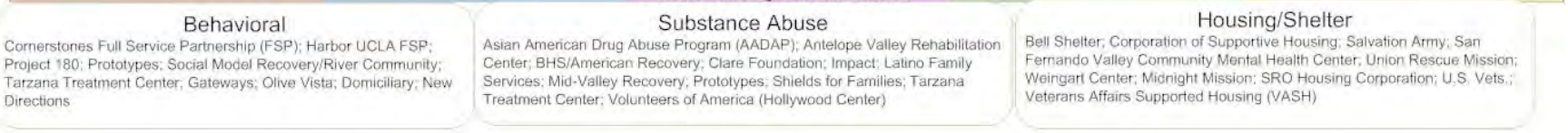
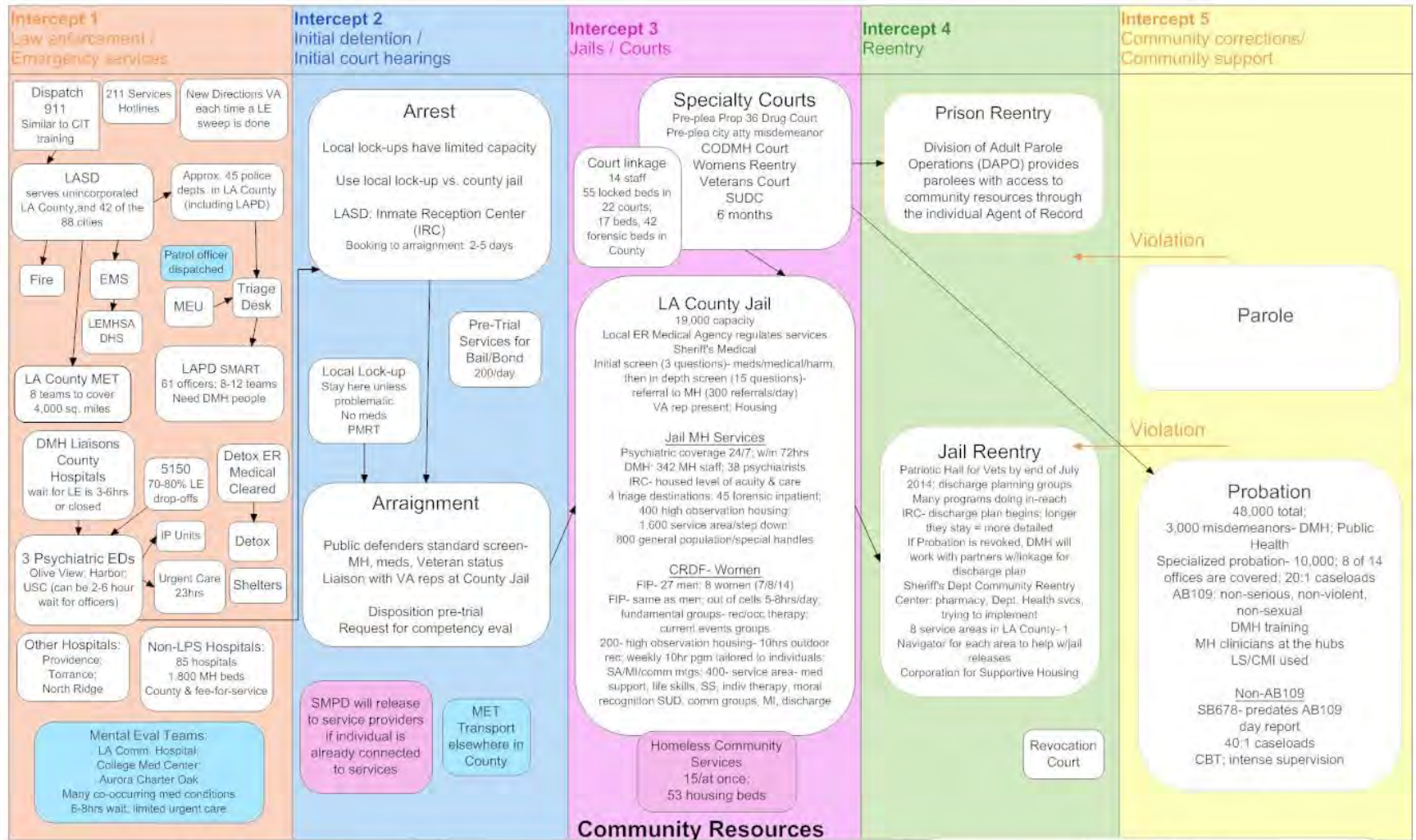
Forty-six (46) people were recorded present at the LA County SIM.

Follow-Up to Mental Health Summit
Sequential Intercept Mapping and Action Planning Workshop
Los Angeles County District Attorney's Office
July 8, 2014

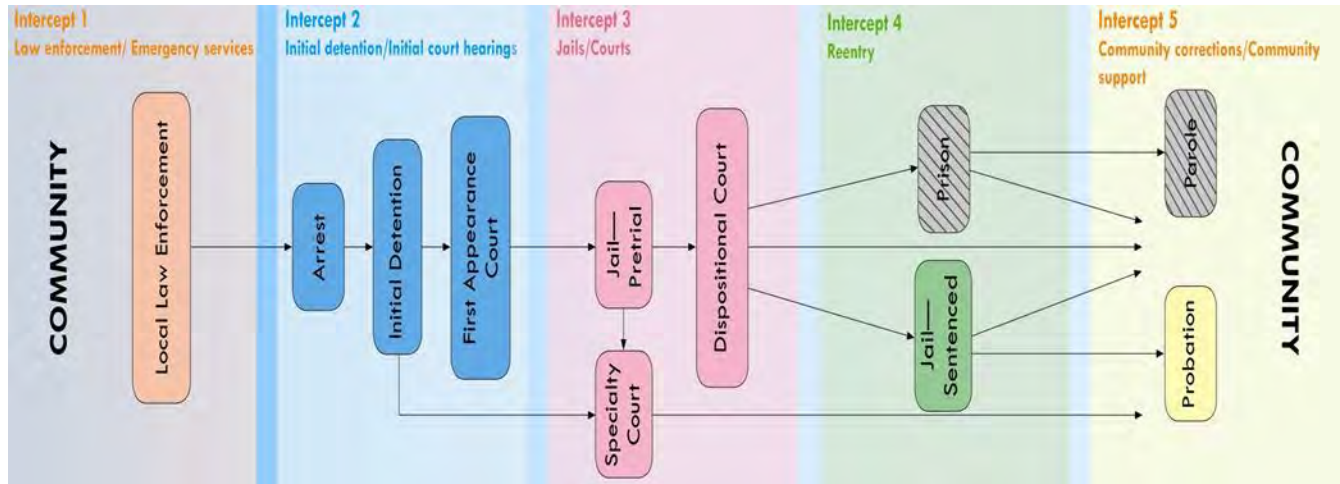
8:00- 8:30a.m.	REGISTRATION AND CONTINENTAL BREAKFAST
8:30 – 8:45 a.m.	WELCOME BY DISTRICT ATTORNEY JACKIE LACEY
8:45 – 9:45 a.m.	REVIEW SUMMIT BREAKOUT GROUP PRIORITIES
9:45 – 10:00 a.m.	BREAK
10:00 a.m. – 12:00 p.m.	MAPPING L . A . EXCERCISE FOR INTERCEPTS I, II/III, AND IV/V
12:00- 1:00 p.m.	LUNCH
1:00- 2:30 p.m.	MAPPING L . A . (Cont.)
2:30 – 2:45 p.m.	BREAK
2:45 – 3:15 p.m.	REFINE AND VOTE ON PRIORITIES
3:15- 4:00 p.m.	ACTION PLANNING IN INTERCEPT GROUPS
4:00 – 4:30 p.m.	REPORT-OUTS TO FULL GROUP

*Special thanks to the California Endowment and the Aileen Getty Foundation
for their generous support.*

Los Angeles County Sequential Intercept Map



Intercept 1



Resources

- Long Beach Police Department has one Mental Evaluation Team (MET) available per day (usually for one shift between 7 a.m. and 1 a.m. depending upon the day of the week).
- Local police departments or the Sheriff's Department will "triage" calls as they come in and determine if the fire department, Emergency Medical Services, etc. is needed for a response as well.
- LA County: 23 Sheriff's stations to serve 42 out of the 88 cities in LA County. Eight (8) MET teams, but only 2-3 on at any given time
- The LAPD dispatcher received Critical Incident Team-like training course. Thirty (30) or more are on duty in the San Fernando Valley.
 - SMART Team can be dispatched upon patrol's request; 8-12 teams per day; 61 staff members.
 - Patrol must contact EMS for direction.
- There are 99 hospitals scattered throughout LA County.
- Long Beach has hospitals; however they have limited psychiatric capacity.
- The Urgent Care Center is a possible alternative to the Emergency Department, although there are capacity issues.
- Private hospitals (Providence) cannot release individuals, which is easier for law enforcement.

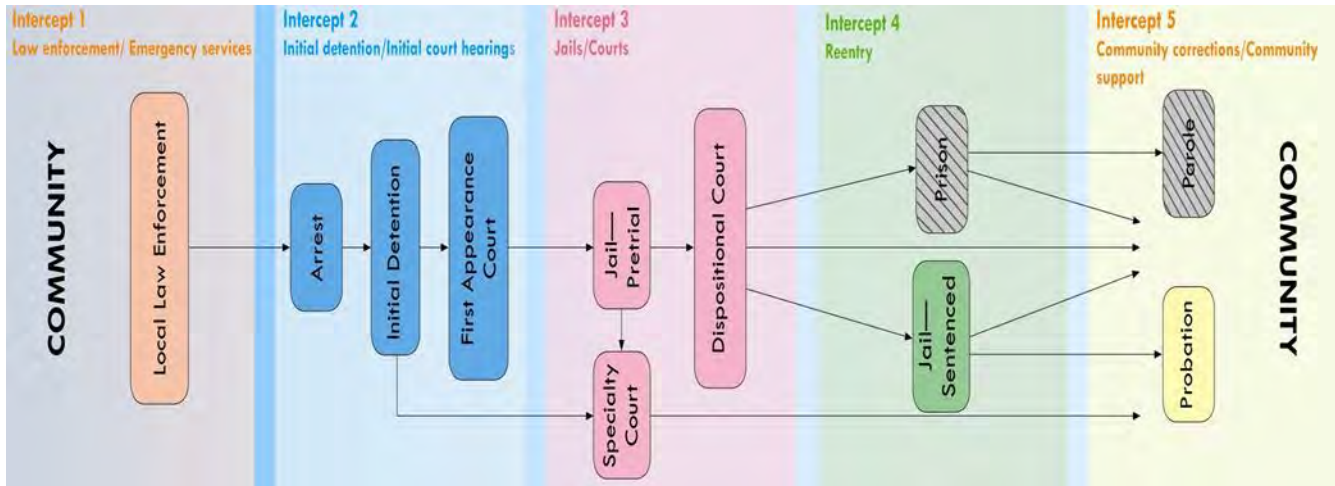
- Aurora Charter Oak and College Hospital-Cerritos have 6 law enforcement beds each, as well as 3 for youth.
- Psychiatric Emergency Departments offer some system decompression and serve as a valuable resource for law enforcement.
- County-wide resource management
- Department of Mental Health liaisons are available/working in inpatient units and Emergency Departments for linkage, as well as linkage/referrals for those without insurance.
- The Corporation for Supportive Housing and the Department of Health Services co-fund an emergency room diversion program.
 - CSH funds 15 hospitals
 - DHS funds 3 hospitals
- County hospital has DMH/DHS databases. A new Integrated Behavioral Health Information Systems data system is on the way.
- AB 1424- Family Form: “You shall take family information about mental illness”
- Street to Home (FUSE): housing voucher and mental health services
- The University of Southern California has an integrated urgent care facility.
- Santa Monica has mental health staff within the police precinct.
- West LA (Skid Row) has a clinician within the police precinct.

