

Impact Brief

October 2017

LOS ANGELES 10TH DECILE PROJECT 2012-2017

Joining Together Health Care and Housing for
Patients Experiencing Homelessness and
Complex Chronic Health Conditions



CSH has been the national leader in supportive housing for 25 years. We have worked in over 40 states and 300 communities to create homes for individuals and families – housing that has transformed the lives of 200,000 people who once lived in abject poverty, on our streets or in institutions. A nonprofit Community Development Financial Institution (CDFI), CSH has earned a reputation as a highly effective, financially stable organization, with strong partnerships across government, community organizations, foundations, and financial institutions. Through our financing resources and knowledge, CSH is advancing innovative solutions that use supportive housing as a platform for services to improve lives, maximize public resources, build healthy communities and break the cycle of intergenerational poverty. Visit us at www.csh.org to learn more.

CSH's signature Frequent User Systems Engagement (FUSE) initiative helps communities identify and engage super utilizers of public systems and place them into supportive housing to break the cycle of repeated use of costly crisis health services, shelters and the criminal justice system. In 10 healthcare FUSE pilot sites across the country, CSH has helped convene Managed Care Organizations (MCOs), hospitals, Federally Qualified Health Centers (FQHCs), and homeless services providers to connect a subset of the homeless population utilizing a disproportionate share of hospital/emergency care services to housing and appropriate care. As a result of these collaborative FUSE pilots, to date, these communities have housed close to 1,000 chronically homeless frequent users. CSH piloted its first Los Angeles 10th Decile FUSE pilot in 2011 to help hospitals reduce readmissions from a small number of high-cost homeless individuals. This paper focuses on the expansion Social Innovation Fund (SIF) 10th Decile Project expansion implemented between 2012-17.

AUTHOR

Susan Lee, CSH , susan.lee@csh.org

ACKNOWLEDGMENTS

This Impact Brief would not have been possible without the contributions and support of the following individuals:

John Maceri, The People Concern (formerly OPCC)
Mary Luthy, Providence St. John's Health Center
Natalie Profant Komuro and Marifel Sison, Ascencia
Amber Roth and Mark Casanova, Homeless Health Care LA
Celina Alvarez and Robert Morrison, Housing Works
Robert Friant and Marcella Maguire, CSH
Julie Han, CSH (former Intern)

PERMISSIONS REQUESTS



CSH encourages nonprofit organizations and government agencies to freely reproduce and share the information from CSH publications. The organizations must cite CSH as the source and include a statement that the full document is posted on our website, csh.org. Permissions requests from other types of organizations will be considered on a case-by-case basis; please forward these requests to info@csh.org.

table of contents

I.	impact in the field	
A.	overview of current trends in housing and health care, nationally and in Los Angeles County	4
B.	best practices and innovations: how <i>10th Decile Project</i> grantees respond and contribute to emerging housing and healthcare trends	5
II.	impact on organization	
A.	partnerships	9
B.	scaling up	12
III.	impact on frequent users: results of the five-year investment	
A.	impact on 10 th Decile Project cohort	13
B.	impact on healthcare and housing collaborations and larger systems	14
IV.	moving forward into “a perfect storm”	16
V.	tools and reference materials	
A.	Los Angeles County Homeless Initiative	17
B.	healthcare resources: Medi-Cal waivers, MCOs, health homes	17
C.	state housing bills	20
D.	blueprint for planning	22
E.	case studies	23
F.	endnotes	24

The 10th Decile Project has three intended levels of impact:

“Frequent User Systems Engagement,” or FUSE, is a CSH program model that convenes housing and healthcare systems and community-based providers to work together to **coordinate care and supportive housing** for chronically homeless individuals who comprise the community’s highest-cost homeless individuals.

Page | 4

CSH is helping hospitals and health plans to collaborate with homeless service providers and community health centers to house the highest-cost, highest-need homeless individuals in LA County. The **10th Decile Project** is a FUSE model that connects the highest-cost, highest-need homeless individuals with complex health needs to supportive housing— stable, affordable housing linked to wrap-around services coordinated within community-based partnerships.



I. impact in the field

A. overview of current trends in housing and health care

As the nation continues to focus on health care, comprehensive solutions are needed to effectively bend the cost curve, improve quality of care and advance population health. In Los Angeles, leading managed care organizations (MCOs), hospitals, federally qualified health centers (FQHCs), housing developers and homeless service providers are collaborating in innovative ways to improve health outcomes of patients identified as chronically homeless. By linking care management and supportive housing, we are not only realizing stabilization of our most chronically ill homeless patients, but also reduction of emergency department and inpatient readmissions, and health care cost savings. Communities, working together, can effectively address the social and economic complexities of homelessness.

Even in the current economic and healthcare environment, managed care organizations and hospital systems across the country are developing new models of care for vulnerable populations, including homeless member and high utilizers. These new models of care are difficult to implement, require healthcare services to be provided outside the walls of the clinic, need to be addressing key social determinants of health, and require new and robust community partnerships. Linking care management to supportive housing for high-risk homeless clients has been demonstrated to both dramatically improve health outcomes and decrease costs. Permanent housing stabilizes participants, and case management services connect them to preventive and primary care, reducing use of costly crisis care.



In 2014, with Medicaid expansion, a new chronically homeless, complex population entered managed care. This led to new models of health care delivery focusing on “Triple Aim,” and patient-centered, whole-person care. To both improve care and control costs, health-care payers are increasingly are focused on frequent users, particularly homeless frequent users.

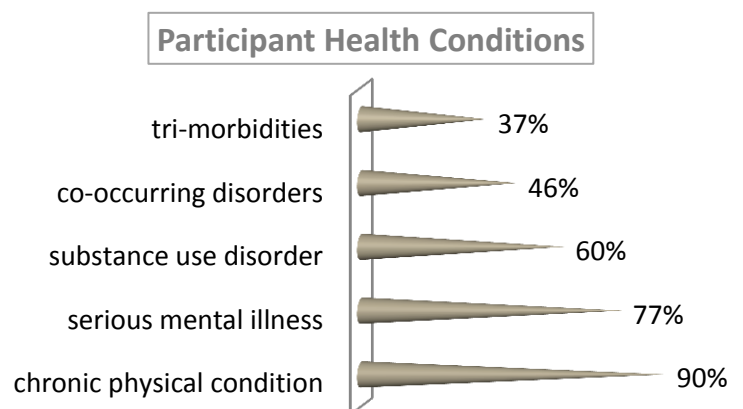
The University of Illinois Chicagoⁱ found that healthcare costs for super-utilizers are five to 15 times the average patient’s costs, and 70% of super-utilizers are chronically homeless. The 30-day inpatient hospital readmission rate among homeless patients was 51% in one studyⁱⁱ. A Toronto study in the *Journal of General Internal Medicine*ⁱⁱⁱ found that “homeless patients had nearly four times the odds of being readmitted within 30-days as compared to low-income controls matched on age, sex and primary reason for admission to hospital.”

Most homeless frequent users of crisis services are caught in a revolving door, cycling between emergency rooms and the street. These patients present complex, co-occurring social, health and behavioral health problems; are not adequately served by mainstream systems of care; and demand comprehensive interventions - encompassing medical and behavioral healthcare, housing, and intensive case management. MCOs and hospitals have strong fiscal incentives to design more effective care for high-need, high-cost individuals.

MCOs and hospitals around the country are taking steps to help homeless people find housing, including supportive housing. Doing so will limit unnecessary ER visits and reduce wasteful health care spending. It allows many of our partners like Dignity Health, Orlando-based Florida Hospital and Providence Health & Services in Portland, OR, to fulfill their missions and community service obligations. CSH estimates healthcare organizations have invested \$75 million to \$100 million into supportive housing projects we have embraced over the past several years.

B. best practices and innovations: how 10th Decile Project grantees respond and contribute to emerging housing and healthcare trends

CSH piloted its first Los Angeles 10th Decile FUSE pilot in 2011 to help hospitals reduce readmissions from a small number of high-cost homeless individuals. These individuals suffer from co-occurring disorders, including chronic health ailments, mental illness and substance abuse disorders, as well as homelessness, which make them less likely to utilize primary care and very likely to end up in hospital emergency rooms.

