

# Key Connector: The Role of Hospital Liaisons in Building Relationships Between Health and Housing Sectors to Reduce Chronic Homelessness

This document, which summarizes the operations and outcomes of a hospital liaison program in Los Angeles’s South Bay, is written in response to the request from The State of California’s Homeless Coordinating and Financing Council (Council) for white papers, and in particular in response to question #1 in that request: “What are the top strategies the State of California should employ to make the largest difference in ... reducing the number of individuals and families experiencing chronic homelessness.” Although nothing written here is intended to imply that exploring, establishing, and expanding programs of this kind is the *only* means to reduce the number of such individuals and families, this reports’ authors – the Los Angeles Homeless Services Authority (LAHSA) and L.A. Care Health Plan – believe that programs of this kind can and should be a promising part of a broader approach to this problem.

## PROGRAM ABSTRACT

Five county and non-profit hospitals in Los Angeles’s South Bay developed a *hospital liaison* program which demonstrated early success in housing chronically homeless high-utilizers. The program’s liaison is responsible for:

- Providing on-call support to hospital staff about resources available to patients experiencing homelessness;
- Linking individuals to homeless support services and resources through the Coordinated Entry System;
- Building homeless services capacity and knowledge among hospital social work staff; and
- Tracking a number of chronically homeless individuals and families in the South Bay to facilitate unified patient care across local human and health service providers.

In its first year of operation, the liaison focused on system coordination through relationship building, increasing hospital staff capacity through trainings, and ensuring successful referrals and connections were made to services. Contact was made with 207 patients and 17 were able to be linked to permanent housing. Until July 2018, the program operated at no cost to hospital partners. After the expiry of the program’s initial one-year grant from the United Way of Greater Los Angeles, the hospital partners unanimously committed to funding the program out of pocket for three more years. The partners are currently expecting improved outcomes as a result of lessons learned from challenges the first year, e.g., liaison role clarity and data sharing amongst partners. They are also seeking improved evidence on program outcomes, cost savings, better strategies for data-sharing, and additional continuous improvement opportunities.

## KEY FACTS AND FIGURES

- Five non-profit and county hospitals in Service Planning Area (SPA) 8 (South Bay).
- Program implemented by one liaison based at Harbor Interfaith Services.
- 207 patients served between 11/1/17 and 7/1/18.
- 17 patients permanently housed between 11/1/17 and 7/1/18.
- Early indications of improved patient outcomes.
- Year One funded by the United Way of Greater Los Angeles.
- Years 2-4 funded by participating hospitals from community benefit dollars.

## COMMUNITY CONTEXT

In January 2018, on the night of Los Angeles’s most recent Point in Time Count with available data, Los Angeles’s Service Planning Area (SPA) 8—which covers much of the South Bay—was home to more than 4,000 people

experiencing homelessness. Nearly one in four of those people were chronically homeless.<sup>1</sup> This means that the South Bay is home to approximately 1,000 individuals who have either been continuously homeless for one year or more, or have been homeless at least four separate times in the last three years, and more than a year in total.

Individuals experiencing chronic homelessness are, generally speaking, both sicker than the population as a whole *and* far more likely to use hospital emergency rooms as their primary medical providers—or as emergency shelters or warming rooms even when their need for medical care is not acute. Cumulatively, those visits generate high costs to hospitals and communities that could better address needs through ensuring that patients experiencing homelessness are connected to resources that put them on the path to secure, stable, and affordable housing and self-sufficiency.

In early 2017, a group of five hospitals operating in the South Bay decided to address this issue by expanding an existing partnership with Harbor Interfaith Services – the homelessness coordinated entry system lead for SPA 8. This partnership was centered on a program intended to help patients experiencing homelessness discharge from participating hospitals to the L.A. coordinated entry system (CES), and thereafter into stable permanent housing.

Prior to the establishment of the liaison position, and despite the existence of technical solutions like the Emergency Department Information Exchange (EDIE), staff at area hospitals had no access to tools that allowed them to establish whether a patient presenting in their emergency room two times a week was also doing the same at other hospitals, whether that patient was already known to homelessness service providers through Los Angeles’s Homelessness Management Information System (HMIS), or what resources might be available to them through the coordinated entry system. Homeless services agencies like Harbor Interfaith, meanwhile, were blind to valuable information about their clients’ health, care management, housing and other social service needs collected by hospital social workers. In other words, all the resources leveraged by the program existed before the program’s establishment; the goal of the liaison program was to connect them to one another. This critical missing piece has been instrumental in avoiding duplication of services and care plan development while improving the patient experience of care by avoiding multiple, disjointed, episodic care in multiple healthcare settings.

## PROGRAM OPERATION

The current liaison came to the role in November 2017 with a strong background in homeless services and significant experience in working with individuals experiencing homelessness, first as a case manager, and later as a program and building manager, for LAMP Community in downtown L.A. Although her prior experience was in a different region, her director at Harbor Interfaith reported that the liaison was able to quickly develop a deep knowledge of the resources available in SPA 8. This skill allowed her to effectively refer staff at participating hospitals to the resources their patients experiencing homelessness needed. Future efforts to duplicate this program should target individuals who can bring this skillset to bear on the role.