Gaps

- Long Beach PD patrol officers have limited training.
- Once the Long Beach MET has been activated, patrol officers are on their own if a psychiatric crisis arises in the meantime.
- The LAPD SMART Teams function 20 hours per day. During the remaining 4 hours each day, the triage of psychiatric crisis calls transitions to the command post.
- It is often more time efficient for law enforcement to book an individual into jail on a minor charge in order to get back into service more quickly, rather than spend many hours waiting in a psychiatric emergency department for the individual to be seen.
- While there are approximately 1,800 hospital beds throughout LA County for psychiatric purposes, only a small percentage of those beds can actually be accessed by individuals who are uninsured or who most frequently come into contact with law enforcement.
- 70-80% of law enforcement drop offs are at the Emergency Department.

- The police can wait up to 3-5 hours in psychiatric emergency departments due to capacity issues. Law enforcement cannot go back into service until the individual is seen by a psychiatrist. Long Beach does not have the resources for a 6-8 hour wait, as staff are working 10 hour shifts.
- Capacity issues at the emergency department cause delays/waits for law enforcement.
- The Volunteers of America Center had a detox program which lost funding.
- Long Beach does not have a practical and available detox facility.
- There are a lack of emergency department and inpatient hospital discharge planning options. Some are referred to urgent care, while others are referred to inpatient treatment or rehabilitation beds.
- There is not a service capacity priority given to persons who are discharging from emergency departments or hospitals for community based treatment.
- There is often a “communication gap” between social workers, community agencies and family members in assisting an individual during their transition from hospital-based to community-based care. If the individual does not sign a release of information form, the social worker will typically not speak with anyone, even in instances of care transitions, coordination, etc. This frequently causes stress and poor outcomes for individuals who already cycle in and out of the criminal justice system, as well as costly, more intense behavioral health treatment settings.
- There is a lack of state support for Crisis Intervention Teams (CIT).
- Private facilities have difficulty with discharge planning and poor family access.
- Law enforcement/crisis response is needed for Veterans.
- Long Beach Urgent Care is not designated to evaluate and treat persons involuntarily detained for mental health reasons under the Lanterman-Petris-Short (LPS) Act.
- Urgent care facilities are needed throughout LA County.
- Centralized drop off locations for law enforcement are needed throughout LA County in an effort to make early diversion a reality.
- Long Beach brings inebriates to jail instead of to a detox center/facility.

Intercepts 2 & 3



Resources

- Psychiatric Mobile Response Teams consist of Department of Mental Health licensed clinical staff assigned to a specific Service Area in Los Angeles County. These licensed clinical staff have the authority to initiate applications for evaluation of involuntary detention.
- The LAPD has access to 21 local lock up facilities throughout the county.
- The Long Beach- MET team can provide reach-in services when individuals are already in lockup and state that they feel like harming or killing themselves.
- Santa Monica- the individuals can be released from local lock-up to a known provider.
 - Ocean Pacific Community Center
 - St. Joseph Center
- LASD Inmate Reception Center (IRC)
 - A 15 question screen is utilized
 - 1,000 booked daily; 1/3 are referred
 - 342 mental health staff (of which 38 are psychiatrists)
 - 24/7 psychiatric coverage
- The Public Defender screens for mental health/veteran status.
- Veterans resources
 - Long Beach/LA for resources
- The LA County Jail has psychiatric coverage 24/7/365, either in person or over the telephone.

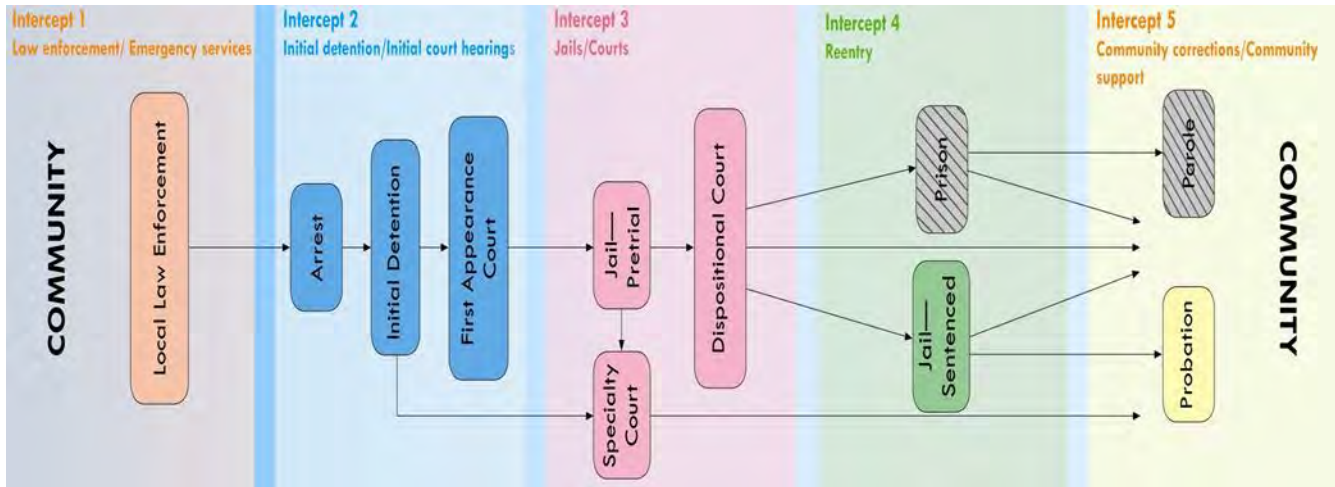
- Co-occurring disorders court diversion is available.
- Mental Health Court Linkage Program has 14 staff members serving 22 courts in LA County to assist with diversion and release to services.
- Sentenced offenders Drug Court- Homeless Community Court- Santa Monica; last created specialty court in 2006-2007 (felonies, generally nonviolent)
- Co-occurring Drug Court- Proposition 36- LA countywide post-conviction
- Specialty courts: Women’s Reentry, Veteran’s Court, Mental Health Court
 - All generally accept non-violent felonies.
- AB 109
- Revocation
- Department 95
- Mobile crisis with housing vouchers
- Integrated clinics
- Institutes of Mental Disease (IMD) step down programs- residential treatment and living situations
- Abandoned property could be used for housing.
- Shared/congregate housing
- Innovative locally-funded (non-HUD) housing models
- Funding is available to match with people who meet criteria.
- Co-located probation and treatment or peer support groups

Gaps

- There is no medication in lockup; this poses problems, particularly on weekends.
- At the LA County Jail, it can take up to 72 hours for an individual to be seen for needed psychiatric medications.
- Long Beach- no assessment or clinical presence
- Develop strategies for multi-disciplinary and collaborative approaches.
- No formalized Intercept 2 diversion exists at the current time.
- It is extremely rare for the Mental Health Court Linkage Program to get someone into services at the point of arraignment court.
- At the time of lockup, there is a heavy reliance primarily upon the individual to self-report key health information.
- No supervised Pretrial Release Program

- No pre-plea diversion
- Specialty courts have very limited capacity and only address a small fraction of cases which could go to specialty courts.
 - Funding is needed to expand capacity.
 - Very restrictive criteria to get into specialty courts
 - Lack of service providers to work with/be dedicated to specialty court participants
- Specialty courts are post-conviction courts; this allows the person to penetrate the criminal justice system even farther.
- Jail-based diversion via non-specialty courts is needed.
- Additional funding for court linkages is needed.
- The capacity of courts and treatment services has remained the same for the last 10-15 years.
- Small numbers of Supportive Housing slots
- Housing requirements are very restrictive for persons with mental health issues and criminal histories.
- The housing demand is much greater than the supply.
- “Not in my backyard” (NIMBY) housing issues throughout LA County

Intercepts 4 & 5



Resources

- 211 services hotline
- Patriot Hall Veterans
- 30-45 days of notice from jail release- can get on the medical list to make certain they leave the jail with a paper MediCal card
- Families are part of the solution.
- Track recidivism rates
- Jail and court linkages work together.
- The LA Sheriff's Department has a Community Reentry Center that has been open since July 2014.
 - Referrals to job centers, substance abuse treatment, assistance with benefits, mental health services and health insurance
- The LA County Jail can keep persons for up to 16 hours after their scheduled release date for further discharge planning/transitioning.
- Productive programs are now in place at the jail for mental health.
- Mental health clinicians are embedded within the Probation Department.
 - Receive information from the prison/jail; transfer information to providers

- 35% are rearrested
- Area offices in multiple locations
- Probation has assumed parole functions with AB 109- Specialized probation- 10,000; 8 of 14 offices are covered with specialized probation; 20:1 caseloads
- Mental health is co-located at Probation Department hubs.
- AB 109 funds the services.
 - Not for the other 48,000 on supervision
 - Work with the Department of Mental Health to establish training on recognizing mental health
- Day Reporting Centers- the state allocated funding to counties for evidence-based practices for adults.
- Probation uses the Level of Service/Case Management Inventory to determine needs and risk assessment.
- Probation is exploring the utilization of SB 678 funds (which predates AB 109) to develop services for the probation population which has served time in state prison and is not AB 109 eligible.
- The National Alliance on Mental Illness could be better utilized to connect individuals discharging from incarceration with their families or other key supports who will be critical to their success and increased community tenure.

Gaps

- Lack of immediate/emergency housing
- Prison release: family connections need to be made sooner; a warm handoff to the families is needed at discharge.
- Little lead time for the jail navigator to put services in place
- Each Service Area has a jail navigator, but oftentimes they are overwhelmed. For example, San Fernando only has one jail navigator for the entire area.
- The LA Sheriff's Department Community Reentry Center is only able to be open 5 days per week.
- The jail has many services, but many inmates have not heard of reentry services.
- With so many inmates incarcerated at the LA County Jail, it is often difficult for good discharge planning and handoffs to occur.
- Probation is generally not available for misdemeanor offenders. Misdemeanor diversion is strongly needed.

- Dr. Frank Pratt (Medical Director for the LA County Fire Department) discussed how being on MediCal offers fewer physical and behavioral health treatment options than having no insurance coverage in some instances.
- There is a need for more Integrated Health Homes. Existing Integrated Health Homes are underdeveloped at this time.

Priorities for Change as Determined by Mapping Participants

- Training for all criminal justice professionals in the system- multi-disciplinary and holistic (17 votes)
- Expand capacity for treatment- continuum of care- for justice-involved persons (16 votes)
 - How much is needed?
 - What is the population?
- Data study to examine services needed, capacity needed, populations most in need, etc. (12 votes)
- Better communication/coordination between all system partners/data system/remove silos; develop policies and procedures to guide capacity utilization; develop resource database (10 votes)
- Crisis Alternative Centers/Crisis Stabilization Centers- law enforcement, families, individuals (9 votes)
- Expand housing for justice-involved persons (8 votes)
- Funding for initiatives and sustainability (4 votes)
- Define future configuration of Mental Health Court/Court Diversion (3 votes)
- Implement a pre-booking diversion program. Shorter drop-off times for law enforcement (3 votes)
- Creation/re-creation of an Intercept 2 diversion point (2 votes)
- Public education about behavioral health, homelessness, stigma, etc. (1 vote)
- Expand/enhance co-response models Psychiatric Mobile Response Teams, SMART, etc. (1 vote)

RECOMMENDATIONS:

Participants in the Summit and Sequential Intercept Mapping Workshop (SIMW) showed genuine interest and commitment to improve the continuum of resources available to justice involved persons with behavioral health disorders. Los Angeles County has many exemplary programs and strategies on which to build. As noted below, there are several on-going initiatives that currently address gaps identified in the report (e.g., SB 82) or can increase access to care for justice involved individuals with behavioral health disorders if awareness is raised and needs identified.