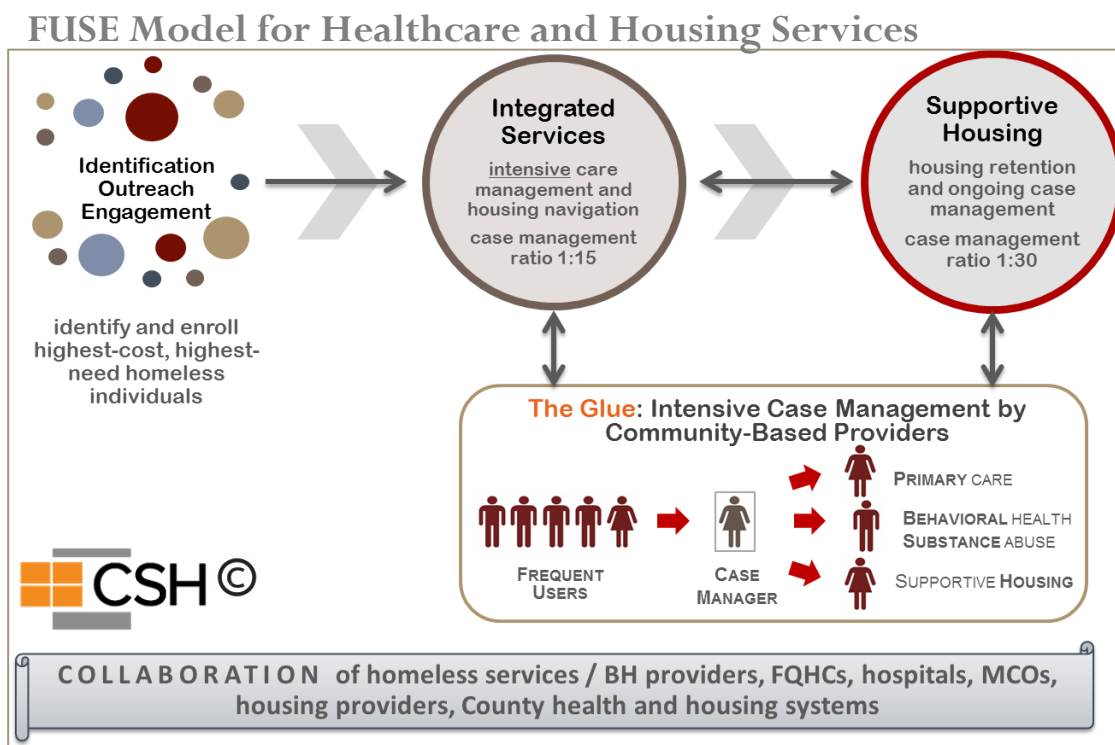


- **Targeting:** This initiative targets the top 10% highest-cost, highest need homeless individuals in Los Angeles County. This is a data-driven process, using a triage tool for identification. The 10th Decile Triage Tool was developed to identify the likelihood that an individual is in the top 10% of

homeless individuals regarding cost to systems and individual need. This tool uses an algorithm to identify these individuals based on demographics and health status.

- **Collaboration:** The 10th Decile Project created collaborative networks throughout Los Angeles. Each collaborative includes homeless services, hospitals, and community health centers.
- **Supportive Housing:** Each participant in this initiative is placed in supportive housing. Rent is subsidized by either Section 8 or Shelter plus Care vouchers.
- **Intensive Case Management:** This initiative provides intensive case management to participants, which includes care management, housing navigation, management of referrals and clinical care, such as medication review, and care coordination. Case managers directly link individuals to primary and behavioral health services and communicate with health and housing providers.

Despite the complexity of treating these members, who present serious co-occurring health issues, the 10th Decile Project has resulted in dramatic reductions in hospitalizations and ER usage, and improved overall health outcomes for 200 of Los Angeles County's most vulnerable homeless individuals. Housing stabilizes participants, and ongoing case management services connect them to preventive and primary care, reducing their use of costly crisis care.



Integrating care management and supportive housing lowers public costs while stabilizing health conditions. The critical role is in the process that of the 10th Decile Project case manager who stays with the participant from enrollment to housing to stabilization. The role of case manager is to:

- provide intensive case management and coordinates housing and social services — by working with a team of hospitals, FQHCs, mental health providers, homeless services and housing providers
- screen frequent users at the hospital: if the member is in the 10th Decile, a warm face-to-face hand-off from hospital staff to case manager begins the relationship - with member history, clear discharge instructions, and 30 days of medication provided by the hospital
- utilize motivational interviewing and place participants in temporary housing and enroll in SSI/ Medi-Cal

- enroll clients in primary care and behavioral health homes and schedule visits and accompany clients to see primary care providers and appropriate specialists, mental health providers, and SUD treatment
- provide complete housing navigation services include preparing housing applications for housing authorities in LA County, conducting housing searches, negotiating with landlords
- help clients with move-in and transition support to supportive housing
- provide continued case management, including daily living skills, financial management, and community integration

A number of best practices and innovations in outreach and engagement, care management, care coordination, and social supports have come out of our 10th Decile Project homeless services agencies: Housing Works, The People Concern (formerly OPCC), Ascencia, Homeless Health Care LA, LA Family Housing, Northeast Valley Health Corp., JWCH, Community Health Alliance of Pasadena, Watts Health Care Corp., and Venice Family Clinic.

Best Practices in engaging clients: Initial engagement may take anywhere from a few months to over a year, but engagement is a continuous and evolving process.

- Warm hand-offs from hospital partners to homeless services agency staff are critical. Because it can be much harder to locate and engage clients after they are discharged from the hospital, it is important to maximize the time clients are in the hospital for engagement.
- Homeless services agency staff must build momentum in early stages of the relationship with clients. Homeless services agencies should prepare as much as possible from a program perspective so certain action steps (e.g., securing interim housing) can be taken as soon as a client expresses readiness.
- Prioritize action steps according to the needs of the individual client. Instead of following a set program model of which needs to address first, case workers should individualize the plan to what makes the most sense for the client.



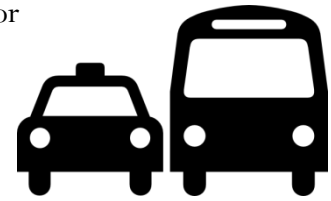
Best Practices in providing comprehensive care management: 10th Decile Project clients often have co-morbidities or tri-morbidities of health, behavioral health, and substance use disorders. The presence of multiple conditions can exacerbate negative health outcomes and complicate treatment and recovery. Comprehensive care management is integral in ensuring that all aspects of a client's health and well-being are addressed^{iv}.

- Meet clients "where they are" by employing the Harm Reduction model. Harm reduction "is a set of practical strategies that reduce negative consequences of drug use and mental illness."
- Individualized wellness plans: only the client can define his/her progress. Clients should always be in charge of defining their progress and determining when it is being made.
- Ensure adequate staff capacity to provide consistent and responsive case management for as long as necessary. The intensity of case management services required at a particular time will depend on the client's experience in homelessness, health and behavioral health status, trauma history, relationship with the case worker and other providers, and other factors.



Best Practices in care coordination: Care coordination involves working with clients, their care providers, and health plans to implement their individualized wellness plans.

- Convene case conferencing meetings that bring together homeless services agencies, hospitals, and care providers. Meeting regularly in-person provides opportunities to not only talk through care coordination challenges but also to strengthen agency partnerships to improve collaboration.
- Ensure both availability and accessibility of services. Transportation, poor health, and long wait times are some of the barriers to accessing health care services for 10th Decile Project clients. Some case workers may directly provide transportation to health care appointments while others may arrange for transportation services (e.g., Access Services or reduced fare programs for public transit).
- Facilitate communication and understanding between clients and providers. In addition to accompanying clients to appointments, case workers should be prepared to help facilitate communication and understanding between clients and providers when necessary.
- Maximize community transitional care resources to minimize readmission and return to homelessness. Because hospital emergency departments are required by state law to have a discharge plan for homeless patients, it is in the best interest of hospitals, homeless services agencies, and clients for program staff to work closely with hospital discharge planners and recuperative care providers, if needed.



Key Innovations:

- OPCC created multiple “Home Teams,” composed of clinical and non-clinical staff providing a range of supportive services (including clinical services, case management, and linkage to community resources) to clients who have moved into permanent housing.

Best Practices in providing community & social supports:

- Meet clients “where they are” by providing Housing First with supportive services. The Housing First approach is considered to be the most effective strategy to engage a homeless client with physical health conditions or behavioral health conditions. It is based on the idea that individuals can recover and heal best when housed, rather than on the streets.
- In Housing First, a client’s eligibility for and retention in housing are not contingent on participation in mental health treatment, participation in substance abuse treatment, or abstinence from drugs. In order to be eligible for and retain housing, the client must simply abide by the lease (for which participation in services is not a condition).
- For most 10th Decile Project clients, merely moving into permanent housing is not enough, and this period of transition may be especially difficult for many. Supportive services, while not a condition of the lease, should be easily accessible for clients who wish to utilize them. Supportive housing buildings that offer on-site services for tenants can be helpful for clients in need of more intensive services.
- Case workers should build relationships with landlords, property managers, and on-site service providers. In order to succeed, supportive housing requires effective partnerships among property owners, property managers, on-site service staff, case workers, and clients.
- Case workers should be familiar with and utilize community resources to meet clients’ needs. The case worker must stay informed about available community resources, their eligibility criteria, and the steps necessary to advocate for their clients. This requires maintaining relationships with other community agencies and programs through networking and collaboration.