The liaison described her role as that of an “air-traffic controller,” responsible for making sure that hospital social work staff —often responsible for a wide range of patient conditions including but not limited to homelessness—knew to contact her if a patient who appeared to be experiencing homelessness presented in their emergency room. The liaison would help the patient and the social worker understand what resources were available to them and what might be necessary to get the patient on a path to stable housing. *The liaison was emphatic that her role was not that of a case manager with a case load but rather that of a facilitator between hospital workers and CES case managers.*

During the first few months of program operation, the liaison held regular office hours at participating hospitals. She conducted trainings with hospital staff that were intended to provide participants with a basic understanding of L.A.’s CES and the resources available to people experiencing homelessness in the South Bay. Although these trainings were well-received, it quickly became apparent that pre-scheduled office hours were not the right mechanism for

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<sup>1</sup> See LAHSA, “Homeless Count – Count by Service Planning Area (SPA)” (2018). 2019 data was not yet available at the time of publication.

connecting homeless patients to the liaison, because it was hard to predict when particular patients might present at any given hospital. The liaison therefore switched to an on-call system shortly thereafter, based on a daily census of patients that hospitals reported was extremely helpful in establishing ER staffing structure, while continuing to conduct capacity-building trainings for hospital staff throughout the region.

In most cases, the liaison's first engagement with a patient came as the result of a call from that patient's hospital-assigned social worker. After establishing the patient's homelessness status and desire to receive services, the liaison and the social worker would coordinate with one another over the phone or in person, depending on the liaison's availability, to determine whether the patient's information had previously been tracked in L.A.'s HMIS. If so, the liaison would attempt to connect the patient to their existing case manager. If not, the liaison would connect the patient to CES by linking them to a case manager and ensuring that they had support to access other resources.

### SUCSESSES, CHALLENGES, AND OUTCOMES

The liaison and hospital staff alike reported that slow and sustained relationship and trust-building—between the liaison and hospital staff, and between all staff and patients—was critical to the program's success. Many individuals experiencing homelessness in the South Bay have a deep-seated distrust of hospitals and large institutions in general. It is common for a patient to require many separate conversations with staff in order to feel safe enough to express their needs and the complexity of their situation. Relatedly, a number of hospitals noted that they were occasionally unable to serve patients experiencing homelessness because they were not cooperative with staff.

The liaison's advocacy for herself and her role as that of a connector *between* resources, and not as a resource herself, was also critical. The liaison was successful in her role because, instead of adding to the number of individuals who were responsible for navigating the patient through the system, she identified the patient as a possible recipient of an *existing* resource, and made the connection between the patient and that resource. Navigation, rather than initiating a new process each time the patient presented, while connecting resources is a critical way to reduce waste and improve the patient experience of care.

As with any new partnership, this program had challenges. Throughout the first year of operation, the liaison and hospital partners struggled to manage and share data. A large portion of the liaison's time was taken up with looking up individual patients in HMIS at the request of hospital staff. This time could have been dedicated to further capacity-building if hospital staff had had access to HMIS. On the hospital side, hospital staff found it difficult to share patient records among participating hospitals even when they knew, through the liaison's work, that a particular patient had presented at multiple hospitals in the South Bay.

Although outcome tracking is difficult since patients who "succeed" do not present again at an emergency room, hospital participants reported positive impressions of the program's performance to date. Hospital and Harbor Interfaith staff alike reported very positively on their working relationship and indicated a high level of trust in one another. On June 29<sup>th</sup>, 2018, hospital partners announced that they would fund the liaison position out of their own funds for an additional three years.

#### EMERGING BEST PRACTICES

- Build on existing partnerships, where they exist.
- Work on data-sharing procedures early.
- Hire the right liaison—and know why they're the right person.
- Make sure everybody understands what the liaison is meant to do.
- Connect liaison directly to discharge staff *before* discharge.
- Recognize that relationship-building takes time.
- When possible, focus attention on high-utilizers.