Rather than focusing on the development of new initiatives and resources, the focus of the 11 recommendations listed below is to “Adapt and Expand.”

1. *Formalize a County Wide Planning Body to address the needs of justice involved persons with co-occurring mental health and substance use disorders.*

This recommendation is consistent with Recommendation 5 (p.19) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report (April 2011).

http://www.courts.ca.gov/documents/Mental_Health_Task_Force_Report_042011.pdf

The first and fifth ranked priorities from the SIMW, as voted on by the participants, identified the need for improved cross system training, communication and planning. Workshop participants expressed the need for on-going dialogue, joint planning and increasing awareness regarding system resources. Implementation of initiatives to increase diversion opportunities will require involvement of a broad group of stakeholders with sufficient authority to impact state, county and municipal level change. An LA County planning body should coordinate activities with the Task Force for Criminal Justice Collaboration on Mental Health Issues, which is prepared to implement recommendations from its 2011 report.

Bexar County (Texas), Memphis (Tennessee), New Orleans Parish (Louisiana), and Pima County (Arizona) are examples of counties and municipalities that have developed Criminal Justice Mental Health Planning Committees.

Los Angeles County has 88 cities, 7 of which have over 100,000 residents. As a result, Criminal Justice/Mental Health resources, needs and strategies across the county vary widely. Development of additional localized planning structures to coincide with Department of Mental Health (DMH) Service Areas, judicial districts or municipal regions may facilitate planning, development and the implementation

of programs. Existing DMH Systems Flow Charts can also prove useful in supporting some of this work (Appendix 1).

2. Data Analysis/Matching; Add a County CJ/MH Technical Assistance/Resource Center.

The fourth highest priority identified during the SIMW was to utilize data to inform decisions. Across Intercepts there has been limited data collection and sharing of existing data regarding persons with mental illness in the justice system. Without adequate screening and data collection, it is difficult to identify and prioritize service needs, plan interventions, and target resources for the highest need and highest risk populations.

Participants acknowledged having data on existing programs, but data is not routinely analyzed to inform planning priorities, often due to a lack of resources and data not being strategically disseminated to interested stakeholders.

Resources to address data collection/analysis strategies include:

- The Urban Justice Institute published “Justice Reinvestment at the Local Level Planning and Implementation Guide”
<http://www.urban.org/publications/412233.html>

The guide offers an excellent overview of planning, data collection and justice reinvestment strategies across the criminal justice system.

- The “Mental Health Report Card” used by the King County, Washington Mental Health, Chemical Abuse and Dependency Services to document progress in meeting relevant client outcomes
<http://www.kingcounty.gov/healthservices/MentalHealth/Reports.aspx>
- Data matching between jail admission data bases and community provider databases, as is done in Maricopa County, AZ as described in, “Using Management Information Systems to Locate Persons with Serious Mental Illnesses and Co-occurring Disorders in the Criminal Justice System for Diversion” http://gainscenter.samhsa.gov/pdfs/jail_diversion/using_mis.pdf and in the Illinois Jail Data Link Program, (Appendix 2).
- In 2013, the LA County DMH Jail Team developed a Pre-booking Diversion Proposal, “An Open Door to Recovery” which included a prevalence study of potentially divertible individuals

in Antelope Valley and Long Beach. The study's conclusion was that 72 individuals per day were potentially divertible from jail. This analysis is an excellent example of how data can confirm need and focus system resources. (Appendix 3)

The first and fifth ranked priorities by the participants identified the need for better cross system training, communication and planning. Recommendation 1 focuses on the need for a criminal justice/mental health planning structure.

With a county as large and complex as Los Angeles, there is a need for a resource center where criminal justice/mental health resources, events, and Initiatives can be centralized to:

- Disseminate information
- Track diversion activity
- Publish performance outcome measures
- Aid in planning
- Provide published resources
- Provide Technical Assistance and Training

Such a center can be modeled after technical assistance centers (Centers of Excellence - CoE) in the following states:

- Ohio Coordinating Center of Excellence (CCOE) <http://www.neomed.edu/academics/criminal-justice-coordinating-center-of-excellence>
- Illinois Center of Excellence for Behavioral Health and Justice
University of Illinois Rockford
<http://www.illinoiscenterofexcellence.org/>
- University of South Florida, Criminal Justice Mental Health Reinvestment Technical Assistance Center <http://www.floridatac.com/>
- Pennsylvania Mental Health and Justice CoE
<http://www.pacenterofexcellence.pitt.edu/>

3. Integrate Task Force Activities with system wide initiatives.

LA County has a number of mental health and criminal justice initiatives that can either directly support the work of the Task Force or that can be integrated with the work of the Task Force. Some of these initiatives already involve criminal justice partners. It will be critical for this Task Force to not only consider how it will relate to on-going planning efforts, but also how it will influence the planning and implementation of future efforts. Existing efforts include, but are not limited to:

- Healthy Way LA
- Integrated Behavioral Health Information Systems (IBHIS)
- Mental Health and Wellness Act of 2013
- AB 109 Funding
- Corporation for Supportive Housing (CSH) Mental Health, Jail Diversion and Supportive Housing Proposal (Appendix 4)
- CSH/DMH funded Emergency room diversion programs
- Policy Research Associates through its SAMHSA GAINS Technical Assistance Center recently provided a Train the Trainer event: *How Being Trauma-Informed Improves Criminal Justice System Responses*. The lead agency for the event was Tarzana Treatment Centers, which provides Seeking Safety Training as part of the Healthy Way LA initiative and provides outreach recruitment services into the jail for transitional housing programs. For a list of trainees at the recent event see Appendix 5.
- Program planning for LA County's new jail
- Advancing Safe and Healthy Homes Initiative/DMH Healthy Home Initiatives

4. Integrate Peer Programs and Peer Support Staff into planning and service delivery.

This recommendation is consistent with Recommendation 73 (p.42) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report. The California Health Report recently published an article regarding Peer Respite Centers (Appendix 6). The programs described are excellent examples of utilization of peer models and an opportunity to adapt and expand existing programs.

Participants reported peer involvement in service delivery at various Intercept points.

Peer involvement in the Summit and Mapping Workshop was minimal. It is recommended that peers be formally involved in planning efforts moving forward. Depending on whether or not peers are currently employed, they may need stipends to travel to meetings, for meals and/or be paid for their time.

5. Expand screening for Veterans across Intercepts. Allow early diversion and misdemeanor alternatives for Veterans.

There is currently a felony, post-conviction Veterans Court in LA County. While this program is an important component of diversion alternatives for Veterans, providing diversion for misdemeanors, as well as lesser felony offenses earlier in the court process will allow for earlier intervention and likely better outcomes for Veterans. [It should be noted here, as well as throughout this document, “diversion” means diversion from jail or prison, as opposed to the more narrowly circumscribed statutory authorized diversion set forth in California Penal Code section 1000 et seq.]

Using the “Adapt and Expand” philosophy, LA County already has substantial resources for Veterans. Aside from the Department of Veterans Affairs services, the following programs, for example could be adapted, expanded or linked to diversion activities:

- Los Angeles City Attorney’s Office HALO program
- Los Angeles City Attorney’s Office VALOR program
- Patriotic Hall

In addition, the Department of Mental Health has Veteran specific mental health programs which could service Veterans who are not eligible for VA services or who do not wish to utilize VA services.

6. Consider broad approaches to improving accessible housing for justice involved individuals.

This recommendation is consistent with Housing Recommendations (pp.43 and 44) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Both Summit Participants and Mapping Workshop participants identified housing as a critical gap across Intercepts.

LA County is fortunate to have the Corporation for Supportive Housing as a stakeholder and they have already proposed housing strategies for justice involved individuals (Appendix 4).

INTERCEPT SPECIFIC RECOMMENDATIONS:

Intercept 1

7. Enhance/Expand Police Specialized Response and Mental Health Crisis Response, such as Systemwide Mental Assessment Response Teams (SMART), Mental Evaluation Teams (MET), and Crisis Intervention Teams (CIT).

This recommendation is consistent with Recommendations 7 and 8 (pp.19 and 20) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Expansion of specialized police response (e.g., SMART, MET, CIT) and improved crisis response was the third highest ranked priority identified in the SIM Mapping Workshop. In addition, participants in the Mental Health Summit, Intercept 1 Workgroup also identified insufficient resources for Psychiatric Mobile Mental Response Teams (PMRT) and crisis response options as gaps.

Participants in both the Summit Workshop and Mapping Workshop were satisfied with police specialized response teams, but noted that the LAPD SMART Team responds to approximately 35% of all calls. Elsewhere in the County, specialized police response is available in Long Beach and Santa Monica, as well as through the Los Angeles Sheriff's Department, which has 8 MET teams.

Participants in the Summit Workshop and the Mapping Workshop identified lack of crisis response options, especially crisis stabilization units as a significant gap. The Long Beach Police Department in particular identified long wait times (up to 6-8 hours) in area emergency departments as a significant issue. Participants noted that waiting for an available psychiatrist in the psychiatric emergency departments often accounted for delays. Lengthy delays for these types of important diversionary services often leave law enforcement with the difficult decision of whether to spend several hours "out of service" with a person while he or she waits to be seen in an emergency department or a psychiatric emergency department or, in the alternative, to take the person into custody, book him or her into a local jail, and return to service. The Psychiatric Mobile Mental Response Teams were also seen as valuable partners, but participants noted that there were insufficient resources to meet demands.

The Department of Mental Health has several initiatives underway to address this recommendation (Appendix 7).

Representatives from the City of Long Beach also identified a lack of a detoxification (sobering) facility, which has resulted in serial inebriates being incarcerated. San Diego has had a successful Serial Inebriate Program for several years and information about their program can be found at:

<http://www.sandiego.gov/sip/index.htm>

Intercept 2

8. Expand diversion opportunities at arraignment and improve screening for diversion at later stages:

- *Bring the Department of Mental Health Court Liaison Teams to scale.*
- *Improve alignment regarding diversion at this intercept among stakeholders.*
- *Implement a Probation Pre-Trial Release Program*

This recommendation is consistent with Recommendations 12,15,16,17 and 18 (pp. 23-24) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Systemic screening for mental health issues and Veteran status is not present at the first court appearance or arraignment. Key mental health screening partners at this diversion point are defense counsel and the Probation Department. Resources may have to be added to these agencies to enhance screening and referral.

The DMH Mental Health Court Linkage Program is an innovative resource that LA County has operated for 10 years. Participants reported that the program's capacity to serve persons has not increased during that same period. Utilization of the DMH Court Liaison Program, a component of the Mental Health Court Linkage Program, was uneven across the county and there was a lack of alignment between the judiciary, prosecutors and Court Liaison Program regarding diversion philosophy.

Participants also expressed the opinion that housing was a barrier to diversion at this Intercept. While housing would likely improve successful diversion, diversion can be successful with individuals who are homeless, as demonstrated by the New York City CASES Transitional Case Management Program (Appendix 8). Reports from the Court Liaison Program also indicate that successful diversion can be accomplished with individuals who are homeless.

Diversion programs which emphasize engagement strategies, direct linkage, focus on immediate needs, and prompt access to community services can be successful even when there are not significant court sanctions available.

People with mental illness have more bail risk factors and are more likely to be remanded to jail. Pre-trial supervision programs allow for greater access to pre-trial release for persons with mental illness.

When additional court leverage is preferred, implementation of a Probation Department pre-trial supervision program can reassure the court that individuals are appropriately monitored and held accountable for adhering to release conditions.

