START-ODS
SYSTEM TRANSFORMATION TO ADVANCE RECOVERY AND TREATMENT

Los Angeles County's Substance Use Disorder Organized Delivery System

HOMELESS SERVICES

April 5, 2018

Los Angeles County Department of Public Health
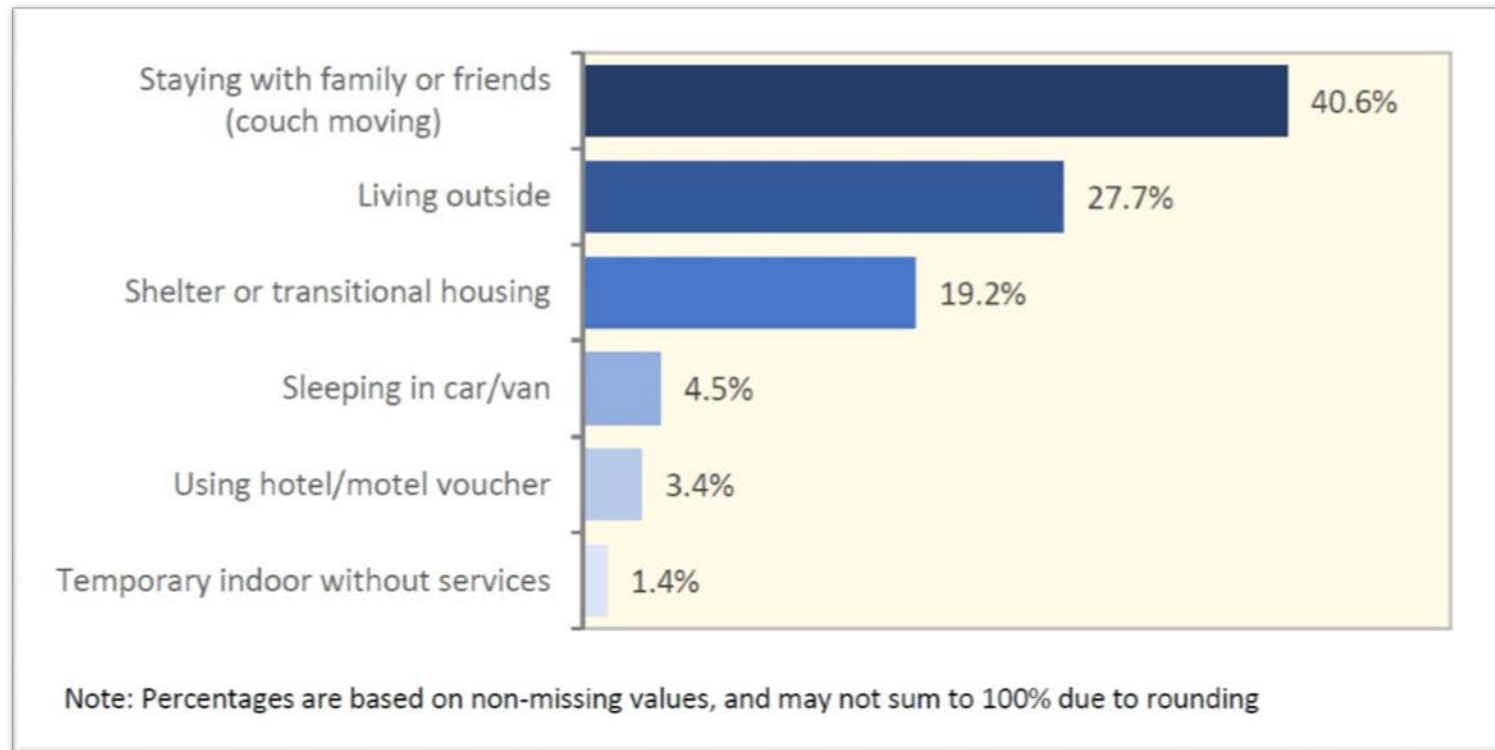*Substance Abuse Prevention and Control (SAPC)*

SAPC's Homeless Population

Homeless and Unstably Housed Patients

- 21.5% or 9,166 patients were homeless or unstably housed at admission in FY 15-16.

Living Arrangements Among Homeless Patients, FY 15-16

Living Arrangement	Percentage
Staying with family or friends (couch moving)	40.6%
Living outside	27.7%
Shelter or transitional housing	19.2%
Sleeping in car/van	4.5%
Using hotel/motel voucher	3.4%
Temporary indoor without services	1.4%

Note: Percentages are based on non-missing values, and may not sum to 100% due to rounding

Homeless and Unstably Housed Patients

- 34.5% of patients who were homeless at admission were no longer homeless at discharge.

