Integrating Healthcare and Social Services for Older People and People Experiencing Homelessness

by

Chris Rubeo

A dissertation submitted in partial satisfaction of the

requirements for the degree of

Doctor of Public Health

in the

Graduate Division

of the

University of California, Berkeley

Committee in charge:

Professor Amanda L. Brewster, Chair
Professor Emmeline Chuang
Professor Hector P. Rodriguez

Spring 2024

Abstract

Integrating Healthcare and Social Services for Older People
and People Experiencing Homelessness

by

Chris Rubeo

Doctor of Public Health

University of California, Berkeley

Professor Amanda L. Brewster, Chair

States are increasingly leveraging waivers and other flexibilities in the Medicaid program to experiment with using Medicaid to fund services to address health-related social needs. This trend has created new financial incentives for cross-sector collaboration and integration of care. Better integrated social and medical care is expected to lead to more effective services, lower costs, and improved outcomes for patient populations that frequently use high-cost medical services, but is challenging to achieve. This dissertation examines care integration efforts for two populations that have been the focus of recent reforms: older people and people experiencing homelessness.

The first study uses qualitative interviews with county aging services leaders in the San Francisco Bay Area to identify the challenges and opportunities counties face in delivering services to older people and people with disabilities. The second study uses qualitative interviews to describe motivations and concerns of healthcare and social services organizations when integrating social and medical care for people experiencing homelessness in Los Angeles County. The third study uses participatory methods to explore street medicine providers' perspectives on the impact of newly available Medicaid funding on their service model. Taken together, these studies elevate the voices of providers, payors, and county leaders to document early lessons and insights from their experiences delivering integrated services.

To my family — who made this possible.

Table of Contents

Introduction 1
Research Aims 2

Chapter 1: Bay Area Adult & Aging Services Strategic Planning 2022 4
- Abstract 4
- Background 4
- 1. Grow the adult and aging services workforce 7
- 2. Adopt new policies, procedures, and approaches to management 11
- 3. Build partnerships 13
- 4. Integrate services and use a client-centered approach 16
- 5. Seek new and more flexible funding 19
- 6. Develop equitable and responsive programs and workplaces 22
- 7. Educate about ageism 25
- Conclusion 28
- Appendices 28

Chapter 2: Integrating homeless services and medical care in Los Angeles County: Motivations and tensions. 29
- Background 29
- Methods 30
- Results 33
- Discussion 44
- Limitations 46
- Conclusion 46

Chapter 3: Medi-Cal Reform and the Future of Street Medicine in Los Angeles County 47
- Background 47
- Methods 49
- Results 52
- Discussion 56
- Limitations 57
- Conclusion 58
- Tables 58
- Figures 63

Conclusion 65
References 68

Acknowledgements

I am so greatly indebted to the many people who have helped along the way:

When I somewhat reluctantly decided to do a doctoral program, my one rule was that I would work with people whose way of working I admired. That is to say, people who are kind, supportive, and bring out the best in the people around them. My committee was just that — brilliant, inspiring, tough, and supportive — and they made all of this research possible. I am grateful to Amanda, whose class on health care quality was the spark that got me excited about studying organizations and whose guidance throughout the program was invaluable. To Leslie, who gave me the opportunity to work on my first large nationwide research project and whose way of managing a research team I've tried to emulate in my work since. To Hector, who always asked the long-view questions and kept me thinking about my career. And to Em, whose thoughtful questions and careful feedback pushed me to think more expansively and in new ways about so many of the topics in this dissertation.

I would not have made it to Berkeley without many friends, colleagues, and mentors along the way—too many to name here. Nor would I have made it through Berkeley without the guidance of so many colleagues and friends. I especially want to thank Dr. Ndola Prata, who encouraged me to stick around after my MPH and who has been a mentor and collaborator these past four years.

This process would have been miserable without the love and support of friends. I am beyond grateful for Kavita, Mia, Dawson, Benjamin, and Rachel, who I am so lucky to call my community here in the Bay Area—my family away from home. Thank you for all of the long walks, dinner parties, deep conversations, and reminders not to take things too seriously.

To my family — Mom, Dad, Anna, Paul — I see you in everything that I do. Your unwavering support and love have been my anchor throughout this journey, and for that, I am eternally grateful.

Introduction

Since the early 2000s, healthcare payment reform efforts in the United States have been guided by the "triple aim" of improving the experience of care, improving the health of populations, and reducing per capita costs of health care.[1] Over that same period, a preponderance of evidence shows that environments where people live, work, and grow play a significant role in determining peoples' life trajectories and health outcomes.[2] That evidence along with a growing consensus that the United States overspends on medical treatment and underspends on social services[3] has led to policy and payment reforms that redirect healthcare spending towards addressing the social determinants of health.[4,5]

States are increasingly leveraging waivers and other flexibilities in the Medicaid program to experiment with using Medicaid to fund services to address peoples' health-related social needs.[6] In a growing number of states, Medicaid has begun to pay for care management for people who frequently use high-cost healthcare services and, in some states, Medicaid programs are experimenting with paying for housing-related supports, nutrition assistance, transportation, employment assistance, personal care assistance, and other non-medical support services as a substitute for medical care.[6] The new availability of Medicaid funding to pay for health-related social services has created financial incentives that are driving cross-sector collaboration[7] and integration of social and medical care.[8,9] But it has also called into question the appropriate scope and role of healthcare in addressing social needs[10] and has raised concerns about the potential harms of medicalizing social problems.[11]

Still, despite those concerns, care integration has become a policy imperative based on the expectation that it will lead to more effective services, lower costs, and improved outcomes for patient populations that frequently use high-cost medical services.[12] Integration of care is defined as whether people receive services that address their needs and which are coordinated across all sectors with which they are involved.[13] It can occur at multiple levels in a care system and involve the linking of structures, functions, norms, interpersonal relationships, and processes among organizations in a health system or teams within organizations.[14] Often, in its most basic form, cross-sector integration manifests as healthcare organizations screening patients for health-related social needs and making referrals to local CBOs to address those needs.[12] In other cases, organizations engage in more intensive integration efforts by bringing social and medical services into the same location or onto the same team[15,16] by "building" new capabilities within an organization or "buying" them through cross-sector partnerships.[17]

Though promising, social and medical care integration has proven challenging to achieve.[18,19] Screening and referral processes often involve very little true integration of care or coordination between the referring and receiving agencies, therefore, its impact may be limited by patients declining assistance, not following through on referrals, or not qualifying due to narrow eligibility criteria for accessing community resources.[20] On the

other hand, integration efforts that rely on cross-sector partnerships have proven challenging due to the need to align operations and services across organizations that may have very different values, priorities, regulations, funding, staffing, and capacity.[8,21–23]

This dissertation examines care integration efforts for two populations that have been the focus of recent reforms in California: older people[24] and people experiencing homelessness.[25]

Research Aims

The first aim is to identify the challenges and opportunities counties in the San Francisco Bay Area face in delivering services to older people and people with disabilities (Aim 1). County Adult and Aging Services (AAS) departments play a critical role in caring for older and disabled adults.[26,27] In the Bay Area, rapid growth in the number of people seeking county AAS services,[28] coupled with increased complexity of service needs,[29] has placed tremendous pressure on county AAS to expand capacity. Additionally, recent policy changes at the federal[30] and state level[24,31] call for more integrated social and medical services for older and disabled Californians and present unique challenges and opportunities to county AAS as they work towards creating a Bay Area where people of all ages and abilities can thrive.

Second, we describe the motivations and tensions reported by healthcare and homeless services providers in Los Angeles County who are involved in integrated housing and health services for people experiencing homelessness (Aim 2). People experiencing homelessness have high rates of co-occurring physical health, mental health, and substance use disorders compared to housed people.[32,33] The complexity of seeking services from multiple organizations in separate care systems is a known barrier to care.[34,35] To address that barrier, many organizations that serve unhoused people are taking steps to integrate care, often by partnering with other organizations within and across sectors.[36–38] However, little is known about the motivations and concerns of healthcare and social services organizations when integrating social and medical care for people experiencing homelessness.

Lastly, we explore street medicine providers' perspectives on the impact of newly available Medicaid funding on their service model (Aim 3). Street medicine is the practice of providing integrated medical care and social services to people experiencing unsheltered homelessness in their own environments, often in locations like encampments, parks, and under bridges.[39] The model is becoming more widely used in Los Angeles County due to the availability of new Medi-Cal funding and recent state and federal policy changes.[40–42] However, little is known about how these changes are impacting street medicine providers or the services they deliver. Street medicine teams are well-positioned to bridge the gap between the housing and healthcare sectors, and an improved understanding of how these

providers are experiencing changes in their payment environments could impact broader adoption of the model.

Chapter 1: Bay Area Adult & Aging Services Strategic Planning 2022

Abstract

County Adult and Aging Services (AAS) departments play a critical role in caring for older and disabled adults. In the Bay Area, rapid growth in the number of people seeking county AAS services, coupled with increased complexity of service needs, has placed tremendous pressure on county AAS to expand capacity. Additionally, recent policy changes at the federal and state levels present unique challenges and opportunities to county AAS as they work towards creating a Bay Area where people of all ages and abilities can thrive. This report summarizes key findings from a year-long strategic planning process by the Bay Area Social Services Consortium Adult Services Committee and makes seven recommendations for strengthening AAS in the region.

Background

a. California's population is aging and disability is becoming more common

California is undergoing a historic demographic change. Older adults are the fastest growing age group in the state. Between 2010 and 2040, the number of adults 60 years or older will more than double (from 6.1 million to 12.6 million); by contrast, the overall state population is projected to increase only 16%. This trend is mirrored in the Bay Area, where the fastest population growth is concentrated among the oldest adults, 75 and older (Figure 1). The number of adults with disabilities is also increasing: In California, almost 1 in 4 adults has a disability, and this number is projected to grow.[43,44] Finally, California is already one of the most diverse states in the country and will only become more so in the future.[45] All of these changes will have a significant impact on county services in the region.

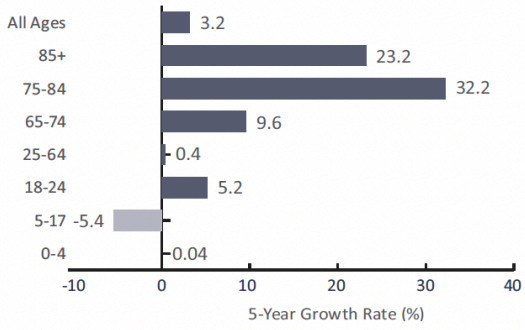


Figure 1 | Bay Area 2022-2027 population growth rate by age group

Source: California Department of Finance. Demographic Research Unit. Report P-3: Population Projections, California, 2010-2060 (Baseline 2019 Population Projections; Vintage 2020 Release). Sacramento: California. July 2021.

b. More older adults and people with disabilities will rely on county adult and aging services for support

County Adult and Aging Services (AAS) play a critical role in caring for socioeconomically vulnerable older adults and people with disabilities. Current trends indicate that a growing number of people will rely on county programs for support as they age. Caseloads for county AAS programs have been growing for decades, particularly In-Home Supportive Services (IHSS)[46] and Adult Protective Services (APS).[47] Research from the Public Policy Institute of California finds that the number of Californians who will have difficulty caring for themselves will nearly double from 548,700 people in 2012 to 1,010,100 people in 2030.[29] It is also becoming more common for older people to be single, childless, or living alone. Without family close by to support them day-to-day, more older adults and people with disabilities will rely on county programs for support in the coming years.

As caseloads grow, it is becoming more difficult for counties to ensure that everyone who qualifies for services can access them. For example, IHSS pays for essential services for low-income older adults and people with disabilities, including house cleaning, meal preparation, personal care services, and accompaniment to medical appointments. However, a 2021 report by the California State Auditor[27] found that tens of thousands of IHSS recipients do not receive the services for which they qualify, and that counties are unprepared for future program growth. Without planning and investment by the state and counties, the gap between service eligibility and access will continue to grow. When people who qualify for IHSS or APS go unserved, the chance they will become injured and need expensive medical services and long-term nursing home care increases.[27]

c. The needs of older people are growing more complex

The needs of older people are becoming more complex, and gaps in the county services available to meet these emerging needs are growing. Increasing numbers of older adults are experiencing homelessness,[48] substance use disorders,[49] and untreated behavioral health needs.[50] A growing number of older people also struggle to afford the basics[51]—healthy food, safe housing, and reliable transportation—but do not qualify for means-tested government support through Medi-Cal, California's Medicaid program. On average, cost of living for older adults is much higher in the Bay Area than in California as a whole—$41,275/year or $3,440/ month in the Bay Area compared to $34,008/year or $2,834/month in California. Affording the cost of living in the Bay Area is especially challenging for people over 65, who often rely almost entirely on their Social Security benefits.[24] As a result, Bay Area counties are seeing more "property rich, cash poor" older adults who seek support from the county through programs that have less strict eligibility requirements than Medi-Cal, indicating a growing need for programs that serve middle-income older adults.[52] There is also a notable shortage of services for older adults

who are cognitively impaired, particularly those with dementia.[53] To respond to changing needs, county adult and aging services are adapting existing services and creating new programs.

Jerry's Experience: Client Vignette, IHSS

For over two decades, Jerry worked construction jobs and lived independently. A back injury left him unable to work, and his expenses quickly depleted his savings. At the age of 59, Jerry was evicted from his apartment and started living on the streets of San Francisco. To cope with the difficulties of living on the street, Jerry started to use heroin and quickly became addicted. Though he had access to some resources through various services for people experiencing homelessness in San Francisco, Jerry regularly used the emergency room in order to manage medical situations stemming from his diabetes and hypertension. Jerry's substance use disorder and chronic care needs made it hard for him to remain housed. For Jerry and many others like him, new types of programs are needed to address the range of difficulties making it hard for him to thrive. The county stepped in to support Jerry during the COVID-19 pandemic. His story highlights the emerging need for "contract mode" or agency-managed IHSS to support recipients who struggle to direct their own care. Contract mode IHSS is currently only available in San Francisco, but multiple directors have expressed the need for similar support in their counties.

d. Emerging policy reforms are directing new attention and energy to issues impacting older and disabled Californians

Today, counties face the unique opportunities, challenges, and realities of an aging population. New statewide initiatives such as the California Master Plan for Aging and California Advancing and Innovating Medi-Cal (CalAIM) provide tremendous opportunities for innovation in aging services yet also place new demands on an already lean service system. Meanwhile, the COVID-19 pandemic highlighted the critical shortage of home care workers (also referred to as "caregivers") and revealed the vulnerability of older adults to sudden economic downturns, evidenced by the rise in food insecurity during the pandemic.[54] The Home Safe pilot program—a 2018 to 2021 initiative designed to improve county capacity to support APS clients who are homeless or at risk of becoming homeless—has resulted in new partnerships with local homelessness service providers and new staff expertise and capabilities in housing navigation.[55] In the coming years, more older adults will require assistance with self-care, placing even greater demands on a safety net already approaching the limits of its capacity.[29]

e. To create a Bay Area where people of all ages and abilities can thrive, counties will need to develop new programs and refine how existing ones are delivered

As communities across the state adapt to become more inclusive to people of all ages and abilities, county governments will play an important role as funders, conveners, and direct providers of support. Expanding the capacity of county AAS will be necessary to ensure Bay Area residents have the support they need in the coming years.

In 2021-22, the Bay Area Social Services Consortium Adult Services Committee (BASSC-ASC) engaged in a year-long data gathering and strategic planning process in order to: identify current and emerging needs among older and disabled adults; describe key accomplishments and challenges in service provision; and develop strategies to expand service capacity. This report summarizes findings, outlines seven strategies to strengthen AAS, and describes how Bay Area counties are already taking action to improve the lives of older adults and people with disabilities in their communities. The seven strategies are:

1. Grow the adult and aging services workforce
2. Adopt new policies, procedures, and approaches to management
3. Build partnerships
4. Integrate services and use a client-centered approach
5. Seek new and more flexible funding
6. Develop equitable and responsive programs and workplaces
7. Educate about ageism

1. Grow the adult and aging services workforce

Key Findings: *An expanded workforce is needed to serve the growing population of older and disabled adults and ensure service access and quality. As counties plan for the future, they seek staff with new capabilities and expertise, including bilingual staff and staff with skills to address homelessness, behavioral health, and substance use. However, recruiting and retaining social workers for AAS is challenging[56] due to salary competition, the limited number of Master of Social Work (MSW) program applicants interested in gerontology, limited training in gerontology within schools of social work,[57] slow and bureaucratic county hiring processes, and other county-specific issues.*

a. A larger workforce is needed to meet the needs of the growing aging population

County AAS departments operate with a lean workforce and are grappling with how to serve the growing number of clients. AAS leaders report that if they are unable to hire more staff, they expect service quality and access will suffer in the coming years as their client population grows. Although county AAS departments may administer a range of programs,[26] this section of the report focuses primarily on core county programs for which AAS directors report unique workforce challenges: In-Home Supportive Services, Adult Protective Services, Public Conservator, and Public Guardian.

> *"I don't know that the work is sustainable without the department growing. It just has to grow, it's necessary."*

In-Home Supportive Services (IHSS)

The IHSS program serves more than 591,000 individuals statewide, helping recipients live independently in their own homes and avoid long-term care arrangements that would be much more costly to the state.[27] Historically, the state's IHSS caseloads have grown by approximately 7% each year, from just over 200,000 clients in 1999 to just over 500,000 clients in 2018.[46] Bay Area AAS directors report that their departments have grown considerably over that same period but not enough to keep up with the growth in demand for IHSS services. From January 2015 through December 2019, the number of recipients statewide who lacked care grew from 33,000 to more than 40,000 on average each month.[27] In addition, although counties must generally make an initial determination of an applicant's eligibility for IHSS within 30 days, applicants in 2019 waited more than 72 days on average.[27]

IHSS faces two distinct workforce challenges. First, IHSS relies on caregivers to work with older adults and people with disabilities in their homes. However, there is a statewide caregiver shortage, which is expected to worsen. Currently, a large share of IHSS caregivers are family members of IHSS recipients. However, as the number of divorced, single, or childless older adults increases, IHSS will increasingly rely on non-family professional caregivers.[29] The low wages that counties pay to caregivers also makes recruitment difficult. In 2021, no county in California paid its IHSS workers a living wage,[58] and many IHSS caregivers had sufficiently low income to qualify for county social services themselves.[27] County directors are concerned that the increasing population of older people, changing family caregiving norms, low wages for IHSS caregivers, and existing caregiver shortage will make IHSS very difficult to operate in the coming years.

> *"In IHSS you've got the combination of really low wages and hard work. Caregivers are not being paid living wages. So people are leaving the caregiving field and I don't blame them, I would too. Who can survive with the wages that are provided? … Some of our clients have such severe needs, and there's no way for us to compensate caregivers for more intense work. Whether you're having to clean somebody's body or you're having to vacuum someone's house you get the same amount of pay. There's just no fair way to compensate people for the work that they do. And so the number of providers is dwindling."*

In addition, more county social workers are needed to process applications for the program, guide applicants through the application process, and conduct annual reassessments. In some counties, large caseloads prevent social workers from offering clients adequate, timely support, and as a result, a growing number of clients are enrolled in IHSS but not connected with caregivers. The challenges navigating the IHSS application process and hiring a caregiver experienced by some clients (e.g., people living in shelters) compound the problem. As caseloads grow more complex, social workers experience

decreased bandwidth, focusing attention on clients with the greatest needs, leaving higher-functioning clients with less support. County directors are concerned that quality and timeliness of IHSS services will suffer if counties fail to increase the number of IHSS social worker positions in their AAS departments.

Adult Protective Services (APS)

County APS programs provide a critical safety net to protect older adults and dependent adults from abuse, neglect, and financial exploitation. County APS staff respond to reports of abuse and neglect and conduct case investigations. Similar to IHSS, the size and complexity of APS caseloads are increasing. Santa Clara County, for instance, reports that since 2013, the overall APS volume of reports and active cases has increased approximately 14% each year.[47] Other Bay Area counties report similar growth, yet growth in the APS workforce has not kept up with increased demand.

Another challenge for APS relates to providing ongoing case management to meet the growing need for more extensive support. This is particularly true for clients experiencing homelessness and those with dementia. Given limited state or federal funding, counties often struggle to offer ongoing case management to APS clients. Many communities also lack the specific resources that clients need (e.g., memory care, affordable housing). In response, county AAS directors report efforts to create new programs to address service gaps within the community (e.g., for case management and other supportive services).

