



Health Care for Los Angeles Communities

Integrating Health, Mental Health, Substance Use and Housing Services

A report on the forum convened April 20, 2016, by the USC Suzanne Dworak-Peck School of Social Work, Department of Adults and Healthy Aging in partnership with the Serious Mental Illness Services and Recovery and Homelessness and Housing Insecurity Research Groups

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I. Executive Summary

In January 2015, in an effort to provide more effective integrated health care to its 10 million residents, the Los Angeles County Board of Supervisors approved the creation of a single health agency to unify the departments of health services, mental health and public health.

To realize that goal, efforts are being made to streamline operations, break down bureaucratic barriers impeding effective and efficient care and identify synergies to better meet the needs of all Angelenos accessing county health care facilities. The intent is to solve health care disparities for those who are especially underrepresented and marginalized.

The significant objective of the Los Angeles County Health Agency is to improve coordination of services in conjunction with a multitude of community partners (including organized labor, faith-based organizations, community providers and agencies, health plans and academia) with intent to bridge population and personal health.

According to the Los Angeles County Chief Executive Office: “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.”

On April 20, 2016, the USC Suzanne Dworak-Peck School of Social Work convened a forum at the USC Ronald Tutor Campus Center on current efforts to transform the Los Angeles County health care system. This forum, **Health Care for Los Angeles Communities:**

Integrating Health, Mental Health, Substance Abuse and Housing Services,

focused on the status, challenges and goals of the newly formed health agency. The event aimed to place the transformation in its historical context, update participants on progress and facilitate collaboration. Furthermore, the presenters identified potential opportunities to overcome hurdles to the adoption of innovative and integrated

services that incorporate sociocultural determinants of care.

The half-day forum coalesced a broad array of faculty members from USC; University of California, Los Angeles; nearby California State University campuses; social workers serving as field supervisors for master of social work students; and staff members from local hospitals, health and mental health centers, housing programs and social services agencies.

This report summarizes the day’s events, focusing on the remarks of the featured speakers with concluding thoughts from the event conveners.

Integrated health care transformation is the systematic alignment of physical health and behavioral health (mental health and substance use disorders) services along with coordination of other services such as housing that affect individual and community-based health and wellness.

II. Agenda

Introduction and Welcome

Suzanne L. Wenzel, PhD

*Richard M. and Ann L. Thor Professor in Urban Social Development
Chair, Department of Adults and Healthy Aging
Director, Research Cluster on Housing Security & Community Development
USC Suzanne Dworak-Peck School of Social Work*

Marilyn L. Flynn, PhD

*Dean
2U Endowed Chair in Educational Innovation and Social Work
USC Suzanne Dworak-Peck School of Social Work*

Featured Speakers

Hortensia Amaro, PhD

*Associate Vice Provost for Community Research Initiatives
Dean's Professor of Social Work, USC Suzanne Dworak-Peck School of Social Work
Professor of Preventive Medicine, Keck School of Medicine of USC*

John Connolly, PhD, MSED

*Deputy Director for Policy, Strategic Planning and Communications
Los Angeles County Department of Public Health, Substance Abuse Prevention and Control*

Roderick Shaner, MD

*Medical Director
Los Angeles County Department of Mental Health*

Marc H. Trotz, MPA

*Director of Housing for Health
Los Angeles County Department of Health Services*

III. Introduction and Welcome

Suzanne L. Wenzel and Marilyn L. Flynn



Dr. Suzanne Wenzel opened the forum by welcoming participants and thanking members of the planning committee chaired by **Dr. Ann Marie Yamada**. Wenzel noted the importance of successfully integrating health, mental health, substance use and housing services. At stake, she said, are the lives of those who suffer from serious mental health and substance use problems. These persons often die decades earlier than others because of physical illnesses that could have been prevented or treated through access to fundamental community supports, such as safe housing and proper navigation through a complex service system.

In her welcoming remarks, **Dean Marilyn Flynn** placed the work of integrating health care in Los Angeles in a global context. Over two decades of travel to some of the world's megacities—London, Hong Kong, Sao Paulo—and in her work in Los Angeles, Flynn has observed the challenges of each setting.

“I’ve noticed the struggle large urban environments are experiencing in trying to provide continuity of care—[including] any consistent connection with the human beings who live in these very large urbanized areas where there is often so little social

connection,” she said. “Frankly, nobody has figured out exactly how to do this. Nobody has figured out how to deal with the scale and the complexity of service delivery that we’re facing in the 21st century.”

Flynn expressed hope that in the next 10 to 20 years, Los Angeles can produce solutions useful to the world’s other megacities as they struggle to integrate care in diverse societies where the variety of human problems makes prevention and care a challenge.

Flynn characterized the forum as the beginning of a conversation about not just the reorganization of health care delivery, but also a reimagining of how universities and community partners can join together.

“Our interest as a school of social work is in collaboration with our community partners and with other disciplines and actually with other great megacities across the world,” she said.