Intercept 3

9. Expand post-arraignment diversion opportunities for defendants charged not only with misdemeanors but also felonies.

This recommendation is consistent with Recommendations 12,15,16,17 and 18 (pp. 23-24) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Strategies listed above in Intercept 2 also apply for this Intercept. Expanding capacity for the Court Liaison Teams, improving stakeholder alignment regarding diversion and implementing a pre-trial supervision program can increase diversion opportunities.

In addition, adding a jail diversion screening component at the jail can increase identification of potential diversion candidates. Jail diversion staff can work with the Court Liaison Team and defense counsel to present a diversion plan to the courts.

Diversion strategies at this Intercept should seek to minimize collateral sanctions, such as barriers to employment, housing, court fines, access to public benefits and voting rights. The Legal Action Center's ***After Prison: Roadblocks to Reentry*** (<http://www.lac.org/roadblocks-to-reentry/>) is an excellent review of sanctions which create employment and housing barriers and impede recovery.

Specialty Courts are not required for Intercept 3 diversion. Pre-trial supervision or periodic status updates by providers to the court for proscribed time frames can be effective. For more serious charges, persons can be sentenced to Probation with appropriate conditions.

Court Self-Help Centers could help address the unplanned releases from courts (see "Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report" Recommendation 39, p.30).

Intercept 4

10. Expand DMH Jail Navigator capacity and capacity of existing reentry programs.

Both the Summit and Mapping Workshop participants identified extensive resources devoted to reentry planning. Many of these programs reported being able to service additional individuals with additional funding. The DMH Jail Navigators in particular were identified as needing more resources to keep pace with the high volume of referrals and short time-frames with which to link individuals to services. Other providers include, but are not limited to:

- Just In Reach
- HALO Program
- Women’s Reentry Court
- LASD Community Reentry Center

Intercept 5

11. Provide training on the Risk, Need, Responsivity (RNR) and Cognitive Behavioral Interventions.

This recommendation is consistent with Recommendations 57, 60, 62, 63 and 64 (pp. 36-37) of the Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report.

Other than housing, which was a gap across all Intercepts, there were no specific gaps or priorities identified for this Intercept. There are many best practices and innovative programs operating at this Intercept, including specialized mental health Probation caseloads, co-location of Department of Mental Health staff in Probation Department offices and peer-run programs for Probation clients.

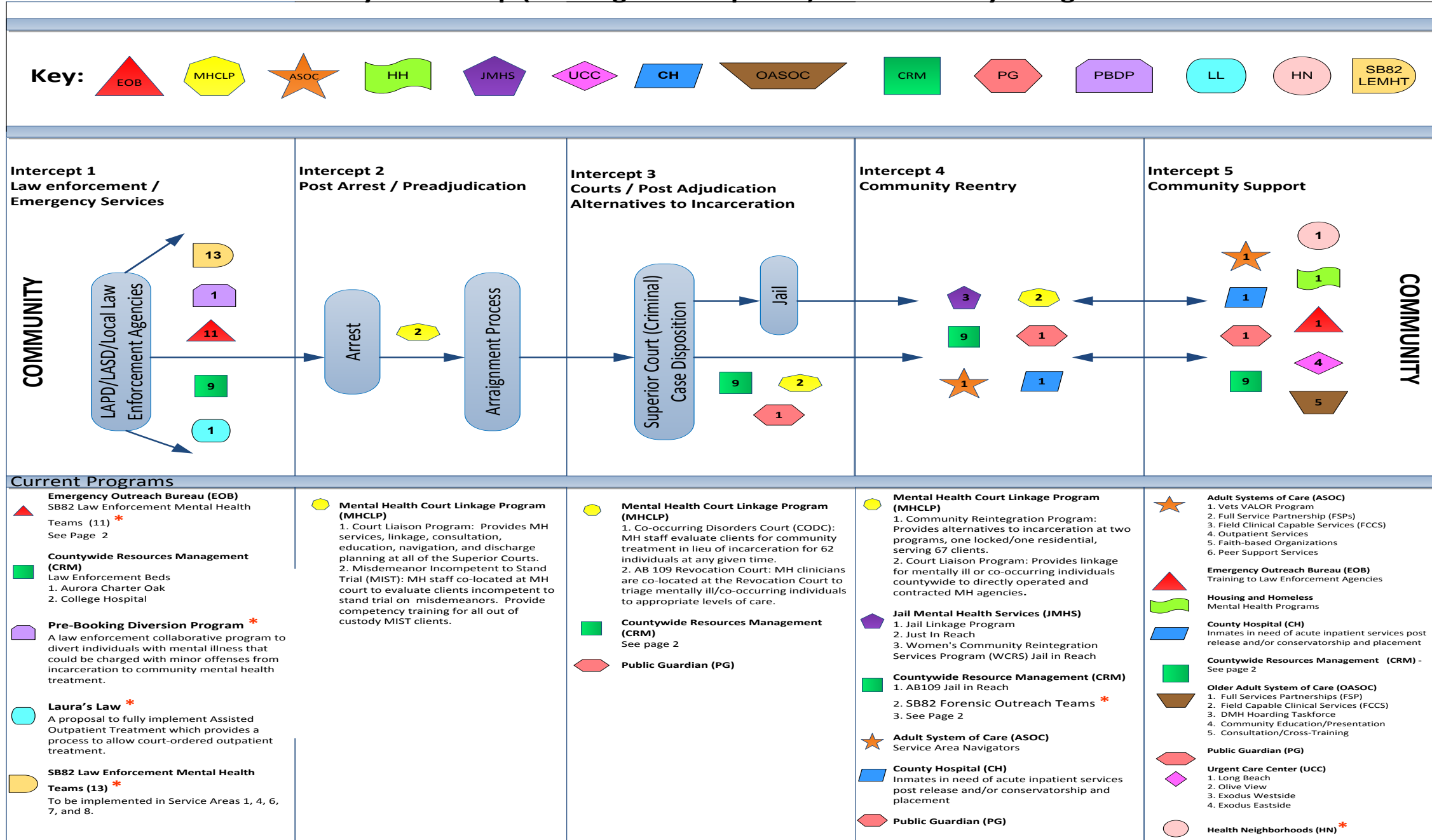
The Probation Department performs risk assessments to determine supervision and program needs utilizing the Risk, Need, Responsivity (RNR) principle. This principle targets specific criminogenic risk factors to reduce recidivism and guide the intensity of supervision required.

https://cpoc.memberclicks.net/assets/Realignment/risk_need_2007-06_e.pdf. It is important for the Probation Department to uniformly share risk assessment information with behavioral health providers and to expand RNR training and Cognitive Behavioral Treatment interventions which insure that criminogenic needs are addressed in behavioral health settings.

Appendix 1:

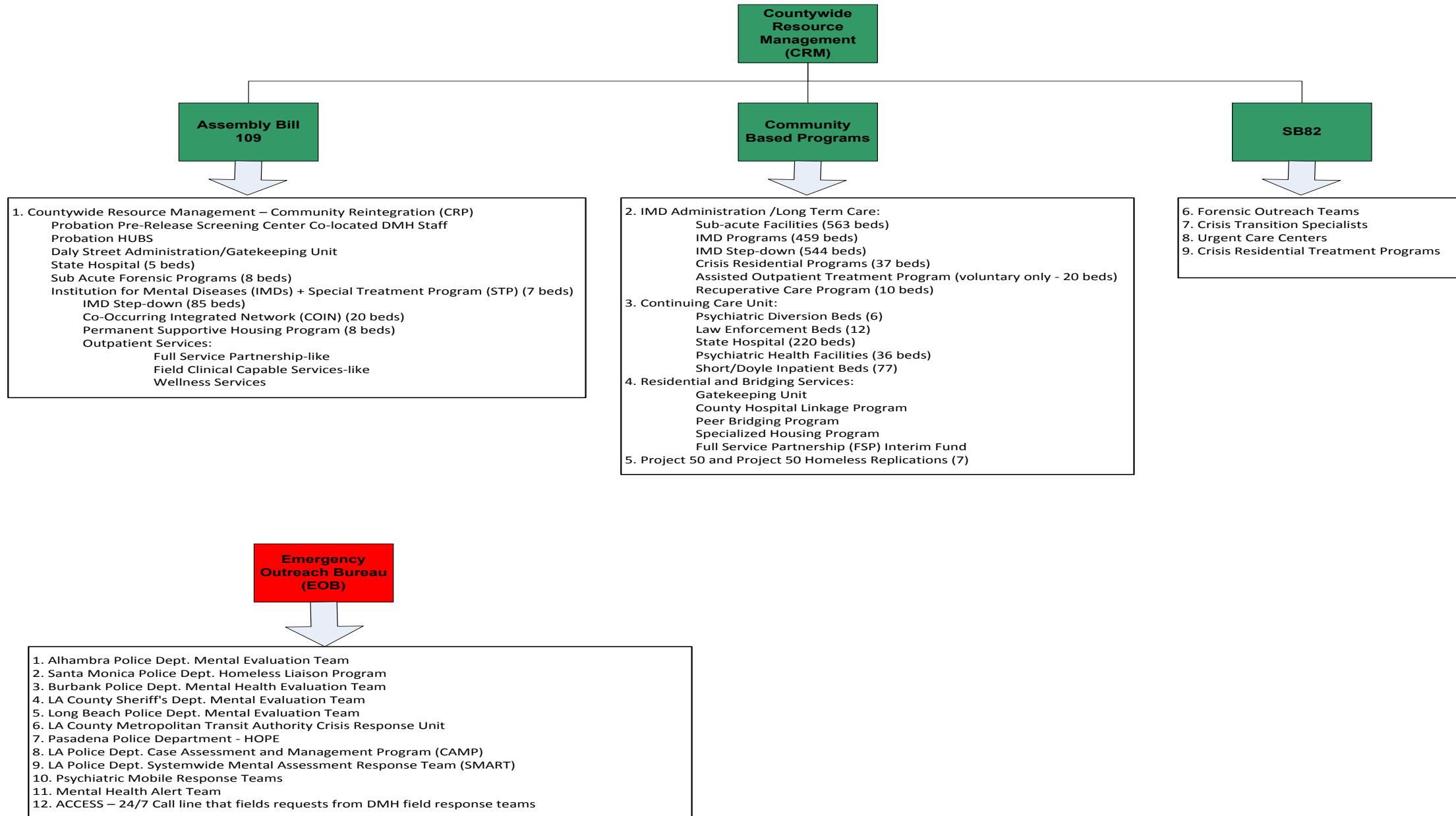
LA DMH Systems Map

County of Los Angeles – Department of Mental Health Systems Map (Existing and Proposed) – Diversion by Design



* Proposed

County of Los Angeles – Department of Mental Health Systems Map (Current)



Appendix 2:

IL Jail Data Link

Jail Data Link Frequent Users A Data Matching Initiative in Illinois

Overview of the Initiative

The Corporation for Supportive Housing (CSH) has funded the expansion of a data matching initiative at Cook County Jail designed to identify users of both Cook County Jail and the State of Illinois Division of Mental Health (DMH).

This is a secure internet based database that assists communities in identifying frequent users of multiple systems to assist them in coordinating and leveraging scarce resources more effectively. Jail Data Link helps staff at a county jail to identify jail detainees who have had past contact with the state mental health system for purposes of discharge planning. This system allows both the jail staff and partnering case managers at community agencies to know when their current clients are in the jail. Jail Data Link, which began in Cook County in 1999, has expanded to four other counties as a result of funding provided by the Illinois Criminal Justice Information Authority and will expand to three additional counties in 2009. In 2008 the Proviso Mental Health Commission funded a dedicated case manager to work exclusively with the project and serve the residents of Proviso Township.

Target Population for Data Link Initiatives

This project targets people currently in a county jail who have had contact with the Illinois Division of Mental Health.