> *"An increasing number of our clients are coming in with severe mental health issues, homelessness, substance use, which requires a lot more intensive work."*

Public Conservators and Public Guardians

In California, Public Conservator and Public Guardian (PC/PG) programs play a critical role in caring for individuals who do not have capacity to do so themselves. Public conservators arrange mental health treatment and placement for people who are unable to provide for their food, clothing, shelter, and treatment needs, as a result of a mental health disorder.[59] Public guardians assist adults who are substantially unable to provide for their own basic needs like food, clothing, and shelter, (e.g., older adults with severe limitations or individuals with serious cognitive impairments). In over half of California counties, AAS departments are responsible for administering these two programs.[26] Counties do not receive any targeted state funding to support PC/PG operations, which hinders their ability to adequately staff these programs. Upcoming implementation of California's new CARE Court system[60] is expected to increase referrals to PC programs, placing further strain on their ability to meet client needs.

b. Recruiting and retaining social workers for adult and aging programs has proven challenging

All counties report facing barriers to recruiting and retaining social workers. Findings from the BASSC 2021 AAS workforce survey and interviews with county AAS leaders, presented below, identify the primary recruitment and retention challenges faced by counties, and the strategies they are using to overcome them.

> *"I've had to do two rounds of recruitment to try to fill a position—8 months—and that really hurts. It takes a long time to get people in, if you even can."*

Directors experience broad, structural challenges to hiring such as a shortage of social workers graduating from Bay Area universities with interest or training in gerontology, and recruitment has become even more difficult as counties seek to hire bilingual social workers to provide culturally and linguistically appropriate services. In the 2021 survey, eight of the eleven Bay Area counties noted language proficiency as a recruitment criterion that was difficult to fulfill.

The low pay social workers in AAS receive relative to other social work specialty areas is a common issue across counties. For example, in most Bay Area counties, compensation for social workers with comparable training and experience is higher in children's services than in AAS.[26] Directors also note that AAS departments compete with other public sector organizations and private employers, both within their county and in neighboring counties, to attract social workers. Some directors report hiring and training staff only to see them move to another department, county, or non-county organization for higher pay or better benefits.

Other challenges are county-specific. For example, counties with a high cost of living experience difficulties attracting applicants who are willing to move to their county for relatively low-paying jobs, or commute from distant, low-cost counties. Counties that border higher-paying counties lose applicants to counties that offer better pay or benefits. Rural counties report challenges attracting social workers to live and work in their communities, citing the distance from Bay Area schools of social work. Finally, slow county hiring processes can also hinder recruitment efforts.

c. Strategies to expand and strengthen the workforce

County AAS directors highlight the importance of state support for workforce development, particularly investment in stipend programs and other pipeline programs to make careers in Adult and Aging Services more compelling to social workers while they are still in graduate school. Directors note that to be effective, local schools of social work might also

need to enhance available training in gerontological social work practice. Directors report developing an array of strategies to expand the AAS workforce and make their positions more attractive to potential applicants. Key strategies include succession planning, professional development opportunities, and flexible work arrangements (e.g., telework). Retention is supported by creating pathways for professional growth (e.g., career ladders), while recruitment is aided by offering field placements to current students or opportunities for clinical supervision to recent graduates.

> *"When they come to the interview people are asking, 'Do you offer clinical supervision?' Because it's so important. A lot of them are coming in halfway through getting their clinical hours, and so we need to support that. About 80% of the staff we hired in the last three years came in wanting clinical supervision. It can make or break someone's decision to come to the county."*

Counties are working to build new capabilities to serve more older people who are experiencing homelessness, have behavioral health needs,[26] or seek care in a language other than English. Hiring staff with necessary expertise (e.g., staff who are bilingual or reflect the demographics of the clients they serve) is another priority for AAS directors. Serving older people experiencing homelessness represents a new role for AAS departments.

> *"One challenge is the growing homeless older adult population and all the issues around that. We do not have the expertise. We're not housing experts. We're not mental health experts. [But] we're trying to do better."*

Case Study: The Santa Cruz Design Team

In 2016, Santa Cruz AAS leadership created the Design Team within Santa Cruz County's Division of Adult and Long-Term Care in response to a staff survey that found limited trust and lack of communication between management and line staff. The Design Team works to build trust and improve communication by facilitating collaborative decision making—bringing staff and leadership together to develop new initiatives and projects. The Design Team improved staff morale by creating a work environment where staff feel that their perspectives and experiences are valued.

2. Adopt new policies, procedures, and approaches to management

Key findings: *All BASSC-ASC directors report adopting new policies, procedures, and approaches to management. These changes are designed to improve staff recruitment and retention or the access, quality, and efficiency of services. Key changes to improve staff recruitment and retention include implementing flexible work arrangements, offering more supervisory support and professional development activities, and changing workplace culture to encourage bottom-up communication from staff. To improve access, quality, or efficiency of*

services, directors are implementing new approaches to performance management, redesigning how services are provided, and investing in new data / IT infrastructure or other technology to support meaningful use of data to inform decision-making and practice.

a. Recruitment and retention

The COVID-19 pandemic placed immense strain on local health and social safety net providers,[61] and fundamentally altered the nature of work in the U.S.[62,63] To protect employee health and safety, Bay Area human services agencies instituted new or revised remote work policies. As the pandemic abates, in order to improve recruitment and retention, most counties have extended remote work policies to permanently allow staff to work remotely at least 1-2 days per week.[26] Implementing telework and other flexible work arrangements can require lengthy negotiations with labor unions, investment in technology, and development of new supervisory practices and organizational workflows; equitable implementation can also be a challenge, as some adult and aging services can only be provided in person. However, multiple directors describe flexible work arrangements as critical to their ability to successfully recruit and retain staff.

> *"That's a question staff ask at interviews, 'Do you offer alternative work schedules? … COVID has really changed the way people look at work and balance and we need to meet them where they're at."*

AAS directors also describe efforts to improve staff retention by strengthening the quality of supervisory support, offering more professional development opportunities (e.g., "on the job" field placements for social work degree programs or clinical supervision towards licensure), and changing workplace culture to encourage more bottom-up communication. For example, Santa Cruz created the Design Team to allow for greater staff input in decision-making while Alameda established new processes for regular, bi-directional communication between leadership and staff. To mitigate impacts of pandemic-related administrative turnover, several directors report engaging in more purposeful succession planning.

> *"We've had so many changes in managers and supervisors, I implemented a policy where if you are leaving your management position, you must write a detailed transition document so the person coming into your position has a good lay of the land. It's been a good way to capture knowledge for new people entering."*

b. Service Improvements

All county AAS directors describe changing organizational policies, practices, and management approaches to improve access, quality, and efficiency of services. Key strategies include redesigning services, implementing new approaches to performance management, and investing in new data and IT infrastructure or other technology to support meaningful use of data to inform decision-making and practice. With regard to service redesign, several counties report cross-training staff from different programs to facilitate more holistic, client-centered approaches to care. Other counties describe restructuring their units or redesigning care processes to improve quality and efficiency of care provided. For example, to improve timeliness of the IHSS intake process, Contra Costa changed existing workflows, including timing of case assignments and responsibility for intake assessments.

Multiple counties also emphasize the importance of collecting and meaningfully using data to identify community needs, guide performance management and performance improvement efforts, demonstrate program impact, and support advocacy efforts. For example, Sonoma is one of several counties that use Results-Based Accountability to inform how they describe, measure, and report on program performance. In San Mateo, use of a new data analysis and visualization software, PowerBI, is helping the leadership team rapidly review data on changing community needs and identify where targeted program improvements might be needed.

Case Study: Transforming In-Home Supportive Services in Contra Costa

In FY 2020/21, Contra Costa's IHSS intake assessment performance was among the worst in the state. In 2021/22, the Adult & Aging Services leadership team made significant changes to how the program was administered, including changes to how intake cases were assigned and to staff responsibilities. These changes resulted in significant improvement in intake performance, from 22.78% of cases with timely assessment to over 90%.

Case Study: Meals on Wheels San Francisco

Meals on Wheels San Francisco (MOWSF) is a home-delivered meal assistance program that serves over 4,000 people daily, including older adults and people with disabilities in the community. Over a four-year period, MOWSF shifted from a paper-based client tracking system to a Salesforce-based customer relationship management platform and staff-facing mobile application. Developing and implementing the platform was described as resource-intensive but transformative for the organization. The platform is used to track active clients, inform routing and mapping logistics for drivers, and provide real-time updates on delivery, client condition monitoring, and visit follow-up. Data from the platform are also used to support management decision-making, quality improvement efforts, and to demonstrate program impact to funders.

3. Build partnerships

Key findings: *Maintaining strong ties with local organizations, other county departments, and at the state level is a priority for AAS leaders in the Bay Area. Partnerships keep directors*

informed about changing community needs, allowing them to respond with new programs and services. Partnerships also enable counties to respond more quickly and effectively to natural disasters, successfully advocate for new funding or programs to support older and disabled adults, and better integrate care for the people they serve.

County AAS departments rely on strong ties with community partners to stay informed about and respond to emerging needs or natural disasters, and to successfully advocate policy and practice change. Counties responsible for administering local Area Agencies on Aging (AAAs) often report relying closely on the AAAs to stay connected to key stakeholders in the community and help advocate for the needs of older adults. Many counties also describe using advisory boards, councils, or collaboratives to engage community partners.

a. Area Agencies on Aging

Since the 1970s, AAAs have served as local leaders that plan, coordinate and deliver services and programs that enable older adults to live at home and in the community with dignity and independence. AAAs can be private nonprofit organizations or administered by local government; in most Bay Area counties, the AAA is located within the county AAS department. In these counties, AAS directors say the AAA plays an important role in partnership development. In all counties, AAAs provide core services such as congregate and home delivered meals, transportation, case management, benefits/health insurance counseling, and family caregiver support programs.[64] AAAs also play an important role in advocating for the needs of older adults, and in many counties, work with community partners to help identify and address gaps in services.

> *"AAAs can be purely administrative or they can be very involved. Our AAA takes leadership on aging issues like getting our county designated age-friendly … Our AAA can be a leader because our community is involved, we have staff who are driven to carry out a vision, and elected officials that support that. The key ingredient is having a community that gets involved."*

b. Community Engagement

Many Bay Area counties also report relying on advisory boards, councils, and collaboratives to help alleviate the concerns of community members and support community engagement in the creation of age- and disability-friendly programs and policies. For example, Alameda's Age-Friendly Council provides a platform for the county and the community to come together on issues impacting older adults and was responsible for drafting the county's Age-Friendly Workplan. Similarly, Marin's Aging Action Initiative leveraged a

strong network of organizations from different sectors to support policy and program change through advocacy, education, and service innovation.

> *"The intention of the Age-Friendly Council is for the agency to partner with community-based organizations to make policies and procedures … focused on the older population."*

c. Emergency Response

Strong partnerships also enable county AAS departments to respond more quickly and effectively to natural disasters. For example, Marin's strong ties with partner organizations in the Aging Action Initiative allowed the county to quickly launch its "Great Plates Delivered" meal delivery service for older adults during the COVID-19 pandemic: "[During COVID] we needed to infuse much, much more than we normally had into the system. […] Delivering groceries is not something we had done before. But there were so many organizations working together and we were all very well connected. We had good relations with local organizations, we had worked with each other before. Even if I didn't have a contract with them, I knew them from this collaboration." Several counties report that recent natural disasters (e.g., wildfires and the COVID-19 pandemic) exposed areas for improvement in existing emergency preparedness and response systems, particularly by highlighting the need for appropriate outreach and access to services for individuals with functional disabilities.

d. Service Integration

Finally, many AAS directors report partnering with other departments or with organizations outside of their agency to better integrate care. Older and disabled clients of county services are often served by multiple programs or could benefit from additional services if they were offered. Integrating services is a key strategy for overcoming system fragmentation. Care integration and client centeredness are often discussed together by county directors, who emphasize the need to ensure that services are easy to access, well-coordinated to support data-sharing and avoid duplication, and responsive to individual needs. The next section of this report details the steps county AAS directors are taking to integrate programs.

Case Study: Santa Clara's Seniors' Agenda Program

In Santa Clara, the Seniors' Agenda program helps ensure that the county maintains a leadership role in meeting the needs of older adults within the community. Dedicated funds for a full-time project manager allows for focused attention on building relationships needed to enact change. Key accomplishments include helping all 15 cities in the county join the World Health Organization's Global Network of Age-friendly Cities and Communities and participating in the Dementia Friends Initiative.

Case Study: Napa's Healthy Aging Population Initiative

The Healthy Aging Population Initiative (HAPI) is a collaborative network of public and nonprofit agencies serving older adults in Napa. HAPI's purpose is to assess and identify priorities for older adults in the community, develop and implement community-appropriate plans and programs for addressing these priorities, and advocate for age-friendly policies. It facilitates concrete support and inter-agency information sharing among members. HAPI has helped expand the capacity of AAS services to address mental health challenges by securing MHSA funding to develop and implement Napa's Healthy Minds, Healthy Aging Program, a prevention/early intervention program for older adults who show early signs of depression or cognitive decline. HAPI members have raised over $2.5 million in grants to support development of new initiatives, many of which have been sustained by member organizations. HAPI advocacy efforts have supported community, institutional, and governmental policies to make Napa County more age- and disability-friendly.

4. Integrate services and use a client-centered approach

Key findings: *Integrated services provide a more comprehensive, client-centered experience of care. County AAS departments are partnering with organizations from a range of service sectors to integrate services, including housing, other human service departments, behavioral health, healthcare, and law enforcement. Overarching strategies being implemented in Bay Area counties to support service integration involve improving care coordination, cross-training staff or creating blended staff roles, and creating single entry points for care.*

County directors report integrating services to provide a more comprehensive, client-centered experience of care. The three most prevalent strategies for service integration include providing care coordination, cross-training staff, and creating single entry points for care. In implementing these strategies, county AAS directors report partnering with organizations from a range of service sectors to integrate services, including housing, other human service departments, behavioral health, healthcare, and law enforcement.

a. Care coordination

Multiple directors report providing care coordination or care management services to older adults and adults with disabilities to help connect them with needed care. For example, Sonoma AAS administers three different care management programs focused on helping eligible clients find and manage services needed to remain safely and independently in their homes. To help fund these services, several counties are considering or have developed contracts with healthcare payors. For example, Sonoma is in the process of developing a community integrated health network that could contract with health plans to provide care management and other services. In 2022, San Mateo began contracting with

the local Medicaid managed care plan to provide eligible Medi-Cal beneficiaries with health and social services case management and other supportive services.

b. Cross-training staff or creating blended staff roles

Several directors report cross-training staff or creating "blended" roles to help reduce silos in care between different county human services departments. For example, in one of its offices, Monterey cross-trains frontline staff in AAS and CalWorks Employment Services. Cross-trained staff have a more comprehensive understanding of different resources available within-county and are better equipped to direct clients to appropriate services. In San Mateo, social workers are trained to serve clients in both Medi-Cal IHSS and Enhanced Care Management (ECM) services, thereby reducing risk of care fragmentation or service delays for clients eligible for both programs.

c. Creating single entry points for care

Finally, multiple directors report partnering with external organizations to create single entry points for care. For example, Marin's One Door initiative aims to provide a "one-stop shop" to help clients navigate the array of services and supports available to older adults, adults with disabilities and family caregivers within the county. Services are provided through the county's Aging and Disability Resource Connection (ADRC), a joint effort between county Adult & Aging Services and the Marin Center for Independent Living, and include enhanced information and assistance, options planning, 90-day short-term service coordination, and support to help clients living in residential care facilities return to live in their own homes.

To implement these strategies, directors report partnering with public and private partners in a range of sectors, particularly housing, behavioral health, healthcare, and law enforcement.

d. Housing

As the state begins to increase support for older people experiencing homelessness through programs like Home Safe, AAS departments are increasingly partnering with housing providers to address needs of older adults experiencing or at risk of homelessness.

> *"Home Safe funding … has allowed us to partner in a very meaningful way. We have started working more closely with our Department of Public Health. They identify clients for us who are the most at risk, enabling us to focus our efforts on transitioning those clients into board and care facilities."*

e. Behavioral health

Several AAS departments are working with mental health providers and other partners to extend their ability to identify and address behavioral health needs in older adults, particularly dementia. For example, Napa's Healthy Minds-Healthy Aging Program works to address mental health and cognitive impairment issues among older adults and their caregivers,[65] while Santa Clara's "Connections'' program provides mental health services to ethnically diverse elder and dependent adults who have been referred to APS and may be exhibiting signs and symptoms of mental health issues.[47] Monterey is exploring the possibility of piloting a new program modeled after San Bernardino's Age Wise, which offers mental health services for high-risk and underserved older adults, including in-home behavioral health and case management services, counseling services, peer and family advocacy.

> *"Mental health services are critical for any age. Three years ago San Bernardino was seeing what we're seeing today: a high-risk older adult population with unmet mental health needs costing the county a lot of money through various services. So they established a unit called Age Wise. … Age Wise therapists became their support system, their advocates. It was a very successful approach. I want to bring that to our county."*

f. Healthcare

Multiple directors report efforts to improve coordination of care between county Health and Human Services departments or with clinics and hospitals in the community. Several directors also describe partnering to explore feasibility of securing new funding for care management and other supportive services from healthcare payors. For example, Sonoma AAS used pilot grant funding to embed a social worker on-site at a local health clinic to provide depression screening and county service information and referrals to older adults and is currently exploring the possibility of funding through CalAIM to sustain and expand the program.

g. Law enforcement

Finally, a few counties report partnering with law enforcement and other county departments to address increased financial abuse of older adults. For example, San Mateo partnered with the District Attorney's Office and the County Counsel's Office to develop an Elder Dependent Adult Protection Team (EDAPT) that focuses solely on investigating financial abuse of older adults.[66]

Case Study: Medi-Cal Enhanced Care Management and Community Supports in San Mateo

In 2022, San Mateo's Adult and Aging Services (AAS) successfully contracted with the county's Medicaid managed care plan as a CalAIM Enhanced Care Management (ECM) and Community Supports (CS) provider of health and social services case management and other supportive services needed to help older adults and adults with disabilities live safely and independently in the community. Critical success factors included the ability to co-locate managed care plan and AAS staff to streamline communication and collaborative ties, and the location of AAS within county health rather than in a separate human services agency, which allowed for use of social workers to serve both ECM and IHSS beneficiaries. A key lesson learned in early implementation of ECM and CS is the need for careful attention to how to meaningfully engage and enroll eligible beneficiaries in services; "cold calls" were described as less effective than more person-centered forms of outreach and engagement.

Client Story: Charlie Jackson, Sonoma County

Charlie Jackson, 67, is a retired private school teacher who lives alone in rural, wooded West Sonoma County. He was navigating early symptoms of Parkinson's disease until a fall in his home caused a significant change in his disability and mobility. Charlie was struggling to care for himself while living at home when he first came into contact with Adult Protective Services (APS). Sonoma's Linkages case management program played an important role in helping Charlie receive home modifications needed to stay safely in-home, even though his income made him ineligible for certain means-tested programs.

5. Seek new and more flexible funding

Key findings: *Limited federal and state resource support for AAS programs pose challenges to counties' ability to effectively serve vulnerable older adults and people with disabilities. Bay Area counties have responded by seeking new and more flexible sources of funding and advocating for systems change. Multiple counties have successfully secured grants, philanthropic funding, and other funds to strengthen local capacity, create new programs to address existing gaps in care, or extend services to new populations. Increased funding is critical to counties' ability to continue meeting needs of older adults and adults with disabilities in the future.*

a. Background on funding of county adult and aging services

In-Home Supportive Services

IHSS is a statewide Medi-Cal program administered by counties under the direction of the California Department of Social Services. As an entitlement program, all eligible applicants are guaranteed to receive benefits, and services are jointly funded by California and the federal government. However, in practice, IHSS applications are often not processed in a timely manner, resulting in long wait times.[27] Many participants also do not receive all authorized hours, either because of difficulties recruiting and retaining IHSS workers or because they lack capacity to direct their own care.[67] There are also many older adults and

adults with disabilities who could benefit from IHSS but do not currently qualify. Recent and upcoming changes to asset limit tests for Medi-Cal eligibility[52] are expected to increase the number of aged, blind, and disabled individuals eligible for IHSS. This Medi-Cal expansion will help improve the safety net for those newly eligible for IHSS, but it will exacerbate the caregiver shortage and place further strain on a program already struggling to meet community demand.