Key Innovations:

- Homeless Health Care Los Angeles (HHCLA) operates a Wellness Program, which provides a range of groups and workshops to a number of clients with substance use problems. Clients experience a decreased urge to consume alcohol and showed improvements in mental health, sense of control, and other factors related to well-being.
- OPCC's Respite Program has grown into a "Wellness Beds" Program, which provides on-site nursing care, as well as a full range of OPCC's core services, to clients with both acute and chronic medical conditions. These beds allow for extended stays for people who require recuperative care and need interim housing while waiting for supportive housing.

II. impact on organizations

A. partnerships

The key foundational requirements for FUSE to be successful are:

1) effective community-based providers

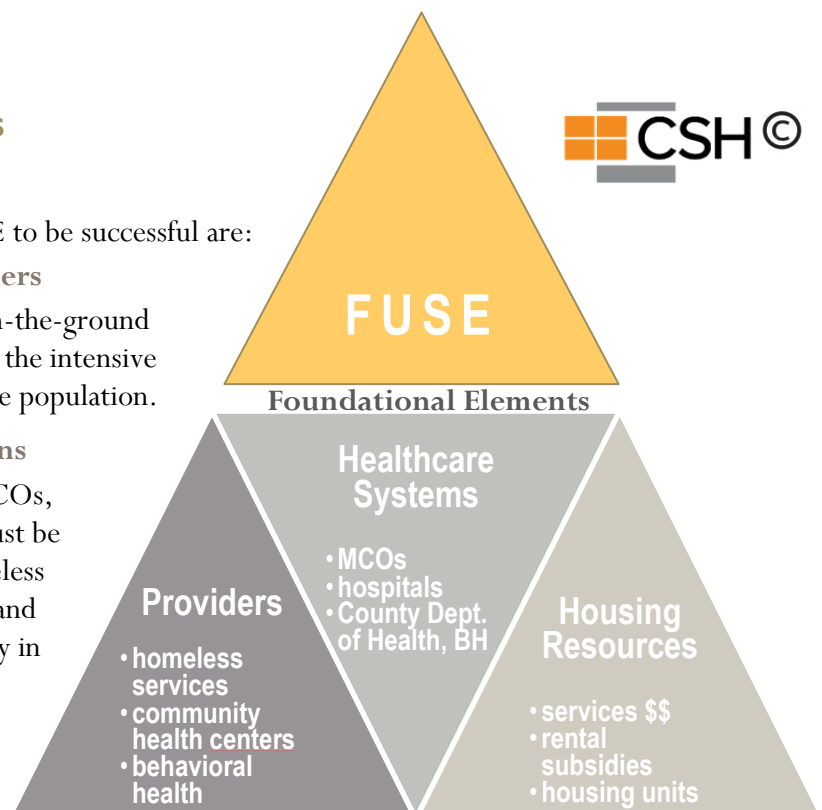
In a community starting a FUSE pilot, the on-the-ground services capacity must be in place to provide the intensive case management required for this vulnerable population.

2) collaborative healthcare institutions

Partner healthcare institutions, including MCOs, hospitals, and community health centers, must be committed to truly improving care for homeless members, support Housing First strategies, and have the staff capacity to engage meaningfully in the FUSE program.

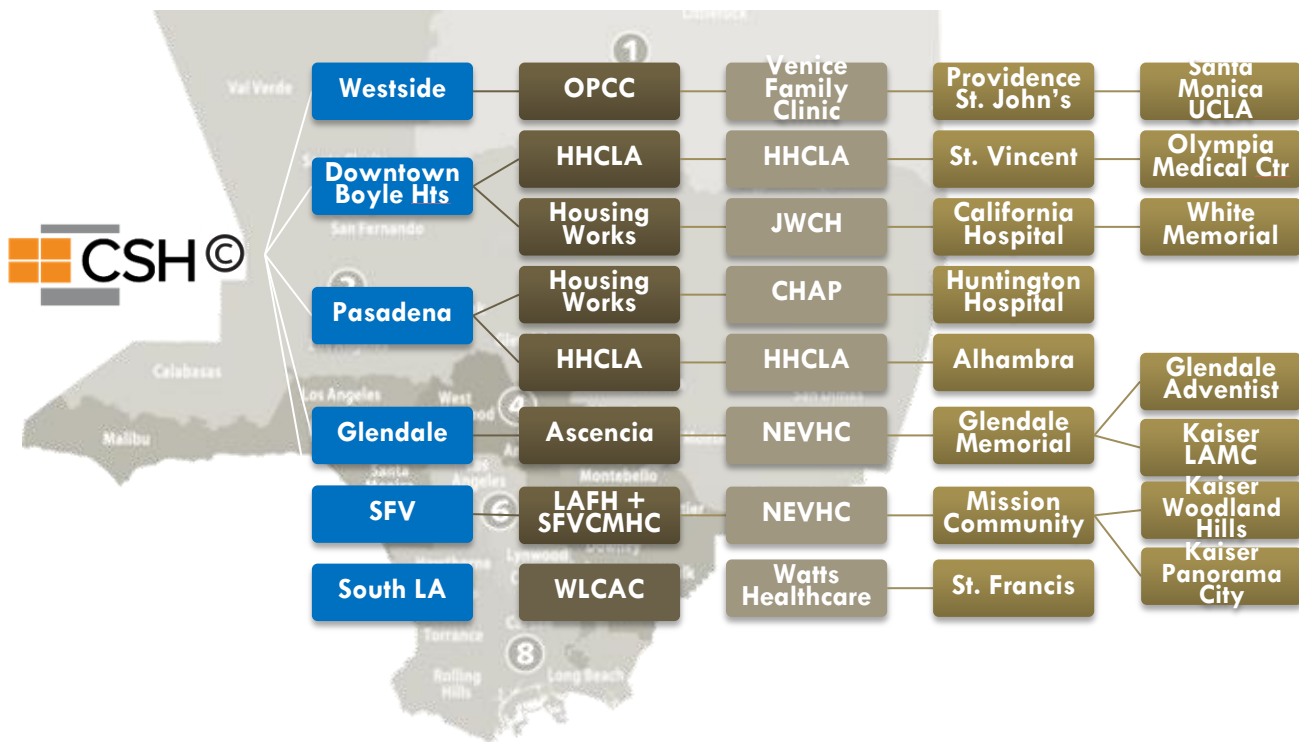
3) aligned housing resources

Finally, the community should have the housing vouchers and housing units to support the size of the FUSE initiative.



In Los Angeles County, 29 organizations, including seven homeless services providers, six community health centers, 15 hospitals, and L.A. Care Health Plan, have participated in 10th Decile Partnerships throughout the county over the past five years to successfully address the needs of the top 10% highest-cost, highest-need individuals experiencing homelessness.

Los Angeles County 10th Decile Project Network (2012-17)



Best Practices in identifying homeless frequent users: Identifying individuals who are eligible and appropriate for the 10th Decile Project requires much planning and collaboration. Homeless services agencies and hospital partners of the 10th Decile Project identified the following best practices for client identification:

- Homeless services agencies must build and maintain close relationships with hospital partners. Many 10th Decile Project participants are identified through their interactions with local hospitals. Strong relationships between hospital partners and homeless services agency staff can better facilitate communication about client referrals, warm hand-offs, and follow-up steps.
- Ongoing education and support save time and resources by giving homeless services agency staff and hospital liaisons the ability to make more appropriate referrals. Lack of familiarity with the 10th Decile Project and inappropriate client referrals (i.e., those who do not meet the eligibility criteria) are two barriers to successful client identification. Support and training schedules will depend on the agency and hospital environments.

Strategies to build and strengthen relationships:

- Convene regular partnership meetings for case conferencing, problem solving, and program updates. Meeting regularly in-person provides opportunities to not only talk through care coordination challenges but also to strengthen agency partnerships to improve collaboration.
- Identify a hospital liaison or health plan liaison (e.g., Community Health Navigator or Social Worker) to streamline communications and facilitate access to health care services.
- Create opportunities for hospital partners to receive updates on former patients in the 10th Decile Project (e.g., presentations at hospital meetings or inviting hospital partners to community events).
- Ensure homeless services agency staff spend time 'on the floor' with hospital partners to learn about the hospital environment, answer any questions, and meet with potential clients.
- Secure a space within the hospital, preferably the Emergency Department, to meet with potential participants.