- **Jail Data Link – Cook County:** Identifies on a daily basis detainees who have had documented inpatient/outpatient services with the Illinois Division of Mental Health. Participating agencies sign a data sharing agreement for this project.
- **Jail Data Link – Cook County Frequent Users:** Identifies those current detainees from the Cook County Jail census who have at least two previous State of Illinois psychiatric inpatient hospitalizations and at least two jail stays. This will assist the jail staff in targeting new housing resources as a part of a federally funded research project beginning in 2008.
- **Jail Data Link – Expansion:** The Illinois Criminal Justice Information Authority provided funding to expand the project to Will, Peoria, Jefferson and Marion Counties, and the Proviso Mental Health Commission for Proviso Township residents.

Legal Basis for the Data Matching Initiative

Effective January 1, 2000, the Illinois General Assembly adopted **Public Act 91-0536** which modified the Mental Health and Developmental Disabilities Administrative Act. This act allows the Division of Mental Health, community agencies funded by DMH, and any Illinois county jail to disclose a recipient's record or communications, without consent, to each other, for the purpose of admission, treatment, planning, or discharge. No records may be disclosed to a county jail unless the Department has entered into a written agreement with the specific county jail. Effective July 12, 2005, the Illinois General Assembly also adopted **Public Act 094-0182**, which further modifies the Mental Health and Developmental Disabilities Administrative Act to allow sharing between the Illinois Department of Corrections and DMH.

Using this exception, individual prisons or jails are able to send their entire roster electronically to DMH. Prison and jail information is publically available. DMH matches this information against their own roster and notifies the Department of Corrections Discharge Planning Unit of matches between the two systems along with information about past history and/or involvement with community agencies for purposes of locating appropriate aftercare services.

Sample Data at a Demo Web Site

DMH has designed a password protected web site to post the results of the match and make those results accessible to the Illinois Department of Corrections facility. Community agencies are also able to view the names of their own clients if they have entered into a departmental agreement to use the site.

In addition, DMH set up a demo web site using encrypted data to show how the data match web site works. Use the web site link below and enter the User ID, Password, and PIN number to see sample data for the Returning Home Initiative.

- <https://sisonline.dhs.state.il.us/JailLink/demo.html>
 - UserID: cshdemo
 - Password: cshdemo
 - PIN: 1234

Program Partners and Funding Sources

- **CSH's Returning Home Initiative:** Utilizing funding from the Robert Wood Johnson Foundation, provided \$25,000 towards programming and support for the creation of the Jail Data Link Frequent Users application.
- **Illinois Department of Mental Health:** Administering and financing on-going mental health services and providing secure internet database resource and maintenance.
- **Cermak Health Services:** Providing mental health services and supervision inside the jail facility.
- **Cook County Sheriff's Office:** Assisting with data integration and coordination.
- **Community Mental Health Agencies:** Fourteen (14) agencies statewide are entering and receiving data.
- **Illinois Criminal Justice Authority:** Provided funding for the Jail Data Link Expansion of data technology to three additional counties, as well as initial funding for three additional case managers and the project's evaluation and research through the University of Illinois.
- **Proviso Township Mental Health Commission (708 Board):** Supported Cook County Jail Data Link Expansion into Proviso Township by funding a full-time case manager.
- **University of Illinois:** Performing ongoing evaluation and research

Partnership Between Criminal Justice and Other Public Systems

Cook County Jail and Cermak Health Service have a long history of partnerships with the Illinois Department of Mental Health Services. Pilot projects, including the Thresholds Justice Project and the Felony Mental Health Court of Cook County, have received recognition for developing alternatives to the criminal justice system. Examining the systematic and targeted use of housing as an intervention is a logical extension of this previous work.

Managing the Partnership

CSH is the primary coordinator of a large federal research project studying the effects of permanent supportive housing on reducing recidivism and emergency costs of frequent users of Cook County Jail and the Illinois Department of Mental Health System. In order to facilitate this project, CSH funded the development of a new version of Jail Data Link to find the most frequent users of the jail and mental health inpatient system to augment an earlier version of Data Link in targeting subsidized housing and supportive mental health services.

About CSH and the Returning Home Initiative

The Corporation for Supportive Housing (CSH) is a national non-profit organization and Community Development Financial Institution that helps communities create permanent housing with services to prevent and end homelessness. Founded in 1991, CSH advances its mission by providing advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing. CSH seeks to help create an expanded supply of supportive housing for people, including single adults, families with children, and young adults, who have extremely low-incomes, who have disabling conditions, and/or face other significant challenges that place them at on-going risk of homelessness. For information regarding CSH's current office locations, please see www.csh.org/contactus.

CSH's national *Returning Home Initiative* aims to end the cycle of incarceration and homelessness that thousands of people face by engaging the criminal justice systems and integrating the efforts of housing, human service, corrections, and other agencies. *Returning Home* focuses on better serving people with histories of homelessness and incarceration by placing them to supportive housing.



Corporation for Supportive Housing
Illinois Program
205 W. Randolph, 23rd Fl
Chicago, IL 60606
T: 312.332.6690
F: 312.332.7040
E: il@csh.org
www.csh.org

Appendix 3:

Pre-Booking Diversion Proposal

**LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PRE-BOOKING DIVERSION PROPOSAL
"AN OPEN DOOR TO RECOVERY"**

September 2013

BACKGROUND

The Department of Mental Health (DMH) is a participant in a variety of collaborative criminal justice projects including law enforcement/mental health crisis intervention teams such as Mental Evaluation Teams (MET) and the Systemwide Mental Assessment Response Team (SMART), the Mental Health Court Linkage Program and most recently the Assembly Bill (AB) 109 Realignment Program. These interagency partnerships address the special needs of persons with mental illness who become involved with the criminal justice system. DMH is proposing to enhance its partnerships with law enforcement entities and the criminal justice system through the implementation of two pre-booking jail diversion programs, initially as pilot projects serving the Long Beach (LB) and Antelope Valley (AV) areas, and subsequently to be extended throughout Los Angeles County, utilizing the experience gained through the pilot projects.

The need for a pre-booking diversion program is significant. Police response to calls involving individuals with mental illness takes more time to complete than calls involving individuals who are not mentally ill. In the Los Angeles County jails, the cost to provide mental health treatment, as well as custodial care, to a daily census of over 2900 inmates with mental illness is substantial. Incarceration disrupts treatment in the community, impedes recovery, and may result in the exacerbation of symptoms. Defendants who are mentally ill and unable to afford bail have been found to spend longer times in custody than those that are not suffering from mental illness. Their court cases often take multiple court appearances to adjudicate, adding costs to the judicial system. A pre-booking interagency diversion program would provide a means of reducing the number of individuals entering the criminal justice system and a safety measure for individuals experiencing crisis.

Pre-booking diversion programs have been implemented in a number of jurisdictions throughout the country. Research indicates that these programs produce positive outcomes for persons with mental illness and for the community. The principal goal of the proposed project is to link individuals with mental illness to recovery services at the first point of contact with the criminal justice system as an alternative to repetitive incarcerations.

In August 2013 DMH Jail Mental Health Staff conducted a prevalence study to determine the number of potential mentally ill males incarcerated from the AV and LB areas that might benefit from a pre-booking diversion program. Findings indicate that 14% of those arrested for felonies and 33% of those arrested for misdemeanor charges may be more appropriately served by mental health treatment rather than incarceration (See Attachments 1 and 2).

PROJECT DESCRIPTION

The proposed LB and AV pilot projects would be housed in Urgent Care Centers (UCC) located in the AV and LB areas. The UCCs would serve as the entry point for the AV and LB Police Departments to link individuals to mental health services in lieu of their being charged with low level offenses. UCCs typically provide up to 24 hours of intensive crisis services and immediate care, including referrals to community based solutions, to individuals who otherwise would be brought to emergency rooms. The AV and LB UCCs would be expanded to allow specially trained law enforcement to divert individuals to mental health services whose low level offenses appear to be the result of or associated with their mental illness and who voluntarily agree to treatment. The diversion project would have the ability to link clients to needed services directly, including all levels of mental health care, health services, substance abuse treatment, housing, benefits (re)establishment, education and employment, and social services. The UCCs would be designated to receive or place individuals on 72-hour holds.

The goals of the Program are as follows:

- Enhanced coordination among law enforcement, mental health and other participating agencies
- Improved access to services for people with mental illness
- Diversion of people with mental illness from the criminal justice system
- Improved efficiency of police response to mental health related calls

DMH will use established partnerships to develop the proposed projects. As a first step, DMH plans to engage stakeholders such as the AV and LB Police Departments and law enforcement/mental health teams, the City Attorneys, the District Attorneys and Countywide Criminal Justice Coordination Committee to support the project. Once support is secured for the projects, a work group would be needed to coordinate tasks such as establishing agreements among participating agencies in each geographical area; identifying target populations and offenses; establishing program capacity and notification protocols when at capacity; developing training for police dispatchers and

specialized police officers; delineating the range of mental health and other services to which participants could be linked; establishing protocols, including information sharing; defining data tracking and outcome measures; and identifying funding sources.

This proposal would leverage existing County and local services - UCCs, other mental health providers and the mental health/law enforcement teams - to implement the programs. In addition to leveraging existing services, the projects will require additional funding including AB 109, Mental Health Services Act (MHSA) and Senate Bill (SB) 82. It is anticipated that both projects will require capital development and services funding including UCC staffing, recruitment, training, and development of enriched residential capacity to serve this population. Included in the UCC staffing will be a short-term case management team that can immediately house program participants if needed, provide treatment for mental health and co-occurring substance abuse disorders and follow participants for up to two months until connected to community services and supports. The timeline for the implementation of the AV pilot will be lengthier than LB pilot due to the need to develop a new UCC in the area.

Anticipated outcomes of the program include:

- Reduction in arrest for minor offenses of persons with mental illness
- Increased access to mental health services for individuals who come into contact with law enforcement
- Increased satisfaction of persons with mental illness with law enforcement services
- Increased training of police officers on recognizing mental health symptoms and resources.

Following successful implementation of these pilot projects, DMH envisions working with its partners to expand the programs in order to offer law enforcement personnel countywide a means to redirect people with mental illness away from the criminal justice system to recovery-based community treatment and services and to promote an end to the cycles of repeated incarcerations.

**Pilot: Identification of Potential
Correctional Mental Health Clients
for Pre-Booking Diversion**

Method: A prevalence study was conducted on August 5, 2013. All incarcerated inmates from Service Area 1 and 8 (Antelope Valley and Long Beach) were surveyed.

Total	N = 169	
Felony	N = 133	77%
Misdemeanor	N = 36	21%

Recommended Diversion Exclusions

Arrest Charge

1. Murder, Attempt Murder
2. ADW with use of firearm and/or GBI
3. Robbery 1st and 2nd degree
4. Manslaughter, 1st or 2nd degree
5. Any sexual offense
6. Any child offense
7. Domestic violence
8. Arson
9. Battery GBI
10. Kidnapping, False Imprisonment, Car jack
11. Co Ret. (State Hosp. Returnees)
12. All other offenses with 4 or more previous arrest as determined by CII (Criminal Information Index)

Felony Charge

Excluded by criteria	N = 48	36%
County Returnees	N = 11	8%
CII 4 or more (criminal charge)	N = 38	29%
CII 4 or more (drug charge)	N = 17	13%
Acceptable for Diversion	N = 18	14%

Misdemeanor Charge

Same exclusion criteria as for felonies, but previous arrests by CII increased to 10 with no previous arrest constituting any of above exclusions (item 1 – 11).

Misdemeanor Results

N = 36

Excluded by criteria	N = 19	53%
County Returnees	N = 5	14%
Acceptable for Diversion	N = 12	33%

Total (Felony and Misdemeanor) acceptable for Diversion = 30 18% of whole sample
(e.g. based on 400 bookings in a day 72 would be diverted from jail)

These diversion criteria are considered to be based on conservative criteria.

2.