> *"A lot of clients don't meet medical criteria for Medi-Cal placement but their income isn't high enough to get them a placement in a decent facility, so they're in a gap where they can't manage in the home setting and don't have people to support them in home but they can't go into placement because they can't afford it."*

b. Other Adult and Aging Services programs

Until recently, federal funding for other AAS programs such as APS and PG/PC/PA has been limited, with state or local governments bearing most of the cost. Historically, the Older Americans Act (OAA) has served as the primary source of federal funding for non-clinical home and community-based services, nutrition assistance for older adults and adults with disabilities, and for local Area Agencies on Aging. However, between federal Fiscal Year (FY) 2011 and FY 2019, total OAA funding levels remained stagnant ($1.81-$2.06 billion/year). In FY 2020 and 2021, supplemental funding issued in response to the COVID-19 pandemic resulted in large but temporary increases in financial support for AAS programs; most of these increases were not sustained in federal FY 2022.[30]

In general, limited federal and state resource support for AAS programs pose challenges to counties' ability to effectively serve vulnerable older adults and adults with disabilities. These challenges are only exacerbated by rising caseloads and increased complexity of needs among older adults and adults with disabilities.

> *"We need more and better facilities, especially dementia care facilities. That is a really big gap. It takes a significant amount of staff time to navigate and a lot of times we still don't have solutions for people … and these are things we have no money to help to do."*

c. Strategies

Counties have responded to these resource challenges by seeking new and more flexible sources of funding and advocating for systems change. At the state level, advocacy efforts have resulted in recent legislative changes that have helped support growth of AAS programs such as APS. For example, the California Budget Act of 2021 changed the definition of "elder adult" eligible for APS investigation or services from aged 65+ years to

age 60+ years; funds appropriated to support this program expansion helped create new staff positions within APS.

At the local level, Bay Area counties have successfully secured grants, philanthropic funding, or other funding to strengthen local capacity, create new programs to address existing gaps in care, or extend services to new populations. For example, in San Francisco, local advocacy efforts resulted in establishment of the Dignity Fund in 2016, which set aside county funding specifically for older adults and adults with disabilities and helped strengthen and improve access to AAS in the community. In 2019, Bay Area counties also partnered with the California Department of Social Services and with the California Social Work Education Center to fund and pilot a regional APS MSW stipend program, which in 2022 was expanded statewide to help grow California's AAS workforce.

Within Medi-Cal, changes introduced via CalAIM, including 2022 Enhanced Care Management (ECM) and Community Supports (CS) benefits and the upcoming carve-in of long-term care within Medicaid managed care, raise new possibilities for improving integration of care and funding non-clinical services[68] for older adults and adults with disabilities. To take advantage of this funding, county AAS departments must develop contractual agreements with Medicaid managed care plans and meet reporting and claims requirements, which could require significant and costly systems change, e.g., to develop needed interorganizational relationships, data sharing infrastructure, and administrative expertise. In 2021, Sonoma secured grant funding to develop its capacity as a community integrated health network that could successfully contract with third party payors to deliver care to older adults and adults with disabilities in the community. In 2022, San Mateo's AAS department was one of the first in the state to successfully contract with Medicaid managed care as an ECM provider.

Case Study: Enhanced Funding for Social Services Through San Francisco's Dignity Fund

In 2016, San Francisco's Dignity Fund was established through a voter-approved charter amendment to enhance funding for social services for older adults and adults with disabilities in the community. Funding was initially set at a baseline allocation of $38 million and increased by $6 million in FY 2017/18, with additional $3 million increases planned each year through FY 2026/2027 except in years when the city experiences a budget deficit. The certainty and flexibility of funding available through the Dignity Fund has helped stabilize the AAS network in San Francisco and improved equity of services for historically disadvantaged groups and underserved neighborhoods. Strong community advocacy was critical to passing the legislation.

Case Study: Developing a Community Integrated Health Network in Sonoma

In 2021, Sonoma's AAS Division secured funding from the National Council on Aging Network Development Learning Collaborative to work closely with community partners to develop their capacity as a community integrated health network (CIHN). A CIHN refers to a network of partners that work together to deliver services that address health-related social risk factors within a specific geographic area. By creating a single contracting entity with centralized administrative processes, CIHNs allow smaller organizations to more effectively compete for contracts with health plans and other payors. Some key lessons in partnership

development have emerged from Sonoma's efforts including the importance of: ensuring adequate time and resources for CIHN development; assessing partners' readiness to engage in a CIHN; ensuring appropriate data sharing infrastructure and business capacity (e.g., to develop Business Associate Agreements with CIHN partners and successfully negotiate with and secure contracts from third-party payors); and the value of securing funding for a business development manager to serve as a neutral lead in moving CIHN activities forward.

6. Develop equitable and responsive programs and workplaces

Key Findings: *Adult and Aging Services departments in the Bay Area are identifying ways to provide culturally appropriate and responsive services to increasingly diverse communities and clients. Directors also report working to ensure an equitable and inclusive workplace for staff. Important strategies to promote diversity, equity and inclusion (DEI) involve hiring diverse and multilingual staff, creating equity-focused workplace training and supports, implementing trauma-informed practices, engaging in community outreach, and using data to identify and address service gaps.*

Older Californians are becoming a more racially and culturally diverse group, mirroring trends in the overall population. By 2027, almost 1 in 2 Californians over 60 will identify as a non-white racial or ethnic minority. Similar trends are predicted in the Bay Area. Among clients served by AAS programs, the proportion of non-white racial/ethnic minorities and immigrants is high in many counties.

> *"About 32% of our county population are not born in the United States and there is no majority ethnic or racial group. We are a diverse county, but our client population is not very diverse. It pretty much consists of Black and Brown individuals living below the poverty level. We have a good number of individuals that speak English as their second language as well."*

Among the Bay Area county human services agencies, there is a growing emphasis on providing culturally appropriate and responsive services, and ensuring an equitable and inclusive workplace. Key strategies across the Bay Area include hiring a diverse and multilingual workforce, broader efforts to develop an equitable and inclusive workplace, outreach and engagement efforts, and using data to identify and address service gaps. In support of this work, almost all counties are members of the Government Alliance on Race and Equity (GARE), a national network of government entities working to achieve racial equity.

Agency strategic plans and other guiding documents increasingly highlight principles and strategies focused on racial equity. For example, the Santa Cruz County Human Services Department's 2021-2022 Annual Report highlights strategies including analysis of disaggregated data and targeted training and supports focused on racial equity and inclusion, and notes use of GARE tools in this work. The Alameda County Social Service

Agency 2019-2024 Strategic Priorities Report notes the use of racial equity tools "designed to integrate explicit consideration of racial equity in decisions, including policies, practices, programs, and budgets", and summarizes activities in a number of areas, including advocacy, language accessibility, and immigrant services. In San Francisco, the Human Services Agency's Office of Diversity, Equity, Inclusion, and Belonging (DEIB) supports agency efforts to meet the City's goals for addressing structural and institutional racism in the services it delivers, and developing an equitable workplace, "by building a culture of belonging and inclusion for our employees while also supporting policies that minimize disparities in the workplace".

a. Promoting DEI in the workplace

Counties are engaged in efforts to ensure hiring, training, and support processes are equitable and responsive to the needs of staff who are Black, Indigenous, and people of color (BIPOC). For example, the San Francisco HSA DEIB 2021 Racial Equity Action Plan Progress Report summarizes progress on workforce related efforts in seven strategic areas (Hiring and Recruitment, Retention and Promotion, Discipline and Separation, Diverse and Equitable Leadership, Mobility and Professional Development, Organizational Culture of Inclusion and Belonging, Boards and Commissions). With respect to hiring, some agencies have instituted an equity and diversity focus at multiple stages of the process as a component of their DEI Strategic Plan. Specific strategies include DEI-focused questions in the application and interview, and blinded review of applications.

> *"We have an agency commitment to ask DEI questions on all of our recruitments. … At every stage of the interview process we include at least one question addressing DEI. And our agency director really pushed to have HR blind the applications, so you can't see names when you're doing the scoring of the supplemental questions, just to address any potential implicit bias based on somebody's name or gender."*

DEI training is another common strategy employed to create an equitable and inclusive workplace. Often this training emphasizes a trauma-informed approach. In some agencies, employees play an active role in designing the trainings, through participation in DEI-focused workgroups.

Finally, as mentioned previously, the pandemic highlighted specific equity issues related to opportunities for remote work, as individuals in lower level classifications were less likely to be permitted to work from home; individuals in these positions are more likely to be BIPOC in comparison to managerial positions. A number of counties are updating their remote work policies with a focus on equity, to provide broader access to flexible work arrangements.

"Right now, we, like everybody else, are doing a big DEI review, and what we discovered is it's generally the clerical staff who've had the burden of coming into the office to do the mail, to do the scanning. Those are mostly people of color and we're trying to work around the inequities of that."

b. Developing culturally appropriate programs

Bay Area AAS leaders report several strategies they are pursuing to design equitable and culturally responsive services, including building a workforce that reflects the community and client population, creating structures and processes to share staff knowledge across the agency, and using assessments and outreach to identify the needs of specific groups within the community. Some smaller counties with lower staffing numbers report challenges to providing accessible services to all racial and ethnic groups. However, even in smaller counties, hiring strategies are in place to promote community representation and language access.

"So the huge challenge we have is that when you're trying to provide equitable services, it can be really difficult because we don't have the infrastructure, if you will, that a large county would."

In Solano County, Caucus to Advance Racial Equity (CARE) groups were developed to facilitate discussion and collaboration among staff focused on the needs and priorities of specific racial and ethnic groups. In addition to providing an opportunity for participants to share experiences and support, the CARE groups have played a central role in developing training and tools for staff.

"[CARE Groups] are a way for people to just think and talk, and share what their experiences have been, what some of the challenges are, what can we do to make a difference. … Out of some of those groups have come education to help people understand some of the highlights that we want you to know when you're caring for this population. 'Here are some helpful tools, here are some helpful resources.' … We developed a resource manual that allows us to reach the population in a more sensitive way, as well as to access resources in the community for the population."

Agencies emphasize the importance of assessing community and client needs to ensure they appropriately target services to diverse communities. For example, in San Francisco, a community-wide needs assessment is conducted every four years. Data analytics are employed to identify areas of the city that could most benefit from services or resources and the populations affected, so the county can be more targeted in Requests for Proposals put out to the community.

In some instances, AAS directors conduct assessments drawing on existing data from county administrative systems, to track caseload data and examine health disparities for different groups in the community. Finally, directors note that community outreach and engagement is often needed to identify service barriers related to race, ethnicity or culture. For example, one county determined that its pandemic Great Plates program funding restaurant-provided meals was not being used by Spanish speaking clients, and worked to address the issue.

7. Educate about ageism

Key Findings: *Many county AAS directors are concerned that lower levels of funding for AAS relative to other county programs, as well as organizational structures and decision-making processes, may reflect unexamined bias against older people. In order to address potential biases and strengthen programs and services, AAS divisions and departments are engaging in educational and advocacy strategies that include public education campaigns and Age-Friendly initiatives.*

The World Health Organization (WHO) defines ageism as: "the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or oneself based on age."[69] While ageism can be experienced by members of any age group, negative impacts for older adults are particularly notable: "Ageism is associated with earlier death (by 7.5 years), poorer physical and mental health, and slower recovery from disability in older age."[69] Ageism experienced by older adults is associated with adverse consequences for health care, participation in the labor market, and involvement in community life.[70]

Ageism can be expressed in many ways including through the interactions older people have with care providers and the framing of news stories. For example, research on ageism shows that age related bias can be expressed toward older adults seeking supportive services when people assume older adults are responsible for their circumstances due to life choices they have made, and they are therefore undeserving of care. A study of narratives about aging in media and advocacy focused communications concluded that the biggest issue among the dominant patterns of public understanding of aging was:

> *"[T]he common assumption that individuals are exclusively responsible for how they age. This idealized vision of aging is rarely achievable in the real world, according to experts. When the media and advocacy organizations fail to link successful aging to policies that actually enable older adults to remain active and socially engaged, they reinforce the public's highly individualistic understandings of the aging process. The result is that people will understand successful aging to be achieved exclusively through lifestyle choices rather than as affected by supports, larger social structures, or public policies. Further, when the ideal is not achieved,*

many Americans will assume that the reason for the failure lies in poor individual decision-making [by older adults]." [71]

At the county level, when these kinds of beliefs are prevalent among community members and government decision makers, they can act as barriers to effective policy and planning, and contribute to resource disparities for agencies and programs serving older adults.

a. Policy and planning challenges

The structure of the Human Services Agency or integrated Health and Human Services Agency creates challenges for policy and planning decision making related to AAS in some counties. For example, agency structure may not provide the AAS director adequate access to agency leaders who play a critical role in approving policy and planning decisions. This form of structure may reflect a historical lack of attention and priority given to the needs of older adults. In contrast, the AAS division or department in some counties is positioned at a level that ensures participation in relevant executive level meetings and discussions. Difficulties may also arise where leadership transitions within the agency or among the county Board of Supervisors lead to a reduction in awareness among decision-makers regarding the needs of older adults. In these situations, AAS directors are called upon to provide information to incoming leaders to orient them to AAS programs, services, resources, and challenges.

b. Resource challenges

At the state level, and in some county Human Service Agencies, there may be limited understanding of key issues and policies related to AAS funding, including unfunded mandates.

Directors report working within their counties to strengthen understanding and advocate for investments in addressing the needs of older people. For example, one director recalled a conversation with a colleague about California's FY 2011/2012 realignment of state program responsibilities and revenues to local governments that reflected the belief that protective services revenue realignment related to Child Protective Services only, although APS was included. The director emphasized that even in a supportive collegial county work environment, accidental omission or inattention to the needs of older people can occur.

"We are so underfunded in Adult and Aging Services. And finally, in the last year, we started getting attention because of the Master Plan for Aging … [But] adding new demands without needed resources is a concern, because we can only do so much. 'What else is going to be added to our plate?' What else will be unfunded or we just have to make it work and stretch?"

In many counties, there are differences in the level of resources allocated to AAS compared to other services and programs. For example, children's services are often a primary focus for funding decisions. The disparity in social worker compensation between APS and Child Protective Services is one illustration of the resource "competition" between children's and adult services. Finally, some AAS directors perceived health departments in their counties as frequently prioritized over AAS in funding allocation decisions.

> *"I think that it's the kids, or the vulnerability of kids, that always gets the attention over the vulnerability of adults or people with disabilities. I think that that's changing, but competition for having the attention and getting the services that we need has historically and continues to be a pretty significant challenge."*

c. Strategies to address ageism

To address ageism, counties have begun to develop and participate in educational and advocacy-focused initiatives, in partnership with community organizations and other agencies. In San Francisco, the San Francisco Reframing Aging Campaign represents a "collaborative effort to increase public awareness of ageism, disrupt negative stereotypes of aging, and connect residents with supportive resources and services," created through a partnership between the San Francisco Department of Disability and Adult Services, the Community Living Campaign, the Metta Fund, and community-based organizations. In Santa Cruz, the Human Services Department was a sponsor of "We're Still Here," an exhibit at the Santa Cruz Museum of Art & History created by a community group of local seniors, advocates, and artists. The exhibit, also sponsored by the Community Foundation of Santa Cruz County, community-based service providers, local businesses, and community members, included artwork focused on loneliness, solutions to build connection, and words of wisdom for future generations.

The WHO/AARP Age Friendly initiative is another strategy being used in counties to change perceptions of older adults and promote services and supports that promote higher quality of life for all community members.[72] For example, Marin is a very active county in the age-friendly community: "There are 11 municipal jurisdictions in the county; nine out of 11 of them are actively part of the World Health Organization and AARP's Global Network of Age-friendly Cities and Communities. The county voted to become a part of that network in 2018; we developed an age-friendly plan called Age Forward that was approved by the board last year. And its intent is to bring the lens of aging to policy and programs across all our departments." Similarly, Santa Clara became an age-friendly community in 2018, and worked rapidly to engage cities in the initiative: "We also, in a year and a half, brought in all of 15 cities in Santa Clara County, to also be designated age-friendly with the World Health Organization. We then became the first county to have all its cities be

designated age-friendly, which gives us some common vision, and goal and construct to do the work together (Santa Clara Case Study: Seniors' Agenda IV)."

Conclusion

As communities across California adapt to become more inclusive to people of all ages and abilities, county governments play an important role as funders, conveners, and direct providers of support. County AAS departments will continue to provide essential services to socioeconomically vulnerable older and disabled adults. However, current trends indicate that a growing number of people will rely on county programs for support as they age, and as caseloads grow, it is becoming more difficult for counties to ensure access to everyone who qualifies for services. To respond effectively to these challenges and take advantage of new policy and funding opportunities, it will be necessary to expand the capacity of Bay Area county AAS departments. This report summarizes current and emerging needs among older and disabled adults; describes key accomplishments and challenges in service provision; and outlines emerging strategies to expand and strengthen services. We hope that the report will serve to inform discussion and collaboration among county staff and officials, community organizations, and community members, in order to better support older and disabled adults in our communities.

Appendices

Table A1. Description of study methods

This report incorporates information from an array of sources, including 31 key informant interviews with Bay Area leaders in Adult and Aging Services, county administrative data, and publicly available data sets. Interviews were conducted between March and July 2022. Data were analyzed to highlight current issues in Adult and Aging Services and to illustrate key accomplishments, challenges, and strategic priorities identified in this report. The BASSC research team conducted interviews, analyzed available data, and drafted the report and case studies. Adult and Aging Services directors developed the case vignettes to illustrate the experiences of elderly and disabled clients receiving services and supports. Case studies were reviewed by interview participants for accuracy. BASSC Adult Services Committee members reviewed and provided input on the full report.

Chapter 2: Integrating homeless services and medical care in Los Angeles County: Motivations and tensions.

Background

People experiencing homelessness have high rates of co-occurring physical health, mental health, and substance use disorders compared to people with stable housing.[32,33,73–76] Unhoused people also face complex and intersecting barriers to accessing healthcare and housing, including competing needs and priorities, poor physical access to services, challenges contacting services, affordability, and stigma and mistrust of service providers.[34,35,77] The high prevalence of medical and social needs coupled with inaccessible services contributes to a high and growing mortality rate among the homeless population.[78,79]

To make care more accessible, organizations that serve unhoused people are taking steps to integrate care, often by partnering with other organizations within and across sectors. Integrated care occurs when people receive services that address their needs and when services are coordinated across all sectors with which they are involved.[13] For example, care models such as supportive housing,[80] medical respite,[81] and street medicine[42,82] bring together medical care and social services onto the same care team or into the same physical location. These models emerged and have grown in use over the past two decades.

Recent research suggests that integrated social and medical care can lead to improvements in housing retention for chronically homeless individuals.[38,80] These care models are also presumed to improve health outcomes and be cost effective. However, the evidence on both health outcomes and cost of care is nascent and mixed.[80,81,83] Still, states are pursuing Medicaid waiver programs that will direct health spending towards housing-related services for high-cost, high-needs beneficiaries in the hope it will improve health and reduce Medicaid spending for people who frequently use high-cost medical services.[6]

Integrating care across sectors can be challenging due to the need to align operations and services across organizations that may have very different values, priorities, regulations, funding, staffing, and capacity.[8,22,23] Evidence is emerging about the factors that motivate organizations to integrate social and medical care and finds that organizations are responding to community need, institutional pressures, financial incentives, and mission alignment.[17,36,84] However, most of this emerging literature has examined cross-sector collaboration efforts broadly and has not described the specific dynamics that emerge between the homeless services and health care sectors.[18,19,85,86]

Little is known about the motivations and challenges experienced by healthcare and homeless services professionals as they integrate care for people experiencing homelessness, even though their perspectives and experiences are likely to impact the success of these state and local efforts. Therefore, an in-depth rigorous exploration of providers' experiences with care integration, especially their motivations to engage in care integration and the tensions they experience with those efforts, can serve as a practical resource for communities seeking to use integration as a strategy to improve health and housing outcomes for people experiencing homelessness. This study draws on rich, qualitative data from key informants in Los Angeles County to examine motivations and tensions associated with integrating medical and social care for people experiencing homelessness.

