Quality and Productivity Commission

32nd Annual Productivity and Quality Awards Program

"Innovating for Impact"

2018 APPLICATION

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):

NAME OF PROJECT: HOMELESS TASK FORCE: HOME IS WHERE YOUR HEALTH IS

DATE OF IMPLEMENTATION/ADOPTION: AUGUST 1, 2016
(Must have been implemented at least one year - on or before July 1, 2016)

PROJECT STATUS: __X__ Ongoing _____ One-time only

HAS YOUR DEPARTMENT PREVIOUSLY SUBMITTED THIS PROJECT? _____ Yes __X__ No

EXECUTIVE SUMMARY: Describe the project in 15 lines or less using Arial 12 point font. State clearly and concisely what difference the project has made.

In response to the increase in homeless individuals living in and around the hospital campus and to the multiple Emergency Room (ER) visits and inpatient admissions, Harbor-UCLA Medical Center's Clinical Social Work department formed the Homeless Task Force (HTF), a specialized group of County staff and community partners, who work to identify, assess and link homeless patients to placement and other relevant community resources. The HTF has highly specialized knowledge of community resources relevant to the homeless population and works closely with DHS' existing Housing for Health program. Since its inception, the impact of the HTF is evident. Patients feel their care is specialized to what they really need. ER staff are pleased that they can utilize their skills for true medical emergencies and that they know how to get the patients the help they need. The hospital campus is revitalized and looks nice for existing patients, new patients, hospital staff and the surrounding community. During the first year of the task force's work, they secured placement for over 250 patients and saved Los Angeles County approximately $5,682,332.

BENEFITS TO THE COUNTY

(1) ACTUAL/ESTIMATED **ANNUAL** COST AVOIDANCE	(2) ACTUAL/ESTIMATED **ANNUAL** COST SAVINGS	(3) ACTUAL/ESTIMATED **ANNUAL** REVENUE	(1) + (2) + (3) = TOTAL **ANNUAL** ACTUAL/ESTIMATED BENEFIT	SERVICE ENHANCEMENT PROJECT
	$5,682,332		**$ 5,682,332**	☒

ANNUAL = 12 MONTHS ONLY

SUBMITTING DEPARTMENT NAME AND COMPLETE ADDRESS DHS-Harbor UCLA Medical Center, Clinical Social Work Dept. 1000 Carson Street, Box 413 Torrance, CA 90502		**TELEPHONE NUMBER** 310-222-3278
PROGRAM MANAGER'S NAME Jennifer Murray, LCSW; Veronica Turner, LCSW; Sandra Maldonado-Aviles, LCSW; Azar Kattan, COO		**TELEPHONE NUMBER** 310-222-3278 **EMAIL** jmurray@dhs.lacounty.gov
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE (PLEASE CALL (213) 893-0322 IF YOU DO NOT KNOW YOUR PRODUCTIVITY MANAGER'S NAME) Lisa Finkelstein Lisa Finkelstein	**DATE** 7/6/2018	**TELEPHONE NUMBER** (213) 288-8108 **EMAIL** lfinkelstein@dhs.lacounty.gov
DEPARTMENT HEAD'S NAME AND SIGNATURE Christina R. Ghaly, M.D.	**DATE** 7/6/2018	**TELEPHONE NUMBER** (213) 288-8101

We Support Plain Language

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):
NAME OF PROJECT: HOMELESS TASK FORCE: HOME IS WHERE YOUR HEALTH IS

1st FACT SHEET – LIMITED UP TO 3 PAGES ONLY: Describe the **challenge(s), solution(s), and benefit(s)** of the project. What quality and/or productivity-related outcome(s) has the project achieved? Provide measures of success. Use Arial 12 point font.

Challenge: Harbor-UCLA (HUCLA) was seeing increasing numbers of homeless individuals who were living all over the hospital campus, both in outside areas and inside the buildings, including the Emergency Department (ED) waiting room. Once in the ED, the homeless patients would sign in, complaining of medical symptoms they did not really have, just to have a reason to remain inside the hospital. When approached, these individuals would often admit that they were not in need of medical care, but that they were living here because they felt safe on a hospital campus. For many of these patients, their homelessness was often further challenged by concurrent, untreated mental health problems and substance use issues. The situation was having a widespread, detrimental effect. ED resources were being utilized inappropriately. These individuals, who truly only needed social services, would clog up the waiting line and might even be seen sooner than patients who were in the ED for true medical emergencies. This created feelings of frustration and anger for existing patients, and a service-access barrier for potential patients (for which we are now competing in the current managed care environment). More broadly, there was an impact on staff morale from seeing these individuals residing on the hospital campus, but not being able to provide the level of assistance they really needed.