Discussion

Pilot study results regarding the possible diversion of mental health arrestees from incarceration are very promising, but these data must be viewed in context. First, subjects were selected from 2 Los Angeles County Service Areas (Antelope Valley and Long Beach). Due to possible variances in personal and demographic differences, these results may not be readily generalizable to different County Service Areas, (e.g. Downtown). Additionally, these data were collected via a "spot prevalence" count of mental health men incarcerated on a single date. Length of jail stay was not determined. Positive diversion factors tend to correlate with short jail tenure and vice versa. This factor needs further exploration and may well result in an increase in the percentage of potential diversion candidates.

The concept of diversion of the mentally ill from incarceration is clearly supported by these preliminary data and has very broad and promising ramifications for appropriate community based treatment of the mentally ill.

Appendix 4:
CSH Mental Health, Jail
Diversion and
Supportive Housing
Proposal



Mental Health, Jail Diversion, and Supportive Housing:

A Model for Community Integration and Stabilization

July 2014

Introduction

Men and women experiencing homelessness and suffering from mental illness are substantially more likely be involved with the criminal justice system than those individuals who live with mental illness, but are stably housed. For these men and women access to supportive housing (stable, safe, affordable housing combined with supportive services, mental health treatment and healthcare) has the single greatest impact on their likelihood of recidivating. A stable home in the community not only provides safety, security and shelter, but allows a level of stability, dignity and community integration that cannot be provided by any other intervention.

Supportive Housing

Supportive housing is an evidence-based practice that reduces homelessness and improves health outcomes for individuals experiencing long term homelessness and disabling conditions. By definition supportive housing is affordable housing combined with a wide array of supportive services. The housing is not time-limited. Tenants rent apartments and sign a lease that grants them full protection under state and local tenant landlord laws. Tenants can stay in their apartments as long as they choose granted that they do not violate the conditions of their lease. The housing affordability is generally provided through rental assistance in the form of the Housing Choice Voucher program or other federal and local rental assistance programs that allow tenants to pay rent based on 30% of their income regardless of how low their income may be or in some cases lack of any income at all.

Supportive housing is linked to comprehensive voluntary and flexible supportive services, behavioral healthcare and primary healthcare that is based on the tenants’ needs and preferences. While the housing and services are linked, tenants are not required to participate in services. Services are completely voluntary and tenants cannot be asked to leave their housing because of their lack of participation in services or adherence to treatment plans. Services are provided using a proactive approach, where service providers actively engage tenants and develop treatment plans based on tenants’ preferences.

To understand what supportive housing is, it is instructive to also understand what supportive housing is not. Supportive housing starkly differs from transitional housing, shelters, sober living programs, group homes or board and care facilities, including the following:

Supportive Housing Tenants	—versus—	Transitional Housing Residents
<ul style="list-style-type: none"> • Sign a lease (or sublease if master-leased) with landlord, have rights & responsibilities of tenancy under state & local law, are free to come & go or have guests • Have no restrictions on length of tenancy, can remain in apartment as long as complying with lease terms & desires to remain in apartment 		<ul style="list-style-type: none"> • Do not have leases, have no rights under landlord-tenant law, have restrictions on coming & going, as well as guests • Do not determine their own length of stay (program decides length of stay)

Supportive Housing Tenants	—versus—	Transitional Housing Residents
<ul style="list-style-type: none"> • May participate in accessible, usually comprehensive, flexible array of services tailored to needs of each tenant, with a case manager on call 24/7 • Are not required to participate in services as a condition of tenancy, of admission into housing, or of receipt of rental subsidies • Have rent based on income, in compliance with federal affordability guidelines (30-50% of income). • Work closely with services staff who collaborate with (but are usually separate from) property management staff to resolve issues to prevent eviction • Live in housing that meets federal quality standards for safety & security • Usually occupy own bedroom, bathroom, and kitchen &, if sharing common areas, choose own roommates • Are protected by Fair Housing law 		<ul style="list-style-type: none"> • Service availability varies from program to program, without choice in services • Are required to participate in services, or cannot remain in program or access subsidy • May be asked to pay rent based on program's guidelines, not based on federal affordability guidelines • Often have no advocate for resolving issues that may lead to eviction, as service providers usually the same as staff running home • May live in substandard conditions • Have no choice over housemates, usually share bedroom with at least one (usually multiple) other tenants • Are not protected by Fair Housing law

Supportive housing is community-based housing that can be provided in a single-site, or congregate, based model, mixed-population model, or a scattered-site model. Single-site supportive housing is a traditionally a single multi-family apartment building where all apartments are occupied by supportive housing residents. Single-site supportive housing is traditionally produced using community development or affordable housing financing and has the benefit of including on-site supportive services.

Mixed-population supportive housing is traditionally a single multi-family apartment building where a portion of the apartments are set-aside for supportive housing residents. Mixed-population models tend to combine traditional affordable housing dedicated to working families or individuals with a smaller or equal portion of apartments dedicated to supportive housing residents. Mixed-population developments are also traditionally produced using community development or affordable housing financing. Depending on the number of apartments dedicated to supportive housing residents these developments may or may not include on-site supportive services.

Scattered-site supportive housing is provided by dedicating tenant-based rental assistance to supportive housing residents who then secure rental housing from private landlords in the community. The most common program providing this form of supportive housing is the Housing Choice Voucher, or Section 8, program. In this model services are provided through mobile teams who provide services to tenants throughout the community.

Each of the models described above include unique opportunities and challenges. Some service providers prefer providing on-site services through a single-site model. While others prefer the community integration provided through scattered-site models. Similarly, some public agencies prefer the community development opportunities and increased housing supply produced by single-site models, while others prefer the speed of scattered-site approaches.

Across the country we have learned that communities need all models. Programs to expand supportive housing should include multiple approaches.

Los Angeles County currently has no supportive housing dedicated to justice-involved individuals. Today justice-involved individuals access supportive housing through the homeless service delivery system and by independently applying for housing. As a result, justice-involved individuals face long wait lists and may be denied housing as a result of their history of incarceration. Any strategy to divert individuals experiencing mental illness from entering or returning to jail must include the provision of new supportive housing.

Financial Modeling

CSH has prepared a financial model based on providing 1,000 new units of supportive housing for justice involved individuals. Each model includes housing, as well as supportive services and program administration. 400 of these supportive housing units would be provided through new construction or rehabilitation of single-site or mixed population developments. This model assumes leveraging community development and affordable housing financing including project based rental assistance provided by public housing authorities.

600 of these supportive housing units would be provided through a scattered-site model. CSH recommends investing in an existing Department of Health Services program, the Flexible Housing Subsidy Pool. The Flexible Housing Subsidy Pool has infrastructure in place today, which would allow virtual immediate access to housing. The Flexible Housing Subsidy Pool is also designed for a similar population, frequent users of LA County health services who, by in large, also suffer from mental illness, substance use disorders and histories of trauma.

Each model assumes a 5-year operating cycle. It should be noted that supportive housing is not time limited. These models would need a new investment at the end of the 5-year operating cycle to continue. For the new construction/rehabilitation model this would require an investment in social services only because the rental assistance is provided by the federal government. The Flexible Housing Subsidy Pool would require an additional investment in both rental assistance and social services.

Permanent Supportive Housing New Construction/ Rehabilitation	400 Units	5-Year Cost
Capital Subsidy	\$75K/unit*400	\$30,000,000
Integrated Case Management Services	\$400/mon*60 mon*400 people	\$9,600,000
Program Administration	1 FTE/5 years	\$500,000
Total		\$40,100,000

*Assumes leverage of Project Based Section 8 or Shelter Plus Care and traditional affordable housing capital financing including Low Income Housing Tax Credits

Flexible Housing Subsidy Pool	600 Units	5-Year Cost
Move-in Assistance	\$2,000*600 people	\$1,200,000
Rental Assistance	\$800/mon*60 mon*600 people	\$28,800,000
Program Coordination	\$125/mon*60 mon*600 people	\$4,500,000
Integrated Case Management Services	\$400/mon*60 mon*600 people	\$14,400,000
Program Administration	1 FTE/5 years	\$500,000

Total		\$49,400,000
--------------	--	---------------------

Funding Sources

There is no magic bullet to fund supportive housing. That said, funding sources do exist that could offset a portion of the cost of this model.

County-Owned Land

The County owns large parcels of land, such as medical centers, that may include properties that are being under-utilized. This land could be made available to supportive housing developers to help offset the cost of development.

Medi-Cal

The majority of justice-involved individuals in the County became eligible for Medi-Cal under the Affordable Care Act beginning January 1, 2014. Medi-Cal can reimburse providers for a portion of case management, mental health treatment, primary healthcare and even substance abuse treatment. While Medi-Cal reimbursement is limited, there is a new option in the Affordable Care Act called Health Homes that could provide more comprehensive coverage for services. The state passed a bill, AB 361, in 2013 to implement this option of the Affordable Care Act and will soon begin a planning process for implementation.

Mental Health Services Act

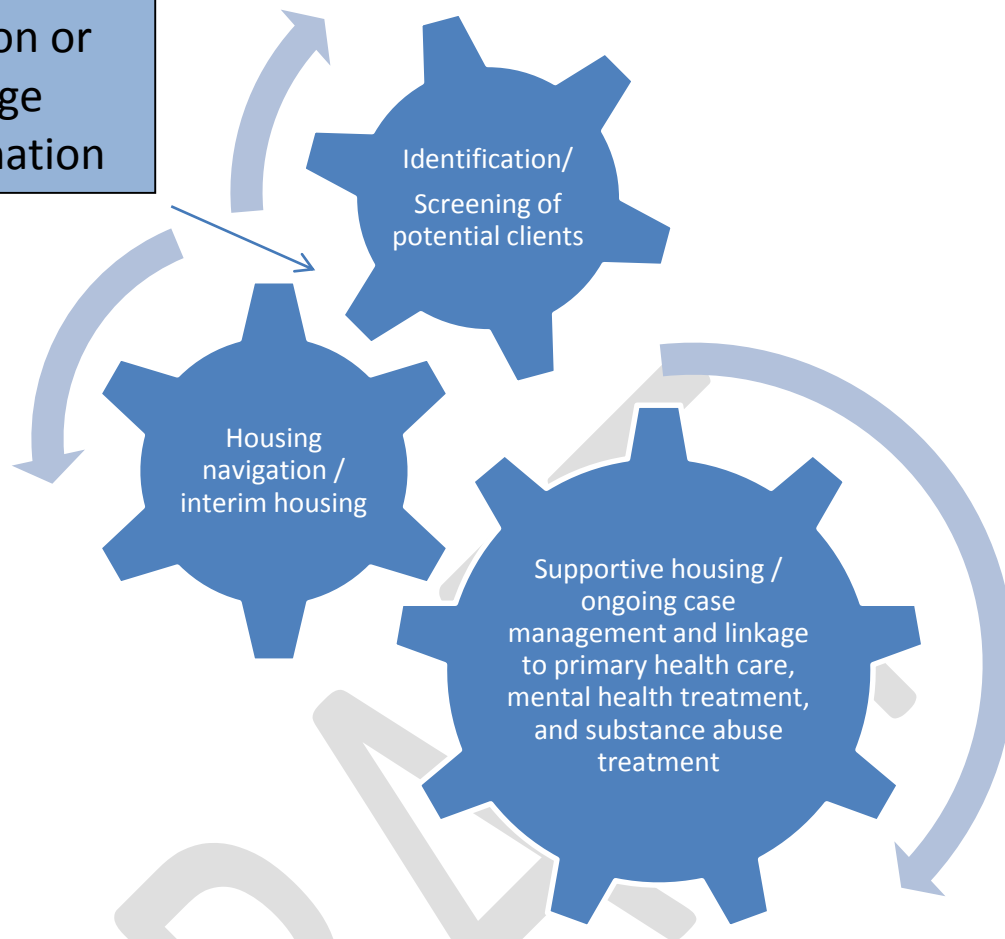
The Mental Health Services Act also includes funding that could be utilized to offset the cost of services. The Department of Mental Health currently has a program called Integrated Mobile Health Teams that combines Medi-Cal reimbursement with MHSA Innovations funding to fund a package of services that is similar to the integrated case management services included in the models above.