Methods

Study Design

We conducted an exploratory case study using a single case design.[87] We selected Los Angeles County as the study site because it offers an environment with many opportunities to examine our phenomenon of interest (i.e., social and medical care integration for people experiencing homelessness). Los Angeles County has a high burden of homelessness and a particularly large and complex services system. This allowed us to explore variation across preselected stakeholder groups involved in care integration efforts. We chose qualitative data collection methods to explore the case because care integration is known to be a complex phenomenon and the evidence gap that needs to be filled requires understanding nuances in provider experiences and interpersonal relationships.

Study Context

The study took place in Los Angeles County, California. Although only 12% of the nation's population lives in the state, Californians make up 30% of the nation's homeless population and half of the nation's unsheltered population.[32] Much of the state's homeless population lives in Los Angeles County, where in 2023 there were an estimated 75,518 people experiencing homelessness.[88] A 2021 report from the state auditor found that the state's approach to addressing homelessness is "disjointed," and that "at least nine state agencies administer and oversee 41 different programs that provide funding to mitigate homelessness, yet no single entity oversees the State's efforts or is responsible for developing a statewide strategic plan."[89] Meanwhile, the state and county are making significant investments in trying to address homelessness,[90] and recent Medicaid Section

1115 waivers in the state have also created new financial incentives for healthcare and homeless service agencies to integrate care.[91]

Sample and Data Collection Procedures

Stratified purposeful sampling was used to select key informants[92] from four stakeholder groups that would provide relevant perspectives on the integration of medical and social care for people experiencing homelessness in Los Angeles County: (1) staff members at health care provider agencies that have developed programs and services for homeless patients; (2) homeless services agencies that have integrated medical, behavioral health, and substance use treatment into their outreach, shelter, and housing services; (3) staff at Medi-Cal managed care plans that are directly engaged with building health-related social needs provider networks to deliver CalAIM services; and (4) staff at local government agencies that fund and oversee traditional homeless services and homeless healthcare programs. Once initial key informants were identified in each sector, snowball sampling was used to sample additional interviews within each of the four stakeholder groups.

Forty-two interviews were conducted between October 2022 and September 2023 with a total of 54 key informants from 23 unique organizations across the four stakeholder groups (Table 1). Some interviews were attended by multiple key informants, and multiple interviews were conducted with some organizations to include staff from a range of roles and departments relevant to the study aims. Thirty-four of the interviews were conducted over Zoom, lasted ~60 minutes each, and were attended by two members of the study team (one interviewer and one notetaker). Eight additional interviews were conducted in person during field observations. Data collection concluded when interviews produced no new information about key themes, suggesting saturation was achieved.

Semi-structured interview guides were developed to focus on the history of collaboration within and between the homeless services and healthcare sectors, the perceived value of collaboration and partnerships and their relevance to the organization's mission, the interviewee's personal experience with successful or unsuccessful cross-organizational work to integrate care, perceived barriers and facilitators to partnerships, and strategies used to form and sustain partnerships. Questions differed between guides depending on the interviewee's role and sector. Researchers provided an explanation of the study and its aims and answered questions before the interviews and verbal consent was received by all participants. Interviews were recorded and transcribed using a professional transcription service.

Table 1. Sample description: key informant characteristics by sector and role

Sample by sector		Sample by role
Sector (n=organizations)	Organization type (n=key informants)	Job title* (n=key informants)
Homeless services (n=8 agencies)	Homeless services provider (n=16) Policy advocacy (n=2) Funder (n=1)	Director (n=16) Senior leader (n=14) Manager (n=7) Consultant (n=4) Associate director (n=2) Senior director (n=2) CHW / Peer (n=2) Coordinator (n=2) Analyst (n=1) Case manager (n=1) Fellow (n=1) Outreach mental health (n=1) Specialist (n=1)
Healthcare (n=10 organizations)	Community health center (n=8) Consortia (n=4) Academic medical center (n=3) Medical group (n=1) Funder (n=1)	
Government (n=3 agencies)	County government (n=7) Joint powers authority** (n=4) City government (n=1)	
Medi-Cal managed care plan (n=2 health plans)	Managed care plan (n=6)	

** Job titles are simplified and grouped to protect the identity of key informants. For example, "senior leader" may include such roles as CEO, CMO, and CIO.*
*** A Joint Powers Authority permits 2+ public agencies to jointly exercise common powers. Powers and governance are spelled out by joint powers agreement.*

Data analysis

A team of four trained qualitative researchers (C.R., E.C., and two research assistants T.P., M.E.) supported the analysis process using an iterative inductive and deductive approach.[93] During data collection, while interviews were being conducted, C.R. produced in-depth memos for fifteen of the early interviews to identify emerging themes. C.R. produced an initial codebook based on interview guide domains, and C.R. and E.C. refined the codes based on a review of the memos. All coders (C.R., T.P., M.E.) conducted iterative double coding until all coders and the lead author agreed and were confident about the consistency between coders. The team refined the codebook during this process based on coder feedback. Then, for all transcripts, the research assistants conducted a first pass and met with C.R. to discuss code applications and review each transcript. While the team was engaged in coding and drafting initial findings (C.R.) met with 12 study participants for member checking interviews to receive feedback on early interpretations of the findings. Each lasted between 30 and 60 minutes, was recorded and professionally transcribed, and

added to the data set to be included in coding and analysis. For this article we conducted analysis specific coding on the integration mechanisms, motivations, and tensions reported by key informants. Two coders, (C.R., M.E.) sub-coded code excerpts and C.R. reviewed all of the sub-coded data. We (C.R., M.E., T.P.) met weekly to discuss coding.

Results

Overview

Participating healthcare and homeless services professionals were diverse in role and sector (Table 1). All study participants were directly involved with efforts within their organizations to integrate social and medical care for people experiencing homelessness.

Professionals from all four stakeholder groups — healthcare, homeless services, local government, and managed care plans — recognized the importance of integrated care and expressed a belief that it made services in both the healthcare and homeless services fields more accessible and effective. They emphasized that cross-organization and cross-sector partnerships play an important role in their care integration efforts. As one homeless services leader explained, "not one person is housed through just one agency, it just doesn't work that way" (Director, Homeless Services Agency, ID 27). At the same time, many also described building new capabilities within their own organizations to address patient or client needs that were traditionally handled by other sectors. Study participants from both sectors described using a wide range of approaches to integrate care, including jointly staffing outreach teams, co-locating services, and other mechanisms that bring together social and medical supports into the same location or onto the same team.

Medical and homeless services providers described multiple interrelated motivations for integrating care, including (1) increased institutional pressure to address the homelessness crisis, (2) growing awareness of the relationship between housing and health, and (3) funding and policy shifts that support integration of care (Table 2). Despite having compelling motivations to engage in care integration, healthcare and homeless services professionals also described tensions associated with care integration efforts relating to (1) resource scarcity, (2) conflicting goals, (3) conflicting beliefs, and (4) governance dynamics (Table 3). Despite these tensions, providers were determined to find ways to better integrate care for their patients and clients. Each motivation and tension is described in detail in the sections that follow.

Motivation: Increased institutional pressure to address the homelessness crisis

A strong motivation for funders and organizations to integrate social and medical care was institutional pressure stemming from a growing public awareness of the homelessness

crisis over the past decade. Healthcare and homeless services leaders report that as the homeless population in Los Angeles grew, it attracted public and media attention and calls for elected officials to address the growing crisis, which subsequently increased political pressure on local government agencies to demonstrate progress moving people off the streets. As a homeless services funder explained, "The visibility of homelessness took off [and] downtown LA developed in a way that spread homelessness out. So homelessness spread, visibility went up, [and] public desire and interest in doing something grew" (Senior Leader, Funder, ID 14).

Homeless services providers believed that the growth of tent encampments following a 2018 Ninth Circuit Court decision, *Martin v. Boise*, which limited the state's ability to prohibit sleeping outside, contributed to a public perception that homelessness was getting worse and that the current approaches were not working. County leaders expressed concern that if public perception does not improve, they may lose key funding they rely on to provide services:

> *"Our primary focus over the next two years really has to be around showing the voters of LA that their investment is a good one and that the streets still look like this because there's systemic structural issues, not because those taxpayer dollars aren't being put to good use. We have to be able to demonstrate some success." (Senior Leader, Government, ID 45)*

The pressure to demonstrate success became heightened when the COVID-19 pandemic accelerated the growth of encampments. In response, politicians took unprecedented steps by dedicating significant funding to convert motels into temporary housing and move people off the streets. Some homeless services providers expressed frustration that, "COVID put our politicians at front and center, and they're kind of making a lot of our decisions right now instead of service providers and best practices" (Director, Homeless Services Agency, ID 27). Healthcare and homeless services providers said that the pandemic resulted in more collaborative norms within and across the sectors serving people experiencing homelessness. A community health center leader described how, "being forced to come to the table because we were dealing with a pandemic changed the landscape from, 'we should work together', to, 'we have to work together'" (Senior Leader, Community Health Center, ID 47).

Motivation: Growing awareness of the relationship between housing and health

Along with institutional pressure, healthcare and homeless services providers acknowledged the widespread adoption of novel practice ideologies that emphasize the link between housing and health as setting the stage for care integration. Over the past decade, the Housing First approach and the social determinants of health (SDOH)

framework became widely accepted by professionals in each field and created a practice environment in which integrated care was seen as legitimate and necessary.

Housing First is an approach that aims to provide people who are homeless with housing quickly, with minimal barriers, and without preconditions like demonstrating sobriety:

> *"Thirty years ago, we didn't have this thing that we now call Housing First. We didn't have this kind of unified dominant framework that said, you can't end homelessness without housing people who consume alcohol or illicit drugs." (Consultant, Healthcare, ID 10)*

As the Housing First approach became seen as a best practice in the mid-2010s, homeless services professionals report it increased the level of medical acuity of people entering housing, and therefore the demand for integrated services to help people thrive in housing also grew.

Similarly, a managed care organization leader described how one of the factors that drove their health plan to start addressing homelessness was when, "social determinants of health became something that health plan people talk about instead of just MPHs at health plans talk about" (Director, Medi-Cal Managed Care Plan, ID 2). Growing acceptance of the SDOH framework was believed to have expanded the perceived scope and responsibility of healthcare providers and organizations to include addressing patients' health-related social needs like housing.

Providers in both sectors endorsed the view that housing and health are intimately linked, and said they were motivated to integrate services to make them more effective. For example, a homeless services leader described how medical care is needed to support the transition into housing:

> *"We've always had this challenge … people who are not able to follow through with their medical care and their psychiatric care [and] struggle to transition into housing. … We are seeing people die every day because we can't meet their needs, and the institutions have failed them. … We need a system that funds higher levels of support and care that includes housing, medical, and meals." (Director, Homeless Services Agency, ID 16)*

A county leader also recalled how addressing patients' housing needs became seen as critical to the success of healthcare delivery organizations through the advocacy of county leaders who, a decade ago, said, "We can't address the healthcare needs of our most vulnerable patients without getting into the homeless services game" (Director, Government, ID 52).

Motivation: Funding and policy shifts that support integration of care

Finally, new funding over the past decade fueled the adoption and growth of integrated care models. Study participants from all stakeholder groups described how new funding through county grants, tax revenue, and Medicaid, coupled with recent changes in federal and state policy, created the right incentives to motivate organizations to launch and expand integrated care models.

Homeless services professionals discussed a series of grants over the past fifteen years that successively built the integrated outreach approaches that exist today. For example, the Integrated Mobile Health Team (IMHT) model was seen as a precursor to the current Multi-Disciplinary Team approach. Then, the passage of Measure H in 2017, a ¼-cent sales tax that created a revenue stream dedicated to addressing and preventing homelessness in Los Angeles County, provided an influx of flexible funding for services and caused homeless services agencies and the departments that fund them to "double or triple in size." As one community health center leader recalled,

> *"Measure H passing was a big turning point ... because then we were able to partner with [homeless service agencies], and that integration between housing and health really started to solidify or coalesce." (Senior Leader, Community Health Center, ID 47)*

Over the same time period, a series of state Medi-Cal waivers — Whole Person Care (WPC), Health Homes (HH), and California Advancing and Innovating Medi-Cal (CalAIM) — created flexibility to use healthcare spending to address Medi-Cal members' health-related social needs. The novel introduction of Medicaid funding to pay for care management, housing navigation, and tenancy supports motivated Medi-Cal managed care plans to begin contracting with social services providers. As a managed care plan leader described, "Health Homes ... was the first time the health plan was financially responsible, even if in a tiny sliver, for housing navigation and tenancy services for people enrolled in Health Homes who were homeless" (Director, Medi-Cal Managed Care Plan, ID 2). It also motivated healthcare provider organizations to partner with community-based organizations to access non-medical support for their patients. As a health center leader noted, "the clinics who have been able to do really well in this space [with CalAIM] — they've been able to work directly with the community-based organizations in their area, screen the patients for SDOH, stratify the patients based on SDOH and clinical factors, and have the appropriate workforce in place to connect them to community resources" (Director, Community Health Center, ID 46).

Policy and regulatory changes have also encouraged the growth of integrated care. Recently, the state of California released new guidance (All Plan Letter 24-001), which allows street medicine providers to become contracted Medi-Cal providers to deliver primary care as well as ECM and CS services. Describing the response, one county leader

said that, “Everybody and their brother now, because of the state APL [All Plan Letter], wants to do street medicine” (Senior Leader, Government, ID 29).

Table 2. Motivations to Integrate Medical and Social Care

Motivation	Description	Quote
Increased institutional pressure to address the homelessness crisis.	The growing number of people experiencing homelessness and the visibility of homelessness began attracting public attention and political urgency, especially during the COVID-19 pandemic. The new attention put pressure on funders and service providers to demonstrate results.	*“There was a social awareness of homelessness as a uniquely Californian problem and that it was terrible and growing.” (Director, Medi-Cal Managed Care Plan, ID 2)*
Growing awareness of the relationship between housing and health.	Practice philosophies that emphasize the link between housing and health grew in prominence in the medical and homeless services fields, which increased the legitimacy of care integration among providers and funders. As models like Housing First and SDOH gained support among professionals, they offered shared language, tools, and approaches that made care integration more possible.	*“10 years ago, the director of DHS said, ‘We can't address the healthcare needs of our most vulnerable patients without getting into the homeless services game.’” (Director, Government, ID 52)* *“Yes, there's a lot of important healthcare for the homeless work that needs to happen and it is extremely valuable. But ... if I want to make the best difference to someone's actual health, I should really focus on their housing first. Not only, but first.” (Director, Medi-Cal Managed Care Plan, ID 2)*
Funding and policy shifts that support integration of care.	It wasn’t until funding became available to start and expand integrated care models like street medicine or medical respite that they became more commonly used in practice. Measure H and then Medi-Cal 1115 waiver programs, in particular, were said to have played key roles in fueling the growth of integrated care for people experiencing homelessness.	*“Measure H passing was a big turning point ... because then we were able to partner with [homeless service agencies], and that integration between housing and health really started to solidify or coalesce.” (Senior Leader, Community Health Center, ID 47)* *“Health Homes ... was the first time the health plan was financially responsible, even if in a tiny sliver, for housing navigation and tenancy services for people enrolled in Health Homes who were homeless.” (Director, Medi-Cal Managed Care Plan, ID 2)*

Tension: Resource scarcity

While providers from each sector were highly motivated to integrate care, healthcare providers felt as if they were becoming increasingly accountable for helping unhoused patients secure shelter and housing in an environment where those resources were scarce and mostly not in their control. They expressed frustration that, in their view, the healthcare sector had not done enough to ensure community-based organizations had the capacity to receive referrals from healthcare:

> *"In CalAIM, the investments in social care services almost came as an afterthought. In terms of, well, if we are bringing all of these folks into case management that are experiencing significant hardship, but we haven't invested in the social supports out in the community to provide those additional resources, where do we refer them? All housing organizations are maxed out right now, food pantries the same thing." (Senior Leader, Community Health Center, ID 26)*

A county employee, reflecting on the healthcare sector's growing interest in referring patients to shelter and housing, explained, "there's just not enough resources. We just don't have enough interim housing. We don't have enough shelter to be able to give all the hospitals in LA County a number to refer to when they're discharge planning. We just don't have enough resources to be able to support that magnitude." (Manager, Government, ID 23). The mismatch between available resources and the growing demand for them was seen as a reason many healthcare providers struggle to understand the homeless services system. As one managed care leader explained,

> *"Healthcare people will go like, 'Well, why don't I just refer to you? You tell me your criteria and I'll refer people in.' Whereas housing people say, 'Yeah, I have resources to serve about 20% of the people who meet the criteria for federal housing vouchers.' The fact that we have underfunded the affordable housing system to that degree is so nuts and that often creates a fundamental mismatch." (Director, Medi-Cal Managed Care Plan, ID 2)*

Several healthcare and homeless services professionals observed that the lack of shelter and housing beds could undermine CalAIM's primary approach to improving patients' access to housing. As a managed care plan leader and others pointed out, "housing navigation itself doesn't help without the housing part" (Director, Medi-Cal Managed Care Plan, ID 2).

Tension: Conflicting goals

Because organizations often rely on cross-sector partnerships to integrate care, differing organizational goals and priorities can cause tension in care integration efforts. This was especially evident in the case of integrated outreach teams (e.g., street medicine, MDT). When teams are jointly staffed by a medical agency and a homeless services agency, it can be the case that the medical staff feel compelled to prioritize the sickest patients, whereas the staff from the homeless services agency are drawn to working with the most housing-ready clients. Integrating a team through partnerships can also impact the efficiency of services. For example, a street medicine provider described these tensions as follows:

> *"What happens in street medicine when you partner is that you have very different goals. If you're a homeless services agency, you're going to end up seeing people that are most housing ready, which are not necessarily the people who are the sickest. And so if I hook onto your team, which is how the multidisciplinary teams work, I'm doing street medicine, you're doing housing, there's a lot of sitting around for me while you're going through your housing paperwork and we're not seeing the sickest people. When we first started our street medicine program, our one team that was partnered with a homeless services agency was seeing about a quarter of the volume that our other street medicine team was seeing." (Street Medicine Provider, Academic Medical Center, ID 7)*

However, there was disagreement among providers about the optimal structure of integrated outreach teams. Some preferred a partnered approach, which could potentially offer the team access to two organizations' resources and capabilities to support their work. While, others believed teams should be staffed by a single agency to maximize oversight and resolve the potential for different organizational priorities to disrupt team functioning.

Tension: Conflicting beliefs

Individual providers hold a wide range of beliefs about care that do not always align with partners. They described conflicting beliefs as something that, in some cases, were resolved over time as partners learned more about how each other's sectors operate. As a homeless services provider recalled,

> *"Back when we first started working with nurses, it took us a while to figure out those relationships because the medical model doesn't love seeing people's situations in housing. I remember a nurse coming to [one of our housing sites] and she was like, 'He can't live here. Do you see how he's living?' I was like, 'I understand that he's not taking care of himself. We have no ability to tell him he can't live in this apartment. You have no ability to tell him. [But] we*

need to help him [anyway], otherwise he's going to remain not attending to his medical needs.'" (Senior Leader, Homeless Services Agency, ID 41)

Medical providers discussed seeing a similar tension when starting to work with homeless services agency partners:

> *"A fundamental flaw is if they do not share the same fundamental healthcare belief that we share, whether it's believing in harm reduction, which is giving out needles and syringes for people to use drugs. ... We believe in engaging with the patients and using motivational interviewing and other techniques, to offer them psychiatric medications to treat schizophrenia and bipolar disorder, primarily with medications and we strongly believe in the idea of giving them long-acting injectable antipsychotics. If they don't believe in treating psychiatric conditions with medications, then that's going to be a big impasse." (Street Medicine Provider, Community Health Center, ID 18)*

Although, some providers described resolving their disagreements over time. It was far more common that providers talked about having to live with or manage challenging partnerships where providers disagreed on what constitutes appropriate care because those partnerships were seen as strategically important for their organization or were required by a funder.