Key Innovations:

- Community Health Workers: Since 2013, Housing Works, John Wesley Community Health, (JWCH) and California Hospital Medical Center (CHMC) have placed a Community Health Navigator (CHN) on-site at CHMC to conduct outreach and referrals in the inpatient and emergency departments. The Navigator is employed by JWCH and works closely with both CHMC social workers and Housing Works case managers to ensure warm handoffs and linkages to medical homes for 10th Decile Project participants. Because of the volume of activity at CHMC, social workers need the assistance of an on-site CHN who can give homeless patients sufficient attention to ensure they are linked to the services and housing they need.
- Off-Hours: Ocean Park Community Center (OPCC) and Providence Saint John's Health Center started a new program in 2015 to place an OPCC staff member in Saint John's emergency department from 4:00 pm to midnight. The pilot program allows OPCC staff to better understand how the hospital system works and what barriers and challenges exist from the hospital's side. The program also gives OPCC staff a "boots on the ground, first-hand" look at the homeless patients who are coming to the emergency room for medical help.
- Health Plan Liaisons: L.A. Care Health Plan assigned two Interdisciplinary Care Team members as point people for 10th Decile Project case managers in dealing with individual member issues – one for medical issues and another for mental health issues. This structure increased and/or expedited access to health care services such as In Home Supportive Services and medical equipment, and increase quality of care for participants.

Best Practices in data collection & exchange:

- Establish clear information-sharing guidelines and protocols early in the partnership. Clear channels of communication and data sharing are critical to client care coordination and comprehensive care management. Create policies to support information sharing and agree on preferred methods of information sharing (e.g., spreadsheets, faxes, e-mail, etc.) and expectations for timelines. For example, hospital liaisons may agree to provide weekly lists of frequent utilizer visits to homeless services agency staff via e-mail.
- Share regular program updates with stakeholders. Newsletters, meetings, or monthly reports can be used to show what services are being provided, the number of frequent utilizers being served, the number of frequent utilizers who are eligible, and trends highlighting emergency department admission and inpatient day reductions.



B. scaling up

A five-year grant awarded by the Corporation for National and Community Service's (CNCS) Social Innovation Fund (SIF) helped CSH support the 10th Decile Project as well as similar CSH-led initiatives across the country. The initiative funding allowed some providers to replicate the program in new communities – with new local partners, and all providers to expand in their existing locations.

One example of “going deeper” includes a new program by Housing Works called Hollywood 4WRD, to provide intensive engagement, care management, and housing navigation services for a number of individuals on the streets of Hollywood who are considered “super chronic.” Housing Works created Hollywood 4WRD to house people suffering with chronic untreated mental illness and substance abuse issues who have survived on the streets for decades. Each individual suffers from severe mental illness and rarely budges from a spot they have inhabited for years. Housing Works case managers provide placement into appropriate treatment settings and develop expertise in the world of conservatorships, extended stays in skilled nursing facilities, and other living situations that provide a level of care beyond what is offered in supportive housing.

CSH convened a 10th Decile Project Learning Community to allow collaboratives to share best practices, discuss dilemmas, and learn new information about local and state policy developments. Two providers developed and expanded regional hospital collaboratives to further engage hospital partners in the issues.

With the Western Center on Law and Poverty, CSH co-wrote AB 361, which authorized California to implement the **Health Homes Program** (HHP) and required CA to include chronically homeless and frequent hospital users as Health Homes target beneficiaries. CSH advised Department of Health Care Services (DHCS) staff on the implementation of a Health Home benefit in California. DHCS's Concept Papers incorporated CSH's recommendations, including funding new “Housing Navigator” positions at homeless service providers, and targeting and criteria strategies. DHCS asked CSH to convene a technical workgroup in 2015 to develop a Health Homes benefit specifically designed for homeless Medicaid beneficiaries. CSH developed a comprehensive training program for homeless services providers and FQHCs to build local capacity for health homes. The new Health Home Program (HHP) in California, scheduled to launch in Los Angeles County in July 2019, will be a critical funding stream for sustaining collaborative models like the 10th Decile Project.

Methods of Scaling Impact

1

Replicating a program in new sites

- Housing Works: Pasadena, Boyle Heights, South LA
- Ascencia: Burbank

2

Expanding/going deeper in existing locations

- The People Concern: Santa Monica
- HHCLA: Metro LA
- Housing Works: DTLA, Hollywood 14
- Ascencia: Glendale

3

Providing TA and convening Learning Communities

- CSH 10th Decile Project Learning Community
- The People Concern: Westside Hospital Collaborative
- Ascencia: Glendale Hospital Collaborative

4

Advocating for changes in policies and practices

- CSH: Advocacy with State for robust Health Homes Program

III. results of the five-year investment

A. impact on hospital utilization and costs

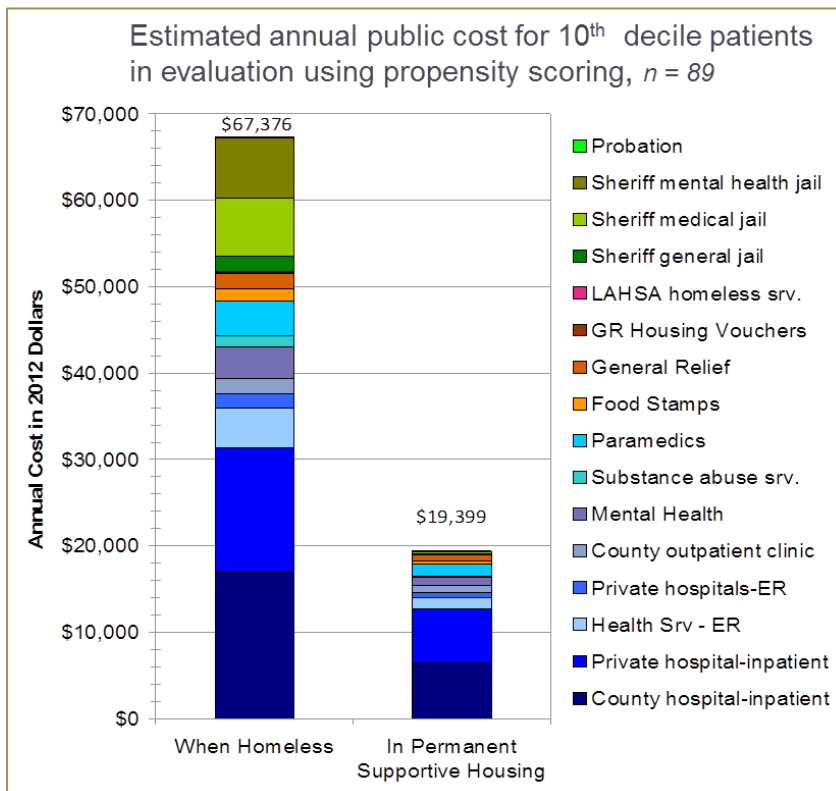
Supportive housing requires three funding streams: capital, operating (or rental) subsidies, and services funding. Often the most difficult to secure funding is services funding. The 10th Decile Project makes a compelling case for committing services funding to match housing resources in a community.

The 10th Decile Project's program and interim evaluation data show that participants came in with chronic health needs coupled with long histories of homelessness:

- 90% have **chronic medical conditions** (hypertension, diabetes, heart disease, COPD, asthma);
- 33% experienced medical problems every day in the month prior to enrollment;
- 77% have **serious mental illnesses** (bi-polar disorder, schizophrenia, major depression);
- 31% heard voices in the month prior to enrollment;
- 60% have **substance use disorders** (alcohol, heroin, cocaine);
- 46% have **co-occurring disorders**;
- 37% have **tri-morbidities**; and
- 61% experienced **homelessness for 4 or more years** – some for decades.