Linkages to Supportive Housing

Supportive housing works as diversion and discharge strategy when clients are effectively linked to supportive housing. Effective linkage is dependent on comprehensive programs that include the following components:

- Targeted and easily-implemented screening tools to identify clients
- Warm-hand off to Housing Navigators, who begin engagement in the court-room, jail, hospital or crisis stabilization unit
- Immediate access to low-barrier interim housing
- Immediate assistance with identification documents and housing application process
- Case management provided through a “whatever-it-takes” approach including transportation, food assistance, etc.
- Housing placement and ongoing intensive case management
- Linkage to primary healthcare, behavioral healthcare, and substance abuse treatment
- Connections to community, education, employment and family re-unification

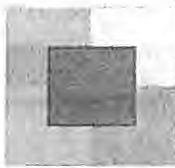
Diversion or
discharge
coordination



CSH has implemented two programs that utilize this model to connect individuals in institutions to supportive housing in Los Angeles County. The **Just in Reach 2.0 project** connects individuals experiencing long-term homelessness in LA County jails to supportive housing through the provision of in-reach, discharge coordination, housing navigation, interim housing, supportive housing placement and on-going case management. The **10th Decile project** (including the Frequent Users System Engagement program and the Social Innovation Fund program) connects individuals experiencing long-term homelessness who are frequent users of the healthcare system to supportive housing through the provision of discharge coordination, housing navigation, interim housing, supportive housing placement and on-going case management. Both of these programs are ideal models for future diversion and re-entry programs.

Appendix 5:

LA Trauma TTT Participants



SAMHSA's GAINS Center
How Being Trauma-Informed Improves Criminal Justice System Responses
Train-the-Trainer Event
Los Angeles County, CA • July 15-16, 2014

PARTICIPANT LIST

Carol Bishop

Clinical Supervisor
Tarzana Treatment Centers
7101 Baird Avenue
Reseda, CA 91335
Phone: 818-342-5897 ext. 2195
Email: cbishop@tarzanatc.org

Kasey Bogoje

Clinical Supervisor
Tarzana Treatment Centers
44443 N. 10th Street West
Lancaster, CA 93534
Phone: 661-726-2630 ext. 4308
Email: kbogoje@tarzanatc.org

Cheryl Branch

CEO
LA Metropolitan Churches
3320 S. Central Avenue
Los Angeles, CA 90011
Phone: 323-273-4586
Email: cherylbranch@gmail.com

Stephen Brodi

Parole Agent II
CA Dept. of Corrections & Rehabilitation
21016 Pathfinder Road, Suite 200
Diamond Bar, CA 91765
Phone: 626-840-1139
Email: stephen.brodi@cdcr.ca.gov

Nancy Chand

Deputy Public Defender
Public Defender's Office
210 W. Temple Street
Los Angeles, CA 90012
Phone: 213-974-2837
Email: nrichards-chand@pubdef.lacounty.gov

Mark Faucette

California Community Relations
Amity Foundation
3745 South Grand Avenue
Los Angeles, CA 90007
Phone: 559-786-1000
Email: mfaucette@amityfdn.org

Santiago Flores

Parole Agent II
CA Dept. of Corrections & Rehabilitation
21015 Pathfinder Road, Suite 200
Diamond Bar, CA 91765
Phone: 310-991-2490
Email: santiago.flores@cdcr.ca.gov

Fabian Garcia

Regional Program Coordinator
City of Los Angeles
200 N. Spring Street
Los Angeles, CA 90012
Phone: 231-880-7101
Email: fabian.garcia@lacity.org

Art Gutierrez

Custody Officer
Los Angeles Sherriff's Department
4700 Ramona Boulevard
Monterey Park, CA 91754
Phone: 213-893-5248
Email: A2gutier@lasd.org

Karla Martinez

GRYD Case Manager
CISG LA
8743 Burnet Avenue
North Hills, CA 91343
Phone: 818-891-9399 ext. 111
Email: kmartinez@cisgla.org

Armond Oganessian

Deputy
Los Angeles Sherriff's Department
4700 Ramona Boulevard
Monterey Park, CA 91754
Phone: 213-893-5248
Email: aoganes@lasd.org

Giovanni Oliva

Case Manager
El Centro del Pueblo
1157 Leomyne Street
Los Angeles, CA 90026
Phone: 213 483-6335 ext. 117
Email: goecdp@gmail.com

Enrique Rodriguez

Regional Program Coordinator
GRYD
200 N. Spring Street
Los Angeles, CA 90012
Phone: 213-304-5778
Email: rodriguez.enrique.j@gmail.com

Isadora Romero

Psychiatric Social Worker II
Public Defender's Office
4848 East Civic Way, 3rd Floor
Los Angeles, CA 90022
Phone: 323-780-2072
Email: iromero@pubdef.lacounty.gov

Jimmy Singh

Research Analyst II
Dept. of Public Health – SAPC
100 South Fremont Ave., Bldg. A-9E 3rd Fl.
Alhambra, CA 91801
Phone: 626-299-3214
Email: jisingh@ph.lacounty.gov

Willette Stewart

Sup. Deputy Probation Officer
LA County Probation
23759 West Valencia Blvd., Rm. 20
Valencia, CA 91355
Phone: 661-253-7278
Email: willette.stewart@probation.lacounty.gov

Shirley Torres

Reentry Director
Homeboy Industries
Email: storres@homeboyindustries.org

H. Dawn Weinberg

Director
LA County Probation
9150 E. Imperial Highway
Downey, CA 90242
Phone: 562-714-9154
Email: dawn.weinberg@probation.lacounty.gov

Debby Westcott

Deputy Probation Officer II
LA County Probation
9150 E. Imperial Highway
Downey, CA 90242

Raymundo Zacarias

GRYD Supervisor
CISG LA
8743 Burnet Avenue
North Hills, CA 91343
Phone: 818-891-9399 ext. 121
Email: rzacarias@cisgla.org

**SAMHSA'S
GAINS CENTER**

Jackie Massaro

Senior Consultant
SAMHSA's GAINS Center for Behavioral
Health and Justice Transformation
Policy Research Associates, Inc.
345 Delaware Avenue
Delmar, NY 12054
Phone: 518-634-7363
Email: jmassaro.step@gmail.com

Travis Parker

Senior Project Associate
SAMHSA's GAINS Center for Behavioral
Health and Justice Transformation
Policy Research Associates, Inc.
345 Delaware Avenue
Delmar, NY 12054
Phone: 402-437-4282
Email: twparker@magellanhealth.com

Appendix 6:

Peer Respite

Peer respites for mental health consumers prevent hospitalizations

August 12, 2014

By Lynn Graebner

As people with mental health crises overwhelm California's hospitals, jails and homeless shelters, counties across the state are gradually embracing residential respite houses located in neighborhoods and staffed by peers — people who have been consumers of the mental health system.

For people on the verge of a crisis, staying at a peer-run respite, typically for a couple of days or up to two weeks, can help them recover with support from people who have had similar experiences.

That can prevent incarceration or forced hospitalization, which often damages family relationships and can cause the loss of housing or jobs, said Yana Jacobs, chief of outpatient adult services for Mental Health and Substance Abuse Services at the Santa Cruz County Health Services Agency.

California has three peer-run respites, two in Los Angeles County and one in Santa Cruz. San Francisco and Santa Barbara Counties are in the process of opening respites and Alameda County is considering one.

The latter three would likely be largely staffed by peers but not considered peer-run as peers probably won't be in administrative positions. That distinction makes a big difference, say advocates.

"If respites are run by the traditional system, even peer workers can start behaving like clinicians," said Oryx Cohen, Director of the Technical Assistance Center at the National Empowerment Center, a Massachusetts-based nonprofit peer-run mental health organization.

Without peers at the helm, hierarchical administrations can undermine shared decision making; the sense of clients and support staff being equals, each having something to offer and the dropping of clinical labels.

The peer-run model is growing throughout the country with 12 peer-run respites and two hybrid programs in 11 states. Six more are planned and funded, said Laysha Ostrow, a postdoctoral fellow at Johns Hopkins Bloomberg School of Public Health.

Growth is slow but steady. One barrier is the stigma that mental health consumers can't handle crisis situations, Cohen said.

"Departments of mental health and behavioral health just need to be educated and need to see that this is a viable alternative," he said.

It has been for Asha Mc Laughlin, who knows well the trauma of being hospitalized. She suffers post-traumatic stress disorder, major depression and anxiety due to being abducted, raped and threatened with murder when she was 16. Chronic back pain also plagues her mental health.

She's spent a lot of time in psychiatric hospitals in the past, but rarely uses them now since finding the Second Story peer respite in Santa Cruz three years ago.

Peer counselors there are trained in the Intentional Peer Support method and, unlike psychiatrists, can share their own experiences, alleviating some of the isolation people feel, and creating relationships that are mutually supportive.

"It seems there's just automatic healing in that," Mc Laughlin said. "And when my understanding supports them, it means a lot to me."

At Second Story guests talk conversationally with peer counselors, handle their own meds, cook meals and can join or lead group sessions ranging from art and meditation to dealing with conflict and alternatives to suicide.

"We've found that when we treat people like responsible adults they behave like responsible adults," said Adrian Bernard, one of the administrators and a peer counselor.

"We have had a huge amount of success getting people out of the [mental health] system," he said.

San Francisco is one of the latest cities experimenting with peer respites. Its Department of Public Health plans to launch a psychiatric respite next to San Francisco General Hospital and Trauma Center this fall, said Kelly Hiramoto, acting director of Transitions at the San Francisco Department of Public Health.

San Francisco desperately needs these types of alternatives to hospitalization, incarceration and homelessness. Last year the city had almost 800 jail inmates diagnosed with a psychotic, bipolar or major depressive disorder, reported San Francisco Mayor Edwin M. Lee's office.

The San Francisco respite is one of several remedies the city is trying. It will start with four beds with room to grow to 12 or 14, and five peer counselors as well as six entry-level mental health rehabilitation workers, Hiramoto said.

The city didn't go as far as some local mental health advocates had hoped, but they say it's a start.

"We're very supportive of the psychiatric respite. We think that's a great thing that will fill a gap," said Michael Gause, Deputy Director, Mental Health Association of San Francisco, a nonprofit advocacy organization. But they would also like to see a pure peer-run respite, he said.

Several other counties are also getting their feet wet. In the last year two peer-run respites have opened in Los Angeles County, Hacienda of Hope in Long Beach and SHARE! Recovery Retreat in Monterey Park. They're both funded by the Los Angeles County Department of Mental Health Innovations Program as three-year pilots.

Santa Barbara County has approved a largely peer-staffed respite and is seeking a site, said Eric Baizer, with the Santa Barbara County Department of Alcohol, Drug and Mental Health Services.

And Manuel Jimenez, director of Alameda County Behavioral Health Care Services, said a stakeholder group has proposed a peer-staffed respite for his county and he's supportive.

Statewide, California had less than half the national average of psychiatric beds per capita as of 2007, according to a 2010 report by the California Mental Health Planning Council, an advisory body to state and local government.

Respite could help fill that gap. Crisis residential programs, including peer respites, cost roughly 25 percent of hospital inpatient care and are often more effective, the report states.

Jacobs said one of the reasons these respites are successful in reaching people is they don't focus on diagnosis. She believes only about 25 percent of people being diagnosed schizophrenic actually are.

"The rest have trauma and are being labeled," she said. "You don't want to tell someone they have a serious mental illness and will be disabled the rest of their lives."