Tension: Governance dynamics

Homeless services and healthcare are managed by different government agencies that have very different rules and ways of working, creating tension for those trying to bridge the two sectors. Broadly speaking, a fundamental tension is that healthcare is a government entitlement for specific populations, meaning anyone who meets certain qualifications (e.g., age, income) is entitled to receive services. Whereas housing is not an entitlement:

> *"Healthcare is the only entitlement besides public school for grades K through 12, ... The fact that housing is not an entitlement makes things so screwy and it also makes healthcare not understand housing … and often creates a fundamental mismatch." (Director, Medi-Cal Managed Care Plan, ID 2)*

Moreover, the governance structure of homeless services in Los Angeles is particularly complex with both the city and county playing a role. Since many homeless services provider organizations get funding from multiple sources they experience the process of negotiating those relationships as a tension: "We need to get government agencies like DMH and DHS, and Public Health to work together collaboratively instead of shooting at each other. We work with all of them. But sometimes, I feel like I'm tiptoeing

between them" (Senior Leader, Homeless Services Agency, ID 39). Frontline providers also expressed frustration at the apparent lack of coordination between government agencies:

> *"It would work better if we had one czar, maybe in the country, maybe in the state, that ran all the programs. There's so many different programs going on that don't add up together. Why do we have CARE Courts and Home Team? They're doing the same damned thing. Why is it not just one cohesive project? Why do we have cities and counties doing different things, adding different services?" (Street Medicine Provider, Community Health Center, ID 18)*

Because of CalAIM, managed care plans were becoming more involved in the homeless services funding ecosystem, which reportedly created confusion and heightened tensions among other funders. As one funder noted:

> *"Money is flowing differently … it's [CalAIM] just rewired networks in a way that didn't feel natural. And some people still look at the county for leadership. They're not looking at managed care plans for leadership. And I don't know that managed care plans want to be leaders in this homelessness realm anyway, so it just feels like, okay, well, who's picking up the mantle? And really nobody is because it doesn't make sense for anyone." (Manager, Funder, ID 20)*

Many service providers wondered if homeless services are compatible with the constraints that come with paying for services through Medicaid. For example, medical respite (also called recuperative care) is a service that offers short-term housing to unhoused people so they have a place to recover after receiving hospital care. Traditionally, it was paid for by hospitals or the county and would be covered for between 14 days and a year, depending upon a person's needs. But when it became a covered Medi-Cal service, medical respite providers found that the hospitals became more reluctant to pay, assuming it would be covered by the health plans. Meanwhile, providers say that health plans were approving very few people for medical respite by setting narrow eligibility requirements. Given their experience so far, providers wonder if medical respite is compatible with managed care:

> *"Counties do things drastically different than health plans. The counties have some people that are in the recuperative care [medical respite] beds that have been there over a year. There's no health plan in the country that is going to pay to house somebody in recuperative care [for that long]. … [Meanwhile,] the state was allowing the health plans to basically create their own eligibility criteria and create this long list of eligibility exclusions. It got to the point where they were authorizing very few people for recuperative care, and yet the hospitals had said, 'We're not paying anymore,' because the plans threw their hat in the ring and said, 'We're going to pay.'" (Consultant, Healthcare, ID 43)*

Street medicine providers had similar questions about the compatibility of managed care as a payor for their services. Street medicine providers pointed out street medicine teams often act in a public health capacity when they contain outbreaks of communicable diseases in encampments, which may not be compatible with a system where they would only be paid to serve people with insurance from a particular health plan.

Finally, managed care leaders and others questioned whether they would be able to pay for homeless services in a way that was cost neutral, which is one of the requirements of the state Medicaid waiver:

> *"When you have the number of homeless members that we have in LA County, providing housing navigation and tenancy support services and housing deposits to all of them, I can guarantee you it is not a money saver. … it's going to cost more to do housing navigation and tenancy supports than what they're costing the system. It doesn't mean we shouldn't do it, but I think the state just needs to recognize it's going to cost a lot of money to do it. And unfortunately, I don't think LA County is going to save anybody any money on the homeless stuff." (Director, Medi-Cal Managed Care Plan, ID 19)*

They believed paying for homeless services through Medi-Cal would not be cost-neutral in Los Angeles County for two reasons: first, they argued that "there's a huge number of homeless individuals in LA County that are not costing anybody any money, whether it's because they die on the street or they just don't go to the hospital when something's bothering them"; second, they said that, "there are some ERs in LA County that have extremely cheap rates."

Table 3. Tensions associated with care integration

Tension	Quote	Potential approaches to mitigate tension
Resource scarcity	*"In CalAIM, the investments in social care services almost came as an afterthought. … All housing organizations are maxed out right now, food pantries the same thing." (Senior Leader, Community Health Center, ID 26)*	• Seek collaborative grants: *"I feel like it's not fair to ask a community-based organization to provide or to reserve X amount of visits or services for [our clinic's] patients when we're not also investing in their infrastructure. So now, as we're writing new grants, we're directly communicating with partner organizations who provide these services and sharing the resources, adding them as a subcontractor." (Senior Leader, Community Health Center, ID 26)* • Build shared administrative infrastructure: *"We're looking into creating … hubs where there can be a shared administrative cost that the plan will pay actually on top of the cost of the service to help support billing and contracting … [to] empower the CBOs … so that we can actually get the community into the work and fulfill on the promise of CalAIM." (Senior Leader, Medi-Cal Managed Care Plan, ID 44)*

Conflicting goals	*"What happens in street medicine when you partner is that you have very different goals. If you're a homeless services agency, you're going to end up seeing people that are most housing ready, which are not necessarily the people who are the sickest." (Street Medicine Provider, Academic Medical Center, ID 7)*	• Have regular meetings with partners to align on shared goals: *"When we develop new programs, we always sit down with all of the stakeholders, community stakeholders, law enforcement, fire, DMH, DHS, everybody, and [say] 'let's get the parameters right.' But everybody has to be on board to begin with; that communication at the beginning is key. And you've got to keep that communication going." (Senior Leader, Homeless Services Agency, ID 39)* • Integrate care under one organizational roof: *"There's different ways to get integration … I saw mergers, and frankly, I also saw organizations that over time got frustrated and decided they'd rather keep all the money themselves rather than partner and subcontract with one another. And if they could keep all the money themselves, then they could build their own internal capacity. So in other words, rather than partner with another organization that brought in workers with a different discipline and training, they created teams of their own workers so they could do that integration under one organizational roof." (Consultant, Healthcare, ID 10)*
Conflicting beliefs	*"A fundamental flaw is if they do not share the same fundamental healthcare belief that we share, whether it's believing in harm reduction, which is giving out needles and syringes for people to use drugs. ... If they don't believe in treating psychiatric conditions with medications, then that's going to be a big impasse. (Street Medicine Provider, Community Health Center, ID 18)"*	• Tie the use of particular practice models to funding: *"We've been really lucky that [our funder] has really adopted harm reduction. … I've done trainings [on harm reduction] for other organizations and they're maybe moderately receptive to that, but I think it has to come from the funding sources as a requirement to keep their contract. [Our funder] is working on that right now. You have to believe in harm reduction to get the contract, and agencies are… their minds are exploding." (Director, Homeless Services Agency, ID 16)* • Advocate for patients on a case-by-case basis: *"I think communication is important and coming to the table to say, 'Hey, this is our scope, this is our approach. We recognize there's some tension, or there's some differences in the way we approach. How can we reconcile things?' … You sort of just have to navigate it as it comes. … Oftentimes, it's a case-by-case advocacy thing that you do to really ensure that we're staying true to our philosophy." (Senior Leader, Community Health Center, ID 47)*
Governance dynamics	*"Whole Person Care was run out of the counties and CalAIM isn't. ... And some people still look at the county for leadership. They're not looking at managed care plans for leadership." (Manager, Funder, ID 20)*	• Build trust across sectors by forming individual relationships: *"In my previous [homeless services] roles, I automatically was suspicious of managed care plans, of anyone who wasn't the county health department. I was like, 'You're just looking at your bottom line,' especially the hospital. … I was framing it as us versus them, [but] people matter. Who you talk to within those agencies can really make a big difference*

about how your perspective changes, and understanding that, sure, … we're in a capitalist society, of course money matters, but the people who you're engaging with, if they care about the same things you care about, they care about patients, then I think you can build trust that way and hopefully not see them as the enemy, but as a partner who you might not always agree with, but that's okay." (Manager, Funder, ID 20)

Discussion

Participants from all four stakeholder groups — healthcare, homeless services, local government, and managed care plans — reported engagement in care integration activities. They used a variety of approaches to integrate care, including jointly staffing outreach teams, co-locating services, and other mechanisms that bring medical care, mental health care, substance use treatment, and housing support into the same location or into the same team.

Our study suggests that homeless services and healthcare professionals have embraced practice ideologies that see social environments and health as closely linked. The widespread adoption of the Housing First approach in homeless services and the social determinants of health framework in healthcare created a practice environment where integrated care is seen as legitimate and necessary by professionals in both fields. As the number of people experiencing homelessness in Los Angeles County grew and tent encampments in parks and other public spaces proliferated during the pandemic, it put pressure on elected officials and homeless services organizations to demonstrate progress addressing the crisis and has motivated public and private investment in homelessness. Meanwhile, organizations had already begun responding to changes in their policy and funding environments that were enabling them to integrate care, especially the passage of Measure H in 2017 and a series of Medi-Cal waiver programs that brought new funding that incentivized organizations to launch integrated care models.

Although providers believed that integrated care models were necessary to make services in each sector more effective, they experienced several tensions associated with their efforts to start or sustain integrated care. Similar to prior research,[22] we found that resource scarcity in the homeless service system presented a significant barrier to care integration efforts. In an environment where not everyone who needs housing and shelter is likely to receive it, providers are in a delicate position where they are forced to collaborate with one another to access resources, but must also find ways to ensure their patients or clients are prioritized for limited resources. In other words, they must demonstrate organizational effectiveness and attract grants and funding in a competitive

funding environment while also depending on other organizations for key resources that are perceived as necessary to accomplish their work.

Indeed, we observed that organizations are weighing the tradeoffs between partnering with others to gain new integrated care capabilities and building them within their own organizations. This decision, often called a "build or buy" decision, has been described by other researchers examining the dynamics of cross-sector collaboration.[17] Street medicine teams, for example, can be structured as partnerships between healthcare and homeless services organizations or as a fully integrated team under the management of a single organization. Providers described tradeoffs with either approach. Partnered teams could potentially leverage the resources of two separate organizations to the benefit of their clients, and could serve as a bridge between organizations that have a more extensive set of capabilities than any one organization does on its own. However, partnered teams also confront the tension of negotiating organizational priorities and managing how those priorities shape the work. Whereas, fully integrated teams were described as being easier to manage and their work could be more easily aligned with the goals and priorities of the home organization. In either case, providers said they struggle to work with other professionals who have differing beliefs about what constitutes appropriate care. They said differing views on the use of practices like harm reduction, conservatorship, long-acting injectable antipsychotics, and others made it difficult to collaborate with other providers to effectively integrate care.

Homeless services providers saw the new entrance of managed care into the homeless services funding ecosystem as disruptive to and in conflict with the traditional county governance systems. Indeed, many providers observed that healthcare organizations' efforts to address their patients' housing needs clashed with the reality that access to most shelter and housing resources is controlled by county agencies and homeless services providers, and therefore is outside of healthcare providers' direct control and discretion. Furthermore, homeless services providers point out that they already have limited resources to meet the needs of their current clients and referral pathways and are not always able to accommodate or prioritize an increased volume of referrals from healthcare providers. Since much of the strategy of healthcare organizations has been to invest in housing navigation and care management, they are worried that their efforts may be offset by the lack of places to navigate patients to. "Housing navigation," as many observed, "doesn't help without the housing part."

Providers who engaged in integrated services like medical respite and street medicine wondered if Medi-Cal would allow them to maintain elements of their models that they believed to be core to their effectiveness. For example, street medicine providers often play a public health function, which may not be compatible with the need to serve people based on their insurance. And medical respite providers said that managed care plans have had much more restrictive criteria than their previous county and hospital funders and approve shorter lengths of stay, which may not be enough time for people to fully recover

after hospital care and may make the service less effective. Finally, managed care plan leaders and others expressed concerns that due to unique conditions in Los Angeles County — the high cost of services, the lack of housing, and number of unhoused Medi-Cal members — providing homeless services through Medi-Cal in Los Angeles County may not be cost neutral, which is a requirement of the state waiver.

Limitations

These findings should be considered in light of several limitations. First, our purposeful sampling method aimed to identify providers who were already engaged in efforts to link housing and healthcare services. Therefore, it is well suited to our study aims to understand the full range of provider experiences with and perspectives on care integration, but may under-represent the views and perspectives of providers at agencies that have chosen not to pursue care integration. Second, it is possible that homeless and healthcare services in Los Angeles County may be meaningfully different from services in other counties (i.e. more rural counties), and therefore some of the experiences of providers documented in our study may differ from other county contexts.

Conclusion

Healthcare and homeless services professionals expressed excitement about the influx of funding from Medicaid to pay for integrated services for people experiencing homelessness. New Medi-Cal funding through the CalAIM 1115 waiver and HHIP program has enabled them to extend their services and reach more people experiencing homelessness, and has allowed them to focus on integrating care for unhoused Medi-Cal members who frequently use high-cost services. Despite that, the tensions they experience echo previous research suggesting that Medicaid funding should not be considered a substitute for addressing upstream structural challenges.[5,11] For instance, stakeholders from all sectors believe that more needs to be done to prevent homelessness, including building more affordable housing and doing something about rising rents to prevent people from becoming homeless in the first place. There is only so much that the homeless services system can do in such a resource-scarce housing landscape, they said, and the lack of affordable housing will almost certainly place upward limits on the potential benefits that can be achieved through Medi-Cal investments in housing navigation and care management for unhoused patients.

Chapter 3: Medi-Cal Reform and the Future of Street Medicine in Los Angeles County

Background

Street medicine emerged in the United States in the 1990s to extend medical care to people living on the streets. It aims to offer a critical access point to healthcare for people experiencing unsheltered homelessness who often have significant barriers to accessing traditional brick-and-mortar healthcare settings.[34,77] For many years, there were only a handful of street medicine programs. Some of the first were based out of teaching hospitals on the East Coast, most notably Dr. Jim O'Connell's work at the Boston Health Care for the Homeless Program[94] and Dr. Jim Withers's work with Pittsburgh Mercy's Operation Safety Net.[95] In California, a recent statewide survey found that nearly half of street medicine teams were based at federally qualified health centers (FQHC), while others were sponsored by hospitals, nonprofit organizations, government entities, academic institutions, and health plans.[42] Street medicine has historically relied on a patchwork of government contracts, grants, and philanthropic support.[42]

The few medical providers practicing street medicine in the early days of the model would typically bring only the supplies they could carry in a backpack to deliver care to wherever people were living — on the streets, in parks, under bridges — the guiding mantra being "go to the people."[96,97] In fact, many street medicine providers still practice with just a backpack today, seeing it as the purest form of street medicine because it allows them to travel to the hardest-to-reach people. However, the model has become more complex over the years. Today, many street medicine teams have access to Mobile Medical Units, which are vans (or, in some cases, even RVs) customized to include exam space and allow providers to carry considerably more supplies into the field.[98] As street-based care evolved and new approaches emerged, street medicine providers have maintained a distinction between "street medicine" and "mobile medicine";[98] the mobile medicine model, they point out, often requires people to leave where they are living and travel to where the mobile van is parked, which can create a barrier to care and exclude the most vulnerable patients, whereas street medicine brings care to the person in their own environment. In practice, many street medicine programs in Los Angeles combine street and mobile medicine approaches in their day-to-day work and adapt their care models in response to local needs and available resources, which aligns with the findings of a recent scoping review by Michael Enish and colleagues;[99] it found that although most street medicine teams share a common definition of the model and philosophical approach, there is considerable variation in the actual services offered by street medicine teams. Street medicine expanded into a global movement over the past twenty years,[99] but, until recently,

growth of the model remained slow due to regulatory ambiguity and an unfavorable payment environment.[100]

Recent policy and payment changes in California have led to a sudden growth in the number of street medicine providers. According to the California Street Medicine Collaborative, based at the University of Southern California (USC), the number of street medicine programs across the state nearly doubled last year, growing from 26 to 49 programs between August 2022 and August 2023.[101] Brett Feldman, director and co-founder of USC Street Medicine and vice chair of the Street Medicine Institute, expects growth to continue. He says that many more organizations across the state are in the process of starting programs.[102] The recent growth comes as a response to the availability of new funding through Medi-Cal as part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative ECM benefit and the Housing and Homelessness Incentive Program (HHIP),[103] as well as new guidance from the California Department of Health Care Services (DHCS) that encourages the state's Medi-Cal managed care plans to contract with street medicine providers.[39,104] CalAIM is an 1115 waiver program that gives the state flexibility to fund care management and health-related social needs services for qualifying Medi-Cal members who frequently use high-cost medical services, and HHIP enabled Medi-Cal managed care plans to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed.[105]

Managed care plans in Los Angeles County have responded to CalAIM and HHIP by making significant financial investments in street medicine providers,[106,107] and are beginning to seek contracts with street medicine providers to deliver CalAIM and primary care services to unhoused Medi-Cal members. Proponents of street medicine point to its potential to impact healthcare costs and utilization by reducing emergency room visits, hospital admissions, and hospital lengths of stay,[108] though more rigorous studies of its effectiveness are needed. At the same time, others have raised concerns about lack of oversight and regulation and have called for greater standardization of the model.[99,109] Street medicine providers have expressed concerns that contracting with managed care plans could change the care model in ways that make it less effective due to increased demands for service volume which could disincentivize working with the hardest to reach patients.[102] Further, the success of the state CalAIM initiative is likely to depend, in part, on whether managed care plans are able to effectively leverage integrated care models like street medicine to address the medical and social needs of Medi-Cal members who are experiencing homelessness. However, little is known about how these recent policy and payment changes are impacting street medicine providers and their programs. We address this knowledge gap by engaging street medicine providers in Los Angeles County in a participatory research project to explore their perspectives on the future of street medicine and the challenges and opportunities they see today. In this paper, we present the findings from a co-design event we hosted for street medicine providers in Los Angeles County and share timely and actionable recommendations to support street medicine expansion.

Methods

Study design

We held a co-design event with street medicine providers from Los Angeles County to document their experiences with the changes in their practice environment brought on by recent changes to Medi-Cal, California's Medicaid program. Los Angeles County is an ideal study location to study street medicine expansion because it has one of the largest homeless populations of any city in the United States with an estimated 75,000 people experiencing homelessness in 2023[88] 70% of whom are experiencing unsheltered homelessness, which is what street medicine is specifically designed to address.[110] Meanwhile, political support for street medicine from leaders in city[111] and county[112] government, along with unprecedented financial investments from health plans[107] and the state[113] are driving the rapid expansion of street medicine in the county, making it an ideal location to examine how street medicine providers are navigating changes to their practice environments.

The event served as the main site for data collection for the study, although we also considered data collected prior to the event (e.g., minutes collected during the event planning meetings), and after the event (e.g., as part of a member checking process) in our analysis. Qualitative data including documents, videos, and audio recordings were produced by street medicine providers through their participation in the event workshops and were analyzed by the study team using content analysis and memoing. Study findings were refined iteratively with input from the event participants through a member checking process.

Study Context

Data are drawn from a gathering of street medicine providers in Los Angeles County held in September of 2023. The event was co-hosted by the Center for Care Innovations (CCI) in partnership with the Community Clinic Association of Los Angeles County (CCALAC). Previous research by our study team found that street medicine is one promising example of how organizations in Los Angeles County deliver integrated social and medical care to people experiencing unsheltered homelessness.[114] Further, street medicine providers reported that new policy and funding changes were driving rapid growth in the number of street medicine teams in the county. Given those findings, the research team believed it was an opportune moment to gather street medicine providers to help shape the model's future.

Sampling

Study participants were sampled from a collaborative of street medicine providers in Los Angeles County called the LA County Street Medicine Coordination Collaborative.[115] The collaborative has 20 member organizations and is convened by CCALAC monthly to discuss emerging issues and respond to shared challenges and opportunities. Members are street medicine providers who work at healthcare, homeless services, or government organizations. The collaborative provided an ideal sampling frame as our partner CCALAC noted it is attended by the majority of street medicine organizations in the county, and no comprehensive list of street medicine providers in the county is publicly available.

Sampling occurred in two stages: First, the study team met with CCALAC staff and identified six organizations to invite to participate in the event. Teams were selected using a purposive sampling approach[92] to ensure geographic representation from across Los Angeles County and from the full range of types of organizations that run street medicine programs (e.g., FQHC, academic medical center, medical groups, county government, city government). Next, the study team sent an email to a leader at each of the six selected organizations explaining the purpose of the event and inviting them to participate. All six organizations responded expressing interest in participating and were invited by the study team to select up to five of their frontline street medicine providers or direct supervisors of frontline providers to register for the event. The majority (95%) of people who registered were direct providers of street medicine (Table A1). The sampling and data collection process is described in detail in *Figure A1*.