These chronic health conditions and long homeless history of participants led to extremely high rates of hospital utilization:

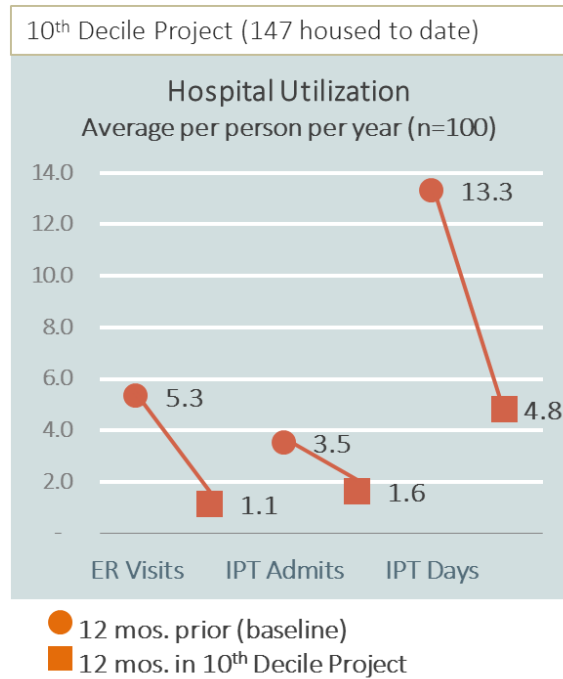
- 82% had **ER visits** in the 12 months prior to enrollment;
- 49% had **more than 4 ER visits** in the prior 12 months;
- 66% had **inpatient admissions** in the prior 12 months; and
- 33% had **at least 1 psychiatric hospitalization** in the 12 months prior to enrollment.



A 2013 Economic Roundtable interim report on the 10th Decile Project found that the highest-cost, highest-need 10% of the homeless population in Los Angeles County presented total public costs, on average, of \$67,376 per year when homeless – compared to \$19,399 when in supportive housing. The majority of public costs (in blue) are healthcare costs, and the majority of healthcare costs are inpatient costs.

In the 10th Decile Project funded by the Social Innovation Fund (2012-17), 147 participants with complex health needs moved into supportive housing, and 117 remain in supportive housing—above the original target of 107.

The project's housing retention rate is 93% after one year in housing. We had a total of 30 participants exit housing: 7 passed away, 3 moved to independent housing, and 2 moved in with family. We had 18 "negative" exits, including 3 becoming incarcerated, 3 moving to a higher level of care (such as a SNF or board and care), 6 being evicted, and 6 returning to homelessness.



Outcomes from the five-year 10th Decile Project are based on program data, including 10th Decile triage tool data and program tracking data reported quarterly.

Participants decreased ER visits by 79% and inpatient days by 64% in the first year after moving into supportive housing.

Participants decreased their emergency department (ED) visits by 79% during their first year in housing, decreased in inpatient admissions by 54%, and inpatient days by 64% in the first year in supportive housing. While 98% of participants had visited the ED and 95% had been admitted to a hospital in the year before enrollment, in the past year, only 31% of participants have been to the ED and 28% have been admitted to a hospital after moving into housing.

Decreases in hospital utilization led to an average cost avoidance of **\$80,000** per participant over the initiative. Hospital cost avoidance is estimated at **\$10 million** to date.

Furthermore, 79% of participants are regularly making primary care visits since moving into housing, 58% of participants with chronic physical conditions are accessing specialty care, 62% of participants with mental illness are making mental health visits, and 35% of participants with SUDs are accessing substance abuse treatment.

B. impact on healthcare and housing collaborations and systems

The 10th Decile Project has contributed to five systemic shifts in Los Angeles County.

- 1** Increase in the **quality of supports** for health and housing for high-acuity homeless people

 - The 10th Decile Project model was refined into a high quality model of intensive case management for the highest acuity populations. Recommendations from providers have informed program development & scale up for Housing for Health, Whole Person Care, and Health Homes.
- 2** Collaboratives working with homeless beneficiaries **across sectors**

 - The 10th Decile Project introduced supportive housing and supportive services to hospitals and managed care organizations in Los Angeles County. Transitions of care from hospital to community-based providers were refined, and partners are committed to warm hand offs.
 - The lack of SH units and bridge housing were major challenges in the program, but moving forward, new bridge housing will be funded by Measure H and new PSH built with HHH funds.

3

Collaboratives increasing the number and types of **innovations**

- Collaboratives are implementing pilot programs to meet service gaps and scaling existing services to reach more homeless frequent users. The Westside team has two on-site patient navigators at Providence St. John's Health Center, and California Hospital has an on-site Community Health Navigator as well to do outreach and engagement for homeless patients.

4

Increased **partner accountability** & commitment to sustaining **collaborative** activities & structures

- Health and housing collaboratives are starting to articulate a common vision and shared agenda - Westside, Glendale. However, this will to collaborate and is not in place in every community.

Page | 15

5

Increased **investments** for health and housing

New funding dedicated to health and housing integration

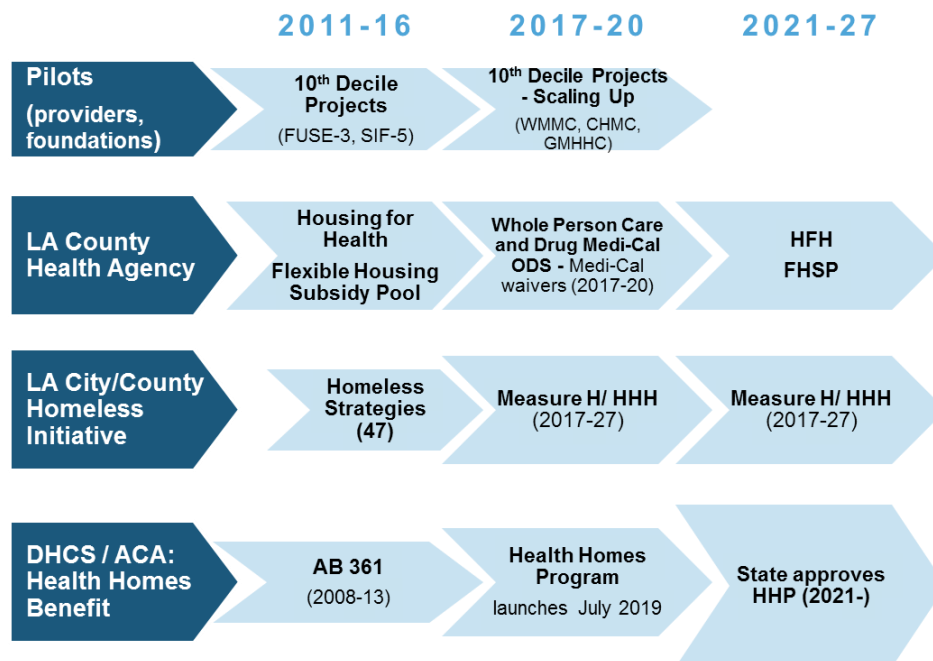
Expanding funding streams to better support scaling

Pilots (2012-17) **Approximately \$8M Total**

- CNCS Social Innovation Fund, Conrad N. Hilton Foundation, L.A. Care, Dignity Health

Scale Up (2017-20)

- **WPC, H4H** \$1.2 billion over 5 years
- **FHSP/L.A. Care** \$20 million over 3 years
- **Measure H** \$355 million per year for 10 years
- **Measure HHH** \$1.2 billion over 10 years
- **Health Homes Program** \$250 million per year for 2 years plus potential of permanent HH benefit



IV. moving forward into “a perfect storm”

There is an unprecedented confluence of housing and healthcare funding streams now falling into place in Los Angeles County, a “perfect storm.” The combination of funding from the Department of Health Services (via Housing for Health and the Flexible Housing Subsidy Pool), the Whole Person Care pilot, Measure H, Proposition HHH, the Drug Medi-Cal waiver, the Health Homes Program, and state housing bills will scale supportive housing for frequent hospital users experiencing homelessness. We have come a long way from two small FUSE pilots in 2011 to today. And we should systematize the innovations and best practices that have developed into effective strategies over the past six years, and incorporate them into the emerging new array of integrated services in Los Angeles County.