Bernard, for example, hears voices but hasn't been hospitalized since 2003.

"Now I have a community around me and three or four times they've kept me from going to the brink," he said.

Jason Davis, who first came to Second Story as a guest and is now a peer counselor, agreed that the enormous camaraderie there is what helped him overcome his paranoia.

"I support the house and the house supports me," he said.

The nonprofit Human Services Research Institute is doing a five-year evaluation of Second Story, required by the grant it received from the federal Substance Abuse and Mental Health Services Administration. Early analysis suggests a reduction in use of high-cost hospitalizations and other emergency services by those who use the respite, said Bevin Croft, Policy Analyst for the organization.

That's certainly true for Bernard, Mc Laughlin and Davis since joining the Second Story community.

"For the first time in my life I feel like people understand me and can support my growth," Bernard said.

<http://www.healthycal.org/archives/16402>

Appendix 7: DMH Fact Sheet

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
Investment in Mental Health Wellness Act of 2013 Fact Sheet
December 2013

OVERVIEW

In June of 2013, Governor Jerry Brown signed the Investment in Mental Health Wellness Act of 2013 (MHWA) into law. MHWA establishes new grant opportunities that funds California counties or their nonprofit/public agency designates to develop mental health crisis support programs. The MHWA provides \$142.5 million in capital funding and \$6.8 million for mobile crisis support teams to increase the capacity for client services, crisis intervention and stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. The California Health Facilities Financing Authority (CHFFA) will support capital improvement, expansion and limited start-up costs. The County of Los Angeles (County), along with Tri-City Mental Health Authority is eligible for \$40 million of these funds including an additional \$1.9 million for mobile crisis support teams.

PROPOSED PROGRAMS

Utilizing the capital funding from the MHWA, the County of Los Angeles Department of Mental Health (DMH) intends to develop five new Psychiatric Urgent Care Centers and establish 10-15 Crisis Residential programs in each of the eight Service Areas (SA). Additionally, there will be an expansion of our current mobile crisis support teams throughout the county.

Urgent Care Centers—Provide short-term (23 hour), crisis intervention services to individuals 13 years and older who would otherwise be taken to or access care in emergency rooms.

DMH currently utilizes four adult urgent care centers:

- Olive View—SA2
- Eastside Exodus Urgent Care Center—SA 4
- Westside Exodus Urgent Care Center—SA5
- La Casa Mental Health Urgent Care Center—SA8

The MHWA would fund an additional five urgent cares to be located on the campus of Harbor UCLA Medical Center, SA 7, the Antelope Valley, the greater Hollywood area, and SA 3. A UCC at Martin Luther King, Jr. Medical Center is also scheduled to open early 2014.

Crisis Residential Programs—Each program serves 10-12 persons for an average of 10-14 days. This program provides immediate, structured housing and supportive mental health services, most frequently as an alternative to extended acute psychiatric hospitalizations.

DMH currently funds three crisis residential programs:

- Hillview Crisis Residential Program—SA 2
- Didi Hirsch Excelsior House—SA 8
- Didi Hirsch Jump Street—SA5

DMH proposes to increase crisis residential bed capacity by 160 beds countywide through the development of approximately 10-15 new crisis residential programs

Mobile Crisis Support—DMH operates a psychiatric mobile emergency response system twenty-four hours per day, seven days per week. The Emergency Outreach Bureau has several programs that provide field response services including Psychiatric Mobile Response Teams (PMRT), Law Enforcement Teams (LET), School Threat Assessment and Response Team (START), and Homeless Outreach Mobile Engagement (HOME).

The \$1.9 million for mobile crisis support teams will expand the field response operations personnel. In addition, there is a total of \$500,000 that can be used for the purchases of vehicles for these teams.

EVALUATION CRITERIA

CHFFA will evaluate an applicant's ability to meet the following criteria:

1. Project* expands access to and capacity for community based mental health crisis services that offer relevant alternatives to hospitalization and incarceration.
2. Application demonstrates a clear plan for a continuum of care before, during, and after crisis mental health intervention or treatment and for collaboration and integration with other health systems, social services, and law enforcement.
3. Identifies key outcomes and a plan for measuring them.
4. Project is feasible, sustainable and ready or will be feasible, sustainable and ready within six months of the Final Allocation.

* Project means startup or expansion of Program(s) and acquisition, construction, renovation or financing of capital assets; or equipping and staffing a Mobile Crisis Support Team.

Appendix 8:

CASES TCM Program Brief



SUCCESSFULLY ENGAGING MISDEMEANOR DEFENDANTS WITH MENTAL ILLNESS IN JAIL DIVERSION: THE CASES TRANSITIONAL CASE MANAGEMENT PROGRAM

Goals of this document:

- Provide a description of the development and operation of an alternative-to-incarceration program for repetitive misdemeanants
- Outline the strategy used by the program to promote engagement with behavioral health services through case management
- Review the program's effectiveness in reducing arrests, compliance with the court mandate, and linking participants to long-term treatment services
- Explain the role of positive court relations, standardized court screening, same-day engagement, and flexibility of service provision in the program's success.

Individuals convicted of misdemeanor offenses receive relatively modest punishment within the criminal justice system. As a result, programs that divert misdemeanants with mental disorders into treatment services lack judicial leverage to counter noncompliance. Yet misdemeanor cases constitute a huge burden for criminal courts. For example, in 2007, misdemeanor cases accounted for three-quarters of all arraignments in the Manhattan Criminal Court. The behavioral, medical, and public safety implications of noncompliance present courts and service providers with a need for more effective engagement strategies.

The Center for Alternative Sentencing and Employment Services (CASES) launched the Transitional Case Management (TCM) alternative-to-incarceration program in 2007 for misdemeanor defendants in Manhattan Criminal Court. TCM has received funding from the New York City Department of Correction, New York Mayor's Office of the

Criminal Justice Coordinator, Bureau of Justice Assistance Justice and Mental Health Collaboration Program, Jacob and Valeria Langeloth Foundation, van Ameringen Foundation, Schnurmacher Foundation, and the Manhattan Borough President's Office. TCM provides screening, community case management, and coordinated support for individuals with mental disorders or co-occurring mental and substance use disorders at risk of jail sentences.

Background

CASES clinical staff identify participants in arraignment, before sentencing, and also while completing a day custody program court mandate after sentencing. The participants are individuals with mental disorders or co-occurring mental and substance use disorders who have completed three days in the day

custody program or are mandated by the court to participate in three or five community case management sessions as an alternative to incarceration.

Participants recruited from the day custody program voluntarily enter TCM after completing the court mandate. Defendants mandated to TCM directly from court can voluntarily continue in the program for up to three months after satisfying the court mandate. TCM is staffed by a psychologist responsible for court-based screening and project coordination, a licensed social work supervisor, a bachelor-level substance abuse case manager, and a part-time forensic peer specialist.

Participants

TCM enrolled 178 individuals from July 2007 through November 2010. Approximately three-quarters (78%) of participants were male. The mean age of participants was 40. About half (56%) were Black, 25% were Hispanic or Latino, 12% were White, 2% were Asian, and 5% were multi-ethnic.

The majority of participants had a psychiatric diagnosis of bipolar disorder (38%), depressive disorder (20%), or schizophrenia (19%). Most participants (85%) had a co-occurring substance use disorder. Ninety-five participants (53%) were homeless upon entry into TCM.

TCM participants had an extensive criminal history, with a mean of 27 lifetime arrests and a mean of 3.6 arrests in the past year. Every participant had at least one prior misdemeanor conviction and 53% had one or more prior felony convictions.

The conviction that preceded enrollment in TCM was for a property crime in about

half of the cases (51%). One-quarter (25%) were convicted of possession of a controlled substance. Seventeen percent (17%) were convicted of a crime against a person.

Outcomes

Rearrest

In the year after program entry, the participants experienced 2.5 mean arrests. This figure, compared with 3.6 mean arrests in the year prior to program entry, represents a 32% reduction between the two periods. This reduction is statistically significant at the $p < .001$ level. Seventy-two percent (72%) of participants were arrested at least once in the year after program entry.

Pre-Entry and Post-Entry Mean Arrests for TCM Participants, by Lifetime Arrests (n=178)

Lifetime Arrests	No.	%	1 Year Pre	1 Year Post
0-3	15	8.4	1.3	0.3
4-10	32	18.0	2.4	0.7
11-20	33	18.5	3.5	2.2
21-40	62	34.8	4.2	3.1
≥41	36	20.2	5.1	4.2
Total	178	100.0	3.6	2.5

Participants with more lifetime arrests experienced an attenuated reduction in arrests between the two periods. Participants with the most lifetime arrests (41 or more) experienced only an 18% reduction in mean arrests prior to and after program entry. Yet participants with three or fewer lifetime arrests experienced a 75% reduction in mean arrests. Mean arrests fell 70% for participants with 4 to 10 lifetime arrests, 37% for participants with 11 to 20

lifetime arrests, and 25% for participants with 21 to 40 lifetime arrests.

Compliance and Service Linkage

The majority (82%) of the mandated participants successfully completed the court mandate, and 85% of those participants chose to continue to receive case management services beyond the mandated period. On average, participants took part in 16 voluntary case management sessions over the course of 156 days. Thirty-nine percent (39%) of the TCM participants were linked to long-term services prior to TCM program enrollment, and the program linked and transferred 25% of participants to long-term treatment services.

Keys to Program Success

Positive Court Relations

The TCM program benefits from having a professional clinician maintain a daily presence in the arraignment parts. This criminal justice-savvy individual is readily available to administer the screening protocol, engage with defense counsel, and provide pertinent information to judges to advocate for defendants who are eligible for the program. The clinician fine-tunes the program's court operations in response to feedback from defense counsel and the judges.

Standardized Court Screening

The clinician administers the structured screening protocol in the courtroom interview pens to all referred defendants. The 75-minute protocol reviews mental health (Mental Health Screening Form III) and substance use (Texas Christian University

Drug Screen II), psychosocial domains, risk factors, court mandate conditions, and program expectations and goals. As a result, the clinician is able to determine whether a defendant is eligible for TCM during the period before the individual appears before the judge. The majority of defendants referred by defense counsel and judges are eligible for TCM.

Same Day Engagement

The TCM case management protocol calls for immediate engagement of new participants in a standardized orientation protocol. The objective of the protocol is to increase the likelihood a new participant will engage in the case management services. Participant engagement begins with an orientation session that takes place immediately after release from court (participants referred from the day custody program are oriented on the day of admission). The project coordinator introduces the participant to project community staff. An evaluation of the participant is provided to staff, with a focus on immediate needs, risk factors, and details about the court mandate.

Flexibility in Service Provision

The high engagement in services is attributed to TCM's flexibility in delivering services to participants. TCM has the capacity to provide the frequency and duration of service contacts to participants based on their immediate and ongoing needs. Program participants are seen by program staff as often as needed in any community setting convenient for the participant. They are seen if they arrive late or miss an appointment. The participants are welcomed by the program whenever they arrive or make contact with the staff to obtain services.

Conclusion

The TCM program points to the value of case management services to support reductions in the criminal recidivism of people with mental disorders or co-occurring mental and substance use disorders arrested for misdemeanor crimes. The program is now working to enhance the nature of its case management services with the use of a validated risk and need instrument. This will provide the staff with specific information regarding the criminogenic needs of their clients that should be addressed with services to achieve greater reductions in recidivism.

For More Information...

For more information, contact:

Allison Upton, PsyD
Program Coordinator, Criminal Court
CASES
646.403.1308
aupton@cases.org

Reference

Criminal Court of the City of New York.
(2008). *2007 annual report*. New York:
Office of the Administrative Judge of New
York City Criminal Court.

<http://www.langeloth.org>

<http://www.prainc.com>