For instance, she added, “we’re going to be starting a department of nursing in the School of Social Work—the first of its kind in the country—organized around the social determinants of health, beginning in the fall. We hope this is one example of how universi-

ties can begin to reorganize themselves in terms of the way they think of the work of professions and the collaboration between professions. And I know we’ll have many other examples of connection and collaboration and integration as we all move forward together.”

“It’s possible that Los Angeles could come up with a solution that’s useful to the world’s other great megacities. And I would hope so.”

Marilyn Flynn

IV. Social Determinants of Health: Integrating Services in Los Angeles Communities

Hortensia Amaro, PhD

Associate Vice Provost for Community Research Initiatives

Dean's Professor of Social Work and Preventive Medicine, University of Southern California



“I have to ask myself, does it make sense to invest all of this money and effort into individual or family-level treatment, and then have people return to the same environments that put them at risk to begin with?”

Hortensia Amaro

Dr. Hortensia Amaro spent 33 years in Boston engaged in public health research focused on the development and implementation of cultural adaptations of evidence-based treatment approaches primarily on Latino, African American and white women and their families. What she observed has enormous implications for the integration of primary care, mental health, substance and housing services in Los Angeles. Her studies are particularly relevant because they highlight the community context and environment, specifically the role of place in health.

“One thing we learned is that **gender-specific treatment approaches and services are really important,**” Amaro said. “We also learned that **race, ethnicity and culture are significant factors to be considered when we design individual-level interventions and systems of care.**”

As further evidence of the need for integrated services, Amaro’s research has shown an almost universal link among substance abuse, mental health disorders and trauma.

An integration model that Amaro’s team used in Boston at the system and individual levels did indeed result in better outcomes, including the length of time women stayed in treatment, compared to traditional substance abuse treatment at comparison sites.

However, big improvements in population health will not happen with integrated health services alone, Amaro said, noting the outsize focus in the United States on health services

versus broader interventions that require the context in which people live, their environment or community. Here she highlighted the significance of social determinants of health on overall health and well-being. Referring to her work in Boston, she characterized the relationship between neighborhoods with socioeconomic disparities (high rates of poverty, infectious and chronic diseases, lack of safety) and mental health, substance health problems and trauma history.

“We focus on disease manifestations and sometimes on unhealthy behaviors, but we rarely focus on the things that really drive those, which are the living conditions and economic and social disparities.” she said, citing “poor quality of the built environment, neighborhood stressors, neighborhood disorder and violence and degree of social support available” as examples of significant influences on health and wellness.

Amaro cited statistics showing that **community factors—education, employment, income, family and social support—are the largest social determinants of health**, at 40 percent of the equation. **Physical environment contributes 10 percent and health care itself is only 20 percent.**

She noted that a community conditions study conducted in Boyle Heights, near the USC Health Sciences Campus, showed high prevalence of families with children living in poverty,

low reading levels and low levels of investment by financial institutions that significantly affect local businesses and opportunities. Other findings included high levels of violent crime, low amounts of green space and lack of access to healthy foods.

Improving such neighborhoods, and by extension the health of their residents, might depend on anchor institutions playing a larger role in neighborhood economies, Amaro said.

Universities, hospitals, local governments and some businesses are examples of anchor institutions, so called because their identity and mission are tied to a place. Amaro observed that such place-based institutions spend billions of dollars on procurement. She noted recent efforts to track that spending with the goal of better targeting such investments and encouraging more local hiring.

Improving population health is going to require more than health care integration, Amaro said. It will require collaborations with multisector partners, including anchor institutions and building awareness of the role they can play in local economic development. Amaro underscored the need for action among agencies and systems to move beyond identification of social determinants of health to actually developing new multisector partnerships that could play a significant role in population health and local economic development.

V. Critical Issues and Historical Perspective on Integrating Health Services

Roderick Shaner, MD

Medical Director

Los Angeles County Department of Mental Health



Dr. Roderick Shaner began his remarks by noting that the process of integrating mental health services with other areas of health care is the latest and most promising opportunity in a centuries-old progression in how society treats those with serious mental illness.

“At stake is a remarkable opportunity to improve medical and social outcomes for those with severe mental illness,” he said.

Since the 1800s, which saw widespread segregation of individuals with mental illness from the rest of society, mental health services have fallen in and out of the general health system. Promising strides were made in the early 1900s, when mental wards were first integrated into

hospitals. That led eventually to the Mental Health Services Act of 1963, which established the community mental health center system.

In California, mental health services were most recently segregated from the general health system in 1978 in an effort to improve treatment. Advocates created a better system, with independent funding, more humane care, patient empowerment and a much broader range of rehabilitative resources.

This division, however, drove a wedge between mental health and the general health care system, Shaner said.

“For those with biological mental illnesses, having a carved-out system created challenges because there was less access to other specialties, to labs and such,” he said. “The biological treatment was substandard. . . . Psychopharmacologic treatment was not well integrated with treatment for general medical conditions. In fact, there was almost no communication back and forth. Access to addiction medicine was also extremely limited. People with mental illness were ostracized from primary care and frankly from substance abuse and addiction medicine.”