STATE and LOCAL HOUSING RESOURCES

Measure H (2017-27)

- \$3.5 B over 10 yrs (\$355 M annually) for implementing services and local subsidies
- LA County (quarter-cent sales tax)

Proposition HHH (2017-27)

- \$1.2 B over 10 yrs for projects to create 10,000 SH units
- City of LA (bond)

Affordable Housing Fund (2016-)

- Allocation: Y1/2/3/4/5 = \$20/40/60/80/100M thereafter; at least 75% AH/up to 25% RRH
- LA County

No Place Like Home (1st NOFA in 2018)

- \$2 B for development of SH for persons in need of mental health services and experiencing homelessness
- California (bond)

State Housing Package (2018-)

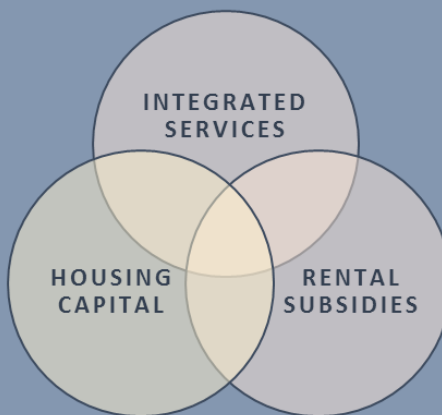
- SB2: Building Homes and Jobs Act, \$1.2 B over five years for permanent state source of funding for AH
- SB 3: \$4 B state housing bond Nov '18 ballot
- 13 other bills to streamline /ensure AH development to meet state housing needs

AB 74: Housing for a Healthy CA (2018-20)

- \$20 M in capital and subsidies per year from National Housing Trust Fund tied to WPC & HHP services for supportive housing for chronically homeless Medi-Cal beneficiaries

CES
Coordinated Entry
System

FULL ARRAY
OF INTEGRATED
SERVICES IN
SUPPORTIVE HOUSING



Health & Housing Symposium #1
Oct 23, 2017



FEDERAL, STATE, LOCAL HEALTHCARE RESOURCES

Housing for Health (DHS)

- Outreach, Intensive Case Management Services, bridge housing, permanent housing and navigation
- LA County

ODR: Proposition 47 and SB 678 (DHS)

- Prop 47: \$20 M
- LA County
- SB 678: \$200 M over 5 yrs
- California

Whole Person Care LA Pilot (2016-20)

- \$1.2 B over 5 yrs for high-cost, high-need Medi-Cal beneficiaries
- 10,000 housed by 2020
- LA County / under CA 1115 Medi-Cal Waiver

Drug Medi-Cal Organized Delivery System (2016-20)

- New case management and field-based substance abuse treatment services
- LA County / under CA 1115 Medi-Cal Waiver

Health Homes Program (July 2019- ?)

- New Medi-Cal benefit for integrated, person-centered service delivery system for populations with complex, chronic conditions
- Serve approx. 10,000 beneficiaries experiencing homelessness per year
- California / under ACA Health Homes Option CMS

V. tools and reference

A. Los Angeles City/County Homeless Initiative

After the City of Los Angeles declared a State of Emergency regarding homelessness, the City Council adopted a Comprehensive Strategy for Homelessness in February 2016. The Homelessness Reduction and Prevention, Housing, and Facilities Bond (**Proposition HHH**) was passed by voters in November 2016, allowing the city to borrow up to \$1.2 billion over 10 years for construction projects to build 10,000 supportive housing units, at a rate of 1,000 units per year. To support this larger pipeline and unit production, CSH is working with the Los Angeles Housing and Community Investment Department (HCIDLA) and multiple foundations, including The Conrad N. Hilton Foundation, to expand the Los Angeles Supportive Housing Loan Fund (SHLF). In June 2017, the City Council approved nearly \$74 million for nine permanent supportive-housing projects, which will pay for a total of 615 housing units that are mostly aimed at helping those who are chronically homeless or need on-site services. Another \$12 million was approved for other types of facilities for the homeless.

In March 2017, Los Angeles County voters approved **Measure H**, a ballot initiative to generate \$355 million annually for the next 10 years, to be used exclusively for combating homelessness in LA County. This is the second phase of the two-step strategy developed by the city and county as part of the Homeless Initiative begun in February 2016. A 50-member Measure H Revenue Planning Group convened in April-June 2017 to deliberate and make funding allocation recommendations to the County Board of Supervisors. These final recommendations were approved by the Board of Supervisors in June 2017. In its first year (FY 2017-18), Measure H will fund \$19 million for outreach, \$69 million for emergency/ interim/ bridge housing, and \$25 million for case management services (which grows to \$72 million annually by 2020), as well as \$ millions for rapid re-housing, homeless prevention, and the Coordinated Entry System. Together, these will provide substantial resources for intensive case management and housing navigation for homeless frequent hospital users.

B. healthcare: Medi-Cal waivers, MCOs, health homes

The shift to integrated care, population management, payment reforms and cost savings underlie exciting new healthcare funding mechanisms in California. These reforms to California's health systems offer counties opportunities to address the health needs of vulnerable populations.

At the same time as Measure H and Prop. HHH, the **Whole Person Care (WPC) waiver** launched in September 2017, bringing in \$1.2 billion between 2016-2020 for services for high-cost, high-need Medi-Cal beneficiaries. The vision of Whole Person Care Los Angeles (WPC-LA) is to ensure that the most vulnerable Medi-Cal beneficiaries in Los Angeles County have the resources and support they need to thrive. The pilot will bring together health and social service delivery entities across the County to build a more client- and community-centered system of care and develop the foundational infrastructure necessary to deliver seamless, coordinated services to vulnerable Medi-Cal populations – with approximately 40% dedicated to intensive case management and housing navigation services for Medi-Cal beneficiaries experiencing homelessness.

The WPC pilot is building a county-wide infrastructure to improve care to high-risk, high-need Medi-Cal beneficiaries that are “high-users” of multiple public systems. The target populations are: homeless high-risk beneficiaries, justice-involved high-risk, mental health high-risk, SUD high-risk, medically complex high-risk, and perinatal high-risk. Strategies will focus on creating an integrated delivery system; care coordination during high-risk times; addressing social and behavioral health needs; and creating jobs for individuals with shared lived experience. The WPC pilot for homeless beneficiaries will work primarily through supportive housing and re-entry “Intensive Case Management Services” (ICMS) community-based providers under contracts with DHS.

WPC-LA will build a seamless, integrated health delivery system for each of the target populations.

1. **Care support and coordination:** use of care management strategies that bridge care and services delivered in disparate locations by disparate personnel in order to build a coordinated and comprehensive plan for each patient.
2. **Mobile Health Care Support Teams:** mobile, multidisciplinary health care support services teams to address complex care needs.
3. **Connection to clinical services:** referrals and connections to core clinical services reimbursable through Medi-Cal.
4. **Direct provision of non-Medi-Cal-reimbursable clinical and support services:** clinical or care support services that are not Medi-Cal reimbursable.
5. **Physical infrastructure:** expansion of recuperative care and sobering centers.
6. **Training and performance improvement:** new collaborative Training Institute for the County with key training partners across the county to improve care for our highest risk clients, with a particular focus on community health workers (CHWs); a performance improvement infrastructure for data-driven, continuous quality improvement.
7. **Use of new workforce members:** a “novel” workforce strategy in which we will employ workforce members that are not typically involved in care of the target population. CHWs, including those with life experiences shared by the target population, will be integral members of our care management teams.
8. **Outreach and engagement:** mobile, community-based engagement approaches out of our Regional Coordinating Centers.
9. **Housing and placement support services:** move-in assistance, tenancy support, help managing landlord interactions, linking enrollees to interim and permanent supportive housing and to rental subsidies via federal rental subsidies and the non-WPC funded housing pool.
10. **Enabling services:** benefits establishment and enhanced care support supplements as needed.
11. **Care management platform (CMP):** allows interdisciplinary care plan to be visible across providers in real-time.
12. **Other information technology (IT) solutions:**
 - a. Community resource platform – a searchable, continuously updated, web-based platform that connects LAC residents to community resources and enables referral tracking.
 - b. ClientTrack – a housing IT platform that enables management of client intake and triage, as well as continuous tracking of clients and housing units.
13. **Countywide data integration:** data integration approach and advanced analytics to identify high-risk individuals in multiple settings (e.g., emergency departments, hospitals, institutes of mental disease and jails).

The **Drug Medi-Cal Organized Delivery System (DMC ODS) waiver** launched in July 2017, through an amendment to an existing 1115 Medicaid Waiver. DMC ODS significantly expanding reimbursable services under the DMC program – such payments for case management services for beneficiaries with substance use disorders, as well as payments for field-based substance abuse treatment services. According to the Los Angeles County Department of Public Health, the Drug Medi-Cal Organized

Delivery System is “the greatest opportunity in recent history to design and implement a substance use disorder (SUD) system of care that has the financial and clinical resources to more fully address the complex needs of all our patients.” There is now a single benefit package based on DMC, where all beneficiaries/patients have the same access to services regardless of health coverage or funding/referral source. DMC covered services are significantly expanded, and most are not capped if medically necessary (except residential) and available for all Medi-Cal beneficiaries. New DMC benefits include: individual, family, and group counseling; case management and care coordination; recovery support services; short-term residential (youth: up to two 30-day episodes, adults: up to two 90-day episodes); withdrawal management (ambulatory and residential).