Event planning

Next, the study team met with each of the six invited street medicine teams for planning sessions that lasted approximately 30-minutes each. Street medicine providers were asked to give input on the event activities and focus areas and the study team took notes. After analyzing the providers' input, the study team sent a follow-up email to all of the invited teams proposing that the morning workshop at the event be used to focus broadly on "generating ideas for how to improve street medicine coordination and care continuity" and the afternoon workshop be used to focus on "creating space for providers to share their perspectives on street medicine expansion and shape the future of the model." Providers responded in agreement that those were the right focus areas for the event.

Event description and co-production of data

On Thursday, November 30, 2023, 21 street medicine providers from six street medicine programs in the county gathered at CCALAC's offices in downtown Los Angeles. The event was facilitated by staff from CCI, the study team, and CCALAC. The agenda included two

co-design activities: A Design Dash workshop in the morning, and an Open Space workshop in the afternoon.

A Design Dash[116] is a human-centered design activity that helps groups come up with creative solutions quickly and collaboratively. During the workshop, providers were asked to come up with ideas for how to improve coordination and continuity of care for people being served by street medicine teams in Los Angeles County. The event participants were divided into five design teams. Each team was made up of attendees from different organizations with differing roles and training (e.g., doctors, PAs, nurses, peers). The diverse makeup of the teams was meant to encourage cross-organization relationship building and ensure each team would benefit from a range of perspectives as they worked on the design problem. At the start of the activity, five providers in the room were asked to play the role of "storytellers," or someone with firsthand experience of the topic. Each team then interviewed a storyteller about their experience with care coordination, or lack thereof, in their work. Next, each team identified pain-points in the story they heard then brainstormed, prototyped, and tested a solution. At the end of the workshop, each team wrote a five-minute "pitch" and presented their proposed solution to the group. The goal of the pitch was to give providers an opportunity to practice generating support for their ideas. The Design Dash lasted two hours. See *Table A2* for detailed activity instructions and *Table A3* for a description of each team's work.

Open Space[117] is a facilitation technique where meeting participants create and manage the agenda themselves. The theme for the activity was "shaping the future of street medicine," and the group identified topics they wanted to prioritize for discussion. At the start of the workshop, the event participants proposed topics that they would be excited to discuss with their peers related to the workshop's theme. A vote was conducted and the topics with the most votes were selected. Each selected topic was made into a breakout session and assigned a physical location at the conference space. Event participants volunteered to host each breakout session. All other participants were encouraged to pick a breakout session based on their interests. Participants documented their conversations. At the end of the activity, one person from each breakout session had ten minutes to present a summary of the topic they discussed to the full group, tell an illustrative story about the topic, and share any key takeaways or "aha" moments from the breakout session. The Open Space activity lasted two and a half hours. See *Table A4* for detailed activity instructions, and *Table A5* for a summary of each breakout session topic.

Analysis

The study team (C.R., J.H. and I.C.) conducted a first pass at analyzing materials produced during the design event. Documents (such as posters and worksheets) produced by participants during the event were analyzed using content analysis. Videos and audio recordings taken by facilitators during the event were reviewed by the study team using a

memoing approach to identify the key themes. The study team's summary of participants' work during the event workshops is presented in *Table A4* and *Table A6*. In addition, the study team produced a draft of five recommendations based on the event findings.

Member checking

A first pass of the study findings and recommendations was shared with all 21 event participants with an invitation to provide feedback. Six participants met with the study team for 30-minute Zoom calls to discuss their feedback. Three participants provided written feedback by email. The findings in this paper reflect the study team's notes from the event planning calls, synthesis of the output of the co-design event, and feedback and suggestions received by participants during the member checking process.

Results

Street medicine providers who participated in the study come from diverse professional training and organizational affiliation (Table A1). They said that "street medicine is in a pivotal moment," and reported a mixture of trepidation and excitement about the growing interest in and funding for street medicine. Findings from the co-design event workshops regarding challenges, opportunities, and recommendations are described in detail below.

Challenges and opportunities

Despite growth in the number of street medicine teams operating in Los Angeles County, providers reported that most unhoused people in the county still lack access to medical care. Therefore, they said that organizations launching and expanding teams should coordinate to cover underserved areas of the county. Although, they noted, it can be more challenging to serve some parts of the county where homelessness is more spread out due to the time it takes to find patients.

Providers report challenges recruiting enough staff to keep up with the growing demand for street medicine services. They said that before the last couple of years,

> *"…there were lots of big hearts and interest in street medicine but very few jobs. I remember you'd talk to students about street medicine, for example, but then there'd be no jobs for them when they graduate. So we were always tempering their excitement." (Street medicine provider, ID 5)*

Now, as a result of new funding initiatives in California, there are more street medicine jobs available but an underdeveloped pipeline to onboard and retain a street medicine workforce. Challenges included developing accurate and clear job descriptions, the need for

robust onboarding, the need to be "strategic, creative, and assertive" when recruiting, and the need to establish clear street medicine competencies (e.g., substance abuse, mental and behavioral health, trauma-informed care, harm reduction, principles of homeless outreach, and de-escalation techniques).

As the number of street medicine teams grew, they said it created a need for more coordination and data sharing. For example, providers reported that multiple street medicine teams from different organizations have been sent by funders and other stakeholders to offer services to unsheltered people living in MacArthur Park in the Westlake neighborhood of Los Angeles. Providers who frequent the park are finding that they are serving the same patients, and there is a need for better coordination. As one provider reported,

> *"The need for services in MacArthur Park is high and lots of funders, the council district, and others send teams there. So, we're stumbling upon finding out that other teams are there, which presents challenges because it is a location where things change quickly and people are coming in and out. We need a way to figure out how to better coordinate." (Street medicine provider, ID 14)*

Further, they described how street medicine providers rely on formal (e.g., using data systems) and informal (e.g., phone calls with colleagues) approaches to collaborate. But the lack of a consistent approach and compatible tools gets in the way of effective collaboration. Providers say that both formal and informal structures are needed but could be leveraged more effectively than they are today.

Providers worried that contracting with managed care plans would increase demands for greater efficiency and volume of services, and emphasized the need to protect time for trust building with unhoused patients:

> *"I worry about what the data and reporting is going to look like with these contrats. Part of the beauty of street medicine is I can care for the patient, and look them in the eye, and spend the time on the ground with them, and not have to think about the nine things I have to put in the chart. Now, I'll have to think about the health plan reimbursing me or not." (Street medicine provider, ID 14)*

For example, they worry that the incentive structure of managed care may lead teams to provide more services in shelters, where it is easier to see a large volume of patients in a shorter amount of time than it would be to provide a similar amount of care on the street:

> *"It will effectively kill street medicine in Los Angeles if they [managed care plans] pay the same to see someone in the drop-in center as they will on the street. If the health plan contracts incentivize seeing ten patients in a drop-in clinic because it's really easy, but you can only see*

three on the street, then you are disincentivizing street medicine." (Street medicine provider, ID 4)

Still, many are seeking contracts with managed care plans to deliver CalAIM ECM and CS services and primary care for people on the streets. They expressed optimism that contracting with managed care plans would expand access to specialty care and other medically necessary services. However, they noted that since street medicine teams are based at different types of organizations, Medi-Cal reimbursement is likely to impact each differently. They emphasized the need for street medicine providers to develop a "unified response" to negotiate a contracting arrangement with the managed care plans that doesn't advantage one type of organization at the expense of another. For example, they said that health plans would need to set equitable and sustainable rates, providers would need to be able to see patients on the street regardless of provider assignment, and they would need support developing additional infrastructure and capacity to handle referrals.

Finally, providers argued that county leaders should do more to leverage street medicine as an entry point into housing. Because they build trust with patients on the street and have team members who can assist unhoused people with their housing and medical needs, they believe that street medicine could serve as an effective bridge between healthcare and housing. Although, to play that role, they said they need access to low-barrier housing, including medical respite, rehab, or motels for their patients, and they believed street medicine providers should continue to provide care to their patients in transitional and permanent housing including motels. As one street medicine provider put it, their team should be able to say to patients, "Here's housing for you in the interim while we are waiting for permanent housing." Further, providers argued that they need to be able to offer patients "long-term care planning" because "when a patient with complex needs gets housing, they will need ongoing support." (Street medicine provider, ID 4)

Recommendations

Street medicine providers agreed on five recommendations for ways to address challenges and opportunities they see in the street medicine landscape concerning (1) geographic service gaps, (2) coordination and data sharing, (3) trust building with patients, (4) access to housing, and (5) access to specialty care and other medically necessary services. Each recommendation is described in detail in *Table 1*. The wording of each recommendation was reviewed, edited, and agreed upon by the street medicine providers who attended the event.

Table 1. Recommendations regarding the future of street medicine

Recommendation	Description
1. Improve access and address geographic service gaps	The availability of new funding through Medi-Cal and recent changes in state and federal guidance are driving the growth of street medicine teams in Los Angeles County. But even though the number of programs has grown, access remains an issue. Providers report that some areas, including Skid Row and MacArthur Park, are now being served by multiple teams, while other areas have little to no street medicine coverage. Providers say there is a need to extend street medicine coverage to underserved parts of the county.
2. Coordinate care and increase data sharing	As more organizations start street medicine programs, growth has been concentrated in a limited number of areas where providers are increasingly encountering each other in the field and finding that they are serving the same unhoused patients. Providers say that better coordination and data sharing between teams is needed to avoid duplication of services in areas being served by multiple teams. As teams expand, they are looking to hire more medical providers and community health workers to keep up with growth. However, street medicine providers report that an underdeveloped pipeline to onboard and retain a street medicine workforce is hindering growth.
3. Protect time for trust building	Many people living on the streets are hesitant to seek care, often because of prior negative experiences with health professionals. Street medicine providers say building strong, trusting relationships with people takes time and is often a necessary step before a person will agree to receive billable medical care. A critical component of street medicine is getting someone comfortable enough to agree to become a patient, which hasn't traditionally been billable work, resulting in unfunded time. Providers anticipate that contracting with managed care plans may increase demands for efficiency and volume of services, and they emphasize the need to protect time for trust and relationship building.
4. Create more connections to housing	For street medicine to serve as an effective link to housing for some of the most medically vulnerable people on the streets, street medicine teams say they need timely access to temporary housing for their patients, such as medical respite, rehab, and motels. Providers currently rely on the Los Angeles County Coordinated Entry System (CES) — a network that aligns homeless services in the county and manages referrals to and prioritization for a limited supply of available housing resources — to find temporary shelter and housing for their patients. However, long wait times for accessing shelter and housing resources through CES have led many teams to develop relationships with shelters outside of the CES system to speed up the process for patients with the most urgent needs. They also face systemic barriers that prevent them from directly referring patients to housing through CES. Because of these barriers they often rely on other agencies to refer their patients to housing resources, which slows down an already slow process. Street medicine providers argue that they are well-positioned to guide patients to the appropriate level of ongoing care to ensure successful housing outcomes and access to a primary medical home. And providers see a need to offer continued medical support to patients as they transition from the street to shelters and other forms of temporary housing. But they say to make that possible, better integration of street medicine teams into CES is needed.

5. Expand access to specialty care and other medically necessary services	Street medicine providers in Los Angeles describe gaps in services for pregnant people and people with mental illnesses who are living on the streets. They also stress the need for more access to specialty services, including orthopedics, cardiology, nephrology, rheumatology, dental care, and vision care. Providers say they need a mechanism to get the people they encounter on the streets into specialists quickly and with minimal bureaucracy. Recently, the state of California released new guidance (APL 24-001), which may offer a path to expanded access for people experiencing homelessness by allowing street medicine providers to become contracted Medi-Cal providers. Providers and managed care plans in Los Angeles are still working on implementing the new guidance. Providers say they are eager to work with the managed care plans to extend specialty care and other medically necessary services to people experiencing homelessness.

Discussion

This study describes the perspectives of street medicine providers on the impact of new Medi-Cal funding and state and federal policy changes on the street medicine landscape in Los Angeles County. Street medicine providers say the new attention and resources have been a mixed blessing. They are grateful for the additional funding that is enabling them to bring more care to people on the streets and hopeful that they will soon be able to offer specialty care — including orthopedics, cardiology, nephrology, rheumatology, dental care, and vision care — which has been largely inaccessible to homeless people who often have significant barriers to accessing traditional brick-and-mortar health care settings. But they also say that the rapid growth has led to new challenges, such as a more crowded service environment and duplication of services. Providers report that people living in the most frequented encampments sometimes get seen by as many as four separate street medicine teams from different organizations, which can be confusing for patients and is an inefficient use of limited resources. While some parts of the county are being served by multiple teams, other areas have a very limited street medicine presence, leaving many people experiencing homelessness without accessible medical care. Thus, we find that coordination is needed both to improve the efficiency of care in highly served areas and to fill gaps in care for underserved parts of the county.

Street medicine providers are concerned that Medi-Cal contracting may introduce new pressures for service volume and efficiency. They also anticipate that new or expanded reporting requirements could increase the administrative burden and take time away from patient care on the streets. As street medicine becomes a more formal part of the mainstream medical system, providers say that there is a need to preserve the values[118] that have made street medicine distinct, including its focus on the dignity and humanity of people living on the streets, taking time to build trusting relationships with unsheltered patients, and its commitment to providing care in the patient's environment.[42,102] Similar to prior research,[99] we find that street medicine providers share a very similar set of values

that guide their work, despite considerable variation in the particular services offered across different teams. Our study indicates that providers perceive some dissonance between the culture of street medicine practice and the culture of mainstream medicine and managed care in particular. Therefore, stakeholders interested in engaging with street medicine teams should be attentive to those values, identity, and practice culture.

Street medicine providers are eager to tap into the resources they could gain from closer ties with managed care; however, they are also deeply concerned with maintaining a practice model that is true to the value of bringing care to the hardest-to-reach people experiencing homelessness. Historically, street medicine has been disconnected from many of the systems that could support better coordination between street-based care and brick-and-mortar medical and housing resources. For example, providers say they have struggled to gain access to the Homeless Management Information System (HMIS) and face administrative barriers to referring people directly to housing services through the Los Angeles County Coordinated Entry System (CES). Similarly, they reported facing barriers to accessing specialty medical services through the managed care plan's sub-contracted specialty networks. Connecting street medicine teams to these critical re-housing and specialty medical services could potentially leverage street medicine as a bridging service between street-based care and other critical care systems that serve people experiencing unsheltered homelessness.

Limitations

These findings should be considered in light of several limitations. First, how study participants engage in a social research setting like a co-design workshop is likely to be influenced by social pressures and biases. For example, social desirability bias, or the desire to be seen in a positive light, may have discouraged the discussion of important but controversial topics. Or, recency bias, may have led to the discussion of issues that are current but not as important as other issues, because they happen to be top of mind and easiest to recall on the day of the co-design event. However, comparing the study team's meeting notes from our one-on-one event planning calls three months before the event to the event data, we see almost total agreement between the topics mentioned on our planning calls and the topics we observed being discussed at the event. With the exception of one: the impact of street sweeps on street medicine patients was mentioned in the planning calls but was a minor part of the overall event discussion. Thus, providers may have avoided discussing street sweeps at the event due to its highly political nature. Further, because we spent months planning the event and we asked providers to think about the types of topics they would like to discuss far in advance of the event, we believe recency bias is unlikely to have significantly impacted the data co-production. Finally, we used an established street medicine collaborative as the sampling frame, which may have biased the sample towards more well-established street medicine programs from large and

relatively well-resourced institutions, which may be more visible and well-connected organizations. The study findings, therefore, may not reflect the perspectives of street medicine providers at smaller organizations or from newer and less well-connected street medicine programs. However, by seeking a diverse sample by sector and organization type, we believe we were able to account for a wide range of perspectives and experiences, and the findings are likely to be reflective of the perspectives of the majority of street medicine providers in Los Angeles County.

Conclusion

We found that the street medicine landscape in Los Angeles County is changing quickly, and street medicine providers are responding by calling for the preservation of the model's core elements even as they seek contracts with the Medi-Cal managed care plans that will pull the model from the margins into the medical mainstream. Street medicine providers are excited and cautious about the changes. They are grateful for the new resources and attention that are allowing them to deliver more care to people on the streets, and they are aware that in the coming years, they may see changes to the model as they adapt to being a part of the managed care ecosystem such as greater standardization and more reporting requirements. They are hopeful that the lessons they have learned about how to deliver compassionate care to people experiencing homelessness can contribute to redesigning the traditional care system so that medical care, wherever it's delivered — on the streets, in shelters, or in clinics and hospitals — reflects the unique needs, preferences, and priorities of people experiencing homelessness.

Tables

Table A1. Event participants

Participant ID	Organization Type	Role*	Training**
ID 1	Academic medical center	Director	Clinical (MD)
ID 2	Academic medical center	Director	Clinical (RN)
ID 3	Academic medical center	Mental health provider	Clinical (LMFT)
ID 4	Academic medical center	Director	Clinical (PA)
ID 5	Academic medical center	Director	Clinical (PA)
ID 6	Academic medical center	Director	Clinical (MD)
ID 7	Academic medical center	Community Health Worker	Non-clinical
ID 8	Academic medical center	Senior leader	Clinical (MD)

ID 9	City government	Supervisor	Non-clinical (MPH)
ID 10	County government	Director	Non-clinical (BA)
ID 11	Federally qualified health center	Coordinator	Clinical (MA)
ID 12	Federally qualified health center	Director	Clinical (RN)
ID 13	Federally qualified health center	Physician Assistant	Clinical (PA)
ID 14	Federally qualified health center	Chief officer	Clinical (NP)
ID 15	Federally qualified health center	Registered Nurse	Clinical (RN)
ID 16	Federally qualified health center	Coordinator	Non-clinical (BA)
ID 17	Federally qualified health center	Director	Clinical (MD)
ID 18	Federally qualified health center	Director	Clinical (DO)
ID 19	Federally qualified health center	Physician assistant	Clinical (PA)
ID 20	Medical group	Chief officer	Clinical (MD)
ID 21	Medical group	Chief officer	Non-clinical (MBA)

* Job titles are simplified to protect participant identities.

** The vast majority of participants are direct service providers as a large part of their role, although some of the titles (chief officer, director, supervisor, etc.) reflect that they also serve in a management role at their organizations.

Table A2. Design Dash Workshop Instructions

Phase	Steps	Time
Intro to Design Dash	☐ Draw a picture of yourself on a sticky note. ☐ Add your name.	3 min
Get to know your team	☐ Brainstorm associations you have with the topic (one idea per sticky note). ☐ Introduce yourself to your team — name, organization, and role — and share at least three associations you have with the topic. ☐ As you introduce yourself, place your sticky notes up on a piece of poster paper.	5 min
Pick a role	☐ Pick a role for the activity — storyteller, interviewer, artist, or notetaker.	2 min
Observe a new perspective	☐ Storyteller switch tables. ☐ Interviewer asks the storyteller about their experience with the topic. ☐ Artist and notetaker document the conversation.	10 min
Clarify	☐ Each person asks one clarifying question.	5 min
Define your challenge	☐ On a piece of poster paper, in big clear writing, define your challenge: ○ We talked to...	10 min

	○ They told us... (summarize) ○ Challenge and pain points (list) ○ Summarize “the problem” (1 – 3 sentences)	
Brainstorm	☐ Use sticky notes. One idea per sticky note.	5 min
Ask for feedback	☐ Invite the Storyteller back to give you feedback on your ideas. ☐ Identify the three most exciting ideas.	5 min
Draw idea & build a prototype	☐ Team picks one idea out of the Storyteller’s three favorites. ☐ Draw a storyboard and build a prototype.	15 min
Test your prototype	☐ Pair up with another team. ☐ Each team has 5 minutes to share their idea and 5 minutes to receive feedback.	20 min
Refine your idea and develop a pitch	☐ Refine your idea based on their feedback. ☐ Develop a pitch using the value-based messaging model ○ Value, Problem, Solution, Action	10 min
Share your idea	☐ Pitch your idea to the full group (~3 min each, with ~2 min of feedback)	30 min

Table A3. Design Dash Activity, Ideas to Improve Street Medicine Care Coordination

Team	Topic	Description
Team 1	Maternal health	Problem: There is a gap in services for pregnant people on the streets. Street medicine providers say they lack the “teams and care systems” to meet the needs of high-risk OB patients experiencing homelessness. Solution: Develop multidisciplinary teams to staff new facilities and outreach to provide specialty care at all stages of pregnancy.
Team 2	Social connections & relationships	Problem: Human connection should be central to the practice of medicine. However, street medicine providers say that “care systems are not set up to honor our human need for connection and relationships.” Lack of communication and coordination can even cause harm to patients and lead to conflict between providers. Solution: Focus on the need for human connection and building relationships. Make time for developing relationships with colleagues and patients to ensure relationships are not just transactional.
Team 3	Mental health	Problem: There is a gap in care for people with mental illness on the streets. The issue is both access and service design. Today, mental health services in Los Angeles are neither “accessible” nor “engaging” and are not designed to meet homeless people “where they are.” Solution: Develop a process to co-design and test multiple solutions to improve accessibility to and engagement with mental health care, with the end goal to find a model to scale.

