Whole Person Care- Los Angeles Policy Brief

April 2021

Los Angeles County Homeless Care Support Services (HCSS) and Tenancy Support Services (TSS) Reduce Acute Medical Care Use and Increase Primary Care Use

SUMMARY: The Whole Person Care-Los Angeles permanent supportive housing program, in conjunction with Homeless Care Support Services (HCSS) and Tenancy Support Services (TSS), places high acuity homeless patients into sustainable, long-term housing. Since the Whole Person Care program began supporting permanent supportive housing in 2017, there has been an 11% decrease in inpatient hospitalizations, 7% decrease in ER visits, and 8% increase in primary care usage.

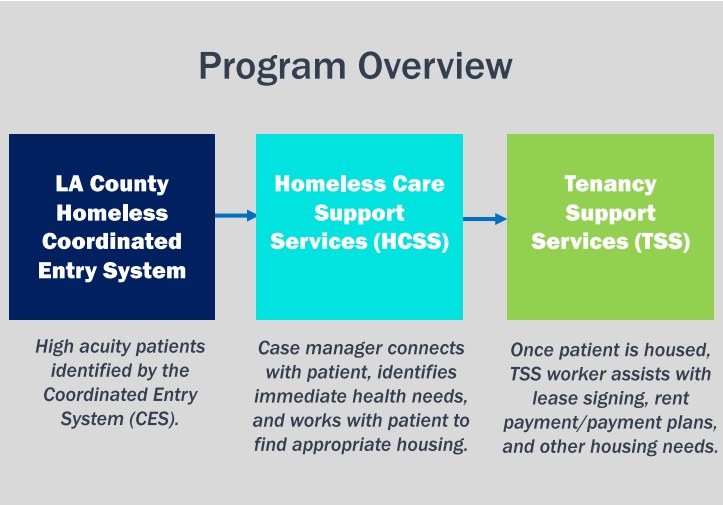
PROBLEM: Health Care Utilization Among Patients Experiencing Homelessness (PEH)

From 2019 to 2020, the PEH population in Los Angeles County increased 12.7% to 66,436 people.[1] Within the City of Los Angeles, the PEH population rose 16.1% to 41,290 people. The unique medical, behavioral, and social needs of PEH coupled with limited access to care result in increased emergency department (ED) and inpatient hospitalizations.[2] As compared to housed individuals, hospitalizations for PEH on average cost an additional $2,500.[3] This paradigm leads to poor PEH health outcomes and increased medical costs incurred by the health system.

Permanent supportive housing programs within the LA County Housing for Health program have led to significant decreases in health care utilization.[4] Continued and expanded permanent supportive housing measures in LA County are imperative to continue serving the growing PEH population, reducing acute medical care use, and promoting preventative care use. Further collaboration between the LA County Department of Health Services, Department of Public Social Services, Department of Public Health, Department of Mental Health, and the Los Angeles Homeless Services Authority is central to the success of these efforts.

SOLUTION: Homeless Care Support Services (HCSS) and Tenancy Support Services (TSS)

The LA County Department of Health Services (LAC-DHS) Housing for Health (HFH) program, in conjunction with Whole Person Care-Los Angeles, administers permanent supportive housing via **Homeless Care Support Services (HCSS)** and **Tenancy Support Services (TSS)**, also referred to as Intensive Case Management Services (ICMS) and Property Rental Tenancy Services (PRTS). PEH are referred by the LA County coordinated entry system and paired with a case manager who initially finds the patient on the street through the homeless management information system and tends to their immediate needs. Case managers then work with the patient to find housing and connect them with primary care, behavioral health, or any other medical services. Case managers meet with patients at least once a month during this initial phase, and find appropriate housing based on the patient's unique needs. Once the patient is housed they begin to receive tenancy support services (TSS), which provide assistance with move-in, discussions with landlords, lease signings, and ensuring that rent payments are made on time. TSS workers are county contractors who provide invaluable geographic and community expertise. These workers meet with patients frequently in the immediate period after being housed and at least once a quarter after that. In some buildings, the TSS worker lives on-site to provide continued care. HCSS also continues working with patients once housed to ensure their health, financial, and any other needs are met.