By the early 1990s, two entirely different concepts of mental health and behavioral health emerged. The first focused on recovery, empowerment and reintegration (or integration) into the community. The other focused on increased understanding of the brain and biological causes of mental illness. The 2005 California Mental Health Services Act established a remarkable new funding stream that

supported the creation of more robust mental health services. Despite these advances in service delivery, fiscal restrictions severely limited opportunities for true integration of mental health and physical health systems, particularly for hospital-based or physical health care.

The federal Patient Protection and Affordable Care Act, however, created a fresh start for the reintegration of health care, Shaner said, with its triple aim of lower costs, better population health and a better care experience.

“The idea was to reorganize this [care] around primary care where all other services, including behavioral health services, would be spokes from the hub of primary care,” he said. “Properly done, this could eliminate silos, but for mental health, there are some severe challenges.”

Meeting those challenges requires:

- Primary care health homes with the capacity to manage reasonably stabilized patients with mental health challenges
- A second type of health home, behavioral health homes, with a broader range of disciplines to accommodate patient needs, from social and physical to psychological, and better resources to address the complex needs of persons with severe mental illness
- A proper range of rehabilitative services in both settings, including mental health consultation and cost-effective psychopharmacologic management

California has become a laboratory for such innovation thanks to the 1115 Waiver granted by the federal government in 2010 in response to the state’s \$10 billion budget shortfall. The waiver called for:

- Extended Medi-Cal coverage to a large part of the formerly uninsured population
- Development of medical homes for the Medi-Cal population through Medi-Cal physical health plans

- Preservation of substance abuse services and specialty mental health carve-outs, which are obstacles to fully integrated care

Although the 2015 renewal of California’s 1115 Waiver, called Medi-Cal 2020, continues the specialty mental health carve-out, it also provides the option of Whole Person Care Pilots. The pilots, which counties may opt into, focus on populations with repeated incidents of avoidable emergency department use, hospital admissions or nursing facility placement; populations with two or more chronic conditions; those with mental health or substance use disorders or both; and people who are homeless or at risk of homelessness, including people likely to become homeless upon release from various institutions.

The Whole Person Care Pilot program provides \$300 million a year in federal funds for program infrastructure to better integrate health, behavioral health and community supports. The community supports pillar of the program, which includes housing, is a significant step forward, Shaner said.

“No one’s ever done this. It’s an experiment. It may work,” he said. “It even includes ... medically necessary housing and county housing pools.” Still, he said critical issues remain. For example, “How will we integrate housing into this?”

Shaner concluded by summarizing “three centuries of lessons” in addressing serious mental illness. “Unique structures are necessary, but integrated care in health will be critical, he said. “We’ve learned from the last five-year waiver that we must have an infrastructure for housing and support for other social and other nonmedical services.”

In addition to reducing the stigma of mental illness and substance use disorders, he hopes this integration will “have positive financial effects on the range of other publicly funded services.”

VI. Los Angeles County Substance Use Disorders System Transformation

John Connolly, PhD, MEd

Deputy Director for Policy, Strategic Planning and Communications

Los Angeles County Department of Public Health, Substance Abuse Prevention and Control



These remarks by **Dr. John Connolly** signified an unprecedented period for transformation of the substance use system of care in Los Angeles County. This new substance use treatment delivery system, launched following the approval of the California Department of Health Care Services' Drug Medi-Cal Organized Delivery System, is aimed at expanding substance use disorder services and enhancing eligibility for Los Angeles County residents.

“We are engaged in launching this new delivery system, called START—system transformation to advance recovery and treatment of

substance use disorders,” Connolly said.

The county is in the process of receiving feedback from state and federal officials, and will spend the rest of the year seeking the remaining approvals necessary to launch its new benefit and delivery system.

“We really have an opportunity here to build a meaningful substance use disorder benefit ... to organize, enhance and integrate in a way that we’ve really never done before. And that could make a tremendous difference in bringing substance use disorder services into the center of the health care delivery system,” Connolly said.

The waiver imposes new guidelines for county administrators and providers. The new system must be patient centered, not program centered, and must follow American Society of Addiction Medicine criteria for determining the type and duration of care people need, all with an aim toward quality improvement.

The waiver rules also introduce a level of flexibility never before possible. For example, agencies can offer field-based services outside of the four walls of their facilities, which was not an option under Drug Medi-Cal, Connolly said. Other changes include adding evening and weekend hours, which are now uncommon. Leaders want to make the program as patient friendly as possible by improving the ease of accessing services.

Other major provisions of the new program include the following components.

Certification. All network providers must be certified through Drug Medi-Cal. The county will also attempt to bring new providers into the delivery system. All residential Substance Abuse Prevention and Control treatment contractors were required to submit Drug Medi-Cal certification applications by January 31, 2016. All nonresidential contractors had to apply by July 1, 2016, and by July 1, 2017, all providers must be certified.

Payment to providers. Drug Medi-Cal will become the major source of payment for providers of substance use disorder services. Previously, separate programs, such as Cal-Works, county-level General Relief or the criminal justice system, meant different payment systems. With a unified system comes a unified benefits package, a unified payment for services and a more consolidated safety-net delivery system.