Trends in Housing Status at Discharge Among Homeless Patients, FY 15-16

Note: Percentages may not sum to 100% due to rounding.
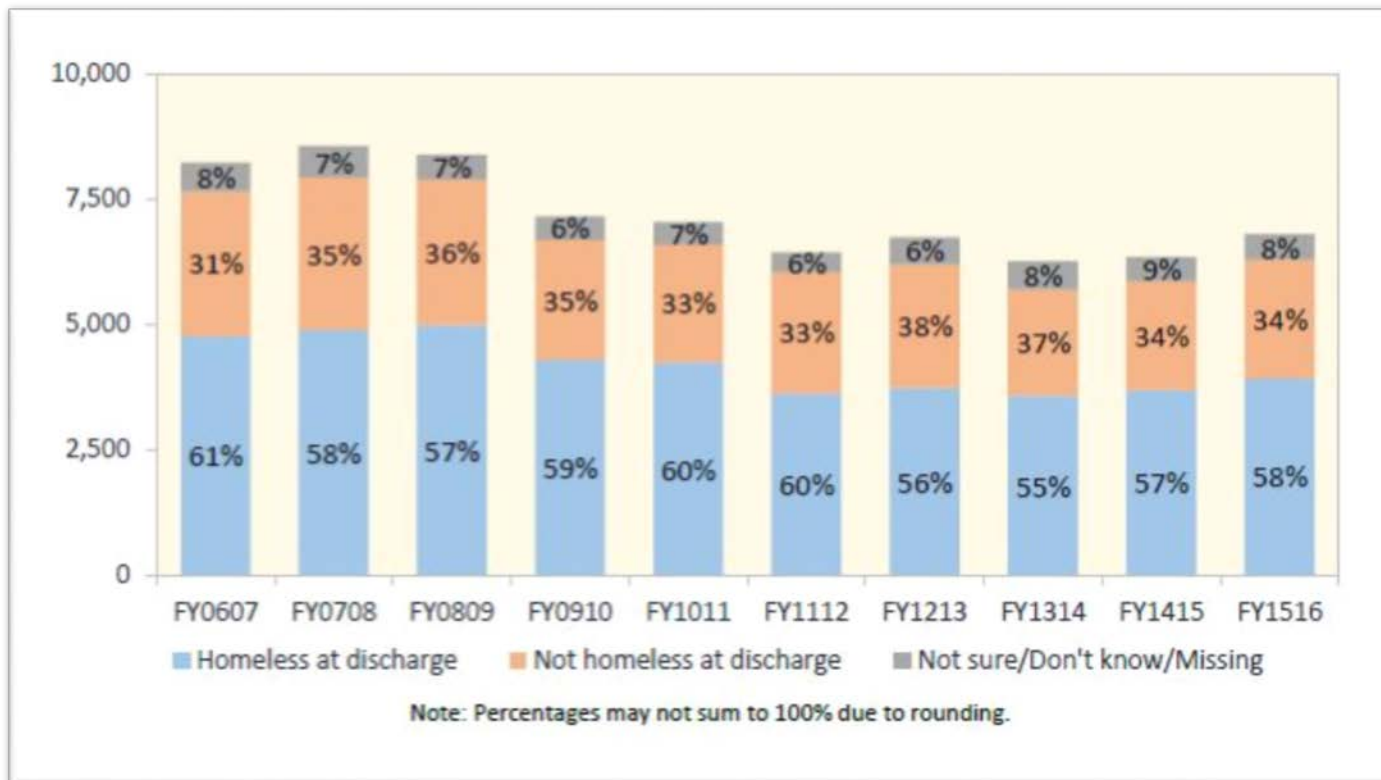
Homeless and Unstably Housed Patients

- 38% patients reported having mental health issues, 22% medical problems, and 21% criminal justice involvement.

- 36% reported methamphetamine as their primary drug problem, followed by heroin (28%).

- 46% were treated in residential service programs, followed by outpatient programs (21%).

- 50% were discharged with positive compliance.

- 41% were Hispanic/Latino, followed by White (35%) and Black/African American (19%).

- 30% were age 26-34, followed by 35-44 (23%).

- 44% finished high school, followed by some high school (32%).

- 35% were unemployed and not seeking, followed by those seeking (23%).

Countywide Homeless Initiatives

County Homeless Initiatives

The Los Angeles (LA) County action plan to combat homelessness.