Program Goals

The Housing for Health permanent supportive housing program, through the work of HCSS and TSS, strives to reduce the use of acute medical care services and increase primary care and preventive services for PEH. Patient to case worker ratios are 1:20 and 1:75 for HCSS and TSS, respectively, allowing patients to receive personalized care and consistent communication. HCSS works on a "whatever it takes" model ensuring that patient health and tenancy needs are always met. Case managers accompany

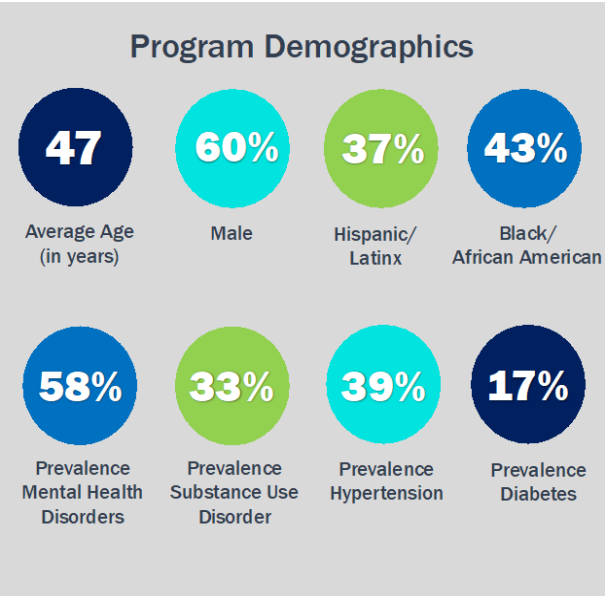
patients to primary care appointments, physically inspect units with patients before move-in, and ensure that patients never miss an appointment. Once patients are housed, they receive further support through the TSS worker, who ensures that the patient remains housed. By providing the patient with an HCSS case manager and TSS worker, the permanent supportive housing program ensures that all health, social, and tenancy needs are met to improve the overall health, wellbeing, and continued tenancy of enrolled patients.

Program Eligibility

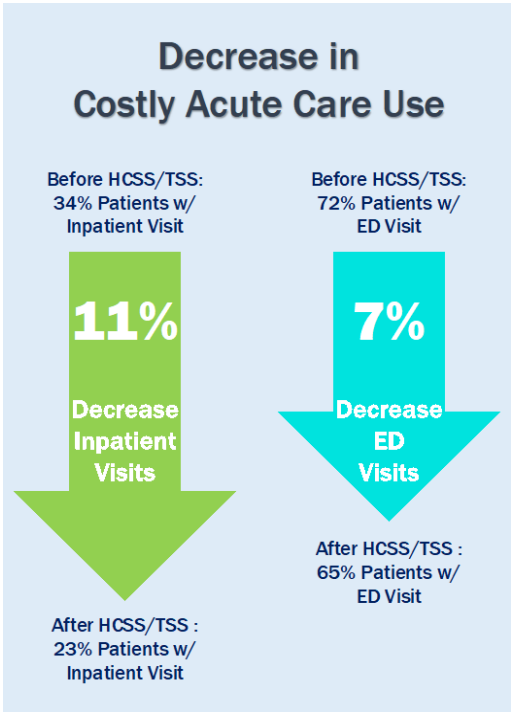
HCSS and TSS serve high acuity adult PEH who have a wide range of health needs and are housed accordingly. To determine eligibility, patients are referred through the LA County coordinated entry system. Patients are risk-stratified by a two-step intake process. First, patients submit a self-reported assessment, called the VI-SPDAT, with topics including medical and mental health conditions, length of homelessness, and desired housing. Then, once accepted to the HFH program, the patient is risk-stratified via a 5x5 tool to place patients in housing that will meet all their needs. Upon admission to the program, all patients are identified as high acuity. After two years of being housed, a patient's needs are reassessed, and they can move up or down the continuum of care, to low acuity or maintenance designation, as appropriate. Overall retention has been excellent with 90% and 81% of patients retaining housing (remained in unit) after 12 months, and 24 months, respectively.[5]

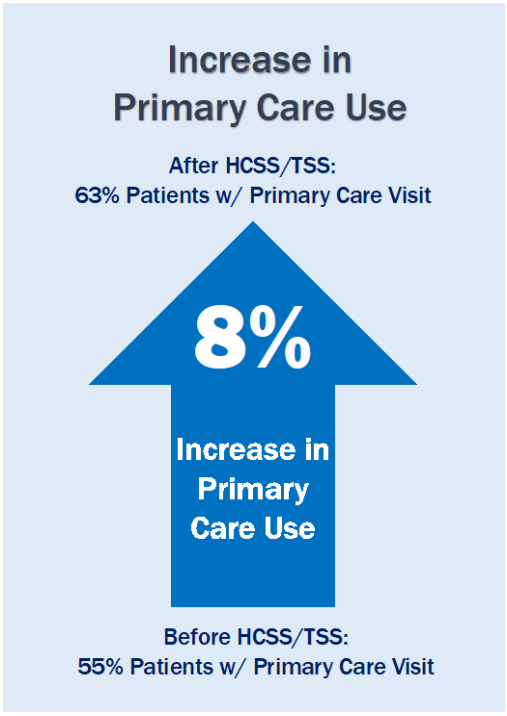
OUTCOMES: Reduction in High-Cost Care and Increase in Primary Care

From January 2017 to December 2018 8,945 patients were enrolled in the permanent supportive housing program. Among participants, the mean age was 47 years old. Additionally, 43% or patients were Black/African American, and 25% were Hispanic/Latinx. Patients had a variety of medical conditions including chronic pain (48%), hypertension (39%), diabetes (17%), asthma (16%), and congestive heart failure (7%). More than half (58%) of patients had behavioral health conditions, and 33% of patients also had a concurrent substance use disorder.