Regional networks and business relationships. Regional networks will become more important as the system transforms over the next three years. Especially for small- and medium-size agencies, developing formal business relationships with other providers might help cover the costs of required new infrastructure (e.g., medical directorship and quality assurance programs).

Connolly emphasized the importance of smaller providers to the overall system. “Many smaller providers serve communities that nobody else is serving,” he said. “They speak languages that other providers in the communities around them might not be speaking. They have competencies to serve people in the criminal justice system, LGBT

communities, undocumented, etc. There are lots of different needs among our patients, and so we want to make sure that we preserve as many competencies as possible in this process.”

Treatment options. “We want to support a variety of different options for people to seek treatment,” Connolly said. “What we’ve tried to do is link different programs that may have had different philosophies, different approaches to treatment. ... We’re trying to bring everybody together into a more organized delivery system, in which referral relationships and information transfer happen much more smoothly than right now.”

“I think it’s really a watershed moment for Los Angeles County, for the Medi-Cal program and for the federal Medicaid program as well. We’re really doing something that’s pretty new and unique.”

John Connolly

“Medication-assisted treatment is another [priority emphasized by] the Centers for Medicare and Medicaid Services ... and something we’re trying to expand with our physical health and mental health providers,” he added. “There are many prescribers in both of those networks that we would like to link with our providers. That’s part of our integration effort.”

Residential treatment programs, including case management and recovery support services, will be more broadly available in Drug Medi-Cal, Connolly said. “So, if at the end of a period of treatment ... outpatient treatment concludes, and somebody is in recovery, you can call your provider, check in, go to group if you need to, get services [and have] linkages to other supportive services, employment training, withdrawal management, things like that,” he said, adding later, “I think that’s a really important advance toward treating this as a chronic disease care model.”

Quality improvement. Utilization management teams will authorize residential treatment, keep track of how long people receive treatment at a specific level of care and assess how treatment decisions align with American Society of Addiction Medicine criteria.

Rates. The waiver, with its new requirements and expectations, offers the opportunity for the county to negotiate for new and higher rates.

“We’re trying to be as assertive as we can in that process and to articulate [what] we want to use that new financing for within the network,”

Connolly said. “In addition, we had a bridge-funding package to help our present provider network move toward the new requirements.

“There are lots of investments that they’re going to have to be making in the next year or so to comply with the terms and conditions of the waiver, and so we gave them an augmentation to help them prepare for that. It allows them to have a more unified payment structure, a more unified benefits package, a more unified set of rules and hope to mirror structure, package and rules to non-Drug Medi-Cal beneficiaries.”

VII. Audience Participation: Questions and Answers



Michael R. Cousineau, DPH, said: “I’m concerned that the waivers and our effort to integrate do not include enough about prevention. ... I’m concerned that, even with all the integration, the needs are so great that it’s going to overwhelm the delivery system. **It seems like we’re not doing enough on the prevention side.**”

Amaro expanded on the question: “I had the same concern when I heard the presentations. So my question is: **Where’s population health here?** How are we going to improve community and population health if we only focus on individual or even family-level services? I would love to hear how population health is integrated into this approach because we know that health care—whether it’s health care or mental health care or substance abuse treatment—really is only a very small part of the pie.”

Shaner responded: “**I think that is the greatest issue—where do we get the resources?** Because right now, for health care, most of the funding streams are what we call categorical. You use Medi-Cal to buy medication, but if you use it to do something else, you go to jail. The answer, I think, at least from our initial view of the 2020 waiver, is the Whole Person Care initiative. The money that comes with it is not insignificant at \$300 million a year, and that’s just the federal component. It must be used to integrate community supports. It cannot be used to supplement what Medi-Cal and other health funding streams pay for. So you have to use it for housing, for social services, for navigators, for other public health projects. And what the fine print says, at least as we can understand it, is: We’re not going to tell each pilot what the limits are. Amaze us. Write your proposal. So I think we have the opportunity

over the next five years to do just what Dr. Cousineau and others have said—try this and see if in fact it can have a major impact on the cost and the quality of health care.”

Connolly said community engagement and education are crucial to improving population health. “One of the things that we’re trying to emphasize through the waiver launch is, as I said, **creating a recovery support services benefit that links individuals to all of the different services they need: job training, child care, etc. So it’s a much broader set of issues that people are wrestling with. It’s not just substance use**, it’s often a manifestation of many other things that are going on in their lives and in their communities.”

Another strategy, he said, is connecting providers with community resources: “Making sure there are linkages between all kinds of community assets, whether they’re faith based or schools, parks and recreation, etc., so people really have more connected and enriching communities that they can participate in.”

Amaro responded by noting a greater opportunity now exists to **involve anchor institutions in improving community health**. “I think the integration efforts really should facilitate that, because these agencies are now under one umbrella and could work together beyond what the reimbursement structures define to really think about what multisectorial collaborations could be developed to improve community conditions that really are at the root of some of the issues that we’re talking about today.”

Marleen Wong, PhD, clinical professor and senior associate dean of field education at the

USC Suzanne Dworak-Peck School of Social Work, noted the increasing role of anchor institutions and asked **to what extent schools might become medical homes for families, children and others in the community**.