- On February 9, 2016, the Board of Supervisors approved 47 interconnected strategies focusing on homeless prevention, case management and services, subsidized housing, coordinated system, affordable housing, and increasing income

- SAPC leads the implementation of HI Strategy E2 on Drug Medi-Cal Organized Delivery System (DMC-ODS) for Substance Use Disorder (SUD) Treatment Services

- DPH serves as a collaborating partner in about 25 other HI strategies, including HI Strategy B7: Interim/Bridge Housing for those Exiting Institutions

Proposition HHH

LA City's Permanent Supportive Housing (PSH) Loan Program to develop PSH for the homeless and those at risk of homelessness throughout LA.

- Passed by LA voters in November 2016, approving the 35 cents per square foot property tax
- Aimed at reducing homelessness by creating affordable housing units, and increasing accessibility to services
- Targets the creation of 10,000 affordable housing units for $1.2 billion over the span of 10 years

Measure H

The LA County quarter cent sales tax dedicated to fund programs that prevent and combat homelessness.

- Passed by County voters in March 2017
- Aimed at generating approximately $355 million annually over the next 10 years for homeless-related services
- Measure H Ordinance added 4 new HI strategies including D7: Provide Services and Rental Subsidies for PSH
- Supports 21 of the 51 HI strategies, including HI Strategy B7 and D7 for Recovery Bridge Housing (RBH), and Client Engagement Navigation Services (CENS) at PSH sites, respectively.

START-ODS Benefits Focused on the Homeless and Unstably Housed

Increasing Access to Housing Options for Homeless Individuals with Substance Use Disorders

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BACKGROUND

Safe, stable and supportive living environments are essential to individuals recovering from substance use disorders (SUD). Patients with SUDs who are unstably housed or homeless are at greater risk of not completing treatment or relapsing. Beginning July 1, 2017, new services will be available under the System Transformation to Advance Recovery and Treatment (START-ODS) to help SUD providers link their clients to housing, such as **Case Management** and **Recovery Bridge Housing.**

RECOVERY BRIDGE HOUSING

Recovery Bridge Housing (RBH) is defined as a type of abstinence-based, peer-supported housing with concurrent treatment in outpatient (OP) intensive outpatient (IOP) or Opioid Treatment Program (OTP) settings. RBH is appropriate for individuals with minimal risk with regard to acute intoxication/withdrawal potential, biomedical and mental health conditions.
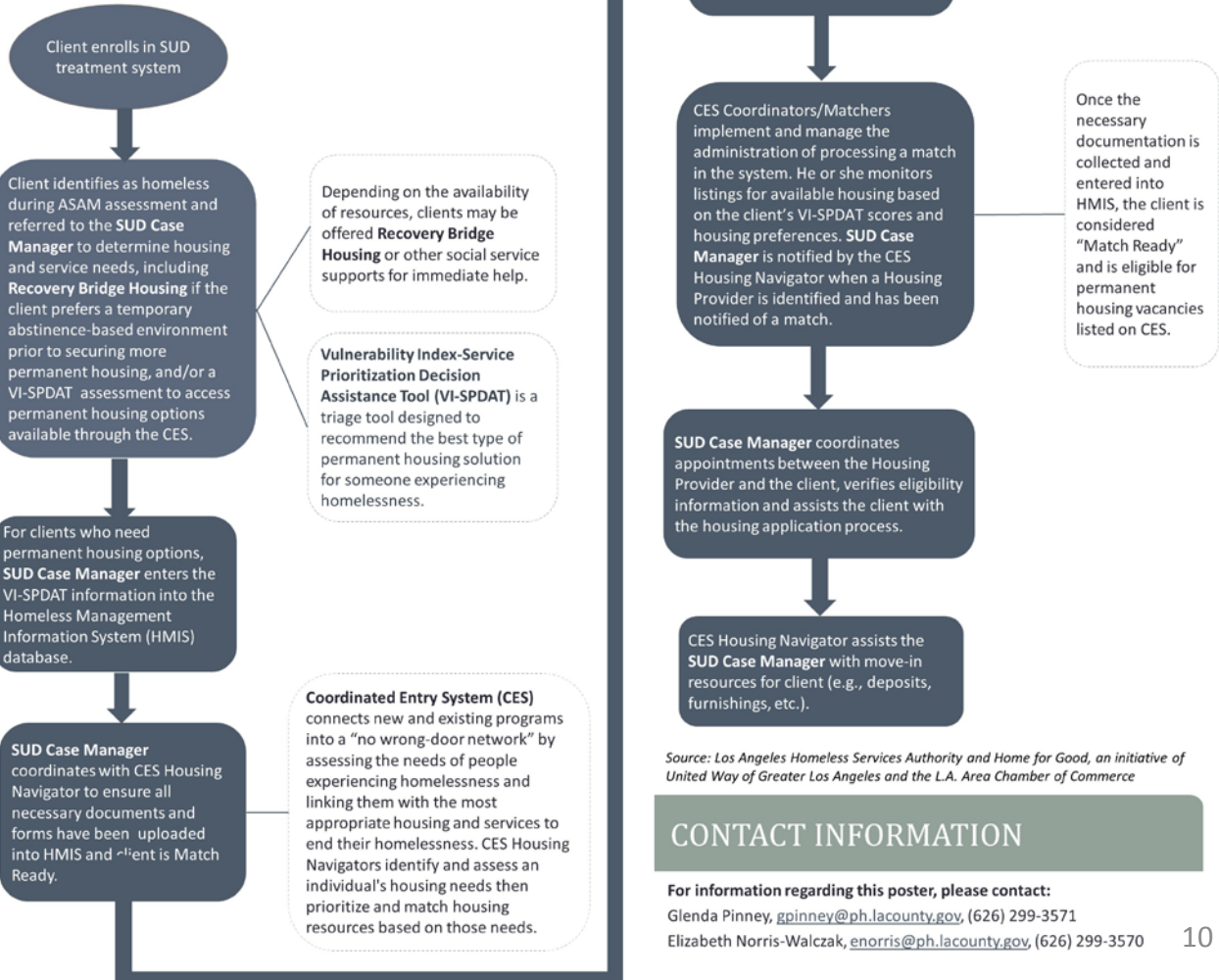
SAPC HOUSING GOALS