Solution: The solution was the creation of a specialized unit within HUCLA's Clinical Social Work department called the Homeless Task Force (HTF), with essential support from DHS's existing Housing for Health Program. The HTF is led by a Senior Clinical Social Worker who has experience and passion for working with the homeless population. The team also includes a Medical Case Worker and community partners [two housing case managers from People Assisting the Homeless (PATH) and two substance abuse counselors from Behavioral Health Services (BHS)]. This team works collaboratively to identify, connect with and assess homeless patients in need, and thereafter refer to housing resources (primarily through close work with DHS's Housing for Health Program and the Los Angeles Homeless Services Authority), mental health treatment (through collaboration with the Department of Mental Health (DMH)) and substance abuse treatment through BHS. Patients are placed in interim, transitional or permanent housing or, if more appropriate, connected with detoxification or rehabilitation placement for a substance use disorder. HTF receives referrals from hospital staff in the ED and/or the Urgent Care Clinic (UCC) and assists in placement of homeless inpatients. They also conduct outreach in and around the hospital to identify homeless individuals in need of housing. This dedicated team possesses a wealth of knowledge about relevant community resources and is able to see homeless patients quickly. This keeps our ED clinical social work resources available for trauma and crisis cases without having to reallocate our staff.

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Use Arial 12 point font.

Benefits:

1. Have homeless patients housed and get them off the streets so they can better attend to their own medical conditions and obtain appropriate care for medical and other ancillary services.
2. Connect homeless patients to resources that can enhance the skills needed to sustain their housing, mental health assistance, substance use/abuse information/rehabilitation, financial assistance, food security, etc.
3. Streamline the ED waiting queue by implementing ED Lobby Rounds (attended by HTF staff, Nursing, Sheriff/Security) 2-3 times a day where patients needing only social services are taken out of the ED waiting queue and seen by HTF staff. This leaves only patients needing true emergency medical care in the ED waiting queue and therefore shortens their waiting time. We have received positive feedback from both the homeless population and those non-homeless patients regarding this process. Patients expressed feelings of being heard and of getting the help they really needed.

Quality/Productivity-Related Outcomes:

1. Reduced ED and UCC repeat visits by homeless patients who would otherwise have continued to return to HUCLA and Department of Health Services (DHS) emergency rooms in order to obtain shelter and food if they had not been properly housed by this program. This improved the quality of patient care by focusing on the patient's immediate social service needs and, once housed, helped the patients maintain proper compliance with medical care and medications for chronic illnesses.
2. Decreased number of inpatient hospital stays for this population, which allowed beds to be utilized for patients with acute medical issues. This decreased denied days and allowed the hospital to receive reimbursement for patients who were now receiving care in those beds.
3. With the wait queue being streamlined, ED medical staff were able to focus their time and effort on patients with true medical emergencies, which only helped them improve the quality and productivity of their patient care.
4. Improved the quality of patient care by earlier and better identification of patient needs and more efficient assistance with patient's social service needs.
5. Provided consistency in social work staff working with the homeless population, positively affecting the quality of patient care. Consistency is crucial in order to establish trust and relationships with patients who must share close, personal information during the resource-connection process.
6. Improved the quality of the hospital environment. The hospital campus is a nicer environment for existing and potential patients as well as the surrounding community and HUCLA hospital staff.

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Measures of Success and Assessment Time Frame:
The following shows the cost savings that the HTF has had for HUCLA:

- August 1, 2016 to July 31, 2017 (1st year): $5,682,332 cost savings and 250+ individuals placed
- August 1, 2017 to present (May 31, 2018): $2,846,129 cost savings and approximately 135 individuals placed

Please see page 6 for detailed information on how these savings were calculated.

Examples of Success:

1. Patient A (one of the first patients housed by the HTF): 47 y/o homeless male with untreated mental health problems and an alcohol dependence disorder who was living in the bushes outside the hospital for several years. Prior to placement, he had 40 Harbor-UCLA ER visits where he would sign himself in, not answer until the third and final time he was called and then he would tell the ER staff that he was homeless and needed help to get housed. Due to his alcohol dependence, he failed the first several placements, but the HTF team stuck with the patient and, after the fourth and final placement in March 2017, he has only been seen at his clinic for regular appointments. He has had no ER visits since placement and no inpatient admissions for placement. This resulted in a cost savings to DHS of approximately $21,320.
2. Patient B: 38 y/o male with paraplegia moves to Los Angeles from Utah with no plan for where he will stay and comes straight to HUCLA for help and housing. He was admitted for placement and had no family or friends to help. He had a protracted inpatient stay with behavioral problems, untreated mental health issues along with substance dependence. Social Workers were unable to find an accepting facility for this patient and the patient was restless, leaving his hospital room for hours each day. After the patient left the hospital for longer than four hours, he was discharged and reappeared in the ER later that same day. The HTF became involved with the patient in the ER and was able to work closely with him and obtain placement for him. Patient was stably housed in March 2018 and, since that time, has not presented to the ER again. This resulted in a cost savings to DHS of approximately $209,894.
3. Patient C: 66 y/o male with untreated mental health problems living on hospital campus. He would regularly come to the ER and check himself in so that he could get off the streets, get into a sheltered environment and get some food. He had a total of 223 ER visits prior to his placement in a supportive shelter in September 2016. He continued to work with the Housing for Health program and eventually obtained his own apartment. The patient has not been back to the ER since his placement. He has been able to keep his DHS clinic appointments and he has repeatedly expressed his thanks to the HTF. This placement resulted in a cost savings to DHS of approximately $118,859.