Shaner responded that, thanks to the leadership of Wong and **Marvin Southard, DSW**, previous director of the Los Angeles County Department of Mental Health, the majority of the department’s mental health providers already have a presence in schools. “The new health agency is exploring the ways that we can bring substance abuse, physical health care and mental health together as a primary care home.” The key, he said, is getting the right experiment and the right measurements, and demonstrating the sustainability of such an arrangement.

“The new health agency is exploring the ways that we can bring substance abuse, physical health care and mental health together as a primary care home.”

Marvin Southard

Under the Drug Medi-Cal drug waiver, **will there be funding available for long-term residential treatment**, such as sober living, and how

long would such treatment be paid for?

Connolly explained that the maximum length of treatment was articulated by the federal government. “They ... will pay for it for up to 90 days, two times a year, two different episodes, with a one-time extension of 30 days tacked on to either of those two treatments. So that’s what we can pay for through Drug Medi-Cal.” He explained that the waiver notes that it might be medically necessary to serve someone involved in the criminal justice system, for example, for up to six months. In that case, it would be incumbent on the county to use other funding to support that treatment.

For now, the county has access to substance abuse prevention and treatment block-grant

funds that could be used to fund ancillary services or extensions beyond what Drug Medi-Cal covers. Regarding sober living environments or alcohol- and drug-free living centers, “that is a very limited service in our network right now, but we do want to expand that. ... I don’t know that at this point we’ve articulated we’re going to pay for it for three months, for six months. ... **We do think in general that pairing intensive outpatient or outpatient treatment with a recovery residence or a sober living environment is a very good idea and something we want to make available.**”

Southard thanked the presenters and said there might be an even bigger challenge than they had mentioned. “As we’re talking about integrating our public programs in a way that serves the public, we’re also dealing with integration into a larger health care system that is itself fundamentally fragmented. So we’re trying to create something that connects up with our larger insurance-based system as though our larger insurance-based system worked really well.” Southard asked **how system integration with those insurance systems can be done in a way that protects the interests of individuals who rely on the public health infrastructure.**

Shaner said there are efforts underway to examine the difficulties of such integration. Insure the Uninsured, with which Connolly was previously involved, is an example of an effort to examine where multiple insurance systems intersect. In Los Angeles, he noted, there are five Medi-Cal health plans, each with its own structure.

“We’re working on a project to develop a framework where the health care plans, the agencies, other stakeholder groups work together to try to come up with an agreed-upon framework and set of transactions and procedures to get people to where they’re supposed to go.”

Connolly said one of the struggles is help-

ing primary care providers who haven’t been involved with the county system or mental and substance use treatment systems understand a very different delivery system.

Amaro said one challenge is devising a definition of recovery that can be measured to determine whether programs being delivered are in fact promoting recovery. She chairs a committee in the National Academy of Medicine that is examining how to use epidemiological studies to better measure chronic mental illness, substance abuse and recovery. As an example, she said using the law enforcement strategy of identifying and focusing on crime hotspots could be applied to **pinpoint community hotspots with high rates of mental health and substance abuse disorders.**

“While mental health and substance abuse don’t discriminate, they’re not equally distributed across populations and across communities. And that’s kind of my point, that we really need to look at the community level. ... We could offer integrated treatment, we could offer wonderful wraparound services to individuals, but if we do nothing about the community factors that place people at risk ... it’s going to be hard to, one, have a long-term impact on individuals, and, second, to have really a population-level impact. I hope that the new integration structure opens the window for those kinds of discussions.”

Connolly emphasized the importance of **helping physical health providers** and other partners understand the unique challenges and needs involved in **dealing with people they might not be used to interacting with—for example, homeless individuals, those involved in the criminal justice system, sex workers or undocumented individuals.** “I think many different primary care providers are not as familiar with people who have those experiences, or are at least not used to exploring the implications of those experiences.”

VIII. Housing for Health: Addressing Homelessness in Los Angeles County

Marc H. Trotz, MPA

Director of Housing for Health

Los Angeles County Department of Health Services

Housing for Health is a new program creating a broad range of residential housing options that are linked to the public health system in the Department of Health Services. Director **Marc Trotz** expressed hope that integration of services will offer a brighter future for Los Angeles County's homeless population, but he urged participants to stay focused on at-risk individuals as the new system is being established.

"After more than 20 years of working with homeless [persons in San Francisco], I'm coming to the conclusion that it's not all that complicated," Trotz said. "We need to figure out a way to look beyond the funding sources and work together to help a bunch of people in really grave need. The population we're working with every day are literally at risk of dying on the streets and do die at regular frequency."

Still, their capacity for rebuilding their lives should not be underestimated. "**People spring back.** Folks that look like they're on their last leg, I see in our supportive housing environments a year later gardening, playing guitars, [spending time with] their children who they've been embarrassed to reunite with for the last 15 years and enjoying life," Trotz said.

Trotz said there is a danger that those in government used to dealing with bifurcated and siloed funding sources will lose sight of the end goal. "Either we genuinely like to dance in all of those complexities or we just are so mired in it, we can't get the job done."