Improve housing access and linkages for homeless individuals receiving substance use disorder treatment.

OBJECTIVES

- Increase access to linkages to recovery housing, including recovery residences, for persons with substance use disorders.
  Timeframe: July 2017

- Train SUD treatment providers on how to complete the Vulnerability Index Service Prioritization and Decision Assistance Tool (VI-SPDAT) with homeless clients.
  Timeframe: June 2017

- Connect SUD treatment providers with the Coordinated Entry System (CES) to match their homeless clients to appropriate available housing.
  Timeframe: June 2017

- Develop a guide on housing options for homeless individuals, including bridge housing, transitional housing, recovery housing and permanent supportive housing. The housing guide will include descriptions of the housing types and client eligibility criteria.
  Timeframe: January 2017

- Organize a panel of housing providers to educate SUD treatment providers on housing options for homeless individuals with SUDs, including bridge housing, transitional housing, recovery housing and permanent supportive housing.
  Timeframe: October 2016

LINKAGES TO HOUSING

Clients seeking SUD treatment services will be assessed using the American Society of Addiction Medicine (ASAM) criteria. If, through the assessment, the client identifies as homeless, the assessor will refer the client to the **SUD Case Manager** for further assessment on housing, including **Recovery Bridge Housing**, and other service needs.

Client enrolls in SUD treatment system

Client identifies as homeless during ASAM assessment and referred to the **SUD Case Manager** to determine housing and service needs, including **Recovery Bridge Housing** if the client prefers a temporary abstinence-based environment prior to securing more permanent housing, and/or a VI-SPDAT assessment to access permanent housing options available through the CES.

Depending on the availability of resources, clients may be offered **Recovery Bridge Housing** or other social service supports for immediate help.

Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) is a triage tool designed to recommend the best type of permanent housing solution for someone experiencing homelessness.

For clients who need permanent housing options, **SUD Case Manager** enters the VI-SPDAT information into the Homeless Management Information System (HMIS) database.

SUD Case Manager coordinates with CES Housing Navigator to ensure all necessary documents and forms have been uploaded into HMIS and client is Match Ready.

Coordinated Entry System (CES) connects new and existing programs into a "no wrong-door network" by assessing the needs of people experiencing homelessness and linking them with the most appropriate housing and services to end their homelessness. CES Housing Navigators identify and assess an individual's housing needs then prioritize and match housing resources based on those needs.

SUD Case Manager assists the client in filling out the necessary application forms and collecting documentation (e.g., source of income, veteran status, substance use, identification papers, etc.).