DMC covered services are significantly expanded, and most are not capped if medically necessary (except residential) and available for all Medi-Cal beneficiaries.

Key Changes: Infrastructure Development

- DMC RATES: New fee-for-service DMC rates will be negotiated with DHCS with an opportunity to transition to an alternate reimbursement structure (e.g., performance-based, capitation) in later years of the waiver.
- SAGE: SAPC’s MANAGED CARE INFORMATION SYSTEM: Efforts to support use of MCIS, and other technology based systems.

Key Changes: Business Development

- DMC 1st Payer for Most clients and Services:
 - Medi-Cal eligible individuals must receive DMC reimbursable treatment services by DMC providers.
 - This includes outpatient, intensive outpatient, residential, and withdrawal management (formerly detox), case management, and recovery support.
 - This will be required once the new State-County contract is signed and the SAPC SUD benefit package is launched.

Key Changes: System Of Care Development

- SINGLE BENEFIT PACKAGE BASED ON DMC:
 - All beneficiaries/patients have the same access to services regardless of health coverage or funding/referral source. Other funding sources (e.g., CalWORKs, GR, AB109) will be used for uncovered services or to extend services if capped and medically necessary.
 - My Health LA SUD benefit package for low income uninsured individuals will be the same and commence July 1, 2016.

L.A. Care Health Plan is the newest major investor in the Department of Health Services’ **Flexible Housing Subsidy Pool (FHSP)**. In April 2017, L.A. Care announced their \$20 million investment into the Pool. This is perhaps the most strategic way for hospitals and MCOs to partner with the homeless system today. The FHSP identifies and secures an inventory of decent, safe, and affordable housing countywide, executes agreements to lease/procure housing, provides 24/7 response to property owners and landlords, provides housing retention services to tenants to ensure monthly rental subsidy payments to owners. The FHSP infrastructure is in place in Los Angeles County. All healthcare partners working with homeless, high-acuity Medi-Cal beneficiaries – including hospitals and other MCOs – need to be part of the solution, in collaboration with housing systems like the DHS FHSP and the Los Angeles Coordinated Entry System (CES).

These opportunities promote integration of care across systems of care. These hold promise for MCOs and hospitals to develop a new model of care for homeless Medi-Cal patients with complex conditions and to work with a new universe of community-based providers. We know that smart, strategic collaborations can vastly improve how communities address the needs of homeless individuals with complex conditions.

The **Health Homes Program** is a new program California is developing to take advantage of the “health home option” under the Affordable Care Act. The health home benefit is a new Medi-Cal benefit providing an integrated, person-centered, and physical and behavioral service delivery system aimed at populations with complex, chronic conditions, fueled by exchange of health information, evidence-based practices and care coordination, and intended to improve outcomes by reducing fragmented care and promoting patient-centered care. The Health Home Program (HHP) will launch in 2018 in California - and in July 2019 in Los Angeles County. Since 2013, CSH has worked closely with the California Department of Health Care Services (DHCS) to create a Health Home Program (HHP) that, by design, addresses the needs of both homeless and housed Medicaid beneficiaries. The HHP offers California’s community health centers (CHCs) and community-based service providers an unprecedented opportunity to provide team-based care coordination, housing, and services to high-need, chronically homeless frequent utilizers of health systems. Long-term, this funding stream could bring hundreds of \$ millions for care coordination services for the most vulnerable individuals in the state.

C. state housing bills

In September 2017, the governor signed into law the “**State Housing Package**,” a group of 15 bills to address affordable housing.

STATE HOUSING PACKAGE: HIGHLIGHTS¹

- Senate Bill 2, by Sen. Toni Atkins, D-San Diego, creates a permanent source of funding for affordable housing, imposing fees of up to \$225 on certain real-estate transactions, such as mortgage refinancing. (Home purchases would not be subject to the fee.) It will collect \$1.2 billion over the next five years — and would raise a total of \$5.8 billion, including federal, local and private matching funds, according to committee estimates. Half of the money it raises in the first year would go to programs to address homelessness.
- Senate Bill 3, by Sen. Jim Beall, D-Campbell, will place a \$4 billion state-wide housing bond on the November 2018 ballot. Like SB 2, it would pay for existing affordable-housing programs in California that used to be supported by funds from the state’s redevelopment agencies. If the bond



¹ “As Jerry Brown Signs Affordable Housing Bills, Lawmakers Promise to Stay Focused on the Crisis,” Katy Murphy, *The Mercury News*, September 29, 2017.

measure passes and is approved by voters, \$1 billion of the total would go to extend the CalVet Home Loan Program, scheduled to expire in 2018.

- Senate Bill 35, by Sen. Scott Wiener, D-San Francisco, will try to tackle the state's housing-supply shortage. Currently, cities are told every eight years how many units they need to build to meet their share of regional demand — but are not required to build them. This targets cities that fall short, requiring them to approve more housing developments that fit the bill's criteria.
- Assembly Bill 73, by Assemblyman David Chiu, D-San Francisco, will give local governments cash incentives to create high-density "Housing Sustainability Districts" near transit with some affordable housing.
- Senate Bill 540, by Sen. Richard Roth, D-Riverside, allows cities to determine where housing needs to be built and to create a specific plan for development in that zone, including public hearings and environmental reviews. This is intended to speed up the approval and construction process.
- Senate Bill 167, by Sen. Nancy Skinner, D-Oakland, strengthens the state's 35-year-old Housing Accountability Act, known colloquially as the "anti-NIMBY (Not In My Backyard) Act." Cities that don't comply with a court order to allow development would be hit with automatic fines of \$10,000 per housing unit.
- Assembly Bill 1505, by Assemblyman Richard Bloom, D-Santa Monica, restores the ability of local governments to require developers to include affordable rental units. A 2009 appellate court decision cut off that tool, which cities and counties had used for decades.

CSH worked with Assembly member David Chiu to pass Assembly Bill 74, the **Housing for a Healthy California** Program, which will fund \$20 million in capital and rental subsidies per year tied to Medi-Cal services funding. It will designate National Housing Trust Fund money for supportive housing for beneficiaries who are incurring disproportionate health care expenditures because they are homeless. It will also track Medi-Cal data from people moving from homelessness to SH. AB 74 passed the California Legislature in September 2017, and was signed by the Governor in October 2017.

DRAFT BLUEPRINT FOR PLANNING FOR A FUSE INITIATIVE

Cross-System Data Match <ol style="list-style-type: none"> 1. Identify and execute data MOUs with MCO and hospital partners 2. Conduct data-matching with HMIS: <ol style="list-style-type: none"> a. # homeless members, chronically homeless, formerly homeless b. acuity: health, mental health, SUD chronic conditions c. costs for frequent users 3. Determine size of housing need, depth of provider services 4. Develop target population eligibility criteria for FUSE pilot 	Tools Sample MOUs Data-matching strategies This takes time!
Community-based Provider Network Development <ol style="list-style-type: none"> 1. Assess capacity of potential homeless services providers & FQs across the county 2. Assess housing resources in the county: <ol style="list-style-type: none"> a. supportive housing vouchers and units b. bridge housing and recuperative care beds 3. Promote linkages between MCOs and providers 4. Identify local policy champions 	Rubric for assessing capacity Housing system analysis
Network Services Design <ol style="list-style-type: none"> 1. Effective strategies for outreach and engagement of homeless members: front line screening by network and screening by MCOs <ol style="list-style-type: none"> a. client needs dictate action steps (see acuity above) b. provider readiness / services in place c. care transitions protocols / warm hand-offs from hospitals to community-based providers 2. Evidence-based integrated care management for homeless members <ol style="list-style-type: none"> a. care coordination and wellness plans for homeless members <ol style="list-style-type: none"> i. Supportive Housing Services 101 for MCOs / Managed Care 101 training for providers ii. effective communication and advocacy for clients with healthcare providers b. housing services <ol style="list-style-type: none"> i. Housing First and harm reduction ii. housing navigation and placements iii. adequate housing retention case management c. trainings on integrated health and housing services for providers d. provider staffing plans with adequate staffing / case management ratios e. regular case conferencing and data tracking with health and housing partners 	Outreach and engagement best practices Integrated care management trainings/webinars
Financial Model & RFP <ol style="list-style-type: none"> 1. Supportive Housing finance 101 <ul style="list-style-type: none"> • Capital: private sector equity/LIHTC, loans, grants • Operating subsidies: Section 8 vouchers, CoC Supportive Housing grants • Services: Medicaid, grants 2. Financial Model for FUSE Project <ul style="list-style-type: none"> • Services + housing cost projections • Projected cost savings / ROI • Potential funding sources 3. RFP development 	Financial modelling Sample RFPs
Data Linkage w/HMIS & Data Sharing <ol style="list-style-type: none"> 1. Provider selection, contracting process between MCOs and providers, MOUs, BAAs 2. Data sharing across MCOs and HMIS, such as point of care charting, summary of care records for care transitions, real-time updates 3. Track progress, data on hospital utilization and cost avoidance 	

CASE STUDIES of 10th DECILE CLIENTS

Timothy B., who goes by “Popeye,” had been a fixture in Pasadena on the freeway off-ramp for the past 15 years. Popeye, 53, was homeless for 15 years and suffers from hypertension, asthma, depression, and severe alcoholism, all of which has landed him in the hospital consistently. Popeye is originally from Michigan where he was a fisherman. Popeye was admitted to Huntington Hospital for two months after being struck by a car while riding a bicycle under the influence of alcohol. Popeye was identified as a homeless frequent user in September 2012, using the triage tool, and the hospital called in Anthony Ruffin, a Housing Works case manager, to talk with Popeye about a place of his own. He said no.