Team 4	Breaking down silos	Problem: Patients deserve coordinated healthcare that prioritizes health over business interests. However, today, care can be siloed or duplicated. For example, in MacArthur Park, there are multiple street medicine teams providing overlapping services, which impacts continuity, creates confusion for patients, and negatively affects health. Solution: Focus on addressing the lack of communication among the teams. Establish collaborative case conferencing and a shared document that will open the space for collaboration, decrease service duplication, and demonstrate joint community commitment to health.
Team 5	Formal vs. informal collaboration	Problem: Care systems should be collaborative. However, street medicine providers rely on *formal* [e.g., data systems] and *informal* [e.g., phone numbers] structures to collaborate. The lack of a consistent approach and compatible tools gets in the way of effective collaboration. Providers say that both formal and informal structures are needed but could be leveraged more effectively than they are today. Solution: Focus on improving both structures of collaboration in two high-opportunity moments in the care process: (1) At the point of care at onset of meeting a person and building trust, get information from the person AND from the formal structured data systems (HMIS/ LANES); (2) Given the person's needs, determine the most appropriate method to collaborate (e.g., "visit vs. warm handoff vs. email/call")

Source: Author's transcription from the event posters and recordings of the event.

Table A4. Open Space Workshop Instructions

Phase	Steps	Time
Identify topics to discuss	☐ Start with an individual reflection. What topics would you like to discuss? Write down a few topic ideas. ☐ As a table, share your ideas with one another and narrow down to three favorites. ☐ Write your table's three favorite topics on sticky notes and give them to the facilitators. (one idea per sticky note) ☐ As a group, we will decide on three to five conversation topics based on each table's suggestions. ☐ Facilitators will ask for 1 or 2 volunteers to lead each breakout conversation.	20 min
Start breakout sessions	☐ Join a breakout room. ☐ Discuss the topic. ☐ Remember, the only rule is the "rule of two feet," which means go wherever you feel like you can contribute or learn. ☐ At the end of the activity, we will ask each group to share: ○ A definition/summary of the topic ○ A story about the topic ○ Key takeaways ☐ If you have time, you can also come up with some questions or prompts for the full group to get their input on the topic.	70 min

BREAK		15 min
Presentations	☐ Each group will have ~10 minutes to: ○ Summarize the topic you discussed in your group ○ Share at least one illustrative story about the topic ○ Share "aha!" moments and key takeaways ☐ Others will have the opportunity to add ideas, share reactions, and ask follow-up questions after each group's presentation.	45 min

Table A5: Open Space Activity, Selected Topics and Descriptions

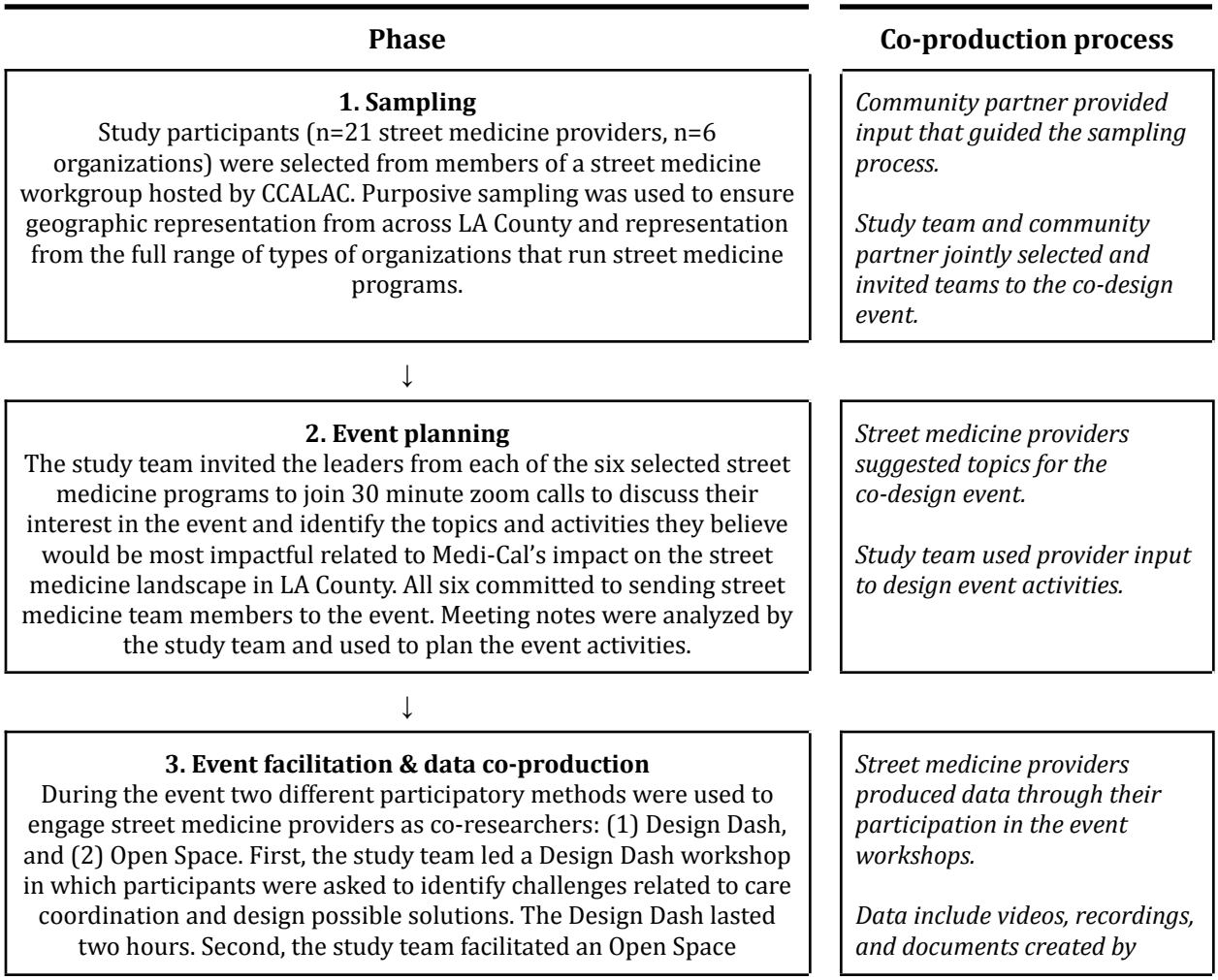
	Selected topics (# of votes received)	**Description**
1	Collaboration, communication, and coordination between street teams in MacArthur Park (25 votes)	Multiple street medicine teams from different organizations have been sent by funders and other stakeholders to offer services in MacArthur Park. Providers are finding that they are serving the same patients, and there is a need for better coordination. The Open Space group designed a pilot project to coordinate the teams coming to the park. The plan includes (1) a community needs and gaps assessment, (2) coordination of "the three Ss," scope, staffing, and schedules, and a dedicated person/agency to handle administrative support, (3) presenting a united front to patients by branding the project (i.e., "MacPark Health"), agreeing on messaging, and forming MOUs across the participating organizations, (4) an information sharing approach that respects patient privacy and monthly case conferencing to discuss complex patients and manage provider panels.
2	Breaking down the LA Care "Field Medicine" funding proposal to create a united response. (22 votes)	LA Care proposed a payment model to cover "Field Medicine" in late 2023 and shared the proposal with street medicine providers for feedback. The Open Space group discussed the details of the proposal and developed an outline of their preferred changes. Since street medicine teams are based at different types of organizations (e.g., hospitals, clinics, medical groups, county), Medi-Cal reimbursement is likely to impact each differently. The group emphasized the need to develop a "unified response" that doesn't advantage one type of organization at the expense of another. Key issues include (1) setting equitable and sustainable rates, (2) seeing patients on the street regardless of provider assignment, and (3) the need for additional infrastructure and capacity to handle referrals.
3	Recruiting and sustaining the workforce and increasing the quantity and diversity of specialty care disciplines. (14 votes)	Before the last couple of years, there was a lot of interest in street medicine but very few jobs. Now, there are lots of jobs, especially in Los Angeles, but an underdeveloped pipeline to onboard and retain a street medicine workforce. Challenges include (1) developing accurate and clear job descriptions, (2) the need for robust onboarding, (3) the need to be "strategic, creative, and assertive" when recruiting, (4) establishing clear street medicine competencies, (5) professional development opportunities, (6) creating a trauma-informed work environment, (7) taking people away from billable hours to support ongoing training and retention.

4	Linking housing and street medicine. (12 votes)	The group came to three assertions about housing and street medicine: (1) street medicine providers need access to low-barrier housing, including medical respite/recuperative care, rehab, or motels; (2) street medicine providers should continue to provide care to their patients in transitional and permanent housing including motels, at least in the short term (an idea, they admit, might be controversial among street medicine providers); (3) street medicine providers have a key role in guiding patients to the appropriate level of ongoing care to ensure successful housing outcomes and successful access to a primary medical home. Key takeaways: street medicine teams want to be able to say, "Here's housing for you in the interim while we are waiting for permanent housing [...] and we need long-term care planning because when a patient with complex needs gets housing, they will need ongoing support."

Source: Author's transcription from the event posters and recordings of the event.

Figures

Figure A1. Sampling and Data Collection Procedures



workshop, which is a facilitation approach that allows participants to vote on any topic they would like to discuss and self-select into participant-led learning sessions. The theme of the Open Space was "the future of street medicine." The Open Space workshop lasted two and a half hours.	*event participants.*
↓	
5. Analysis The study team (C.R., J.H. and I.C.) conducted a first pass at analyzing materials produced during the design event. Documents (such as posters and worksheets) produced by participants during the event were analyzed using content analysis. Videos and audio recordings taken by facilitators during the event were reviewed by the study team using a memoing approach to identify the key themes. The study team's summary of participants' work during the event workshops is presented in tables A3 and A5. We wrote five recommendations based on our analysis of the workshop materials.	*Study team analyzed workshop data and produced tables summarizing the findings.* *Study team drafted five recommendations based on data collected during the event.*
↓	
5. Member checking A first pass of the study findings and recommendations was shared with all 21 event participants with an invitation to provide feedback. Six participants met with the study team for 30-minute calls to discuss their feedback. Three participants provided written feedback. The findings in this paper reflect the study team's initial synthesis of the output of the co-design event, and incorporates all of the feedback and suggestions received by participants during the member checking process.	*Study team shared a draft of the workshop findings and recommendations with event participants.* *Event participants provided input and feedback.* *Study team incorporated input and produced study findings.*

Conclusion

Integrating social and medical care has the potential to make services for older people, people with disabilities, and people experiencing homelessness more accessible, impactful, and cost effective.[12,15,80,119] However, the theorized benefits of integrated social and medical care have been challenging to achieve in practice.[18,19,21–23] This dissertation explores the perspectives of county leaders, healthcare payors, and frontline providers on care integration for older and disabled people in the San Francisco Bay Area and people experiencing homelessness in Los Angeles County.

The first aim of this dissertation is to identify the challenges and opportunities that San Francisco Bay Area counties face in delivering services to older people and people with disabilities. We conducted 31 key informant interviews with Bay Area leaders in Adult and Aging Services and reviewed county administrative data, and publicly available data sets. We found that demand for county Adult and Aging services is growing, outpacing growth in funding, staffing, and service capacity. Further, we found that client and family needs are becoming more complex, demanding new workforce capabilities and program offerings. County leaders reported a need to (1) grow the adult and aging services workforce; (2) adopt new policies, procedures, and approaches to management; (3) build partnerships; (4) integrate services and use a client-centered approach; (5) seek new and more flexible funding; (6) develop equitable and responsive programs and workplaces; and (7) educate about ageism. Overall, our results suggest that quality and access to services can be expected to decline without expanded Adult and Aging services capacity, and that efforts to integrate social and medical care will likely play an important role in improving service quality and access in the coming years.

The second aim of this dissertation is to describe the motivations and tensions reported by healthcare and homeless services providers in Los Angeles County who are involved in integrated housing and health services for people experiencing homelessness. We conducted 54 interviews with professionals from the homeless services and healthcare sectors whose work directly involves integrating social and medical care for people experiencing homelessness in Los Angeles County: 19 staff at homeless services agencies, 17 staff at healthcare provider organizations, 12 staff at local government agencies, and 6 staff at Medi-Cal managed care plans. Qualitative interviews were transcribed, coded, and analyzed using an iterative inductive and deductive approach. We find that medical and homeless services providers described multiple motivations for integrating care, including (1) increased institutional pressure to address the homelessness crisis, (2) growing awareness of the relationship between housing and health, and (3) funding and policy shifts that support integration of care. They also described tensions associated with care integration efforts relating to (1) resource scarcity (2) conflicting goals, (3) conflicting beliefs, and (4) governance dynamics. These results underscore that few organizations have the services and capabilities necessary to meet the full range of care needs of people

experiencing homelessness, and organizations are pursuing care integration often through cross-sector partnerships. It is also clear from our findings that key informants believe that the lack of affordable housing will place upward limits on the potential benefits that can be achieved through Medi-Cal investments in housing navigation and care management for unhoused patients.

The third and final aim of this dissertation is to explore street medicine providers' perspectives on the impact of newly available Medicaid funding on their service model. We held a co-design event attended by 21 street medicine providers from healthcare, government, and private nonprofit organizations in Los Angeles County. Qualitative data including documents, videos, and audio recordings were produced by providers through their participation in the event workshops. Data were analyzed by the study team using content analysis and memoing, and study findings were written with ongoing input from the event participants through an iterative member checking process. We found that street medicine providers reported a mixture of trepidation and excitement about the growing interest in and funding for street medicine. They made five recommendations for ways to address the challenges and opportunities they see in the street medicine landscape concerning (1) geographic service gaps, (2) coordination and data sharing, (3) trust building with patients, (4) access to housing, and (5) access to specialty care and other medically necessary services. These findings highlight how Medi-Cal funding and new state and federal guidance is changing the street medicine service landscape in Los Angeles County, and describe the potential to leverage this new funding to improve access to medical care and housing for people experiencing unsheltered homelessness.

Taken together, these studies suggest that diverse stakeholders including county leaders, payors, and providers of healthcare and social services see social and medical care integration as an important strategy for improving care access and effectiveness. Further, this research also suggests that Medicaid investment in health-related social needs services, while important, is not a substitute for investments in basic resources like housing supply that operate as underlying drivers of the social problems like homelessness[120] or addressing the caregiver shortage to ensure people have the support to safely age in place.[121] Finally, these studies provide early evidence that organizations that provide health-related social services are changing how their services and organizations are structured to position themselves to secure healthcare contracts as a new source of badly needed revenue. Thus, these papers illustrate the importance of considering the impacts of Medicaid policy changes on other sectors of care, such as the traditional homeless services system and county adult and aging services.

These findings should be considered in light of several limitations. First, all three dissertation studies take place in major metropolitan areas in California. Therefore, the findings may not be representative of the dynamics of social and medical care integration in more rural settings. Second, California has gone further than many other states in using Medicaid funding to pay for health-related social needs services, and even among other

states that have implemented similar Medicaid waivers, there is considerable variation in how those waivers are designed. Thus, findings in California may have limited generalizability to other state integration efforts.

Future research should build on these findings by exploring the impact of Medicaid financing on social services that are covered by healthcare payors. In particular, research should explore possible changes in service eligibility, access, scope, duration, desirability, and effectiveness of reimbursable social services. Such research would contribute to our understanding of the suitability and feasibility of delivering narrowly targeted social service interventions under a Medicaid payment regime. Additionally, future research should study the strategies organizations use to manage or resolve the tensions associated with care integration that we and others have identified. Finally, future research should explore mergers, acquisitions, and consolidations among social services agencies that deliver health-related social needs services, the use of strategic alliances by CBOs to secure competitive advantages in healthcare contracting, and the entrance of national for-profit organizations seeking Medicaid contracts to deliver health-related social needs services.

In conclusion, this dissertation explores social and medical care integration for older and disabled people in the San Francisco Bay Area and people experiencing homelessness in Los Angeles County, California. We find that in both cases, demographic changes are straining the capacity of highly fragmented services systems. We elevate the voices of professionals who fund, oversee, and deliver services who say they see a need for more integrated care to improve service access and quality.

References

1. Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, Health, And Cost. *Health Aff (Millwood)*. 2008;27(3):759-769. doi:10.1377/hlthaff.27.3.759
2. Marmot MG. *The Health Gap: The Challenge of an Unequal World*. Bloomsbury Press; 2015.
3. Bradley EH, Taylor LA. *The American Health Care Paradox: Why Spending More Is Getting Us Less*. First edition. PublicAffairs; 2013.
4. Amelia W, Nancy DL, Andre C, Victoria A, Rachael Z, Benjamin D. S. *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*. Assistant Secretary for Planning and Evaluation; 2022.
5. Castrucci BC, Auerbach J. Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health. *Health Aff Forefr*. Published online 2019. Accessed April 27, 2024. https://www.healthaffairs.org/do/10.1377/forefront.20190115.234942/full/
6. Chuang E, Safaeinili N. Addressing Social Needs in Clinical Settings: Implementation and Impact on Health Care Utilization, Costs, and Integration of Care. Published online December 22, 2023. doi:10.1146/annurev-publhealth-061022-050026
7. MACPAC. *Medicaid's Role in Housing*. Medicaid and CHIP Payment and Access Commission; 2021.
8. Fichtenberg C, Delva J, Minyard K, Gottlieb LM. Health And Human Services Integration: Generating Sustained Health And Equity Improvements. *Health Aff Proj Hope*. 2020;39(4):567-573. doi:10.1377/hlthaff.2019.01594
9. Opoku ST, Owens CF, Apenteng BA, Kimsey L, Peden AH. State Expectations and Medicaid Managed Care Organizations' Efforts to Address the Social Needs of Medicaid Enrollees. *Med Care Res Rev MCRR*. 2022;79(6):811-818. doi:10.1177/10775587221096262
10. Glied S, D'Aunno T. Health Systems and Social Services—A Bridge Too Far? *JAMA Health Forum*. 2023;4(8):e233445. doi:10.1001/jamahealthforum.2023.3445
11. Lantz PM. The Medicalization of Population Health: Who Will Stay Upstream? *Milbank Q*. 2019;97(1):36-39. doi:10.1111/1468-0009.12363
12. NASEM. *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*. NASEM; 2019. Accessed February 15, 2021. http://www.ncbi.nlm.nih.gov/books/NBK552597/
13. Crocker H, Kelly L, Harlock J, Fitzpatrick R, Peters M. Measuring the benefits of the integration of health and social care: qualitative interviews with professional stakeholders and patient representatives. *BMC Health Serv Res*. 2020;20(1):515. doi:10.1186/s12913-020-05374-4
14. Singer SJ, Kerrissey M, Friedberg M, Phillips R. A Comprehensive Theory of Integration. *Med Care Res Rev MCRR*. 2020;77(2):196-207. doi:10.1177/1077558718767000
15. Melnikow J, Ritley D, Loureiro S, et al. *Integrating Care for People Experiencing Homelessness: A Focus on Sacramento County*. University of California, Davis. Center for Healthcare Policy and Research; 2020.
16. Programs of All-Inclusive Care for the Elderly Benefits. Medicaid. Accessed April 27,

2024.
https://www.medicaid.gov/medicaid/long-term-services-supports/pace/programs-all-inclusive-care-elderly-benefits/index.html
17. Taylor LA, Byhoff E. Money Moves the Mare: The Response of Community-Based Organizations to Health Care's Embrace of Social Determinants. *Milbank Q*. Published online January 11, 2021. doi:10.1111/1468-0009.12491
18. Alderwick H, Hutchings A, Briggs A, Mays N. The impacts of collaboration between local health care and non-health care organizations and factors shaping how they work: a systematic review of reviews. *BMC Public Health*. 2021;21(1):753. doi:10.1186/s12889-021-10630-1
19. Bryson JM, Crosby BC, Stone MM. Designing and Implementing Cross-Sector Collaborations: Needed and Challenging. *Public Adm Rev*. 2015;75(5):647-663. doi:10.1111/puar.12432
20. Fichtenberg CM, De Marchis EH, Gottlieb LM. Understanding Patients' Interest in Healthcare-Based Social Assistance Programs. *Am J Prev Med*. 2022;63(3 Suppl 2):S109-S115. doi:10.1016/j.amepre.2022.04.026
21. Lanford D, Petiwala A, Landers G, Minyard K. Aligning healthcare, public health and social services: A scoping review of the role of purpose, governance, finance and data. *Health Soc Care Community*. 2022;30(2):432-447. doi:10.1111/hsc.13374
22. Mosley JE. Cross-Sector Collaboration to Improve Homeless Services: Addressing Capacity, Innovation, and Equity Challenges. *Ann Am Acad Pol Soc Sci*. 2021;693(1):246-263. doi:10.1177/0002716221994464
23. Willison CE, Lillvis D, Mauri A, Singer PM. Technically Accessible, Practically Ineligible: The Effects of Medicaid Expansion Implementation on Chronic Homelessness. *J Health Polit Policy Law*. 2021;46(6):1019-1052. doi:10.1215/03616878-9349142
24. California Department of Aging. Master Plan for Aging. Master Plan for Aging. Published 2021. Accessed December 6, 2021. https://mpa.aging.ca.gov/
25. Moses K. Enhancing Care for People Experiencing Homelessness: A Ground-Level View of California's Medicaid Transformation Initiative - CHCS Blog. Center for Health Care Strategies. Published October 3, 2022. Accessed April 27, 2024. https://www.chcs.org/implementing-calaim-for-people-experiencing-homelessness-a-ground-level-view-of-californias-medicaid-transformation-initiative/
26. Chuang E, Carnochan S, Yang E, Davis E, Dill J. *California Adult Social Services Workforce Report*. CA: Bay Area Social Services Consortium, the Mack Center on Public and Nonprofit Management in the Human Services, and the California Social Work Education Center, School of Social Welfare, UC Berkeley.; 2021.
27. Howle EM. *In-Home Supportive Services Program: It Is Not Providing Needed Services to All Californians Approved for the Program, Is Unprepared for Future Challenges, and Offers Low Pay to Caregivers*. California State Auditor; 2021. https://information.auditor.ca.gov/pdfs/reports/2020-109.pdf
28. CDA. Facts About California's Elderly - Data & Reports. California Department of Aging. Accessed April 27, 2024. https://aging.ca.gov/Data_and_Reports/Facts_About_California%27s_Elderly/
29. Beck L, Johnson H. *Planning for California's Growing Senior Population*. Public Policy Institute of California; 2015.
30. *Older Americans Act: Overview and Funding*. Congressional Research Service; 2023.