CES Coordinators/Matchers implement and manage the administration of processing a match in the system. He or she monitors listings for available housing based on the client's VI-SPDAT scores and housing preferences. **SUD Case Manager** is notified by the CES Housing Navigator when a Housing Provider is identified and has been notified of a match.

Once the necessary documentation is collected and entered into HMIS, the client is considered "Match Ready" and is eligible for permanent housing vacancies listed on CES.

SUD Case Manager coordinates appointments between the Housing Provider and the client, verifies eligibility information and assists the client with the housing application process.

CES Housing Navigator assists the **SUD Case Manager** with move-in resources for client (e.g., deposits, furnishings, etc.).

Source: Los Angeles Homeless Services Authority and Home for Good, an initiative of United Way of Greater Los Angeles and the L.A. Area Chamber of Commerce

CONTACT INFORMATION

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HMIS Access and CES Referral

Providers <u>with</u> HMIS Access	Providers <u>without</u> HMIS Access
• 19	• 59
• SUD Case Manager[1] conducts the CES Survey Packet for Adults including VI-SPDAT, or Next Step Tool for Youth[2]	• SUD Case Manager links the patient to CES/housing agencies
• SUD Case Manager enters or updates information into Homeless Management Information System (HMIS)[3]	
• SUD Case Manager advises the CES agency that patient information has been entered into HMIS	

1. At minimum registered-level SUD Counselor   2. Training required   3. Active user license and training required

Case Management

Connection

- Conducting housing assessments (e.g., CES Survey Packet for Adults including VI-SPDAT, and Next Step Tool for Youth)

- Referring patients to housing and homeless service agencies; including the lead CES providers for youth, adult, or families (211)

- Assisting patients with gathering necessary documentation, and completing housing application forms

Case Management

Coordination

- Identifying an RBH provider through the Service and Bed Availability Tool (SBAT), and scheduling an appointment for RBH placement

- Sending RBH providers the necessary re/authorization documentation

- Advising the CES Housing Navigator that a patient's information has been entered into HMIS, and verifying whether or not all necessary forms and documents have been uploaded into HMIS

- Scheduling appointments between the patient and the Housing Provider

- Working with the CES Housing Navigators on move-in resources

Case Management

Communication

- Updating the RBH and other Housing Providers of patients' treatment status

- Entering and updating information into HMIS

- Following up with the CES agencies about the status of matching the patients to housing

- Educating the patient on landlord-tenant responsibilities, budgeting, and life skills

Recovery Bridge Housing

A type of abstinence-based housing that provides a safe interim living environment for SAPC patients, including those in Medications for Assisted Treatment (MAT).

Eligibility Criteria: ☑ 18 years or older

☑ Homeless or unstably housed

☑ Concurrently enrolled in Outpatient, Intensive Outpatient, Outpatient Withdrawal Management, or Opioid Treatment Program

Length of Stay: Up to 180 days for general patients, and up to 60 days postpartum for perinatal patients

Capacity: 750 beds for the initial year, FY 2017-18

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Recovery Bridge Housing

Funding Support: • Measure H for those exiting institutions

• Other applicable SAPC funding sources

Referral Process: ☑ Clients are referred for SUD assessment.

☑ If client meets criteria for OP/IOP/OP-WM/ OTP treatment and for RBH, the SUD provider then initiates the referral to an RBH provider.

Tx Provider Roles: ☑ Refer patients to RBH.

☑ CES housing assessment and/or refer patients to housing resources at the beginning of treatment.

Recovery Bridge Housing

Tx Provider Roles (cont.)

☑ Send RBH providers proof of treatment enrollment, indication of homeless status and need for RBH in the Treatment Plan, and other required re/authorization documentation.

☑ Updating RBH providers if patient has been discharged from treatment.

☑ Document coordination with RBH providers in Sage Miscellaneous Notes.

☑ Complete CalOMS/LACPRS.

☑ If also an RBH provider, refrain from restricting RBH beds to only the providers' patients.