A week after he was discharged from the hospital, Anthony found him.

"I caught up with him on the side of the freeway. He was infested with lice and scabies," Ruffin said. "All his friends moved on and he was just out there by himself."

After a few more weeks of developing trust through street outreach, Popeye said yes.

Housing Works helped Popeye locate a one-bedroom apartment in December 2012 through the Housing Authority of the City of Pasadena. Housing Works also helped Popeye gain access to Medi-Cal and SSI, connect with CHAP, Community Health Alliance of Pasadena, as his medical home, and helped him manage his finances.

With the help of Anthony and Housing Works, Popeye

was able to start receiving care for his chronic medical and mental health conditions, and start putting his life back together. Popeye quit panhandling and gets regular visits from Ruffin to help him shop, cook, and keep his monthly primary care and behavioral health appointments. In 2015, Anthony helped Popeye reconnect with his son after 20 years, and travel to Michigan to meet his new-born granddaughter. In December 2016, Popeye celebrated his four-year anniversary in his apartment. Anthony and Popeye still get together to watch football.

As Popeye put it, “It’s a different world” from living on the streets.

Amy* is a 51 year old Caucasian female with history of chronic health conditions, mental health, substance abuse and chronic homelessness. Amy was found by the HHCLA outreach team sleeping underneath a bridge in the Pico Union area. She had been homeless for 18 years and did not trust any service provider and had no interest in having a primary medical home. Due to a number of health challenges, she had been hospitalized for many years and struggled with connecting with any service provider.

Through the 10th Decile Project, the client was able to secure temporary housing, obtain a primary medical care, secure transportation assistance, utility assistance, furniture assistance, and ultimately re-establish a trusting rapport with a service provider, HHCLA. With the help of HHCLA case managers, Amy was able to successfully find permanent housing in the Pico Union area, where she had been homeless for many years. Now, Amy walks by the bridge she slept underneath, holding up her head high as she walks on to a nice warm place she calls home.

*Pseudonym

In the 1980s, **Connie*** was living in an abandoned car with her mother and sister in Downtown LA - where she watched her mother score crack from the rear passenger window of their dilapidated, rusty Buick. One day their mother told them they were going to Jack in the Box, but instead took them to a foster home agency. Connie can remember the sinking feeling in the pit of her stomach when she heard her mother telling the social worker that she did not want her children anymore. That was the last time Connie saw her mother. Connie and her sister were adopted by an older couple, and they grew up in a fairly stable middle class home. After graduation from high school, Connie married twice, lost custody of two sons, and

struggled with alcoholism and became homeless. In 2015, Connie suffered a mental health episode and landed in an acute psychiatric hospital for the first time. After her third hospitalization, Glendale Memorial Hospital called in Ascencia to enroll her in the 10th Decile Project. Connie was deeply depressed, apathetic, and would not make eye contact with the Ascencia case manager. She answered questions in a monotone voice, stating that she didn't care where she went as long as she had a place to stay. Connie had been homeless since her second marriage ended, and had never been in a homeless shelter, but she was willing to try it.

When Connie came to Ascencia's shelter, she had been a school bus driver, and she was motivated to work. Ascencia helped her to focus and she got a job driving for MTA for the summer - the 91 bus in Glendale. On the weekends she visited her children. Connie had two setbacks while at the shelter. When her sister died of cancer, Connie became depressed and suicidal, resulting in one week in a psychiatric ward. After her hospitalization, Connie was stable until the MTA assigned her an extra route to Downtown LA. She began having flashbacks of her mother smoking crack in the abandoned car. Connie walked herself to a Medical Center where she stayed for two weeks. There, Connie realized that she gave her children away just like her mother gave her away, and that she was an addict just like her mother was. She decided to fight the addiction, asked Ascencia to set her up with a trauma therapist, and kept her appointments every week. She learned to understand her mental health disorder, to recognize the cycles and triggers so she could control herself. While in the shelter, Connie became a positive role model and found her purpose in helping others. Connie was then housed in the Next Step program which is designed for individuals in recovery from drugs and alcohol. She now has a place to live, a support system that helps her to maintain her sobriety, and most importantly, a place she can bring her children to on the weekends.

*Pseudonym

Reginald K. had prostate cancer and struggled on day-to-day with his health, but managed to make all of his housing appointments and attend to his mother's needs as well, using only public transportation. Reginald and his case manager found three beautiful Senior Locations where he submitted applications, but was denied from each building - due to "confidential reasons" that didn't involve the client. On the last day when the voucher would expire, Reginald received a phone call from Laguna Senior apartments, who requested to interview him for a vacant unit. Reginald was approved for the unit, moved in, and has been living there ever since. Living in permanent supportive housing for the past year and a half, Reginald has been able to maintain and stabilize his medical conditions. In January 2017, Reginald reported that his prostate cancer viral loads are decreasing, due to his medication and healthier lifestyle.

Always a high achiever, **David*** entered college at the young age of 16 with a declared major in architecture. Learning that he had an aptitude for mathematics, he changed his major to math. David was smart but still emotionally immature, and he had difficulty adjusting to being away from home. He was diagnosed with Major Depression with symptoms of Obsessive Compulsive Disorder (OCD). He was treated and responded well to medication, so he persevered and graduated from college. David went on to pursue a graduate degree in mathematics at CSULA. He was doing well, so he decided to stop taking his psychotropic medication. When he again began to experience depression / OCD, he began to self-medicate with alcohol. His grades suffered, and he was asked to leave the program. After this failure, his alcohol use increased and interfered with his ability to find and hold a job. Ashamed, he opted not to go back home to his family and he became homeless.

Once homeless, David's alcoholism and untreated mental illness let him in and out of psychiatric facilities. After five years, David sought help for depression / OCD, but not for alcoholism. He took his meds – and continued drinking. He found jobs and housing on and off, but nothing lasting. After three years, he drank so much that he almost died. Scared and detoxed after a hospitalization, he stopped drinking. Sober, he went from shelter to shelter and found a security job. He worked 20-30 hours per week for the same security company for two years. He would find housing but keep losing it after getting into altercations with roommates due to OCD behaviors.

David came to Ascencia's Winter Shelter program and enrolled in year-round services. He lost his place on the waitlist for an emergency shelter bed. He then resurfaced and was admitted in December 2016. He has a Substance Abuse Case Manager. David obtained housing through Ascencia's Next Step grant, a permanent supportive housing program for single adults in addiction recovery and moved in April 2017. Ascencia helped David maintain sobriety by connecting him to nearby community AA meetings and to Ascencia's trauma therapist for individual therapy and psychiatrist for medication management. David is doing very well in his job and intends to complete his graduate degree in mathematics in the future.

*Pseudonym

END NOTES

ⁱ University of Illinois – Chicago fall 2017 paper, Stephen Brown, director of preventive emergency medicine at University of Illinois Hospital.

ⁱⁱ "The Revolving Hospital Door: Hospital Readmissions Among Patients Who Are Homeless," *Medical Care*, September 2013, Lippincott Williams & Wilkins. Doran KM, Ragins KT, Iacomacci AL, Cunningham A, Jubanyik KJ, Jenq GY.

ⁱⁱⁱ "Hospital Readmissions in a Community-based Sample of Homeless Adults: a Matched-cohort Study," *Journal of General Internal Medicine*, 2016 Sep; 31(9):1011-8. Saab, Nisenbaum, Dhalla, Hwang

^{iv} Hwang, S. & Henderson, M.J. (2010). Health Care Utilization in Homeless People: Translating Research into Policy and Practice. Agency for Healthcare Research and Quality Working Paper No. 10002