31. Resnikoff N, Johnson B, Barocio J. *The 2021-22 Budget: CalAIM: New Directions for Services for Seniors and Persons With Disabilities*. The Legislative Analyst's Office; 2021. Accessed May 11, 2022. https://lao.ca.gov/Publications/Report/4404
32. Kushel M, Moore T. *Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness.* UCSF Benioff Homelessness and Housing Initiative.; 2023.
33. Vickery KD, Winkelman TNA, Ford BR, et al. Trends in Trimorbidity Among Adults Experiencing Homelessness in Minnesota, 2000-2018. *Med Care*. 2021;59(Suppl 2):S220-S227. doi:10.1097/MLR.0000000000001435
34. Thorndike AL, Yetman HE, Thorndike AN, Jeffrys M, Rowe M. Unmet health needs and barriers to health care among people experiencing homelessness in San Francisco's Mission District: a qualitative study. *BMC Public Health*. 2022;22(1):1071. doi:10.1186/s12889-022-13499-w
35. Liu M, Hwang SW. Health care for homeless people. *Nat Rev Dis Primer*. 2021;7(1):1-2. doi:10.1038/s41572-020-00241-2
36. Fraze TK, Beidler LB, Savitz LA. "It's Not Just the Right Thing . . . It's a Survival Tactic": Disentangling Leaders' Motivations and Worries on Social Care. *Med Care Res Rev MCRR*. 2022;79(5):701-716. doi:10.1177/10775587211057673
37. Kushel M. The First Step is the Hardest: Overcoming Barriers to Primary Care. *J Gen Intern Med*. 2015;30(7):868-869. doi:10.1007/s11606-015-3279-5
38. Polcin DL. Co-occurring substance abuse and mental health problems among homeless persons: Suggestions for research and practice. *J Soc Distress Homeless*. 2016;25(1):1-10. doi:10.1179/1573658X15Y.0000000004
39. All Plan Letter 22-023. Published online November 8, 2022.
40. Lynch KA, Harris T, Jain SH, Hochman M. The Case for Mobile "Street Medicine" for Patients Experiencing Homelessness. *J Gen Intern Med*. 2022;37(15):3999-4001. doi:10.1007/s11606-022-07689-w
41. Feldman BJ, Kim JS, Mosqueda L, et al. From the hospital to the streets: Bringing care to the unsheltered homeless in Los Angeles. *Healthcare*. 2021;9(3):100557. doi:10.1016/j.hjdsi.2021.100557
42. Feldman BJ, Corinne T. F, Kogan AC, Saluja S, Cousineau M. *The California Street Medicine Landscape Survey and Report*.; 2023.
43. Okoro CA. Prevalence of Disabilities and Health Care Access by Disability Status and Type Among Adults — United States, 2016. *MMWR Morb Mortal Wkly Rep*. 2018;67. doi:10.15585/mmwr.mm6732a3
44. Didier A, Newton MC. *A Long-Term Outlook: Disability Among California's Seniors*. The Legislative Analyst's Office; 2016.
45. Johnson H, McGhee E, Subramaniam C, Hsieh V. *Race and Diversity in the Golden State*. Public Policy Institute of California; 2023.
46. Legislative Analyst's Office. California's Fiscal Outlook: In-Home Supportive Services (IHSS). Published November 14, 2018. Accessed November 1, 2022. https://lao.ca.gov/Publications/Report/3899
47. Menicocci R. *Adult Protective Services FY 2021 Annual Report*. County of Santa Clara Social Services Agency; 2022.
48. Mecca FJ. *California Can Stem the Tidal Wave of Senior Citizen Homelessness.*; 2020. https://calmatters.org/economy/2020/03/california-senior-homelessness-p/

49. Blanco C, Lennon I. Substance Use Disorders in Older Adults: Overview and Future Directions. *Generations*. 2021;44(4):1-7.
50. Frank JC, Kietzman KG, Palimaru A. *California's Behavioral Health Services Workforce Is Inadequate for Older Adults*. UCLA Center for Health Policy Research; 2019.
51. *Addressing the Nation's Retirement Crisis: The 80%*. National Council on Aging; 2023.
52. *Asset Limit Changes for Non-MAGI Medi-Cal*. California Department of Health Care Services; 2024. https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Asset-Limit-Changes-for-Non-MAGI-Medi-Cal.aspx
53. Garfield R, Musumeci M, Reaves EL, Damico A. *Medicaid's Role for People with Dementia*. Kaiser Family Foundation; 2015.
54. *Hunger, Poverty, and Health During COVID-19*. Food Research & Action Center; 2021.
55. *Home Safe Program FACT SHEET*. California Department of Social Services; 2020.
56. *2017 CWDA Adult Services Workforce Survey Summary*. County Welfare Directors Association; 2018. Accessed November 1, 2022. https://www.cwda.org/sites/main/files/file-attachments/2017_cwda_wf_survey_final.pdf?1521479594
57. Institute of Medicine. *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* National Academies Press; 2012:13400. doi:10.17226/13400
58. Living Wage Calculator. Accessed April 27, 2024. https://livingwage.mit.edu/
59. Understanding the Lanterman-Petris-Short (LPS) Act | Disability Rights California. Published January 8, 2018. Accessed April 27, 2024. https://www.disabilityrightsca.org/publications/understanding-the-lanterman-petris-short-lps-act
60. Services D of HC. Senate Bill (SB) 1338: Community Assistance, Recovery, and Empowerment Act CARE-ACT. Accessed April 27, 2024. https://www.dhcs.ca.gov/Pages/CARE-ACT.aspx
61. Nonprofit Finance Fund. State of the Nonprofit Sector Survey: 2022 Survey Results. Nonprofit Finance Fund. Accessed November 1, 2022. https://nff.org/learn/survey
62. Williamson S, Pearce A, Connor J, Weeratunga V, Dickinson H. The future of working from home in the public sector: What does the evidence tell us? *Aust J Public Adm*. 2022;81(4):640-648. doi:10.1111/1467-8500.12556
63. Kochhar R, Parker K, Igielnik R. *Majority of U.S. Workers Changing Jobs Are Seeing Real Wage Gains*. Pew Research Center; 2022.
64. USAging. *Policy Priorities 2022*. USAging; 2022. Accessed May 10, 2022. https://www.usaging.org/
65. Healthy Minds-Healthy Aging. Mentis Napa. Published 2024. Accessed April 27, 2024. https://mentisnapa.org/our-services/older-adults/
66. Measure K Funding Update. San Mateo County Measure K. Published 2024. Accessed April 27, 2024. https://smcmeasurek.org/
67. Benjamin AE, Matthias R, Franke TM. Comparing consumer-directed and agency models for providing supportive services at home. *Health Serv Res*. 2000;35(1 Pt 2):351-366.
68. Center for Health Care Strategies, Decipher Health Strategies, Chapman Consulting. *CalAIM and Institutional Long-Term Care: Lessons for Medi-Cal Managed Care*. California Health Care Foundation; 2022.

69. Ageing: Ageism. World Health Organization. Published March 18, 2021. Accessed April 27, 2024. https://www.who.int/news-room/questions-and-answers/item/ageing-ageism
70. Robbins LA. The Pernicious Problem of Ageism. *Generations*. 2015;39(3):6-9.
71. O'Neil M, Haydon A. *Aging, Agency, and Attribution of Responsibility: Shifting Public Discourse about Older Adults*. The FrameWorks Institute; 2015:31.
72. About the Global Network for Age-friendly Cities and Communities. Age-Friendly World. Accessed November 1, 2022. https://extranet.who.int/agefriendlyworld/who-network/
73. Caprara C, Obermark D, Rountree J, Santillano R. *Serious Mental Illness among People Who Are Unsheltered in Los Angeles*. California Policy Lab; 2022.
74. Gutwinski S, Schreiter S, Deutscher K, Fazel S. The prevalence of mental disorders among homeless people in high-income countries: An updated systematic review and meta-regression analysis. *PLoS Med*. 2021;18(8):e1003750. doi:10.1371/journal.pmed.1003750
75. Liu CY, Chai SJ, Watt JP. Communicable disease among people experiencing homelessness in California. *Epidemiol Infect*. 148:e85. doi:10.1017/S0950268820000722
76. Stringfellow EJ, Kim TW, Pollio DE, Kertesz SG. Primary care provider experience and social support among homeless-experienced persons with tri-morbidity. *Addict Sci Clin Pract*. 2015;10(Suppl 1):A64. doi:10.1186/1940-0640-10-S1-A64
77. Davies A, Wood LJ. Homeless health care: meeting the challenges of providing primary care. *Med J Aust*. 2018;209(5):230-234. doi:10.5694/mja17.01264
78. O'Connell JJ. *Premature Mortality in Homeless Populations: A Review of the Literature*. National Health Care for the Homeless Council, Inc.; 2005.
79. *New Public Health Report Shows Sharp Rise in Mortality Among People Experiencing Homelessness*. Los Angeles County Department of Public Health; 2023.
80. National Academies of Sciences, Engineering, and Medicine (U.S.), ed. *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes among People Experiencing Chronic Homelessness*. The National Academies Press; 2018. doi:10.17226/25133
81. Doran KM, Ragins KT, Gross CP, Zerger S. Medical respite programs for homeless patients: a systematic review. *J Health Care Poor Underserved*. 2013;24(2):499-524. doi:10.1353/hpu.2013.0053
82. Withers J. Street medicine: an example of reality-based health care. *J Health Care Poor Underserved*. 2011;22(1):1-4. doi:10.1353/hpu.2011.0025
83. Aubry T, Bloch G, Brcic V, et al. Effectiveness of permanent supportive housing and income assistance interventions for homeless individuals in high-income countries: a systematic review. *Lancet Public Health*. 2020;5(6):e342-e360. doi:10.1016/S2468-2667(20)30055-4
84. Potter AJ, Wilking J, Nevarez H, Salinas S, Eisa R. Interventions for Health: Why and How Health Care Systems Provide Programs to Benefit Unhoused Patients. *Popul Health Manag*. 2020;23(6):445-452. doi:10.1089/pop.2019.0217
85. Cheng SM, Catallo C. Conceptual framework: factors enabling collaborative healthcare and social services integration. *J Integr Care*. 2020;28(3):215-229. doi:10.1108/JICA-11-2019-0048

86. Agonafer EP, Carson SL, Nunez V, et al. Community-based organizations' perspectives on improving health and social service integration. *BMC Public Health*. 2021;21(1):452. doi:10.1186/s12889-021-10449-w
87. Yin RK. *Case Study Research and Applications Design and Methods*. SAGE Publications, Inc; 2017.
88. LAHSA Releases Results Of 2023 Greater Los Angeles Homeless Count. Accessed April 27, 2024. https://www.lahsa.org/news?article=927-lahsa-releases-results-of-2023-greater-los-angeles-homeless-count
89. Howle EM. *Homelessness in California The State's Uncoordinated Approach to Addressing Homelessness Has Hampered the Effectiveness of Its Efforts*. California State Auditor; 2021.
90. Kimberlin S, Davalos M. *Understanding Homelessness in California & What Can Be Done*. The California Budget & Policy Center; 2023.
91. Services D of HC. Medi-Cal Transformation: DHCS is transforming Medi-Cal to ensure that Californians get the care they need to live healthier lives. Published n.d. Accessed April 28, 2024. https://www.dhcs.ca.gov/CalAIM
92. Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Adm Policy Ment Health*. 2015;42(5):533-544. doi:10.1007/s10488-013-0528-y
93. Bradley EH, Curry LA, Devers KJ. Qualitative Data Analysis for Health Services Research: Developing Taxonomy, Themes, and Theory. *Health Serv Res*. 2007;42(4):1758-1772. doi:10.1111/j.1475-6773.2006.00684.x
94. Ruder DB. *Street Doctor: For Three Decades, James O'Connell Has Cared for the Homeless.* Harvard Magazine; 2016. https://www.harvardmagazine.com/2015/12/street-doctor
95. Withers J. Jim Withers' Story and Blog. Published 2024. Accessed April 27, 2024. https://www.streetmedicine.org/letters-from-the-founder
96. Doohan NC, Mishori R. Street Medicine: Creating a "Classroom Without Walls" for Teaching Population Health. *Med Sci Educ*. 2020;30(1):513-521. doi:10.1007/s40670-019-00849-4
97. Melissa J. *Healing Hands: Street Medicine and Outreach: Bringing Care to People Where They Are.* Street Medicine: Creating a "Classroom Without Walls" for Teaching Population Health; 2022.
98. *Street Medicine or Mobile Medical Unit? Considerations for Expanding Medical Outreach*. National Health Care for the Homeless Council, Inc.; 2022.
99. Enich M, Tiderington E, Ure A. Street Medicine: A Scoping Review of Program Elements. *Int J Homelessness*. 2022;Vol. 3(No. 2). doi:https://doi.org/10.5206/ijoh.2022.2.15134
100. Birnbaum M, Burns J. Under historic rule, providers will get paid for treating the homeless. Association of Health Care Journalists. Published November 14, 2023. Accessed April 27, 2024. https://healthjournalism.org/blog/2023/11/under-historic-rule-providers-will-get-paid-for-treating-the-homeless/
101. California Street Medicine Collaborative. Street Medicine. Accessed April 27, 2024.

https://keck.usc.edu/street-medicine/california-street-medicine-collaborative/
102. *Dissecting the Street Medicine Landscape Analysis with Street Medicine Leaders.*; 2023. Accessed April 27, 2024. https://www.youtube.com/watch?v=j49BuP0vuJg
103. *California Advancing and Innovating Medi-Cal (CalAIIM) Homelessness or Housing Instability*. California Department of Health Care Services; n.d. https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-HHI-a11y.pdf
104. *A Game Changer for Street Medicine: Key Takeaways from New Medi-Cal Guidelines*. California Health Care Foundation; 2022.
105. Services D of HC. Housing and Homelessness Incentive Program. Published n.d. Accessed April 27, 2024. https://www.dhcs.ca.gov/services/Pages/Housing-and-Homelessness-Incentive-Program.aspx
106. Health Net Awards $1.5 Million Grant to Keck School of Medicine to Enable Street Medicine Teams to Better Serve Unsheltered Populations Across California | Health Net. Published February 14, 2023. Accessed April 27, 2024. https://www.healthnet.com/content/healthnet/en_us/news-center/news-releases/2023-02-14-hn-awards-grant-to-keck-school-of-medicine-to-enable-street-medicine-teams-to-better-serve-unsheltered-populations-across-ca.html
107. L.A. Care Invests More than $4 Million in a Street Medicine Initiative | L.A. Care Health Plan. Published August 23, 2023. Accessed April 27, 2024. https://www.lacare.org/news/news-releases/la-care-invests-more-4-million-in-street-medicine-initiative
108. About Us: What is the Street Medicine Institute? Published n.d. Accessed April 27, 2024. https://www.streetmedicine.org/about-us
109. Tito E. Street Medicine: Barrier Considerations for Healthcare Providers in the U.S. *Cureus*. Published online May 9, 2023. doi:10.7759/cureus.38761
110. Kuhn R, Henwood B, Chien J. *Periodic Assessment of Trajectories of Housing, Homelessness and Health (PATHS): Fall 2023 Update: Encampment Sweeps and Housing Trajectories*. UCLA Campuswide Homelessness Initiative; 2023.
111. Mayor Bass Announces Appointment of Deputy Mayor of Homelessness & Community Health | Mayor Karen Bass. Published February 13, 2024. Accessed April 28, 2024. https://mayor.lacity.gov/news/mayor-bass-announces-appointment-deputy-mayor-homelessness-community-health
112. Street medicine for those most in need – Homeless Initiative. Published January 9, 2020. Accessed April 28, 2024. https://homeless.lacounty.gov/the-way-home/street-medicine-for-those-most-in-need/
113. UCLA Health receives $25.3 million for street medicine program caring for homeless. UCLA. Published March 1, 2023. Accessed April 28, 2024. https://newsroom.ucla.edu/releases/ucla-health-homeless-medicine-program-gets-25-million
114. Rubeo C, Chavez I, Heibel J. *Linking Social and Medical Care for People Experiencing Homelessness: A Study of Partnerships in Los Angeles County.*. Center for Care Innovations; 2024.
115. LA County Street Medicine Coordination Collaborative. Community Clinic Association of Los Angeles County. Published February 18, 2022. Accessed April 28, 2024.

https://ccalac.org/services/policy-and-advocacy/la-county-street-medicine-coordination-workgroup/
116. Wilson MC. Introducing the Design Dash. Molly Clare Wilson. Published January 20, 2018. Accessed April 28, 2024. https://molly.is/writing/design-dash/
117. Owen H. A Brief User's Guide to Open Space Technology | Open Space World. Published n.d. Accessed April 28, 2024. https://openspaceworld.org/wp2/hho/papers/brief-users-guide-open-space-technology/
118. Our Vision & Mission. Street Medicine Institute. Published n.d. Accessed April 28, 2024. https://www.streetmedicine.org/our-vision-mission
119. World Health Organization. *Integrated Care for Older People (ICOPE): Guidance for Person-Centred Assessment and Pathways in Primary Care*.; 2019.
120. Colburn G, Aldern CP. *Homelessness Is a Housing Problem: How Structural Factors Explain U.S. Patterns*. University of California Press; 2022.
121. Chapman SA, Greiman L, Bates T, et al. Personal Care Aides: Assessing Self-Care Needs And Worker Shortages In Rural Areas. *Health Aff (Millwood)*. 2022;41(10):1403-1412. doi:10.1377/hlthaff.2022.00483