Permanent supportive housing with HCSS and TSS was successful in meeting its goals of reducing acute medical usage (ER visits and inpatient hospitalizations) and increasing primary care visits and usage of preventive services. In the 12 months after entering the program, compared with the 12 months prior, participants had an 11% decrease in inpatient hospitalizations and 7% decrease in ER visits. There was also an 8% increase in primary care visits.





Program Strengths

- *Whole Person Care Increases Case Management Capacity:* WPC funding supports expansion of case management

services, thereby allowing other County funding sources to direct investments to housing.

- *Whatever it Takes Model*: Case managers work on the individual level to ensure that all patient needs are met. This includes accompanying patients to health care appointments and inspecting potential units together. Case managers continue to work with patients after being housed to ensure patients make all scheduled appointments, continue to receive primary and preventive care, and continue tenancy. Providing patients with both a case manager and tenancy support advocate – HCSS and TSS – who work with each other and the patient allows for personalized and comprehensive care.

- *Focus on Primary Care:* One of the first goals of case management after a patient enters the program is to find and accompany the patient to a primary care appointment. Case managers work under a patient centered philosophy whereby case managers are instrumental in helping PEH access health care, utilize health care in the best possible way, build strong long-term alliances with medical care providers, and achieve better health and wellbeing. This focus on primary care can help PEH live healthier lives and help reduce unnecessary illness, disability, and even death.

- *Innovative Contracting Expands Community Partnerships:* Through work with the board and contracts division, HFH created an innovative contracting framework that accelerates and expands community partnerships. These community partnerships play an essential role in providing knowledge of neighborhoods and care for the unique needs of the PEH population.

- *Low Client to Case Manager Ratio:* HCSS and TSS members work at ratios of 1:20 and 1:75, respectively, for high-acuity patients allowing them to receive attentive, individualized care.

Program Challenges

- *Limited Affordable Permanent Housing:* The scarcity of affordable permanent housing, and housing in general within LA County, limits the number of units available to patients. Currently, the permanent supportive housing program is short 500,000 marketable units, making it difficult to find fair market rent units.

- *Funding Restrictions on Housing:* Whole Person Care funds cannot be used on building housing, and therefore cannot help address the shortage of housing units available for the PEH population. This prolongs the time patients spend on the street, which can contribute to worse health outcomes and continued over-use of acute medical resources.

- *Poor Communication with Hospital Systems:* Lack of data sharing and handoffs of patients shared between hospital systems and HCSS disrupts continuity of care. Ideally, HCSS workers would have access to ER and inpatient physician recommendations to ensure health needs continue to be addressed post-discharge.

- *Navigating a Novel Program during Implementation:* The HCSS permanent supportive housing program is novel, and thus the structure of the program has evolved throughout its initial implementation. Future planning and guidelines will aid in the structure of this program.

Policy Recommendations

- *Support Sustainable Housing Funding:* The limited affordable permanent housing units in Los Angeles has decreased the capacity to house PEH. While recent funding streams such as Measure H funding have significantly increased the programs capacity to house PEH, a continued and sustainable funding source is needed.

- *Continue Innovative Contracting to Promote Community Partnerships:* Innovative contracting via the board of supervisors and HFH has expedited community contracts and relationships that have been invaluable to the program. Community contractors are crucial to providing knowledge and recommendations on how to best serve the PEH population. Allowing the HCSS-TSS program to continue forming expedited contracts will be an imperative tool as the program continues.

- *Case Manager Support:* One of the strongest advantages of the HCSS-TSS program is the individualized support and care case managers provide patients. Continuing the low ratio of case workers to patients is vital to the continued success of the “whatever it takes” model.

- *Promote Data Sharing with Hospital Systems:* Lack of communication and data sharing between hospitals and case workers leads to poor care coordination. Supporting an electronic data sharing method between hospitals and on-the-ground case managers can further ensure utilization of primary care services to promote better health outcomes and reduce high-cost medical usage.

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Data and Methodology

Demographic data for patients enrolled from January 2017 to December 2018 are pulled from CHAMP, the database used to document demographic information on WPC-LA Recuperative Care patients. Outcomes for patients with any emergency department, inpatient, or primary care visit from January 2016 to December 2019 are preliminary. Data are pulled from enrollment, utilization and diagnosis files from Los Angeles County Department of Health Services, LA Care, and Health Net.

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