Among the many challenges, he said, is providing housing quickly and on a large scale. In



most communities, the job of providing even 100 units of supportive housing is daunting. After five years of begging for rent subsidies and support services, advocates in those communities are exhausted, Trotz noted.

Considering the humanitarian crisis represented by homelessness in places such as Skid Row, Venice and Hollywood, "it's just tragic. ... We as a county and as a community have to figure out a way to [provide housing and support] over and over again very quickly."

An important step is an integrated system that knocks down silos and allows advocates for homeless individuals to provide help when and where it is needed. “Don’t put them on lists,” Trotz said as an example of how to knock down those silos.

Another important point he made is that a person who is homeless, in any given month, may show up in various places in the community—on the street, in the prison, or at a hospital or psychiatric emergency unit. “But how do we slow down and attach to that person and help them change their trajectory? Because you are busy and have a different role [as a General Relief worker, discharge nurse, or jail discharge social worker], it’s not your mandate.”

“We want to have a no-wrong-door policy. ... So a homeless person who comes in anywhere can get assistance,” Trotz said. “You’ll hear that the Housing Authority has 10,000 people on their list or 10 million people on their list, or whatever it is. That doesn’t work, and it’s not equitable, especially for homeless people, because they’ll never come up on that list. They’re never where they were two or three years ago.”

Housing for Health and any program that helps homeless people must be able to react immediately to serve clients in need. “We get them into some sort of stable living environment,” Trotz said, “and then the next day we stay in touch with them, and then we ultimately, hopefully, get them into housing.”

That requires a cultural transformation, one

that allows advocates to work easily across agencies and one that Trotz believes is in reach with the county’s integration of services.

The goal, Trotz said, is to do whatever is necessary to **“engage, assist and house.”** He cited as an example his agency’s City–County–Community (C3) initiative in Skid Row, which has the highest population of unsheltered people in the country. C3 broke up Skid Row into

four quadrants and assigned an integrated six-person team to each area. All teams feature a substance abuse worker, mental health worker, nurse and three outreach workers. The teams report to a single director, with whom they meet every morning.

“We’re having to actually retrain a lot of the ... workers who have done outreach in the past, who are on these teams. They want to check off boxes. They’ve been taught to show that, at the end of the year, they’ve had 10,000 encounters about something,” Trotz said. That approach, he

said, prioritizes process over outcomes.

To prioritize outcomes and make a dent in the county’s homeless population of approximately 50,000, Housing for Health is arranging for what it calls stabilization housing, in which a person at risk can be moved immediately from the streets. An example is 100 units of recuperative care housing that Housing for Health recently opened on the Martin Luther King, Jr. Community Hospital campus, where the first two floors of a former dorm were repurposed.

Trotz said recuperative care housing joins intensive case management with rent subsidies.

“So in my mind, when someone touches our system and they’re homeless, in the ideal world, like balloons would come down from the ceiling and we would just stop everything, I mean, because we’re talking about somebody who literally doesn’t have a home.”

Marc Trotz

“It’s not a 10-minute conversation. It’s caring over a fairly long period of time. It takes a lot of time to help people regain their stability.”

Housing for Health’s strategies to scale-up case management and rent subsidies quickly include master agreements with more than 30 organizations, which allows adding intensive case management slots by the hundreds without having to go back to the Board of Supervisors for approval. The 15-year master agreements come with a standard of 20 clients per case manager. To provide rent subsidies for housing that often doesn’t need to comply with all federal requirements, Housing for Health started the Flexible Housing Subsidy Pool, which started with a \$4 million gift from the Conrad N. Hilton Foundation.

Initiatives like C3 are also taking innovative outreach approaches, going beyond the four walls and meeting people where they are. Trotz highlighted the locus of control approach that C3 has implemented in Skid Row, allowing integrated care teams to reach people in a more efficient way. Trotz said the program’s intensive

case managers are finding and pairing up with approximately 1,000 people a month who are bouncing between jails, mental health centers and emergency rooms and are the county’s most prolific users of health care services.

Brilliant Corners, the program’s housing intermediary, is another unique strategy overseen by Housing for Health. Brilliant Corners is finding ample housing for the program’s clients, Trotz said. “There are landlords who are willing to rent to people to give them a second chance. We have housing everywhere from Antelope Valley to Santa Monica, downtown to South L.A.”

He cited several examples of supportive housing, including single-family homes and multiunit apartment buildings. He said Housing for Health expects to provide more than 1,200 rental subsidies this year and more than double that number in 2017. **Housing 50,000 homeless people and providing them with intensive case management is possible, Trotz said, if advocates employ some creativity and use the tools that integration is poised to provide.**

IX. Building a Strong Academic–Community Collaboration to Support the Transformation of Health Care in Los Angeles County

Ann Marie Yamada

Associate Professor

Suzanne Dworak–Peck School of Social Work, University of Southern California



From the enthusiastic response of university-affiliated participants and the expressed appreciation of this response on the part of the presenters, it is clear that there is a role and a mutual need for further enhancing the partnership between the Los Angeles County Health Agency and the university in addressing the most pressing challenges of health care transformation.