- Build on existing partnerships, where they exist. The hospitals involved in the first year of program implementation had already worked together before. This foundation of trust gave the group the flexibility to take on a pilot project without a proven track record. *Efforts to establish programs like the liaison program elsewhere should build upon existing networks where possible, not replace them.*
- Work on data-sharing procedures early. Data-sharing was a challenge in year one (see discussion below). Avoid unnecessary privacy and confidentiality barriers by understanding every stakeholder’s legal ability to share certain types of information with hospital liaisons as early in program implementation as possible. Establishing data sharing practices and standards can take time, but has ongoing benefits if done early.
- Hire the right liaison—and know why they’re the right person. Because the program is the responsibility of a single person, that person must be able to (1) provide on-call support to hospital staff seeking information about resources available to patients experiencing homelessness; (2) build homeless services capacity and knowledge among hospital social work staff; and (3) track chronically homeless individuals and families in the South Bay to facilitate unified patient care across local human and health service providers.
- Make sure everybody understands what the liaison is meant to do. The liaison position should be a link between existing resources, not a supplement to them, and *not a resource itself*. Both Harbor Interfaith and the United Way emphasized that a key risk to program success was that the liaison would be viewed as a case manager rather than an “air-traffic controller” or coordinator, thus stopping them from building capacity among hospital staff and being a useful on-call resource for new patients.
- Connect liaison directly to discharge staff *before* discharge. The liaison should be brought into discharge conversations as early as possible—ideally just after the patient presents at a hospital. Discharge into the CES works best when the liaison has time to assess various housing and shelter resources available on a given night, or week, and not when the process is in its last stages.
- Recognize that relationship-building takes time. Particularly when coordination between CES and hospital staff has previously been limited, it may take time for even talented liaisons to build trust with hospital colleagues. Even when that trust has been achieved, gaining the trust of patients who may be skeptical of healthcare systems or large institutions takes time and dedication and may not return immediate results.
- Focus attention on high-utilizers. Many patients experiencing homelessness present at multiple hospitals in the course of a month, week, or even day. Housing these patients can have a disproportionately positive effect on hospital- and system-level outcomes and costs.<sup>2</sup> Participating hospitals and liaison should make an effort to identify, track, and assist high-utilizers in their communities while identifying upcoming best practices, e.g., hospital and health plan partnerships with recuperative care, board and care, and skilled nursing facilities, which may allow these high need individuals to be matched with supportive housing sites.

#### ONGOING CHALLENGES

- There isn’t enough affordable housing in Los Angeles.
- Data-sharing is difficult.
- Medical care is expensive and hard to find, even with Medi-Cal.
- Relationship-building takes time and results are not immediate.
- Tracking patients between hospitals is difficult too.
- Hospitals without community benefit requirements may struggle to find program funds.

<sup>2</sup> The precise amount of savings depends on the type of care provided: Bridge or interim housing is typically least expensive in the short run, although rates of re-entry into homelessness can be relatively high; permanent supportive housing or recuperative care can be more expensive in the short run but often lead to more durable positive outcomes.

- There isn't enough affordable housing in Los Angeles. Although Los Angeles has established city- and county-level goals to increase the supply of affordable housing available to Angelenos, the current stock of affordable housing—and, in particular, of permanent supportive housing—is too small.
- Data-sharing is difficult. Program stakeholders found it difficult to establish data-sharing practices that allowed coordination of care between hospital staff, Harbor Interfaith, and other housing and homelessness service agencies. It is possible that AB210 and increased access to HMIS licenses for hospital partners as of July 2019 will make data sharing easier in the future. For now the lack of processes for allowing hospitals regular HMIS access, and the lack of the sharing of medical data between hospitals, remains a barrier to program effectiveness.
- Medical care is expensive and hard to find, even with Medi-Cal. Many patients experiencing homelessness can only be served by hospitals and primary care providers who accept Medi-Cal—or may not be covered by any insurance at all. This, in turn, limits the number of locations in which those patients can receive follow-up care, creating high costs that challenge efforts to provide care to homeless patients.
- Relationship-building takes time and results are not immediate. The population targeted by this program can be distrustful of the medical system and of large institutions in general, and so program outcomes should be measured on a timeline that acknowledges that returns may not be quick. Sometimes it can take ten conversations with a person experiencing homelessness before that person is willing to cooperate and open up about their needs, or commit to seeking help in partnership with hospital liaison.
- Tracking patients between hospitals is difficult too. Patients who are experiencing homelessness are a difficult population to track given their lack of a fixed nighttime residence. This means that patients who present at a given hospital, apparently for the first time, might already be in another hospital's EMR, or in HMIS. Establishing more effective data-sharing procedures can limit the degree to which a patient finds themselves with five “coordinators,” each operating without knowledge of others and sometimes at odds.
- Hospitals without community benefit requirements may struggle to find program funds. All hospitals which participated in the program in the first year did so through their community benefit departments, which were as a requirement of the ACA and which have a specific goal of establishing or facilitating programs like this one. For-profit hospitals may find it difficult to identify institutional champions for this work.

#### FUTURE DIRECTIONS AND NEXT STEPS

- Continue program operations on an ongoing basis.
- Better understand the program's costs and benefits.
- Find more effective ways to share and manage data.
- Fund complementary continuous-improvement efforts.

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## APPENDIX

### GLOSSARY OF TERMS AND DEFINITIONS

**Coordinated Entry System (CES)**: The Los Angeles County Coordinated Entry System (CES) facilitates the coordination and management of the resources that comprise the homeless crisis response system in the county. CES allows users to efficiently and effectively connect people to interventions that aim to rapidly resolve their housing crisis. CES works to connect the highest need, most vulnerable persons in the community to available housing and supportive services equitably.

**Emergency Department Information Exchange (EDIE)**: The Emergency Department Information Exchange (EDIE) is a centralized system of records of individuals entering emergency room departments for coordination of care.

**Homeless Management Information System (HMIS)**: The Homeless Management Information System (HMIS) is a locally-administered centralized system of records used to gather and analyze client services and housing outcomes for individuals and families who are homeless or at-risk of homelessness. It is designed to help users manage information and services in order to better assist homeless or at-risk populations achieve housing stability and self-sufficiency.