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Linkage to the County Strategic Plan – 1 page only. Which County Strategic Plan goal(s) does this project address? Explain how. Use Arial 12 point font.

This program links directly to each of Los Angeles County's three goals in its 2016-2020 Strategic Plan: making investments that transform lives; fostering vibrant and resilient communities; and realizing tomorrow's government today. Specifically, the HTF program directly aligns with the following strategies that support these three goals:

1. Strategy I.1 – "Increase Our Focus on Prevention Initiatives"
    a. Providing housing to the homeless individuals who seek care at DHS facilities directly and positively affects this strategy by increasing the patients' ability to focus on practicing better compliance with medical visits and taking medications now that they are safely housed. This helps to avoid exacerbation of their chronic illnesses and could also help to prevent the diagnosis of other chronic illnesses that can result from living on the streets.
2. Strategy I.2 – "Enhance Our Delivery of Comprehensive Interventions"
    a. Linking these homeless individuals with HTF services, and eventually services by DHS's Housing for Health, ensures that the patient receives comprehensive services from their assigned Intensive Case Management Services provider. Services can include housing management, arranging for mental health services, and arranging for substance use disorder treatment services. These services are those directly specified in strategies I.2.1 (Provide Subsidized Housing for Vulnerable Populations), I.2.2 (Streamline Access to Integrated Health Services) and I.2.3 (Integrate Substance Use Disorder Treatment Services).
3. Strategy II.2 – "Support the Wellness of our Communities"
    a. Providing stable housing for this population includes concurrently addressing the patient's mental health and substance use disorder conditions, which directly positively affects the patients' better mental health and well-being.
4. Strategy III.3 – "Pursue Operational Effectiveness, Fiscal Responsibility, and Accountability"
    a. The HTF program facilitates use of the hospital's ED resources as intended which helps to 1) maximize our hospital revenue and 2) maximize the effectiveness of our ED resource usage. Clinical staff can be utilized for what they were hired for, not for provision of social services to patients who are not appropriately accessing the ED.

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COST AVOIDANCE, COST SAVINGS, AND REVENUE GENERATED (ESTIMATED BENEFITS TO THE COUNTY): If you are claiming cost benefits, include a calculation on this page. Please indicate whether these benefits apply in total or on a per unit basis, e.g., per capita, per transaction, per case, etc. You must include an explanation of the County cost savings, cost avoidance or new revenue that matches the numbers in the box. Remember to keep your supporting documentation. Use Arial 12 point font

Cost Avoidance: Costs that are eliminated or not incurred as a result of program outcomes. Please indicate whether these are costs to the County or to other entities.

Cost Savings: A reduction or lessening of expenditures as a result of program outcomes. Please indicate whether these were expenditures by the County or by other entities.

Revenue: Increases in existing revenue streams or new revenue sources to the County as a result of program outcomes.

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$	**$5,682,332**	**$**	**$5,682,332**	☒

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Calculation of Cost Savings:

For each patient, we noted the date s/he was placed by the Homeless Task Force (HTF). We counted how many ER visits and inpatient admission days the patient had prior to the placement date and how many the patient had after the placement date. Harbor-UCLA's Finance Department provided the following approximate, variable costs for an ER visit and for one day of an inpatient stay:

- ER Visit: $533 per visit
- Inpatient admission: $1,258 per admitted day

Using these numbers, we were able to calculate the "cost" to Harbor-UCLA (DHS) prior to the patient's placement and the "cost" for any ER visits and inpatient admissions after the patient was placed. We deducted the post-placement cost from the pre-placement cost and arrived at the cost savings for DHS for that patient. As an example, Patient B from the previous page:

- Prior to placement, patient had two ER visits and one lengthy inpatient admission (166 days). Using the numbers provided by finance, this produced a cost to DHS of $1,066 for the ER visits and $208,828 for the inpatient stay. Together, this cost came to a total of $209,894. As the patient has not been seen at a DHS facility since his placement, we are using the total of $209,894 as the cost savings to DHS.

We totaled the cost savings (and deducted any patients who actually cost DHS more post placement) for each annual time period (August 1, 2016 – July 31, 2017 and then the majority of the second time period, August 1, 2017 – May 31, 2018) to arrive at our total cost savings of $5,682,332 for the first year and $2,846,129 thus far for the second year.