Building opportunities for collaboration and learning may foster intellectual sharing of ideas, problem solving and evaluation efforts that ultimately improve community conditions underlying many of the health concerns affecting county residents. Numerous benefits are possible from strengthening partnerships across stakeholder groups. These benefits could be even greater with commitment to a more durable and pervasive relationship between USC and the Health Agency, as outlined in this section.

Universities such as USC train a substantial portion of the future county-based professional health care workforce. With access to real-time information regarding the latest changes to policies and care delivery procedures, the university is better able to collaborate with the Health Agency to train future professionals prepared to serve as leaders, change agents and highly skilled service providers.

Health, public health and mental health departments employ thousands of health care employees who are expected to be well trained in best practices with cultural relevance to the county's diverse multicultural population. Continuing education is strengthened by infusing curriculum and instruction methods that capitalize on the Health Agency staff's culturally responsive practice experience and knowledge of the populations served and access to state-of-the-art technology and research-supported interventions of university-based scholars.

Los Angeles County residents with chronic and complex health needs receive intensive services that are individualized to address the socioeconomic and sociocultural factors that contribute to poorer health and reduced quality of life. Through federal funding and foundation support, university scholars are able to work with the Health Agency to develop and test new approaches to meeting the multifaceted needs of these residents, who may not benefit from standard service delivery options.

Merging mental health, physical health and substance use disorder services (with a specific focus on housing and other support services) under one umbrella is an enormous undertaking and will require a change in culture for agencies, providers and service recipients in Los Angeles County. Implementation of integrated health care requires a multilayered and multifaceted strategy that is responsive to especially vulnerable linguistically and culturally diverse, often underserved and high-need urban populations. Health Agency officials and community partners must focus on developing effective models for delivering integrated care to individuals and entire populations of people with multiple, chronic, fluctuating and interconnected social, mental, physical and substance use treatment needs.

Current organizational, professional and individual-level barriers that deter this collaboration must be acknowledged and mutually resolved among stakeholder groups. For example on the academic side, university scholars may not know what Health Agency collected data are available and how to access these data. Conversely, Health Agency leaders may be wary of the motives of researchers and have natural concerns about the security of their data. Organizational barriers such as complex procedures for approval of even low-risk studies involving county service recipients or service providers can deter university scholars from pursuing research interests.

Building on the momentum of the forum, there are several potential next steps in support of true collaboration among the Health Agency, USC and other community partners.

Identifying leaders across stakeholder groups who are committed to fostering routine and emergent opportunities for collaboration is imperative.

Planning regular opportunities for conversations across stakeholder groups could serve to foster greater appreciation of the views, expertise, interests and needs of each group (academics, providers, administrators, service recipients). These gatherings should not be designed to discuss collaborative action steps but to promote trust. Identifying mutual interests may lead to shared visions that offer great value to the people and communities being served.

Determining efficient means to communicate real-time information such as new initiatives, systemwide changes to policies and procedures and training or resource needs of the respective stakeholder groups. Possible strategies could include circulation of meeting schedules for Health Agency committees and taskforce groups open to the public and notices regarding university-based lectures and trainings.

Developing mechanisms to recruit university students to volunteer by assisting with evaluations of newly developed programs, data collection, report writing and information gathering. This would afford students with invaluable real-world applications of skills and represent tremendous learning opportunities.

Hosting townhall-type meetings during which Los Angeles residents could share concerns and needs with both Health Agency and university panelists regarding timely issues that are viewed as priority areas of interest across stakeholder groups.

X. Concluding Statement

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Building an accessible, affordable, high-quality health care system requires addressing social determinants responsible for health disparities, generating strategies to promote community-based health and behavioral health and instituting care coordination approaches that are culturally and locally tailored, all of which are strengths of social work.¹ In a discussion of the primary grand challenges of social work—which feature goals that are ambitious but achievable, Uehara and colleagues¹ noted that “we must bridge the gap between the science and the practice of social work and between social work and other disciplines and fields.”

As of January 2015, Los Angeles County built the first bridge among departments of physical health, public health and mental health by creating a family of services with oversight from one health agency. The Los Angeles County Health Agency has taken on the challenge of improving service coordination in an effort to better meet the needs of public health care recipients while decreasing duplication of services and reducing costs.

Successfully integrating care, health and wellness requires focusing on a broader population beyond those with current health and behavioral health issues.

Integration of health care agencies has been implemented in other communities throughout the United States and is the normative operating system in many other countries, with varying degrees of success in meeting the needs of the most vulnerable and underserved people. Transformation of the Los Angeles County system of care must occur with knowledge of these existing models and practices and great attention to the need to tailor the process to the specific cultures of the communities and people of Los Angeles.

Fundamentally, the key to successfully integrated care, health and wellness is focusing on a broader population beyond those with current health and behavioral health issues. It is essential to incorporate a focus on social determinants of health and implement population-based health efforts that serve all residents of Los Angeles.