References: • RBH Bulletin   • Provider Manual 3.0
               • Checklists: Sage and Manual versions

Client Engagement and Navigation Services

Permanent Supportive Housing Sites

- SUD screening, referral, and service navigation to residents at project-based PSH housing throughout Los Angeles County
- Funded by Measure H under Homeless Initiative Strategy D7

Homeless Outreach

- Street outreach, engagement, screening, referral, and navigation services to homeless individuals in Venice, Spring Street, around Harbor-UCLA Medical Center, and at the Pomona Armory Shelter

Homeless Programs
Next Steps

HMIS License Issuance

☑ Adult Providers: Goal to provide each one with HMIS license

Youth Providers: Topic to be discussed at the next Youth Provider Network Meeting

☑ SAPC to gather HMIS users information from providers

☑ Providers to submit HMIS <u>Organizational</u> Agreement to LAHSA

☑ At minimum SUD Registered Counselor to submit the HMIS <u>User</u> Agreement to LAHSA

☑ Required Trainings

: CES Overview

: CES Survey Packet for Adults and/or Next Step for Youth

: HMIS Policy

: HMIS for Adult and/or Youth Systems

Trainings

SUD Provider Capacity Building

- ☑ **System Overview and Assessment Tools**: *CES Overview; CES Survey Packet (including VI-SPDAT) for Adults; CES Next Step Tool for Youth*

- ☑ **Database**: *HMIS Policy; HMIS for Adult and/or Youth Systems*

- ☑ Data Collection: *CalOMS/LACPRS Homeless-Related Items*

- ☑ Service Skills: *Cultural Competency*

- ☑ Housing Resources and Partners: *Supportive Housing, Harm Reduction, CES Partners*

SUD Referral Pathways

- ☑ START-ODS Benefits and Referrals Webinar to CES Agencies

Homeless Provider Network

☑ Network launch, and subsequent regular meetings

☑ SBAT Homeless Provider list

Timeline

| Homeless Action Plan		April	May	June	FY 18-19
HMIS License Processing		■	■	■	
Trainings	System Overview and Tools		■		
	Database		■	■	■
	Data Collection	■			
	Service Skills	■	■	■	■
	Housing Resources and Partners		■		
	SUD Referral Pathways	■			
Homeless Provider Network Launch and Meetings		■		■	■

Homeless Data Collection

Why Data is Important?

- Data is a critical resource of value-based managed care program:
  - Track and forecast utilization, revenue, and cost
  - Demonstrate effectiveness/outcomes
  - Inform and enhance business, policy, and operational decisions in managing costs, quality of care, and revenue.
- "What gets measured, gets managed"
  – Peter Drucker

Cal-OMS/LACPRS Homeless-Related Items

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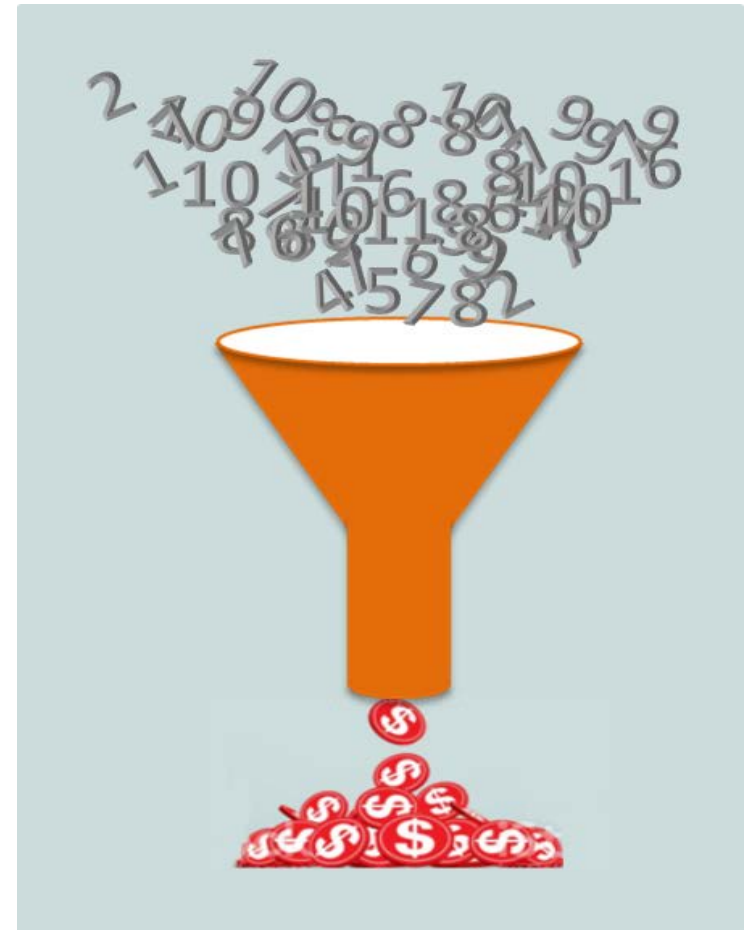
THANK YOU

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START-ODS Webpage: *http://www.publichealth.lacounty.gov/sapc/HealthCare/HealthCareReform.htm*