The opportunity afforded by the state and federal governments to the county in pursuing such dramatic change, however, holds

¹Uehara, E., Flynn, M., Fong, R., Brekke, J., Barth, R. P., Coulton, C., ... Walters, K. (2013). Grand challenges for social work. *Journal of the Society for Social Work and Research*, 4(3), 165–170.

great potential both for Los Angeles and other megacities that are struggling with how to deliver comprehensive services to vast populations in need.

This forum offered an opportunity to introduce the new Health Agency and educate attendees on the developmental trajectory, current status and forthcoming changes to the Los Angeles County health care system. The largely university-based and university-affiliated attendees represented stakeholders with a great need for and appreciation of the information shared during the event. Attendees also represented an underutilized stakeholder group with great potential to add insight, resources and collaborative solutions to the challenges involved throughout the multiyear process of further developing and implementing systemwide health care transformation.

We are grateful to the forum presenters for sharing their experiences in implementing the first piloted integration projects—it is imperative that their passion and voices catalyze future efforts designed to improve the health and well-being of Angelenos. Further, we hope that the positive responses from forum attendees will inspire others and generate momentum for ongoing collaboration of academic scholars, professional health care providers and administrative and policy leaders to formally continue the conversation started on April 20, 2016.

Collaboration across stakeholder groups is consistent with the mission of this promising integrated care approach to reduce the current unacceptable disparities in the availability, accessibility and acceptability of health care services across the communities and cultures that comprise the heart and soul of Los Angeles County.

XI. Speaker Biographies

Hortensia Amaro, PhD

Hortensia Amaro is associate vice provost for community research initiatives at USC, Dean's Professor of Social Work and Preventive Medicine at the USC Suzanne Dworak-Peck School of Social Work and professor of preventive medicine at Keck School of Medicine of USC.

Before joining USC in 2012, Amaro spent 10 years at Northeastern University, serving as dean and distinguished professor of health sciences and counseling psychology in the Bouvé College of Health Sciences and as founding director of the university's Institute on Urban Health Research. She previously served as a professor in the Boston University School of Public Health and the Department of Pediatrics at the Boston University School of Medicine; distinguished visiting professor in women's health at Ben Gurion University in Israel; and on the board of Boston's public health department. She was awarded honorary doctoral degrees in humane letters by Simmons College in 1994 and the Massachusetts School of Professional Psychology in 2012, and is a member of the National Academy of Medicine.

Her studies on treatment for women with co-occurring drug addiction, mental illness and trauma resulted in the Boston Consortium Model of Integrated Treatment, chosen by the Substance Abuse and Mental Health Services Administration as an evidence-based model. Her current clinical trial, funded by the National Institute on Drug Abuse, is testing the efficacy of a mindfulness-based intervention on treatment adherence and relapse.

Amaro earned her doctorate in psychology from UCLA.

John Connolly, PhD, MSED

John Connolly is deputy director for policy, strategic planning and communications at the Los Angeles County Department of Public Health, Substance Abuse Prevention and Control. He leads the department's Policy, Strategic Planning, Communications and Adult System of Care units. He is also centrally engaged in the county's implementation of the Drug Medi-Cal Organized Delivery System and efforts to build integrated care programs for people experiencing homelessness and those involved in the criminal justice system.

He previously served as deputy director of the Insure the Uninsured Project, a senior policy analyst at the Kaiser Family Foundation and a Teach for America corps member.

Connolly holds a bachelor's degree in political science from the University of Chicago, a master of science in education from Bank Street College and a PhD in health policy from Harvard University.

Roderick Shaner, MD

Roderick Shaner is medical director at the Los Angeles County Department of Mental Health. His major responsibility is to ensure quality treatment for individuals and families who receive services through the department's programs.

He previously served as director of the Psychiatric Emergency Service at LAC+USC Medical Center, and is a clinical professor of psychiatry at the Keck School of Medicine of USC. Shaner's research focuses on public mental health systems. He is certified in general, child and geriatric psychiatry and addiction medicine. He is a past president of

the Southern California Psychiatric Society, serves as cochair of the California Psychiatric Association Public Psychiatry Committee and is a recipient of a National Alliance on Mental Illness Exemplary Psychiatrist Award.

Shaner received his MD from the UCLA School of Medicine and completed his residency training in general and child psychiatry at USC.

Marc H. Trotz, MPA

Marc Trotz is director of Housing for Health at the Los Angeles County Department of Health Services. He focuses on the develop-

ment of supportive housing for homeless individuals, including those with chronic health conditions, older adults and other populations in need of housing with on-site services.

He has 25 years of experience working on housing and health policies in the public sector in California. As housing director of the San Francisco Department of Public Health, he introduced the Direct Access to Housing Program, nationally recognized as a pioneering approach to housing and health care services for people with long histories of homelessness who are living with complex medical and behavioral health issues.

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Event photos credited to Bjanka Pasic.



Organizers and presenters (left to right): Mr. Marc Trotz, Dr. John Connolly, Dr. Suzanne Wenzel, Dr. Ann Marie Yamada, Dr. Roderick Shaner, and Dean Marilyn Flynn.



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